Patient, Quality, Safety & Outcomes Committee

Wed 11 October 2023, 09:30 - 12:30

Microsoft Teams

Agenda

0 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 26th July 2023

Attached *Chair*

1.4 Draft PQSOC Minutes 26th July 2023 Chair Approved.pdf (16 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 DRAFT PQSOC Action Log October 2023 UPDATED following 26.7.23 meeting.pdf (4 pages)

0 min

2. Items for Approval/Ratification

No agenda item for this section

0 min

3. Items for Discussion

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

Attached *Clinical Executive Directors*

Pillars of Quality:

- Infection Prevention Control and Safeguarding
- Incident Report and Health & Safety and Security
- Patient and Staff feedback and Complaints and Concerns

3.1 PQSOC Performance Report - October 2023.pdf (108 pages)
3.1a Draft PQSOC QOF paper Sept 23.pdf (4 pages)
3.1b 202326 Quarter 2 Outcome and Performance Quality and Safety_Final.pdf (37 pages)

3.2. Mental Health and Learning Disabilities

Attached *Director of Nursing*

- NHS Wales Delivery Unit Review of Mental Health Crisis & Service for Older Adults
- HIW Mental Health Discharge Review

3.2 SBAR DU report on crisis liaison Sep 23 Final Draft.pdf (6 pages)
3.2a . NHS Wales Delivery Unit Review of Older Adult Crisis and Liaison Servcies in ABUHB Final Report March 2023.pdf (28 pages)
3.2b HIW CTM discharge recomendations docx.pdf (4 pages)

3.3. Committee Risk Report

Attached *Director of Corporate Governance*

3.3 Strategic Risk Report_PQSOC_Oct2023 Final.pdf (7 pages)
3.3a Appendix E SRR 010_Transformation & Partnership Working Risk to a Page_Director of Nursing.pdf (1 pages)
3.3b Appendix 2 RGH Robot Operational Risk to a Page_Final 28.09.23 .pdf (1 pages)
3.3c Appendix A PQSOC Strategic Risk Register.pdf (1 pages)
3.3d Appendix B SRR 003A - Compliance & Safety Risk to a Page_ Director of Nursing.pdf (1 pages)
3.3e Appendix C SRR 003B_Compliance & Safety Risk to a Page_Chief Operating Officer.pdf (2 pages)
3.3f Appendix D SRR 005A_Service Delivery_Risk to a Page_Chief Operating Officer.pdf (1 pages)

3.4. Maternity Service Update

Attached *Director of Nursing*

To include:

- Maternity Services Organisational Improvement Plan
- Maternity and Neonatal Safety Support Programme
- MBBRACE

3.4 06062023- TheGrangeUniversityHospitalEN (002).pdf (44 pages)
3.4a 03477 GUH Maternity HIW - Immediate Assurance - ABUHB Response - updated 26.09.2023(1).pdf (8 pages)
3.4b 03477 GUH Maternity Improvement Plan - July 2023 (002).pdf (10 pages)
3.4c mat neo ssp26Sept.pdf (6 pages)
3.4d 2023-08-07 - MatNeoSSP Discovery Phase Priorities - Working Spreadsheet - to Share - Copy.pdf (11 pages)

3.5. Pharmacy Robot

Attached *Medical Director*

3.5 PQSOC - Pharmacy RGH Robot Risk Update.pdf (18 pages)
3.5a Worksheet in C Users fe052001 AppData Local Microsoft Windows INetCache Content.Outlook FJ1C466F PQSOC - Pharmacy RGH Robot Risk Update.pdf (1 pages)

3.6. Committee Self Assessment

Attached *Director of Corporate Governance*

3.6 PQSOC_Self Assessment of Committee Effectiveness Cover Report.pdf (4 pages)
3.6a Appendix One PQSOC Self Assessment Template RD.pdf (10 pages)

3.7. National Incident Reporting Policy

Attached *Director of Nursing*

3.7 Patient Safety Incident Policy SBAR.pdf (6 pages)
3.7a Patient Safety Incident Reporting Management Policydocx.pdf (32 pages)

0 min

4. Items for Information

4.1. Highlight Reports

Attached *Clinical Executive Directors*

A) Clinical Effectiveness and Standards Committee Report

- 4.1c Minutes Clinical Standards Effectiveness Group July 2023.pdf (10 pages)
- 4.1c PQSOC Final Clinical Audit Activity Report Oct 2023.pdf (45 pages)

4.2. WHSSC QPS Committee Report

Attached *Director of Nursing*

- 4.2 Quality Patient Safety Committee Chairs Report August 2023.pdf (7 pages)
- 4.2.c Appendix 3 - WHSSC Newsletter Spring-Summer 2023 Welsh.pdf (10 pages)
- 4.2a Appendix 1 - Summary of Services in Escalation.pdf (8 pages)
- 4.2b Appendix 2 - WHSSC Newsletter Spring-Summer 2023.pdf (10 pages)

4.3. Organ Donation Committee Annual Report

Attached *Medical Director*

- 4.3 SBAR - ODC Annual Report 2022-23.pdf (41 pages)

4.4. PSOW Press release 09/08/2023 - Annual Report

Attached *Director of Nursing*

- 4.4 ABUHB - ENG - 22-23 Annual Letter.pdf (8 pages)
- 4.4a Signed Letter Re Annual Letter.pdf (2 pages)

0 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 13th December 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	Wednesday 26th July 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 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 Moira Bevan- Head of Infection and Prevention Chris O'Connor - Divisional Director for Mental Health and Learning Disabilities Paul Underwood, General Manager - Urgent Care Division Krisztina Kozlovszky - Internal Audit Manager Rebecca Atkinson, Committee Secretariat
APOLOGIES	Nicola Prygodzicz- Chief Executive Stephen Chaney- Deputy Head of Internal Audit Leanne Watkins – Chief Operating Officer Rani Dash- Director of Corporate Governance Karen Hatch- Assistant Director of Therapies and Health Science

PQSOC 2607/1	**Preliminary Matters**
PQSOC 2607/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 2607/1.2	**Apologies for Absence** Apologies for absence were noted.
PQSOC 2607/1.3	**Declarations of Interest** There were no declarations of interest.

PQSOC 2607/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 20th June 2023 were agreed as a true and accurate record.
PQSOC 2607/1.5	**Committee Action Log- July 2023** The Committee received the action log. Members were content with progress made in relation to completed actions and against any outstanding actions. **PQSOC/2504/3.3.2 - Pharmacy and Medicines Management:** The Committee was updated on the report relating to the Pharmacy Robot. James Calvert reported that this update would be presented at a future meeting and the action log updated. **Action: Medical Director / Committee Secretariat** **PQSOC/2006/3.1 - Patient Quality and Safety Outcomes Performance Report, June 2023:** Peter Carr (PC), Director of Therapies and Health Sciences, provided an update on this action. The falls data was proving difficult to collect and confidence was needed in the quality of data before it was presented to a future meeting. **PQSOC/2006/3.3 - MMBRACE UK Perinatal Mortality Data:** Jennifer Winslade (JW), Director of Nursing, reported that this update was now complete and would be brought to the October meeting together with the draft HIW report, and Safety Collaborative Maternity Neonatal report. It was agreed to have a focus on maternity services at the Committee's meeting in October. **Action: Director of Nursing / Committee Secretariat**
PQSOC 2607/2	**Items for Approval/Ratification**
PQSOC 2607/2.1	**No agenda Items for this section**
PQSOC 2607/3	**Items for Discussion**
PQSOC 2607/3.1	**Patient Quality and Safety Outcomes Performance Report, July 2023** Clinical Executives presented the Patient Quality & Safety Outcomes Performance Report for July 2023 to the Committee. The report provided an update on the work being undertaken relating to: • 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.

Jennifer Winslade (JW) Director of Nursing outlined the Performance report for July 2023 the following areas of the presentation were noted.

JW outlined the purpose, benefits, accreditation framework, how to gain accreditation and the project plan for the Ward Accreditation Pilot at Ysbyty Aneurin Bevan. This accreditation will be run in conjunction with other monitoring and assessments as set out in the Health and Social Care (Quality & Engagement) Wales Act 2020. AMaT (Audit Management and Tacking Programme) will be used to manage the process. JW reported that the quality measures were Pressure Ulcer Incidents, falls with harm, Nutrition and Hydration management, Infection Control, Medicine Management, Deteriorating patients and Safeguarding. JW further reported that these are the only metrics needed for the accreditation but not for reporting against the Quality Outcomes Framework, which included other metrics. JW explained the Award Recognition Matrix with an 85% compliance rate for Bronze, Silver, Gold and Platinum (Full accreditation).

Pippa Britton (PB), Chair, thanked the team for work on this project.

Helen Sweetland (HS), Independent Member, asked how the data for this project would be captured. JW reported that the data would be collected centrally with ward managers playing a part.

Paul Deneen (PD), Independent Member, asked if there was any input with Llais and anything visual for patients to see and any barrier that the IM's can help with. JW reported that there had been no barriers reported and all nursing staff were positively engaged. Patients would be able to see the data and improvement plan as they enter the ward, and the data would be published for the public to see. JW will be liaising with Llais at a meeting next week.

	Tracey Partridge-Wilson (TPW), Assistant Director of Nursing outlined the National Reportable Incidents following changes to the NRI Policy in May 2023. Process are currently being streamlined to bring them into line with the new reporting criteria. TPW reported that the data presented for Serious Incidents was incorrect due to data validation and needed the be altered. In May there were 4 red serious incidents which all Executive-led. These cases focussed on areas of nutrition and hydration, treatment, misreporting and access to admission to follow-up and assessment investigations. Since June, and following a meeting with the NHS Executive, ABUHB has reported more as the criteria had changed and the health board was reporting every serious incident with severe harm. TPW reported that there were no new never events for the reporting period. There had been good engagement cross divisionally to reduce the number of these events which is very positive. PB questioned the 'wrong site injection' event. JC assured the Committee that a training programme has been developed to standardise the site injection programme and procedures. JW reported that there had been a never event in July regarding a retained swab. Helen Sweetland (HS), Independent Member, asked whether the Serious Incidents that were not reported before the changes to criteria were investigated and recorded. TPW assured the committee that they were all recorded and investigated via divisional reviews. PD asked for assurance on supervised practice. JC assured the Committee that there is open reporting from theatres regarding incidents and they are highly engaged. Work is ongoing to deliver human factors training, which JC had attended and reported that it was impactful for the staff. Any concerns about any individuals are highlighted and dealt with quickly using supervised practice. Feedback is given from the supervisor and any necessary further action taken.

	The Committee noted that all incidents are being taken seriously, the right actions are being taken and the staff are engaged, and quality and safety are at the heart of the actions. JW reported on the Duty of Candour. Divisions had been engaged and some validation around data was still needed. Welsh Government had given ABUHB some time to embed this Duty given the significance culturally. JW reported that recruitment to the PALs service were being finalised. These would oversee early resolution and intervention with concerns before they become complaints. Targets had been set to 70% as early resolutions and teams were engaged to ensure this happens. Huge progress had been made to reduce the backlog of concerns more than 12 months old and work was now underway to reduce concerns between 9 – 12 months old. JW reported that Hospital Acquired Pressure Ulcers (HAPU) would be a focus for the Quality Outcomes Framework. The data presented was provided with the caveat that validation with staff was required and extra work was needed. JW outlined three areas for development namely improvements with data collection, pressure ulcer care bundles and recording incidents as avoidable and unavoidable. Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided an overview of the Medication Safety Strategy Progress Goal 1. This was a report for information on critically times medicines. A report was received from the NHS Executive asking the Health Board to look at medicines for Parkinsons Disease. LL outlined the work that had been undertaken to date. Pharmacy had looked at how critical times medicines could be accessed in a timely manner and at night. Critically timed medicines have been identified and nurses undertaken training on new systems. LL presented a perfect patient journey flow chart showing the availability of medicines and their locations. PD asked what we provide to patients for them to identify their critically timed medicine needs. LL reported that there has been a campaign around identifying conditions needing critically timed medicine and patients with these conditions were identified using stickers and posters to place above their beds, so staff were able to easily identify their medicine needs. Patients are encouraged to self-administer

their medication as they are aware of the times that they take their medication. Currently there are no electronic ways of identifying a patient's needs.

PD further asked if any patient groups had been consulted to provide a patient view. LL reported that they will be engaging with the Patient Centred Group to identify patients' needs but timescales with the reply to the NHS Executive did not allow for that consultation to take place at this time.

Peter Carr (PC), Director of Therapies & Health Science, provided an update on Health and Safety Executive (HSE) Engagement. PC reported that the recommendations arising from the inspection of pathology at the Royal Gwent Hospital had been actioned and the investigation was now closed as sufficient assurance had been provided to the HSE. PC reported that the HSE had visited Nevill Hall Hospital in June 2023 to review a patient fall at the hospital in 2019 (Pre-pandemic). The HSE engaged with staff and the visit was positive with recognition of the significant improvements in documentation, processes and governance. The HSE was satisfied that it was able to collect sufficient information to inform the investigation. PC will update the Committee on the outcome at the next PQSOC Meeting.

Action: Director of Therapies & Health Science

PD queried why the visit was being undertaken 4 years after the incident. PC advised that the pandemic might have had an effect, but the timetable was set by the HSE as it is their investigation. PC further assured the Committee that when the incident happened in 2019 a full Red 1 serious incident internal investigation was undertaken, and our report was shared with the coroner.

PC outlined the data regarding Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Reporting is variable and one of our challenges as a Health Board is to report in a timely manner. Work is ongoing to improve this and currently we have improved by 9% from the previous report. PC reported that the Corporate Health and Safety teams are closely monitoring this reporting.

PC provided an update on Health and Safety Mandatory Training. At the end of May 2023 training compliance was

	reported as 84% for Health and Safety Training, 82% for Violence and Aggression, 79% for Fire Safety and 52% for Manual Handling. Manual Handling training currently has a practical element which can be a barrier to compliance, the Health and Safety team was therefore looking for innovative ways to improve the training i.e. Ido training. PC reported that there was a wider issue regarding compliance with all statutory and mandatory training throughout the Health Board. He noted that Sarah Simmonds, Director of Workforce and OD, has established a core learning committee to oversee all Statutory and mandatory training. The purpose was to provide governance for all Statutory and mandatory training across the organisation, oversee compliance, and help determine any new training requirements and help shape the organisations training requirements. PB asked if the highlight reports from the Core Learning Committee will be presented at the People and Culture Committee. PC advised that was his understanding that this will happen, and the Executive Committee will be monitoring progress. PC would include an update on this in the Health and Safety element of the PQSOC Performance reports. PC reported that a Traffic Management working group had been established to review and assess the risks at hospital sites. This follows concerns raised at the Royal Gwent Hospital and the fatal incident at Withybush Hospital. PC reported that a Corporate Health and Safety Annual Report had been produced. It is hoped to bring this report to the PQSOC Meeting in October to provide robust data on Health and Safety. **Action: Director of Therapies & Health Science** JW reported that herself, Leanne Watkins, Chief Operating Officer, and Nicola Prygodzicz, Chief Executive, had briefed the Board last week around some of the concerns arising from a number of serious incidents in Mental Health and Learning Disability services. At the Board meeting it was agreed that the Patient Quality and Service Outcomes Committee will provide oversight and assurance to Board on the improvement actions. JW reported that Health Inspectorate Wales (HIW), Welsh Government and the NHS Wales Directorate had all been made aware of the issues. Work has been undertaken with

	the division to provide support and constructive challenge around how the assurance and governance within the division could be strengthened and improved. Welsh Government would be meeting with JW and Leanne Watkins on a regular basis to provide support from an external basis and a number of 'make safe' actions had been implemented and would be outlined on the improvement plan to be received at the next PQSOC meeting. Chris O'Connor (CC), Divisional Director for Mental Health and Learning Disabilities, advised the Committee that this was an opportunity to improve the quality of care of individuals accessing services and to strengthen and review processes around escalation and assurance and to improve staff experience and wellbeing in the workplace. Strong engagement was needed to implement the improvement plan and work was ongoing to ensure that this is ideas led by the staff within the Division. Helen Sweetland (HS), Independent Member, asked for assurance that these situations are not happening elsewhere, how these situations are escalated quickly and whether it was a result of the HIW inspection. JW assured the Committee that the HIW inspection was the first to identify concerns but there had been other incidents that have followed raising further concern. JW confirmed that these issues within the Mental Health & Learning Disabilities Division were unique and due to several reasons, including the pandemic, which a created a different environment. CC noted that the pandemic had a profound effect on Mental Health and a focussed approach was needed to help the most vulnerable patients. This had resulted in work around quality improvement and quality assurance being put on hold, but this was now an opportunity to go back and review those processes. JW reported that a Quality, Safety and Governance Escalation Process for the Mental Health and Learning Disabilities Division had been established with clear Terms of Reference. This formal process would report to the Executive Committee through to PQSOC and Board. PD queried if patient and families views were being considered on the quality of the services. JW provided assurance to the Committee that the Mental Health and Learning Disabilities division was first on the roll-out plan

	for Civica (patient experience gathering) and Llais had been consulted. JW provided an overview of the HIW Inspection of Ty Lafant, Llanfrechfa Grange from 31st January 2023 and 1st February 2023. From this inspection there was 1 outstanding action (out of date), 8 recommendations identified by HIW, 28 actions identified by the Division and no outstanding actions (in date). The action plan had been developed and was being embedded within the Division. PD asked why the additional concerns raised by HIW were not in the report received in March. JW reported that HIW was an Inspectorate and do not highlight incidents relating to individuals in a public report. HIW met with JW and CC directly after the inspection in February to discuss these additional concerns which is why broader actions were put in place to meet those. CC further clarified that the data on the overarching improvement plan and draft inspection report issued by Health Inspectorate Wales on 23rd March 2023 slide of the presentation was because of the meeting with HIW in March and encompasses all the actions identified by HIW and the Division. All these actions are being monitored on a weekly basis within the Division. CC reported that there had been a number of leadership changes within the Wards, an increase in the presence of the Senior Nurse within the ward and a strengthening of the multidisciplinary leadership. JW assured the Committee that the new style report and Improvement plan, which would consolidate all actions including the HIW, will be brought to the October PQSOC. **Action: Director of Nursing** Moira Bevan (MB), Head of Infection and Prevention, reported that since the last meeting comparative data with other Health Board's in Wales had been received showing performance for infection. An area of concern highlighted was C.difficile. A deep dive into all cases had been undertaken from 1st April to 30th June 2023 to identify thematic areas. It was noted that there had been a period of increased incidents and 2 cases confirmed by genotyping meaning that cross infection has occurred in the hospital. The Infection Control team was working with staff at grass roots to implement improvements at the patient level. A paper had also been presented to the reducing nosocomial transmission group with

recommendations and a 30-minute slot has been secured at Doctor induction to talk about key measures. Work was progressing with a view to reducing infections.

JW outlined the emerging Escalated Risk Concerns. There had been an increase in serious incidents over the last quarter mainly due to work undertaken on the Policy and a different culture emerging around transparency and reporting. There was a capacity concern with 60 live incidents, but the team was working hard with support from other departments. There was a continuation of a theme of deteriorating patients and surgical never events and an event was being planned for the autumn to bring teams together to discuss further. Work had been undertaken on end of life and bereavement pathways and there were concerns with the depth of the contemporary nature of patient information. The End-of-Life Board would be re-convened, and a report brought back to a future Committee meeting.
Action: Director of Nursing

TPW outlined the Health Inspectorate Wales Inspections update regarding inspections undertaken since January 2023 and the improvement plans with outstanding actions.

Since January the Health Board had 4 inspections, Ty Lafant on 31st January – 1st February 2023, Ionising Radiation Regulation at Nevill Hall Hospital on 25th – 26th April 2023, D2 East and D2West at the Royal Gwent Hospital on 3rd to 4th May 2023 and Maternity at The Grange University Hospital on 6th – 8th June 2023.

The inspections at The Royal Gwent and The Grange University Hospital had gone extremely well with positive feedback. Learning and the experience of the inspection had been shared.

PC reported that the Ionising Radiation (Medical Exposure) Regulations are heavily regulated and there are many standards that the Health Board is rated against. This visit to Nevill Hall Hospital was part of the rolling inspection programme. The radiology team facilitated the inspection, and a good compliance report with full assurance had been received. The only issues raised were minor and related to paperwork.

	TPW outlined the existing improvement plans with outstanding actions for assurance that the actions are being actively monitored. JW welcomed Paul Underwood (PU), General Manager - Urgent Care Division, to the meeting to present an update on Urgent and Emergency Care. PU reported that system flow escalation had been introduced and had made a significant difference and improvement to the amount of transit time for patients through the department. This would continue to be monitored by Executives and work will continue. PU advised the Committee that patients were waiting longer than preferred but inroads were being made. Certain specialities had seen a high spike in demand which had been challenging but improvements were being made but there was still work to do. PU reported that a red release bay had been developed allowing an ambulance to be released back into the community more frequently affecting our ability to support patient handovers and expedite the patient journey. There is fluctuation with times of day, but the new system is making a difference and improved performance will be seen in time. PU outlined the action plan and what steps were being taken to improve the department and experience of patients. PC and JC thanked PU and the wider team for the work and leadership being undertaken. PC shared the observation that a cultural shift has been visible and a improvements made. JC asked if there would be a full complement of staff 24 hours a day with emphasis on senior medical staff. PU advised the committee rosters had been improved and reduced and work was ongoing to improve the midnight to 8am staffing. LW asked how the Division was dealing with members of the public attending the right place for Stroke and COTE. PU reported that work was ongoing into stroke pathways and the patient flow centre was looking at how we can

	better support our patients based on acuity, so they are seen in the right place. Communications with the public was improving and engagement being undertaken. For COTE patients, there was a significant piece of work ongoing as part of the 6 goals work to bring together the flow centre, with single point of access and streamlining our patients to the right place first time. PC assured the Committee that the Stroke Pathway and the Neck of femur pathway had been identified as two pathways to review as a priority. JW reported that a piece of work was being undertaken with WAST as to how we direct patients to where they need to be prior to them attending the Grange University Hospital.
PQSOC 2607/3.2	**Next Steps for the Quality Strategy** Jennifer Winslade (JW), Director of Nursing welcomed Trish Chalk (TC), Assistant Director of ABCi & Interim Deputy Director of Planning, to the meeting. TC outlined the Health Board priority outcomes which had been aligned to the 6 pillars of the Quality Framework. This set out the detail on how the outcomes would be delivered, measures and continuously improved. TC further outlined the progress and implementation plan for Q1. Proposed outcomes and indicators would be benchmarked against other organisation and existing measures aligned with Duty of Quality and Health Board priorities. TC outlined each of the following priorities their outcome description, indicator and ability to report: - Priority 1 – Deliver PATIENT CENTRED care which involves patients, relatives, families, careers and system partners in the planning of care and opportunities to improve patient safety. 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. 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.

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

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.

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

PB thanked TC and her team for putting together this comprehensive report with areas of focus for improvement. The report was clear, allowed people to work through what they need to and provides a clear understanding of how the framework and plan will work with realistic timeframes.

HS asked, given the number of people involved in this report, whether the right people are involved in the project and whether there will be staffing challenges to these priorities being delivered. TC reported that there are currently 3 teams working on this, planning, information team and operations team and TC will be overseeing this going forward.

TPW advised the committee that there is a piece of work ongoing for the validation of data for the Datix system and to be mindful of the data currently available.

PD asked about the barriers to this Framework for example ICT and capacity issues. TC reported that Datix could be a barrier but engagement with staff and presenting more valuable data often resulted in staff using the system more.

TC outlined the goals of the Quality Strategy Implementation Plan which is aligned with the regional strategy. The plan will enable staff to improve quality, implement the Duty of Candour of Quality and meet the requirements of the Duty of Candour. TC advised the committee on the key objectives for the next year as set out in the Implementation Plan and a detailed delivery plan for each priority.

	JW outlined the Quality Assurance Framework and how it fits with the overall Board Governance Framework. This framework simplified responsibilities and accountabilities and how we will move to a different model.
PQSOC 2607/3.3	**Infection Prevention and Control Annual Report** Jennifer Winslade (JW), Director of Nursing welcomed, Moira Bevan (MB), Head of Infection Prevention and Control to the meeting. MB reported that it had been a challenging year for the Infection Prevention Team, however it was important and reassuring to note that Aneurin Bevan University Health Board had a lower average rate of all infections than the rest of Wales. MB advised the Committee that the team worked on priorities from last year, the majority of which had been completed. The team was reconfigured in January, due to extra funding, to include infection prevention in the wider community. The sustainability of this workforce has become challenging as staff were seeking substantive posts. To overcome this teams now worked locality based in all areas. A survey was undertaken to ascertain views from staff and a mission statement was produced from this. MB outlined the following areas from the report. • Gram positives and gram negatives show that respiratory infections are having an impact, but urine remains the highest burden of infections for gram negatives. MB reported that the team are finalists for the Houdini Programme for the NHS Awards in Wales. • Covid and flu data shows lower hospital onset that other Health Boards. • The team has supported serious incidents, a sporadic case of CJD, the M-pox agenda, patient pathways and assessment of patients, increase in wound infections in trauma and orthopaedics, a shigella outbreak in the community and Group A Strep infection. • The annual programme of work for 2023-24 sets out twelve priority areas for the year.

	PB asked how the intranet and internet pages currently being developed are being used to communicate with staff. MB reported that the intranet pages have been updated and the role of the 'link' champion was being reinstated to provide a communication channel in primary and secondary care. MB reported that there had been a 'tick tock' campaign regarding hand hygiene to bring a fresh approach to message delivery. HS asked what progress had been made regarding the legionella outbreak within Maternity Services. MB assured the Committee that work was underway to address this issue and there was a proactive water safety group which carried out regular testing. MB further reported that this was a national issue affecting newly built hospitals with single rooms.
PQSOC 2607/4	**Items for Information**
PQSOC 2607/4.1	**Highlight Reports** The Committee received the following Highlight Reports for Information: - • Safeguarding Group Highlight Report • Clinical Effectiveness and Standards Committee Report PD asked about a request from Gwent Police in the Safeguarding Group Highlight report about representation at a multi-agency Task Co-ordination Group in relation to domestic violence and how we can support. TPW advised that data was currently being provided to Gwent Police regarding this which they were happy about. TPW will continue to scope this data, but the situation was being monitored.
PQSOC 2607/4.2	**Groundhog Day 2: an opportunity for cultural change in complaint handling?** Tracey Partridge-Wilson (TPW), Assistant Director of Nursing assured the committee that the recommendations would be picked up through the implementation of the review of the QPS and PTR Policies. PB asked for a brief report to the committee that the recommendations have been actioned. JW to add to the annual report. **Action: Director of Nursing**

PQSOC 2607/4.3	**Time Critical Medication in Parkinson's Disease** Discussion regarding this report had happened earlier in the meeting in the PQSOC performance report.
PQSOC 2607/4.4	**Early detection of type 1 diabetes in children and young people** There were no questions regarding this report.
PQSOC 2607/4.5	**WHSCC Quality Patient Safety Committee Chair's Report and Appendix 1 - Summary of Services in Escalation** There were no questions regarding this report. PB reported that she was a member of this Committee.
PQSOC 2607/5	**Other Matters**
PQSOC 2607/5.1	**Items to be Brought to the Attention of the Board and other Committees** There were no matters arising.
PQSOC 2607/5.2	**Any Other Urgent Business** Paul Deneen (PD) Independent Member asked why the HIW inspection was not a joint inspection with Care Inspectorate Wales. Jennifer Winslade (JW) Director of Nursing to report back to the meeting in October. **Action: Director of Nursing**
PQSOC 2607/5.1	**Date of the Next Meeting** The next meeting will take place on Wednesday 11th October 2023.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

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**	October 2023	Included on the Agenda (item 3.6)
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**	October 2023	Verbal update to be provided at the meeting
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**	October 2023	Included on the Agenda (item 3.5)

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
26th July 2023	**PQSOC 2607/3.1**	**Patient Quality and Safety Outcomes Performance Report, July 2023** PC to update the Committee on the recommendations arising from the inspection of pathology at the Royal Gwent Hospital and Nevill Hall Hospital.	**Director of Therapies & Health Science**	October 2023	Included in Patient Quality and Safety Outcomes Performance Report (Agenda Item 3.1)
26th July 2023	**PQSOC 2607/3.1**	**Patient Quality and Safety Outcomes Performance Report, July 2023** Corporate Health and Safety Annual Report had been produced. It is hoped to bring this report to the PQSOC Meeting in October.	**Director of Therapies & Health Science**	October 2023	The annual report for Corporate Health, Safety and Fire will now go to the Public Board in November, instead of PQSOC
26th July 2023	**PQSOC 2607/3.1**	**Patient Quality and Safety Outcomes Performance Report, July 2023** JW to present the new style report and Improvement plan for Ty Lafant to the October Meeting	**Director of Nursing**	October 2023	Included as part of Agenda Item 3.5

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ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
26th July 2023	**PQSOC 2607/3.1**	**Patient Quality and Safety Outcomes Performance Report, July 2023** The End-of-Life Board report be brought to a future Committee meeting.	**Director of Nursing**	December 2023	Included in forward work programme for December 2023
26th July 2023	**PQSOC 2607/4.2**	**Groundhog Day 2: an opportunity for cultural change in complaint handling?** Director of Nursing to provide a brief report to the Committee that the recommendations of the report have been actioned.	**Director of Nursing**	December 2023	Included on the forward work programme for December 2023
26th July 2023	**PQSOC 2607/5.2**	**Any Other Urgent Business** Director of Nursing to report on the process for joint HIW and Care Inspectorate Wales investigations.	**Director of Nursing**	October 2023	Included in Patient Quality and Safety Outcomes Performance Report (Agenda Item 3.1)

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

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.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Patient Quality, Safety and Outcomes Committee

Performance Report

OCTOBER 2023

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, working towards including compliments
  - Civica implementation plan underway
  - Patient Experience and Involvement Strategy being implemented
  - PALs team recruited and model will be implemented in Oct 23
- Incident reporting and severity of harm
  - Thematic reviews and learning
  - Pressure ulcers included
  - RAMI and crude mortality updated
  - Duty of Candour update
- Complaints and concerns
  - Continue to focus on closure of historical complaints over 6-12 months
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

Urgent Care

Planned Care

Cancer

Pillars of Quality

Section 1

Good Practice and Learning from Feedback

Infection Prevention & Control

Section 2

Infection Prevention Pillar

Health Board Strategy - Quality Act

Aims & Objectives

Governance /Assurance

- Reducing Nosocomial Transmission Group
- Divisional action plan
- Quality and Patient safety forums
- Investigation process - Datix
- Use of Audit Management and Tracking System (AMaT) for audits

Welsh Government targets

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Aug 23

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

< than same period last FY

= same period last FY

> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	30.79	0.8	14.8	57.98	19.99	4
Betsi Cadwaladr UHB	37.07	0.34	22.79	73.46	20.07	5.1
Cardiff and Vale UHB	23.23	2.37	31.77	65.91	23.71	4.27
Cwm Taf Morgannwg UHB	24.46	2.66	29.78	91.47	23.93	2.66
Hywel Dda UHB	41.13	2.46	24.55	114.17	26.39	8.59
Powys THB	10.79	0	0	3.6	0	0
Swansea Bay UHB	52.01	3.06	37.32	76.49	22.64	6.12
Velindre NHST						
Wales	33.21	1.74	24.75	74.57	21.81	4.75

Hospital Acquired Covid

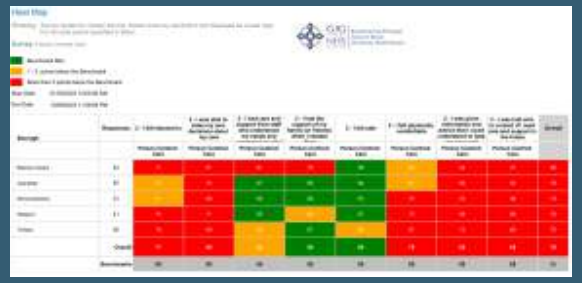
Themes of learning

National Reportable Incidences	Themes/Learning
C difficile Two wards affected by outbreaks	➢ Suboptimal antimicrobial prescribing ➢ Fundamental IP measures – back to basics
Covid-19 Ten ward closures - outbreaks	➢ Change to staff and patient testing ➢ Relaxed visiting restrictions ➢ Shared facilities
D&V/Norovirus Patients with unexplained diarrhoea and/or vomiting. Two wards affected.	➢ Rapid isolation of symptomatic patients ➢ Sample collection
Carbapenemase - producing organisms Patient exposure to resistance organism	➢ Screening on arrival from other HB

Person Centred Care – Patient Experience

Person-Centred Dementia Care Pledges

	Always	Sometimes	Never
1. I felt listened to	☐	☐	☐
2. I was able to make my own decisions about my care	☐	☐	☐
3. I had care and support from staff who understood my needs and respected my choices	☐	☐	☐
4. I had the support of my family (or friends) when I needed them	☐	☐	☐
5. I felt safe	☐	☐	☐
6. I felt physically comfortable	☐	☐	☐
7. I was given information and advice that I could understand to help me keep well	☐	☐	☐
8. I was told who to contact if I need care and support in the future	☐	☐	☐



CIVICA

- Graduated roll-out to support staff training
- **283** Person Centred Care (PCC) Surveys Completed - **75%** satisfaction (benchmark 85%)
- PCC Survey to be included in **Ward Accreditation**
- **Divisional Reporting**: Satisfaction Score, Heat Map, Comment Analysis (Themes), Comment Reports, Listening and Learning, *You said, we did*
- **KPI's** for PCC- 8 core questions
- National **ED** and **COVID** surveys live

Dementia Awareness, Training and Education

- **Patient Education** (OAK, Menopause, Endometriosis)
- **Carer** Induction and Education
- **Anticipatory Loss**
- Public **Hospital Charter** Film - our commitment
- Dementia Training now **mandatory**
- **Meaningful Activity** Training
- Listening and **Learning Events** (Patient Stories)
- **New Registrant** Induction Training
- **International Nurses** (bespoke sessions)
- **'Bite-size'** learning sessions - **250 Champions**
- **MCA training -** Capacity and Best Interest, 'Side by Side' clinical support
- **Educational Films -** MCA, DNACPR
- **Volunteer and Companion** Training
- **Delirium** Training
- **Virtual** Experience

Volunteers and Companions

- **Pre-COVID - 4** Volunteer roles. **Now 23**
- Other role profiles being developed to meet **patient need**
- **National Presentations:** Compassionate Cymru, National Patient Experience Meetings, Helpforce Cymru etc
- **50** volunteers on the Volunteer to Career Pathway

Case Study

Where nurses and multi-disciplinary teams view care as NOT being the sole domain of medical treatment, outcomes and the lived experience improve.

Case Study: Meaningful Engagement at End of Life

Frieda has late-stage dementia and so was not really able to communicate.

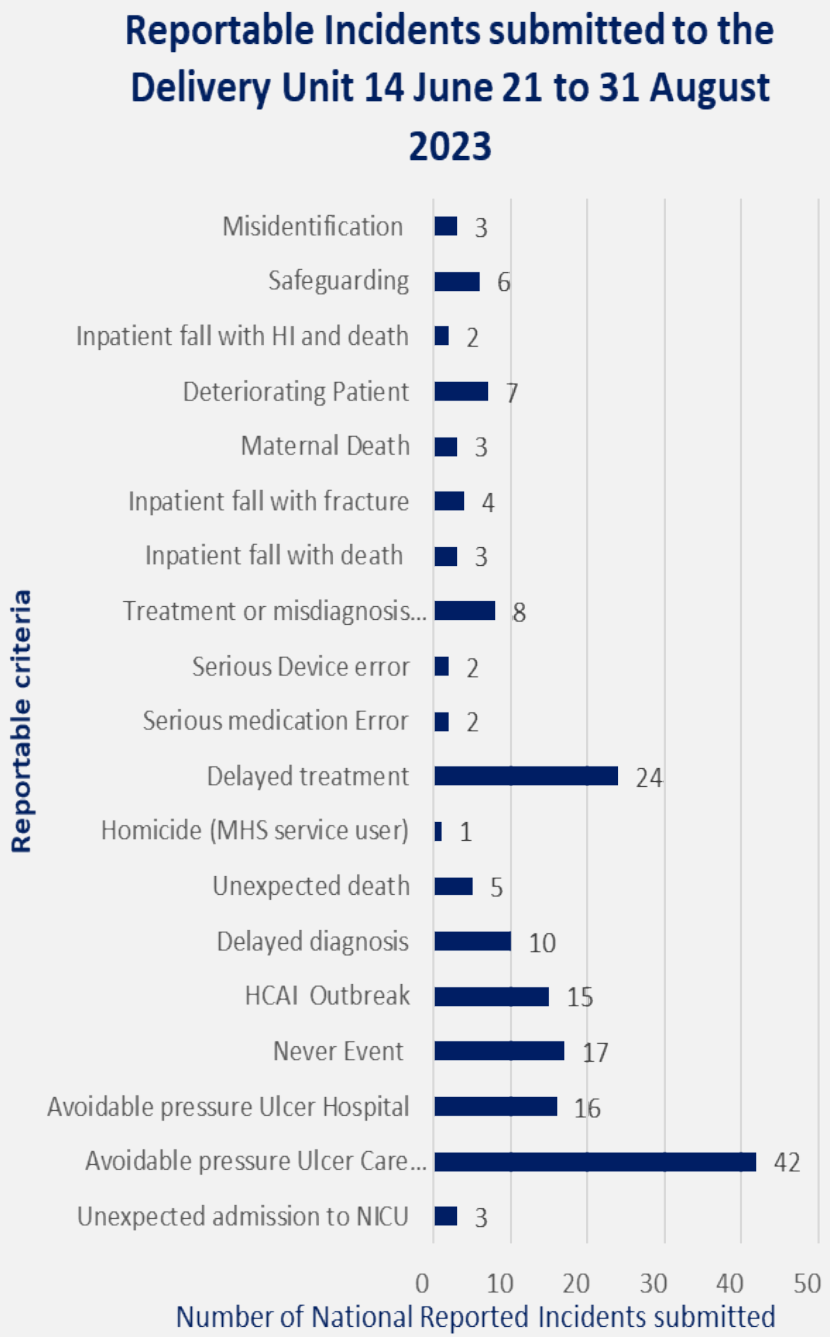
After I had spoken quietly to her for several minutes, without any obvious response, I decided to try playing some quiet music to her on the iPad that I had brought along for the purpose.

That had a dramatic effect. She opened her eyes and took the iPad from me so that she could concentrate on the music.

When the piece that I had selected came to an end, I tried something else that I thought she might like. However, after a few minutes, I gathered from her facial expressions that this selection was not being well received. I consequently stopped that and tried instead the beginning of Richard Burton's reading of Under Milk Wood.

Fortunately, that choice seemed to be to her taste because she listened to it for about 30 minutes before drifting off to sleep. As I was packing up to leave, she woke up again, took my hand and kissed it. I could see that she was mouthing "Thank you" even though no sound came out.

National Reportable Incidents

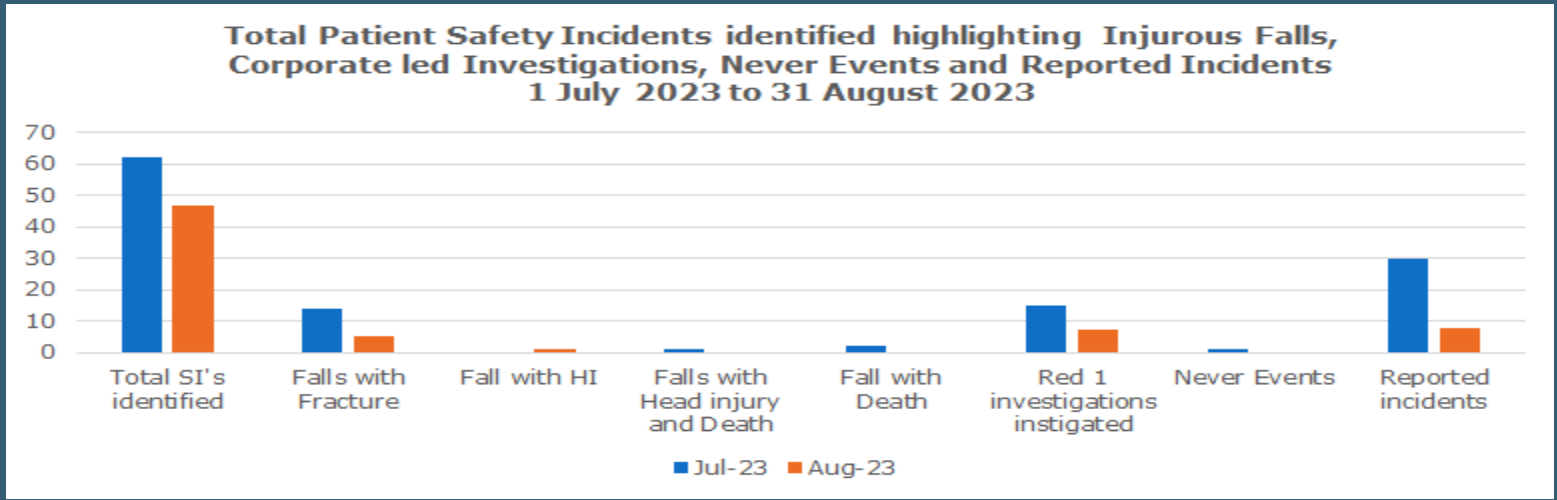


The Health Board saw an increased trajectory in NRI'S reported in July, whereby 30 were reported, with 8 reported during August.

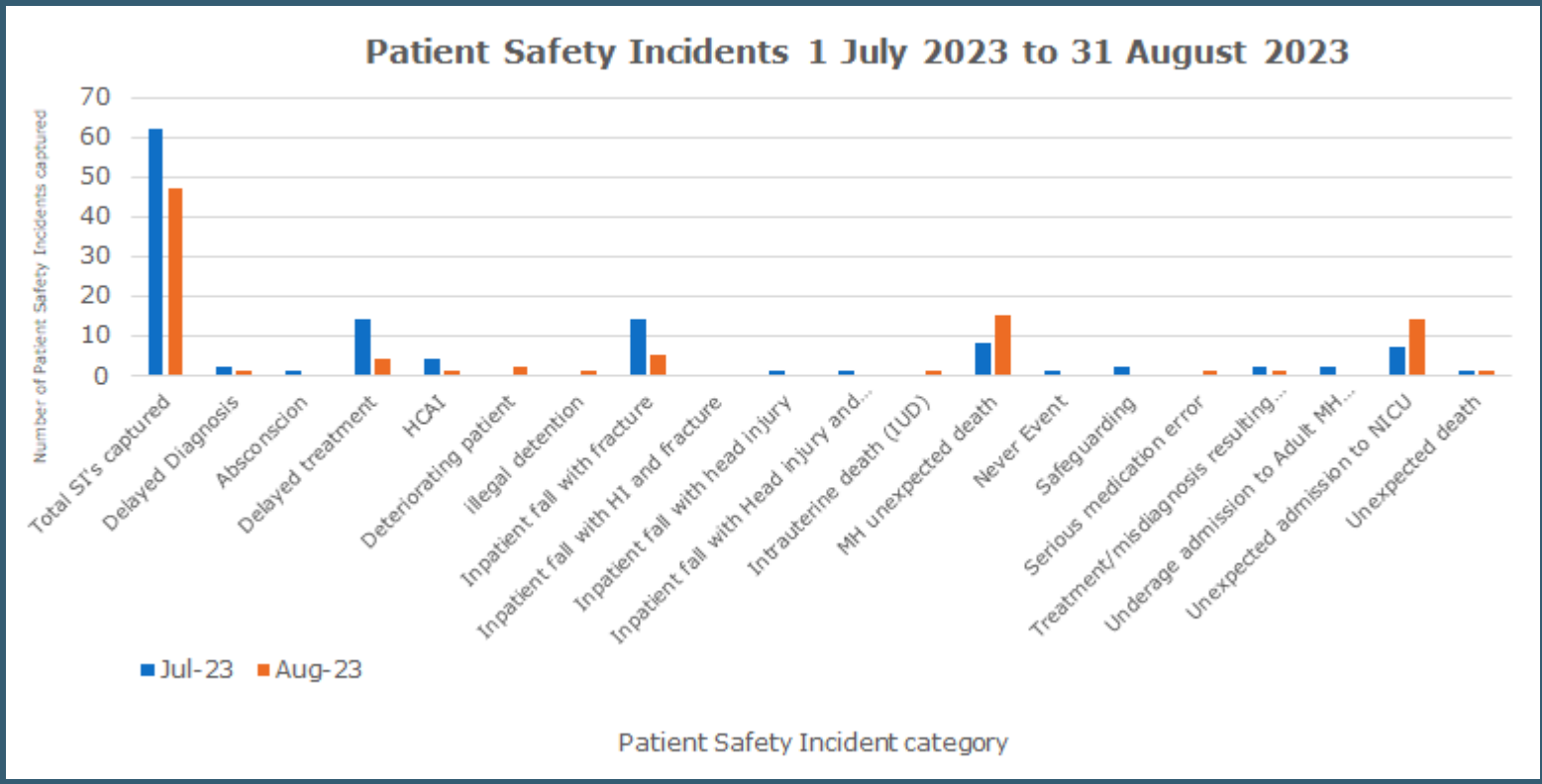
The overwhelming theme related to delay in treatment; Ophthalmology (Glaucoma cases). Other themes included, HCA outbreaks/Covid and fall with death.

Learning from NRIs	Improvement
A patient was referred in January 2023 as an Urgent Suspected Cancer. The referral downgraded to urgent by a Consultant. An appointment was booked Medical Illustration. 3/12 later the pt contacted HB as no results received. The patient had not been booked into an evaluation clinic and the clinical images had not been reviewed by a Dermatology Consultant. Immediate OPA, lesion excised and sent to the pathology laboratory for testing. The pathology report confirmed this to be melanoma.	• Discussed the investigation with Booking Team • Implemented updated process for Booking Staff • Team Leader supervising work flow • Close monitoring of lesion waiting list to highlight potential issues • Meetings in place to review the Teledermatology pathway with a view to reducing the potential for human error • USC referrals not downgraded to urgent unless the GP attaches a photograph which suggests the lesion is not USC
A patient was admitted to an eLGH for planned abdominal surgery. The following day they were was transferred to the ICU Grange University Hospital (GUH) for support and further surgery due to an anastomotic breakdown. The patient passed away the following day. Issues with escalation and referral pathways	• Further communication needed on the correct referral process - Posters informing of the referral and transfer process visible in ward areas with advice on clear communication. • Instruction and education on the transfer process to be presented at the monthly surgical meetings and at the junior meetings. • Updating staff on deteriorating patients' policy. • Deteriorating patient policy being reviewed to include GUH. • Ensure all staff up to date with ALERT • Radiology review/ feedback

Patient Safety Incidents



A total of 109 serious incidents were identified during July and August, 62 and 47 respective months.MH Unexpected Death, Unexpected Admission to NICU and Inpatient fall with # were the top themes.



Early Warning Notifications

There were 19 EWN reported to WG during this period, 7 in July and 12 August. Themes were varied but predominately they related to absconsion and Safeguarding issues.

Anecdotal Themes from Incidents

An additional theme identified, relates to a number of clinical incidents regarding delayed decision making and treatment for acute patients relating to nutrition, whether that is via artificial nutrition or some other means.

A Task and Finish Group has been convened, Chaired by the Assistant Director of Therapies and Health Science. It is anticipated that four meetings will be held, and outcomes reported to the Clinical Executives.

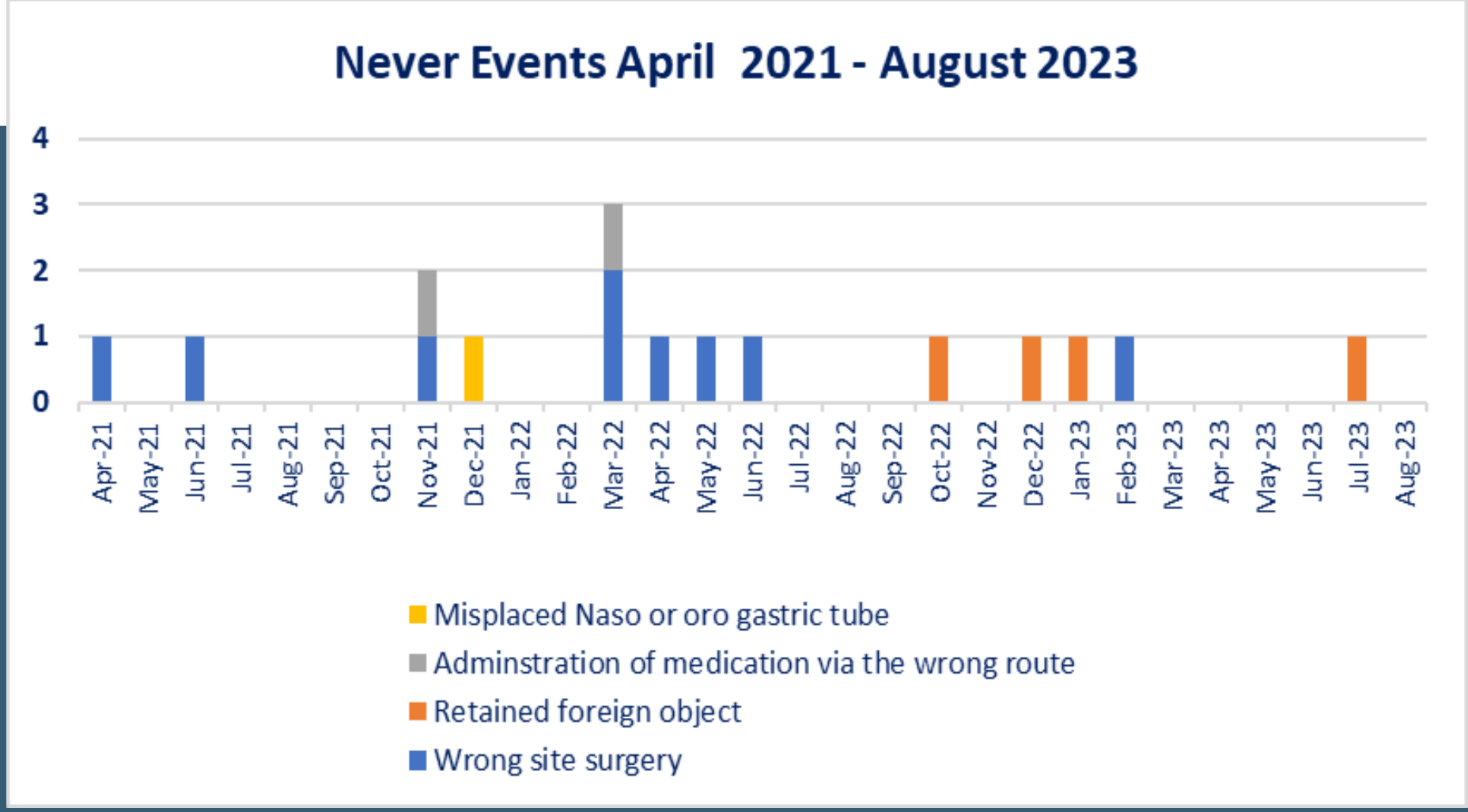
Update Deteriorating Patient

On 5 October the Health Board is hosting an improvement collaborative event with Maxine Power on 'Deteriorating Patient'. This combined learning event and accelerated quality improvement project, will look at sharing data and current work to date.

Review of Patient Safety Incident Process

Issue	Cause	Remedial Action	Who	When
Review of Health Board SI policy required. SI process currently sub-optimal to meet needs of organisation.	Historic process no longer fit for purpose Varying processes across Corporate and Divisions Lack of organisational learning shared	Presentation of all Serious incidents to weekly Executive Huddle for decision regarding level of investigation.	Head of PTR	Ongoing
		Weekly pre- Executive Huddle meeting to form a decision panel.	Assistant Director of Nursing	Complete
		Meeting with EDoN and Corporate SI Team to identify barriers to effectiveness	Director of Nursing/PTR SI team	Complete
		Two workshops arranged to include Divisional QPS colleagues to map out future process	Director of Nursing/ Divisional QPS colleagues	Complete
		SI Policy updated to new Patient Safety Incident Reporting & Management Policy 2023, reflecting and incorporating all-Wales National Policy.	Head of Patient Safety Incidents	October 2023
		SBAR being presented to Executive Team October 2023.	Director of Nursing	October 2023

Never Events



- There was 1 Never Event reported during this period – a retained swab. This is the only 1 Never Event during the last 6 months.
- A focussed approach to preventing Never Events continues across the organisation.
- A report will be presented at December PQSOC, outlining the Improvement Programme for Theatres. It will encompass, a summary of incidents, themes, the Human Factors programme and a plan for the subsequent 12 months.

Duty of Candour

The Health Board remain engaged on a national level to support the implementation.

Good 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.

DoC Dashboard has been developed within the Datix system to support Divisions. The dashboard highlights those incidents triggering the duty and those that require review.

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

Duty of Candour

The image below illustrates the DoC dashboard in the Datix system.

GC - Incidents by Division - Following the Initial/Management review, what level of adverse outcome was considered?								
	Incident occurred Pre 1st April 2023	None	Low	Moderate	Severe	Catastrophic / Death	No value	Total
Complex & Long Term Care	2	37	70	2	0	0	63	174
Director of Public Health	0	13	10	0	0	0	3	26
Estates & Facilities	0	47	36	0	0	1	23	107
F&T	2	212	539	11	0	0	223	987
Medical Director	0	2	1	0	0	0	2	5
Mental Health & Learning Disabilities	0	688	992	6	0	0	18	1704
Nursing Director	1	8	12	0	0	0	13	34
Planning, Performance & ICT	0	14	7	1	0	0	3	25
Primary Care & Community Division	3	541	1114	17	4	0	344	2023
Scheduled Surgical & Critical Care	12	399	1036	13	6	0	49	1515
Medicine	3	870	2550	11	2	4	311	3751
Workforce & OD	0	1	3	0	0	0	4	8
Urgent Care	0	259	455	2	1	1	2	720
Clinical Support Services	0	76	148	1	1	0	38	264
Board Secretary	0	1	1	0	0	0	0	2
Chief Executive / Non Executive	0	1	0	0	0	0	0	1
Total	23	3169	6974	64	14	6	1096	11346

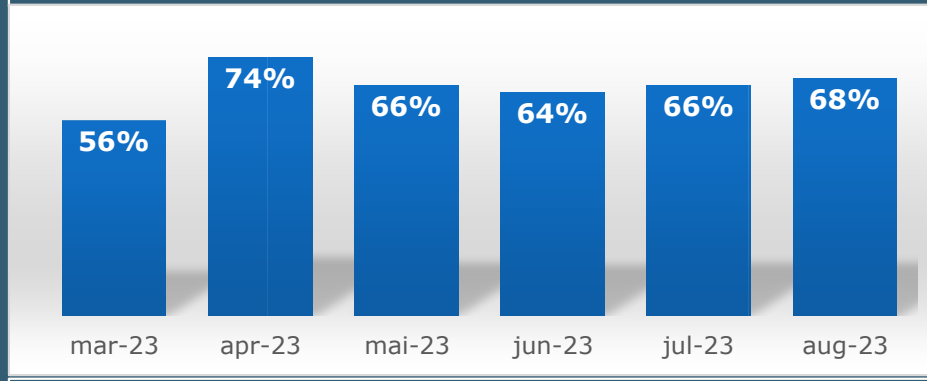
Duty of Candour

Next Steps

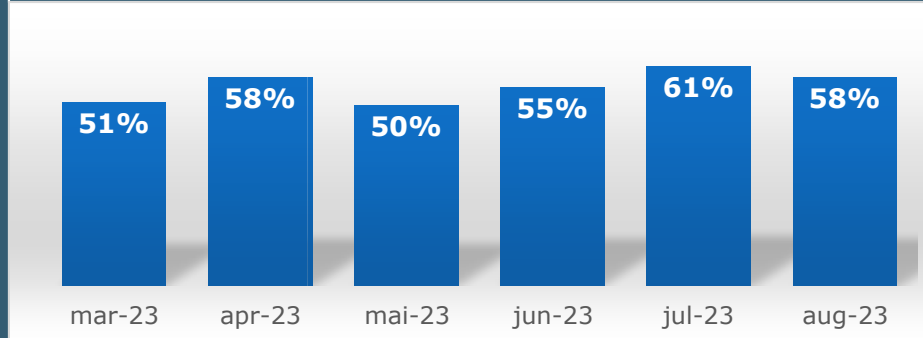
- Meeting planned with key individuals within the Health Board to develop a Duty of Candour performance and compliance report.
- This will include incidents and complaints triggering the duty and measure compliance with the timeliness of the responses.

Complaints

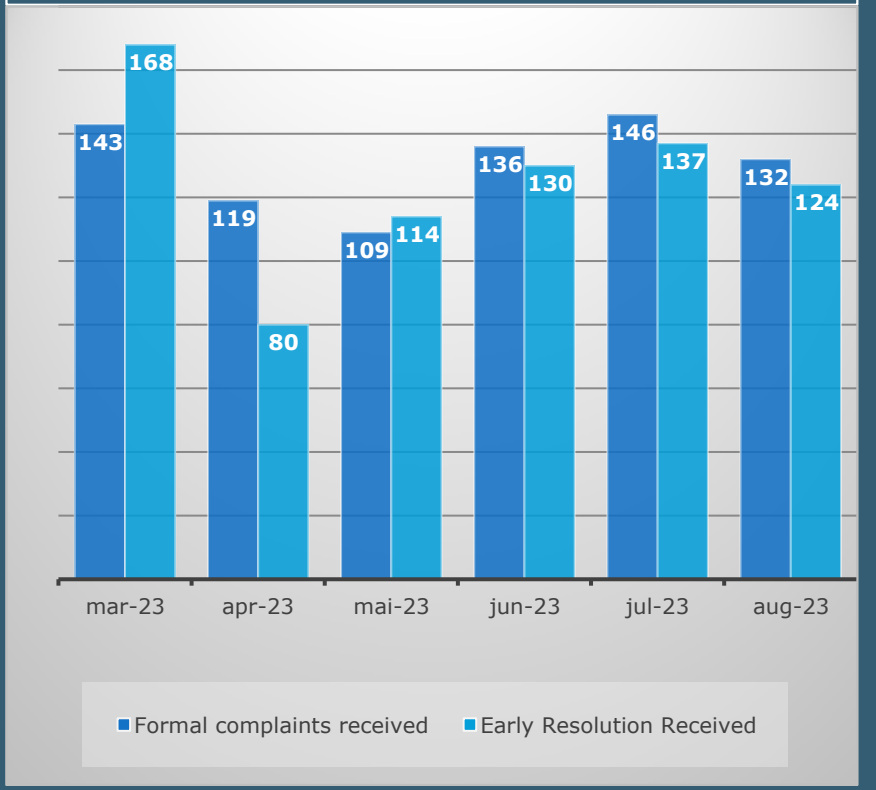
Early Resolution Performance March- August 2023



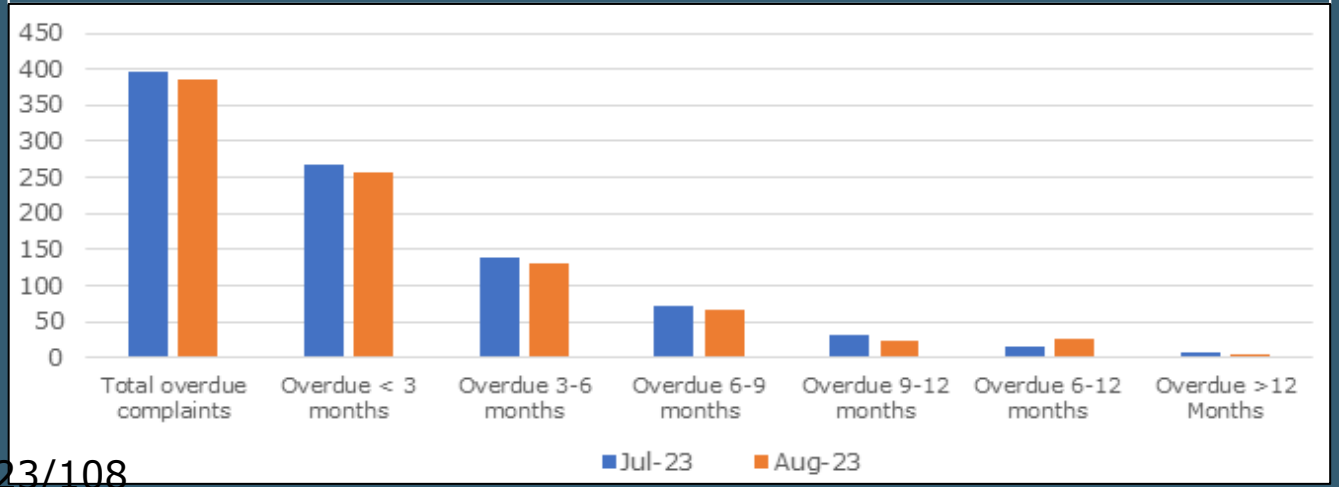
Formal Complaints Performance March –August 2023



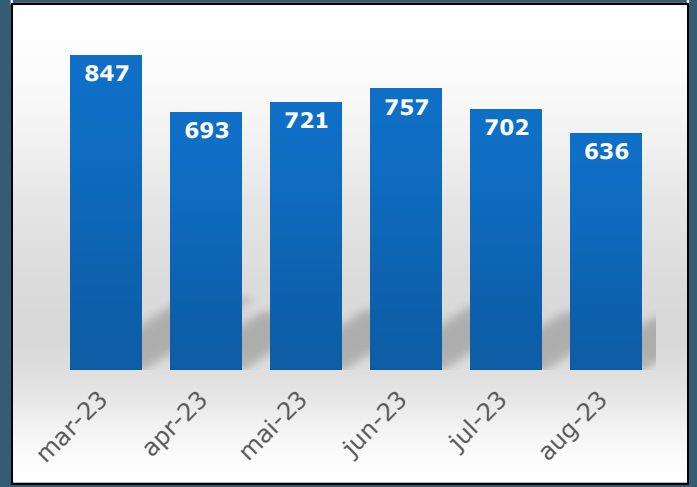
Complaints Received March- August 2023



Total Open Complaints and Overdue complaints July -August 2023



Enquiries Reordered by PLO's March-August 2023



Historic Concerns

The total overdue complaints are reducing.

A focussed approach has been taken and is ongoing to reduce the historic concerns. As of the beginning of September there are 6 overdue complaints > 12 months, a reduction from 8 in July.

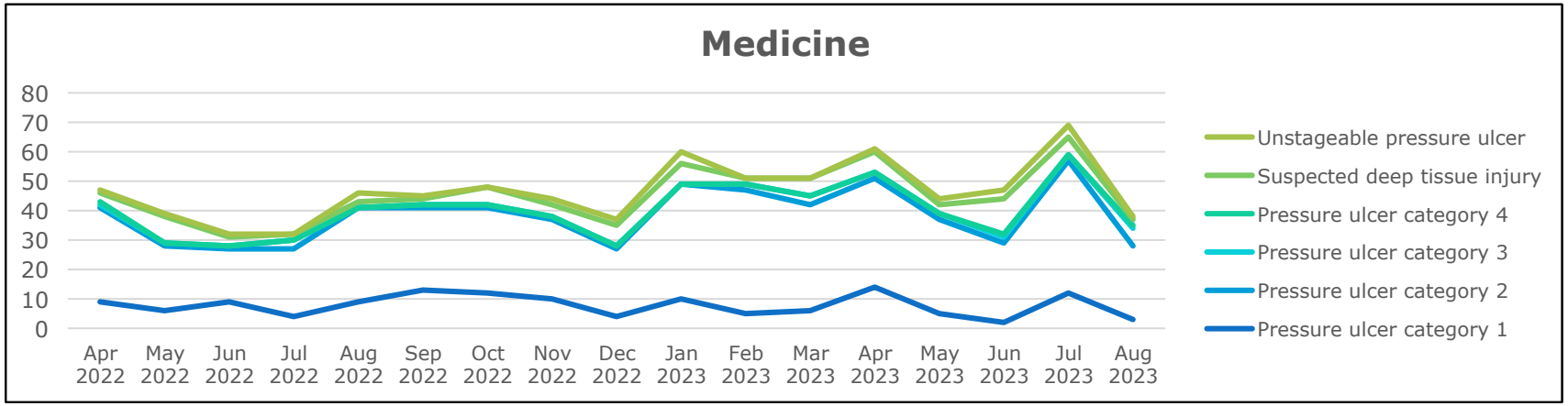
Learning from Complaints

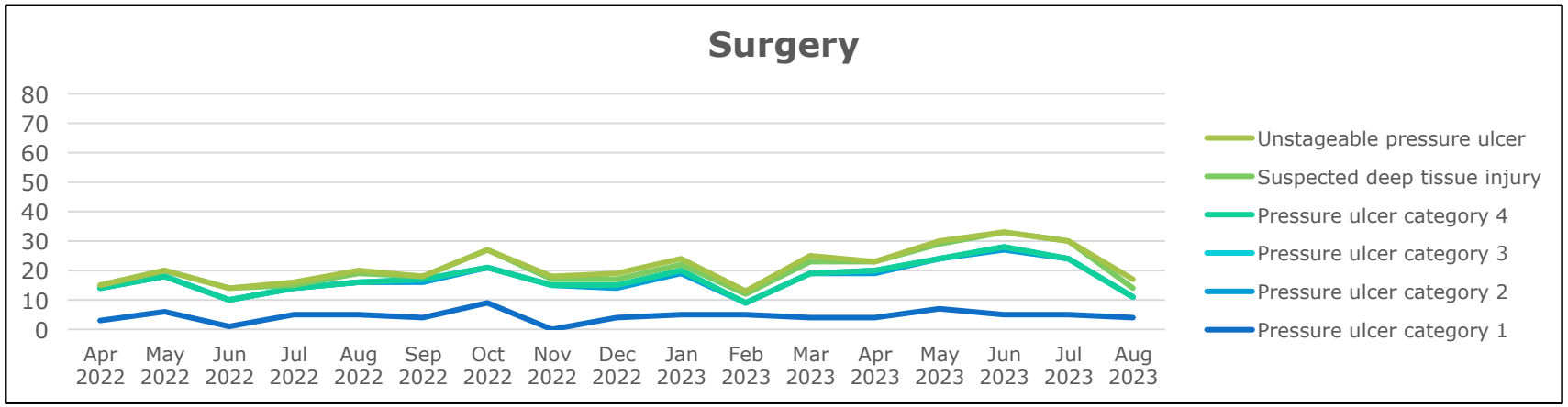
Issue	Cause	Remedial Action	Who	When
Patient falls	No lying and standing blood pressure was performed on admission to the hospital as expected as standard practise.	An induction programme has been introduced for new Health Care Support Workers. All new HCSW's have training of one week as part of their induction/competency booklets to complete.	Medicine Division	Ongoing process for all new staff appointed
A patient had a stroke which was not identified	Care lacked sufficient depth and rigour. No discussions with other relevant clinicians. Conversation not documented on patient records.	Training to be provided for relevant clinicians re NICE Guidelines Focus on Nursing and Medical Documentation and Record Keeping led by Senior Nurses and QPS team and Medical Supervisors.	Unscheduled Care Division	September 2023
Staff failed to act on the Continence Risk Assessment.	A bladder diary should have been completed to identify the level of continence support the patient may have required on discharge.	The Senior Nurse is working with the Lead Nurse from the Bladder and Bowel Service. Education and training has been arranged, and upcoming study days are scheduled. Staff have been involved in educational training to provide them with the knowledge and understanding to support safe and timely discharge. This work is ongoing and is being supervised by the Senior Nurse team and the Head of Patient Discharge.	Lead Nurse Bladder and Bowel Service Head of Patient Discharge and Senior Nurses	September 2023 Ongoing

Pressure Ulcer faculty introduction

Following the COVID-19 Pandemic, the Health board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's).

Divisions reported data via the HAPU Steering Group and the Quality and Patient Safety Operational Group.





The Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers.

Reasons for implementing the PU faculty 2023

ABUHB has previously undertaken a successful Pressure Ulcer Prevention Collaborative from October 2017 to July 2018 resulting in:

1) 51 HAPU's Averted
2) 256 reduction in Bed Demand
3) Estimated cost savings of £333,966
4) No avoidable Grade 3 0r Grade 4 pressure ulcers reported from ED MAU and C4W
5) Only 1 Grade 3 avoidable reported from C5E, ITU and C7E
6) Only 1 avoidable G4 HAPU reported on C7E

With the success of the previous pressure ulcer prevention and reduction collaborative, the Pressure Ulcer Faculty 2023 has been developed, led by the Nursing Directorate and Senior Nurses from Medicine, Unscheduled Care, Urgent Care and Community Care nursing; with support from ABC*i*.

Pressure Ulcer Faculty 2023

Aims and Progress

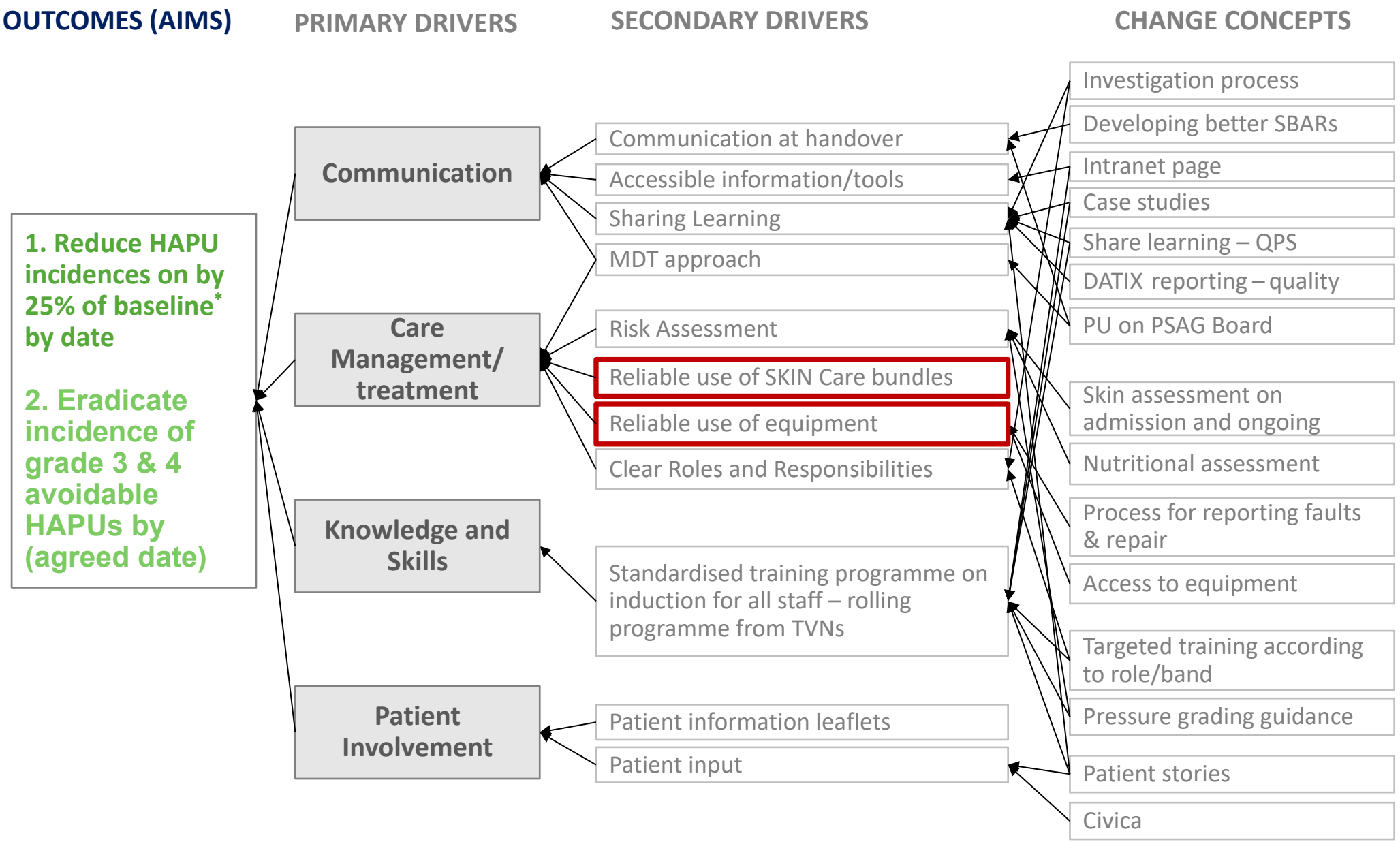
Aim of the Faculty

- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty
- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty

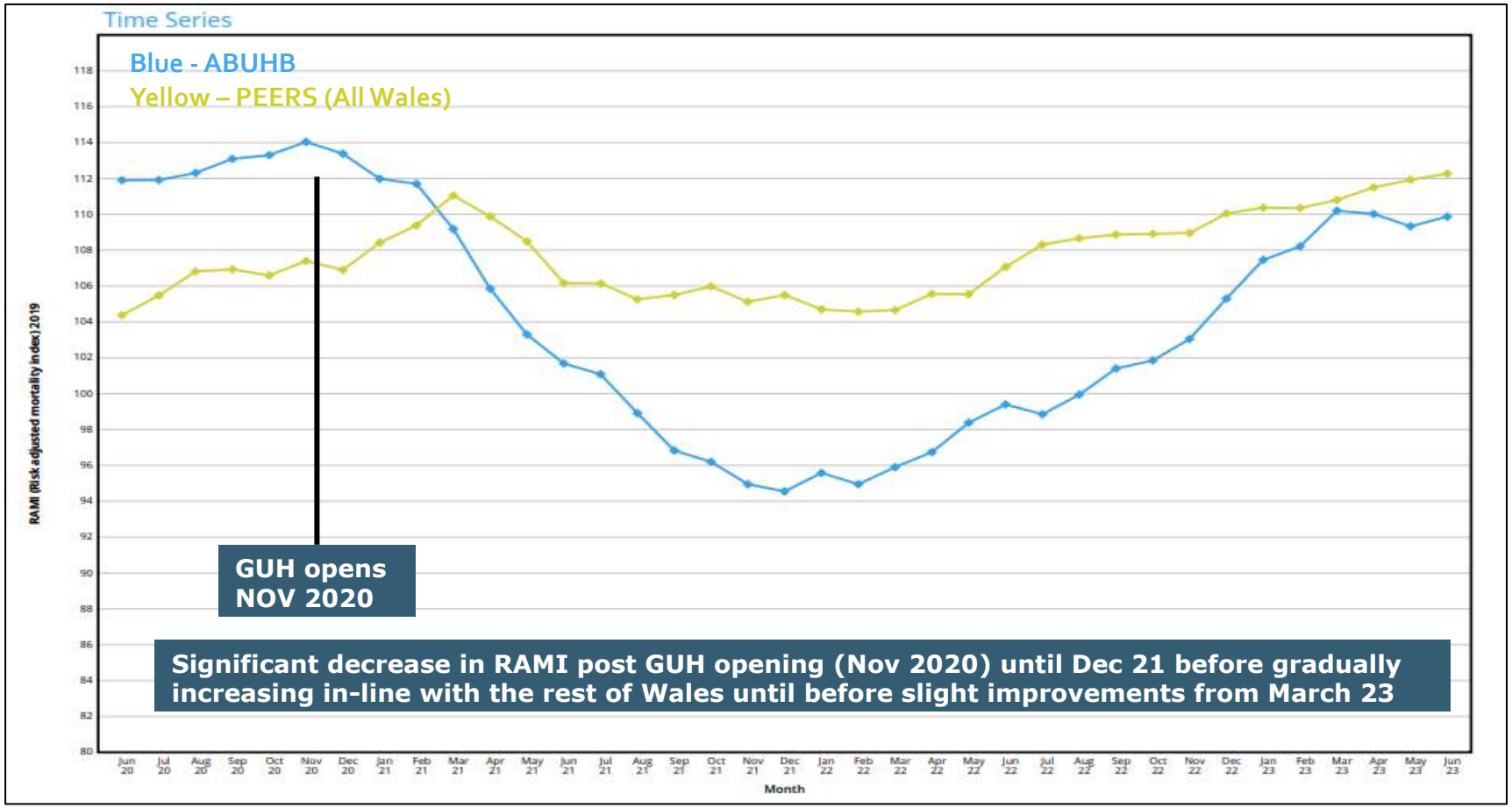
Progress

- Workshop undertaken within Scheduled and Unscheduled care on 23rd August 2023 with positive engagement and outcomes
- Driver diagram developed
- Follow up meeting agreed Divisions to undertake a test for change across all sites within ABUHB
- Faculty group to meet in three weeks to agree date of commencement and timeline for improvement

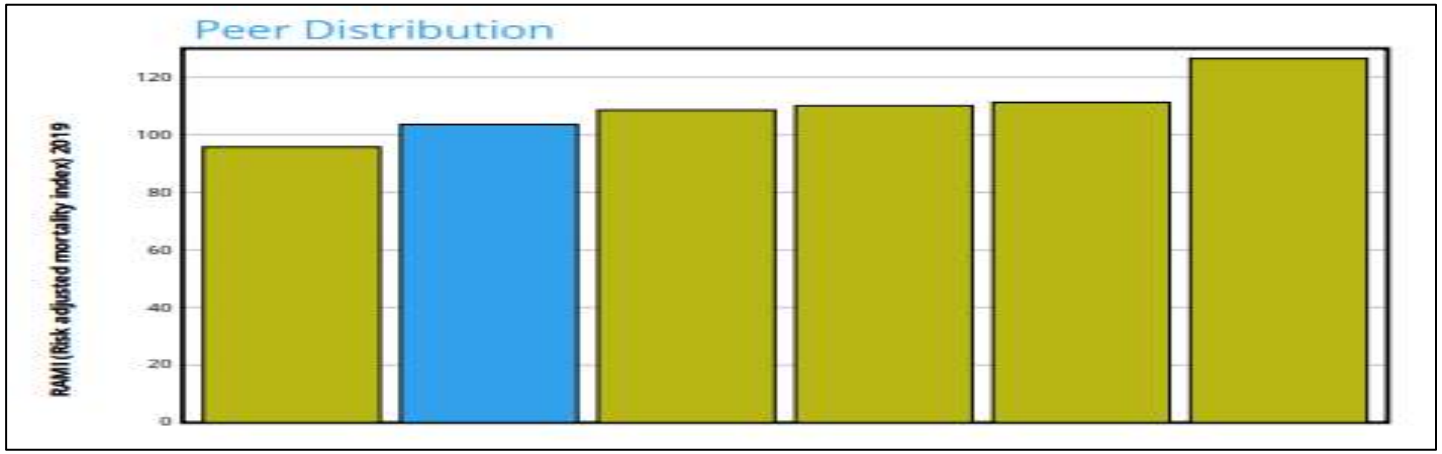
PU Driver Diagram 2023



RAMI (Risk adjusted mortality index)

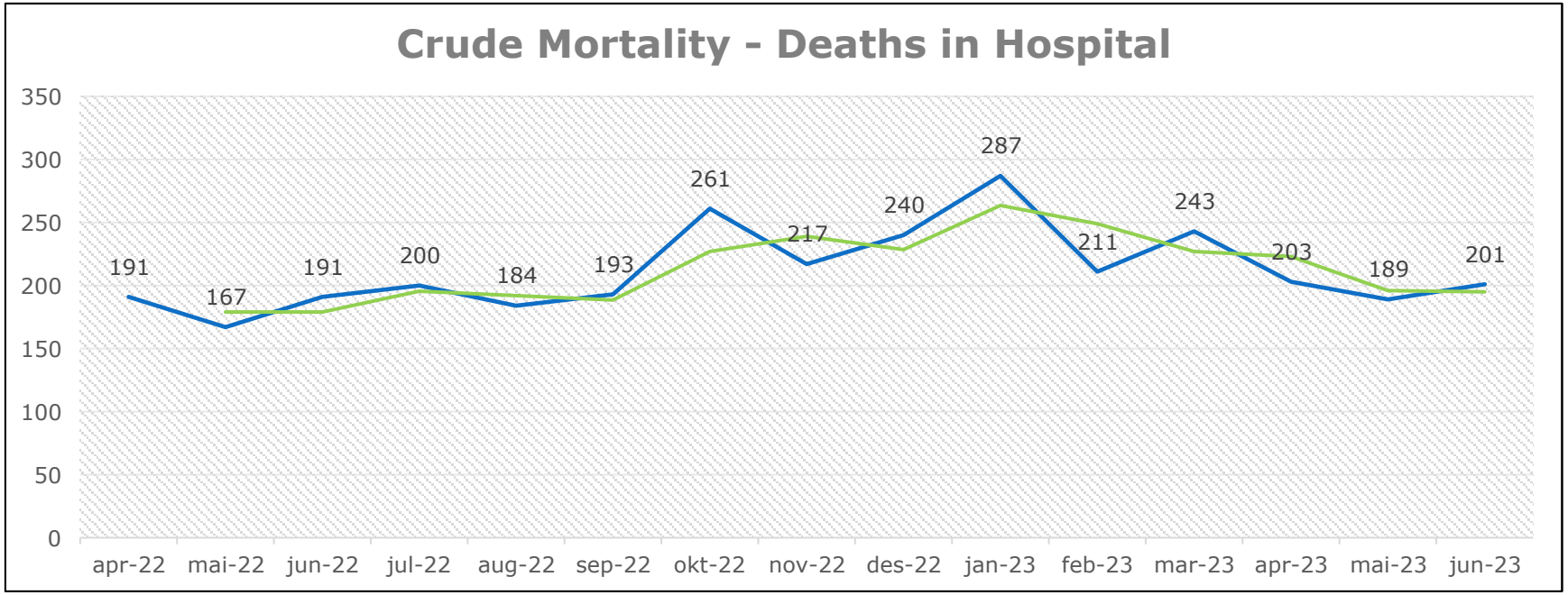


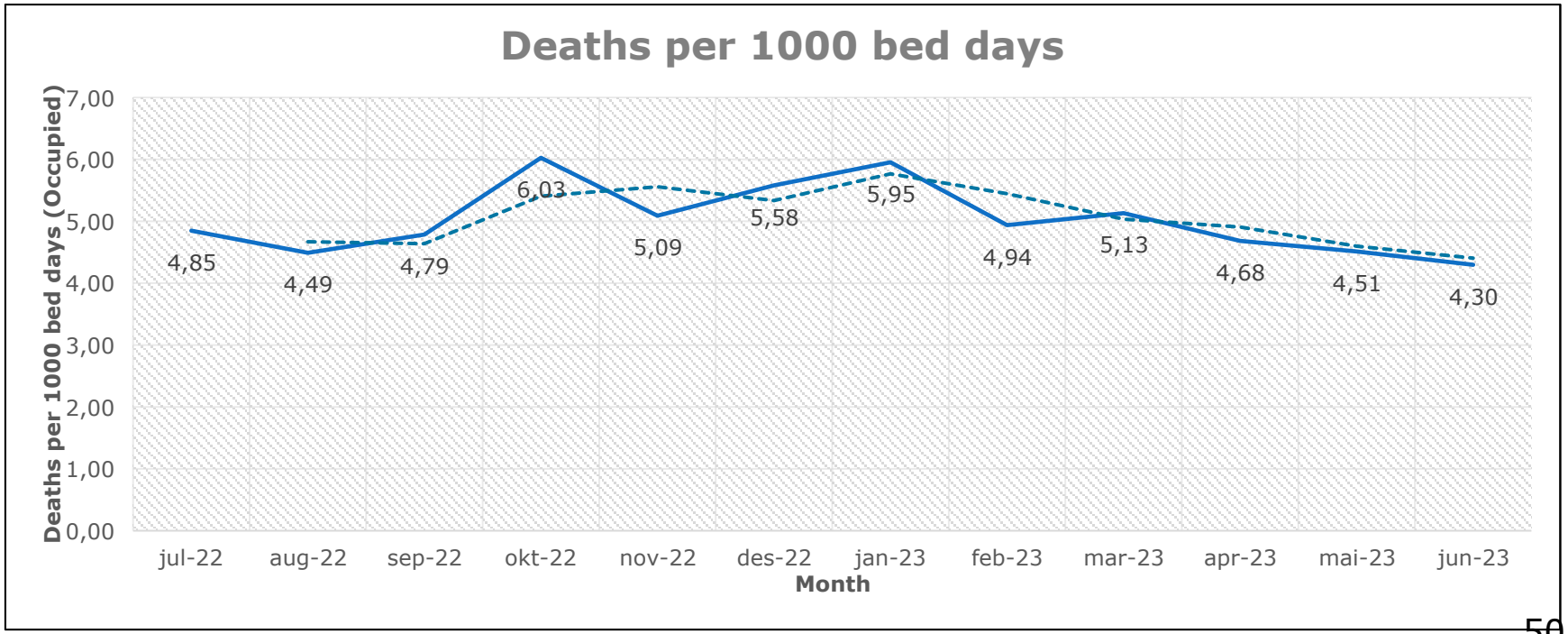
Significant decrease in RAMI post GUH opening (Nov 2020) until Dec 21 before gradually increasing in-line with the rest of Wales until before slight improvements from March 23



Currently performing 2nd of 6 within All Wales peer group

Crude Mortality in Hospital

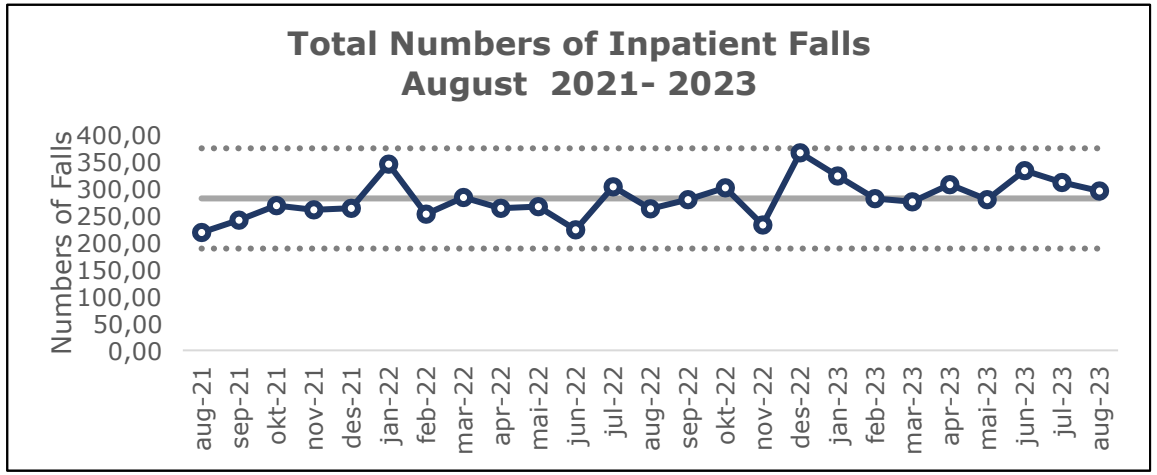




Actions

Issue	Cause	Remedial Action	Who	When
Coding lag	There is a increased time lag with coding records within ABUHB causing a delay in validated data, which affects the reliability of RAMI.	• Target of coding 95% of episodes is not being met. Currently achieving 85%, due to vacancies in coding team. • External audit undertaken of clinical coding has demonstrated 97% accuracy with coding. • Coding has now moved under the management of the Information Team and will be expanding the team. • Medical Director initiating meetings with coding team.	Information Team	On-going
	Inconsistencies within the coding (sign or symptom as a primary diagnosis) this affects the accuracy of calculating RAMI.	• Liaised with CHKS – Coding data considered accurate after 3 months for ABUHB, this varies for other HB's as some do not submit data as regularly as ABUHB.	Information Manager	Complete
Reliability of mortality data	Consistently of mortality reporting and data	• Producing a mortality framework that will look at crude mortality and other mortality indictors that are attributable to Divisions and Directorates, linking in with Clinicians to understand mortality outliers. • All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Dedicated resource to review and utilise CHKS data	• Information Manager now in post and meeting regularly with CHKS	Information Manager	Complete
	Understanding, interpreting and interrogating CHKS data to formulate a clinical outcomes report	• Information Manager and QPS team meeting with Divisions to identify what is currently reported, to progress Clinical Outcomes around Mortality Outliers.	Information Manager and QPS Team	Ongoing
	Developing governance process around mortality outliers	• QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	QPS Team and Information Manager	Ongoing
	Learning from Death framework	• Initial work on learning from Death Framework underway and progressing to drafting stage, this will include the learning for the Medical Examiner service and the mortality review screening panel.	QPS Team and Information Manager	Ongoing

Total Numbers of Inpatient Falls



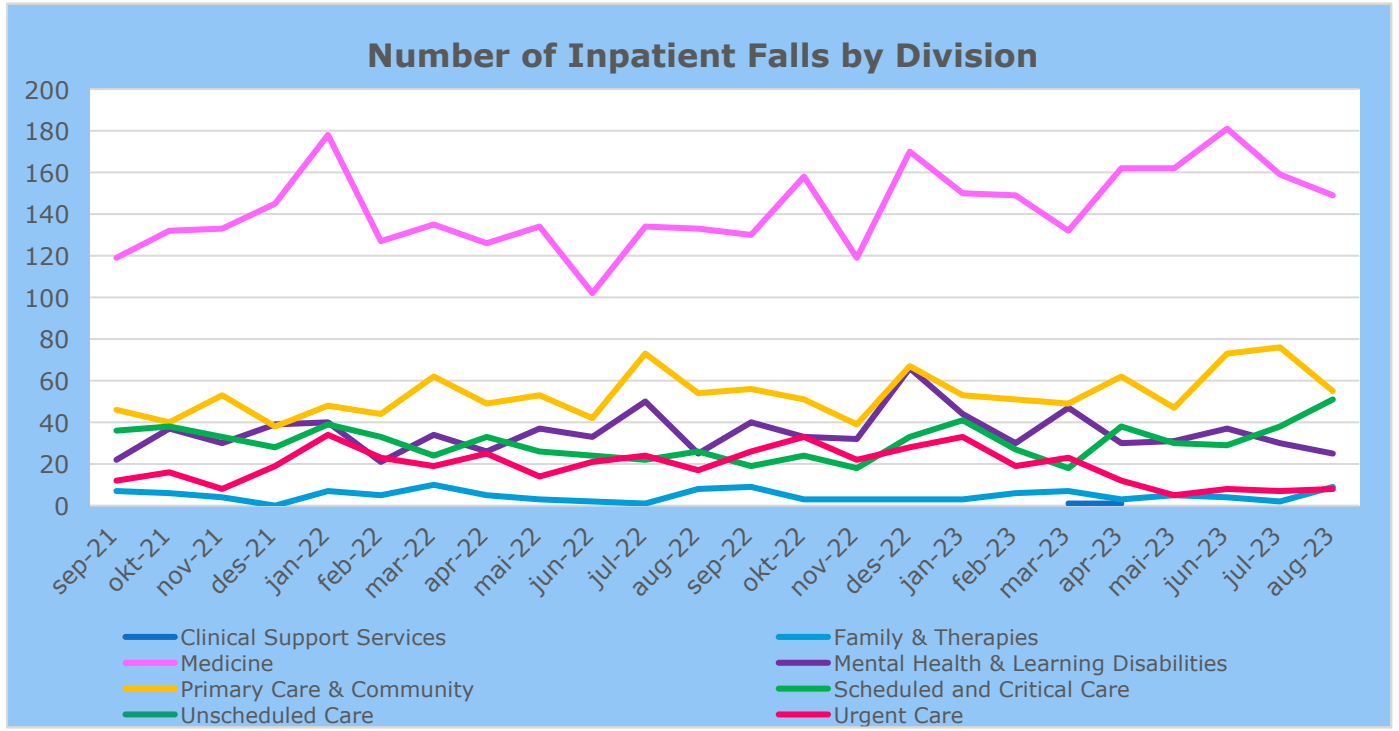
October 2023 - Context

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

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period August 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 276 to 282. • For the year 2022-23 incident reporting numbers remain subject to variation with a peak in December 2022. • February to August 2023 has seen closer alignment to the mean average value with a rise in June followed by a downwards trajectory for July and August 2023.	December 2022 saw the highest numbers of reported falls incidents since January 2022 at 369. June 2023 represents the second highest value for reported incidents in the given period at 334. August 2023 has seen a return to a value more aligned to the average mean.

Inpatient Falls Data by Division



October 2023 - Context

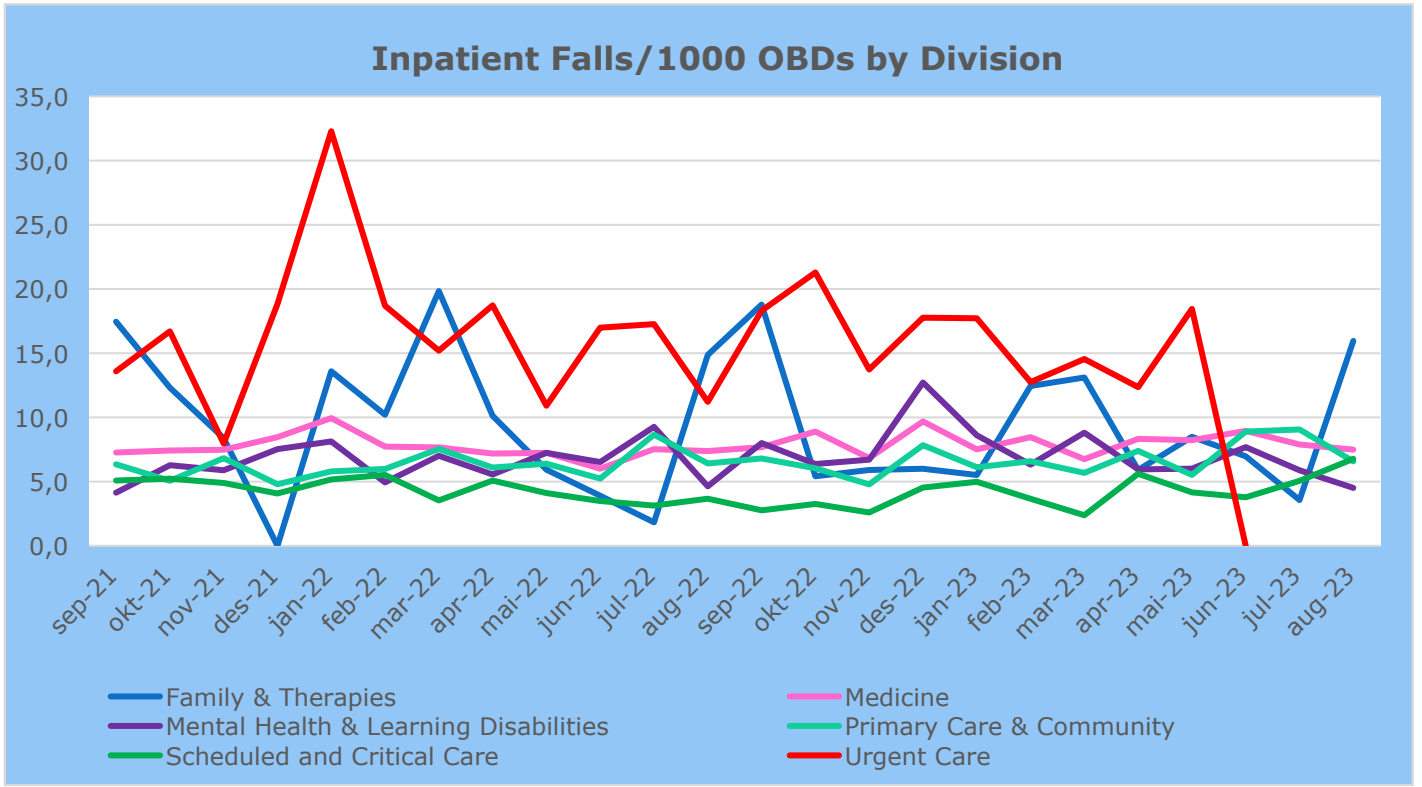
The data used in this chart has been retrieved from Datix.

It is important to consider these values in the context of numbers of patients in hospital within a given service.

Definitions	What the chart tells us	Key Variation Highlights
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• The information provided represents that per Division for the total numbers of inpatients falls for the period September 2021 to August 2023. • As expected, the highest numbers of falls remain linked with those ward that are populated by our frailer and older patients. • Of all the Divisions 63% have seen a downwards trajectory for the numbers of reported falls incidents.	Medicine has seen its lowest value for numbers of falls since March 2023. F&T represents the one Division that has seen a significant rise in falls in August 2023. PCC has seen a value of 55 for the month of August as compared to 76 in July 2023. MH & LD has seen its lowest value for falls incidents since August 2022. Urgent Care has retained its downwards trajectory since April 2023 recording a value of 8 as compared to a value of 33 at the start of 2023.

Inpatient Falls Data

by Division



October 2023 - Context

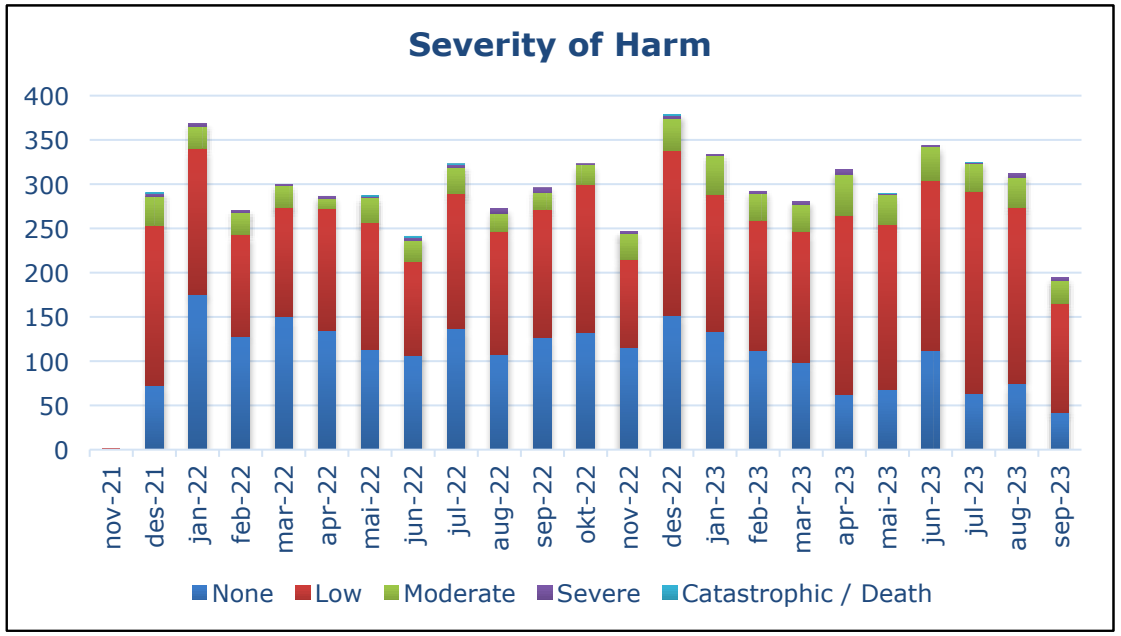
The data used in this chart has been retrieved from Datix.

It is important to consider these values in the context of numbers of patients in hospital within a given service.

Definitions	What the chart tells us	Key Variation Highlights
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	The information provided represents Inpatients Falls per 1000 OBD's per Division for the period September 2021 to August 2023. (For note a value for Urgent Care was unable to be calculated for July/ August 2023).	Of the Divisions represented 84% saw a decrease in the value for Inpatient Falls per 1000 OBDs for August 2023 as compared to July. 60% of which was below or aligned to the National Average of 6.6 MH & LD has seen the most significant downward trend with a value of 4.5 F & T represented the only Division in which a significant increase was seen.

Inpatient Falls Data

Severity of Harm



October 2023 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period November 2021 to September 2023. N.B. September 2023 represents a partial data set.

The severity data is reflective of the identified level of harm recorded at the time of reporting.

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 for the period November 2021 to September 2023. • 36.2% - No harm • 52% - low harm • 9.8% - Moderate harm • 0.9 % Severe harm • 0.1 Catastrophic	For the months of July and August 2023 there was a decrease in reported incidents in both the No Harm and Moderate Harm categories. The category of severe was seen as the same value for both months (4) No incidents were reported as catastrophic at the time of the reporting the view of harm.

Escalated risk concerns

Section 3

Framework for Speaking up Safely in the NHS

- The Framework has been developed, scrutinised and approved in social partnership to provide an all-Wales consistency of cultural expectation, approach and escalation process whilst also strengthening local initiatives.

- A self-assessment will be completed to determine the Health Board's obligation to support people to speak up safely and with confidence.

- Self assessment to be presented to Executive Committee 19 October 2023.

- Submission of self assessment to Welsh Government by end of October 2023.

Escalated Risk Concerns

- Quality, patient safety and governance escalation process Mental Health and Learning Disabilities Division due 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 serious incidents. Collaborative event being held in October to look at learning and quality improvement.

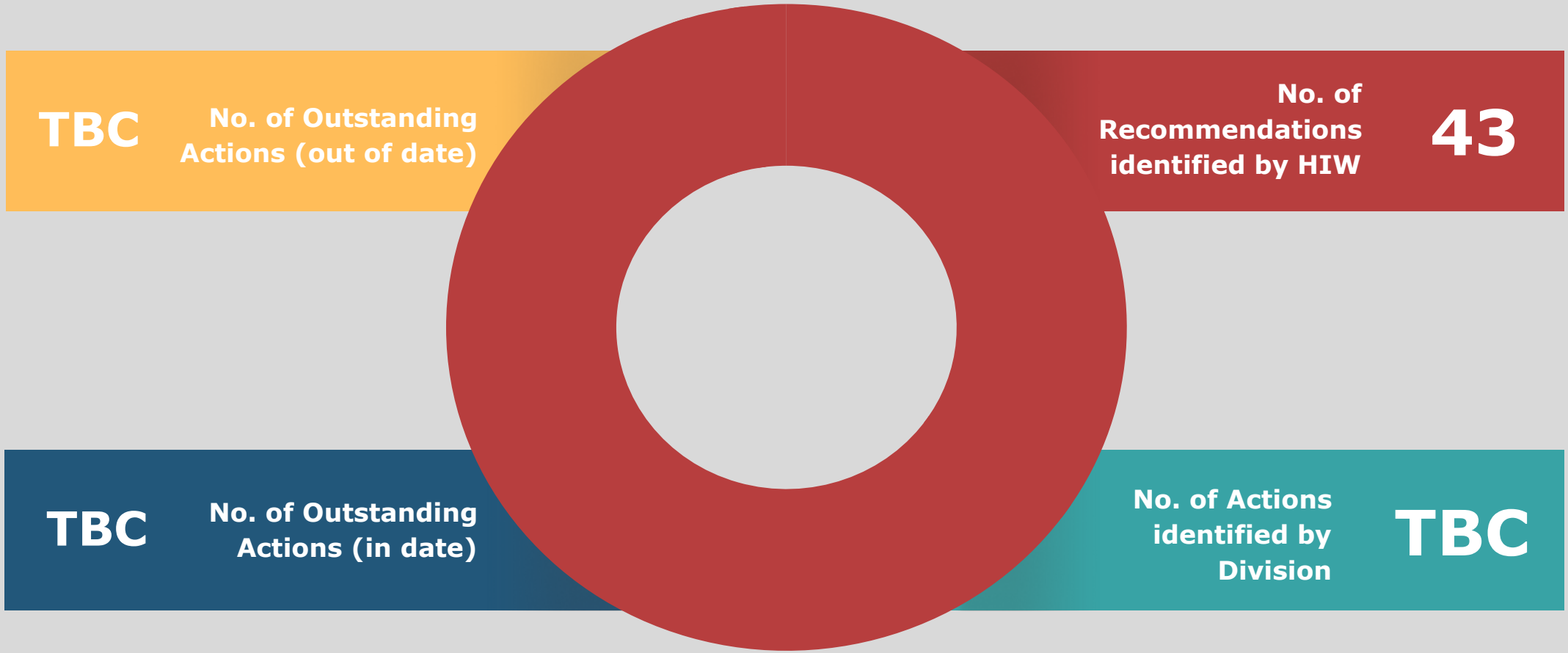
- Good progress being made on end of life and bereavement pathways.

Overview of the Health Inspectorate Wales' Inspection of Cedar Parc, Ysbyty Tri Chwm

1 July – 22 September 2023

- Health Inspectorate Wales undertook an Unannounced Inspection to Cedar Parc, Ysbyty Tri Chwm on 7-9 August 2023.
- An Immediate Assurance notice was issued.

- Overarching improvement plan and draft Inspection Report issued by Health Inspectorate Wales on 19 September 2023.
- Improvement Plan to be submitted by 4 October 2023



Health Inspectorate Wales Inspections Update

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

- Inspections undertaken since July 2023
- National Reviews
- Improvement plans with outstanding actions

ABUHB Inspections/ National Reviews undertaken

July – September 2023

Cedar Parc, Ysbyty Tri Chwm (Inspection)

Date of Inspection: **7 – 9 August 2023**
Immediate assurance improvement plan: **29 recommendations**
Overarching improvement plan: **43 recommendations**
Report Publication Date: **DRAFT received 19 September 2023**
Improvement Plan to be submitted by: **4 October 2023**

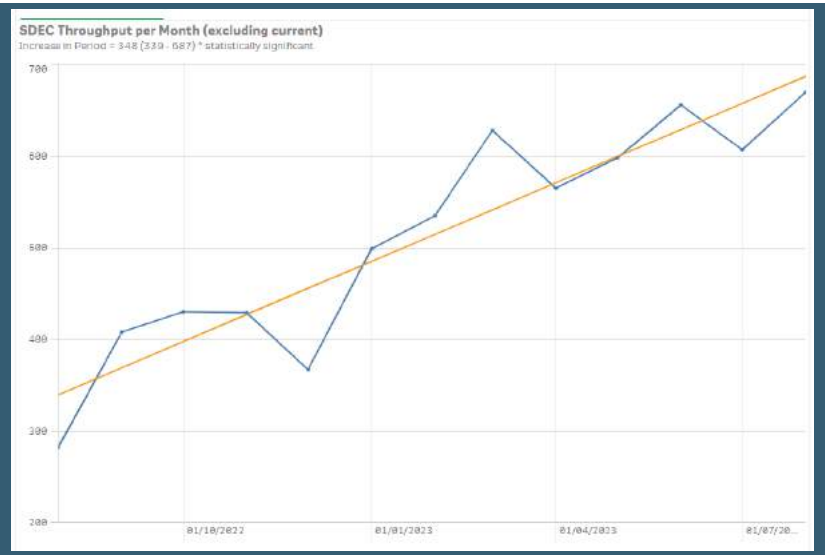
Patient Flow; a Journey Through the Stroke Pathway (National Review)

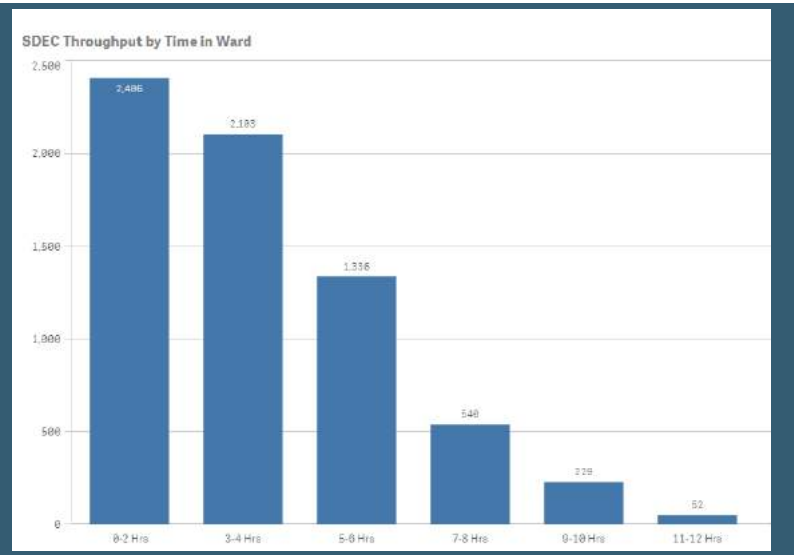
Improvement Plan received: **15 September 2023**
Improvement plan: **50 recommendations**
Report Publication Date: **7 September 2023**
Improvement Plan to be submitted by: **12 October 2023**

Existing Improvement Plans with Outstanding Actions

Division		In-Date	Out-of-Date	Total
Mental Health & LD				
Ty Lafant	Immediate	0	1	**4**
	Overarching	0	3	
Ty Cyfannol & Annwylfan Wards		0	5	**5**
Cedar Parc	Immediate	5	2	**7**
	Overarching	In-development: Deadline to HIW 04/10/23		
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		2	1	**3**
Scheduled Care				
D2 East & West – RGH		1	0	**1**
Diagnostics & Therapies				
Ionising Radiation (Medical Exposure) Regulations - NHH		4	2	**6**

SDEC GUH at a Glance: 08/08/2022 – 15/09/2023





7006 Patients seen

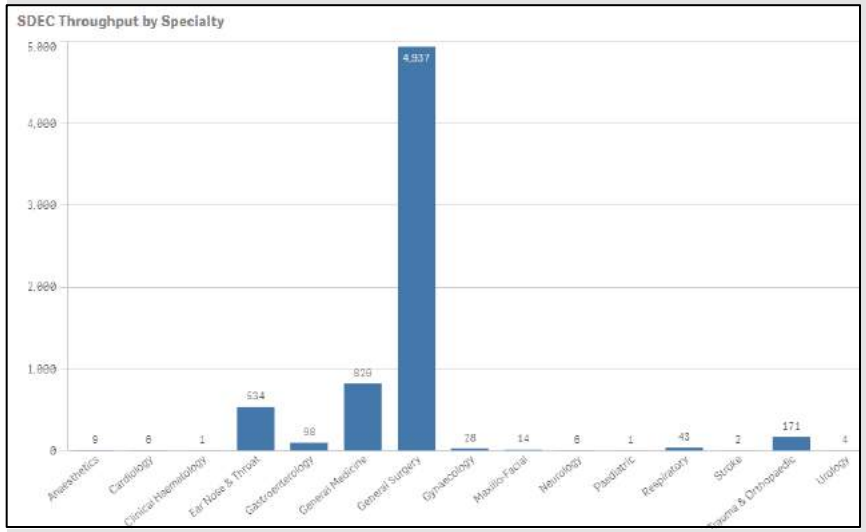
Average 40 Patients per day

434 Next day Returners

Median time 3:48 hours

5744 patients Discharged Same Day (82%)

1262 Admissions

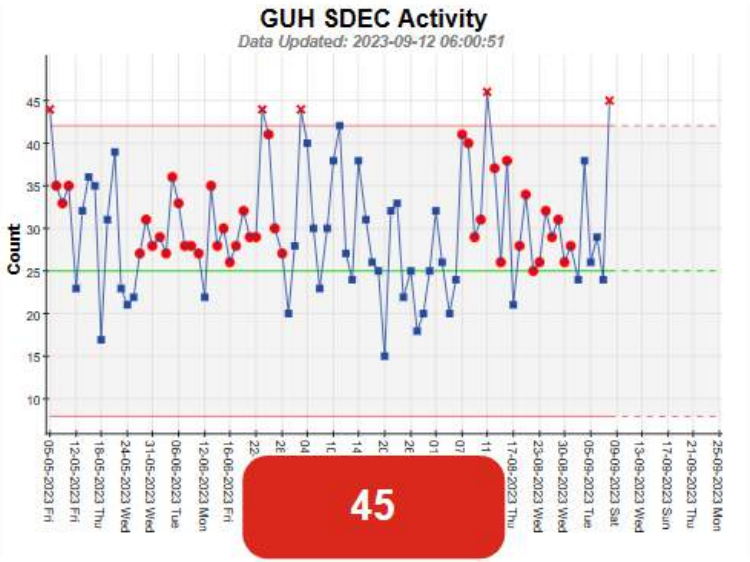


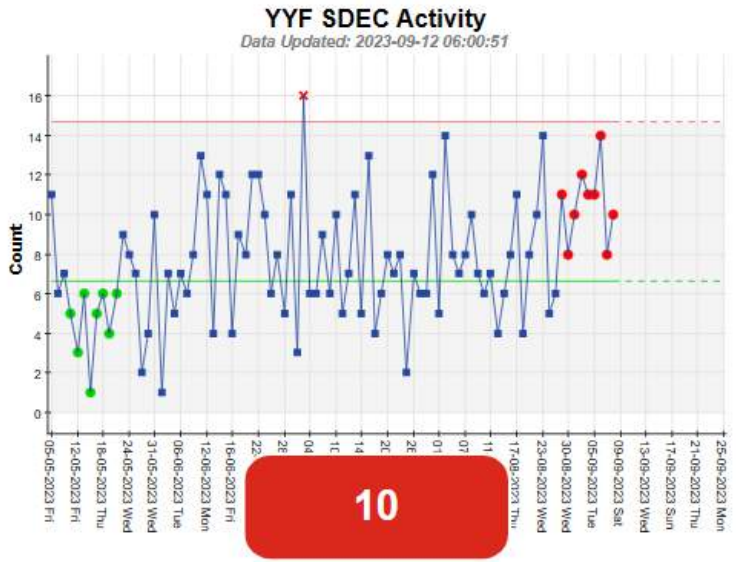
Progress Summary:

- Average daily patient throughput up from 33 to 40
- Surgical model working very well
- Medical Model GP referral process now in place
- Medical referrals increasing substantially, from 10 to 25 per week, with peaks of 38
- Reviewing condition specific pathways for direct referral from ED/MAU to SDEC
- Reviewing WAST access to SDEC
- Consistent Positive feedback from patients and staff
- SDEC has never been used for in-patient capacity

Goal 3: Clinically safe alternatives to admissions to hospital

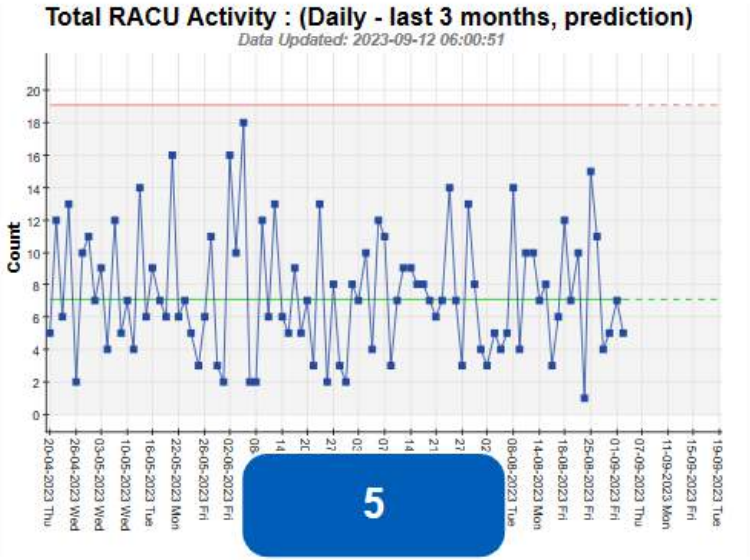
Alternatives to Admission

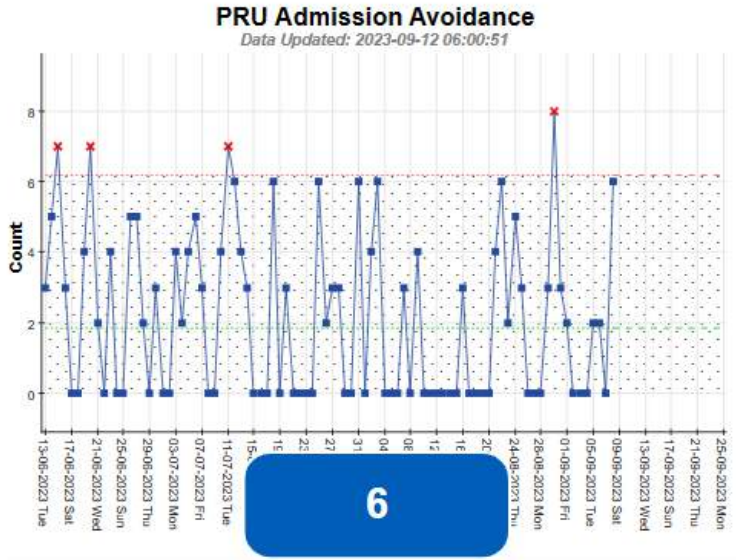




Data Updates & Forecasting:

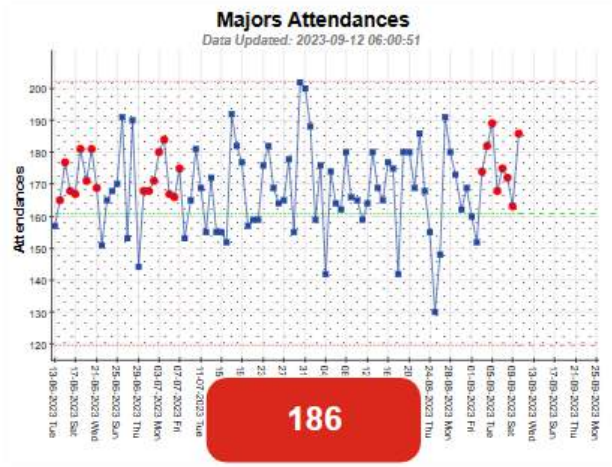
- **GUH SDEC** has been seeing around 25-45 patients/day

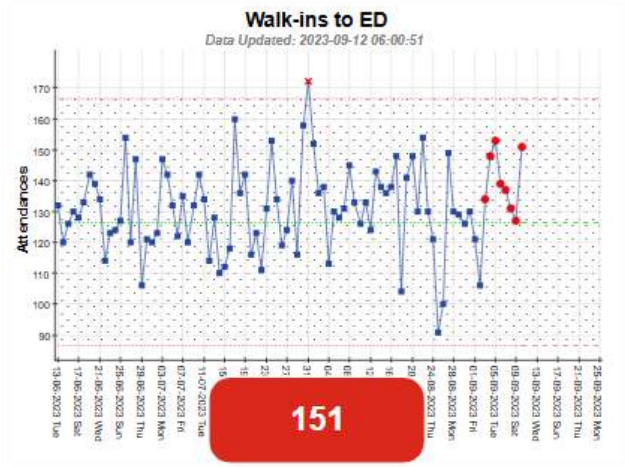


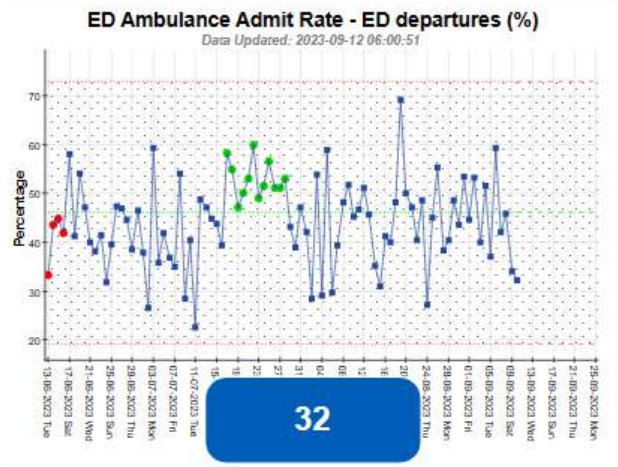


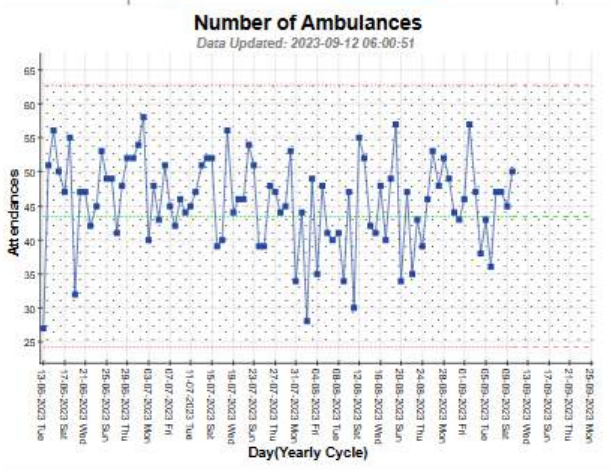
GUH ED Activity

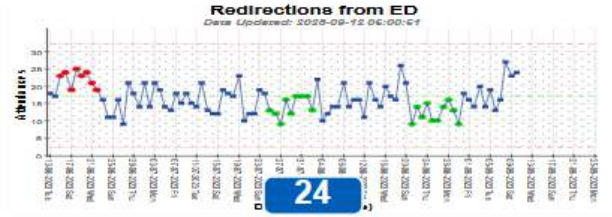
Ambulances	50
Admitted	13

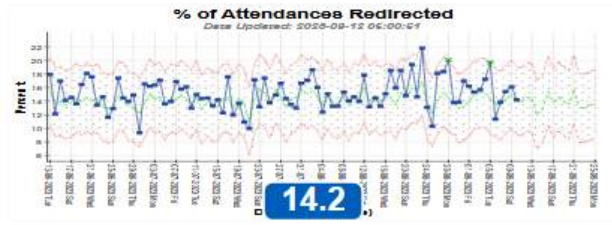


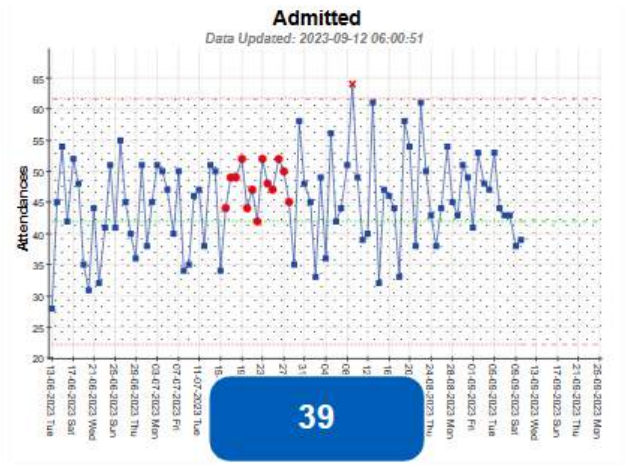


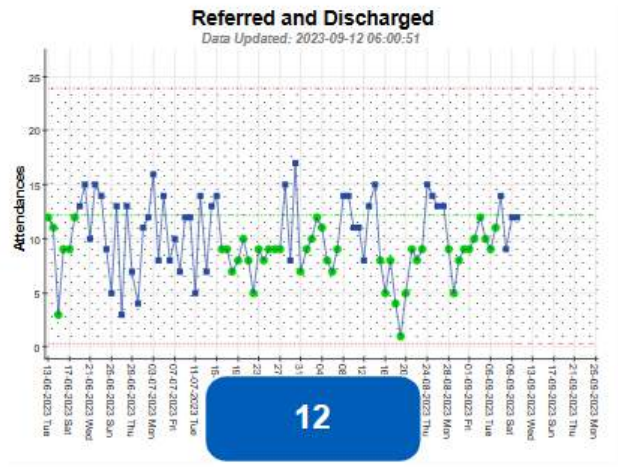


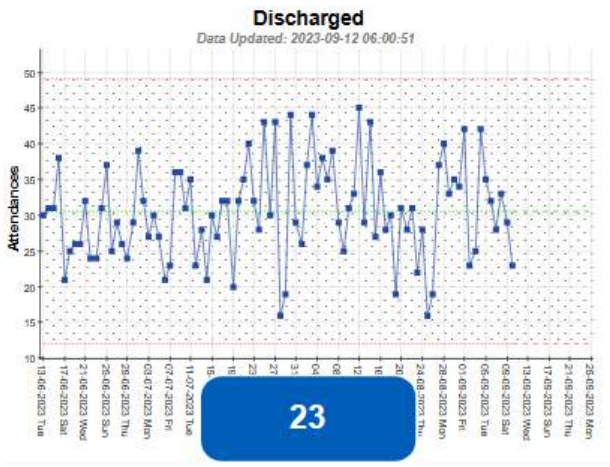




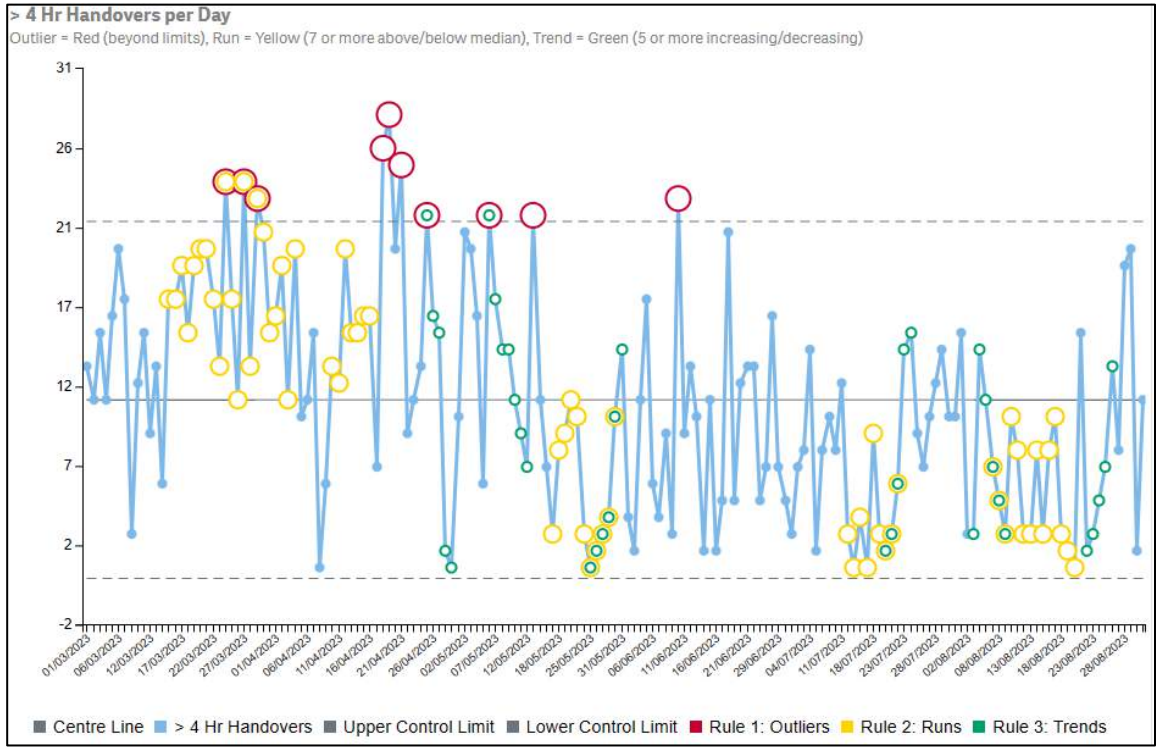


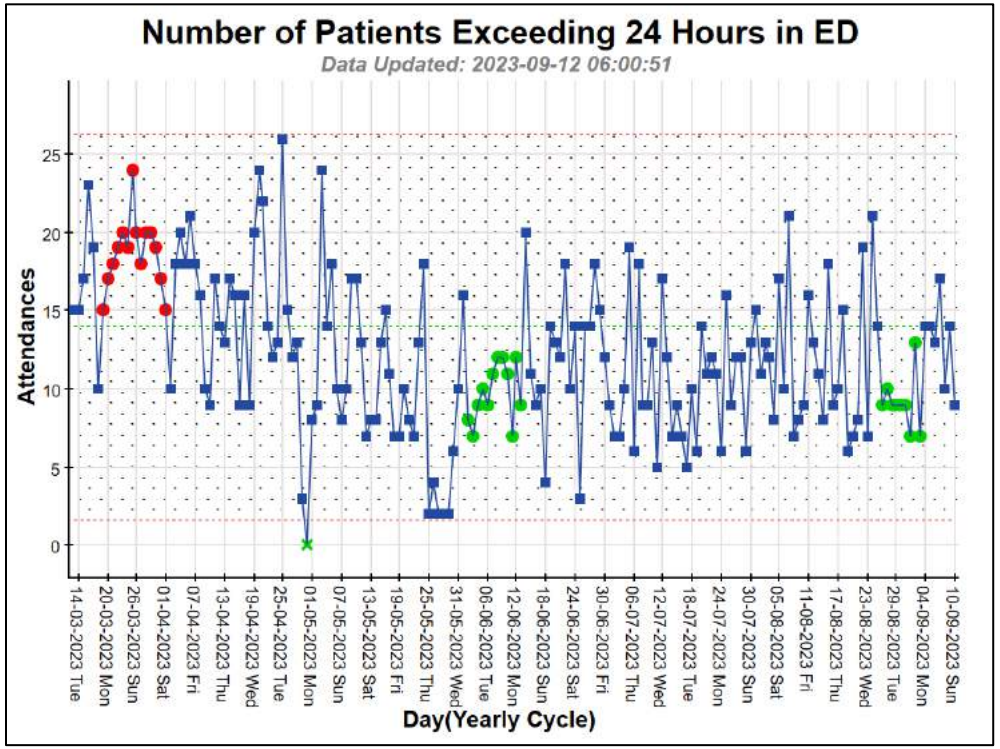






Goal 4: Rapid response in physical or mental health crisis





Data Updates & Forecasting:

- **Around 12 patients a day** waiting over 4 hours for ambulance handovers at GUH
- **Around 14 patients a day** spending over 24 hours in ED

Urgent 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 • Explore & progress alternative roles	Divisional Nurse / Divisional Management Team	Ongoing
Patient / Safety 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) • Full Capacity Protocol (FCP) in place • 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

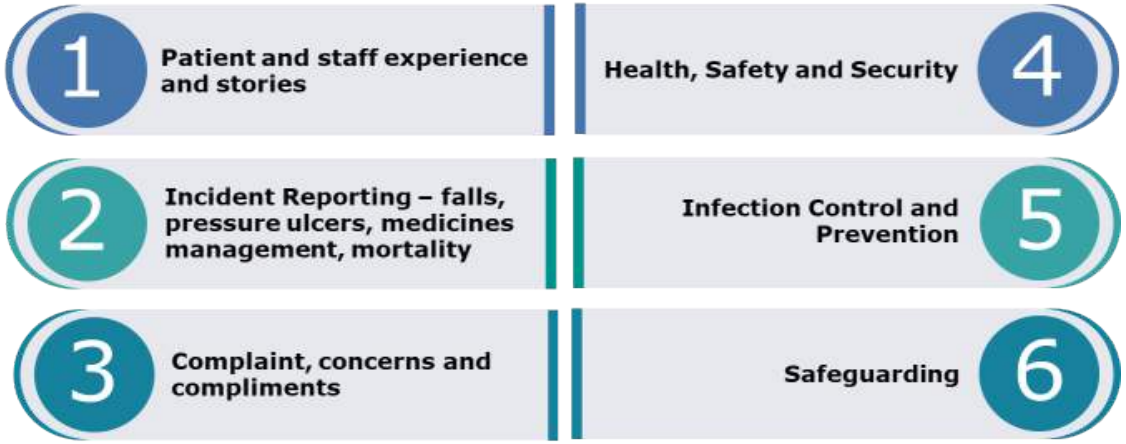
For Information

Section 4

Quality Strategy Implementation Plan

- Continued roll out of Quality Strategy and Patient Experience and Involvement Strategy
- QOF being refined and report presented to PQSOC.
- Two day event with external facilitator Maxine Power – WAST conveyance and collaborative for deteriorating patient.
- Continue to develop Quality 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 QPSOG and establishing forum for learning. Including membership and purpose of the Group (additional members to include WF & OD).
- Safe Care Collaborative ongoing and moving inhouse.

Quality pillars as defined 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 review our performance.

Quality Strategy Update

- Quality narrative report produced for In Committee Board
- Populated QOF ready for next PQSOC, will refine to ensure narrative and learning is captured.
- First learning forum held, mapped to pillars of quality and will map to Six domains of quality (STEEEP).
- QPS resource being realigned.
- Safety first - a redesigned approach to incidents, serious incident management learning and decision making.
- QI refresh – mapping of QI expertise in the organisation, identifying Quality champions. Autumn - big conversation around Deteriorating Patients to create capacity and develop capability and a further conversation on Q1.
- Accelerated quality improvement event with external facilitator on WAST conveyances and deteriorating patients taking place in October.

Person Centred Care:

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Equality and Diversity **(Volunteering and Employment)**	Diverse Cymru indicate that people from diverse ethnic backgrounds need to have better access to volunteering and employment.	Contact made with Diverse Cymru. Person Centred Care Team (PCCT) have undertaken Ethnic Culturally Competent Workforce Awareness Training. Working with Coleg Gwent to support international Health and Social Care students with volunteering and work experience placements.	Members of the PCCT will hopefully achieve Ethnic Culturally Competent Accreditation which will further embed cultural competence in the Person-centred Care Work Programme. PCCT Team will be able to advocate cultural competence across teams to embed ethnic equality across person-centred care activity including volunteer recruitment.	Working with Diverse Cymru, Self-Assessment to be completed within the PCCT. This will indicate the steps to be taken to achieve accreditation.
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 Neurological Rehab Team forwarded PCCT details to those patients interested. Met with Neurological Rehab support group to discuss volunteering opportunities. Two of the volunteers have completed recruitment, 1 commenced at YYF	Co-production will allow people who have experienced a stroke to gain an opportunity in volunteering	Continue with recruitment of volunteers. 2nd volunteer to be inducted on 29th September
Equality and Diversity **(Alcohol Services)**	People who are recovering from alcohol misuse would like the opportunity to volunteer.	PCCT have met with patient group to discuss volunteering opportunities and agreed one support group to be led by all volunteers.	Offering volunteer opportunities will provide people who are recovering from alcohol misuse the opportunity to volunteer and gain a sense of purpose. Patient story shared at QPSOG.	Continue with volunteer recruitment. Look for suitable venue to hold new group.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Neuro Diversity	Patients have expressed concern about 'sensory overload' when attending A&E and lack of awareness of neurodiversity amongst the workforce.	Meeting with patients. Patient story prepared for Board. Agreement with the Division to use feedback as learning and identification of actions needed to improve experience.	Staff will be confident to recognise and respond to patients with neuro-diverse conditions. People's experience will improve.	Film to be taken to Board. Meetings with Divisional Leads and patients to establish 'expert by experience' improvement group.
Patient Experience (PALS)	Relatives have raised concerned about being unable to contact wards and lack of timely information	Introduction of PALS service agreed. Recruitment of 3 PALS Officers (anticipated start date mid-October 2023) Alignment of existing PLO service to PALS. Public information drafted. Meeting arranged with PTR, Customer Services and PCCT Team to finalise process. Meeting arranged with DATIX Leads to prepare the PALS Datix Module for use.	Patients and relatives will be able to access a single point of access to raise enquiries. There will be a reduction in formal complaints due to better processes for Early Resolution.	Await staff to take up positions. Public information leaflet to promote service drafted. Refine/finalise operational procedure.
Patient Experience (CIVICA)	CIVICA roll out across MH/LD division and YYF with the person-centred care survey.	All 18 mental health and learning disability wards were visited with baseline data collected from 14 of 18 wards, totalling 63 surveys, and 6 medical wards and 1 surgical ward totalling 57 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. PCC Survey to be included in Ward Accreditation. Safety Visits to consider asking patients the 8 core PCC survey questions.

Person Centred Care: Listening and Learning from Feedback

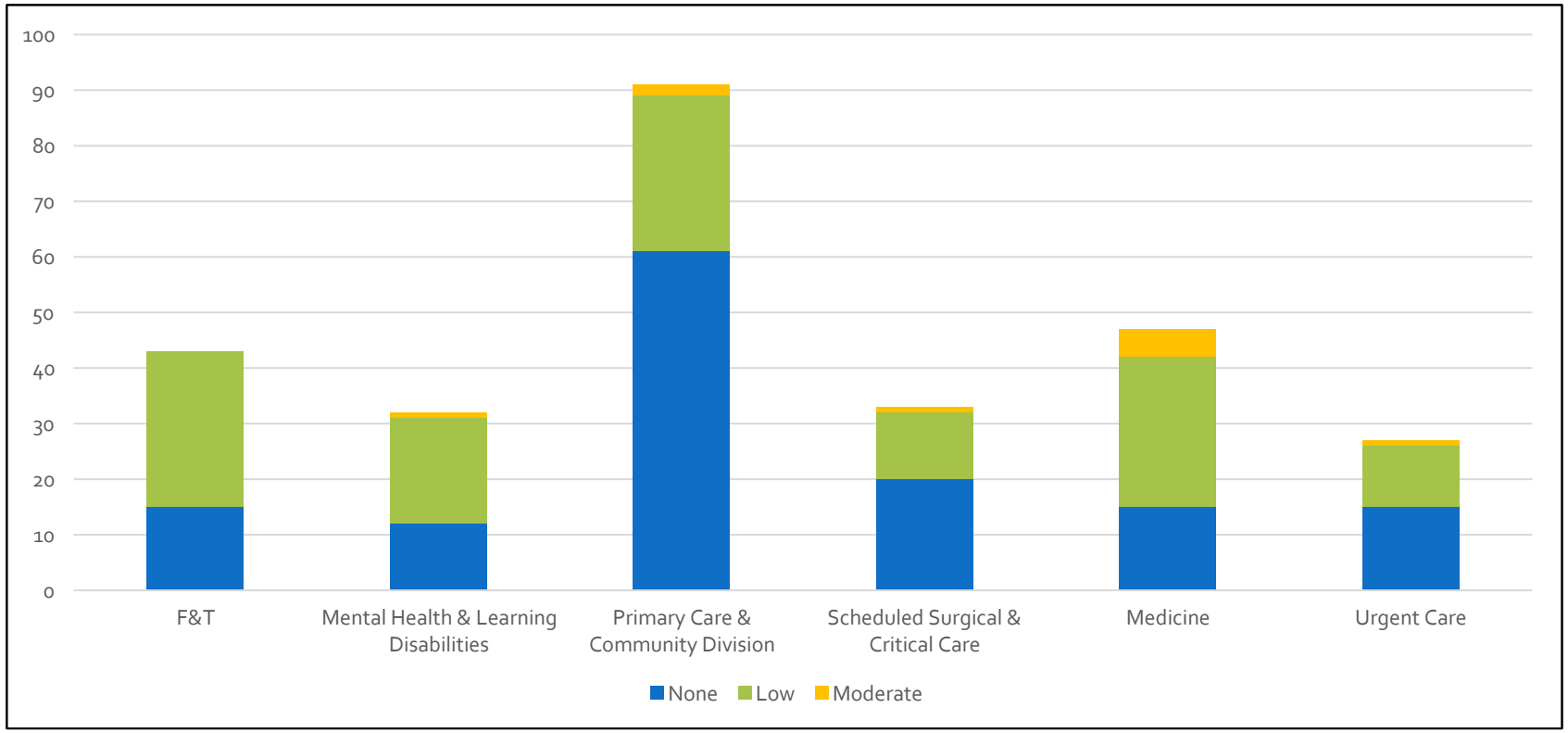
Theme	Feedback	Action Taken	Impact	Next Steps
Cancer Café's	More support is needed for people in the community living with cancer.	Meetings held with Cancer Project Officer to establish Cancer Cafés to support patients in the community. Emails sent to existing volunteers for expression of interest in supporting café's.	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
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. Met with Workforce to update with work plan who in turn signposted personnel to discuss volunteer Wellbeing Assistant. 40 volunteers on the Volunteer to Career pathway. Roadshows at 'Fresher Weeks' held at local colleges. Roadshows and volunteer promotion in community/supermarkets	People with additional learning needs and those with no experience of working in the NHS will be provided with volunteer opportunities to gain experience. Shared initiative at National Bevan Commission Event and National RCN Award presentation.	Ongoing collaboration with WOD, colleges and job centres. Continued promotion of the Volunteer to Career Programme.
Staff Wellbeing **Volunteering**	Request from clinical team for Wellbeing Therapist volunteer to support front line clinical staff providing massage therapies to improve their wellbeing.	Team met with Chaplaincy and Volunteering team. To pilot if agreed, staff can self-refer, or be referred by their line manager.	Staff will have access to wellbeing therapies.	To create a new role profile for a Wellbeing Therapist Volunteer, forward to Staff side for comments Staff member to commence volunteer recruitment process.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Care After Death (CAD)	Feedback from COVID bereaved relatives who require more information.	Meetings with COVID bereaved relatives. CAD public information revised and sent to relatives for comments. CAD and PCCT meeting arranged for September 2023.	People who are bereaved will be able to access meaningful and timely support.	Establish Bereaved 'Experts by Experience' group to collaborate on actions to improve experience. CAD website to be updated. Meetings with English Trust to look at SWAN end of life and bereavement model.
Patient Education (Dietetics)	Community Health Programme (CHP) Nutritional Presentation indicated need to ensure patients better understand balanced diet through improved patient education.	Met with leads to discuss promotion, managing the referrals process and format for patient education sessions. Need to further discuss the current eating guidelines approved by the NHS to enable patients to understand the components of a balanced diet, introduction to the Eatwell Guide and explore ways to make meals more in line with the Eatwell Guide.	Patients will be afforded targeted education sessions to better understand the benefits of a balanced diet.	To email existing patients on waiting lists for other services and arrange dates for service to commence in relation to the demand.

Medication Safety Group

Medication Incidents by Severity and Division Q1 2023-24

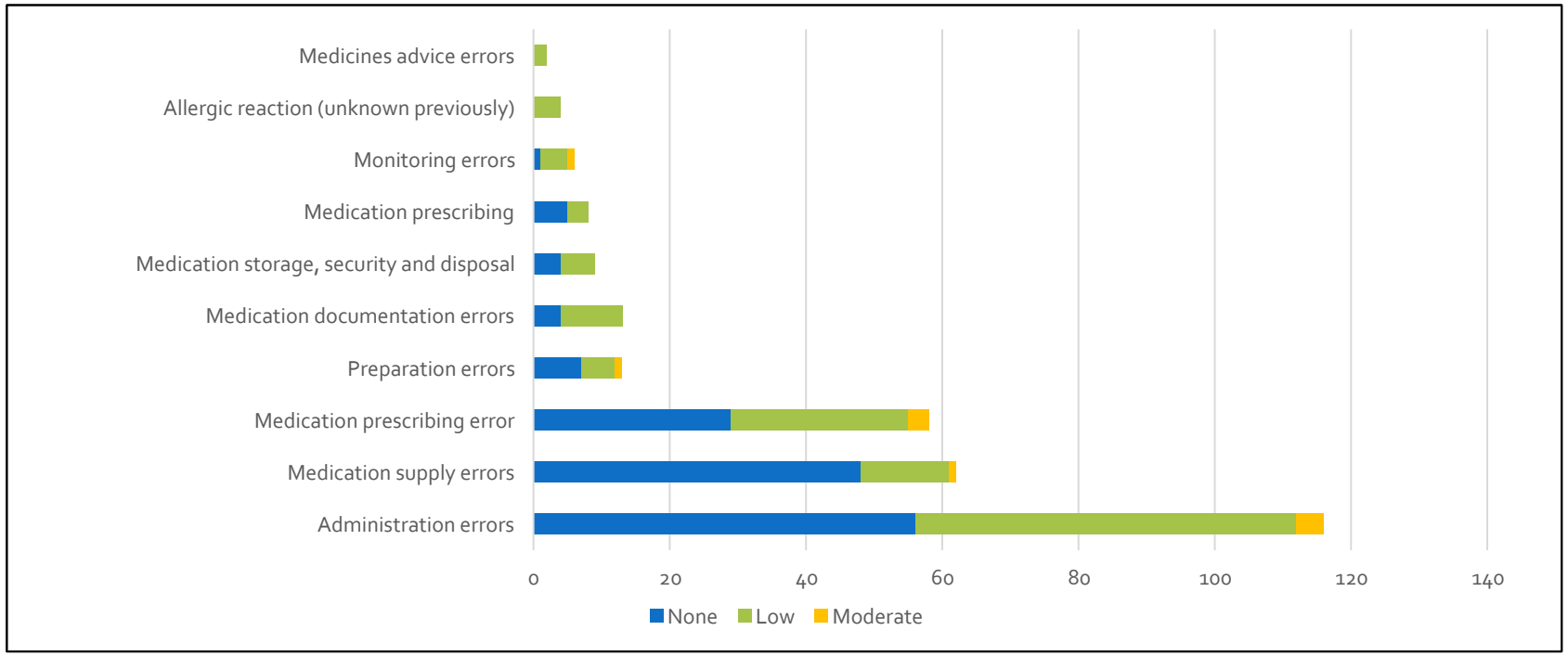


- Total 304 incident reported April to June 2023. July onwards will be in Q2 data.
- Total 291 incidents reviewed and investigated April to June 2023
- Graph relates to total number of incidents by division and "Severity of Incident Post Investigation", table relates to "Reporters View of Levels of Harm"

	Q2	Q3	Q4	Q1
None	224	226	208	188
Low	95	95	98	88
Moderate	41	32	35	21
Severe	0	7	5	7
Catastrophic	1	0	0	0
Total	**361**	**360**	**346**	**304**

Medication Safety Group

Medication Incidents by Sub Type and Severity Q1 2-23-24



Thematic reviews:

- Prescribing and medication reconciliation incidents and subsequent internal alert on "The importance of taking an accurate drug history" June 2023.
- Insulin incidents occur in several sub-type categories and have multifactorial contributory factors. Action plan developed in conjunction with diabetic nurses including raising awareness of work already done e.g., resource file in each acute clinical area, encourage use. Collaboration to deliver on targeted training on sites and within community settings.

Medication Safety Group

- Exception reports received from all divisions and incidents of concern discussed and whether learning was or will be shared for organisational learning e.g., HIW inspection and room temperature monitoring.

- Divisional work streams that align with the medication safety strategy highlighted and celebrated e.g., pregabalin audit in primary care, move to electronic consent forms for school vaccination programme to avoid incidents.

- Yellow Card update – targeted training of pharmacy technicians and school nurses delivering vaccination programme.

- Internal alerts relating to medication included amiodarone PFS shortages and subsequent switch to ampoules (June 2023) and glucagon shortage resulting in a switch of brand (August 2023).

- Current Patient Safety Notices relating to medication:
  - Calcium gluconate risk of underdosing
  - Potent synthetic opioids

- MHRA Drug Safety Updates – await further information on teratogenicity of sodium valproate in males.

Medication Safety Group

Issue	Cause	Remedial Action	Who	When
Insulin safety	Thematic review undertaken – cause multifactorial and incidents appear in several sub-type categories	Action plan developed in conjunction with diabetic nurses. Feedback to MSG in November on outcomes	MSG/ diabetic nurses	November 2023
Calcium gluconate PSN needs work and subsequent changes in dosing from 10mls to 30mls.	Risk of under-dosing identified in PSN.	Short working group formed to review ABUHB hyperkalcaemia policy and will go through scrutiny at next Clinical Standards and Policies. Further action to roll out new policies.	Renal team/ MSG	December 2023 deadline

Health, Safety & Security

Health and Safety Executive Engagement

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.

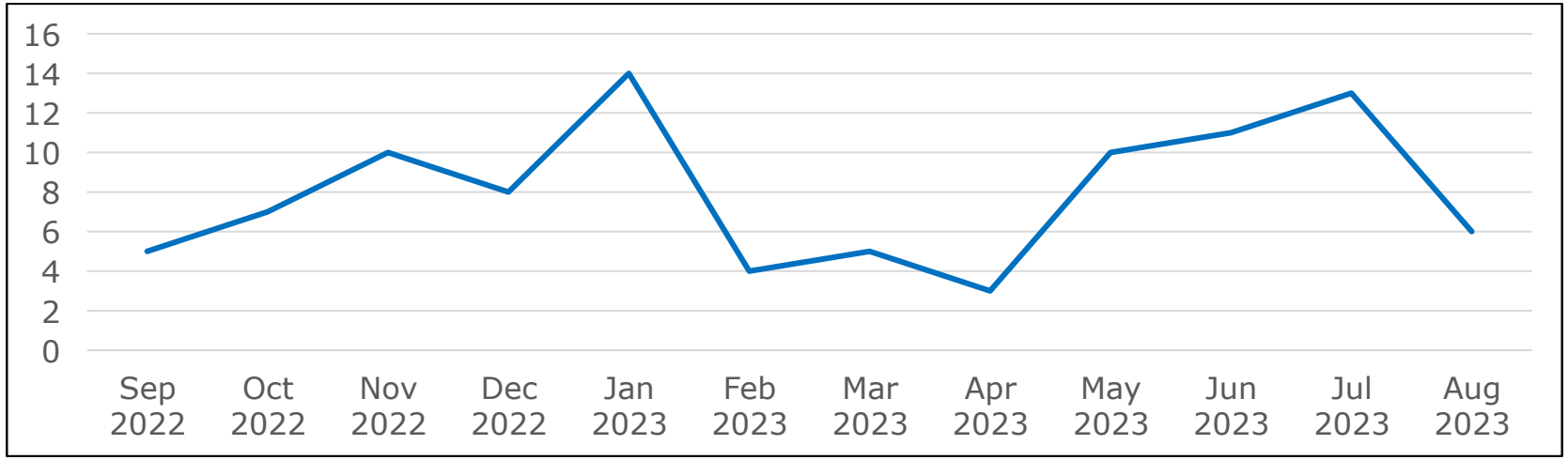
The Health Board have received correspondence from the HSE regarding a concern in relation to **workplace exposure to Diesel Engine Exhaust Emissions (DEEE)** as a result of ambulances waiting idle outside the Grange University Hospital Emergency Department.

Further to the development of a working group comprising of ED Management Team, WAST Health & Safety Representative, WAST Trade Union Representative and ABUHB Corporate Health & Safety Department measures have been implemented to mitigate the risk.

Health, Safety & Security

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period September 2022 to August 2023 the Health Board have reported **96 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).



60% of these cases were reported within the legal timeframes within the legislation. This is an **increase of 2%** from the previous report.

Health, Safety & Security

Health and Safety Statutory and Mandatory Training

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

Health and Safety – 86%
Violence & Aggression – 84%
Fire Safety – 81%
Manual Handling – 56%

There has been an increase in all the health and safety areas compared with the previous report.

A review of all health and safety training strategies is being undertaken to ensure an increase in compliance.

Health, Safety & Security

Reinforced Autoclaved Aerated Concrete (RAAC)

A plan of operational health, safety and fire risk assessments are being completed by Corporate Health and Safety.

The assessments will provide assurance of the safety measures implemented associated with RAAC at Nevill Hall Hospital.

Workplace Inspections

Corporate Health and Safety are revitalising the health and safety workplace inspections in October 2023. The plan is to undertake an inspection of all patient care areas by end of March 2024.

The findings of the inspections will be reported and monitored by the Health Board Health and Safety Committee.

Health, Safety & Security

Violence Prevention & Reduction

The Violence & Aggression Team are currently reviewing the suite of policies and procedures. The plan is to revise the policy and strengthen the supporting procedures/ protocols to support local managers to reduce violence and aggression in the workplace.

Fire Safety

A programme of fire risk assessments across the Health Board is conducted by the Fire Safety Team. There is currently a backlog of assessments, these are being prioritised for completion based on risk.

Claims, Redress & Inquests

July & August 2023

Focus during the Summer

- Welsh Risk Pool LAP – *Learning Advisory Panel*
- ABUHB focus on all aged cases > 6 months
- Over **100** submissions of *evidence/learning/assurance*
- No Financial Penalties at July WRP Committee
- ABUHB representation at LAP Panel
  - Maternity Complaints lead
  - Head of Nursing Urgent Care
  - Legal Service Managers 2023-2024

WRP Learning from Events Report

Key Points for inclusion and Expectations of WRP

Issues – The issue is the failing that led to the breach of duty or harm.

Actions – For each issue identified what action or actions have the health body implemented to reduce the risk of the same happening again to another patient or another member of staff?

Supporting evidence for Actions

Evidence must be current

- Guidelines/SOPs updated and reviewed
- Further training (compliance)
- Induction training periodically updated

Wider awareness/sharing & cascading of learning

- Team meetings (minutes)
- Audit days
- Posters
- Emails with learning
- Huddles
- Case presentation

Monitoring of actions

- Audits
- Spot checks
- Staff walkabouts
- Snapshots of anonymised patient records

Claims, Redress & Inquests

WRP Update

Decisions arising from the Welsh Risk Pool Committee held on: 20th September 2023

Payment deadline (date by which payments will be made): 11th October 2023

Payment will be made on behalf of the WRP by the Velindre University NHS Trust Finance Team

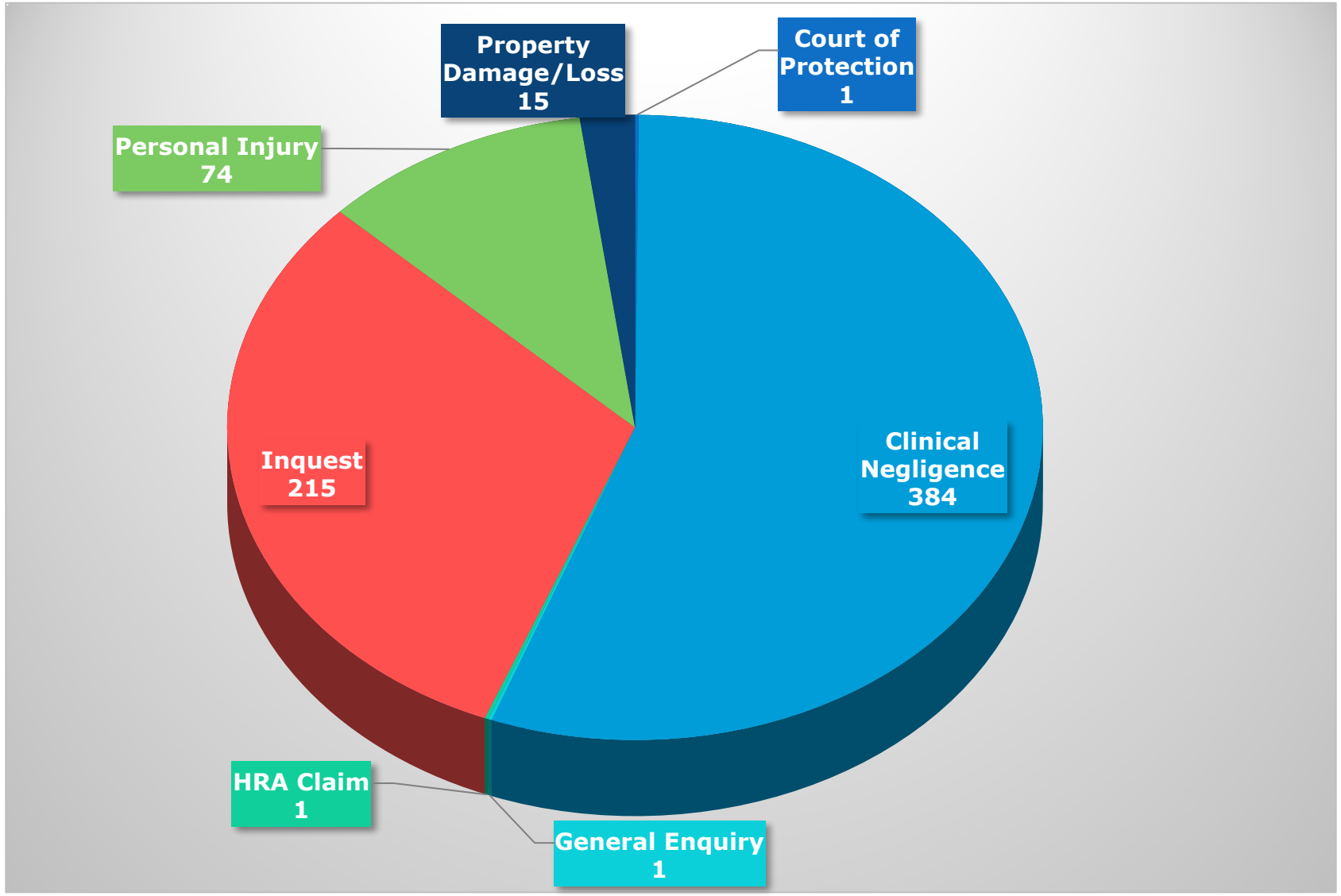
Payment due to health body: £3,244,219.36

- Committee Meeting £3,100,072.33
- Amber Meetings £144,147.03

No Financial Penalties

Claims, Redress & Inquests

Open Caseload as of 31/08/23



Claims, Redress, Inquests & Patient Safety Incidents

Looking ahead ……

- Change of team structures
- Change of names and terminology
- Changes to our Policy
- Change of approach

Update to be provided at PQSOC in December 2023.

COVID-19 Investigations

July & August 2023

	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	1141	322	1033
Investigations Not Started	0	517	6	418
Under Investigation	0	33	1	48
Downgraded/ Recatergorised	32	56	168	233
Referred to Scrutiny Panel	0	259	14	21
Completed Investigations	284	276	133	313
Check +/-	0	0	0	0
Deaths	147	379	51	117

Wave 1: 100% complete

Wave 2: 52% complete

Wave 3: 98% complete (remaining are MHLD cases)

Wave 4: 55% complete

Overall: 64% complete*

*completion rates include cases going through MDT and up to 31 August 2023

Highlights:

- Team performance tracking close to required trajectory to complete programme on time with staff resource in post
- NNCP site visit positive; assurance regarding governance, completion rates, processes provided
- Weekly MDT panels scheduled
- NNCP CIVICA user experience survey live
- Incoming enquiries from patients and/or relatives extremely low
- No queries post investigation outcome responses (except existing complaints pre programme)
- No increase in support requests to Llais
- No escalation of cases to AB Scrutiny Panel or legal
- QPSOG updated with learning feedback, meetings to follow

Challenges:

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

Mitigating Actions:

- Pushing case completion pace for remaining 2023 period
- Early conversations regarding staff plans and redeployment
- Working with divisional colleagues to access records

COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Retention of FTC staff	High FTC 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)	On going
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	On going
General record keeping & access to information	Clinical notes sparse for COVID-19 identification & management.	N/A		
	Locating pertinent notes due to non-chronological back scans.	N/A		
	Mental Health notes in off-site storage facilities.	Liaising with Health Records colleagues. Improvement seen late June.	COVID-19 Investigation Team (CIT)	On going

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
- Staff evaluations post training

- 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
- 5 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 package commenced in April 2023. Both adults and children's training packages are currently evaluating well.
- 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 in 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	November 2023

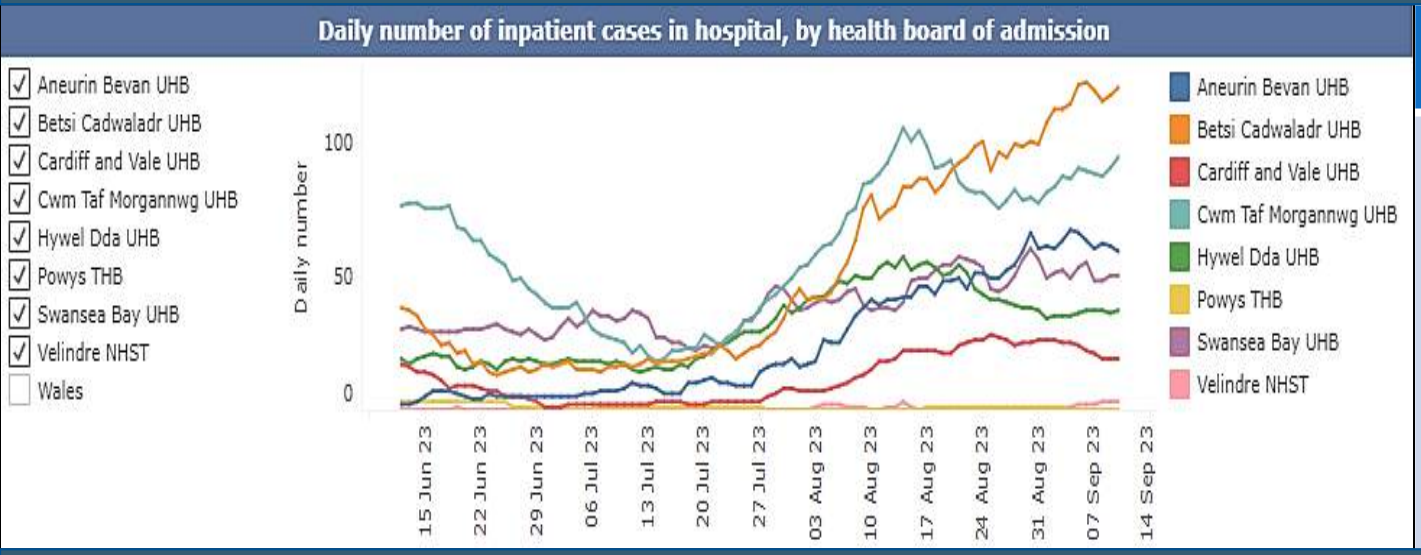
C difficile

Issue	Cause	Remedial Action	Who	When
Cluster of hospital acquired C difficile on Ebbw Ward, YAB	➢ Suboptimal antimicrobial prescribing ➢ Lapse with fundamental IP measures	➢ Microbiology linked with Clinician to discuss treatment plan for individual cases ➢ IP to arrange ward based practical training	Microbiology Infection Prevention	Completed August 23 September 2023
Cluster of hospital acquired C difficile on Ward 3/2, Nevill Hall	➢ Use of broad spectrum antibiotics	➢ Dr acknowledged feedback & shared learning points with team	Doctor	Completed August 2023
General increase of C difficile infection	➢ Antimicrobial prescribing ➢ Lapse with fundamental IP measures	➢ Drs training implemented ➢ IP link with site hub to inform HPV cleans ➢ Promoted the use of SIGHT mnemonic particularly for medical division	Infection Prevention	Completed August 2023 Ongoing

Staph Aureus & Gram Negative BSI

Issue	Cause	Remedial Action	Who	When
Fewer cases in August 2023. no MRSA bacteraemia & no ward clusters		Continue to promote ANTT	Infection Prevention	Ongoing
Seasonal increase in Gram negative BSI	➢ High percentage of cases have urinary tract identified as source of infection	➢ Care homes being offered UTI education ➢ Continue to promote HOUDINI – make the catheter disappear	Infection Prevention	October 2023

Covid-19



Issue	Cause	Remedial Action	Who	When
6 wards closed due to outbreaks of Covid-19	➢ Increase of visitors ➢ Change to testing strategy ➢ Staff working with symptoms ➢ Shared facilities	➢ Promote best practice ➢ Monitor compliance with Covid safety measures ➢ Link with site teams for correct patient placement	Infection Prevention	Ongoing

National Reportable Incidents & Non-Reportable Incidents

Issue	Cause	Remedial Action	Who	When
Patient died within 28 days of a healthcare associated C difficile infection. C difficile was cited on the death certification	➢ Initial treatment was not in line with guidelines. ➢ long gap between stool sample collection (6/7/23) and authorisation of result (13/7/23), and treatment was therefore not commenced until 13/7/23. ➢ Infection Prevention practice not robust	➢ Correct treatment then commenced ➢ Linked with Dr regarding accessing treatment out of hours ➢ Staff education	Infection Prevention Microbiology Infection Prevention	Ongoing Completed Aug-2023 September 2023
Care home residents and staff with shingles & chicken pox	➢ Staff with no history of VzV or vaccine	➢ Advised to risk assess 'non-immune' contacts from Day 8 to 21 post exposure (guidance provided).	Infection Prevention	Completed Aug-2023
Patients with scabies on Cedar parc unit, Ysbyty Tri Cwm	➢ Patient admitted with scabies	➢ All patients and staff received prophylactic treatment.	Occupational Health	Completed Aug-23

Healthcare associated infections – All Wales comparison

August 2023

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	77	2	37	145	50	10
Betsi Cadwaladr UHB	109	1	67	216	59	15
Cardiff and Vale UHB	49	5	67	139	50	9
Cwm Taf Morgannwg UHB	46	5	56	172	45	5
Hywel Dda UHB	67	4	40	186	43	14
Powys THB	6	0	0	2	0	0
Swansea Bay UHB	85	5	61	125	37	10
Velindre NHST	1	1	0	3	5	0
Wales	440	23	328	988	289	63

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	30.79	0.8	14.8	57.98	19.99	4
Betsi Cadwaladr UHB	37.07	0.34	22.79	73.46	20.07	5.1
Cardiff and Vale UHB	23.23	2.37	31.77	65.91	23.71	4.27
Cwm Taf Morgannwg UHB	24.46	2.66	29.78	91.47	23.93	2.66
Hywel Dda UHB	41.13	2.46	24.55	114.17	26.39	8.59
Powys THB	10.79	0	0	3.6	0	0
Swansea Bay UHB	52.01	3.06	37.32	76.49	22.64	6.12
Velindre NHST						
Wales	33.21	1.74	24.75	74.57	21.81	4.75

C difficile

Issue	Cause	Remedial Action	Who	When
Cluster of hospital acquired C difficile on Ebbw Ward, YAB	➢ Suboptimal antimicrobial prescribing ➢ Lapse with fundamental IP measures	➢ Microbiology linked with Clinician to discuss treatment plan for individual cases ➢ IP to arrange ward based practical training	Microbiology Infection Prevention	Completed August 23 September 2023
Cluster of hospital acquired C difficile on Ward 3/2, Nevill Hall	➢ Use of broad spectrum antibiotics	➢ Dr acknowledged feedback & shared learning points with team	Doctor	Completed August 2023
General increase of C difficile infection	➢ Antimicrobial prescribing ➢ Lapse with fundamental IP measures	➢ Drs training implemented ➢ IP link with site hub to inform HPV cleans ➢ Promoted the use of SIGHT mnemonic particularly for medical division	Infection Prevention	Completed August 2023 Ongoing

Staph Aureus

Issue	Cause	Remedial Action	Who	When
Fewer cases in August 2023. no MRSA bacteraemia & no ward clusters		Continue to promote ANTT	Infection Prevention	Ongoing
Seasonal increase in Gram negative BSI	➢ High percentage of cases have urinary tract identified as source of infection	➢ Care homes being offered UTI education ➢ Continue to promote HOUDINI – make the catheter disappear	Infection Prevention	October 2023

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
Cedar Parc	7-9/08/23	✓	29	74	**7**	43	TBC	**N/A**

Outstanding Actions			
An alarm policy must be implemented to support staff in their roles.	Divisional procedure for the use of personal alarms on in-patient units to be produced in addition to manufacturers guidance.	31/08/23	Draft complete & circulated, to be ratified in Divisional QPS (Sept)
The HB must ensure that DNACPR forms are kept in a fixed and accessible location within patient records to ensure patient safety.	Current paper-lite file clasps to be reviewed across MH&LD Division where they are in use.	30/09/23	In progress (recommendations/ options developed for Divisional consideration)
Ensure all staff on Cedar Parc are compliant with PMVA training.	Within the current substantive staffing cohort, all staff are PMVA trained with the exception of one staff member who has been on long term sick. They have been booked for training in October 2023 (first available).	October 2023	In progress – staff booked on
We found multiple missing signatures within the medication charts we viewed. We further reviewed the hospitals weekly medication chart audit completed since 2020 and saw instances when it had not been completed within the set timescales. This audit documented numerous missed signatures with accompanying comments that the staff concerned had been informed or emailed. The monthly Controlled Drugs audit also identified missing staff signatures. During our discussions with staff they were not able to describe any additional governance oversight nor processes implemented to encourage shared learning and prevent reoccurrence of this error. We notified staff of this issue but still found an additional six missing signatures within the medication records over the course of the inspection. Staff did not address the seriousness of the issues present and the remedial actions required. Therefore, we were not assured that patients are being fully protected from harm on the ward.	All staff to complete Medication Management Training on ESR.	28/08/23	In progress
Update the Health board's 'Use of Restrictive Physical Intervention' policy to provide clear guidance to staff.	The 'Use of Restrictive Physical Intervention Policy' has been reviewed and updated. It is currently being consulted upon across the Health Board.	30/09/23	In progress
Some staff we spoke with during the inspection were not aware of the legal requirement for C02 Certificate of Consent to Treatment and C03	MHA training is offered on a rolling basis. MHA trainer to book update	September-October	In progress

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	**3**

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 scheduled for sign-off via EQIA 26/09/23.
Measures should be undertaken to ensure that staff are compliant with the All Wales NHS Dress Code and that workplace clothing must address key Health and Safety recommendations.	The Division will review its position across in-patient services with regard to wearing of uniform across all disciplines.	~~June 2023~~ September 2023	The Divisional Lead Nurse has commissioned a patient-led survey of patient & staff perspectives to inform the review. Nursing staff across the Division have been reminded of the correct uniform code in lieu of the outcome of the survey. Sep: Draft survey developed & to be modified following feedback
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~~ September 2023	Scheduled on QPS agenda for 26/07/23 but no response from dietician. Chased for September QPS meeting.
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.

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	**5**

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 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 scheduled for sign-off via EQIA 26/09/23.
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	Will be completed in October 2023.
	ECA guidelines to be included as appendices, to include required documentation to record ECA stays.	December 2022	Will be completed in October 2023 (as per above)
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	This is not identified in any evidence base/practice guidance and has raised concerns re restrictive practice/ privacy & dignity. Patient survey being administered this month to inform this process

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 – increased focus on PADR's to improve compliance

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	**September 2023** Developing a safe space for families and young people who are in distress (CAMHS Sanctuary Space and Crisis Hub in Bettws Ward in St Cadocs Hospital). The sanctuary space would provide CYP with access to a team of CAMHS staff, who can work directly with them in order to attempt to prevent emotional distress from developing into a crisis situation that can cause further trauma. The Sanctuary Space and Crisis Assessment Hub area is scheduled to be opened June/July 2024.

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	**0**	14	34	**3**

Outstanding Actions			
Review, and consider increasing the availability of birth pools within the unit	Liaise with facilities and request a quotation to move the pool from another hospital to support additional capacity at GUH to meet demand.	September 2023	The request to locate the RGH birthing pool into GUH was approved at accommodation group – awaiting costing from W&E
The health board should review post-natal bed capacity and mitigate any risks associated with capacity shortages to ensure that safe and effective patient care is maintained.	The Health Board are working with the neonatal team by introducing E-discharging for babies. This will expedite the discharge process and improve patient flow.	Full implementation and in place by the 16th September 2023.	Neonatal staff still to be trained. Training planned for 1st November 2023
Review capacity and succession planning for all specialist midwife roles	The Senior Management Team are reviewing succession planning by introducing a shared lead role option. This opportunity will allow staff to maintain their clinical skills and also help develop them to in lead roles as part of succession planning. Midwifery will benchmark with other Health boards	December 2023	Ongoing planning

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	**1**

Outstanding Actions			
The health board is required to provide HIW with details of the action taken to improve staff compliance with mandatory moving and handling training.	A checklist and workbook has been developed and mandated for all staff to complete within 2 weeks of commencing in post.	30 September 2023	Currently developing workbook for new staff to be completed by 15/10/23.

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 – July/Aug 2023	Number of closed incidents/ complaints -July/Aug 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)	7 (There are 4 incidences from May/June still not closed)	4 (2 of which deemed unavoidable)	3	0 (out of the 3 closed) (1- staffing questions not answered)	0 (1 incident staffing a factor even though the planned roster was maintained)
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	6	2	4	2 (out of the 2 closed incidents)	1
Medication errors never events	0	0	0	0	0
Any complaints about nursing care	9 (Adult) 0 (Peads)	2	7	Not known at this time	Not known at this time
Infiltration/ extravasation injuries	0	0	0	0	0

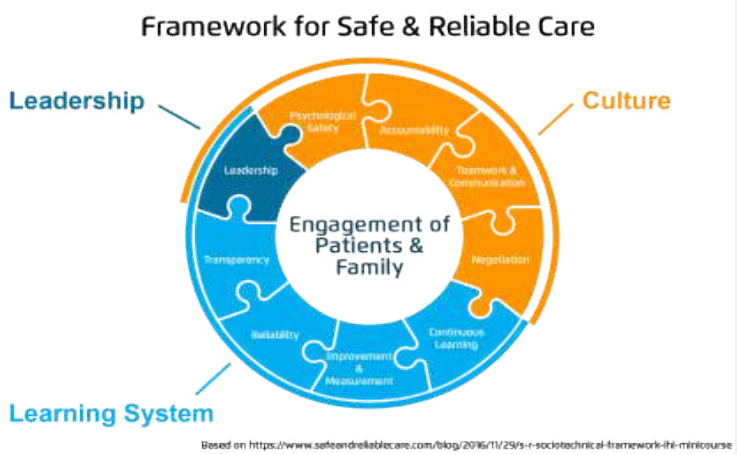
Nursing Staffing Levels Wales Act 2016

Issue	Cause	Remedial Action	Who	When
Delay in undertaking timely RCA of pressure ulcers and falls investigations	Some areas are not undertaking timely investigations of pressure ulcers and falls	Further education and training of the correct process and emphasis on timely reviews	Divisional Nurses Nurse Staffing Programme Lead	August 2023
Investigation section not fully completed to determine nurse staffing levels and whether they contributed to the incident	Ongoing issue-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	Aug 2023
Requirement to report nurse staffing levels aligned to complaints is ambiguous	Ongoing issue-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	August 2023
Complaint handlers do not always answer yes to the question "is this to do with Nursing Care" therefore the staffing Act questions do not open on datix	Complaints often multifaceted, spanning different wards, specialities, divisions and hospitals.		QPS teams to ensure the answer to the question is Yes- if nursing team are involved in the response.	Aug 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: 30/11/2017, updated to 29/09/2023	29-Sep-23	Work underway. Issues pending include, revising the ABUHB Enteral Feeding Policy, plan and commencement of a rolling audit plan, consolidation of training records.	Work in-progress
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	29-Sep-23	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.	Work in-progress
PSA016 Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	15-Dec-23	Work underway. The ABUHB policy for AKI and treatment of hyperkalaemia is currently being revised.	Work in-progress
PSA015 Safe use of oxygen cylinders in areas without medical gas pipeline systems	12-May-23	Completed	Compliant
PSN065 The safe use of ultrasound gel to reduce infection risk	28-Mar-23	Completed	Compliant



Safe Care Collaborative - update

Organisational Update: Stage-Action Period 6

- **Learning Session 3, Sept 19-20** - Preparation: Team Story boards – Workstream coaching sessions – Team time to plan – Charters and measurement plans complete
- **Leadership programme of work** – schedule of executive Safety Walkarounds – 9 completed since last report. QI project to evaluate and improve experience and outcomes
- **Quality Strategy** – Delivery Plan, Outcomes Framework and QI Skills Development Programme complete.
- **Prof Maxine Power** continuing to work with ABUHB, preparing for two sessions being held in October
- **QI Skills Development**– working with Improvement Cymru to deliver bespoke training; Embedding QI sessions at CDx and with Heads of Therapy Services. Jnr Dr QI Forum, PocEd QI, PocED Measurement in place

Team Update:

- **Charters** have been developed to describe QI teams aims, driver diagrams and measurement strategies
- **Leadership for Patient Safety Programme**- Four senior staff members undertaking training
- **Improvement Advisor** - Plans in place to appoint role to support Theatres Human Factors and Never Events work
- **GACU team** on pause due to work pressures and staffing issues
- **Data lead** continuing to work with coaches and teams to develop data viewers especially for the Acute and Ambulatory workstream.
- **Careflow data** being used effectively as part of Acute workstream
- **Improvements** starting to be reflected in the data

Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	2
	Theatres – Human Factors	NEW
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU) at RGH	1.5
	North Monmouthshire Integrated Team	3
Community	Glaslyn Care Homes	NEW
	Mental Health OT Team	2
Leadership	Executives, Leaders for Safety, Faculty	3

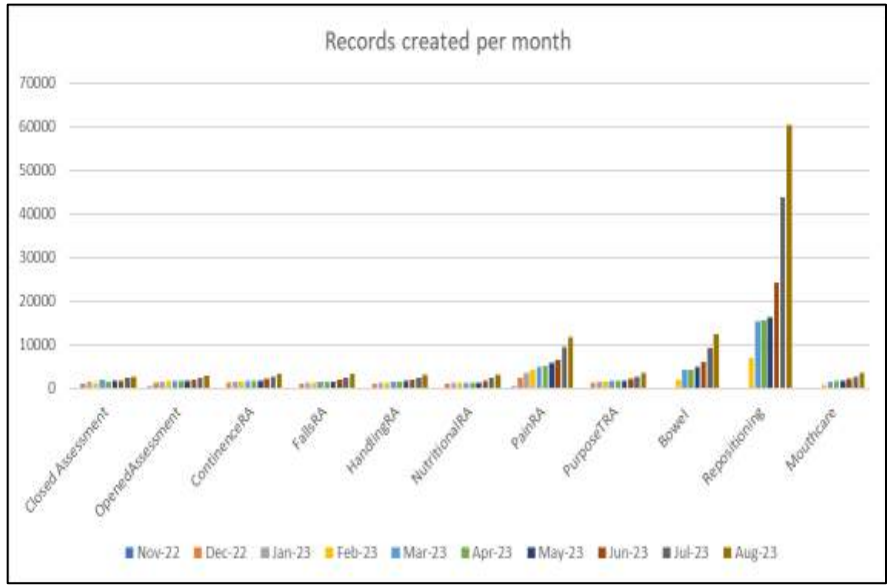
IHI Score	Stage of Project
0.5	Intent to participate
1.0	Forming team
1.5	Project plan begun
2	Activity but no changes
2.5	Changes tested but no improvement
3	Modest improvement
3.5	Improvement
4	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable improvement

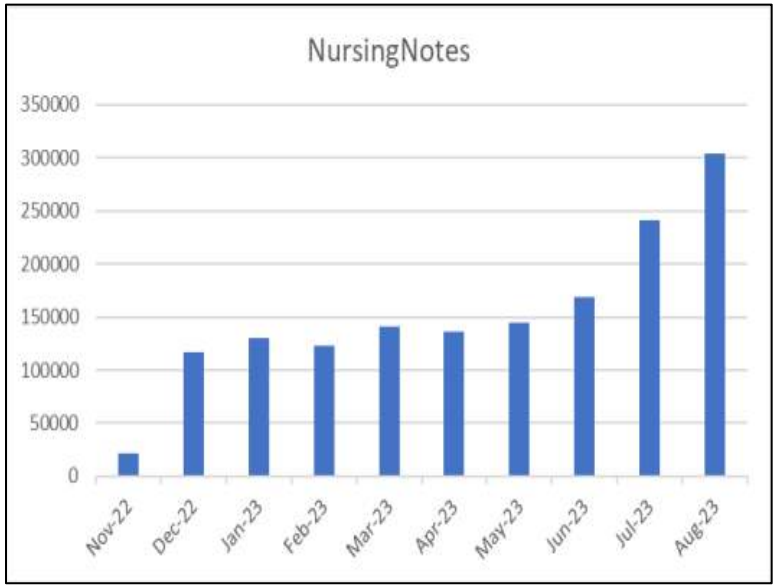
Welsh Nursing Care Record

Rollout completed in RGH with all 17 wards live (26 ward across two sites).

YYF / St Woolos to follow the RGH implementation.

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



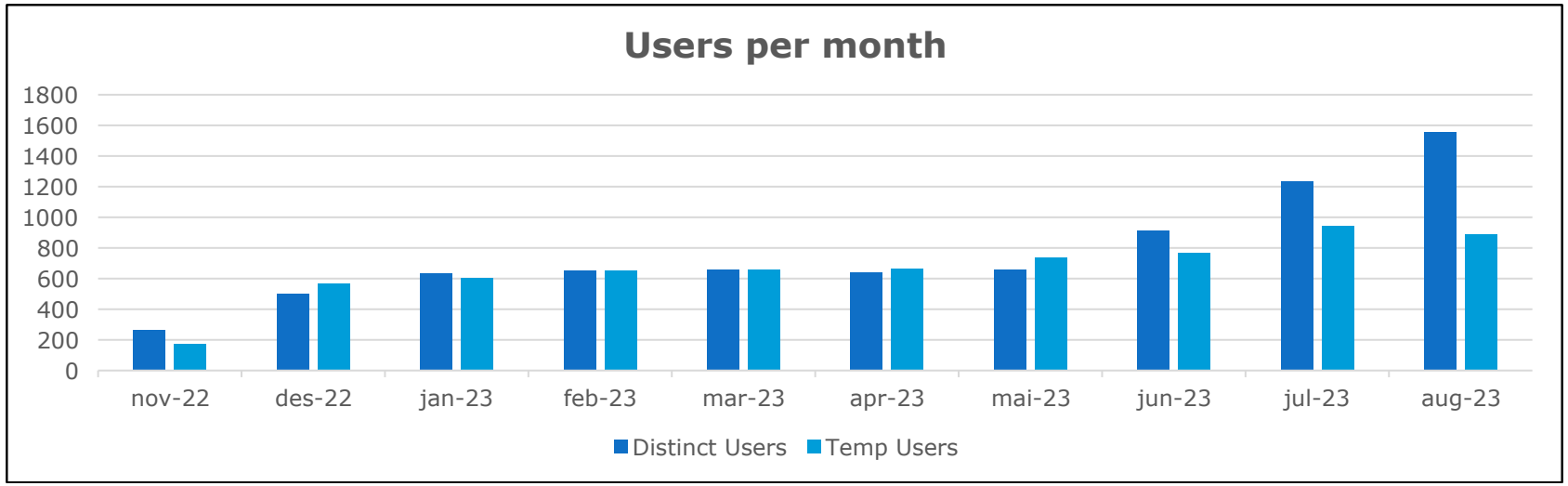


Welsh Nursing Care Record

Wards been provided with data on Temporary user accounts which still 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.

Cull under taken in July and removed all accounts of staff who were permanent; this has shown an improvement.

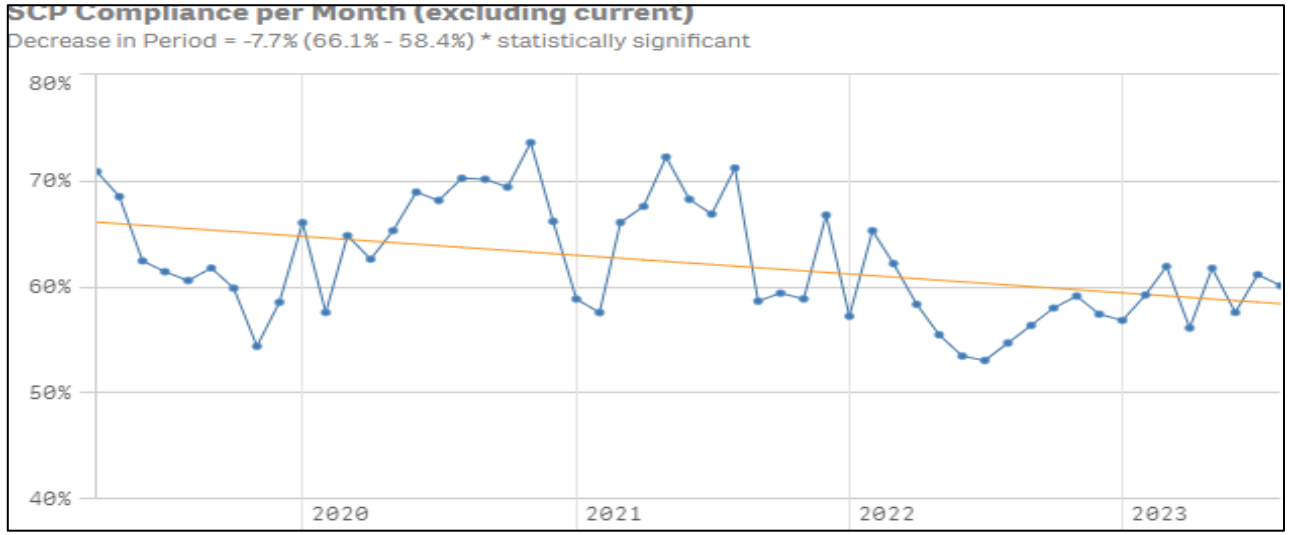


Welsh Nursing Care Record

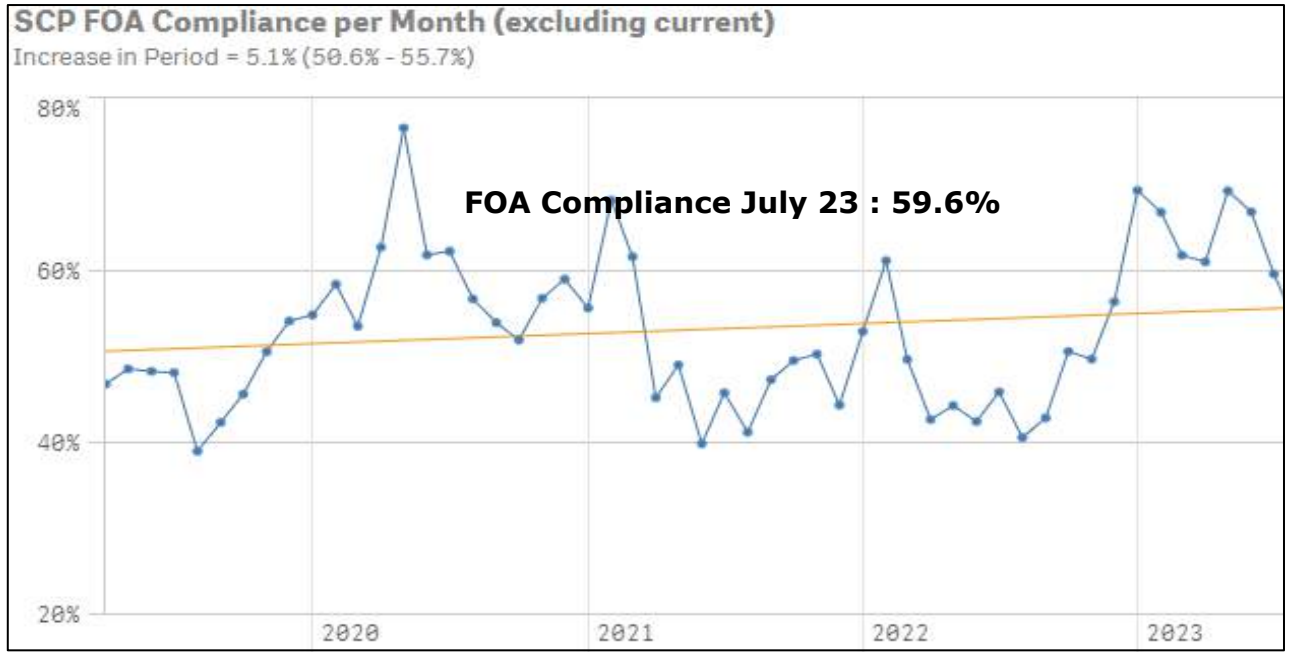
Issue	Cause	Remedial Action	Who	When
Delay in getting a WNCR record started on one wards (one ward resolved) remains an issue	One wards have issues where the patient pathway on WPAS is not completed for semi-elective patients	Training has been provided to support WPAS pathway selection when booking patients	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 on 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	Digitisation Nursing Documents Group	Q2
CNIO availability to support further roll out	CNIO also Clinical Safety Officer for health board	Planning and prioritisation of CSO activity	Directors of Digital	Q3

Cancer – 62 Day Performance

SCP Compliance: July 2023



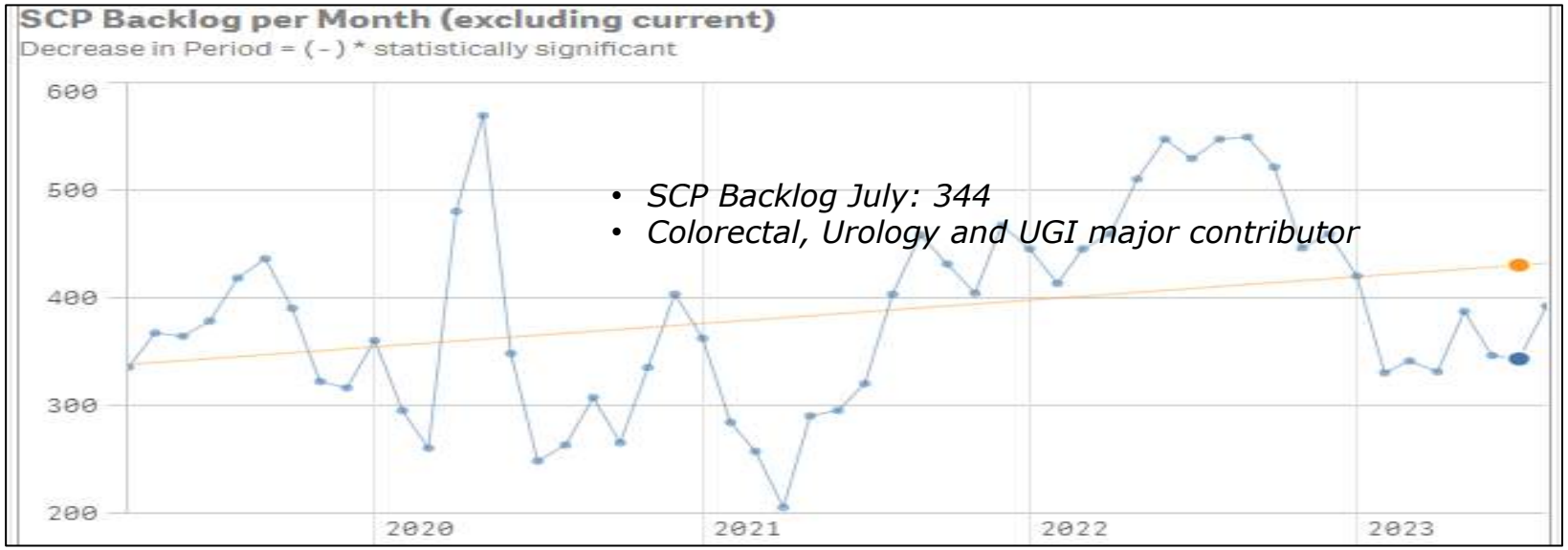
JULY 2023 SCP compliance 60.1% which was an increase of 3.5% compared with June. However overall performance remains below the aspiration target of 75% SCP compliance.



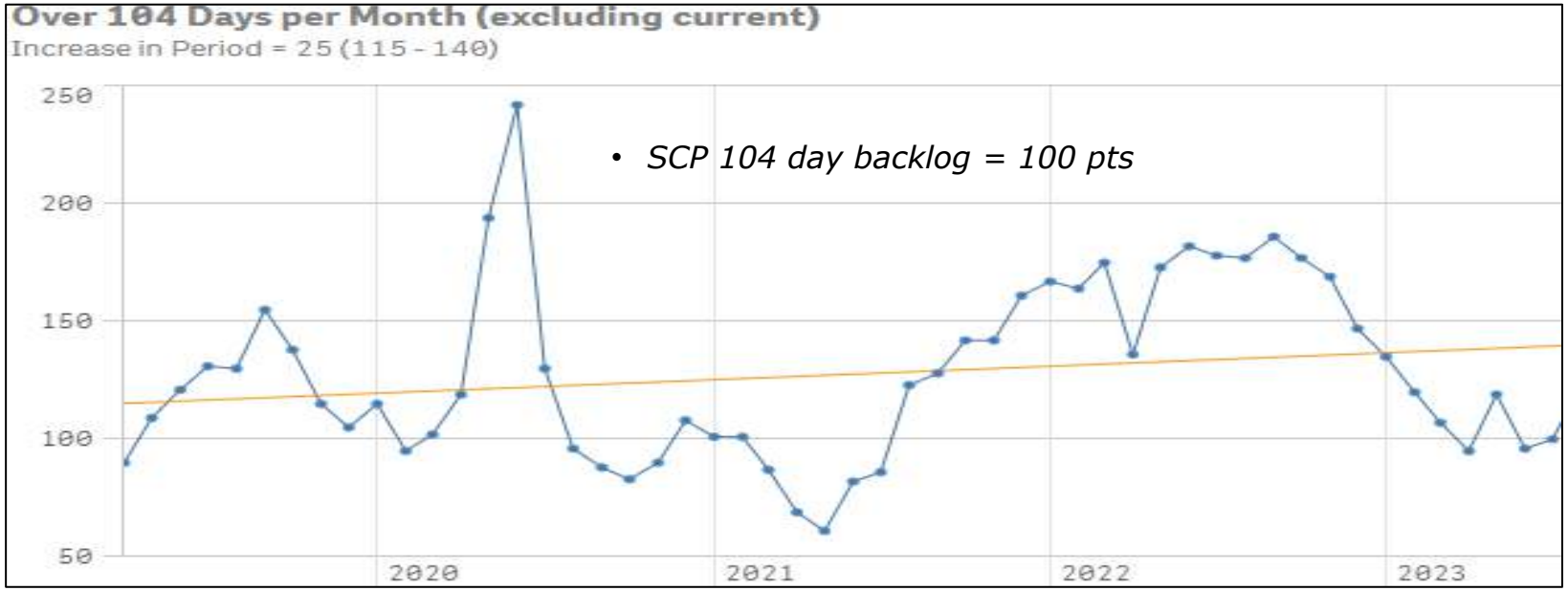
Compliance fell in July due to staff annual leave and patient unavailability.

Cancer Backlog

Reducing the active patients waiting over 62 and 104 days remains the priority laid out at the March 2023 ministerial cancer summit.

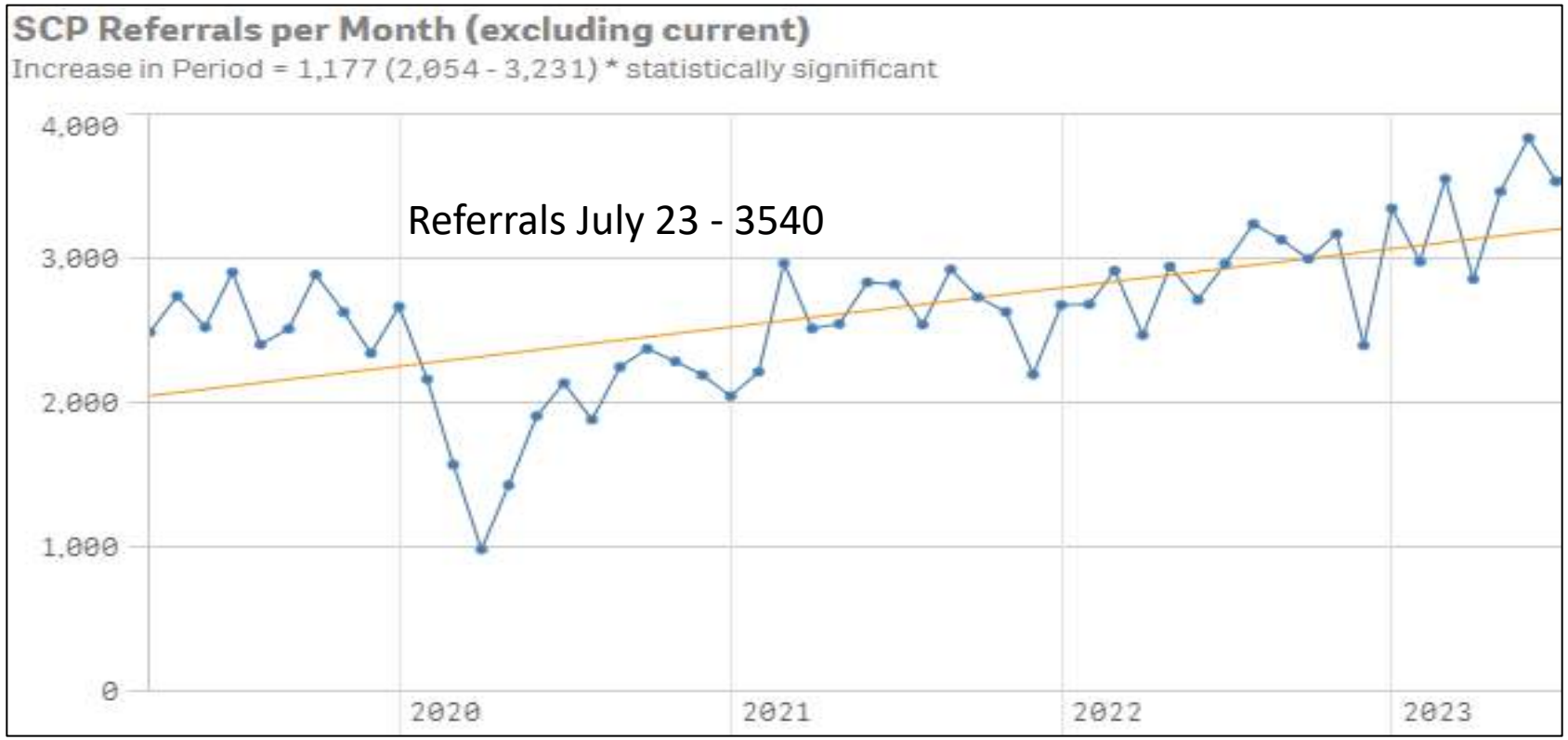


- *SCP Backlog July: 344*
- *Colorectal, Urology and UGI major contributor*



- *SCP 104 day backlog = 100 pts*

SCP Demand



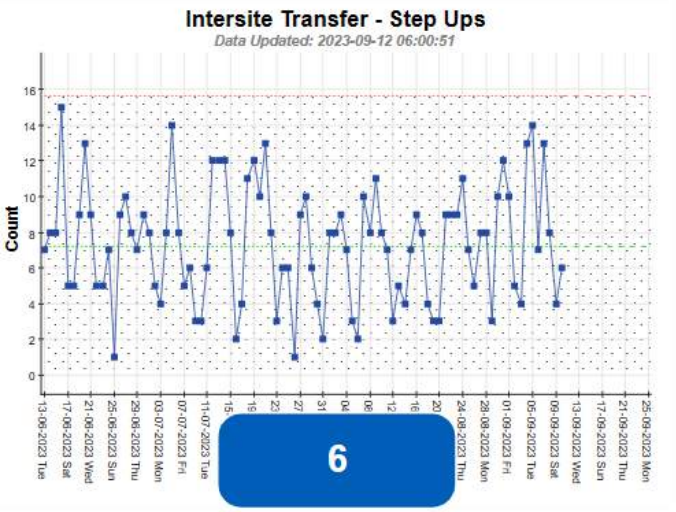
Demand continues to remain high with another spike in referrals in July in most tumour sites but significant increase noted in LGI, Gynae and Skin. Other tumours sites Urology, H&N and UGI increased demand trend continues.

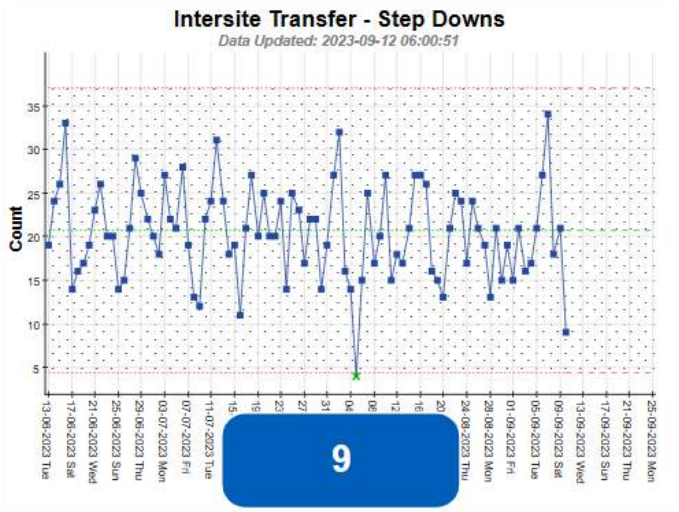
Recovery Challenges

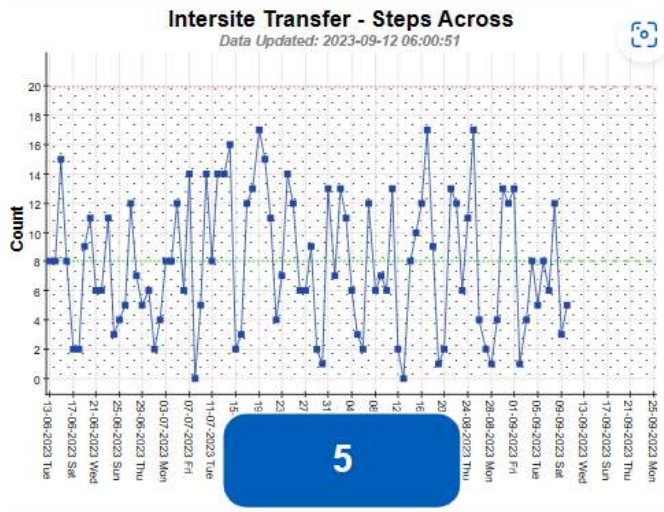
Issue	Cause	Remedial Action	Who	When
Rising backlog	Legacy from previous Bank Holidays/summer annual leave PTL tracking anomalies	• Actions include a full review of the PTL. • Relaunch/re-education of SCP guidance • Developing clear SOPs for tracking, MDT and service staff to ensure timely and seamless patient tracking	Cancer Services Manager	Anticipated actions complete by end of Q3 23/24
Endoscopy waiting times	Ongoing rise in demand for LGI and UGI referrals	• Upon opening of the new Endoscopy Unit the first week's activity will be dedicated to the USC referrals. Anticipated outcome – reduction from current 3 - 4 week waiting time.	Assistant Directorate Manager	End of November 2023
Timely access to colorectal theatres	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.	Directorate Manager	In progress – review at the end of October 2023

Goal 2: Signposting people with urgent care needs to the right place, first time

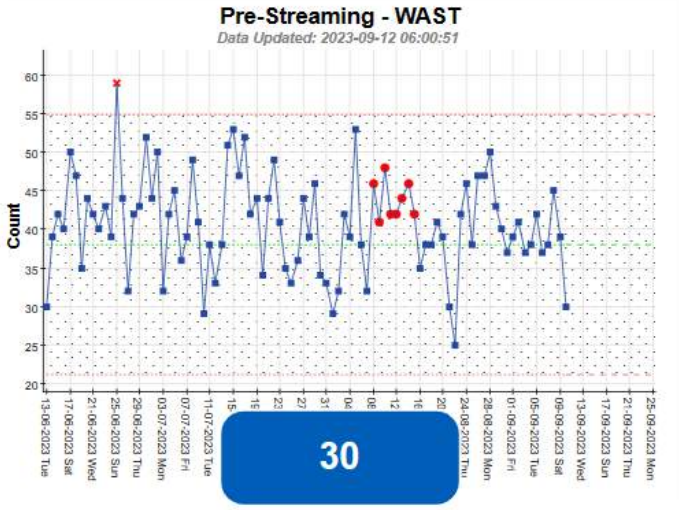
Flow Centre

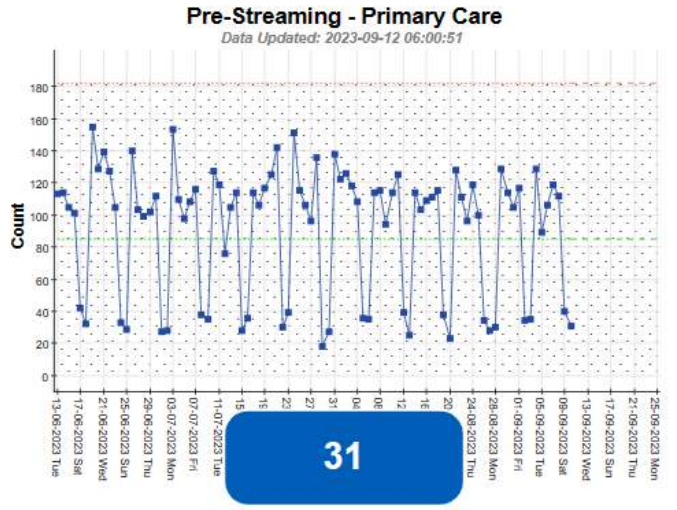




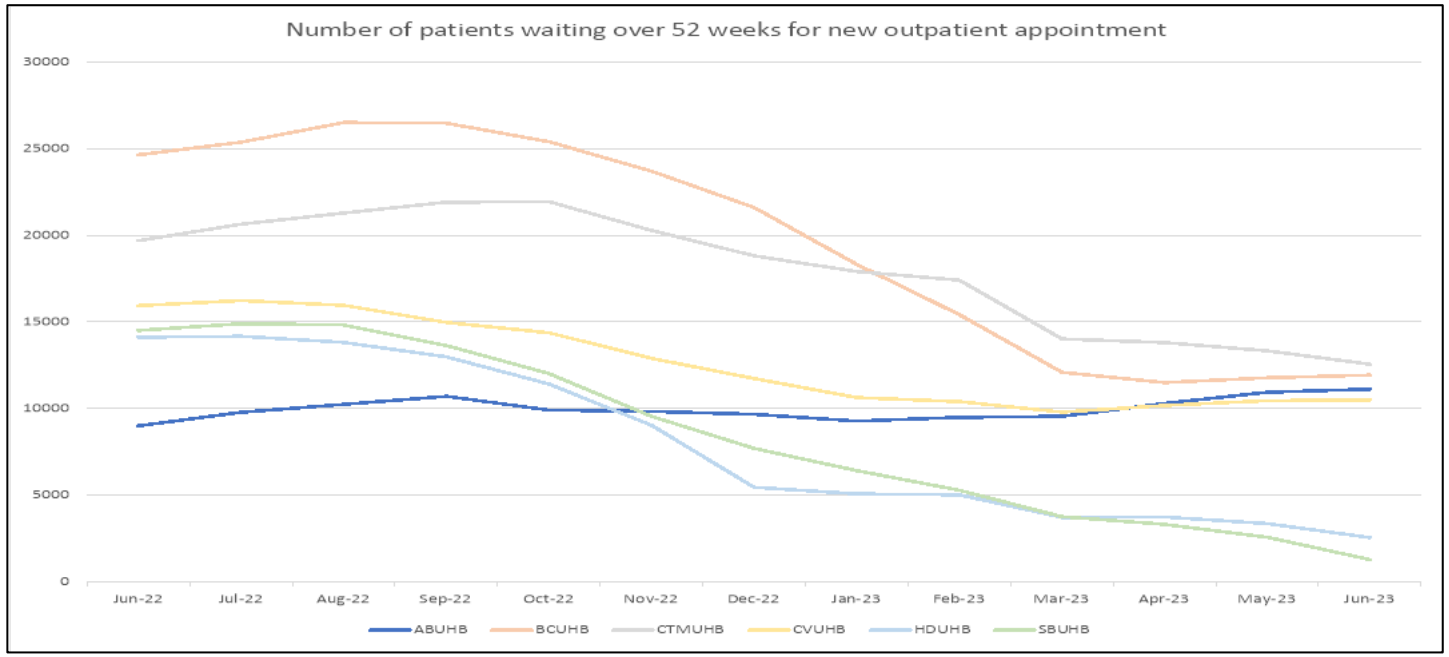


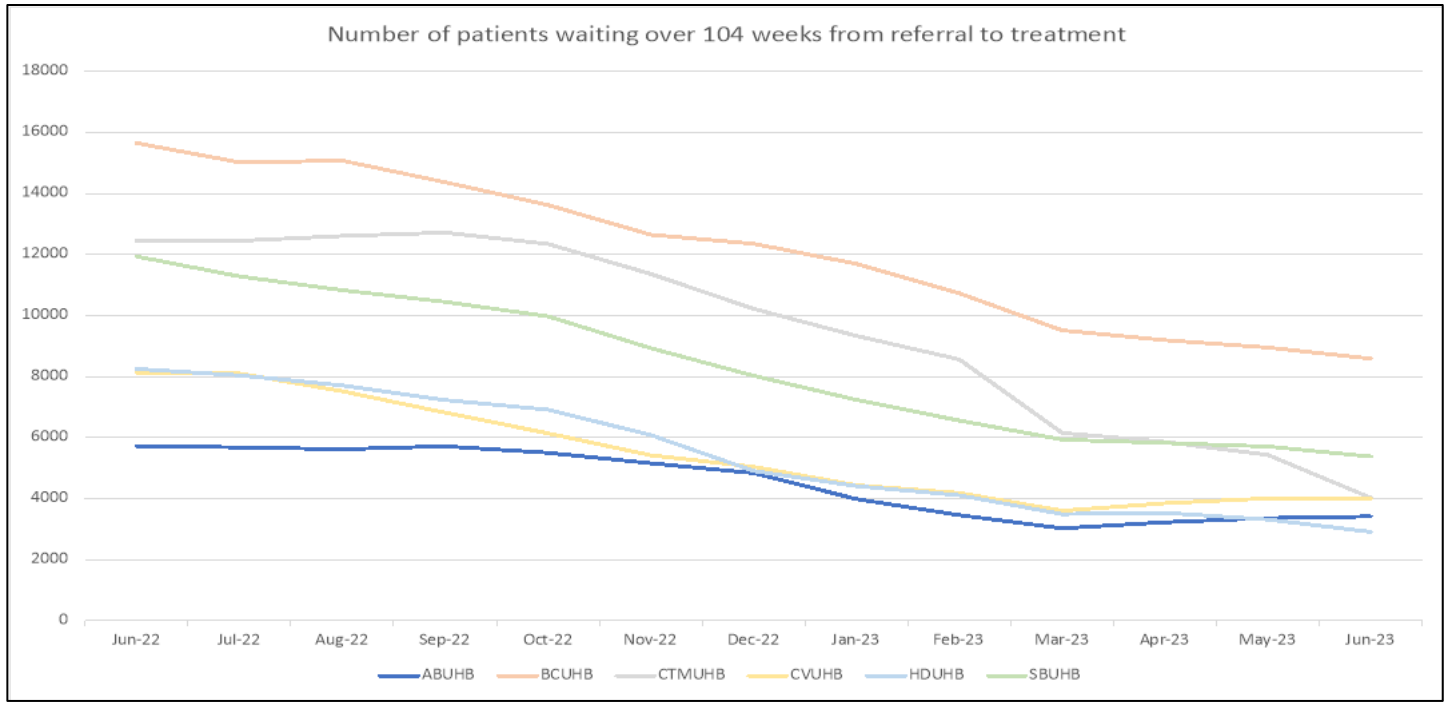
- **WAST Pre-Streaming** has been 270-320/week
- **PC Pre-Streaming** has reduced back to usual levels
- All others operating as normal





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

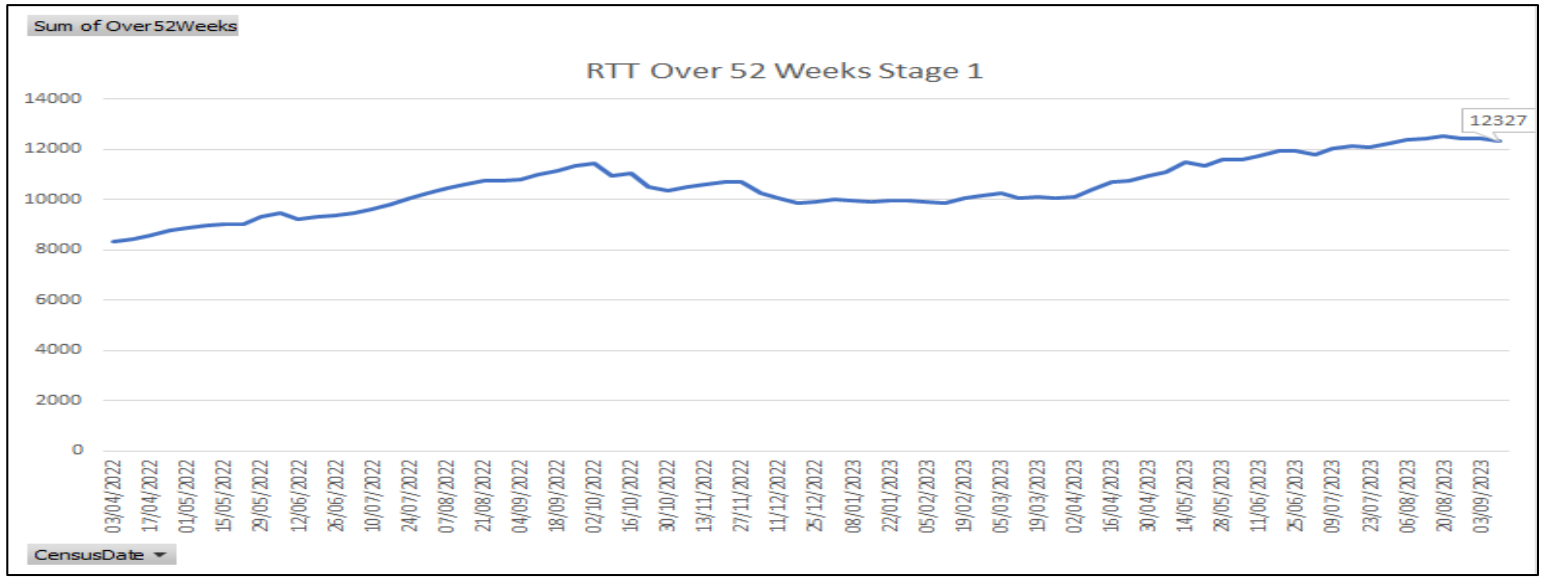




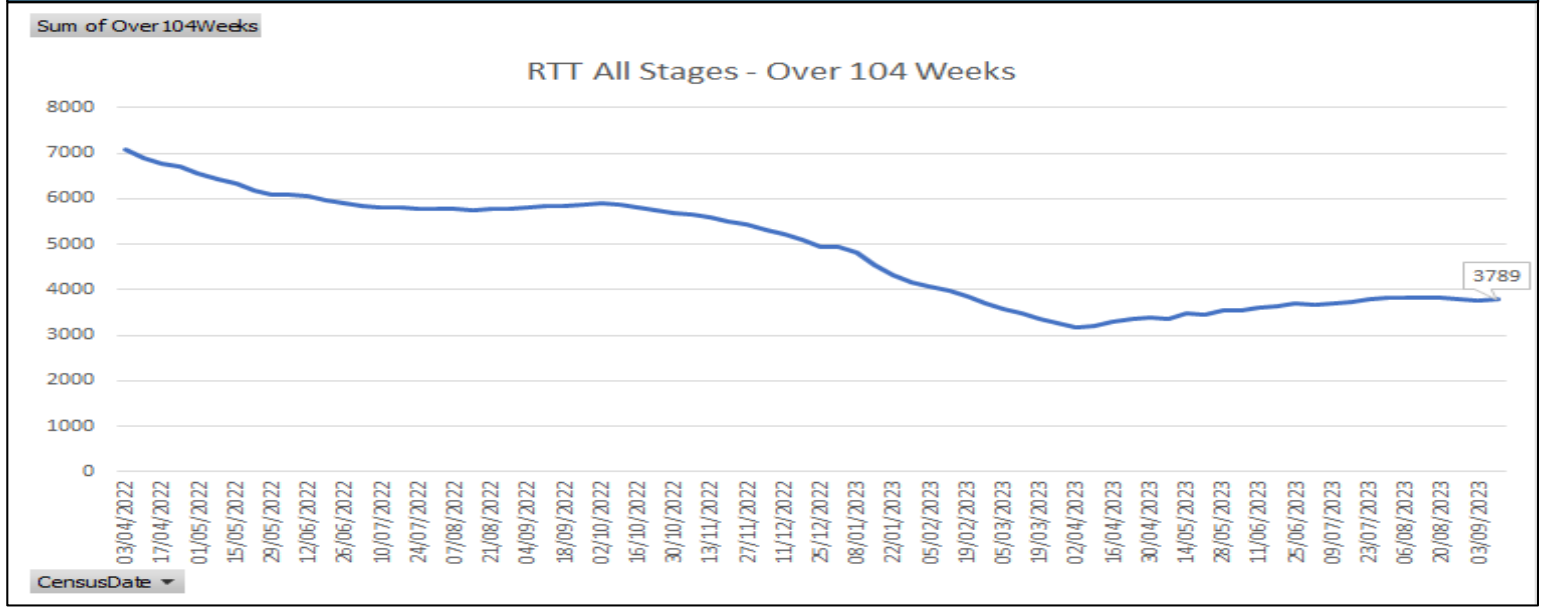
Planned Care

RTT Weekly Snapshot *(reportable activity only)*

RTT – Stage 1 (New Outpatients) Over 52 Weeks



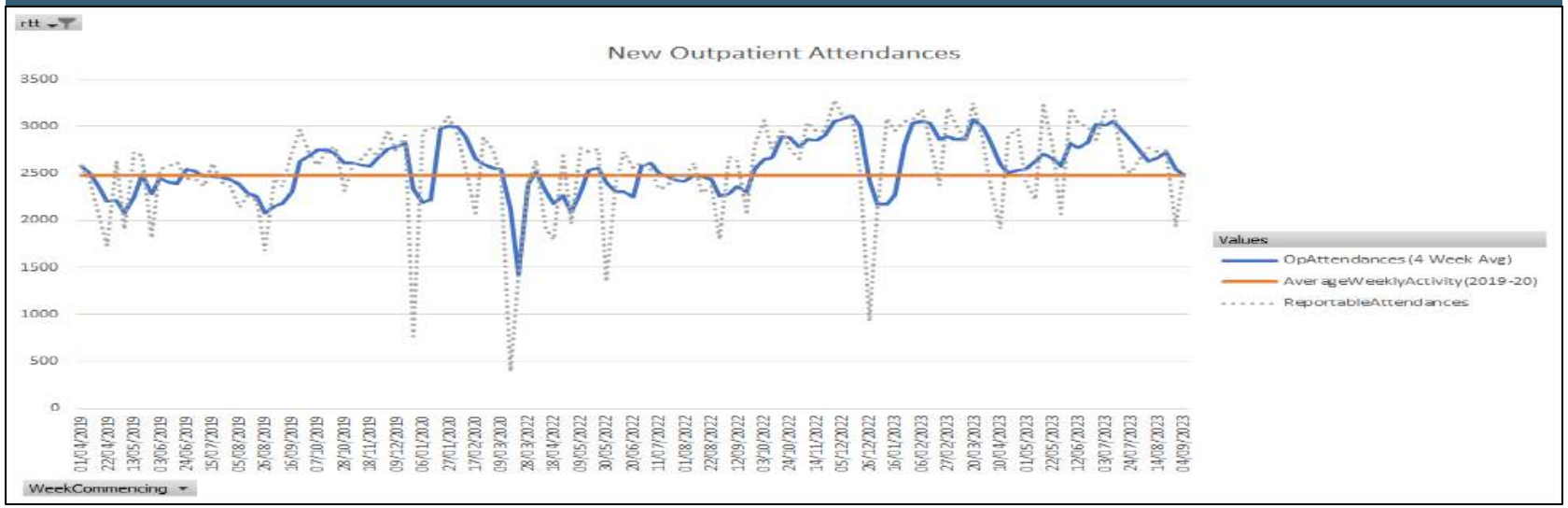
RTT – All Stages Over 104 Weeks



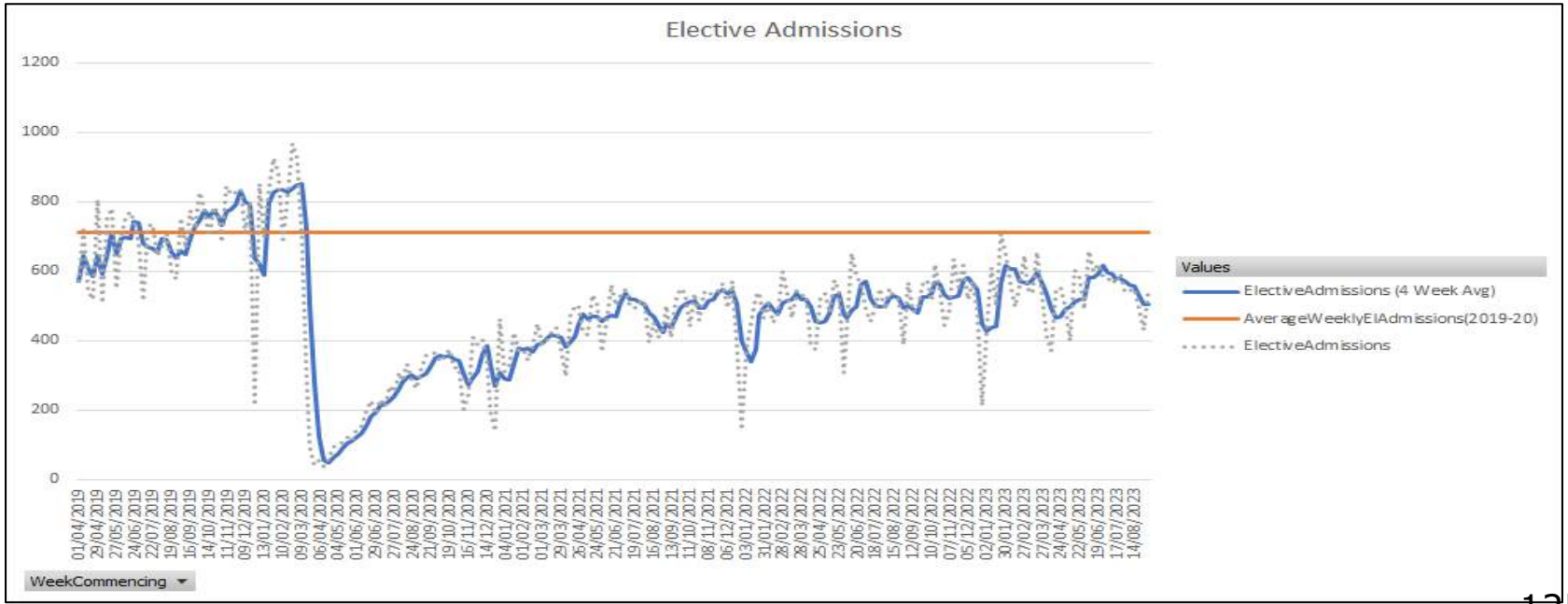
Planned Care

Activity Summary

New Outpatient Attendances (RTT Specialties Only)



Elective Admissions (Surgical Specialties Only)



Planned Care

Performance Overview – Actual (Waiting List Snapshot 18/09/23) 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)
12327	-40	10979
		1348

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)
1810	49	284
		1526

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	% Var Againt Model St 1 52W Status	Change Stage 1 Over 52 Weeks (past 5 weeks)
⊞Clinical Support Services	2		2			-11
⊞Family and Therapies	50		50			17
⊞Medicine	24		24			15
⊟Scheduled Care						
Ear Nose & Throat	4169	4076	93	2%		-60
Maxillo-Facial	860	209	651	311%		51
Ophthalmology	4371	4655	-284	-6%		43
Orthodontics	66		66			-18
Trauma & Orthopaedic	1773	894	879	98%		-71
Urology	1012	1145	-133	-12%		-4
Grand Total	12327	10979	1348	12%		-38

Stage 4 Treatments

Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks (Current Month)
1391	-153	903
		488

Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)	Model Forecast Over 156 Weeks (Current Month)
245	-69	113
		132

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 Weeks Status	Change Over 104 Weeks (past 5 weeks)
⊟Scheduled Care					
Ear Nose & Throat	181	126	55		-21
General Surgery	96		96		-4
Maxillo-Facial	2	0	2		-12
Ophthalmology	127	0	127		-32
Trauma & Orthopaedic	851	777	74		-79
Urology	134	0	134		-5
Grand Total	1391	903	488		-153

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** – continuing to engage in regional diagnostic developments. Endoscopy unit at RGH due to be completed in Oct '23. Breast Unit at YYF due to be completed in Oct '23.
- **Theatres** – dashboard due to be released at end of Sept with reliable and usable data on theatre productivity measures
- **Patient Access and Activation-** Waiting Well landing page – 1,285 views from July-Sept
- **Health Pathways-** initial pathways are in development. Comms plan is being implemented. Go live in Q4 23-24.
- **Outpatients** – business case drafted for an automated clinic booking system to increase clinic efficiencies and utilisation across the HB
- **Planned Care Academy** – 4 workstreams are progressing objectives (e.g. draft training plan has been developed)

Key Milestones and Deliverables for the Next Period

- **Theatres** - 2nd stakeholder event due to take place 20/9/23 to focus on dashboard and theatre plan delivery
- **Patient Access and Activation** – opportunity to apply for WG funding to develop waiting well services
- **Health Pathways** – finalise first pathways. Plan for phase 2 priority pathway development.
- **Outpatients** – focus on increased virtual/video/group activity. Implement plans to reduce 100% past target FUs.
- **Planned Care Academy** – review and refine draft training plan with wider group.

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.

Questions

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Operating Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis – Assistant Director for Quality and Patient Safety Trish Chalk - Assistant Director of ABCi & Interim Deputy Director of Planning Tracey Partridge Wilson - Assistant Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;

We have been clear on our aims to continuously improve and learn. Our quality strategy supports the new legislative requirements.

Cefndir / Background

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 are being developed.

The QOF is now avaible for review by the Committee. It follows a similar template to the IMTP and will be aligned to quarterly reports.

Asesiad / Assessment

This report is the first version for consideration by the Committee which will be updated each quarter. The quarterly reports will then form the basis of the new requirement for an Annual Quality Report. This report will ensure that the Health Board meets its statutory duty of 'always on' reporting as required by the Duty of Quality and the Duty of Candour.

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

Preparing this QOF has provided us the opportunity to reflect on our progress, which shows evidence of the hard work and commitment from the Health Board to develop the quality strategy. The report demonstrates how we are striving to better understand our systems of care. We are maturing our Quality Management System and refining our QOF to enable us to set meaningful targets, monitor, measure and report our performance.

We will be refining the QOF and reconciling with the current Performance report to review overlap of data and define any additional reports needed throughout the year and add onto the forward work plan. The dates for PQSOC and Board will be mapped to align with the quarters to present the QOF and a slide deck will be avaible for meetings where the QOF is not available. An annual quality report will be avaible for September 2024.

We are establishing a learning forum which highlights our creativity, passion, expertise, and our commitment to learn from experiences. This report illustrates how we are improving our insight of data and developing our understanding on insights from multiple sources of information throughout our entire system. We are on track to deliver the key objectives outlined for the first year in the strategy, to publish our annual quality report. Our quality reporting structure will provide a way for us to set progressive implementation plans, adapt plans based on experiences and learning, and monitor progress against our strategic goals.

As part of this work, we will continue to strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

Argymhelliad / Recommendation

This report is to seek the reflections and commentary from the Committee on the content and assurance contained within the QOF report and to provide assurance for the committee on the ongoing work to implement and deliver the Quality Strategy and Patient Experience & Involvement Strategy and therefore the delivery of Compliance with the Duty of Candour and the Duty of Quality.

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 Choose an item.
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.

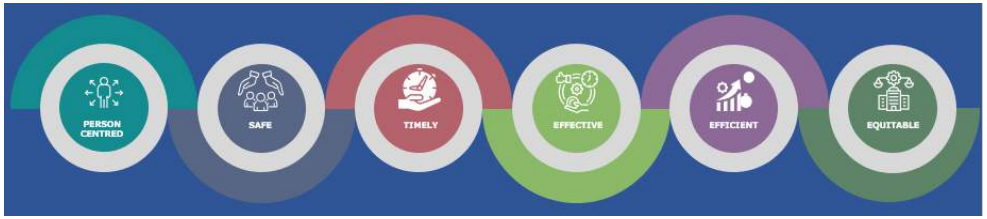
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees 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	Choose an item. 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.

Aneurin Bevan University Health Board

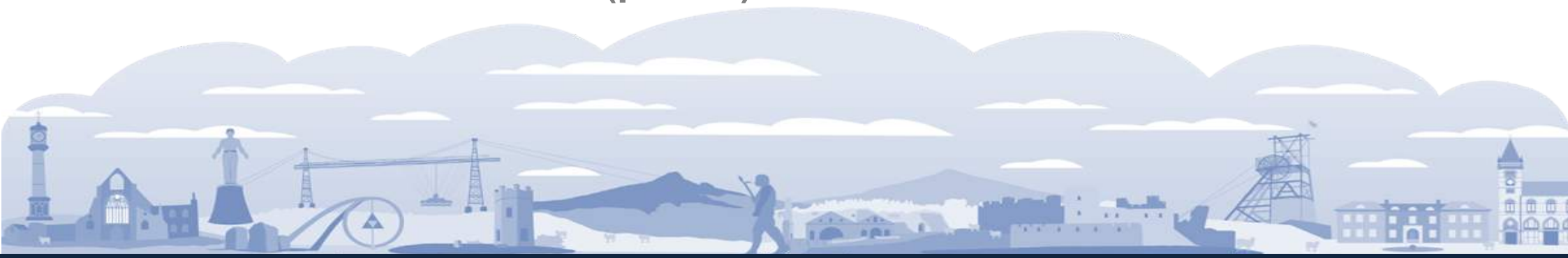
Quality Strategy

Quality Outcomes Framework



2023/24

Quarter 1and 2 (partial)



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

The QOF was approved by the Patient Quality, Outcomes and Safety Committee in Quarter 1 and reflections recognised the expectation and ambition set out in the Quality Delivery Plan and the new legal Duty of Quality and Duty of Candour.

The reporting of this first edition of our new Quality Outcomes Framework recognises the development of some of the measures as we bring online new ways of reporting and capturing what is important for our patients.

The table below sets out the proportion of measures that were expected to be reported versus what has been included in this report.

Priority	Measures Reported	Expected to be able to report for Q2
Person Centred	4 out of 7	5 out of 7
Safe	16 out of 20	18 out of 20
Timely	17 out of 21	17 out of 21
Effective	5 out of 13	6 out of 13
Efficient	8 out of 11	9 out of 11
Equitable	2 out of 4	1 out of 4

The timing and format of the report will be reviewed for Q3 and the interim reporting with between quarters.

In summary, during Quarter 1 and part of 2 the Health Board delivered:

- ✓ An improvement in the complaints backlog
- ✓ Decrease in the number of reportable IPAC incidents
- ✓ Maintained RAMI and Crude Mortality Scores
- ✓ Decrease in the time from admission to surgery for emergency admissions
- ✓ Decrease in the number of longest waiting patients on our waiting lists
- ✓ Improved the number of discharges before midday
- ✓ Improved provision of Safeguarding training
- ✓ Improved cancer programme outcomes through adoption of Quality Improvement methodology.

In Quarters 1 and 2 there are areas of risk that were assessed and will continue to need attention in the following quarters due to known capacity constraints:

- Preventable Health Acquired Pressure Ulcers
- Preventable Health Acquired Venus Thrombosis
- Severity of Medical incidents
- The time taken to see first clinician

The actions to improve the position and risk level have been included in our plans set out later in this document.

Structure
This report is structured across four sections as follows:

2. OUTCOMES FRAMEWORK & PERFORMANCE SUMMARY

The vision set out in the Quality Outcome Framework 2023-2024 is to:

> Drive continuous improvement in the delivery of healthcare services by focusing on measurable outcomes.

In order to achieve this vision, the Strategy focuses on developing and delivering our services around the six domains of quality:

- Person-centred care
- Safe care
- Timely care
- Efficient care
- Effective care
- Equitable care.

The Quality Outcomes Framework is updated quarterly and, depending on data availability, the latest data is reported for each indicator. For the 2023/24 the Quality Outcomes Framework was reviewed and, where appropriate, aligned with the 6 Pillars of Quality. The timescales for indicators vary according to the data source. The 'New Measure' category is used where the indicator is in development but has been recognised as important to include and measure.

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 full outcomes framework can be found in Appendix 1.

Quality Priority 1- PERSON CENTRED and opportunities to improve patient safety.

Delivering **PERSON CENTRED** care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities are key to ensuring improved health outcomes and to improve patient safety.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 1 - Person Centred	Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	*New Measure*	*New Measure*	Q2 2023	75.0%	*New Measure*	Y	Overall satisfaction score as 75% (benchmark is 85%). It should be noted that currently survey completion is small scale
		Balance of complaints received and closed by grade score	Q1 2023	373/314	Q2 2023	269/271	Improved	Y	and managed through PTR was 249 and 265 were managed via Early Resolution. The number of complaints opened and closed remains
		Compliments - Themes identified for improvement	*New Measure*	*New Measure*	Q2 2023		*New Measure*	N	Communication, and recording of information
		Reduction in the complaints backlog	Q1 2023	400	Q2 2023	380	No Change	Y	The backlog has seen a continued decrease with focused work to improve the baseline position established in June 2022
	Increased patient, public and staff involvement.	Increase in number of responses in Civica	*New Measure*	*New Measure*	Q2 2023	446	*New Measure*	Y	(446 Q1/2). A minimum number of surveys per month will be built into Ward Accreditation systems.
	Learning from complaints is implemented	Qualitative feedback use of the learning section in Datix						N	In development
		Increase in the number of actions plans completed						N	Work commenced to collect this data

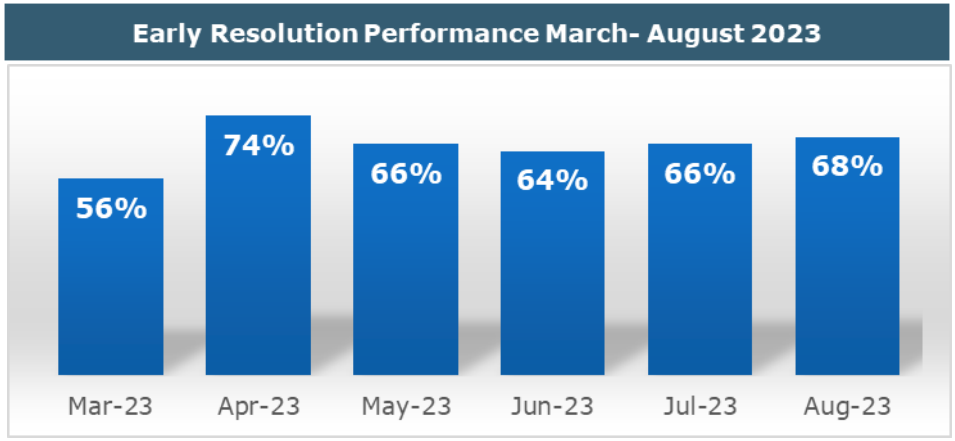
Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations.

The Aneurin Bevan University Health Board introduced the CIVICA Citizen Experience platform across the organisation in February 2023. An organisational hierarchy has been developed across all Divisions. This is to ensure patients can provide anonymous feedback which can be recorded (and retrieved) across several levels, including down to Ward, Team/Department, and service location.

Satisfaction Score Health Board Wide 01/03/23 – 12/09/23

75%

To date, 446 surveys have been completed. These have indicated an overall satisfaction score as 75% (benchmark is 85%). It should be noted that currently survey completion is small scale. A minimum number of surveys per month will be built into Ward Accreditation systems.



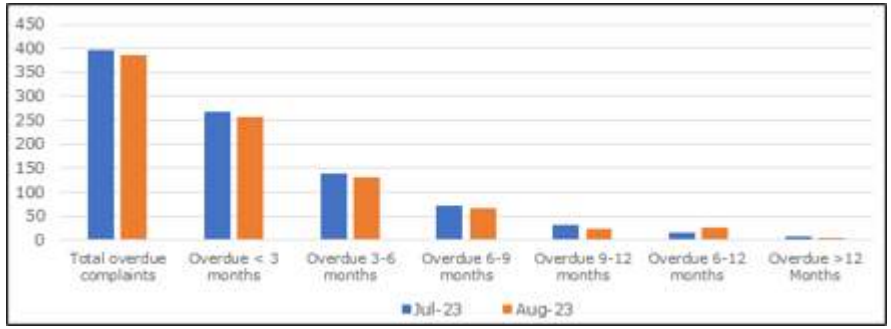
The number of complaints received and managed through PTR in Q2 (Sept partial) was **289** and **271** were managed via Early Resolution. The number of complaints opened and closed remains comparable. Organisational performance of concerns 'managed through PTR' was **56%** (mean) during this period compared with **54.03%** in the previous period.

The total number of overdue complaints are reducing. As of the beginning of September there are 6 overdue complaints > 12 months, a reduction from 8 reported in July.

A focused approach has been undertaken organisationally to close historic concerns. Monthly data provided to the Executives now illustrates concerns 6-9 and 9-12 months old. Previously they were encompassed in 6-12 months. The top four themes (equating to **45%**) identified were: -

1. Delay in appointment/waiting time/transport
2. Delay/Lack of treatment or Assessment
3. Incorrect/insufficient treatment or Assessment
4. Communication with patient/service user

Total Open Complaints and Overdue complaints



Reviewing the complaints and identifying themes and impact is important for continuous learning and change, the following actions as the result of reviews with patients and their families occurred during the past period**.**

Issue	Cause	Remedial Action	Who	When
Patient falls	No lying and standing blood pressure was performed on admission to the hospital as expected as standard practise.	An induction programme has been introduced for new Health Care Support Workers. All new HCSW's have training of one week as part of their induction/competency booklets to complete.	Medicine Division	Ongoing process for all new staff appointed
A patient had a stroke which was not identified	Care lacked sufficient depth and rigour. No discussions with other relevant clinicians. Conversation not documented on patient records.	Training to be provided for relevant clinicians re NICE Guidelines Focus on Nursing and Medical Documentation and Record Keeping led by Senior Nurses and QPS team and Medical Supervisors.	Unscheduled Care Division	September 2023
Staff failed to act on the Continence Risk Assessment.	A bladder diary should have been completed to identify the level of continence support the patient may have required on discharge.	The Senior Nurse is working with the Lead Nurse from the Bladder and Bowel Service. Education and training has been arranged, and upcoming study days are scheduled. Staff have been involved in educational training to provide them with the knowledge and understanding to support safe and timely discharge. This work is ongoing and is being supervised by the Senior Nurse team and the Head of Patient Discharge.	Lead Nurse Bladder and Bowel Service Head of Patient Discharge and Senior Nurses	September 2023 Ongoing

Increased patient, public and staff involvement.

There has been a graduated roll-out to support staff training in CIVICA resulting in **283** Person Centred Care (PCC) Surveys completed to date. This is a new measure and adoption, and completion is expected to significantly increase over the next two quarters. CIVCA is being included in Ward Accreditation and highlighted through Divisional Reporting showing the following measures.:

- Satisfaction Score,
- Heat Map,
- Comment Analysis (Themes),
- Comment Reports,
- Listening and Learning,
- You said, we did.

The KPI's for Primary and Community have been structured in to 8 core questions, and to ensure a whole system approach to provide feedback the National ED and COVID surveys are now active.

Quality Priority 2- Safe Care.

Provide **SAFE** care through reducing harm, preventing errors, and delivering consistently safe care through increased visibility and insight from multiple sources of patient safety information.

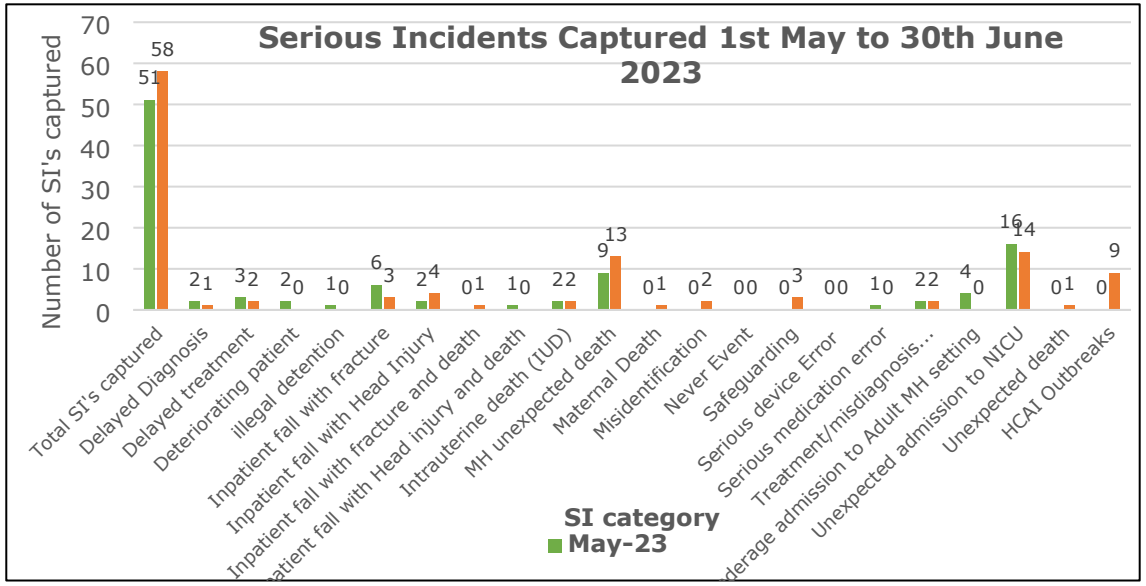
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
	Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category,	Q1 2023	58	Q2 2023	61	Increased	Y	61 incidents have been reported to the NHS Executive, since April 2023 there has been an increasing trend
		Reduction in the number of National Reportable Incidents	No Data	No Data	Q2 2023	173	No Data	Y	Data is from 14th June -31st August, previous period to be re calculated
		Reduction in the number of Never Events	Q1 2023	0	Q2 2023	1	Increased	Y	1 Never Event reported during this period - a retained swab. Positively this is the only 1 Never Event during the last 6 months
		Improvement in the time to respond and close incidents	Q1 2023	70 days	Q2 2023	70 days	No Change	Y	There has been increasing trend over the past year for the time taken to close incidents, and an increase in the number of incidents reported inline with an increased use of the DATIX stem
		Decrease in the number of reportable IPAC incidents	Q1 2023	47/week	Q2 2023	29/week	Decreased	Y	Numbers have been lower since April in line with seasonal trends. Around 41% occur in RGH, and 21% in NHH
		The number of incidents with no harm themes identified						N	
		Increase in the compliance of Health and Safety Statutory and Mandatory Training	Q1 2023	84%	Q2 2023	86%	Improved	Y	There has been an increase in all the health and safety areas compared with the previous report

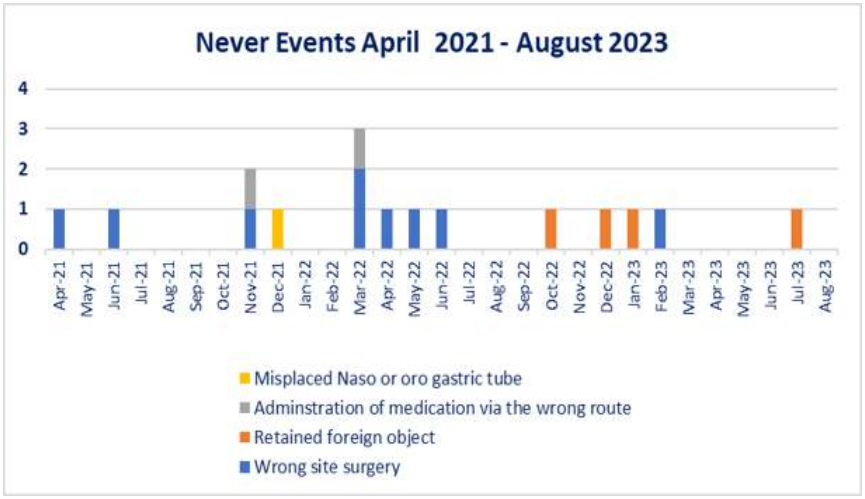
		Training							compared with the previous report
Priority 2 Safe Care	Improved clinical outcomes,	Decrease in the time to complete safety alerts	Q1 2023	4 days	Q2 2023	4 days	No Change	Y	The average time to report has stabilised however the data is highly variable with regular peaks above four days
		Improvement in the severity of harm following a fall in hospital	Q1 2023	10%	Q2 2023	10%	No Change	Y	The number remains in line with Q1 however the variation has decreased
		Decrease in the number of Falls by 10,000 occupied IP Bed days	Q1 2023	10	Q2 2023	9	No Change	N	Compared to the previous period the number have stabilised following a period of reduction
		Decrease in the number of falls treated in ED which have had a previous admission - reattendance	No Data	No Data			No Data	Y	
		Improved RAMI Scores	Q1 2023	110	Q1 2023	110	No Change	Y	There has been a significant decrease in RAMI until December 2021 before gradually increasing in line with the rest of Wales but continued to be below the Welsh average
		Improved Crude mortality by hospital	Q4 2022	5.13	Q1 2023	4.3	No Change	Y	Over the past year ABUHB has seen an improvement in the Deaths by 1000 bed days measure and notably in the first quarter
		Decrease in the number of HA pressure ulcers by grade	Q1 2023	20%	Q2 2023	20%	No Change	Y	The number remains in line with Q1 however the variation has decreased
		Decrease in the number of HA pressure ulcers	Q1 2023	21/week	Q2 2023	23/week	No Change	Y	There has been a small increase in the last Quarter
		Decrease in the severity of medicines incidents	Q4 2022	346	Q1 2023	304	Severe catagory increased	Y	Total 304 incident reported April to June 2023 Total 291 incidents reviewed and investigated April to June 2023
		Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	Q1 2023	32	Q2 2023	28	No Change	Y	36 incidents to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 60% of these cases were reported within the legal timeframes within the legislation. This is an increase of 2% from the previous report.
		Reviewed Cardiac Arrest calls by 10,000 bed days	No Data	No Data			No Data	Y	
		Decrease in Hospital Acquired Venous Thrombosis incidents	Q3 2022	54	Q2 2023	43	Improved	Y	The last available data is Q4 2023. There has been an overall decrease in the number of HAT's in ABUHB, however over Q3 and 4 an increase in the number of preventable incidents
		Increase in the number of PREM Audit and actions						N	

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

As of the 12th September 2023 the Corporate Serious Incidents Team were managing 5**5 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. The NHS Wales National Incident Reporting Policy was introduced June 2021.During May 2023 *'NHS Wales National Policy on Patient Safety Incident Reporting & Management',* was launched, this document merged the Policy and Guidance into one. The Health Board's Patient Safety Incident Process is currently under review, with work being led by the Executive Director of Nursing.



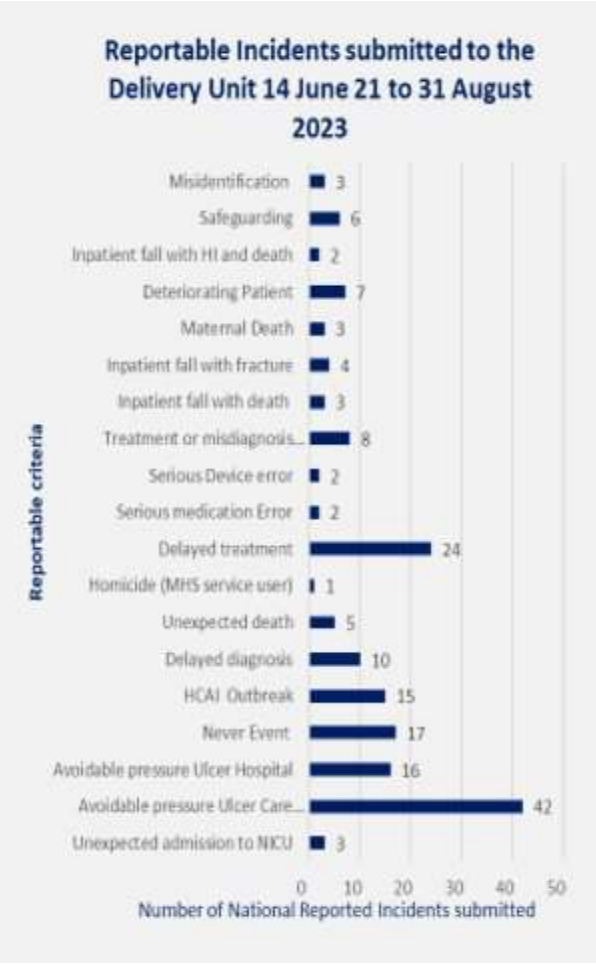


There was **1 Never Event** reported during this period – a retained swab. Positively this is the only 1 Never Event during the last 6 months. A focussed approach to preventing Never Events continues across the organisation. A report will be presented at October's QPSOC, outlining the Improvement Programme for Theatres. It will encompass, a summary of incidents, themes, the Human Factors programme, and a plan for the subsequent 12 months.

61 incidents have been reported to the NHS Executive, since April 2023. There was a marked increased during June and July, when the Health Board were advised to review their reporting criteria. For reassurance, investigations were undertaken, but not all incidents were reported as Nationally Reportable Incidents (NRI's).

Approximately **65%** of the three NRI themes related to: -

1. Delayed treatment
2. HCAI
3. Treatment or misdiagnosis resulting in harm/death.



Decrease in the number of reportable IPAC incidents

There are around 29 infection incidents recorded each week. Numbers have been much lower since April. Around 41% occur in RGH, and 21% in NHH. 74% of infection incidents occur in Medicine settings. The vast majority of these are considered to be "Low" level of harm.

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Aug 23

Additional filters for Table 1.
Select month or FY: Current FY
Select organism group: All organisms

< than same period last FY
= same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	30.79	0.8	14.8	57.98	19.99	4
Betsi Cadwaladr UHB	37.07	0.34	22.79	73.46	20.07	5.1
Cardiff and Vale UHB	23.23	2.37	31.77	65.91	23.71	4.27
Cwm Taf Morgannwg UHB	24.46	2.66	29.78	91.47	23.93	2.66
Hywel Dda UHB	41.13	2.46	24.55	114.17	26.39	8.59
Powys THB	10.79	0	0	3.6	0	0
Swansea Bay UHB	52.01	3.06	37.32	76.49	22.64	6.12
Velindre NHST						
Wales	33.21	1.74	24.75	74.57	21.81	4.75

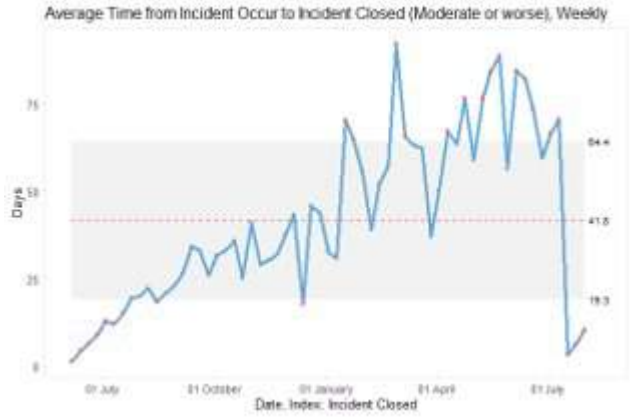
Increase in the compliance of Health and Safety Statutory and Mandatory Training

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

Training	End of May	End of August
Health and Safety	84%	86%
Violence and Aggression	82%	84%
Fire Safety	79%	81%
Manual Handling	52%	56%

There has been an increase in all the health and safety areas compared with the previous report. A review of all health and safety training strategies is being undertaken to ensure an increase in compliance and active engagement with the Divisions to implement the training model is happening.

Improved clinical outcomes,



There has been a notable increase in the time take to report and close incidents over the past year. Q1 and 2 have shown a levelling out of the number, however this should be considered in an increase in reporting overall and positive progress on use of the reporting systems, work is ongoing to improve the access, accuracy, and use of the reporting system. The average time take to report incidents is **4 days** but is still highly variable and regularly above this number.

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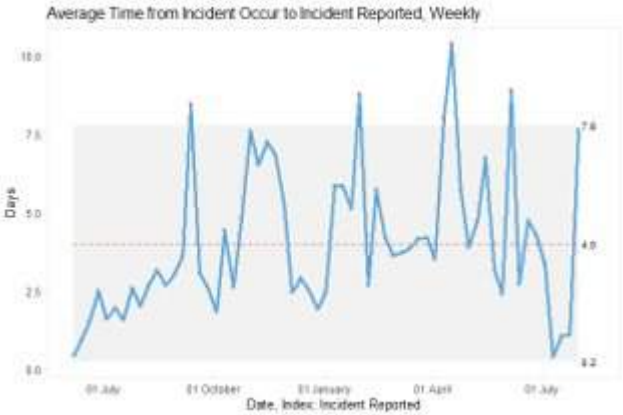
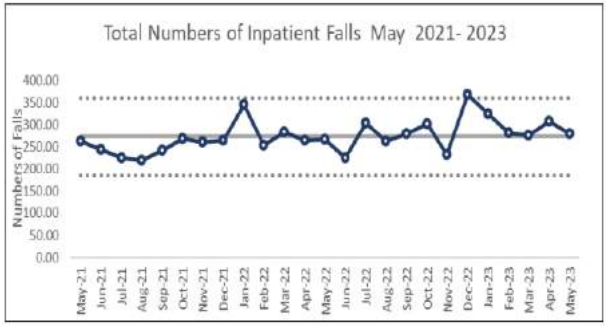
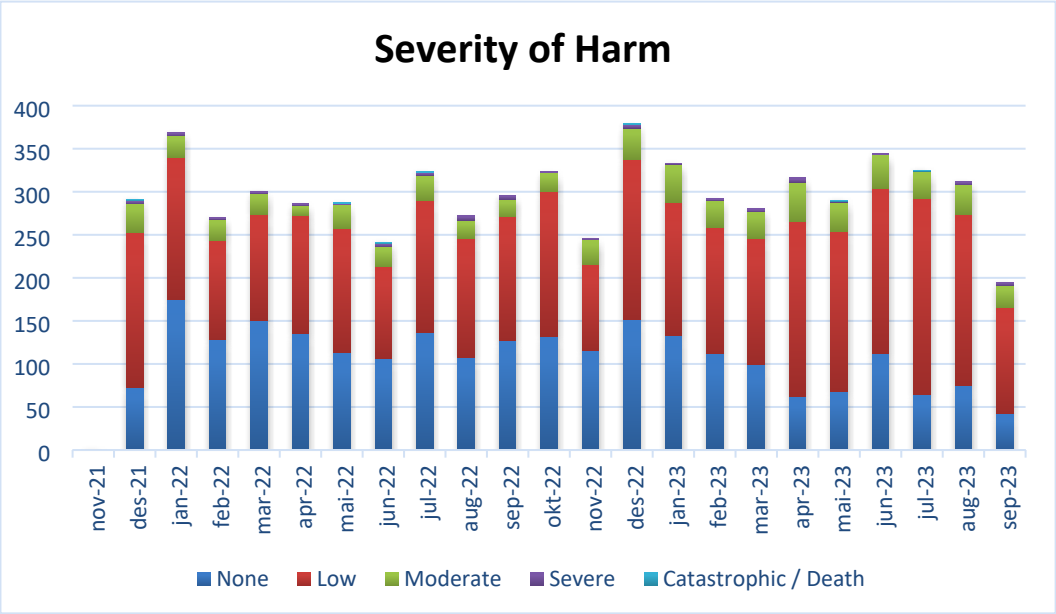


Falls

Falls analysis of data associated with Inpatient falls management continues to be monitored over a two-year rolling period to provide assurance. This approach identifies any changing trajectories or statistical variation in the number of falls incidents. The mean average value for the total number of falls per month has seen a marginal increase to 282 for the data period August 2022-23. For February to August of this year there has been a return to closer alignment to the mean average value with a marginal rise in June followed by a downwards trajectory for July and August 2023. A reduction in variation has been seen across the last 7 months. Of the total numbers of falls for July and August 21% have occurred in GUH with 55% and 24% in the ELGH and Community settings respectively.



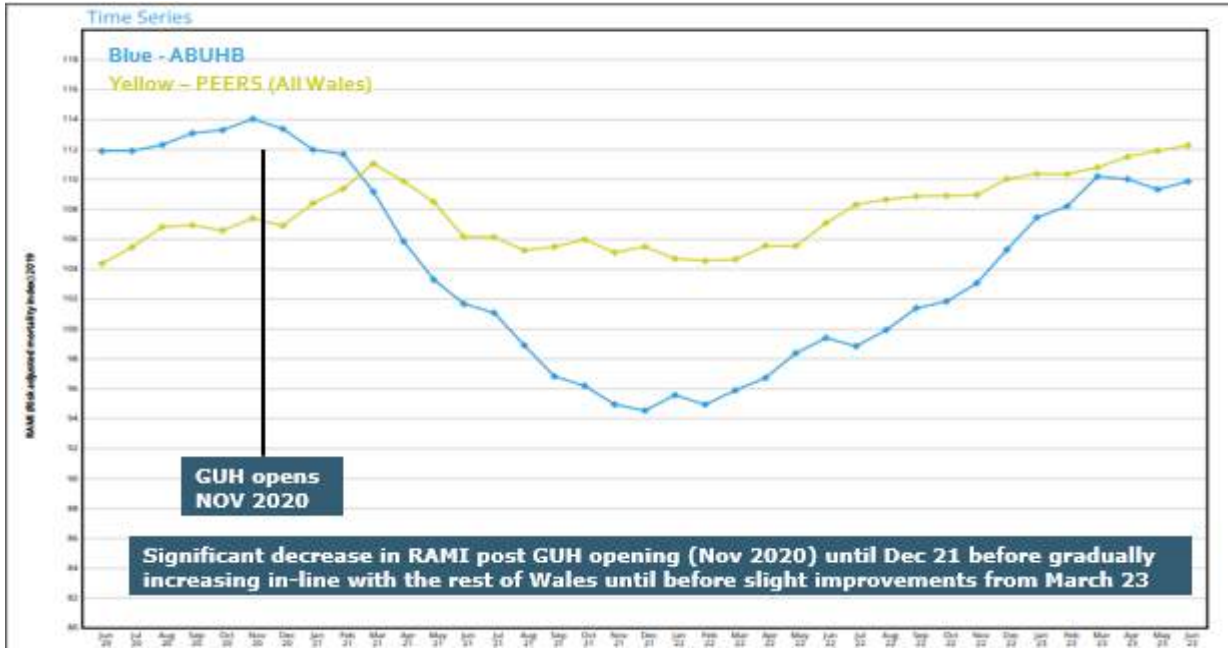
82% of incidents identified at report stage are represented within the no harm or low harm categories. For the months of July and August 2023 there was a decrease in reported incidents across the No Harm to Moderate Harm categories with the Severe Harm category being



the same for both months (4).From a Divisional perspective 63% of those represented as reporting falls incidents demonstrated a downwards trajectory in numbers in August as compared to July. Medicine saw its lowest value since March 2023 with Urgent Care retaining a downwards trend since April 2023. MH & LD has recorded it lowest number of falls since August of 2022. An increase in reported incident has been seen in August within the Division of F&T 75% of which have been where assistance has been provided to lower a patient to the floor.

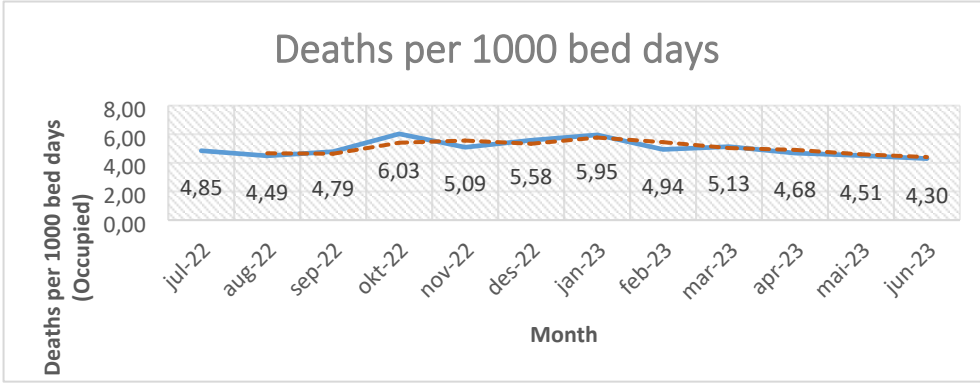
Risk Adjusted Mortality Index (RAMI)

RAMI is used to assess whether inpatient mortality across all medical and surgical patients deviates from the expected, taking risk factors into considerations. Since the opening of the Grange University Hospital, there has been a significant decrease in RAMI until December 2021 before gradually increasing in line with the rest of Wales but continued to be below the Welsh average. To date, the Health Board is performing 3rd of 6 within its peer group.



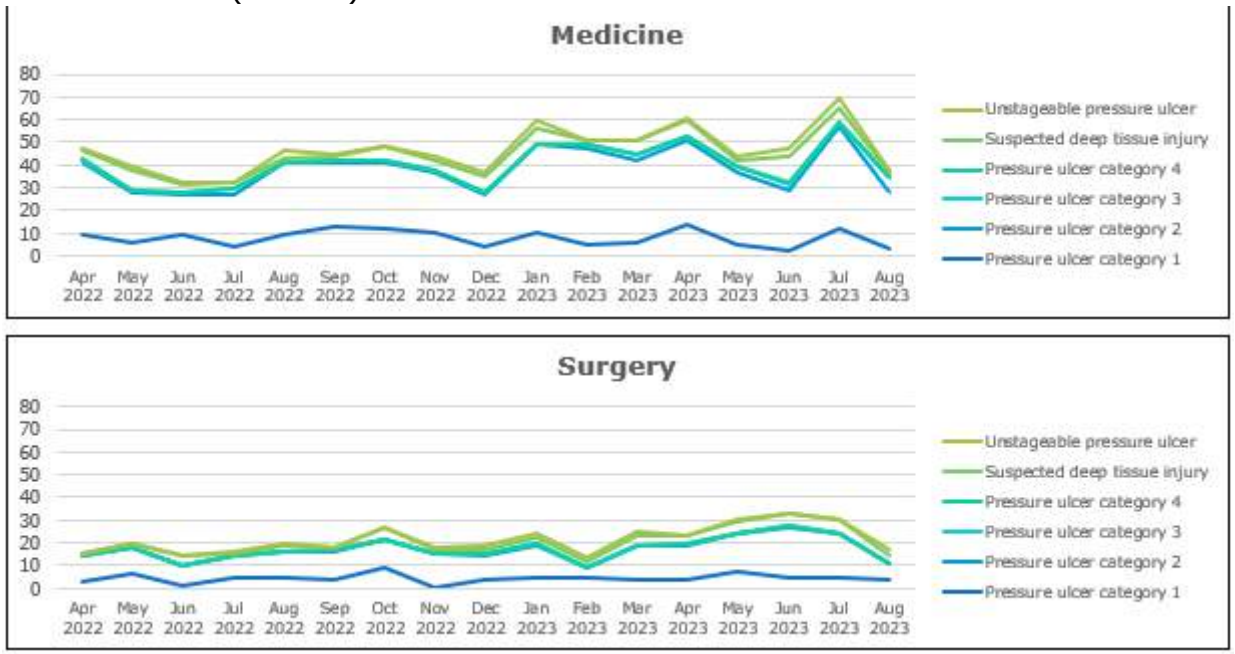
Crude Mortality

The review of mortality rates supports understanding of many questions about the causes, consequences, correlates, and measurement of mortality in a complex environment: Over the past year ABUHB has seen an improvement in the Deaths by 1000 bed days measure and notably in the first quarter.



Health Acquired Pressure Ulcers

Following the COVID-19 Pandemic, the Health board reported increased numbers of unstageable and grade 3 & 4 Health Acquired Pressure Ulcers (HAPU's).



Reported Health Acquired Pressure Damage occurs at a rate of around 23/week. Around 20% are considered Moderate or Severe based on the reporter's view. 34% of these occurred at GUH and 52% in eLGHs.

With the success of the previous pressure ulcer prevention and reduction collaborative, the Pressure Ulcer Faculty 2023 has been developed, led by the Nursing Directorate and Senior Nurses from Medicine, Unscheduled Care, Urgent Care and Community Care nursing; with support from ABCi. The Aim of the Faculty is to Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty and eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty

Medication Incidents

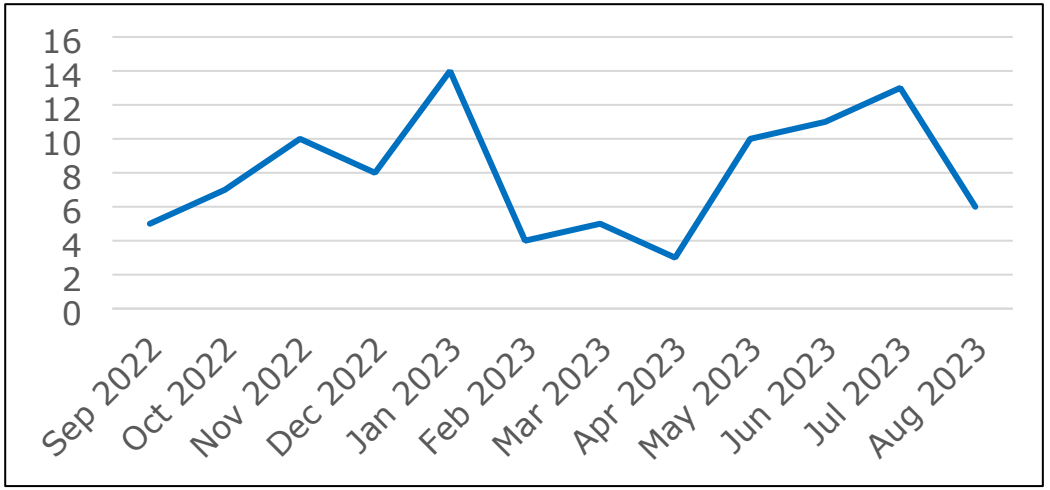
A total of **304** incidents were reported from April to June 2023 and a total of **291** incidents were reviewed and investigated April to June 2023. There are around **25 medication incidents** recorded each week.Around **37% occur** in 'Other' sites outside of the main ABUHB hospital sites. A large portion of the incidents in PC&C were Medication Supply Errors.

There had been a decrease in the total number of incidents between Q4 and Q1 overall however an increase in the number categorised as Severe.

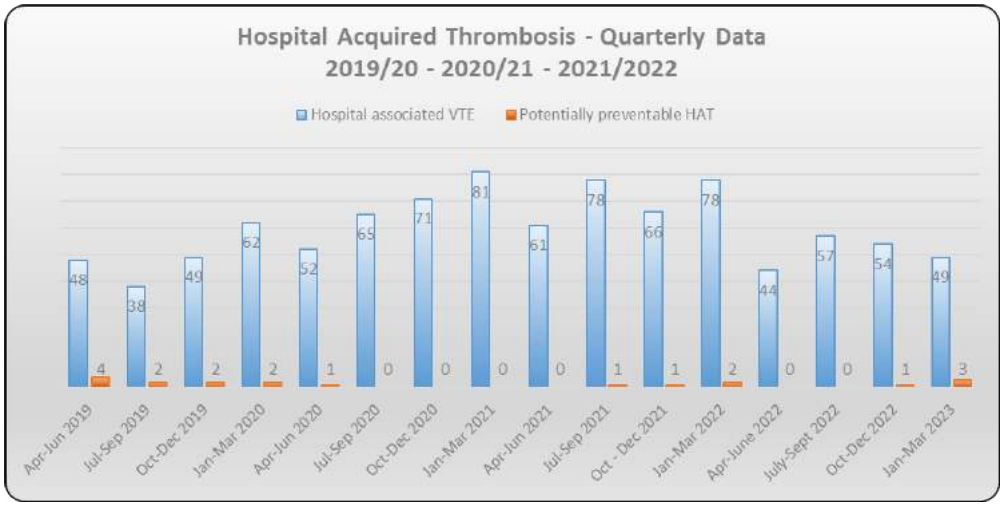
	Q2	Q3	Q4	Q1
None	224	226	208	188
Low	95	95	98	88
Moderate	41	32	35	21
Severe	0	7	5	7
Catastrophic	1	0	0	0
Total	**361**	**360**	**346**	**304**

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period September 2022 to August 2023 the Health Board have reported 96 incidents to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 60% of these cases were reported within the legal timeframes within the legislation. This is an increase of 2% from the previous report.



Health Acquired Venus Thrombosis



The last available data is Q4 2023. There has been an overall decrease in the number of HAT's in ABUHB, however over Q3 and 4 an increase in the number of preventable incidents. There is a focused programme of work with Scheduled Care and Trauma and Orthopaedics who have seen the highest prevalence and an increasing trend.

Quality Priority 3- Timely Care

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

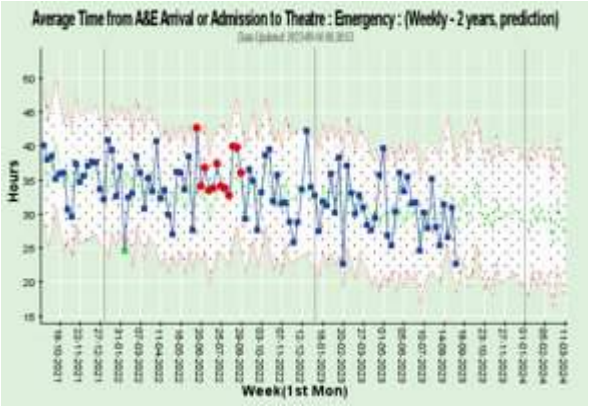
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 3 Timely	Maximising and individuals time and outcomes	Decrease in the time from admission to surgery for emergency admissions	Q1 2023	31 hours	Q2 2023	30 hours	Improved	Y	Average time to theatre from Arrival/Admission is around 30 hours, and has been on a reducing trend over the past 2 years.
		Decrease in the time from surgery to discharge	Q1 2023	3 hours	Q2 2023	3 hours	No Change	Y	Average time from leaving theatre to discharge has been mostly stable around 3 hours
		Decrease in time spent on a waiting lists	Q1 2023	3846	Q2 2023	34.16	Improved	Y	Improving trend for our longest wating patients, ahead of plan for those waiting 156 weeks, emerging issues in ENT and Ortho spines with Divisional actions plans
		Decrease in the number of handovers >1 hour	Q1 2023	1497	Q2 2023	1295	Improved	Y	Improved indicator value through implementation of change programme over the summer
		Decrease in the time for patients to be seen by first clinician	Q1 2023	3.25 hours	Q2 2023	4.5 hours	Deteriorated	Y	Q2 saw a deterioration from previous improvement
		Decrease in the time for bed allocation from request	Q1 2023	10 hours	Q2 2023	7 days	Improved	Y	Improved indicator value through implementation of change programme over the summer
		Decrease in ED waits >12hrs	Q1 2023	350	Q2 2023	350	No Change	Y	
		Increase in discharges before midday;	Q1 2023	0.3	Q2 2023	0.32	Improved	Y	Improving indicator value, expected to see further improvement in Q3
		Decrease in the number of patients with a LoS over 21days	Q1 2023	580	Q2 2023	580	No Change	Y	>21 days Occupancy is following usual trends, around 580 patients.
		Time from Flow Centre call to discharge/ admission from assessment?	No Data	No Data			No Data	Y	
		Number of emergency admissions in hospital over 7 days	Q1 2023	360	Q2 2023	360	No Change	Y	7-21 days Occupancy is following usual trends, at around 360 patients.
		Decrease in the time from request to step up/down to a different site	No Data	No Data			No Data	Y	
		Decrease Overnight bed moves and patient transfers	Q1 2023	38	Q2 2023	36/week%	Improved	Y	Reduced variation was noticeable in Q2
		Reducing time spent in hospital	No Data	No Data			No Data	Y	

	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Q1 2023	56.9	Q2 2023	0.603	Improved	Y	Deterioration in indicator value from 58.2% (Mar 23) to 56.2% (Jun 23)
		Increase in 5 year cancer survival rates	Q1 2023	54	Q2 2023	0.54	Improved	Y	Indicator value is similar and has been sustained. Next update scheduled Sept 23 (provisional)
	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	Jun-22	97.40%	Jun-23	82.90%	Deteriorated	New	Deterioration in metrics, however IMTP target remains achieved.
		Decrease in neurodevelopmental (SCAN) waiting list	Feb-23	42.20%	Jun-23	36.20%	Deteriorated	New	Indicator has deteriorated from 42.2 (Feb 23) to 36.2% (Jun 23)
	Improved mental health resilience in adults	Increase in life satisfaction among working age adults	2020/21	76.40%	2021/22	79.50%	Improved	New	**New Indicator** Increase in value between 2020/21 and 21/23
		Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Q1 2022/23	75%	-	-		New	**Measure will be available from July and will be included within the next quarterly report**
		Increase in life satisfaction among older people	2020/21	75.00%	2021/22	84.20%	Improved	New	**New Indicator** Improvement within indicator from 75% to 84.2%, surpassing the all Wales average of 82.4%.

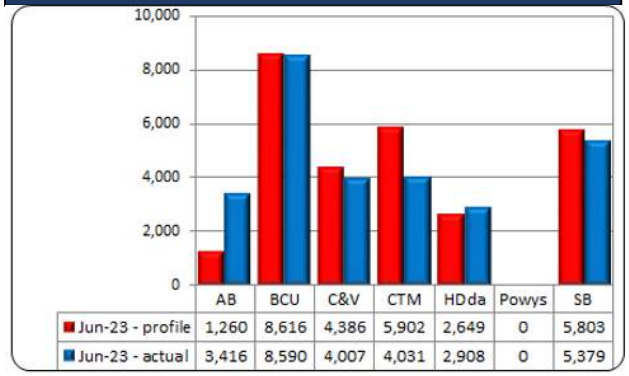
Maximising an Individuals Time and Outcomes

Maximising an individual's time is a core element of planned and emergency care.

As of June 2023, there time take from admission to surgery for emergency admission continues to improve and as illustrated on the chart to the right. The chart shows the weekly trend since 2021. Average time to theatre from Arrival/Admission is around 30 hours and has been on a reducing trend over the past 2 years. Average time from leaving theatre to discharge has been mostly stable around 3 hours.



No of pts waiting more than 104 weeks for referral to treatment

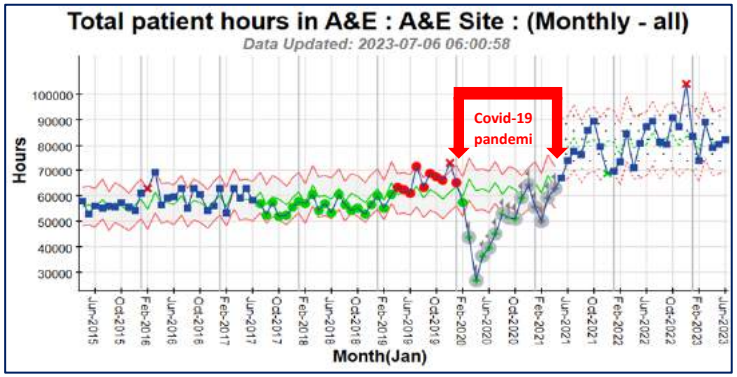


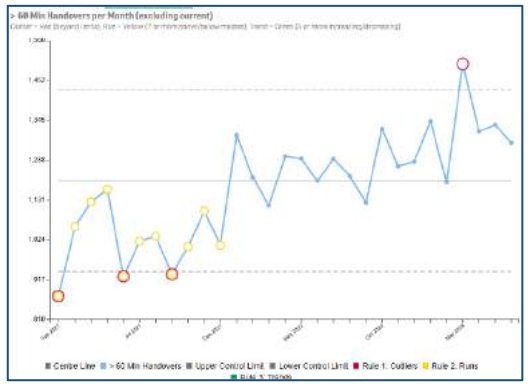
	AB	BCU	C&V	CTM	HDda	Powys	SB
Jun-23 - profile	1,260	8,616	4,386	5,902	2,649	0	5,803
Jun-23 - actual	3,416	8,590	4,007	4,031	2,908	0	5,379

As of June 2023, there are 3,416 patients waiting more than 104 weeks for referral to treatment and as illustrated on the chart to the right, whilst the June trajectory profile has not been achieved, the Health Board maintains the smallest number of long waiters.
With regards to outpatients, as of June 2023, there were 11,503 patients waiting more than 52 weeks and 18,350 waiting more than 36 weeks for a new outpatient appointment. Whilst the Quarter 1 trajectories have not been met, performance is expected to return in line with forecast with the commencement of Ophthalmology contract and a focus on ENT waits in Quarter 2.

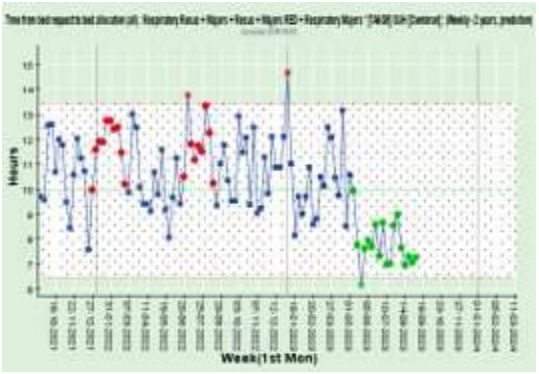
Maximising an Individual's Time- Urgent Care

Urgent Care services continue be under significant pressure both nationally, regionally, and locally, making delivering timely care challenging. There has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.





During Quarter 1, there have been on average 619 daily attendances to the Emergency Department or a Minor Injury Unit and the pressure on the urgent care system has resulted in patients staying in hospital for longer. The average time from arrival to departure in the GUH Emergency Department continues to be above target and significantly above pre-covid levels as the chart above demonstrates. During June, a total of 1,285 patients waited for over 60 minutes to be transferred to the Emergency Department from an Ambulance. Whilst this remains high as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers and as such this has reduced significantly from 1497 reported in March 2023.



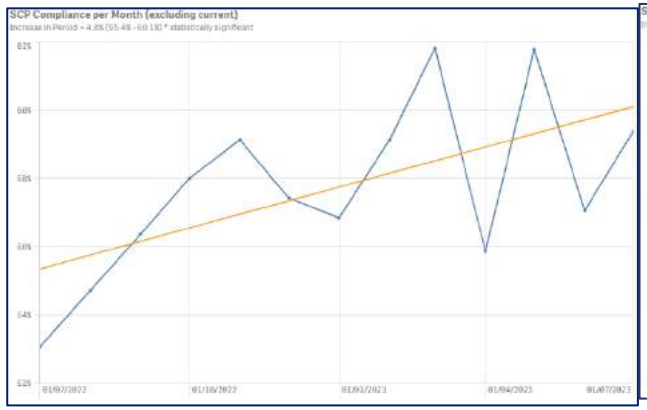
Time to see a clinician in ED has been increasing since January 2023 however as a result of the safety flow programme of work the time to bed allocation as see a significant improvement. Time for bed allocation has been improved since May but remains around a 7-8 hour average. The number of patients waiting in ED for over 12 hours is around 350 patients each week.

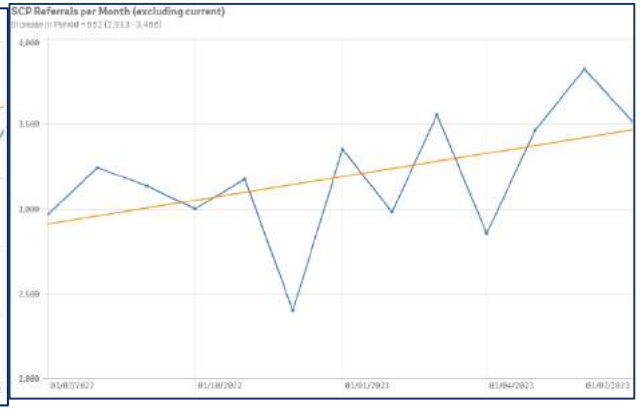
There has been a small improvement in the numbers of patients discharged before midday, the discharge programme of commenced in Q2 and is expected to make an impact has ahead of the winter. 7-21 days Occupancy is following usual trends, around 360 patients. >21 days Occupancy is following usual trends, around 580 patients. The proportion of ward transfers made overnight is around 30-40%. The proportion of discharges made before 1pm is around 28-36%.

The outcome **'Reducing admissions and time spent in hospital'** has seen a sustained position with both indicators, and the number of emergency admissions for over 65 years of age is reported at 1439 at the end of June. Whilst the indicator 'decrease in the length of stay over 21 days' has remained statistically similar to the previously reported position, the gradual decrease from 56% (145/264) in March 2023 to 55% (140/255) in June 2023 has resulted in the IMTP target of 55% being met.

Maximising cancer outcomes

There has been significant improvement in the rate of 5-year cancer survival reported over the last 10 years. Compliance against the 62-day target for definitive cancer treatment, however, have deteriorated from 58.2% as of March 2023 to 56.2% at the end of June 2023. Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,000 referrals per month and this increased demand is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres.





There are a number of factors which have had an impact on overall performance. A primary driver is a considerable reduction in skin treatments. The volumes for this specialty have historically contributed in increasing the performance denominator. This reduction has been influenced by the current pathology pressures. The pressure on the diagnostics part of the pathway is a significant constraint with actions continuing to improve the position through outsourcing of services.

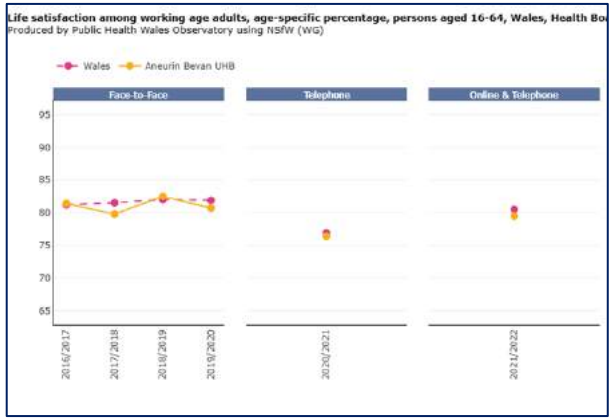
Improve Mental Health Resilience in Children and Young adults

Progress within the 'Improve Mental health Resilience in Children and Young Adults' outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks. Quarter 1 of 2023/24 has seen a continued demand of referrals requesting consideration of a ND assessment and this challenge has resulted in an RTT compliance for the end of June 2023 of 35.4%. A robust ND recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0 - 18 years pathway by separating the cohorts of 0 - 5 years and the 5 - 18 years.

A new pathway has been approved for those aged 0-5 years on the waiting list waiting for an ASD assessment. This will begin to have an impact once the new team is in place following recruitment, that should commence August 2023. For the children and young people on the 5-18 years waiting list, an ND recovery team has been put in place to support with the longest waiters and support the core ND team. Focus will also be on the ND screening of new referrals with completed supporting information.

Mental Health in Working Adults

Mental wellbeing and life satisfaction result in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and improvements have been observed in the 'Improved mental health resilience in adults' outcome measure. The newly developed indicator which measures satisfaction among working age adults increased and from 76.4% in 2020/21 to 79.5% in 2021/22 and shows signs of returning close to pre-covid levels.



Due to the ongoing backlog caused by WCCIS implementation, reporting has only just recommenced this quarter, an update will be provided in Q3. The Division have been working closely with the Informatics Directorate and a resolution to reporting validated activity has been sought and will be in place from next month (July). Unvalidated data indicates that assessments are complaint with RTT targets, however treatments are non compliant.

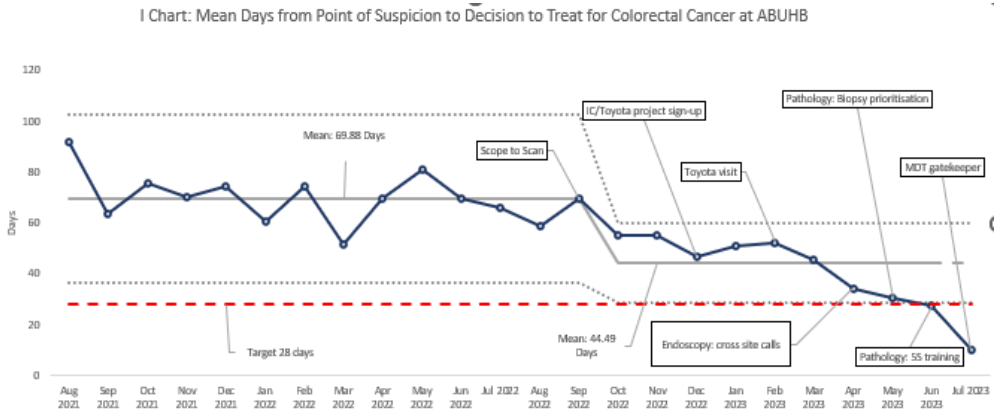
Quality Priority 4- Effective Care

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.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 4 Effective	Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation plans by area						N	New measure reporting from Q3
		Insert ward accreditation measures – to be confirmed						N	New Measure from Q3
	Increased understanding of variation to focus Improvements	Increase in the SMART action plans with accountability in National Clinical Audit						N	New Measure from Q4
		Increase in the numbers of wards participating in accreditation (Audits via AMaT)						N	New Measure from Q5
		Increase in the actionable audit recommendations by National Clinical Audits						N	New Measure from Q6
	Improvement is part of the AB way	Staff Survey – increase in the score for staff being able to raise concerns						N	New Measure from Q7
		Compliance the number of incidents triggering Duty of Candor within 5 days	No Data	No Data			No Data	Y	
		QI projects outcomes (Non SCC)	Q1 2023		Q2 2023			Y	Narrative report
		Outcomes of the SCP teams	Q1 2023		Q2 2023			Y	Narrative report
	Improving Good Health in Pregnancy	Decrease in low birth weight rates	2021	5.10%	2022	6.10%	Deteriorated	New	Increase in indicator between 2021 and 2022. In line with the All Wales average.
		Decrease in stillbirths	2021	3.9	2022	4.5	Deteriorated	New	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	59.20%	56.50%	Q4 2022/23	58.90%	Improved	New	Indicator value has improved by 4.2% between Quarter 3 and Quarter 4.
		Increase of eligible children measured and weighed at 8 weeks	62.50%	35.00%	Q4 2022/23	39.70%	Improved	New	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average.

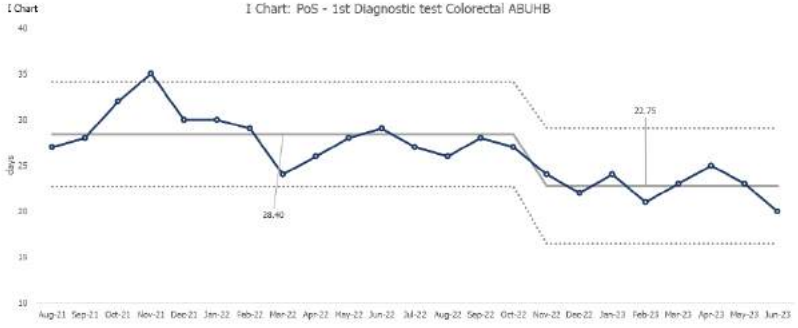
QI projects outcomes (Non-Safe Care Collaborative) - ABUHB Colo-rectal Suspected Cancer Pathway Improvement Work

Health Board is working with the Wales Cancer Network and Improvement Cymru to work with Cancer MDTs across Wales to facilitate and enable improvement to the Suspected Cancer Pathway with a focus on the first 28 days. A Go Look Go See visit to understand the current system followed by a 3-day training programme at Toyotas engine plant in Deeside to focus on improvement work. The people on the training were asked to extract lessons learnt from Toyota into the health setting and their day-to-day work. With this work the persons experience/ story has always been considered in any conversation around reducing the days waiting.



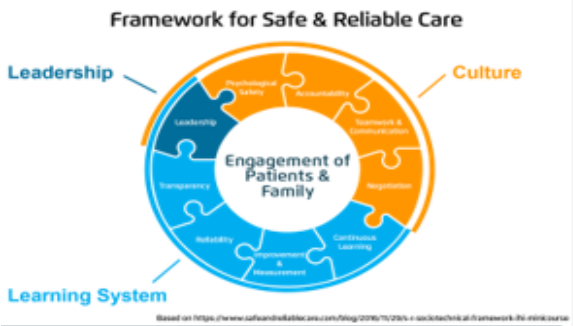
A follow up coaching visit from Toyota was undertaken to hear about improvement changes and ideas. Improvement Cymru provided coaching support to enable application of new knowledge and learning.

The chart shows an overall improvement in a person's journey from **70 days** to a new mean **of 44 days**. The second graph shows an overall improvement in days from a median **of 17 to 12 days** wait between POS to 1st appointment. This appointment can be outpatients or at endoscopy/ straight to test. Work in Endoscopy has included introducing cross site calls each day to coordinate phone calls to book appointments and further work is being undertaken on standardising the calls to ensure people are booked in for the earliest possible appointment available. Further standardisation of all processes is being undertaken to ensure people are booked in within the 2-week target.



Work in Radiology (Pre Toyota) correlates with improvements being made to the Colo-rectal pathway – The Endoscopist can now send an e-referral for same day CT staging scans, whereas previously biopsy results were awaited before arranging these scans. Endoscopies complete all safety and pre scan preparations allowing the staging CT to take place on the same day and MRI within the 72 hrs of the referral. This has helped reducing waiting times to the overall pathway by between **15-20 days**.

Outcomes of the Safe Care Partnership Teams



Safe Care Collaborative - update

Organisational Update: Stage-Action Period 6

- **Learning Session 3, Sept 19-20** - Preparation: Team Story boards – Workstream coaching sessions – Team time to plan – Charters and measurement plans complete
- **Leadership programme of work** – schedule of executive Safety Walkarounds – 9 completed since last report. QI project to evaluate and improve experience and outcomes
- **Quality Strategy** – Delivery Plan, Outcomes Framework and QI Skills Development Programme complete.
- **Prof Maxine Power** continuing to work with ABUHB, preparing for two sessions being held in October
- **QI Skills Development**– working with Improvement Cymru to deliver bespoke training; Embedding QI sessions at CDx and with Heads of Therapy Services. Jnr Dr QI Forum, PocEd QI, PocED Measurement in place

Team Update:

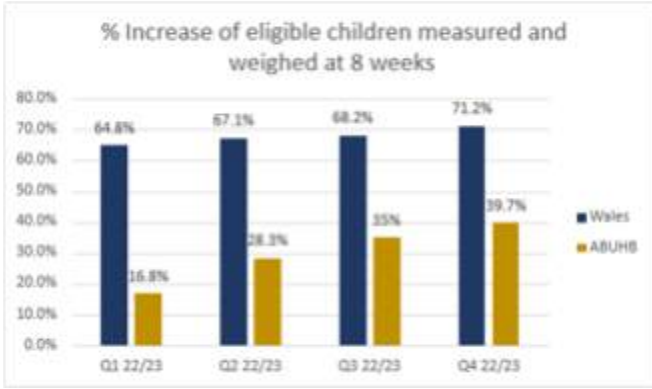
- **Charters** have been developed to describe QI teams aims, driver diagrams and measurement strategies
- **Leadership for Patient Safety Programme**- Four senior staff members undertaking training
- **Improvement Advisor** - Plans in place to appoint role to support Theatres Human Factors and Never Events work
- **GACU team** on pause due to work pressures and staffing issues
- **Data lead** continuing to work with coaches and teams to develop data viewers especially for the Acute and Ambulatory workstream.
- **Careflow data** being used effectively as part of Acute workstream
- **Improvements** starting to be reflected in the data

Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	2
	Theatres – Human Factors	NEW
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU) at RGH	1.5
	North Monmouthshire Integrated Team	3
Community	Glaslyn Care Homes	NEW
	Mental Health OT Team	2
Leadership	Executives, Leaders for Safety, Faculty	3

IHI Score	Stage of Project
0.5	Intent to participate
1.0	Forming team
1.5	Project plan begun
2	Activity but no changes
2.5	Changes tested but no improvement
3	Modest improvement
3.5	Improvement
4	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable improvement

Optimising a child's long term potential

Following the impacts of the Covid-19 pandemic in 2020, the number of Healthy Child Wales Programme contacts have recovered to numbers seen prior to the pandemic. There has been an improvement in one indicator of the outcome 'Optimising a child's long term potential' with an increase from the last reported position **of 28.3%** (Q2 2022/23) to **35%** in the increase of eligible children measured and weighted at 8 weeks as part of the Healthy Wales Child programme.

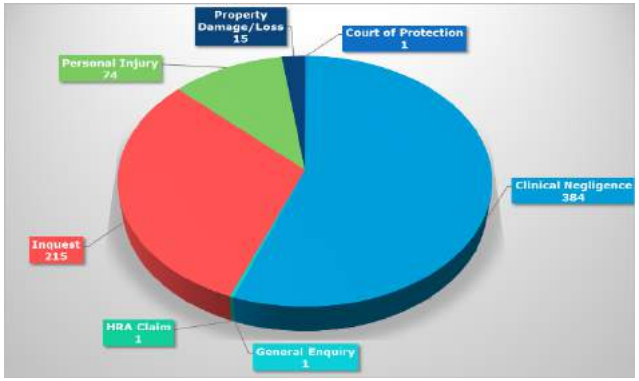


Quality Priority 5- Efficient

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.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 5 Efficient	Patient experiences are visible and acted on	Decrease in the number of personal injury cases	Q1 2023	71	Q2 2023	74	Increased	Y	Over 100 submissions of evidence/learning/assurance No Financial Penalties at July WRP Committee
		Decrease in the number of claims and redress	Q1 2023	3	Q2 2023	0	Decreased	Y	No Financial Penalties at July WRP Committee
		Decrease in the number of inquests open and closed	Q1 2023	197	Q2 2023	215	Increased	Y	Increased from Q1
		Decrease in the DNA's and CNA'S	Q1 2023	6.10%	Q2 2023	5.40%	Decreased	Y	The current rate has reduced from 6.1% (2,762) in March 2023 to 5.4% (2,354) in June 2023 the programme is continuing to work alongside finance and divisional teams, with a particular focus next quarter to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment
		Response time to Public Services Ombudsman for Wales(PSOW)	No Data	No Data	Q2 2023		No Data	Y	
		Number of INNUS's being completed	Q2 2022	518	Q3 2022	457		Y	Remained constant over the year with a small decrease between Q2 and Q3
		Decrease in the number of outliers by Specialty	New Measure					N	New Measure
		Decrease in the number of medically fit for discharge patients	Q1 2023	280	Q2 2023	280	No change	Y	In the past year there has been a decreasing trend in the numbers from 320 to 286, this has now stabilised over the last quarter to 280
		Decrease in the number of patients cancelled on the day of surgery	Q1 2023	130	Q2 2023	110	Decreased	Y	There has been a decreasing trend in the numbers cancelled in the day of surgery the numbers over the past quarter remain circa 110 per week
		Decrease in the % of hospital as a place of death	Q1 2023	4%	Q2 2023	2.50%	Decreased	Y	There has been a notable decrease in the % of hospital as a place of death in the past quarter outside of normal season trends from 3.2% to 2.75%
	Improve care at the end of life	Increase in compliance of issuing of Medical Certificates within 5 days	No Data	No Data	Q2 2023		No Data	Y	

Claims, Redress & Inquests

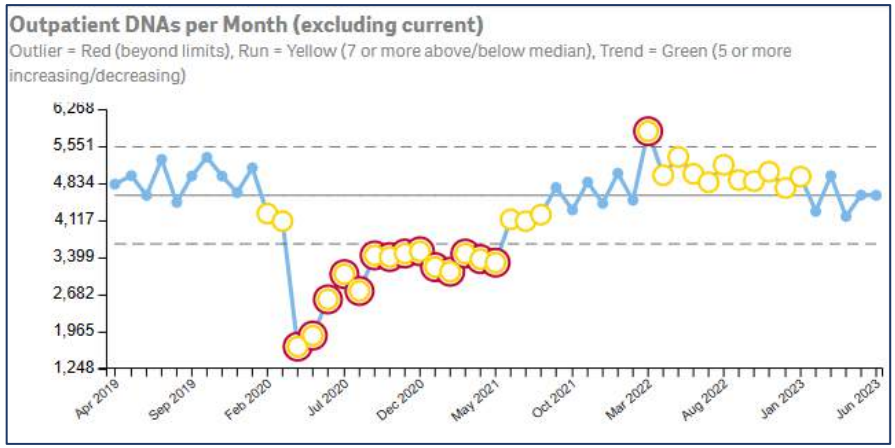


Quarters 1 and 2 have seen a focus om learning through the Welsh Risk Pool Learning Advisory Panel, ABUHB focus on all aged cases > 6 months and returned over 100 submissions of evidence/learning/assurance. There were no financial Penalties at the July WRP Committee. There has been a small increase in the number of personal injury claims between Q1 and Q2, from **71 to 74** and the larger increase noted was in the number of inquests required which has increased from **197 to 215**.

Decrease in the DNA's and CNA'S

The outpatient transformation programme is focussing on its outpatient Did Not Attend (DNA) plan, of which the current rate has reduced from 6.1% (2,762) in March 2023 to 5.4% (2,354) in June 2023. Additionally, the programme is continuing to work alongside finance and divisional teams, with a particular focus next quarter to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment.

The Health Board has worked hard to increase treatment (inpatient day case) capacity post COVID and following the opening of the Outpatient Treatment Unit at the Royal Gwent Hospital, capacity is currently 105% of pre COVID levels. The outpatient treatment unit has two treatment rooms and whilst the first is fully staffed, a plan has been developed and is in place to staff the second room. A business case will be developed during Quarter 2 to seek continued support through the next financial year.



Number of INNUS's being completed

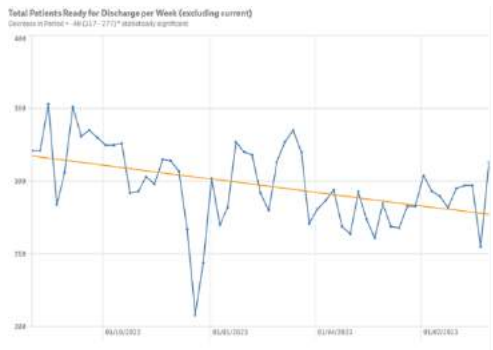
To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, the interventions which are not normally undertaken by the UHB are regularly identified, monitored and reviewed. Interventions Not Normally Undertaken (INNUs) are not routinely available because:

- There is currently insufficient evidence of clinical and /or cost effectiveness or
- The intervention is considered to be of relatively low priority for NHS resources

The number of INNUS's are monitored below is the latest information by specialty which has remained within a consistent range over the past year with a small decrease (Q2 2022 **518 compared to 457** in Q3 2022). The procedure list has recently been updated nationally and will be reported in Q3.

	2022-23										2023-24		
Specialty	March	April	May	June	July	August	September	October	November	December	January	February	Grand Total
Cardiology					1								1
Care Of The Elderly								1					1
Dermatology	48	67	70	48	77	54	40	28	13	71	58	60	634
ENT	22	30	16	27	30	34	36	26	26	40	24	31	342
General Surgery	39	38	53	32	25	45	37	39	28	37	23	34	430
Gynaecology	1	1	2	1	2	2	2	2	1	1		2	17
Maxillo-Facial	18	17	16	10	24	2	12	14	12	14	9	9	157
Obstetrics	2	4	4	9	10	4	4	2	2	1	1	3	46
Ophthalmology	1	1	2		1	1	1	1	2	1	1	4	16
Orthopaedics	39	32	45	32	39	24	34	33	15	41	31	27	392
Paediatric												2	2
Pain Management	3	8	6										17
Urology										1		1	2
Vascular	1	2	5	2	3	2	4	2	1	2	3	4	31
Grand Total	174	200	219	161	212	168	170	148	100	209	150	177	2,088

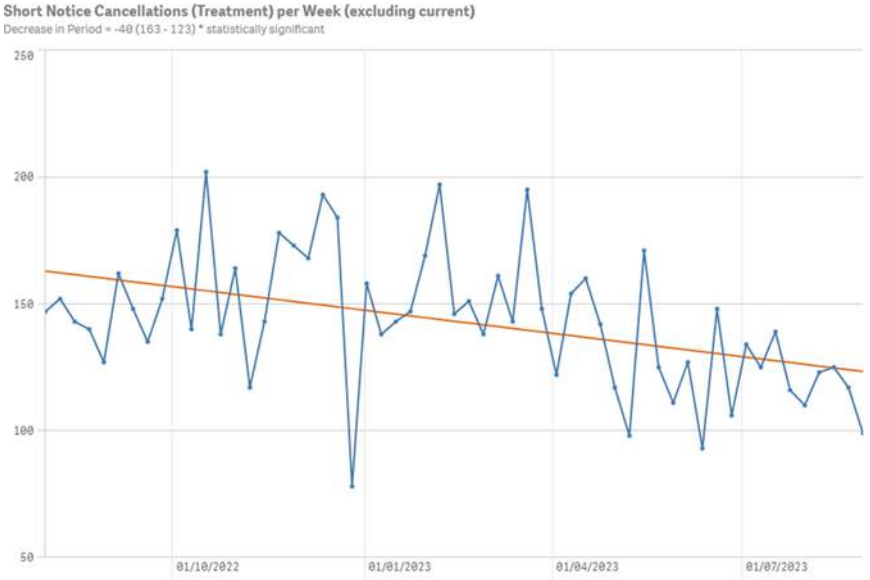
Decrease in the number of medically fit for discharge patients



In the past two quarters there has been a decreasing trend in the numbers of patients who are medically fit for discharge from **320 to 280**. As part of Goals 5 and 6 and Integrated Discharge Board Improvement Board was established, in Q1 and 2 this programme delivered:

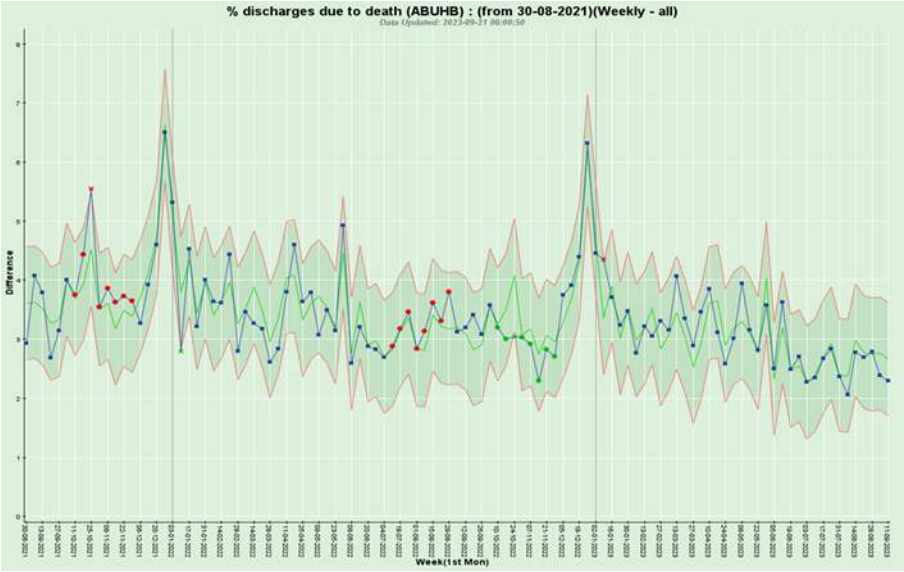
- 'Move it May' campaign with focus on prevention of deconditioning,
- continued roll out the Optimising Flow Patient Framework across all sites, monthly implementation meetings held with the DU.
- Trusted Assessor Task & Finish Group established and mapping of functions and roles to be undertaken across Health and Social Care.
- Pharmacy support secured to support early and timely discharges.

Decrease in the number of patients cancelled on the day of surgery



Cancellation on the day of surgery is costly for patients and the Health Board. It can have profound consequences on patients' health outcome and experience, extending their period of pain, debilitation and worsening long-term outcomes. In the past year there has been a decreasing trend in the numbers from **320 to 286**, this has now stabilised over the last quarter to **280.**

Decrease in the % of hospital as a place of death



Place of death is a key policy marker of end-of-life care success in both the UK and internationally. Research has demonstrated that patient preferences for place of death are complex. Enabling death at home remains an important priority in end-of-life care policy. There has been a notable decrease in the % of hospital as a place of death in the past quarter outside of normal season trends from **3.2% to 2.75%.** Whilst it has not been possible to attribute this change to programmes of work of work further analysis will be completed.

Quality Priority 6 Equitable

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.

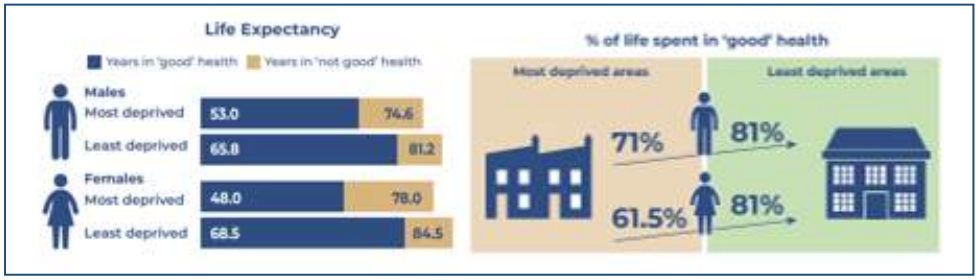
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data	Indicator value	Latest data	Indicator value			
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the access to Safeguarding Training	Q4 2022	Level 1 Adult 84.07% Children 83.05% Level 2 Adult 84.57% Children 82.03%	Q2 2022	Level 1 Adult 84.07% Children 83.05% Level 2 Adult 84.57% Children 82.03%	N/A	N	Compliance remains within tolerance of 85%
		Narrowing of the life expectancy Gap across our Health Board	Q4 2020	Women 20 years Men 13 years	Q4 2020	Women 20 years Men 13 years	N/A	Y	The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities
		Timely closure of Safeguarding incidents		Measure in development		4 Child Practice Reviews 1 Adult Practice Review 5 Domestic Homicide Reviews		N	
		Decrease in the incidents of violence and aggression towards staff						N	

Increase in the access to Safeguarding Training

ABUHB is required to provide Safeguarding Training in relation to Children and Adults in line with national standards. The current compliance levels are in line with expected levels. The Safeguarding offer has been expanded during Q1 and Q2 2023 with Safeguarding level 3 training package commencing in April 2023. Both adults and children's training packages are currently evaluating well, reporting will commence in Q3.

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

Narrowing of the life expectancy Gap across our Health Board



As an organisation our mission is to improve population health, and, through doing this, reduce the health inequalities experienced by our communities. The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities. The consequences of inequality that mean a greater number of citizens require our services; this measure is expected to be next reported in 2024.

Quality Outcomes and Performance Summary

Further details on the individual outcome measures are provided in Appendix 1. Overall, the indicators show that the Health Board is making some progress in key areas. This first iteration has provided a good starting point to understand the quality of our services and the experiences of our patients. There is more work required on the outstanding measures, which will be focus for Q3 and Q4.

Appendix 1

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	All-Wales Delivery Unit Assurance Review of Crisis and Liaison Psychiatry Services for Older Adults – March 23
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jenny Winslade, Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Forkings, Divisional Nurse, Mental Health and Learning Disabilities

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

- The Delivery Unit undertook a focused review of older adult mental health crisis and liaison services in March 2023 as part of a wider national review.
- This report considers the recommendations arising from the review and provides information on the current provision of mental health crisis and liaison services for older adults offered within the Health Board as a background to considering the review recommendations.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

- Aneurin Bevan University Health Board's Older Adult Mental Health Services support individuals with both dementia and functional mental health issues. The service is provided for persons over 65 years of age, or for individuals presenting with a cognitive change below the age of 65.
- As part of the All-Wales Delivery Unit Review of Crisis and Liaison Psychiatry, reviews of children and working age adult services have already been undertaken. The Delivery Unit have now completed a focused review on the needs of the older adult population within mental health services in March 2023.

- This paper provides contextual background information about the current service provision of Older Adult Mental Health crisis and liaison services within the Health Board and considers this in response to the recommendations made within the Delivery Unit report.

Cefndir / Background

A number of key national strategic plans have outlined the need to improve access to crisis support.

- **Together for Mental Health Delivery Plan (2019-2022)** prioritised the need to further progress in developing crisis care with the aim of improving the access to these services across all population age groups:

  "Further improvement to crisis and out of hours provision for children, working age adults and older persons, moving to a common multi-agency offer across Wales."

- The **Dementia Action Plan for Wales (2018-22)** recognises that there may be times when individuals and their families and carers may require a more specialist intensive support - such as from teams experienced in dementia-based crisis resolution. Additionally, delivery of robust carer support has been acknowledged as a key factor in allowing a person with dementia to live as meaningfully as possible in their home setting and reduce crisis presentations.

It is well established that the needs of people living with dementia and their carers require a different skillset, when delivering crisis care, than people presenting with significant mental illness that is functional in nature.

Given this, the Health Board's offer to older persons to enable the aspirations of the Together for Mental Health Plan and Dementia Action Plan to be met, has been challenging to deliver. Older people and their family/carers living with a mental illness often have a greater need for multi-agency working to support avoidance of crisis – such as respite provided through local authority care provisions.

The current service offers for individuals presenting in Emergency Departments, admitted to a hospital or referred to community services are outlined below.

Older Adult Psychiatric Liaison Service

The Health Board has a well-developed Older Adult Psychiatric Liaison (OAPL) service that covers all 9 acute and community hospital sites within the Health Board region, with a priority focus on the Grange University Hospital, Royal Gwent Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr Hospital.

The team provide a multi-disciplinary approach to deliver a full range of interventions including crisis assessment within the Emergency Department. The majority of referrals come from the critical care centre and DGH's, with a focus on timely assessment and supporting patient flow. The service supports key clinical areas to receive specialist assessment and support with a person's mental health presentation and their associated needs, engaging with wider stakeholders to ensure discharge to appropriate settings. This approach is designed to minimise failed discharge and allow for robust partnership working on discharge.

The service is Pan-Gwent but split into North (Nevill Hall) and South (Royal Gwent) team bases, to enable efficient and timely access to key sites. Following additional investment in 2022, the service has been able to be expanded to deliver a 7-day service to the Grange University Hospital and 3 of the Local General Hospital sites (NHH, RGH & YAB) with the exclusion of Ysbyty Ystrad Fawr (YYF). The resource currently available only allows for weekday provision to YYF.

The service works closely and successfully with a range of teams and services such as Home First, CRT/Frailty to support the broader discharge/ flow agenda across wider Health Board services and reduce Delayed Transfers of Care.

Older Adult Community Mental Health Teams

Currently Older Adult Mental Health Services do not have a dedicated community crisis service. The community mental health teams (CMHT) traditionally provide a service within the core hours of Monday – Friday, 9am to 5pm.

Anecdotally, some older individuals are presenting in a crisis to the community mental health teams, however no data was available to understand this demand.
It has been difficult to fully understand demand in relation to crisis presentations, being reliant on individual clinician interpretation. However, preliminary data from on-call staff indicated that relatively few older adults are assessed outside the hours of 8am-8pm by on-call staff.

A 'proof of concept' was therefore designed to develop an extended community mental health team offer by expanding core hours to cover 8am to 8pm, 7 days a week. The purpose of the 'proof of concept' was to both understand the nature, type and frequency of crisis presentations for the older adult cohort and to develop a first stage cost/benefit analysis on the best way to support this cohort.

Following confirmation of new investment of c£190,000 via Welsh Government Service Improvement Fund, the 'proof of concept' for a crisis service through an extended CMHT offer was developed and trialled in the Caerphilly borough from May 2022.

The data from the pilot has been collated and analysed and the findings suggest that the number of persons presenting in need of crisis assessment/support is relatively small. Moreover, all those individuals that have presented had functional mental health presentations rather than dementia. A report outlining the outcome of the pilot and recommendations on a way forward has been prepared and discussed at the Older Adult Mental Health Assurance Meeting.

The information presented confirmed that the extended hours CMHT model being tested may not be a model that supports the most prudent delivery of healthcare due to the small demand. The discussion at the assurance meeting concluded that alternative methods of meeting older people's mental health needs out of hours should be considered as part of a broader community and inpatient review. A Programme Manager is due to start in post in the autumn to support this review.

The information on current service models and delivery needs to be considered in relation to the recommendations arising from the Delivery Unit review.

Asesiad / Assessment

Quality, Safety and Patient Experience Assessment

The recommendations arising from the from the Delivery Unit report on the review of crisis and liaison services for older adult mental health services across the Health Board are highlighted below, together with responses in relation to the current position in meeting each recommendation.

1. **The Health Board should consider extending the Older Adult Psychiatric Liaison resource to provide a consistent 7-day service across all 4 highest referral sites.**

As indicated in the previous section, the current resource allows for a 7-day liaison service to 3 of the 4 main sites, with YYF receiving a 5-day service. To deliver equality of provision across all 4 sites, 7 days a week, additional resources will be required. An assessment of risk, demand and capacity will need to be undertaken and a business case developed, prioritised and funded prior to expanding the service.

2. **The Health Board should consider alternate accommodation for the South OAPL Team base in Clytha Square.**

The current accommodation for the south OAPL team is off the main Royal Gwent Hospital site in Clytha Square. This building is identified as being unsafe and unfit for purpose and the team have received health and safety support in relation to Datix incidents and risks to staff moving between the hospital site and team base, particularly at evening times. The team needs to be based on the RGH site, ideally within the main hospital building, as 80% of the team's work is undertaken there.

Requests to find space on the RGH site have been unsuccessful to date. The issue has been escalated to the Executive Team and alternative accommodation is identified as an outstanding issue within the MH/LD estates plans. This continues to be part of ongoing discussions with Health Board's capital and estates team.

3. **The Health Board should consider provision of appropriate clinical environments for mental health assessments in the specialist critical care centre and DGH's.**

Given that many mental health assessments contain highly sensitive information about a person's wellbeing, the ability to deliver a robust assessment process for people with a mental health need can be compromised due to the choice of environment available on different sites. This is due to the conflict of meeting the person's right to dignity and confidentiality against the ability to access appropriate space to facilitate the assessment. The OAPL service deliver assessments in all hospital sites and settings and each area has different challenges to overcome to enable the assessment process to remain confidential. This challenge is greatly minimised in sites where single bedrooms are provided.

Frequently, on the older estate sites, the assessment will take place in a dormitory or bay space or in whatever private space can be secured. The team will do their utmost to identify the most appropriate area on the ward or clinical area. The person

being assessed is often given the choice about location of assessment if available, sometimes balancing the environment available and the need for privacy. As part of the wider estates work to redevelop/repurpose the eLGH sites, consideration should be given to expand the availability of usable areas to hold assessments/private conversations.

4. **The Health Board should embed an audit cycle of clinical records to standardise the quality of the assessments across teams, ensuring person centeredness and demonstration of the patient voice through the consideration of "what matters to me most".**

The Older Adult Psychiatric Liaison Service is included in the Older Adult Mental Health audit strategy, with regular reviews established following the Delivery Unit Review feedback. Team leads now undertake a monthly review of a randomised selection of assessments as part of clinical and managerial supervision. In addition, a formalised external scrutiny process is now in place, with external reviews commencing in September 2023 on a quarterly basis. 'What matters to me most' is now included as a standard item on the assessment tool.

Argymhelliad / Recommendation

The Committee is asked to note the contents of the report and responses to the recommendations.

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):	4. Dignified Care 5.1 Timely Access 2.7 Safeguarding Children and Safeguarding Adults at Risk 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item. Choose an item.

Strategic Equality Objectives 2020-24	Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	OAPL – Older Adult Psychiatric Liaison OAMH – Older Adult Mental Health
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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

All Wales Assurance Review of

Crisis & Liaison Psychiatry Services for Older Adults

Aneurin Bevan University Health Board

March 2023

1. Introduction:

In 2022 the NHS Wales Delivery Unit completed a review of mental health crisis and liaison services for children and working age adults. This report presents the findings from The NHS Wales Delivery Unit review of mental health crisis and liaison services for specifically designed to support older age adults provided by Aneurin Bevan University Health Board. The overall terms of reference are included in annex 1.

Whilst this is a local report it also forms part of an all Wales review and will be considered as part of the final thematic review presented to Welsh Government.

These findings are predominantly an analysis and reflection of the services that provide a community mental health crisis response and the Liaison Psychiatry service. Additionally, the report also includes the views and experience of a range of stakeholders who may also see older adults experiencing a mental health crisis or interface with the local services that deliver this support.

The review team would like to thank Aneurin Bevan University Health Board, their partner organisations, and all those contributing to and accommodating the review team.

2. Background:

Older adult mental health services are often designed for and accessed by people over the age of 65. Whilst this is not always the case, these services will consider a holistic view of care and treatment in the context of an older age group, with a focus on psychological, physical and social needs. Further people who present to older adult mental health services may do so with what can be described as a functional mental health condition such as anxiety and depression or conditions such as schizophrenia or bi-polar disorder, or a person may require care and support for an organic condition such as Dementia.

Together for Mental Health Delivery Plan 2019-2022 prioritised the need to further progress crisis care with the aim of improving the access to these services across all population age groups:

'Further improvements to crisis and out-of-hours provision for children, working age and older adults, moving to a common, multiagency offer across Wales'.

Further the Wales Dementia Action Plan 2018-2022 (Welsh Government) recognises that there may be times when individuals and their families and carers may require more specialist intensive support such as from teams experienced in crisis resolution and further that carers have strongly conveyed the importance of receiving support to prevent a crisis.

3. Aim and Objectives of the Assurance Review:

3.1 Aim:

To explore the provision of psychiatric liaison and mental health crisis services within the whole patient pathway and where appropriate, to recommend potential service improvements.

3.2 Objectives:

1. To map the current models of Psychiatric Liaison and their allied crisis services for all ages including the provision of services to Emergency Departments (EDs), Medical Assessment Units (MAUs) and General Hospital wards across NHS Wales. This will include gaining an understanding of the availability of 24/7 support and how models and responses differ across the age ranges.

2. To draw on the views of service users, family and informal carers in the responsiveness of mental health unscheduled care provision.

3. To confirm the referral criteria and pathways used by Psychiatric Liaison and their allied crisis services. To test the compliance against these, from the perspective of referrers and crisis and liaison services. This will include understanding where there are different pathways for emergency and routine responses.

4. To understand the current demand on Psychiatric Liaison and Crisis services and how the services link with the wider NHS mental health provision, social care and other agencies.

5. To understand the current workforce of Psychiatric Liaison and Crisis services, including the capacity and skill mix.

6. To understand the impact of Psychiatric Liaison teams on care within DGH services.

4. METHODOLOGY

A mixed-methodology using three principle approaches was utilised by the review team to gather information. They were:

- **Semi-structured interviews** which were designed and implemented to guide meetings with both individuals and focus groups. Focus groups included multi-disciplinary teams, senior management and a range of internal and external stakeholders. Focus groups were also explored for service users and carers but not able to be arranged.
- **A detailed case note audit** of 11 case files was undertaken. The audit tool utilised by the review team evaluated a number of elements of the patient pathway that included reason for referral; initial assessments; risk assessment, outcomes of assessment and any other relevant factors.
- **In depth observations** were made from within the liaison team in the form of a shadowing shift.

Additional Information:

- Additional information was gathered from General Practitioners via an electronic survey (Doopoll) created and sent out to all ABUHB practices to obtain their experiences of referring into crisis and liaison services.
- Anonymised service user written feedback was collated on the review team's behalf through Growing Spaces. Additionally, contacts were made to the Alzheimer's society to better understand any additional challenges experienced by those with organic disorders.

The conclusions and recommendations were reached through a triangulation of these three principle approaches and additional information received from non-face to face sources.

5. DATE OF REVIEW:

This review was Undertaken between July and October 2022.

6. Key Findings:

- Older Adult Psychiatric Liaison (OAPL) have clear proactive structures in place to identify and support people who may have mental health needs within the physical health care settings.

- The team provide a compassionate and person centred approach and observations of care demonstrate that they value the input of each team member. They have access to various resources to meet the needs of dementia patients to reduce boredom, unmet needs and difficulties with behaviours that challenge delivery of care.

- The service reported that the majority of their work is with individuals who have memory issues and a diagnosis of dementia, which may or may not occur concurrently with other functional mental health issues. Teams anecdotally report an increase in suicidality and substance misuse issues in older adults arising since the start of the pandemic.

- Appropriate accommodation to undertake assessments was reported to be a challenge in the assessment units and District General Hospitals. These areas are not always able to provide a private, safe or low stimulus environment.

- The service reported ongoing accommodation issues for the Older Adult Psychiatric Liaison (OAPL) team in Clytha Square.

- Since the opening of the Grange University Hospital, extending the OAPL provision to this additional hospital has stretched existing capacity.

- The Liaison team reported that in order to provide an out of hours' response to Ysbyty Ystrad Fawr as one of their highest referrers they would require additional investment to increase capacity.

- There were challenges in accessing the three clinical systems to undertake the audit for the review. The recent launch of the Welsh Clinical Care Information System (WCCIS) at the time of the review had resulted in instigating the business continuity plan, with some duplication of record keeping and referral management.

- There was significant variation in the quality of the recording of assessments between the north and south OAPL teams.

- OACMHTs provide a degree of home treatment within resources for those with functional and organic illness who may experience crisis. There is no evening or weekend support in 4 of the 5 localities. Team members reported they will occasionally support someone out of hours on a goodwill basis.

- The extended Older Adult Community Mental Health Team (OACMHT) pilot in Caerphilly was reported to offer a more responsive service and have received an increase in referrals since changes to the new service model. A formal evaluation is yet to be completed.

7. RECOMMENDATIONS:

1. The health board should consider extending the OAPL resource to provide a consistent 7-day service across all 4 highest referral sites.

2. The health board should consider alternative environments for the South Team based in Clytha Square to occupy.

3. The health board should consider provision of appropriate clinical environments for mental health assessments in the Specialist Critical Care Centre and District General Hospitals.

4. The health board should embed an audit cycle of clinical records to standardise the quality of the assessments across teams, ensuring person centeredness and demonstration of the patient voice through the consideration of "what matters to me most".

8. Main Findings

8.1 Crisis Resolution and Home Treatment Teams:

8.1.1 Profile and Operating Arrangements:

There are currently no discrete home treatment or crisis teams within older adults, however the Older Adult Community Mental Health Teams (OACMHT) will flex their response to enable people to remain at home with more intensive support where capacity allows. The OACMHTs sit within a locality borough based model of working within older adult services. Each OACMHT will sit under the locality Senior Nurse's management responsibilities. They currently work Monday to Friday 9.00-17.00.

There are 6 OACMHT bases within Aneurin Bevan. The Caerphilly team is based within Ysbyty Ystrad Fawr and co-located with the dementia assessment inpatient unit and Memory Assessment Service (MAS). Newport OACMHT is based within St Cadocs Hospital and co-located with the MAS. Torfaen OACMHT is located in County Hospital with the older adult ward for those with functional needs and the MAS and Blaenau Gwent is located in Ysbyty Tri Cwm along with the older adult dementia assessment unit and MAS. Monmouth OACMHT operates from two bases, Chepstow Hospital in the south and Maindiff Court in the north of the county.

There is currently a pilot running in Caerphilly OACMHT to support a Home Treatment/Crisis response. The OACMHT has funding for one year to trial a 7-day service, with extended hours. The project will incorporate both crisis, intensive home treatment and non-crisis work, for people presenting with any older adult mental health concern – both arising from a dementia or functional mental health diagnosis. The pilot is funded on a temporary basis as a response to the Directorate looking to develop a team who are able to deliver a Crisis Resolution Home Treatment (CRHT) service to older adults. The extended service operates between 09.00 and 19.00 hours with 3 RMN's, and 2 Support, Engagement and Recovery (SEAR) workers daily, between 09.00 and 17.00 hours, 7 days a week.

The outlined ethos of the service is to support people to remain well at home for as long as possible. Where admission is required, the service aims to proactively support discharge, to either an alternative care setting or their usual place of residence. As this is a pilot this is only for those people whose usual residency is the Caerphilly

borough. As an extended OACMHT it will enable team members to schedule visits on evenings and weekends when carers or other family members may have more availability to support the individual as part of the assessment and plan any home treatment. They are supported by SEAR workers (band 3) who will assist the Community Psychiatric Nurse (CPN) with assessments, engage with the service users using Wellness Recovery Action plans (WRAP) and/or other interventions as indicated.

Previously if there were urgent assessments required on weekends this would fall to the on-call doctor without any nursing support whereas there is now the option of a joint assessment within service hours and the opportunity to plan and implement community support to avoid hospital admission where appropriate. They liaise with other services or agencies as required such as Liaison, police, social services and can respond accordingly for older adults reaching crisis.

The Directorate will be evaluating the service using a number of patient reported outcome measures (PROMS) and patient reported experience measures (PREMS) to determine whether this model will meet the needs of older adults for a crisis response, is effective and sustainable with additional permanent investment.

8.2 Staffing:

The total staffing compliment for OACMHT's is indicated in the first table below with the staffing for the Caerphilly extended team is outlined in the second. The resources within each borough locality are based on the size of the population. Medical and psychology support and advice is provided from the total locality resource. They contribute to Multi-disciplinary team (MDT) meetings, patient assessment and reviews as part of their job plans.

Workforce	Banding / Grade	Establishment WTE	Vacancies at time of information request
Nursing	6	25	
	7	5	1
Clinical Psychology	7	1	1
	8a	4	1
Occupational Therapy	6	2	
	7	4	
Support Worker	3	7	
Consultant Medical		10	
Other Medical (please state)		3 middle grade	
Admin	3	9.2	
	4	9.4	

The extended OACMHT within Caerphilly aims to have 3 CPNs on each shift during the week plus a support worker where possible, with 2 staff available on a weekend which can be a mix of 1 registrant and 1 non-registrant. The administration resource is to support the general admin duties within the OACMHT with Consultant Medical staff having this support from the overall locality resource.

Workforce	Banding / Grade	Establishment WTE Aug-22	Vacancies Aug-22
	6	7.5	0
	7	1	
Support Worker	3	2.6	0
Admin	4	.4	

8.3 Referral Management:

For all OACMHT's, referrals are via email or direct calls to the duty desk. They use the same referral process as other Aneurin Bevan OACMHT's. Teams were utilising a paper version of the Welsh Clinical Care Information System (WCCIS) template in preparation for the go live date in August. Following the implementation of WCCIS all referrals received by the duty desk clinician are put directly into the WCCIS. They use a risk tool formulation to determine response priority. They aim for a 4hr (same day) response for those in urgent need. The duty desk clinician will discuss the need with the Consultant Psychiatrist and arrange for a nursing assessment. Dependant on the service users' situation assessments can take place in their own home or they can attend the OACMHT clinic base. For those with suicidal ideation or at crisis where a medical assessment is deemed necessary the Consultant Psychiatrist or Specialty Dr will undertake an urgent review the same day where possible to plan support in the least restrictive way.

8.4 Intervention and Case Management:

The Caerphilly OACMHT aim to support early discharge of the locality patients from the central functional unit located in County Hospital, the Caerphilly dementia assessment unit in YYF and any other Caerphilly residents who are current in-patients situated in other older adult ward settings.

They will also support assessments referred Out of Hours (OOH), on weekends, alongside the on call doctor – within service working hours. This is only in the Caerphilly locality as part of the pilot. The team are now able to undertake a gatekeeping assessment but as yet this has not been required. Only one OOH's assessment has been required in the 6 weeks prior to the Delivery Unit review, so this will be considered as part of the overall pilot evaluation. Usually, the gatekeeping of older adult beds is done through the senior nurse on call following an assessment by the on-call Psychiatric medic or the older adult psychiatric liaison practitioner.

They offer support to high risk individuals with intense needs, including over weekends to reduce risk of admission. The team utilise a wellbeing and recovery model (WRAP) when developing care management plans. This is a fairly recent development and is a work in progress with an aim of empowering people to take more ownership of their recovery. This work is being done in addition to CTP and is dependent of the engagement from the person in receipt of support.

The team report that they are already seeing a near doubling of referrals, with most receiving assessment and then formulation as to signposting or most appropriate interventions. Early anecdotal evidence from the service is that they are supporting additional people and averting a need for hospital admission but this is to be formally reviewed.

8.5 Staff Training and Support:

The team reported they have not undertaken any additional specific training for crisis support however, they

confirmed that have been enabled to complete the Association for Psychological Therapies- DICES "Suicide Awareness and Risk Formulation", "Working with Families living with Dementia" and "Depression in Older Adults" training. The team report that there are some new staff with less experience but there is good sharing of information and skills with each person receiving an individual induction plan that includes undertaking shadow shifts with more experienced team members, formal training as indicated above and, as well as informal opportunities to discuss individual service user needs and approaches. Caseload and formal clinical supervision is undertaken a minimum of 8 weekly and handovers and multidisciplinary team (MDT) meetings are also opportunities for informal peer to peer supervision and knowledge sharing. The team would like to do some training on using psychological approaches to better support those requiring short term intensive support as well as those who remain on the caseload for a longer duration.

8.1.6 Care Home Liaison

The Care Home Liaison service is integrated into each borough within the Memory Assessment Service (MAS). Each person is aligned to the care homes both residential and nursing in their area to support individuals whose placement is at risk of breaking down, due to distress and unmet needs. The majority of their work is with those individuals who have a dementia diagnosis although they do also support people with functional illness where there is no OACMHT involvement. They also have a role in reviewing antipsychotic medication to reduce its use wherever possible whilst maintaining the service users wellbeing. This service currently takes a more medical model approach advising on medication to reduce distress of those with dementia, review of the use and efficacy of antipsychotics and reducing where possible once the individual stabilises. They do offer education on no-pharmacological approaches where capacity allows. Care home liaison plays an important role in keeping people out of hospital both in MH or general care home settings as they will support identification of delirium and work with GP's and/or the Consultant Psychiatrist to reduce the level of distress to keep individuals safe and avoid a breakdown in their placement where possible. The team suggests that additional resources to deliver a more MDT approach would enable them to work with individuals more holistically and continue to upskill the care homes to meet the resident's needs.

8.1.7 Shared Lives:

The Older Adult Directorate also report that they are working with Shared Lives to develop opportunities for older adults to remain in the community for additional support as an alternative to admission. Currently this service is only available for adults under 65. The older adult directorate have a bid for service improvement funding (SIF) to develop a number of placement opportunities for older people. The senior management team reported that this may be challenging as there will be a need to assure host families of sufficient access to support in a crisis out of hours and on weekends.

8.1.8 Summary:

OACMHT's provide support to individuals predominantly with functional needs. Where capacity allows, they will also provide support to older adults with cognitive decline who need support to avoid a deterioration in their condition. They link closely with the MAS teams in their locality as well as the Care Home Liaison nurses to determine how best to support older adults whose mental health may be deteriorating or who may have distress and behaviours that put themselves or others at risk. Most locality teams work Mon-Friday 9-5 with Caerphilly having a pilot 7-day service. The services report that they do whatever they can to reduce the need for hospital admission but recognise that not having a service over weekends and public holidays reduces their ability to support individuals with increasing needs in the community.

Although yet to be evaluated, a rollout of the Caerphilly model would require additional recurring investment to continue and deliver the service across the region as it currently remains a pilot with non-recurrent funding.

The team expressed that the additional resource of registrants and non-registrants support to those residing in their own home or care homes, through the continuation of an extended 7-day service enables them to provide continuity of care, mitigate risk and reduce hospital admission. An extended service model is also better placed to enable discharges later in the week as they can offer daily support for those requiring more intensive support immediately post discharge. The team report that for those with intensive needs discharges were avoided on a Thursday or Friday as they could not previously support over a weekend.

The services have good systems of support for team members with supervision being delivered a minimum of 8 weekly, on top of ad-hoc opportunities for reflection and learning from discussion of individual cases. The team recognise the skills and experience that individual team members bring, but would welcome additional training in psychological skills and approaches to improve the offer to people in their care.

Care home liaison is an integral part of the community response to crisis in maintaining an individual's residential placement. The directorate continue to explore options to reduce and respond to crisis and the need for a hospital admission through schemes such as Shared Lives as well as the extended OACMHT although these will all require additional investment for delivery.

9 Liaison Psychiatry:

9.1 Profile and Operating Arrangements:

The Older Adult Psychiatric Liaison (OAPL) service aims to provide a multidisciplinary team who will provide a biopsychosocial assessment for people with mental health needs, cognitive impairment or memory problems. It includes medical and nursing professionals as well as health care support workers (HCSW). Currently the team also has social workers who are in liaison practitioner positions, who are able to bring these additional skills to support a holistic assessment of need for older adults presenting to the general hospital environment. More recently the team have been successful in a bid to fund a psychologist to enhance the service offer. The teams aim is to improve the patient experience of care through prompt access to mental health team assessment and care planning, aimed at supporting individuals in their hospital journey, reducing length of stay and expediting discharge. Part of the wider role of liaison services is to support the wider hospital team in the recognition, assessment, planning and adjustments in care required for patients with co- morbid mental health and physical health needs.

Currently there are two teams within the health board. A north team based in Nevill Hall hospital (NHH) and south team located in Clytha Square in a building in a road adjacent to the Royal Gwent hospital (RGH). The north team covers NHH district general hospital (DGH), Ysbyty Ystrad Fawr (YYF) which is a subacute hospital in Ystrad Mynach as well as community hospitals in Ebbw Vale- Ysbyty Aneurin Bevan (YAB) and Rhymney. South team cover The Grange as the specialist and critical care centre, RGH DGH as well as St Woolos, County and Chepstow community hospitals. The Senior Management Team were keen to stress the issues with the accommodation at Clytha Square. It was reported that there are significant issues with the condition of the roof as well as other environmental concerns.

They operate a 7-day service that commenced in 2020 as an extension to previous service provision. Hours of service are 08:00-20:00hrs weekdays and 9-5 weekends. Currently weekend cover is only for The Grange, RGH, NHH. There is a hope that they will be able to extend the offer to YYF at some point in the near future as they are significant referrers to the service. As part of the information request a recent service review was shared which demonstrated that YYF was a higher referrer to the service than NHH over the previous 12 months. On weekends, the north and south team cross cover to make best use of resources.

9.2 Referrals:

The service will receive referrals for older people with co morbid physical illness, in need of mental health assessment and adults, presenting with cognition issues which result in distress creating barriers to care or

create risk to themselves or others. All referrers can refer via e-mail. However, the team proactively do a search for potential referrals (trawl) on the main hospital clinical work system. They will proactively look for patients who have been admitted to the Emergency Department (ED) or Medical Assessment units (MAU) with mental health or delirium type presentations who may be new presenters or who have a history of presentations and mental health service involvement. They attend the unit and write this information in the patient paper records advising the unit to contact them if they require assessment and support. At the same time identifying any additional older adult service users who would benefit from a psychiatric liaison assessment. They will then arrange this to take place within the appropriate timescale.

Besides the ED, MAU and wards the team also receive e-mail referrals from non-hospital departments including OACMHT's, social workers (to support with discharge planning), and the In-reach care homes practitioners. The teams confirm that there is good communication between the community mental health teams and liaison to support information sharing and the identification of any ongoing requirements following discharge.

Prior to WCCIS being implemented a referral would be put onto EPEx by the admin staff during usual working hours. During a trawl – even if the team don't assess or intervene, they write a note in EPEx that advice has been given to refer for support if needed. The team report that they do not get many referrals over a weekend although this is variable. Following the introduction of WCCIS the team still attend the assessment units daily for anyone who may need support and a referral is logged on WCCIS for all patients identified for assessment.

Urgent referrals are seen within 4 hours including those from ED's and assessment units with clinical presentation driving response times for other areas. Routine referrals are seen within 24 hours and for community hospitals it is a 48h response time unless the patient's presentation is considered urgent. Weekends can be challenging from a capacity perspective as less staff are on duty to deliver support across the 3 main sites of RGH, the Grange and NHH. In September 2020 the service was extended from 9-5 Monday to Friday to cover until 8pm and then 9-5 on weekends. During weekends there are usually two registrants and two HCSW's on duty. It was not fully understood what the demand would be at that time and in particular the impact of opening the Grange hospital. Therefore, the team now recognise that additional HCSW's would enable them to provide continuous support to those on the caseload and would ensure that registrants could focus on assessment and reviewing those individuals with urgent needs. The HCSW's could support their more routine work such as supporting mealtimes, positive approaches to care and wellbeing activities etc. in particular to those with dementia.

OAPL report that demand can fluctuate which means that sometimes there is insufficient capacity to meet target times for assessment especially when this is spread over 9 hospital sites. However, the team report they generally meet the targets with staff willing to work flexibly to support the service when necessary, such as when an urgent assessment is required at the end of a working day.

9.3 Assessment

Assessments generally occur in the assessment units within the district general hospital's or a ward. Apart from those areas which have exclusively single rooms, (YYF, YAB) there are very limited appropriate space to carry out assessments on some of the ward areas in RGH and NHH in a way that maintains privacy. The Grange has predominantly single rooms and there is a small room available in the ED but was deemed not fit for purpose and often in use, so is not utilised. The assessment unit has partitions between bed spaces with curtains across the front. The team always ask whether the patient is happy to have their assessments in a bay (only separated by the curtain) and always inform them that some subject areas may be sensitive. If a patient requests a more private space the team will endeavour to find a space, often a day or staff room on one of the wards.

The liaison team reported that a standard assessment template is used and includes reason for admission, personal and social circumstances, medical history, MSE, risk and safeguarding. WARRN is used if necessary but there is not a frequent need as the standard assessment has a risk assessment section for the brief assessment and intervention provided. However, on undertaking the clinical case note audit it was confirmed the team use a letter format to record the assessment which generally follows the format above but not exclusively. There was noted to be a marked difference between the quality of the assessment record between the north and south teams, with the north providing very brief information. This is described further within the case note audit.

Outcomes of assessments are recorded in the paper general hospital medical notes and then OAPL assessment notes are typed up on return to the office and added to EPeX and a contact is also recorded in Clinical Work Station (CWS). There are no paper OAPL records. OAPL Practitioner and HCSW follow up notes were also recorded on EPeX. This way of working has changed following go-live of WCCIS, late August 22. The record of assessment is typed as a case note into the patient record in WCCIS as well as being uploaded as a document to CWS. Follow up by team members is added as a case note to the WCCIS.

Follow up is dependent on presentation. There are some typical situations where follow up is offered by the team such as; where patients with delirium require short term additional medication (risperidone/ lorazepam), the team stay involved to monitor the individual response and consider its' reduction or discontinuation prior to discharge. When the patient is to remain on medication following discharge the OAPL team will refer to the OACMHT or the GP for ongoing follow up after the patient leaves hospital. The team support the wards with advice to amend medication regimes for patients who are admitted with dementia exacerbated by physical health complications. For patients who are already open to memory assessment services (MAS), the OAPL team will inform the MAS team to request a follow up appointment on discharge or provide a summary of the liaison input.

The team do not record the frequency of the requirement to follow up in the clinical record but use the electronic boards available in the team base for this purpose. Patients who are followed up are usually seen by the team for 2-3 weeks but some patients may need longer support. The team take the approach that there must always be an end to follow up with appropriate signposting or oversight of the patient's needs. The team write to the service who has referred or where the patient is known e.g. OACMHT, Local Primary Care Mental Health Services (LPMHSS), MAS or In-Reach. If mental health social work is considered necessary, the team will refer to the hospital social worker who will facilitate a referral and assessment. The team also attend best interest meetings on wards to provide a specialist opinion. Additionally, the team can access the alcohol liaison service who support all adults over 18 if required.

OAPL will always endeavour to contact families, carers or significant others to obtain additional information to support the assessment as appropriate. The team reported that families often continue to contact them to be kept informed of their relative's wellbeing due to the busyness of wards and in particular during the Covid 19 pandemic because of the visiting restrictions. The reviewer witnessed this support to families whilst undertaking the case-note audit.

9.4 Intervention and Case Management:

Interventions provided by the OAPL Practitioners include, supporting with compliance of medication, ensuring psychiatric medical recommendations have been carried out, ongoing assessment for signposting on discharge and supporting the ward team with de-escalation techniques. HCSW interventions include, failure free activities, anxiety reduction techniques, distraction, support with diet and fluid intake, and de-escalation of distress and

aggression. The HCSW's can offer individual activities such as craft, manicures, puzzles as well as electronic pets or weighted dolls to support stress reduction and comfort or to engage individuals on a one to one basis. The HCSW team also provide practical support on the ward to support person centred care, including activities of daily living and support for adherence to medical treatment (e.g. wound dressing). The team have recently recruited a clinical psychologist which has extended the interventions that can be provided to patients.

The team report that managing out of hours' demand can be challenging as the OAPL service ends at 8pm with out of hours covered by the on call psychiatrist. Where referrals come in later in the evening and where there is high risk or urgency the team will stay on to complete the assessment and put the patient on the correct pathway. There is no arrangement for the adult service to cross cover. Should there be an emergency assessment required then the on-call psychiatrist will be called to discuss the case and can undertake this in the ED. If admission to an older adult mental health bed is required, the senior nurse on call for the directorate will be responsible for sourcing this. As previously stated OAPL remain involved on average for 3 weeks' follow-up (but often longer, if there is clinical need) and will follow patients through their journey in any of the 9 hospitals covered.

When medication such as antidepressants are started in the hospital, the team will monitor and then signpost to the GP for ongoing follow up after discharge. On discharge the team send a letter to the GP informing them of the need for liaison services whilst in hospital and any ongoing requirements. If a patient is diagnosed with dementia by the OAPL team in a general hospital, a notification letter is sent to the GP and referral made to MAS if needed.

9.5 Staffing:

Workforce	Banding / Grade	Establishment WTE	Vacancies
			At time of information request
Nursing	6	9.8	2wte Mat Leave
	7	2 wte	
Psychologist	8a	1	
Social Worker These work in generic Practitioner roles	6	2wte	
HCSW-SEAR	3	8.8wte	2 wte
Consultant Psychiatrist		1	
Other Medical	Trainee psychiatrists and Specialty doctor	2.4wte	
Admin	3	1.6wte	
	4	0.4wte	

There are two band 7 nurses within the team one who is the clinical nurse specialist and the other who is the team manager with responsibility for coordinating the rota across the two bases covering 9 sites. This is a fairly recent development within the last 18 months alongside the extension of the service to 7 days and the opening of the Grange hospital. Previously there was a north and south team leader with each team worked autonomously under the consultant psychiatrist with nursing supervision and oversight from a locality senior nurse. These changes have supported the team to cross cover more effectively, reduce duplication and develop the specialist practitioner role. To support the team with medical cover there is one consultant psychiatrist covering the whole OAPL service with the support of two trainee doctors (one core, one higher) plus 0.4wte Specialty Dr who is based in YYF. The clinical psychologist is also a recent addition to the team following a successful bid for recurrent funding. This position has taken time to recruit to and therefore is yet to be evaluated against the expected outcomes.

9.6 Supervision and Training:

A range of strategies are in place to support appropriate skill mix including internal and mandatory training in the Mental Health and Mental Capacity Acts as well as recognition of delirium and depression in the elderly and supporting people and their families with dementia. New team members will also undertake shifts on the older adult in-patient units if they do not already have this experience. The team are currently undertaking a skills analysis to better determine a core skills set to support current and new staff members. Supervision is offered on an individual level 6 weekly and the team have lots of opportunity to discuss specific patients during MDT's/ handovers to promote understanding, problem solving and learning.

The team also undertake training to the wider hospital particularly on the recognition of delirium, their team purpose and dementia. This has been a significant challenge over the past two years since the onset of Covid due to the impact not only on staffing numbers within the team but also formal training across the health board was reduced.

9.7 Interface with other Services:

The liaison team report they have good relationships with most areas they support which was also confirmed by those that interface with them such as the ED/ Assessment units and community hospital wards. They are seen as helpful and the support of HCSW's on wards role modelling behaviours and providing activities to support dementia patients is particularly useful to manage patients' challenging behaviours or support general mental wellbeing. On discharge the team will write to the GP and any mental health services that the patient may be involved with to update the clinical record and pass on any relevant post discharge requirements.

10. Observation of Care:

The DU reviewer was able to observe the South team huddle at the start of the day. This meeting utilised a large electronic screen with an excel list of all patients open to the team, their ward and site to support the discussion. They were discussed in detail by practitioners, including the plan for the day and any risks or concerns. The focus on patients wellbeing was noted, with the HCSW's actively planning ways to engage patients in activities they enjoyed, including personal care, crafts, puzzles etc. based on the patient's interests. The team appeared friendly, with team members offering to support each other with visits and share work willingly. Observations of care demonstrated that the team was well structured and delivered a compassionate, empathic service. The team had a large quantity of craft & beauty supplies as well as a number of electronic lap cats & dogs for patients to use.

The team had 30 patients actively open to them on the day of the visit which was considered a usual caseload, with the majority being in RGH. The team reported that the presentations are changing in the older adults that

are referred to them, with more overdoses, alcohol misuse and psychosis alongside a generally higher acuity of need being observed at the point of assessment.

There were IT challenges on the day of the visit, as the usual patient record system, EPEX, had been taken offline as planned the previous week due to WCCIS expected go live on 15/8/22. However, there had been unforeseen issues with this so the team were now without an electronic patient record system with no new start date for WCCIS available on the date of the clinical observation of care.

The first visit was to the Grange Hospital with a Psychiatric Liaison Practitioner to review a patient prior to discharge. The patient was an emergency admission to MAU. The practitioner had checked the history prior to leaving the office and read through the notes on the ward prior to introducing us to the patient. The practitioner was compassionate, friendly and clear in their conversation with the patient. They offered reassurance and communicated the discharge plan to the patients' next of kin by phone at the patients request, as well as discussing the plan with the doctor on the ward. A record of the review was made in the ward notes, including using a sticker to clearly mark the notes as OAPL. A full current list of medications was taken to ensure the OAPL psychiatrist could recommend medication amendment later if required.

The second visit was to a community hospital to visit a 91-year-old patient who was awaiting discharge. On reviewing the notes, it became apparent that the patient's discharge was planned for 7 days previously with a package of care in place, but had been delayed until OAPL had visited. Due to the delay the patient reported that they were frustrated, and desperate to return home. Although the liaison practitioner demonstrated sensitivity there was nowhere for a private assessment. Due to the patients hearing difficulties the liaison practitioner had to speak very loudly, compromising the patients' privacy in an area with 5 other patients.

During the meeting with the review team the OAPL team shared that they were particularly proud of the way the service has adapted over the past two years to change over the past two years especially the shift to an extended service which included weekends from previously being 9-5. Team members have continued to demonstrate a commitment to the service and are reported to by their team leads to go over and above to provide person centred care. The registrants within the team wanted to stress the excellent work the HCSW's undertake in supporting patients on the ward and that if there were opportunities to grow this resource it would add value to the service they could deliver especially on weekends to improve continuity of care to all patients on the caseload. This would support the clinical practitioners to concentrate on new assessments and those patients requiring a nursing review. HCSW's would like some additional basic training on some standard clinical procedures such as wound care and catheterisation in order to better support the ward teams when assisting registrants to undertake these with patients who have dementia.

However, the team did raise the issue of the accommodation for the south team. Staff reported that they can feel unsafe leaving the building at night due to its location outside of the hospital grounds. They reported poor street lighting and no security. They also stated that there had been issues with the condition of the building.

They confirmed that they had good relationships with the ED and assessment units but said that due to frequent turnover of staff within RGH they are often re-establishing these alongside the role and function of the service.

11. Case Note Audit:

There were difficulties for the reviewer in undertaking this case note audit due to delays in being able to obtain access to and navigating 3 systems, WCCIS, EPeX and Clinical Work Station (CWS). Many of the assessments identified for audit were from the period when the business continuity plan had to be initiated and records retrospectively uploaded. The service was asked to randomly choose assessments over the past 12 months for those individuals whose cases were deemed urgent, therefore choosing referrals originating predominantly

from the ED or assessment units. These were randomly picked by the team lead from those assessments that occurred on the 3 acute sites, The Grange, Royal Gwent and Nevill Hall hospitals.

11.1 Age and Gender Profile:

Number of Records Audited = 11

Figures 1 and 2 below show the distribution of age for men and women. 54.5% of assessments were from women. The age range for this sample was between 66 and 85 years.

Fig: 1

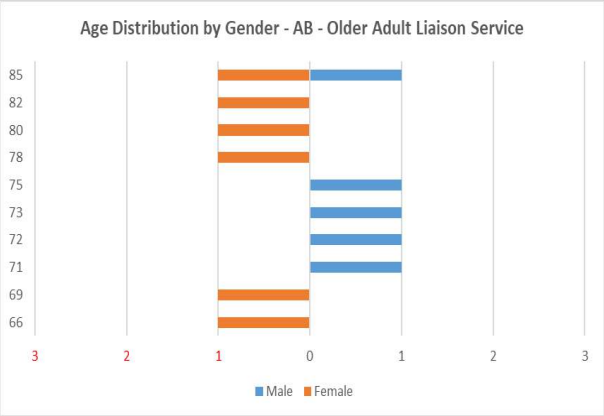
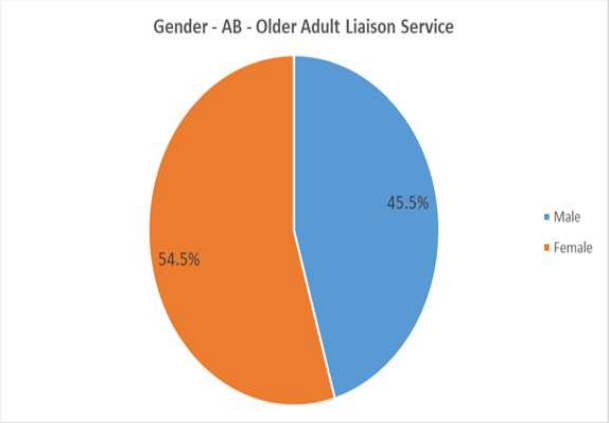


Fig: 2



11.2 Source and Reason for Referral:

The chart below shows the various sources of referral (figure 3). The assessments were from both Nevill Hall Hospital (north team) and Clytha Square (south team). 65% of referrals were from emergency and assessment areas. Figure 4 shows the reason for referral of which approximately half are for functional mental health needs. This does not fit with the teams overall reporting of the workload being predominantly for those with needs arising from cognitive issues and dementia. Within this audit those referred with delirium or dementia presentations are recorded as “other”.

Information provided from a service review in September 21 which evaluated the extended service model showed that approximately 25% of referrals were for people experiencing suicidal ideation, low mood or self-harm including overdose. However, as the DU review occurred towards the end of the Covid pandemic there maybe changes to the patient profile. A larger audit of current referrals would be required to determine if this demonstrates a more significant change in the profile of patient need.

Fig: 3

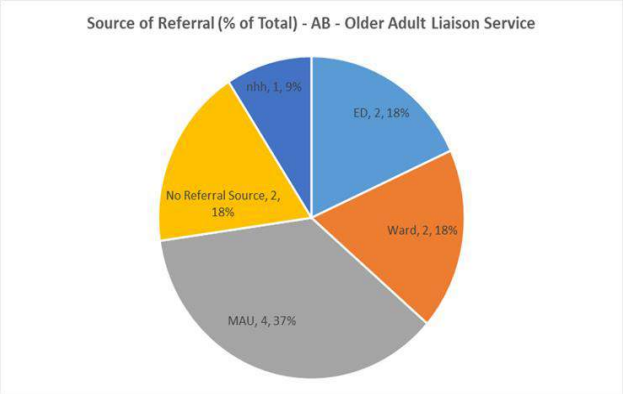
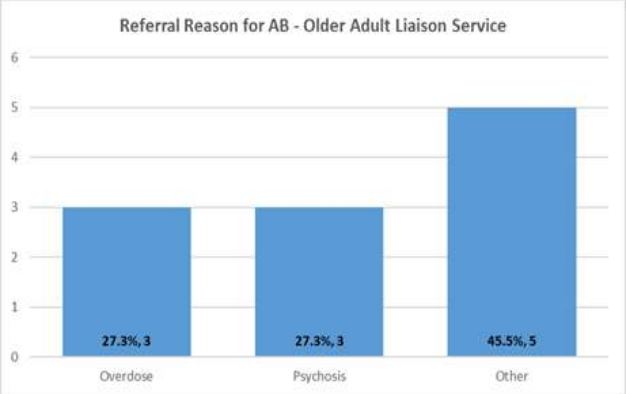


Fig: 4



11.3 Time and Day of Referral:

Figure 5 shows the day of referral which demonstrates that the service accepts referrals across all 7 days in the acute sites. There were only 5 records where the time of referral was recorded (figure 6) although as the team have moved to WCCIS this will be recorded more consistently. The service review shared as part of the initial information request demonstrated over 20% of referrals occurred on a weekend.

Fig: 5

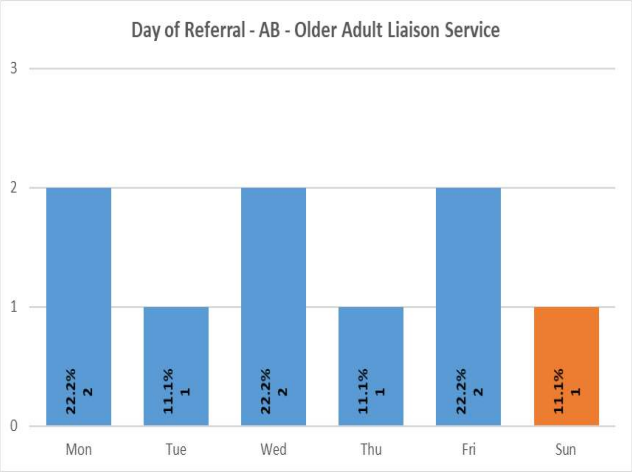
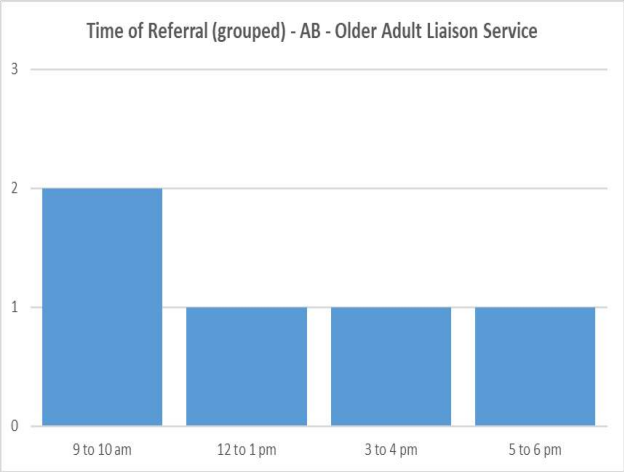


Fig: 6



11.4 Timeliness of Response:

The audit confirmed that assessments were undertaken across the 7 days, see figure 7. However only 5 assessments recorded the time that they occurred, all of which occurred after 3pm, see figure 8. Due to the size of the sample no conclusions can be drawn in relation to timeliness. It is anticipated that this will be consistently recorded with the use of WCCIS and will enable the service to audit their ability to comply with their operational policy standards.

Fig: 7

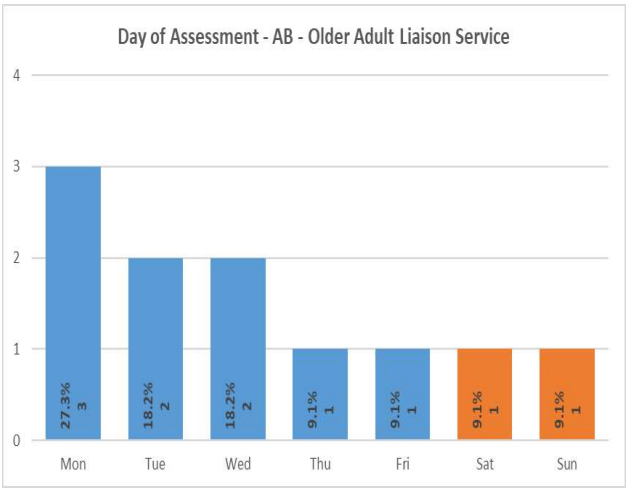
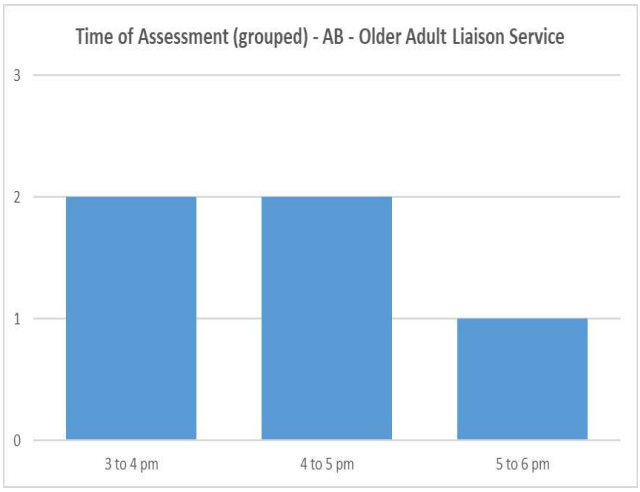


Fig: 8

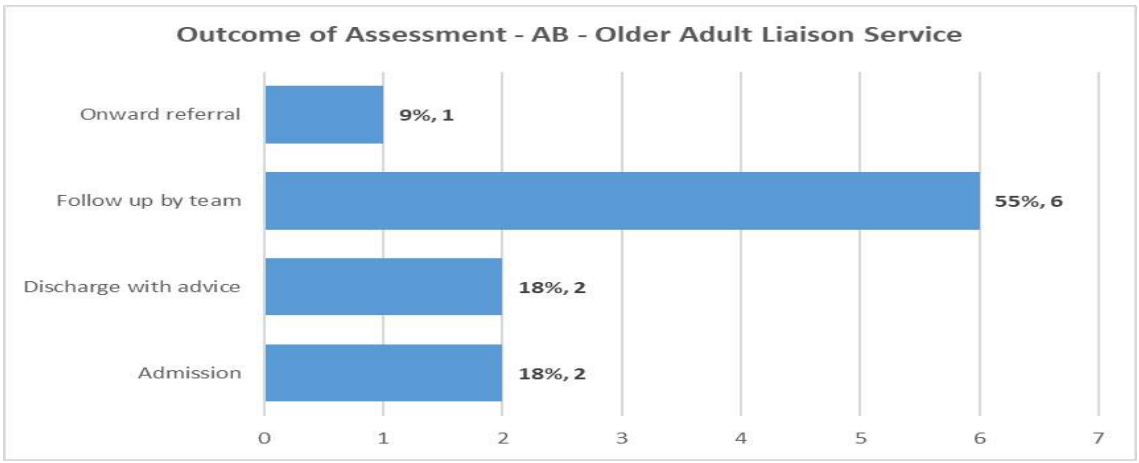


11.5 Outcome of Assessment:

The outcome of assessment is recorded in figure 9. Where an admission is shown this is to an older adult MH bed. For those who require follow up by the team then they will receive various interventions which can be pharmacological as well as non–pharmacological. With interventions and support being delivered from both registrants and non-registrants within the team. Most case notes did not record clearly what the follow up would be as part of the management plan. Where this had been recorded it was most frequently documented as being for PRN medication to be prescribed or support from the HCSW's. Discussion with the team established that individual interventions by the HCSW's are not always indicated as they will undertake a separate visit with the patient and establish the person's preferences for wellbeing activities, or demonstrate alternative positive approaches to care following discussion with the ward team as to when distress and barriers to care occur.

The audit also considered the requirement for frequency of contact as part of the outcome of assessment however, this was not indicated within the documented management plans. The teams utilise the excel spreadsheet displayed on the electronic boards in their bases to record the frequency of visits required and who is to perform them.

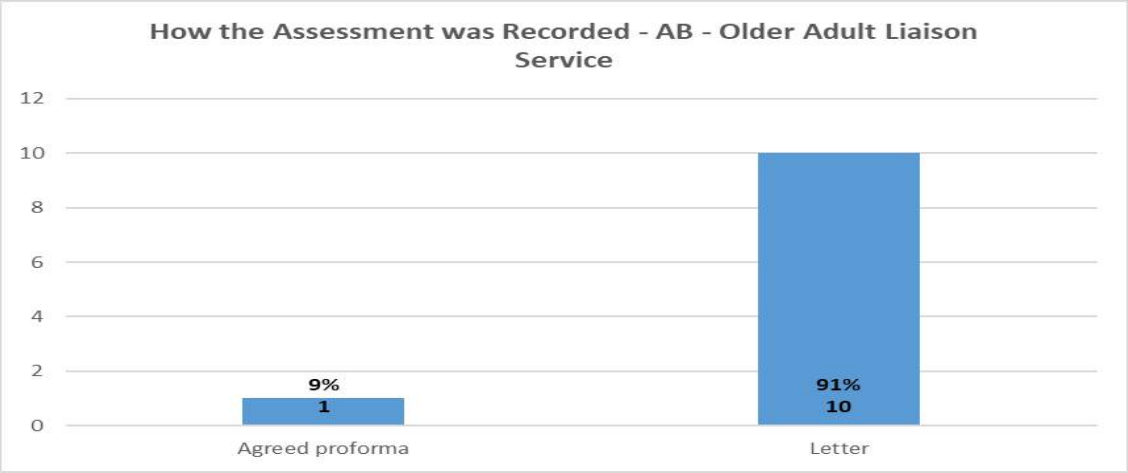
Fig: 9



11.6 Recording and Documentation:

The team reported that they use a consistent approach and a standardised template for undertaking assessments. All recordings apart from one assessment, whether directly into WCCIS or previously uploaded to EPeX or CWS are as a letter style case note, figure 10. There was considerable difference noted between the north and south team in terms of style and brevity of information recorded. Those case notes reviewed from patients in the Grange and RGH were more detailed and comprehensive. The reviewer could gain a clear understanding of the individuals presenting circumstances, need and capacity with a clearer outcome and management plan. A larger sample would be required to understand whether this is a trend within the particular team or with specific practitioners as well as understanding the requirement for a briefer assessment.

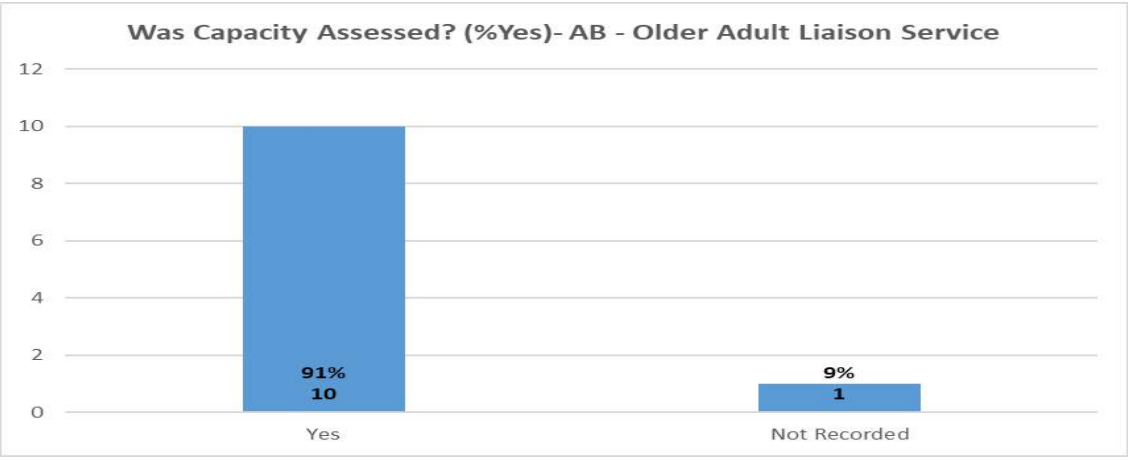
Fig: 10



11.7 Capacity:

Figure 11 shows that the majority of assessments considered capacity although in most cases did not evidence a formal assessment but recorded that the individual did or did not have capacity to engage. The one record which did not record capacity, had limited information overall as they required referral for a Mental Health Act assessment and consideration of admission to a mental health inpatient facility.

Fig: 11

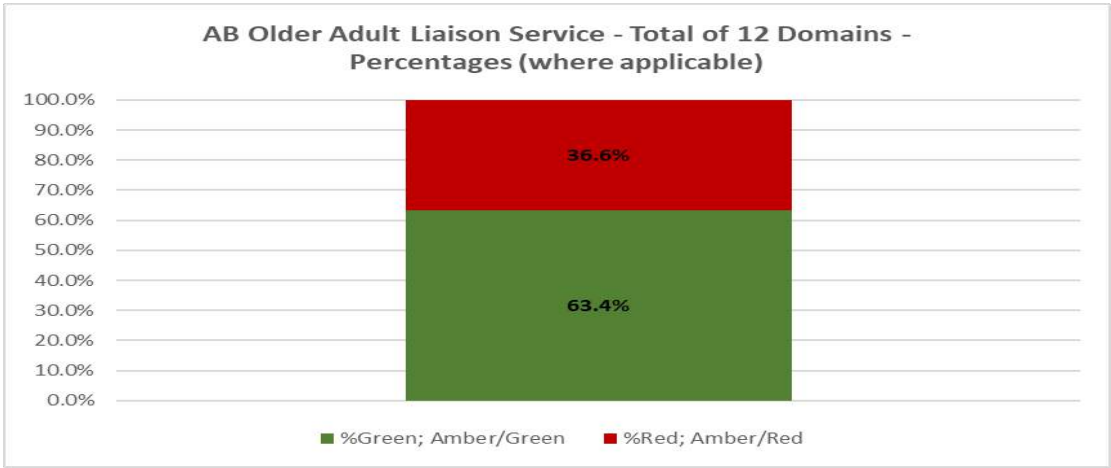


11.8 Assessment Domains:

The consideration of domains within the assessment was rated for quality using a scale of green, amber-green, amber-red and red to determine if information was of good, good-average, poor-average or poor quality. Additionally, the reviewer looked at what happened following assessment as well as whether there was evidence of the patient voice and what matters most to them, incorporated into the assessments.

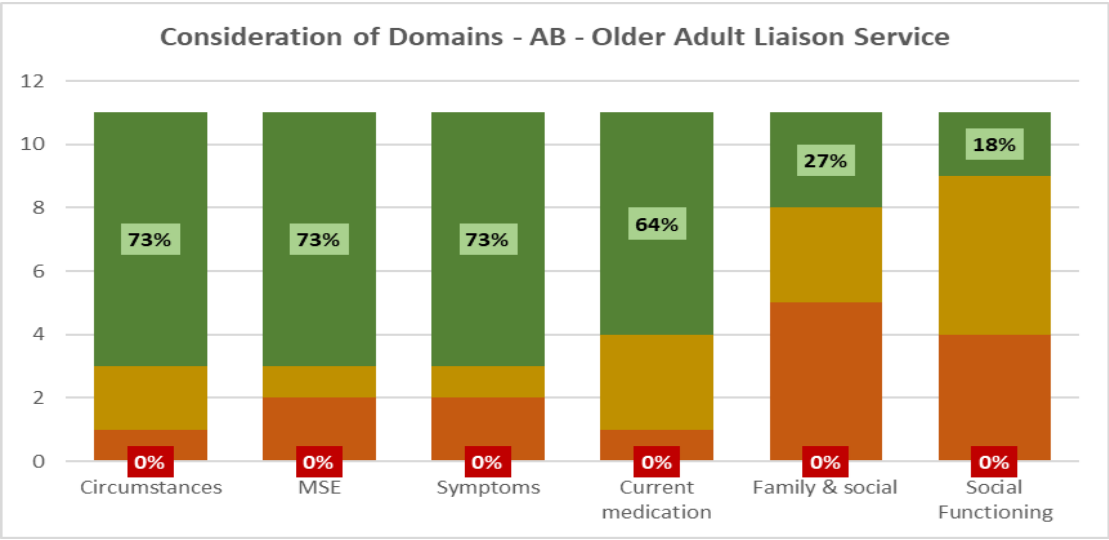
Overall, 63.4% were classed as green or amber green and 36.6% as red or amber-red (figure 12).

Fig: 12



Figures 13 and 14 show the quality of recordings against the domains usually seen within a comprehensive MH assessment.

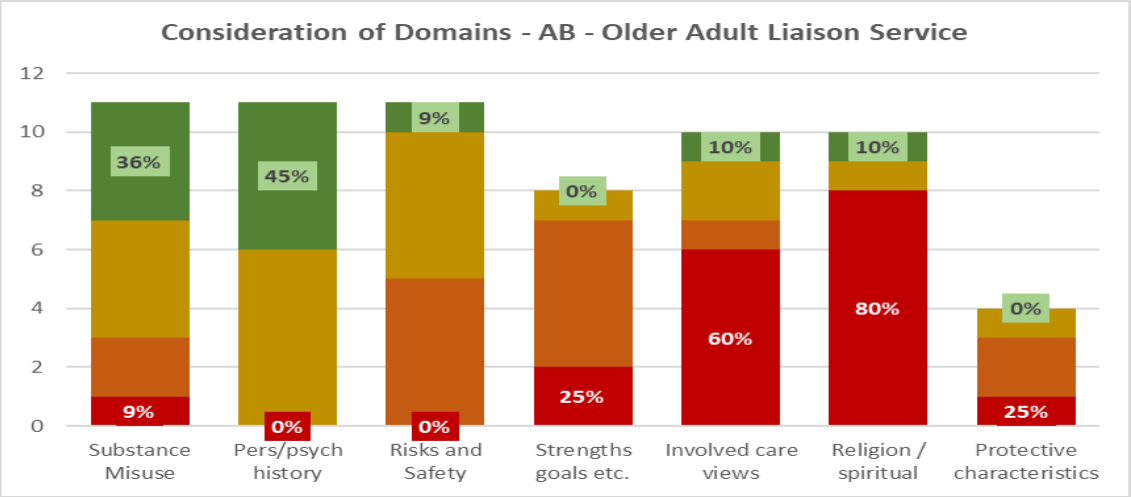
Fig: 13



Some areas of the assessment domains did not have as much consideration as others such as; spiritual needs as they will be dependent on the presenting needs and circumstances for the individual. However, areas such as risk were not detailed with brief recordings such as “hitting out during intervention” being the only mention.

Over 60% did not include involved care views but unless available at the point of assessment the team confirmed they will gather these at a later point in time. The areas that were completed more robustly were those that outline the current need and patient presentation such as circumstances, mental state, symptoms and medication.

Fig:14



Where there are less case notes recorded against a domain such as protective characteristics it was due to these areas not being applicable to the person being assessed. For this domain its applicability was only considered for those individuals where issues such as suicidal ideation or self-harm were the reasons for referral or required exploration as part of the assessment. Those assessments audited from the north team based in NHH tended to be much briefer with less formulation evident.

12. Summary:

This service is seen as highly beneficial and the expansion to a 7-day service is seen by referrers as a step forward however the team do not currently have the resources to provide a consistent service to all hospitals across 7 days.

The team are not collocated to the ED or assessment units and the current RGH accommodation is seen as unsafe due to its location outside of hospital grounds and an ageing building that has suffered leaks and rat infestations. The directorate are aware and it has been escalated via the accommodation board but have been unable to source an alternative to date.

The team are clearly committed to the service and work flexibly to support one another and provide services throughout the pandemic.

There is duplication of notes which will continue following the introduction of WCCIS as there is a requirement to write in the patients' paper notes and general inpatient settings do not have access to this electronic patient record. This is not seen as an issue as it is part of usual working practices. There was a difference in the quality of the recording of assessments between north and south teams but this needs further examination by looking at more case notes as the sample was small and not necessarily representative. The Clinical Lead for the service may wish to explore this further.

13. Views of Stakeholders:

The review team met with a range of stakeholders to understand their views and experiences. This included representatives from Community Mental Health Teams, ED, Local Authorities, Service users and the 3rd sector.

13.1 Internal Stakeholder Views:

Community Mental Health Teams:

OACMHT's shared that there was good communication and support from the liaison services across Aneurin Bevan. Discharge information is considered useful and timely, being received within 10 days of discharge. However, it is anticipated that the introduction of WCCIS should improve this further as teams will be able to see the full assessment from hospital if required.

Experience of LPMHSS

Primary care mental health services have little interface with older adult teams for crisis or liaison. The patient pathway allows direct referral into primary care however, there are rare occasions when someone is referred onto the primary care team following hospital admission. It was stated that on a previous occasion when the primary care team had an older adult who was in crisis and contact was made with the locality OACMHT that advice was given to refer to the GP. Therefore, the team state that they should be able to refer directly into an OACMHT to avoid the person in need having to "bounce" around the services. The LPMHSS recognise that they have few referrals for older adults and although they have undertaken communication with GP's as to the services, they can provide for this group of people there has been little change. The team wondered whether this has had an effect on the complexity of older adults presenting to secondary care in particular as the community emerges from the Covid pandemic.

Experience of the Emergency Unit (EU)

Liaison psychiatry are seen as very helpful by ED and assessment unit staff. They reported the team as being responsive and the proactive review of new patients to offer advice and support. The department refer to the older adult liaison team via a single telephone number where they speak to a clinician or leave a referral by voicemail. They appreciate that liaison will actively check to see if there is anyone who may benefit from the service on a daily basis. The ED team recognise that there is limited space for assessment with most being carried out in the partitioned bed spaces in the assessment unit and confirmed that the room designated for those presenting with mental health needs is often occupied.

The team reported that during office hours the team worked well with other services such as Home First and Red Cross and highlighted the OAPL teams' knowledge of other community based services. There was recognition that the service improvement to extend the operational hours until 8pm and weekend cover between 9-5 has made an improvement to the service offered, citing the previous model as an inhibiting factor that contributed to delays in assessment. The ED team described the response times from OAPL as adequate within hours and reported that they had not experienced an excessive wait with reliable communication about time frames. The ED team understand that liaison practitioners are covering multiple sites and that occasionally this can lead to a longer wait for assessment.

13.2 External Stakeholders:

Experience of Local Authorities

The review team were only able to meet with one Local authority (LA) during the review. At the time of meeting with them neither the extended CMHT pilot had commenced nor had WCCIS gone live therefore comments were based on their previous understanding of services. At the time of the stakeholder meeting, the LA was unclear of a pathway for an older adult with a known dementia to access any crisis or home treatment support. Where protection notices are received, they reported that they were not able to identify the care coordinator to ensure the information is received by the right person in a MAS or OACMHT although there is a duty desk function for both. Since WCCIS go live this may have been resolved. The LA report that services seem to be more working age adult centric without the same parity of care for older adults. They did not elaborate on this view more than to say that adult services have a dedicated CRHTT.

They report seeing lots of men in their 70s displaying agitated and aggressive behaviours with carers who are not clinically trained and who are trying to contain the risk and keep people safe without much support available for them. The LA feel that there is a lack of resources available for those living with dementia in the community and that there is a lack of understanding by health as to the LA role in particular about access to respite to support these families.

Experience of South Wales Police (SWP)

SWP have a vulnerable adult unit for older adults this consists of a small team of RMN's who will provide advice to the police officers to support them with people over 65 are considered at risk or in a crisis situation. They don't interface in the same way as adult services as rarely are older adults taken to a 136 suite. On rare occasions they may need to stay with someone in an emergency department until liaison are able to assess and determine plan of care. If this is at night then they may be there until OAPL are available the following day, although they could not recall a recent incident.

People living with dementia who are at risk to themselves or others are the main cause for concern for whom a police response may be required.

Experience of 3rd sector:

Alzheimer's Society have support workers integrated into the MAS teams. Although these workers are primarily there to support people with advice during their initial year post diagnosis because of their close links with those living with dementia and their families they can see service users who are moving into a crisis situation. The response is to signpost to GP's or MAS for any urgent needs. From their perspective there are insufficient services for individuals and their carers including day services as well as respite to reduce the likelihood of a crisis occurring. This can occur because individuals may start to exhibit behaviours that challenge and the potential for carer burnout increases and limited services being available in the individuals own home to support the management of these.

14. Experience of Service Users

Growing Spaces is a charitable organisation that has a number of groups for individuals to access to support their mental wellbeing. They were approached to gather some service user responses to a survey which considered the following:

- The nature of the individuals' crisis

- Accessibility of the service
- Engagement with the service user and their significant others
- Expectations of what could be delivered and communication including should there be a need to raise a concern.

They were able to gather a small number of responses from 4 individuals who had experienced crisis. All service users had contact OACMHT during or following a crisis situation. One respondent was referred directly from MAS. Service users reported that they found the practitioners communicated well with them and contact was easy once given the relevant information. Half of the respondents had support from both Nurses and HCSW's.

Although the number of responses was small all service users reported a positive experience of the offer from the OACMHT.

Service users who participated confirmed that the team listened to them and were also good at involving the person's significant others to provide support on an individual basis or as a family unit. One respondent did add that:

"sometimes (I think) they listened more to my wife".

None of the respondents reported being aware of services prior to access, but stated that they received clear communication about what would happen and how to access the team between appointments.

"I wasn't sure at the beginning, but my support worker and nurse explained what was going to happen and I believe they did what they were supposed to."

"What support I was able to access was explained well"

The service users reported that the weren't sure of what could be offered in the community but were able to explore options for support with their nurse or HCSW which included ways to manage or cope with their distress as well as activities to promote general wellbeing.

"They would guide me and help me through what I was going through. They were there to give me support options."

"I was given print outs of information and services available to me. My nurse referred me into groups that I found helped, too."

"I don't enjoy a lot of crafts or gardening. But the services I did go to were right up my street."

Even though the service is operational Monday to Friday in Torfaen the team demonstrated their flexibility to meet the needs of an individual which was evidenced in an individual's response to the survey. One individual shared that their crisis happened on a Friday afternoon they were apprehensive that they may not get support. However, they were able to receive an assessment and support and described the service as "second to none".

15. The Experience of General Practitioners (GPs):

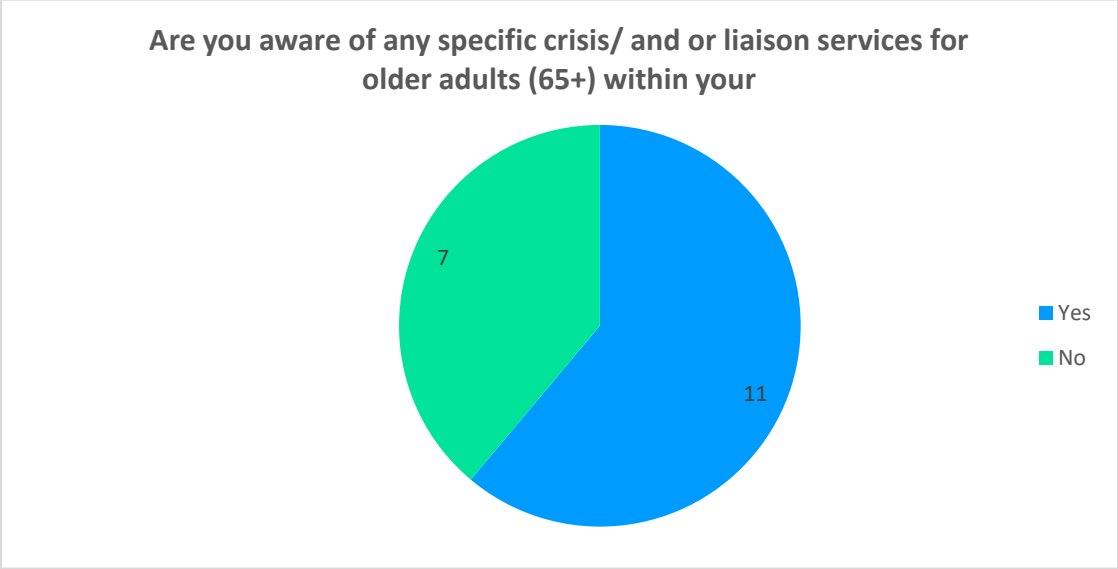
An important component of this review was to attain the views of General Practitioners (GPs) within the Health Board. To achieve this a Doopoll questionnaire was designed and emailed to Practice Managers across ABUHB to be cascaded to all GP practices.

- A total of 18 responses were received.

15.1 Awareness of specific services:

GPs were asked if they were aware of any specific mental health crisis and liaison services for older adults within their area. Responses are shown in figure 16 below.

Fig 16: Awareness of specific services for older adults



- Overall, 11 of the respondents answered that they were aware of specific crisis and liaison services for older adults.
- 7 answered that they were not aware.

15.2 Understanding of Crisis Pathway for Older Adults

There were mixed responses received from GPs in terms of understanding which team they would refer to when an older person is experiencing a mental health crisis.

- *"Ty siriol has a service in my area."*
- *"I am aware of the older adult duty desk and the liaison services that work in the general hospitals for patients over 65 who have mental health difficulties, they work 9-5."*
- *"Yes, I am aware of service, I have tried to refer and very difficult to access service."*
- *"I know we can call the crisis team for help for anyone over the age of 18 but we have found communication between practice level and mental health to be infrequent."*

Other comments suggested that not all GPs were clearly aware of how to refer into or access crisis services:

- *"I am not aware of a specific service - had assumed it was the same generic service as for younger adults."*

- *"I find I get out of date very quickly with MH services so it might be available there's no crisis service that I'm aware of for over 65s in ABUHB."*

15.3 Summary

Of those GP's who responded there was a general understanding of what services are available and how to access them within their locality for older adults who may experience crisis. Of those who were unaware of the service available it was not possible to ascertain whether this was predominantly in one or more areas due to the surveys being anonymous. The Caerphilly OACMHT did share that they had engaged with GP practices in their areas to the new pilot service model and how to access this as part of their communication strategy. Therefore, it would be useful for other teams to take the opportunity to communicate the current pathways of care and services available to their locality practices in order to meet the information gap.

16. Conclusion:

Older Adult CMHT's provide a degree of home treatment and crisis response within their locality's dependant on current capacity, however this is variable dependant on the overall complexity of the caseload.

Liaison services for older adults provide a holistic service to the patients in all of the hospitals in the Gwent region with support for those in need regardless of the origin of their distress. The Older Adult liaison team would like to ensure equity across the health board by increasing their capacity in particular to support Ysbyty Ystrad Fawr where a significant number of referrals arise.

Liaison services have expanded the remit of the service to cover the Grange University Hospital within their previous resources but there remain ongoing challenges with accommodation and IT. However, staff were observed to be compassionate and committed to patients. Of those who responded to the service user survey, all expressed having had a positive experience of OAPL and the OACMHT's.

ACKNOWLEDGEMENTS

The Delivery Unit would like to extend thanks to the staff of Aneurin Bevan University Health Board for their co-operation and contributions during the review, to stakeholders interviewed by the reviewing team and to the General Practitioners who took time to complete the DU questionnaire.

Glossary:

CPN	Community Psychiatric Nurse
CRHT(T)	Crisis and Home Treatment (Team)
CWS	Clinical Work Station
DGH	District General Hospital
DU	Delivery Unit
ED	Emergency department
GP	General Practitioner
HB	Health Board
HCSW	Health Care Support Worker
LA	Local Authority
LPMHSS	Local Primary Mental Health Support Service
MAU/ AU	Medical assessment unit
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MH	Mental Health
MHA	Mental Health Act
MSE	Mental State Examination
NHH	Nevill Hall Hospital
OACMHT	Older Adult Community Mental Health Team
OAPL	Older Adult Psychiatric Liaison
RGH	Royal Gwent Hospital
SEAR	Support, Engagement and Recovery workers
SWP	South Wales Police
WARRN	Welsh Applied Risk Research Network (risk assessment tool)
WAST	Welsh Ambulance Service Team
WCCIS	Welsh Clinical Care Information System
WRAP	Wellness Recovery Action Plan
YAB	Ysbyty Aneurin Bevan
YYF	Ysbyty Ystrad Fawr

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Review of CTMUHB HIW Report (Discharge Planning)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jenny Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Forkings, Divisional Nurse for MH/LD

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of the report is to provide assurance to the Committee following a HIW inspection within Cwm Taf Morgannwg University Health Board (CTUHB) for adult patients being discharged from inpatient mental health services to the community. Of the 40 recommendations the MH/LD Division established it was compliant with 35 and implemented actions to the 5 areas required.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

On 24 March 2023, the Chief Executive of Healthcare Inspectorate Wales wrote to all CEOs of Health Boards in Wales advising them of significant concerns identified following a review undertaken to assess the quality of discharge arrangements in place within Cwm Taf Morgannwg University Health Board (CTUHB) for adult patients being discharged from inpatient mental health services to the community.

The report was shared to ensure that the findings and recommendations were considered within ABUHB mental health services.

Findings have been considered by the Health Board's Mental Health and Learning Disabilities Division and the Committee is asked to receive these findings for information and assurance.

Cefndir / Background

The HIW report identified significant concerns in CTMUHB including issues with:

- Communication and information sharing arrangements
- Patient clinical records management systems
- Patient clinical records concerns
- Capacity and demand for service

The report makes 40 recommendations in total.

HIW requested that each health board completed an equivalent action plan to provide HIW with assurances that the issues identified throughout the review are not replicated within other mental health services across Wales.

Asesiad / Assessment

The 40 recommendations were reviewed and an action plan was completed across the Division (to include Older Adult Mental Health and Learning Disability in patient units) against each recommendation.

Of the 40 recommendations, the Division identified that it is compliant with 35, however it has identified that further strengthening of internal audit and measures would be beneficial for increased assurance. Capacity to include such audits is being explored. The five actions where there was limited compliance/assurance are listed below with actions to improve compliance/assurance:

The health board must ensure that adequate administrative support is available within inpatient mental health units
Whilst all wards across the Division have ward clerks, banding, whole time equivalent, duties and key responsibilities are variable. *The Division is scoping this and exploring options to improve consistency, as part of a wider workforce review.*

The health board must ensure that discharge summaries are completed and sent out to a patient's GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.
Standard practice is that discharge summaries are sent to GPs within a week of discharge. *The Division is developing a Discharge Audit to monitor this standard.*

The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010.
Patients who are **discharged from the MH service** on discharge from the ward do not currently have a discharge letter when they leave. The *Division was to review the approach taken by other Health Boards and consider agreeing a letter/card for patients discharged from the MH service with advice as to how to access the service in the future if required. However, with the introduction of the '111 press 2' service, all citizens now have immediate phone access to MH support and advice on a 24/7 basis.*

The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.
Via the multi-agency MH Delivery group, the Division has agreed a process with the five Local Authorities whereby Approved Mental Health Professionals (AMHPs) can report incidents into the Division. This is a form that is submitted to the MHA Administration team for consideration and review by the Head of Quality & Improvement and others as indicated. Learning and outcomes/actions are discussed in the Delivery group and the AMHP submitting the form then receives feedback. This is a relatively new process within the Division (commenced Autumn 2022). *An annual audit will be implemented to ensure that standards re: feedback, learning and actions have been met*.

The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.
In addition to other meetings, the Division has developed a Learning Group which will be accessible to colleagues across the Division, where findings and learning from patient safety incidents and notable practice will be shared. This will be via Teams to enable better access to a wider group, with a clear focus on learning, service improvement and practice development. The inaugural meeting was held in June 2023. Learning and related action plans are also discussed in the Divisional QPS meeting.

Argymhelliad / Recommendation

The Patient, Quality, Safety and Outcomes Committee is asked to receive this report for assurance.

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):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
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 the access, experience and outcomes of those who require mental health and learning disability services Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee for monitoring, on behalf of the Board. In addition, the report will include a summary of any significant operational risks which are being monitored by the Executive Committee via the Corporate Risk Register.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

At its meeting in July 2023, the Board approved a refreshed assessment of its strategic risks and its approach to risk and assurance reporting arrangements.

The term 'strategic risk' is used to refer to risks which present a direct threat to the Board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP) and as such require a level of focus which cannot be afforded by the Board; therefore, the risks are delegated to committees based on their relevance to the Committee agenda to provide the detailed scrutiny and focus. They are distinct from corporate risks, which are operational risks that necessitate a higher level of ownership than an individual Executive Director can provide but do not directly threaten the organisation's future. Such risks typically span two or more directorates or require plans and resources that exceed the Directorate's capability or capacity to implement.

The Patient Quality, Safety, and Outcomes Committee (PQSOC) has been delegated responsibility for overseeing the management of **3** high-level strategic

risks, which are further subdivided into **4** sub-risks, and as such receives and scrutinises those risks for focus and assurance, on behalf of the Board.

In addition, work is progressing to develop a Corporate Risk Register (CRR) to record all corporate risks (significant operational risks) which require organisational, executive-level oversight. Where relevant to the agenda of the PQSO Committee, these risks are summarised to provide a comprehensive overview of the strategic and significant operational risks being managed within the organisation.

Asesiad / Assessment

Committee Risk Register

In recent weeks, the newly developed strategic risks that comprise the Strategic Risk Register have been subjected to risk assessments to determine how those risks are treated, recorded, and monitored, with a focus on the internal control system and sources of assurance associated with each risk.

For each Risk Assessment, the following information is provided:

- A description of the main risks to achieving that objective – i.e., what are the things that might potentially impact on the Health Board's ability to deliver its objectives;
- The cause of the risks (the threat) - this is a description of why something could go wrong;
- The impact of the risks – this is the consequence should the risk occur;
- The risk appetite level and threshold set for the nature of the risk – informed by the risk appetite statement that is under development and subject to final endorsement
- The key controls in place to manage the risks – these are the actions that are in place to reduce or eliminate the risks;
- The gaps in controls – this is a description of actions that have not been taken, or where systems / processes are not in place to manage the risk;
- The sources of assurance that the risk is being managed – these are the mechanisms we have in place to test the controls are effective and are described in three levels:
    - Level 1 – Operational: the way risks are managed day to day. The assurance comes directly from those responsible for delivering specific objectives and processes.
    - Level 2 – Organisational Oversight: the way in which the organisation oversees the control framework so that it operates effectively.
    - Level 3 – Independent Assurance: objective and independent assurance (e.g., internal audit) or assurance from external independent bodies (e.g., Healthcare Inspectorate Wales and Audit Wales);
- The gaps in assurance against each level of assurance – this is where we do not have the oversight / testing mechanisms in place to give us the assurance needed to have confidence that risks are being addressed;

- The mitigating actions to address gaps in control or assurance – these are the additional actions we need to take, or mechanisms we need to put in place to address any gaps we have identified.

The **3** high-level strategic risks, inclusive of the **4** sub-risks delegated to this Committee for monitoring, are summarised in Table 1 below; the Committee Risk Register and detailed risk assessments is attached as **Appendix A.** The Committee Risk Register is still being developed, and some sections remain blank, specifically the section on the action plan to improve control; there is a commitment to provide a comprehensive update on progress against the actions at the next meeting.

Table 1

Strategic Risk Register				
Risk Identifier	**Risk Owner**	**High Level Risk Description**	**Sub-Risk(s) Reason For the Risk**	**Risk Level**
Risk Theme - Compliance & Safety				
SRR 003	Director of Nursing	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners.	**High**
	Chief Operating Officer		b) Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement.	**High**
Risk Theme - Service Delivery				
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	a) Due to inadequate arrangements to support system-wide patient flow	**Moderate**

Risk Theme - Transformation and Partnership Working				
SRR 010	Director of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	**Moderate**

Corporate Risk Register

As previously mentioned, the Corporate Risk Register is under development and the PQSO Committee has been delegated responsibility for any corporate risks (significant operational risks) relevant to the agenda of the PQSO Committee.

The current mechanism for reporting these risks to the Committee is the Performance Report, which is received as a standing item at each Committee meeting. As the risk and assurance reporting arrangements supported by the escalation process depicted in Figure 1 mature, the Corporate Risk Register will serve as the mechanism for reporting all risks to the Committee relevant to the PQSO agenda.

Figure 1

Table 2 summarises the **1** high-level operational risk that has been escalated to the Corporate Risk Register and has been delegated to this Committee for monitoring. The full risk assessment as detailed above is attached as **Appendix 2.**

Table 2

Corporate Risk Register

Risk Identifier	Risk Owner	Risk Description	Reason For the Risk	Risk Level
Risk Theme Service Delivery				
ERR 004	Medical Director	The current Pharmacy layout/robot at RGH is over 18 years old and the service is not fit for purpose.	Robot has a constantly high number of breakdowns, rendering supply erratic and leading to medication stock issues across South Gwent. RGH department not fit for purpose and significantly inferior to other sites, consequently unable to perform role as Medicines Distribution Hub.	**High**

It is recognised that further development of risk assessments is required, with a particular emphasis on assurance assessment. Further work will be undertaken with the Lead Executive to refine the controls and assurances so that the Committee can take its own assurances that the strategic risks for which the PQSOC has delegated responsibility for are being managed effectively.

An initial indication of each risk was given a RAG-rated assurance level based on a calculation of averages methodology. When determining assurance levels for audit reviews, this is consistent with Internal Audit methodology.

The overarching, high-level indication of the level of assurance the Committee could derive from the risk assessments at the time of writing this report is set out below:

Negative	Reasonable	Positive
	X	

This means that the Committee can take a reasonable level of assurance that the strategic and corporate risks monitored by the PQSO Committee are effectively managed.

The Committee can also be assured that the internal control system in place to manage these risks was deemed reasonable.

Argymhelliad / Recommendation

The Committee is requested to:

- **DISCUSS and NOTE** the delegated Committee risks, as contained within the Strategic Risk Register.
- **DISCUSS and NOTE** the corporate risks as contained within the Corporate Risk Register
- **NOTE** the work being progressed to present in the Committee Risk Report all risks monitored by the Committee

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
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:	N/A
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:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

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**

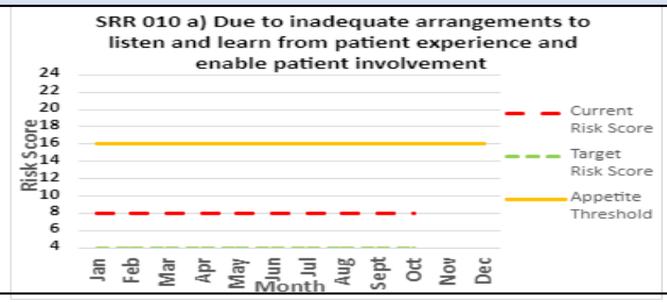
	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 010)	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			
Strategic Threat	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure

Risk Appetite Threshold - SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target but within the appetite threshold. Target level is **within** the set appetite threshold.



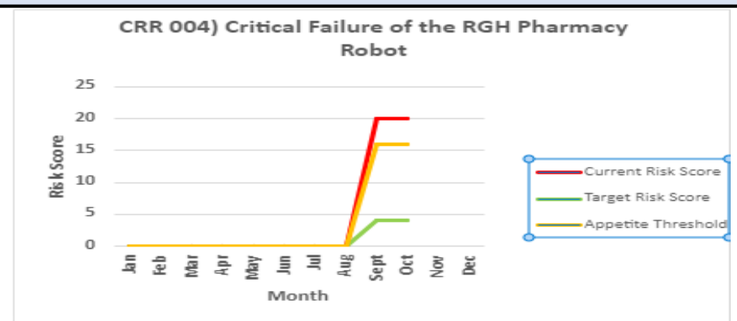
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Person Centred Care Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • LLais Reports • HIW inspections	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor • PALS Single point of contact is being established. PALS officers will have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. • PCC KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Implement PALS DATIX Module	**Reasonable Assurance**

RISK THEME	Service Delivery - Critical Failure of the RGH Pharmacy Robot			
Corporate Risk (Operational) (CRR 004)	The Royal Gwent Pharmacy department is the main pharmacy hub for the Health Board's purchasing, storage, and distribution of medicines, so the site's effective operation is critical. The robot was installed in 2005 and had a 10-year estimated lifespan. This is now the UK's oldest pharmacy distribution robot still in use.			
Threat	A critical failure will result in significant disruption to the timely access of medicines across the Health Board with potential impact on patient safety and flow.			
Impact	➢ Unintended patient harm from missed doses of medicines due to the disruption in supply. ➢ Impact on patient flow through our hospitals due to the delay in supplying medicines at discharge. ➢ Reduced clinical pharmacy service at ward level to support local procurement teams at each pharmacy department, with redistribution of staff to departments with functioning robots to focus on medicines supply. A reduced clinical service will lead to a reduction in medicines reconciliation and reduction in the identification of prescribing errors leading to further patient harm. ➢ Further deterioration in staff morale leading to further vacancies.			
Lead Director	Medical Director	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	5 *(Almost Certain)* *x*	1 *(Rare)* x
Initial Date of Assessment	01 July 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	26 September 2023	**Risk rating**	**= 20** *Extreme*	**= 4** *Moderate*

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - 16 AND BEOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• GUH and YYF staff are trained to complete 'critical low' supplies for bulk items that fall below set PAR levels for onsite Omnicell's prior to top-up trigger from RGH. • Automated daily reports to sites are in place to trigger supply to maintain critical levels of stock across hospital sites in between centralised top-up from RGH. • A contingency plan is in place and would be enacted in the event of a catastrophic failure.	The instigation of further controls will be dependent upon the determined length of time that the robot will be unavailable. Plans include: • **Short Term -** To reduce impact and volume of Omnicell top-ups required to be diverted to other sites a risk stratified approach would be followed as per ABUHB Pharmacy Contingency plan. This would enable high risk and large volume areas to be topped up in priority order e.g., NICU, ICU, GUH ED, GUH MAU, RGH MAU, YYF MAU etc. • **Medium Term** - Redirect Omnicell automation from RGH to GUH for assigned Omnicell's with least diverse stockholding. This will require approximately 1-2 pharmacy assistants to be redirected from ward-based pharmacy services. Due to the use of critical low processes distribution staff at GUH are trained to complete release of Omnicell orders. • **Long Term** - Replacement of the Robot. Executive Committee have agreed that the robot replacement should be prioritised for next year's discretional capital, and that planning for the replacement should commence given the expected lead time for procurement.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Check of critical levels of stock reported daily. • Operational status of the Robot is monitored at Pharmacy, Divisional Senior Leadership Team and at Divisional Assurance meetings. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Operational status of the robot and service delivery monitored by the Executive Committee through the Corporate Risk Register Report • Management of the risk is monitored by the PQSO Committee • Recorded and updated on Datix. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Not applicable	**Gaps in Assurance** • Reporting on the number of medication incidents or patient harm related to a critical failure. **Action to Address Gaps in Assurance** • Ensure that any medication related DATIX reports are reviewed at the point of robot failure to determine the impact. • Ensure that the impact on staff is assessed following any critical failure, lessons learnt, and contingency plan updated where necessary.	**Reasonable**

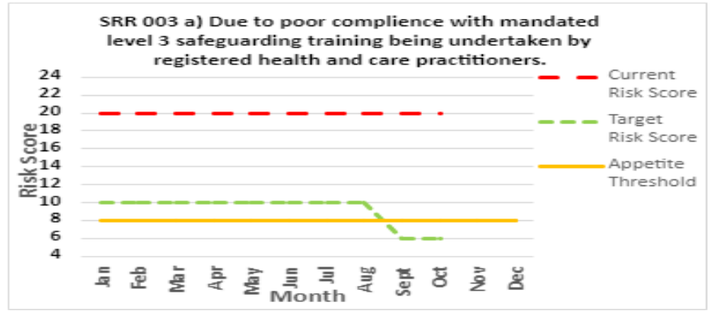
Risk ID	Risk Owner	Risk Theme	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Target Risk Score				Action Plan				Status of Progress Against Actions	Assurance that the Risk is being managed effectively
						Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite Level & Threshold for each Risk	Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Actions to manage risk down to target level	Deadline	Action Holder	Progress against Actions		
SRR 003	Director of Nursing	Safety & Compliance	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	**a)**Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners	•Missed safeguarding concerns, resulting in harm or death •Vulnerable individuals not identified appropriately, resulting in harm or death •Lack of staff understanding of reporting and escalation process •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**4**	**5**	**20**	**Extreme**	**Above Appetite Level**	**MINIMAL = 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	**3**	**2**	**6**	**Moderate**	Updated training packages. Training sessions booked for children and adult level three safeguarding training. Communication with practitioners, via share point intranet pages, emails to divisional nurses. Protected time to complete Level 2 and 3 training where possible. Clear mandate of level 3 training is required on ESR.	**This section is currently being developed and the information will be available for the December Meeting**				Medium
	Chief Operating Officer			**b)**Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	•Harm or injury to patients and/or staff •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**4**	**5**	**20**	**Extreme**	**Above Appetite Level**	**MINIMAL = 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	**2**	**2**	**4**	**Moderate**	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. The CCH is being developed in order to help young people who fit the following criteria: Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. •Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. •Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. •Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.					Medium
SRR 005	Chief Operating Officer	Service Delivery	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Within Appetite Level**	**OPEN = 16 or Below** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	**3**	**3**	**9**	**High**	Escallation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: **1.Focus 2.Processing power 3.Capacity** Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions.					Medium
SRR 010	Director Of Nursing	Transformation and Partnership Working	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	**2**	**4**	**8**	**High**	**Within Appetite Level**	**OPEN = 16 or Below** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	**2**	**2**	**4**	**Moderate**	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.					Medium

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care professionals.			
Impact	➢ Missed safeguarding concerns, resulting in harm or death. ➢ Vulnerable individuals not identified appropriately, resulting in harm or death. ➢ Lack of staff understanding of reporting and escalation process ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*

Risk Appetite Level - MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



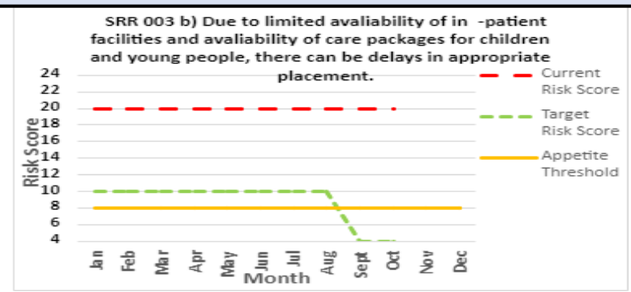
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Safeguarding policies • Safeguarding Training offered at level 1 & 2 via ESR. (Current compliance data - adult & child level 1 -81%; Children level 2 55.7% Adult level 2 58.0) • Supervision and case review available. • Safeguarding Hub –for ad hock advise from a band 7 safeguarding lead nurse: Monday – Friday 09.00 – 17.00 • Utilising all communication methods available to promote completing safeguarding training.	• Updated training packages. • Training sessions booked for children and adult level three safeguarding training. • Communication with practitioners, via share point intranet pages, emails to divisional nurses. • Protected time to complete Level 2 and 3 training wher possible. • Clear mandate of level 3 training is required on ESR.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Training compliance reported at Senior Nursing Team meetings. • Good use of the adult and child safeguarding hub facility **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Robust monitoring of safeguarding activity through the Safeguarding Committee via quarterly reporting • Safeguarding Committee Assurance Report to the Patient Quality, Safety & Outcomes Committee *(PQSOC)* • Audit Reports reviewed by the Audit, Risk and Assurance Committee (ARAC) • Progress of Audit Recommendations monitored and tracked through the ARAC. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit 2023 – 24** 1. Safeguarding (Q1) Reasonable Assurance Outcome • HIW Inspections	**Gaps in Assurance** • As level three training is mandated every three years, the expectation is that we will not see an acceptable level of compliance until 2026. • Level 2 safeguarding training compliance levels below expectation of 85%. **Action to Address Gaps in Assurance** • Spot check of Level 2 safeguarding training through ESR to target improvement. • Monitor at SMT	**Negative Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	b) Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.			
Impact	➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Unlikely)*
Last Reviewed	14 September 2023	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*

Risk Appetite Level -MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• CAMHS now have a team of healthcare support workers, at band 4 (our BOOST team), who are in the process of being trained, prior to being ready to be available over 7days to directly support young people who are in hospital because of a delayed discharge. • CAMHS have an agreement with adult Mental Health Services in place, enabling us to access a 'holding bed 'situated in the Extra Care area at Ty-Cyfanol ward, at YYF. This allows us to support young people experiencing suspected serious mental illness for up to 72 hours, whilst a gatekeeping assessment is carried out by our colleagues at the tier 4 in-patient unit. • Our Emergency Liaison Team are present at GUH on a daily basis, assessing young people at the point of need. • Windmill farm therapeutic residential home, a partnership project between CAMHS and social services, is now open and can accommodate young people struggling with complex mental distress that are environmental and not organic. There are 4 places at the home, and we have already successfully placed, supported, and transitioned several young people who may previously have required an out of county placement. • BOOST team manager in place. • Crisis Outreach Team are the designated team who manage and co-ordinate admission to the holding bed.	• Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: • Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. • Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. • Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. • Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Regular communication meetings between CAMHS teams and the Windmill Farm team. • Senior Management Team meetings to track progress against the action plan. • Join the twice-daily X-Site flow meetings to provide a position report **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee • Regular reporting to the Mental Health Act Monitoring Committee • Reporting to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections of Mental Health Wards across all sites	**Gaps in Assurance** To be determined **Action to Address Gaps in Assurance**	**Reasonable Assurance**

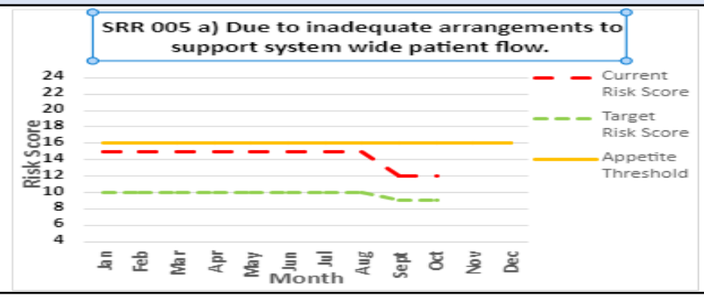
• Standard Operational Policy in place for CAMHS teams to be able to access BOOST workers. • Agreed referral process to Windmill Farm, with a gatekeeping team comprised of CAMHS and social care colleagues who are able to advise whether or not a referral is suitable; attendance at Complex Needs panels to operationalise the gatekeeping process. • Standard operational policy and care pathway in place for admission to the holding bed. • Detailed Standard Operational Policy in place for Windmill Farm.	cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. • Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.			

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) Due to inadequate arrangements to support system-wide patient flow			
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3*(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*

Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. • Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: 1. Focus 2. Processing power 3. Capacity • Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. • Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Twice daily flow meetings to review flow through all acute sites. • Performance against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Weekly safety flow forum – Cross divisional focussed forum to look at priority areas to improve flow from across the system. • Divisional Assurance reviews • Attendance on national calls. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** 1. Intra-site Patient Transfers (Q1) - Not Yet Reported • Robust improvement plans in response to inspections/visits. • WG – IQPD meetings to review areas of focus. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.	**Gaps in Assurance** To be determined **Action to Address Gaps in Assurance** • Performance management framework to be established as part of the wider organisational framework.	**Reasonable Assurance**

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Maternity Unit, The Grange University Hospital, Aneurin Bevan University Health Board

Inspection date: 6 – 8 June 2023

Publication date: 14 September 2023

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at The Grange University Hospital, Aneurin Bevan University Health Board on 6 to 8 June 2023. The following hospital wards were reviewed during this inspection:

- Antenatal Ward – 8 beds
- Labour Ward – 17 beds (including 5 High Dependency beds)
- Postnatal Ward – 16 beds
- Alongside Midwifery Unit (Birth Centre) – 6 beds
- Induction of labour Ward – 8 beds
- Post operative Ward – 8 beds

Our team, for the inspection comprised of a HIW Senior Healthcare Inspector, a HIW Healthcare Inspector, HIW's Head of Quality and Acute Clinical Advice, three clinical peer reviewers (two midwives and one obstetrician) and a patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 48 questionnaires were completed by patients or their carers and 65 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff were observed providing kind and respectful care to women and their families. We found that all staff at all levels worked well as a team to provide patients with a positive experience that was individualised and focussed on their needs. Almost all patients that we spoke to were positive about their care, the staff and the maternity unit environment. We saw staff delivering patient centred care despite some staffing pressures on the department.

This is what we recommend the service can improve:

- Review and consider increasing the availability of birth pools within the unit
- Review visiting arrangements and communicate timings effectively with families ahead of admission
- Review and consider increasing post-natal bed capacity to improve patient flow.

This is what the service did well:

- Patient centred care taking account of individual needs
- Light and spacious individual ensuite rooms and modern facilities
- Pregnancy information available in multiple languages via the Healthier Together website
- Patient representation via the Bump and Birth Improvement group (BABI) used to drive improvement in maternity services.

Delivery of Safe and Effective Care

Overall summary:

We saw arrangements were in place to provide patients with safe and effective care. Some elements of good practice were seen. However, we did identify a small number of issues in relation to equipment checks and infection prevention and control (IPC) where HIW requires immediate assurance from the UHB on the action taken to address these.

Immediate assurances:

- Some furniture, fixtures and fittings in two rooms for care and treatment were observed to be visibly soiled with blood and bodily fluids
- Daily checks of one of the essential resuscitaires was not always recorded

- Daily fridge temperature checking of one of the medicines fridges was not always signed as checked
- Insufficient management and security of some confidential patient information.

This is what we recommend the service can improve:

- Ensuring that all fire doors to cleaning cupboards are closed
- Review capacity and succession planning for all specialist midwife roles
- Ensure that staff have ready access to essential medical equipment
- Implement regular documentation audits and follow up learning for patient records

This is what the service did well:

- Innovative initiatives to identify risks
- Clear and effective pathways of care for women and babies.

Quality of Management and Leadership

Overall summary:
A management structure was in place and clear lines of reporting and accountability were described. Managers were visible on all areas of unit and comments from staff said that they were approachable and receptive to feedback. All staff said that there was a positive, supportive culture in place. We saw friendly, kind, approachable and well-functioning teams that worked well together all areas of the department. Some challenges were seen in relation to staff recruitment and retention. We also noted that compliance with mandatory training in some areas was poor.

Immediate assurances:

- Low levels of mandatory training compliance in some areas including key clinical skills.

This is what we recommend the service can improve:

- Recruitment and retention of staff to fill vacancies at all levels
- Improve staff access to spaces to take time out from clinical area
- Improve system for tracking of staff training.

This is what the service did well:

- Routinely feeding back from patients to staff
- Including staff in learning and good practice identified in incident investigations
- Staff development opportunities available to all staff at all levels.

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

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 48 were completed. All respondents who completed the questionnaire were mothers with the majority of respondents having experienced maternity services within the last year (39/48) and received consultant led care (36/48) whilst the remaining were midwife led.

Overall, the majority of respondents rated their experience positively (42/48) sharing comments such as:

> *"The care and support received by all staff was outstanding and thanks to this my whole birth experience was a positive one"*
>
> *"Better than expected - excelled any expectations. Absolutely excellent!"*
>
> *"Care is very professional and attentive. Impressed with all levels of staff"*
>
> *"Marvellous service - Dreaded coming in because of reviews online - but will be sharing a positive experience!"*

We asked what could be done to improve the service. Comments included the following:

> *"Not sure that anything could be improved"*
>
> *"Not having to leave so soon after baby born"*
>
> *"Visiting times felt very restrictive and at times left me feeling quite alone."*

A mixed response was received on whether hospital visiting hours were sufficient with just over half agreeing their partners or someone close to them were able to stay as long as wanted (26/43).

The health board should review visiting arrangements and communicate timings with families ahead of admission.

We saw that one birth pool was available for the whole unit. This was available in the Birth Centre. People using the unit were aware of the benefits of the birth pool for pain relief and some mentioned their disappointment at not having access to use one during labour.

The health board should review and consider increasing the availability of birth pools within the unit.

Person Centred

Health promotion

During the inspection we met with the midwife specialising in Public Health. We reviewed the "Healthier Together" website that detailed comprehensive health promotion information, advice and guidance for all stages of pregnancy as well as pregnancy planning. Guidance and information on smoking, alcohol, weight, physical activity, breast feeding and other health promotion messages were accessible in multiple languages through the website. The website link was given to all patients in antenatal clinic. We were told that paper based health promotion information was available on request. The availability of comprehensive updated health promotion information means that families can access information to make healthy changes or access support in a timely manner to increase the chances of a healthy pregnancy and healthy baby.

We were told that there were three maternity advisers trained in smoking cessation to support people to stop smoking during pregnancy.

Most patient survey respondents confirmed that information provided during pregnancy including where to go in an emergency (44/47) and what would happen during the birth (38/47) was sufficient.

The Healthier Together website information was noted as good practice.

Dignified and respectful care

Throughout the inspection staff were seen treating people with kindness and respect, communicating in a friendly and professional manner.

The layout of the wards and hospital meant that all in-patients were treated in side rooms with ensuite facilities. This ensured that privacy and dignity were protected. We saw suitable changing facilities for partners to change into appropriate personal protective equipment (PPE) when attending a caesarean section birth.

Almost all survey respondents felt that staff treated them with dignity and respect (45/48) and that staff explained birth options, any risks associated to the pregnancy and any applicable support options (44/48). Comments included:

> *"My pregnancy journey began with no complications and ended with many. I could not have received better care and support. Each member of staff cared for my family and I with compassion, skill and kindness. I made many difficult decisions and encountered many complex health problems however the support I received made my experience positive."*

Staff we spoke with demonstrated a good awareness of their responsibilities in protecting and promoting patient rights when attending the unit. All staff who completed a questionnaire agreed that patient privacy and dignity was maintained and almost all believed that patients were informed and involved in decisions about their care. They were all satisfied with the quality of care and support they gave to patients.

We met the specialist midwife for bereavement who appeared to be committed and enthusiastic, and noted that there was a dedicated bereavement room for families. Staff on the unit received bereavement training to ensure that support is available for bereaved families. We noted that there was currently no medical lead for bereavement.

The health board should review bereavement services to benchmark their services against similar maternity units. Capacity should be reviewed to ensure that the specialist midwife is adequately supported and women who experience bereavement receive equitable specialist consultant care.

Individualised care

Patients told us of supportive and positive interactions with staff during their time in the unit.

Staff within the unit met twice daily, at shift change-over time. We attended two handover meetings and saw effective communication in discussing patient needs and plans with the intention of maintaining continuity of care. These meetings were well-structured and evidence based. It was clear from the handover and the communication board within the handover area, that individual needs are discussed and shared.

There were several specialist midwives in post to support families that needed some additional or specialist support. We spoke with the mental health midwife in place who also provided support for women with substance misuse. We saw individualised care and additional care pathways and advocacy for women with difficulties in these and other areas.

Timely

Timely care
Patients told us that staff were very helpful and would attend to their needs in a timely manner. Staff told us that they would do their best to ensure that all patient needs are met and patient records demonstrated that this took place.

Respondents to the patient survey felt they could access the right healthcare at the right time (44/48).

Whilst patients and families felt that they could access support in a timely manner during pregnancy and labour, feedback on postnatal care was mixed. Some negative comments were received around postnatal care.

> *"During labour the care I received was impeccable, but the aftercare was not good. I did not feel supported with breast feeding and I suffered a very traumatic birth and wasn't fully informed with what happened."*

Many staff that we spoke to during the inspection told us of the challenges around capacity for postnatal patients. The 16 postnatal beds were often full and we were told that this had an impact on patient flow in the rest of the unit. On occasions this caused delays in care. Comments in the staff survey reflected these challenges:

> *"I feel that there is always a bed capacity issue and pressure to discharge women quickly but especially on the weekend there is always difficulty getting medical staff to come to the ward to see women and write prescriptions"*

Senior managers that we spoke to were aware of these challenges and reviewing options for improvements.

The health board should review post-natal bed capacity and mitigate any risks associated with capacity shortages to ensure that safe and effective patient care is maintained.

Equitable

Communication and language

Staff we spoke with told us that additional arrangements would be made if patients had any communication requirements. Staff confirmed there was access to translation services to assist communications if required.

The nine sets of patient records that we reviewed noted appropriate joint decision making, individualised care and also preferred language and birthing wishes.

We saw examples of staff ensuring that women, whose first language was not English, were supported to ensure that they understood their plan of care. We noted that the staff team in the Maternity Department were diverse and spoke many different languages and, on occasions, communicated with some patients in different languages to ensure patient choice and understanding. Patients that we spoke to in the unit said that they felt listened to and everyone that answered the survey said that they also felt listened to by staff.

Information was available in many different languages via the Healthy Together website. We saw a small number of staff wearing the Welsh language logo to indicate they could speak Welsh.

We noted that there was clear bilingual signage from the carpark and through the hospital to the Maternity Department.

We did not see information detailing staff on shift for patients and visitors. This was commented on by some patients who told us that the "my nurse today" information was not being regularly updated.

The health board should implement a system to ensure that patients are aware of staff on shift and the leadership team within the department.

Rights and Equality

All patients said that that had not faced discrimination when accessing or using this health service on grounds of any protected characteristics under the Equality Act (2010)

One person commented that:

"All care was delivered in a completely non-judgmental, open, honest and individualised manner."

The staff that we spoke with were all aware of Equality Act (2010) and provided examples where reasonable adjustments were in place, or made, so that everyone, including individuals with protected characteristics, could access and use the service.

We met a diverse staff team and noted that diversity and equality training was mandatory for all staff.

We noted that the patient experience group, BABI group, had good representation from diverse groups to ensure that all patient experiences can shape care.

The BABI patient experience group and the diverse membership was noted as good practice.

The newly built hospital had accessible rooms, bathrooms and wide corridors to enable easy access for all.

Delivery of Safe and Effective Care

Safe

Risk management
We reviewed processes in place to manage and review risks, and to maintain health and safety at the department. We noted good practice related to the use of an armband for women that have commenced induction of labour process through Propess administration. This meant that these women were easily identifiable and risks related to the pessary were limited.

All areas of the unit were well lit, well equipped and ventilated with wide corridors. Most areas were clutter free and well organised.

We noted that some fire doors to cleaning cupboards were not routinely closed this must be addressed.

Infection, prevention, control and decontamination (IPC)
We found that the most areas of the unit were clean and tidy. However, on arrival in two unoccupied delivery rooms, we observed blood stains on some furniture, fixtures and fittings. Dated labels indicated that these rooms had been cleaned, however we considered this cleaning insufficient given the visible blood that was seen.

HIW were not assured effective processes were in place or being followed to prevent healthcare acquired infections. These issues were addressed immediately by staff during inspection.

We reviewed evidence related to cleaning audits for the department, which indicated a high level of compliance and clearly detailed pass and fail rates as well as indicating responsibility for failures.

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

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow and saw good hand hygiene techniques. Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. Hand hygiene gels were available throughout the unit. We reviewed hand hygiene audit documentation that indicated good compliance.

Safeguarding of children and adults
The health board confirmed the policies and procedures in place to promote the welfare of children and adults that may be at risk. We met with the specialist safeguarding midwife who confirmed appropriate arrangements were in place to safeguard children and adults using maternity services. This included mandatory training for all staff, which, at the time of inspection was at 72% compliance.

We noted that the specialist safeguarding midwife role is a health board wide role and during annual leave and absence there are limited resources available to provide cover.

During the inspection, throughout the unit, we found comprehensive security measures were in place to ensure that families and babies were safe. Access to all areas was restricted by locked doors, which were accessible with a staff pass or by a member of staff approving entrance through an intercom. The inspection team were asked to wear health board badges to identify themselves and were asked to show them on several occasions.

We reviewed evidence of a baby abduction drill that took place earlier this year. There was evidence of feedback and learning provided to staff and other relevant authorities to ensure the continued security of babies in the department.

The health board should review the capacity of safeguarding midwife and wider safeguarding team to ensure that sufficient capacity is available during periods of annual leave or absence and to allow for effective succession planning.

Management of medical devices and equipment
The results of the staff survey indicated that around half of staff disagreed that they had access to appropriate medical equipment to enable them to provide effective care. This posed a risk if prompt observations could not be conducted in a timely manner. One member of staff commented within the questionnaire:

> "*We need basic equipment like manual BP cuffs (small and large), thermometers, baby thermometers/stethoscopes in every labour room*"

> *"We regularly do not have enough equipment for basic checks and stan monitors not working etc."*

We reviewed patient records that indicated that CO2 monitoring may not be being conducted in line with Welsh guidelines. Some staff that we spoke to indicated that there was a shortage of CO2 monitors in the community.

The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.

We found the emergency trolley, for use in a patient emergency, was well organised and contained all the appropriate equipment, including a defibrillator. We noted maintenance checks were taking place on this equipment. The emergency drugs were also stored on the resuscitation emergency trolley.

Emergency evacuation equipment was seen within the birth pool room, which could be used in the event of complications during a water birth. We were also assured that all staff had received training in their appropriate use in the case of emergency.

During the inspection we saw that the daily checks on the resuscitaire next to postnatal ward had not been consistently checked for faults and recorded in line with policy. We noted that there were six dates in May 2023 that were not completed.

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

Medicines Management

We found that there were suitable arrangements for the safe and secure storage and administration of medicines including controlled drugs. Medicines were stored in a safe, secure system with fingerprint access. We saw evidence of temperature checks of the medication fridges to monitor that medication was stored at the advised temperature of the manufacturer. We noted that checklist for the medicine fridge in use in the Birth Centre had logged all of the temperatures for June, however no signature was recorded against two of the six dates checked.

This issue of medicine fridge and equipment checking was dealt with under HIW's immediate assurance process and are referred to in Appendix B of this report.

We noted from discussions with staff and a review of a sample of patient records that the prescribing and administration of medication during induction of labour was in line with the health board policy. From the patient records that we reviewed we saw prescription charts that were fully completed and checked.

Pharmacy support is available to the unit 24 hours a day and an out-of-hours computerised system allows staff to check the stocks of drugs across the hospital to ensure there are no delays in patients receiving medication.

Patients who completed the survey confirmed that they felt supported during their birth (41/43) and that during the birth, they had access to enough pain relief to cope (37/43).

Effective

Effective Care

We reviewed evidence of audit activity including IPC and hand hygiene that were performed on a regular basis. We saw that actions had been taken, tracked and monitored as a result of audits that were completed. We noted that there was a new audit system in place and it was not yet embedded.

The health board must ensure that audit processes within the new system are structured, effective, tracked and monitored to drive improvement.

Nutrition and hydration

We observed the serving of a lunchtime meal and the food looked appetising and was served promptly, patients told us that there was good choice. Organisation and coordination around the mealtime was efficient. There was a tea trolly, water and fruit readily available at all times and a kitchen was also available for patients.

In the patient care records we reviewed, we found that patient nutritional and fluid requirements were well documented.

Patient records

We reviewed nine sets of patient records. The standard of patient records was mixed. Four of the records documented good clear care planning, decision making and risk management. We reviewed one set of records that comprehensively documented a medical emergency that we witnessed during inspection.

We reviewed some records that needed improvements:

- Two of the nine sets of records were disorganised and not in logical order and this could be difficult to ensure safe ongoing care
- Five sets of records documented care that was not always signed off by the staff member providing care
- Two sets of records were missing documentation and information in the MEOWS charts,

We spoke with leaders who confirmed there were plans in place to move to an online portal for maternity records and that this will help with consistent recording of care and treatment.

The health board must ensure that regular documentation audits are conducted and learning takes place from the findings.

Efficient

Efficient

From conversations with staff at all levels we heard examples of efficiency savings that had been made to benefit patients. We were also told of times when processes were inefficient and solutions were being actively sought.

Staff told us that they rotate to different areas of the department to ensure safe staffing and risks are mitigated. We were told that different areas of the department were used flexibly to meet demand when necessary, this included the use of the Birth Centre for low risk labouring women when the delivery ward was full. We were told that doctors supported these births due to the proximity.

We saw that theatre elective caesarean section lists often started late partly due to logistical delays with collecting patients.

The health board should review the options for bringing elective caesarean patients through to recovery bay earlier (prior to briefing) to minimise delays.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain staff views on the maternity services provided at The Grange University Hospital and their experience of working there. In total, we received 65 responses from staff.

The response from staff was mixed in many areas such as management and equality, however areas that scored well included patient care and governance. Many staff were satisfied with the quality of care and support they give to patients (55/65) although fewer felt on the whole, the organisation is supportive (42/65).

Very few staff that responded to the HIW survey felt there are enough staff for them to do their job properly (14/65). There were several comments on staffing issues these included:

"The staff work well under pressure but due to staff shortages it's the majority of the time impossible to have breaks"

Senior management informed us of challenges related to recruitment and told us of initiatives to support recruitment, flexible working patterns and staff retention.

The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.

We spoke to many staff at all levels during the inspection that shared their need for a staff room or a dedicated and appropriate space within the workplace for breaks and meals. Some also us that there was an absence of dedicated desk space on the unit available for all staff to use.

The health board must review and improve spaces available for staff to take time out from clinical area.

Staff comments included the following:

> *"ABUHB Maternity Services is a really great place to work. The provisions are outstanding and the service users love the single room environment with en-suite facilities. I feel well supported by my line manager"*
>
> *"Lack of private desk space and handover areas is a concern , also having a cupboard as a staff rest area is not ideal."*

"The ward was not built with an on ward "staff" room so a very small stock cupboard was converted into a "coffee" room which had no ventilation/windows"

We asked what could be done to improve the service. Comments included the following:

"Training is at times expected to be done in your own time"

"Design of the whole unit is not ideal. There is not enough bed capacity since the merger"

Leadership

Governance and Leadership

We saw a clear management structure in place with clear lines of reporting and accountability. We saw many examples of effective and efficient multidisciplinary working without hierarchy whilst on the unit. Many staff that we spoke to during the inspection said that they felt that they could approach their managers and senior leaders were approachable, friendly and kind.

Our survey indicated that many staff felt that their immediate manager could be counted on to help with a difficult task (47/65) although fewer staff felt that their immediate manager consulted with them before making decisions that affected their work (27/65)

Around half of staff felt that senior managers were visible (37/65) however fewer respondents felt communication between senior management and staff was effective (21/65).

We spoke to obstetricians and midwives at all levels during the inspection and all gave a positive experience of working at the Grange. They commented on effective communications with the senior leadership team and felt that working relationships were positive.

Workforce

Skilled and Enabled Workforce

We met a committed and professional team focussed on provided safe and effective patient care. We saw evidence that 80% of staff had received an appraisal or review in the last 12 months and this was consistent with the staff responses to the HIW survey.

Whilst we saw evidence that mandatory training levels were improving, we noted that, at the time of inspection, mandatory cardiotocography (CTG) training levels was low at 52% and Gap and Grow (foetal growth assessment) training was also low at 49% compliance.

This meant that we were not assured that all staff had the relevant up to date training and skills to provide safe care and treatment to all women and babies in their care.

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

We saw evidence of training and development opportunities being offered to staff members at all levels. This included new and innovative training opportunities.

Many of the staff that responded to the HIW survey felt that they had appropriate training to undertake their role (46/65).

During the inspection we saw evidence of several initiatives to improve patient experience or efficiencies that had been led by team members and rolled out across the unit.

We noted that the system used to monitor training compliance levels was difficult to interpret and we were told that a new system was being rolled out to ensure that mandatory training compliance levels were tracked, current and easily accessible for staff and leaders.

The health board should implement or improve the system / matrix for the tracking of staff training.

Culture

People engagement, feedback and learning
We saw that there was a comments box available on most wards as well as Putting Things Right information for those that wished to comment on their experiences within the department. We spoke with the patient experience midwife who confirmed comprehensive processes in place to capture, monitor, share and learn from complaints and feedback. We reviewed evidence of positive and negative feedback and reviewed learning that had been delivered as a result.
We reviewed information from the Babi patient experience group that indicated that patient voices and experiences are used to shape services.

Staff that we spoke to said that they were encouraged to feedback and raise any concerns. Processes and responsibilities were clear and effective. All staff that we

spoke to confirmed how to report concerns or incidents and none indicated that they had met any barriers. It was confirmed that following any investigations good practice as well as improvements were fed back to staff involved.

Patient feedback is also routinely fed back to staff.

We heard several examples from staff and leaders whereby improvements had been suggested and then accepted and implemented across the unit. **One example of good practice was the recommendation from a midwife to establish a "welcome desk" to the ward to welcome patients into the department. Where previously there had not been any reception area. This ensured that patients and families felt welcome.**

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 within the unit.

On the first night of the inspection, we saw two sets of patient notes unattended in the postnatal area. On 7th June we removed an elective caesarean section list in the general waste bin in the doctors workroom.

We were not assured that patient confidentiality was adhered to and patient information was store and disposed of in line with GDPR requirements.

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

We were told that all staff had their own computer access login to help ensure information governance was maintained.

Learning, improvement and research

Quality improvement activities

Leaders confirmed that many quality improvement activities took place. We heard from the consultant midwife who confirmed effective engagement with research projects. Senior leaders told us of plans to improve services further, scoping opportunities and support for a range of initiatives.

Whole system approach

Partnership working and development

We saw evidence of effective partnership working both within the hospital and health board and with outside agencies. Staff confirmed that some challenges and delays with partnership working had occurred during Covid-19 pandemic however these were now easing.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Maternity Unit, The Grange University Hospital

Date of inspection: 6 - 8 June 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Resuscitaire checking **On 6 June 2023, HIW identified daily checks of a resuscitaire in use on the maternity unit on B3 (between purple and yellow areas) had not been recorded daily. HIW is not assured that daily checks were being conducted on all equipment to identify equipment faults for equipment that may be required in the event of an emergency.**	The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure that all equipment is safe to use, functioning effectively and checked on a daily basis.	1) Fridge checks will be signed and dated daily by the midwife/HCSW and countersigned by the Senior Midwife at the end of each working week to ensure compliance is maintained. 2) All maternity staff have been reminded, via email, of the importance of daily temperature checks. 3) The requirement to undertake and record daily equipment checks of the resuscitaire and emergency	Senior Midwifery Manager	Immediate - action complete

Medicine Storage

HIW identified daily checks of the fridge temperature for the medicine fridge in use in the Birth Centre had not always been recorded. We saw add two out of six days were not consistently recorded in June 2023.

The Medicines Management Policy Code of Practice Issue 4.1 provided to HIW refers to medicines refrigerators. The code states (12.2) that medicines refrigerators must have the temperature monitored and recorded daily.

HIW is not assured ongoing monitoring of the temperatures of all medication fridges on the maternity unit being conducted to check and

equipment has been reinforced with midwifery staff across the Division via email.

4) In addition to the daily checking and signing, the recording sheets will be countersigned by the Senior Midwifery Manager weekly.

5) The importance of checking fridge temperatures, and undertaking resuscitaire and emergency equipment checks will be reinforced at the next Ward Team Meeting on 15th June 2023 and additionally via the clinical supervision route.

6) Regular spot checks to be undertaken by the Divisional Leadership and Management Team to ensure full compliance with daily checking requirements for fridge temperatures,

demonstrate medicines are being stored at an appropriate temperature according to the manufacturer's instructions. This poses a potential risk to the safety and wellbeing of patients who may receive medication that has not be stored appropriately and so may not be as effective when used for treatment.		resuscitaire and emergency equipment.		
Infection prevention and control **On 6 June 2023 in 2 unoccupied delivery rooms, we observed blood stains on some furniture and fittings. In one room this was on the underside of the bed, light handle and trolley. In another room this was on the cot. Dated labels indicated that these rooms had been cleaned, however this cleaning was insufficient given**	The health board is required to provide HIW with details of the action taken to promote effective infection prevention and control and decontamination.	7) Cleaning standards will be upheld across all areas of the department, including clinical and non-clinical areas. 8) All staff have been reminded of the importance to ensure standards and processes for ensuring effective cleaning uphold infection prevention and control standards Copies of all cleaning regimes are displayed in cleaning rooms and audited monthly via symbiotics.	Head of Midwifery	Immediate – action complete

the visible blood that was seen. **HIW is not assured effective processes were in place or being followed to prevent healthcare acquired infections.**		9) The importance of cleaning standards will be reinforced at the next Ward Team Meeting on 15th June 2023 and additionally via the clinical supervision route. 10) A rotational HPV decontamination program of bed cleaning has been generated on a rotational basis by facilities. This will commence on Monday 19th June. 11) Additional cleaning support initiated, with the support of facilities, with immediate effect to raise standards. Commenced 9th June 2023. 12) All rooms cleaned daily and records maintained to demonstrate compliance, a clean sticker placed on doors when rooms are thoroughly cleaned.	

		13) Collaborative approach between the Divisional Leadership Team, IPAC and Facilities has been reinforced to ensure standards of cleanliness are consistently maintained and monitored through cleaning audits.		
Patient records **On 8 June 2023, in the domestic waste bin in the Doctors workroom, we saw an elective c-section list with personal patient information detailed.** **On 6 and 7 June 2023 we saw unattended patient records in the postnatal area of the unit.** **HIW are not assured confidential patient information is consistently used, stored and disposed of in line with GDPR.**	The health board is required to provide HIW with details of the action taken to provide assurance that documentation is stored in line with GDPR.	14) Mandatory Information Governance Training compliance is 73.99% as recorded on ESR. This will be under constant review to ensure increased compliance. 15) Current confidential waste bags will be replaced by secure confidential waste bins with locks. 15 have been ordered and will be placed in all clinical and office areas. 16) All staff have been formally reminded of their information governance responsibilities and of the correct and safe storage of	Assistant Service Manager Assistant Service Manager Assistant Service Manager	Immediate - action complete Ordered 13 June 2023 9 June 2023

		patient information, via email.		
		17) Information governance responsibilities for all staff will be an agenda item for future team meetings and clinical governance meeting on Friday 16th June.	Assistant Service Manager	16 June 2023
		18) An Information Governance notice has been issued on the hospital intranet, to reinforce the importance of upholding and protecting patient information, access to records and the security of confidential waste. This email was shared with all our medical staff and also shared at Clinical Governance where there is multidisciplinary engagement.	Head of Information Governance	13 June 2023
		19) Notes trolleys have been removed and all patient notes will be kept in the room		13 June 2023

		with the women or birthing person.	Senior Midwifery Manager	
Mandatory training compliance **Essential mandatory training was not to required standards.** • **CTG training compliance was low at 52%** • **Gap and Grow – foetal growth assessment training was also low at 49%.** **This meant that we were not assured that all staff had the relevant up to date training and skills to provide safe care and treatment** **to all women and babies in their care.**	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.	20) Foetal 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. 21) An assessment of the Foetal Surveillance lead midwife hours will be undertaken to review the opportunity to increase working hours. 22) GAP and GROW will be mandated as of September 23. 23) Perinatal Institute contacted 6.5.23 and 5 additional funded training places for the NGUS Gap and	Head of Midwifery Head of Midwifery Head of Midwifery Head of Midwifery	July 2023 July 2023 September 2023 Sent for Expressions of

		Grow, at the National GAP User Symposium for Friday 15 September.		interest 9 June 2023
		24) Further reconciliation of training data will be undertaken to ensure all compliance has been received and recorded on the database which will inform future training requirements.	Senior Midwifery Manager	Immediate – action complete Sept 2023
		25) 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.	Digital lead Midwife	
		26) The new database development will be reviewed at the next Senior Management Team Meeting on 20th June 2023.	Digital lead Midwife	20 June 2023 Sent on 9 June 2023

		27) All staff have been emailed about staff training compliance and have been asked to provide evidence by the end of July 23.	Assistant Service Manager

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Jayne Beasley**

Job role: **Head of Midwifery**

Date: **13 June 2023**

Appendix C - Improvement plan

Service: Maternity Unit, The Grange University Hospital

Date of inspection: 6 - 8 June 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Limited availability of Birth pools For the maternity unit, one birth pool is available. This limits the choice of people that may like to use water during labour	Review, and consider increasing the availability of birth pools within the unit	Liaise with facilities and request a quotation to move the pool from another hospital to support additional capacity at GUH to meet demand.	Assistant Service Manager	Subject to approval 6 weeks for costings. Minor Works ticket raised 28.07.2023
Visiting times Around half of HIW patient survey respondents told us that they felt that visiting times were not sufficient	Review visiting arrangements and communicate timings effectively with families ahead of admission	Additional visiting times has been introduced to support additional family members to visit the ward area. Information has also been cascaded on our social media	Senior Management Team	Completed - updated visiting poster

		platforms and displayed in all clinical areas.		
Capacity - post natal beds Many staff told us of challenges around limited post-natal bed capacity negatively impacting on patient flow	The health board should review post-natal bed capacity and mitigate any risks associated with capacity shortages to ensure that safe and effective patient care is maintained.	The Health Board are working with the neonatal team by introducing E-discharging for babies. This will expedite the discharge process and improve patient flow.	Lead Midwives Postnatal Ward	Full implementation and in place by the 16th September 2023
		The Health Board are implementing a staggered approach to Elective Caesarean Section as a pilot.		25th July 2023
		A midwife will be allocated on the roster to undertake Neonatal and Infant Physical Examination (IPE) checks to improve patient flow, this will commence in August		4th August 2023
Bereavement service Conversations with staff indicated that this service did	The health board should review bereavement services to benchmark their services and	A review across Wales has identified that only one health board has a dedicated	Head of Midwifery Clinical Director	

not have a dedicated medical lead and capacity was limited	capacity against similar maternity units	Obstetric lead supporting this provision. The Health Board have a dedicated bereavement Midwife Band 7 full time in post to support families with baby loss.		Complete
Named staff on shift Limited information seen for patients that detailed who was delivering their care	The health board should implement a system to ensure that patients are aware of staff on shift and the leadership team within the department	A leadership board will be made visible on the entrance to each ward area. Midwives providing care to women will write their name on the notice board in the women and birthing peoples rooms. All staff wear name badges.	Senior Management Team Senior Midwives	End of August 2023
Fire doors to storage We noted that fire doors to storage areas were not routinely closed and could pose a risk to those on the unit	Implement measures to ensure that all fire doors to cleaning cupboards are closed	Staff have been reminded of the importance of ensuring fire doors and cleaning cupboards are closed at all times.	All staff	Email shared 24.07.2023 and a notice placed on doors to keep closed

		Spot checks will be undertaken by the senior team.		Door Closed.pdf
Specialist midwife roles capacity A wide range of specialist midwife roles (including safeguarding, clinical governance, concerns, public health, mental health) were in place. These roles were often individuals that, during periods of absence, did not receive substantial cover	Review capacity and succession planning for all specialist midwife roles	The Senior Management Team are reviewing succession planning by introducing a shared lead role option. This opportunity will allow staff to maintain their clinical skills and also help develop them to in lead roles as part of succession planning. Midwifery will benchmark with other Health boards	Senior Management Team	December 2023
Medical equipment Around half of the staff that answered the survey told us that they did not have sufficient access to appropriate medical equipment to enable them to provide effective care	The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment	A review of the medical equipment in the clinical areas has been undertaken and the necessary essential equipment has been ordered of stethoscopes and BP cuffs in all sizes.	Ward Clerks	Complete - orders placed

Audit systems We saw evidence of a new system for auditing and tracking IPC audits. This was not yet embedded	The health board must ensure that audit processes within the new system are structured, effective, tracked and monitored to drive improvement	The unit has a structured decontamination process in place supported by the facilities team, which is ongoing until the 4th August. Going forward the unit will be included in the yearly programme. Training has taken place with HCSW to ensure that hand hygiene audits are being completed. AMAT training sessions have been undertaken with the lead midwives to ensure audit data is collected, tracked and monitored to achieve improvement daily. The lead midwives will cascade the training to staff by 14th August.	Senior Midwifery Manager IPAC Lead	On-going with regular monitoring 25th July 2023
Patient records	The health board must ensure that regular documentation audits are	Quarterly notes audits are undertaken by the Clinical Supervisors of Midwives to	Clinical Supervisors of Midwives	Completed

We saw inconsistencies within patient records around charts, sign off and organisation. This could lead to difficulties in ensuring safe ongoing care	conducted and learning takes place from the findings	ensure standards adheres the NMC Code of Conduct. Monthly audits are undertaken through the fundamentals of care platform.	Lead Midwives Head of Midwifery	
Elective caesarean section arrangements We noted logistical challenges with commencement of caesarean section lists that may lead to inefficiencies	The health board should review the options for bringing elective caesarean patients through to recovery bay earlier (prior to briefing) to minimise delays	A staggered approach of the caesarean lists will be commenced on Tuesday 25th July and trialled for 4 weeks to improve bed flow and patient satisfaction	Lead Midwives	Ongoing commencing 25th July 2023
Training compliance tracking / monitoring	Improve system for tracking of staff training	Digital lead midwife has replaced the current database with a more interactive, visual and accurate representation of staff training. The new database will be rolled out in September. This is the beginning of the new educational year. There will	Digital Lead Midwife	Complete September 2023 rollout

		be an added functionality on the system to prompt staff when compliance requires renewal. PROMPT to be added to ESR to record compliance.		
Recruitment and retention of staff Very few staff that we spoke to and surveyed indicated that there were enough staff on the unit to allow them to do their job properly.	The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes	A monthly review of the workforce has been initiated and will continue. As part of the streamlining process, we have 24.4 WTE newly qualified Midwives commencing October 2023. One new specialist diabetic lead role advertised. The maternity unit have reviewed hours for fetal surveillance role. 1 WTE will be advertised. The maternity unit are working with the senior work force business partner to	Senior Midwifery Management	On-going with monthly review

		develop a structured work force plan.		
Space for staff Limited spaces were available on the unit for staff (of all levels) to take a break from the clinical area. This would be for wellbeing and / or to complete desk based work	Improve staff access to spaces to take time out from clinical area	There is a staff break room on C3 available for staff. We have also created a small staff break room on B3. A wellbeing area just off the main unit for staff to take breaks from the clinical environment is available. This space is well ventilated, well lit with chairs and tables. The maternity unit are in the process of creating more work space in the Senior Midwives office. The space will have additional worktop space with network and power points to enable agile working.	Assistant Service Manager	Complete Estimated completion 17th August 2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Jayne Beasley**

Job role: **Head of Midwifery**

Date: **26/07/2023**

Immediate improvement plan

Service: The Grange University Hospital
Area: Maternity Unit
Date of Inspection: 6 - 8 June 2023
Improvement plan update: 26th September 2023

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure that all equipment is safe to use, functioning effectively and checked on a daily basis.	**Safe**	1) Fridge checks will be signed and dated daily by the midwife/HCSW and countersigned by the Senior Midwife at the end of each working week to ensure compliance is maintained.	Senior Midwifery Manager	Immediate - action complete
		2) All maternity staff have been reminded, via email, of the importance of daily temperature checks.	Senior Midwifery Manager	Immediate - action complete
		3) The requirement to undertake and record daily equipment checks of the resuscitaire and emergency equipment has been reinforced with midwifery staff across the Division via email.	Senior Midwifery Manager	Immediate - action complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		4) In addition to the daily checking and signing, the recording sheets will be countersigned by the Senior Midwifery Manager weekly.	Senior Midwifery Manager	Immediate - action complete
		5) The importance of checking fridge temperatures, and undertaking resuscitaire and emergency equipment checks will be reinforced at the next Ward Team Meeting on 15th June 2023 and additionally via the clinical supervision route.	Senior Midwifery Manager	Immediate - action complete
		6) Regular spot checks to be undertaken by the Divisional Leadership and Management Team to ensure full compliance with daily checking requirements for fridge temperatures, resuscitaire and emergency equipment.	Senior Midwifery Manager	Immediate - action complete
The health board is required to provide HIW with details of the action taken to promote effective infection prevention and control and decontamination.	**Safe**	7) Cleaning standards will be upheld across all areas of the department, including clinical and non-clinical areas.	Head of Midwifery	Immediate - action complete
		8) All staff have been reminded of the importance to ensure standards and processes for ensuring effective cleaning uphold infection prevention and control standards Copies of all cleaning regimes are displayed in cleaning rooms and audited monthly via symbiotics.	Head of Midwifery	Immediate - action complete
		9) The importance of cleaning standards will be reinforced at the next Ward Team Meeting on 15th June 2023 and additionally via the clinical supervision route.	Head of Midwifery	Complete
		10) A rotational HPV decontamination program of bed cleaning has been generated on a rotational basis by facilities. This will commence on Monday 19th June.	Head of Midwifery	Complete. We are now part of the HPV cleaning regime and

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
				the wards will be deep cleaned regularly.
		11) Additional cleaning support initiated, with the support of facilities, with immediate effect to raise standards. Commenced 9th June 2023.	Head of Midwifery	Complete Ongoing
		12) All rooms cleaned daily and records maintained to demonstrate compliance, a clean sticker placed on doors when rooms are thoroughly cleaned.	Head of Midwifery	Immediate – action complete
		13) Collaborative approach between the Divisional Leadership Team, IPAC and Facilities has been reinforced to ensure standards of cleanliness are consistently maintained and monitored through cleaning audits.	Head of Midwifery	Immediate – action complete

Findings:

Resuscitaire checking

On 6 June 2023, HIW identified daily checks of a resuscitaire in use on the maternity unit on B3 (between purple and yellow areas) had not been recorded daily. HIW is not assured that daily checks were being conducted on all equipment to identify equipment faults for equipment that may be required in the event of an emergency.

Medicine Storage

HIW identified daily checks of the fridge temperature for the medicine fridge in use in the Birth Centre had not always been recorded. We saw add two out of six days were not consistently recorded in June 2023.

The Medicines Management Policy Code of Practice Issue 4.1 provided to HIW refers to medicines refrigerators. The code states (12.2) that medicines refrigerators must have the temperature monitored and recorded daily.

HIW is not assured ongoing monitoring of the temperatures of all medication fridges on the maternity unit being conducted to check and demonstrate medicines are being stored at an appropriate temperature according to the manufacturer's instructions. This poses a potential risk

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
to the safety and wellbeing of patients who may receive medication that has not be stored appropriately and so may not be as effective when used for treatment. **Infection prevention and control** On 6 June 2023 in 2 unoccupied delivery rooms, we observed blood stains on some furniture and fittings. In one room this was on the underside of the bed, light handle and trolley. In another room this was on the cot. Dated labels indicated that these rooms had been cleaned, however this cleaning was insufficient given the visible blood that was seen. HIW is not assured effective processes were in place or being followed to prevent healthcare acquired infections.				
Quality of management and leadership				
The health board is required to provide HIW with details of the action taken to provide assurance that documentation is stored in line with GDPR.	Safe	14) Mandatory Information Governance Training compliance is 73.99% as recorded on ESR. This will be under constant review to ensure increased compliance.	Assistant Service Manager	Immediate – action complete
		15) Current confidential waste bags will be replaced by secure confidential waste bins with locks. 15 have been ordered and will be placed in all clinical and office areas.	Assistant Service Manager	Complete
		16) All staff have been formally reminded of their information governance responsibilities and of the correct and safe storage of patient information, via email.	Assistant Service Manager	Complete
		17) Information governance responsibilities for all staff will be an agenda item for future team meetings and clinical governance meeting on 26th September 2023	Assistant Service Manager	Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		18) An Information Governance notice has been issued on the hospital intranet, to reinforce the importance of upholding and protecting patient information, access to records and the security of confidential waste. This email was shared with all our medical staff and also shared at Clinical Governance where there is multidisciplinary engagement.	Head of Information Governance	Complete
		19) Notes trolleys have been removed and all patient notes will be kept in the room with the women or birthing person.	Senior Midwifery Manager	Complete
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.	Safe	20) 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.	Head of Midwifery	Complete
		21) An assessment of the Fetal Surveillance lead midwife hours will be undertaken to review the opportunity to increase working hours.	Head of Midwifery	Complete – full time hours allocated awaiting JD signoff
		22) GAP and GROW will be mandated as of September 23.	Head of Midwifery	September 2023
		23) Perinatal Institute contacted 6.5.23 and 5 additional funded training places for the NGUS Gap and Grow, at the National GAP User Symposium for Friday 15 September.	Head of Midwifery	5 places allocated Complete

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		24) Further reconciliation of training data will be undertaken to ensure all compliance has been received and recorded on the database which will inform future training requirements.	Senior Midwifery Manager	Immediate – action complete
		25) 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.	Digital Lead Midwife	Complete. Database up and working well
		26) The new database development will be reviewed at the next Senior Management Team Meeting on 20th June 2023.		Complete
		27) All staff have been emailed about staff training compliance and have been asked to provide evidence by the end of July 23.	Assistant Service Manager	Complete

Findings
Patient records
On 8 June 2023, in the domestic waste bin in the Doctors workroom, we saw an elective c-section list with personal patient information detailed.
On 6 and 7 June 2023 we saw unattended patient records in the postnatal area of the unit.
HIW are not assured confidential patient information is consistently used, stored and disposed of in line with GDPR.

Mandatory training compliance
Essential mandatory training was not to required standards.

- CTG training compliance was low at 52% - this has now increased at currently at 84%
- Gap and Grow – foetal growth assessment training was also low at 49%. – this is now currently at 60%overall and 71% for community midwives.

This meant that we were not assured that all staff had the relevant up to date training and skills to provide safe care and treatment to all women and babies in their care.

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

All immediate assurances noted will be shared and discussed at the multidisciplinary meeting - Clinical Governance on 16th June 2023. Also shared at Maternity and Neonatal Assurance Group Meeting on 19th September 2023.

Health Board Representative:

Name (print):	**Jayne Beasley**
Role:	**Head of Midwifery**
Date:	**13 June 2023**

Appendix C - Improvement plan

Service: **Maternity Unit, The Grange University Hospital**

Date of inspection: **6 - 8 June 2023**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Limited availability of Birth pools For the maternity unit, one birth pool is available. This limits the choice of people that may like to use water during labour	Review, and consider increasing the availability of birth pools within the unit	Liaise with facilities and request a quotation to move the pool from another hospital to support additional capacity at GUH to meet demand.	Assistant Service Manager	Subject to approval 6 weeks for costings. Minor Works ticket raised 28.07.2023 Update: The request to locate the RGH birthing pool into GUH was approved at accommodation group – awaiting costing from W&E

Visiting times Around half of HIW patient survey respondents told us that they felt that visiting times were not sufficient	Review visiting arrangements and communicate timings effectively with families ahead of admission	Additional visiting times has been introduced to support additional family members to visit the ward area. Information has also been cascaded on our social media platforms and displayed in all clinical areas.	Senior Management Team	Completed - updated visiting poster  Visiting Guidance.zip
Capacity - post natal beds Many staff told us of challenges around limited post-natal bed capacity negatively impacting on patient flow	The health board should review post-natal bed capacity and mitigate any risks associated with capacity shortages to ensure that safe and effective patient care is maintained.	The Health Board are working with the neonatal team by introducing E-discharging for babies. This will expedite the discharge process and improve patient flow.	Lead Midwives Postnatal Ward	Full implementation and in place by the 16th September 2023. Update: Neonatal staff still to be trained. Training planned for 1st November 2023
		The Health Board are implementing a staggered approach to Elective Caesarean Section as a pilot.		25th July 2023 Update: Pilot complete, however due to

				issues with ensuring women were prepped adequately for their surgery an alternative approach has been commenced :use of room 1 for cohort of women prior to elective caesarean section. This has proved successful in ensuring bed capacity at 08:00 when the women are admitted and whilst discharges are being planned.
		A midwife will be allocated on the roster to undertake Neonatal and Infant Physical Examination (IPE) checks to improve patient flow, this will commence in August		4th August 2023 Update: Complete

Bereavement service Conversations with staff indicated that this service did not have a dedicated medical lead and capacity was limited	The health board should review bereavement services to benchmark their services and capacity against similar maternity units	A review across Wales has identified that only one health board has a dedicated Obstetric lead supporting this provision. The Health Board have a dedicated bereavement Midwife Band 7 full time in post to support families with baby loss.	Head of Midwifery Clinical Director	Complete
Named staff on shift Limited information seen for patients that detailed who was delivering their care	The health board should implement a system to ensure that patients are aware of staff on shift and the leadership team within the department	A leadership board will be made visible on the entrance to each ward area. Midwives providing care to women will write their name on the notice board in the women and birthing peoples rooms. All staff wear name badges.	Senior Management Team Senior Midwives	End of August 2023 Update: Complete
Fire doors to storage We noted that fire doors to storage areas were not	Implement measures to ensure that all fire doors to cleaning cupboards are closed	Staff have been reminded of the importance of ensuring fire doors and cleaning	All staff	Email shared 24.07.2023 and a notice placed on

routinely closed and could pose a risk to those on the unit		cupboards are closed at all times. Spot checks will be undertaken by the senior team.		doors to keep closed Door Closed.pdf
Specialist midwife roles capacity A wide range of specialist midwife roles (including safeguarding, clinical governance, concerns, public health, mental health) were in place. These roles were often individuals that, during periods of absence, did not receive substantial cover	Review capacity and succession planning for all specialist midwife roles	The Senior Management Team are reviewing succession planning by introducing a shared lead role option. This opportunity will allow staff to maintain their clinical skills and also help develop them to in lead roles as part of succession planning. Midwifery will benchmark with other Health boards	Senior Management Team	December 2023 Update: Ongoing planning
Medical equipment Around half of the staff that answered the survey told us that they did not have sufficient access to appropriate medical	The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment	A review of the medical equipment in the clinical areas has been undertaken and the necessary essential equipment has been ordered	Ward Clerks	Complete - orders placed Update: Stock and equipment replenished

equipment to enable them to provide effective care		of stethoscopes and BP cuffs in all sizes.		
Audit systems We saw evidence of a new system for auditing and tracking IPC audits. This was not yet embedded	The health board must ensure that audit processes within the new system are structured, effective, tracked and monitored to drive improvement	The unit has a structured decontamination process in place supported by the facilities team, which is ongoing until the 4th August. Going forward the unit will be included in the yearly programme. Training has taken place with HCSW to ensure that hand hygiene audits are being completed. AMAT training sessions have been undertaken with the lead midwives to ensure audit data is collected, tracked and monitored to achieve improvement daily. The lead midwives will cascade the training to staff by 14th August.	Senior Midwifery Manager IPAC Lead	On-going with regular monitoring 25th July 2023 Update: Complete

Patient records We saw inconsistencies within patient records around charts, sign off and organisation. This could lead to difficulties in ensuring safe ongoing care	The health board must ensure that regular documentation audits are conducted and learning takes place from the findings	Quarterly notes audits are undertaken by the Clinical Supervisors of Midwives to ensure standards adheres the NMC Code of Conduct. Monthly audits are undertaken through the fundamentals of care platform.	Clinical Supervisors of Midwives Lead Midwives Head of Midwifery	Completed Maternity services are rolling out digitised records from October 3rd 2023.
Elective caesarean section arrangements We noted logistical challenges with commencement of caesarean section lists that may lead to inefficiencies	The health board should review the options for bringing elective caesarean patients through to recovery bay earlier (prior to briefing) to minimise delays	A staggered approach of the caesarean lists will be commenced on Tuesday 25th July and trialled for 4 weeks to improve bed flow and patient satisfaction	Lead Midwives	Ongoing commencing 25th July 2023 Update: Complete
Training compliance tracking / monitoring	Improve system for tracking of staff training	Digital lead midwife has replaced the current database with a more interactive, visual and accurate representation of staff training.	Digital Lead Midwife	Complete September 2023 rollout

		The new database will be rolled out in September. This is the beginning of the new educational year. There will be an added functionality on the system to prompt staff when compliance requires renewal. PROMPT to be added to ESR to record compliance.		Update: Complete and working well, awaiting PROMPT to be added to ESR
Recruitment and retention of staff Very few staff that we spoke to and surveyed indicated that there were enough staff on the unit to allow them to do their job properly.	The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes	A monthly review of the workforce has been initiated and will continue. As part of the streamlining process, we have 24.4 WTE newly qualified Midwives commencing October 2023. One new specialist diabetic lead role advertised. The maternity unit have reviewed hours for fetal surveillance role. 1 WTE will be advertised.	Senior Midwifery Management	On-going with monthly review Update: 27.7 WTE Midwife Vacancies as of 20.09.2023 Update: Appointed

		The maternity unit are working with the senior work force business partner to develop a structured work force plan.		
Space for staff Limited spaces were available on the unit for staff (of all levels) to take a break from the clinical area. This would be for wellbeing and / or to complete desk based work	Improve staff access to spaces to take time out from clinical area	There is a staff break room on C3 available for staff. We have also created a small staff break room on B3. A wellbeing area just off the main unit for staff to take breaks from the clinical environment is available. This space is well ventilated, well lit with chairs and tables. The maternity unit are in the process of creating more work space in the Senior Midwives office. The space will have additional worktop space with network and power points to enable agile working.	Assistant Service Manager	Complete Estimated completion 17th August 2023 Update: Installation of IT provision to

			support agile working 21.09.2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Jayne Beasley

Job role: Head of Midwifery

Date: 26/07/2023

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mat Neo Safety Support Programme Discovery Phase Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jayne Beasley, Head of Midwifery and Gynaecology

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Improving Together for Wales Maternity Neonatal Support Programme Cymru Discovery phase report was released in July 2023. It describes the findings of the discovery phase of the safety support programme, includes good practice and 124 areas for improvement across 16 themes. The purpose of this paper is to give the Division's response and actions following review of the report. Maternity and Neonatal actions, areas for consideration, resource challenges and risks are highlighted.

Important to note, an email from Welsh Government was received into the Health Board on the 25th August 2023, requesting that 13 of the 124 areas of improvement should to be prioritised and progressed at pace to provide assurance within Welsh Neonatal services following the recent criminal case involving Countess of Chester Hospital. Of the 13 areas of improvement 8 were considered to be solely the responsible of the Health Board of which 5 could be progressed without any additional resource.

Cefndir / Background

The MatNeo Safety Support Programme (MatNeoSSP) was launched in January 2022, with an aim to improve safety, experience and outcomes for maternity and neonatal care. With an integrated approach to maternity and neonatal care delivered through Improvement Cymru it is envisaged that a sustained culture of improvements will be embedded.

As part of the programme national and clinical leads were appointed and local safety champions were funded in each Health Board to begin the discovery phase of the programme. This commenced in December 2022 and was completed in February 2023, following site visits to Health Boards across Wales. The Discovery phase report titled 'Improving Together for Wales' was released in July 2023 and encompasses culture, learning, workforce and clinical outcome measures for mothers and babies.

Asesiad / Assessment

Improving Together for Wales phw.nhs.wales/services-and-teams/improvement-cymru/our-work/matneossp/report/ highlights numerous priorities and actions, applicable at local, regional and national levels, with timeframes - short term 6-12 months, medium term 1-2 years and long term up to 3 years.

Maternity and Neonatal services have been collaborating on a full and ongoing multidisciplinary review of the report. This has been compiled into a live working document, a priority plan, rated for ongoing assessment around improvement work, including timeframes.

The following table articulates the number of actions applicable at a local, reginal and national level:

Area of Responsibility	
Health Board	46
Health Board plus a combination of other organisations	48
Welsh Government	15
Welsh Government plus a combination of other organisations (not health)	9
HEIW	1
WHSCC	3
WAST	1
CHANTS/NWTS	1
	TOTAL: 124

All 124 actions have been RAG rated, progress and mitigation are aligned to each action (appendix 1). The 46 actions which sit purely within the remit of the Health Board have been RAG rated as follows:

RAG Rating Against 46 Actions		Short Term	Medium Term	Long Term
27		18	9	0
14		6	7	1
4		3	1	0
N/A				

RAG - GREEN

Of the 27 actions RAG rated green, 16 do not require any additional resource, 11 of the 27 require minimal resource however each one has been reviewed and mitigation applied to ensure safety, each of these tend to be categorised as 'could be considered' in the report as opposed to 'must be'.

Themes of the additional resource required aligned to those RAG rated green are as follows:

- Additional administrative support
- Responsibilities currently absorbed into people's substantive posts with a suggestion they could be considered as standalone posts.
- Funding required for accreditation
- Funding for a service improvement manager

RAG – AMBER

Of the 14 actions RAG rated amber, 4 do not require additional funding, the remaining 10 do.

Themes of the additional resource required aligned to those RAG rated amber are as follows:

- Data manager for NICU
- Freedom of speak champion for NICU
- Developing new roles – for example research midwives, service improvement managers, specialist roles, additional midwife sonographers, additional administrative roles
- Accreditation (BLISS baby charter)
- Job planning

RAG – RED

All 4 red RAG rated actions require additional funding to progress, 3 of which are short term actions, one of which is a medium-term action.

The main resource required to address those RAG rated red are:

- Job planning
- Additional funded session for Clinical Director/Lead or equivalent post to deliver against recommendations.
- Director of Midwifery to manage the strategic delivery of maternity services locally.

Priority Actions Following Countess of Chester Outcome

As stated earlier in the report, WG requested that 13 of the 124 actions required to be prioritised by way of assurance following the Countess of Chester criminal case. It is important for the purpose of this report to highlight the 8 actions which are within the gift of the Health Board to progress.

Priority Actions		
Action	**Resource Required**	**RAG**
Ensure maternity and neonatal services are a standing agenda item at all Health Board Quality and Safety Meetings. a. Ensuring discussion of themes, learning and action resulting from reported incidents, b. Review of the standardised perinatal quality surveillance dashboard.	No	

Implement quarterly standardised leadership walk-arounds.	No	
All Health Boards to appoint and resource Obstetric and Neonatal Consultant Safety Leaders and a neonatal senior nurse to sit at a senior level within the organisation on Quality and Safety Boards and committees to create a floor-to-board link and ensure quad representation.	No	
All maternity & neonatal services to embed Psychological Safety and the principles of a Just Culture embedded as cultural norms.	No	
All maternity and neonatal units should appoint a Freedom to Speak Up Champion.	Yes	
Health Boards to collaborate and develop local dashboards, to include the standardised perinatal quality surveillance dashboard to enable real-time activity/outcome measurement and monitoring to support local improvements. A standardised perinatal quality surveillance dashboard would incorporate the following: • Clinical outcomes including stillbirths, neonatal deaths, HIE, ATAIN, SBLCBv2 progress and compliance. • Staffing vacancies for maternity and neonatal services for all relevant professional groups. •Training compliance. • Maternity and Neonatal Risk register	No	
All maternity and neonatal units to have robust governance team structure, with accountability and line management to the DoM and CDs. The team should include: e. a designated senior midwife/nurse and medical consultant leads for governance: f. with protected time allocated for fulfilling their roles including external review for PMRT, g. sufficient administrative support, h. and equitable allocation across both maternity and neonatal services.	Staffing Resource	
All incident investigators to be fully trained and competent to undertake their roles, to include consideration of training in: a. Systems Engineering Initiative for Patient Safety (SEIPS) b. Patient Safety Investigation Response Framework (PSIRF).	Staffing resource, Capital / revenue resource	

The actions described above will be given priority as per the Welsh Government directive, however the Divison will continue to progress all other actions and will give particular attention to those considered to be within the gift of the Health Board to advance.

Argymhelliad / Recommendation

The committee is asked to note:

- the ongoing collaborative work regarding maternity and neonatal services and the response to the Maternity Neonatal Support Programme.
- the actions to respond to Welsh Government regarding the events at the countess of Cheshire Hospital.
- the additional actions required to respond to the recommendations.

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):	1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 2. Safe Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Research, Innvoation, Imprevement, Value Choose an item. Choose an item.
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:	phw.nhs.wales/services-and-teams/improvement-cymru/our-work/matneossp/report/ Roles and responsibilities of the consultant workforce report (May 2022 update) (rcog.org.uk)
Rhestr Termau: Glossary of Terms:	GDM: gestational diabetes HbA1c: a blood test used to monitor blood glucose control in people with diabetes NICU: Neonatal intensive care unit SPA: supporting professional activity Transitional care: babies with feeding/IVs are cared for in their cot next to mother's bedside rather than on special care unit USS: ultrasound scan
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	Choose an item. 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 Choose an item.

No.	Priority	Action	Nature	Timescale	Status	Responsible	Resource Needed
1	1.1 Ensure Executive Board members and senior leaders are visible to, and have visibility of, maternity and neonatal services	A.Ensure maternity and neonatal services are a standing agenda item at all Health Board Quality and Safety Meetings. a. Ensuring discussion of themes, learning and action resulting from reported incidents, b. and review of the standardised perinatal quality surveillance dashboard.	Perinatal	Short term	Quarterly mat/neo assurance group and Quality and patient safety meetings embedded into service. Themes, learning and dashboard reviewed and monitored. Attendance at quarterly Divisional Quality & Safety meetings that contribute into Health Board meetings. Weekly multi-disciplinary Q&S meeting looking at themes. Monthly Q&S meeting (during Business meeting) looking at learning and actions – same emailed monthly to the neonatal team.	Health boards	No resource required
		B.All Health Boards to appoint a Director of Midwifery to manage the strategic delivery of maternity services locally.	Maternity	Medium term	Requires an executive nurse steer & All Wales CNO	Health boards	Resource needed
		C.Implement quarterly standardised leadership walk-arounds.	Perinatal	Short term	Lines of communication between division and Executive Team for review of quaterly walkarounds	Health boards	No resource required
		D. All Health Boards to appoint and resource Obstetric and Neonatal Consultant Safety Leaders and a neonatal senior nurse to sit at a senior level within the organisation on Quality and Safety Boards and committees to create a floor-to-board link and ensure quad representation.	Perinatal	Short term	?? Executive decision NICU has a safety leader but this role is as an interest within the Consultant SPA rather than separately resourced. Requires an exec-board link	Health boards	No resource required
	1.2 Ensure leadership and culture are optimised to improve maternity and neonatal teamworking	E.Ensure staff in recognised leadership roles have access to leadership training which includes content on culture and the principles of high performing teams and that resourcing for higher/additional qualifications is supported.	Perinatal	Medium term	Academy leadership programme in place for band 7 and 8. Staff in leadership roles supported to attend recognised programmes, ie HEIW leadership. Leadership training encouraged for all Band 7 NICU nurses Maternity have allocated education and development opportunities which supports 20 USW modules per year, supported to level 7. Regular funding is secured and allocated to support neonatal nurses becoming Qualified in Specialty at either level 6 or 7. leadership programme in place for consultants to take up leadership roles - CDX leadership course	Health boards, NHS Executive, HEIW	Minimal resource
		F.Ensure structures and ways of working, including co-location, which enable midwifery, obstetric and neonatal leads to regularly meet, share, and learn together.	Perinatal	Medium term	Maternity and neonatal co located, this supports regular communication. Twice daily in person meet plus telephone communication with lead nurse and labour ward coordinator regarding activity and updates in place. Watch list created to support review of activity (needs re-energising). Participation in 3 x weekly cot meetings. Shared learning within forums including Perinatal Mortality Review meeting, Maternity and Obstetric Clinical Governance meeting, and HIE Morbidity review meeting	Health boards, NHS Executive	Minimal resource
	1.3 Develop a National Improvement Collaborative for Maternity and Neonatal Services in Wales	G.Ensure improvement-related recommendations from MatNeoSSP Discovery Phase are subject to a test, scale and spread methodology across NHS Wales.	Perinatal	Long term	MatNeoSSP champions in place in both maternity and neonatal services. NICU champion currently looking to spread and share the relevant 'Bright spots' that have been identified. A new monthly Quality Improvement meeting has been introduced on NICU where all QI work can be discussed and monitored.	NHS Executive	How Champions work together
	2.1 Develop a workforce strategy for NHS Wales maternity & neonatal services 2.2 Adherence to national workforce standards from BAPM, RCOG & RCM to deliver optimal care	A.National workforce planning to establish safe standards of care for midwifery, obstetric and neonatal workforce (to include recruitment, retention and training). Strategy to ensure: a. Minimum staffing levels include locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, study leave annual leave and maternity leave. b. NICUs (neonatal intensive care unit) have direct clinical care provision of 12-hour consultant cover over 7 days. c. Maternity units have enough staff to facilitate a consultant ward round every 12 hours. d. Allied Health Professional roles are embedded within services in line with national standards. e. Facilitation of new models of medical care (e.g., Physician's Associates, ANNPs on Tier 2 and nurse consultant roles). f. Facilitation of clear career progression for non-qualified and qualified workforce.	Perinatal	Medium term	A monthly review of workforce initiated and is ongoing, work in place with senior workforce business partner to develop structured workforce plan. Recent birth rate plus completed, with calculated 26.6% uplift includes additional training and focus on specialist posts. Prudent recruitment agreed by Health Board, 29 WTE requested though streamlining did not achieve recruitment above predicted vacancies. C) 78 hours /per week of consultant cover in place to facilitate patient review. (12 hours Monday – Friday with 7.5 hours allocated per weekend with on call out of hours. Further hours would require additional funding/ review of job planning. E) PAs in O and G Nov 2023 x 2 F) National and local workstreams in progress to explore the role of non-registrant Band 4 practitioners. Maternity services developing champion roles as part of succession planning and support specialist services. Establishment for NICU staffing is in-line with BAPM standards based on cot numbers and includes 27% uplift. Prudent recruitment agreed by Health Board, 10 WTE requested though streamlining and all places filled. 12hr Consultant cover Mon-Fri but not at weekends unless clinically required during on-call time. Would need investment of 2-4 sessions per week to achieve 7 day cover. d) Minimal dedicated AHPs within Neonatal Services. A business case has been prepared by Therapies. e) Physician assistant role considered within Division but would need investment. NICU has x1 ANNP working on the Tier 2 rota, and one other transitioning to work at this level. f) Career progression discussed during annual PADR process. Support given to Nursery Nurses to develop new roles such as oral medication administration etc. Career development training sessions in place for midwives, band 4 in place on maternity, review of band 3 MSW is under review.	Health boards, NHS Executive, HEIW	Obstetrcis would require additional resource to fund 12 hours cover to include weekend. Neonatal requires resource to achieve 12 hr consultant cover. Would need a sessional uplift AHP- requires resource, business case developed.
		B.Ensure the Maternity & Neonatal Network is structured to deliver its defined responsibilities under the NHS Executive Mandate and resourced adequately with Medical and AHP leads including a lead Pharmacist.	Perinatal	Medium term	Maternity & Neonatal Network	NHS Executive	
		C.Annual review of workforce collated as part of Maternity and Neonatal Network workforce review.	Perinatal	Short term	Work in place with senior business partner for F&T Workforce data collated and reviewed as part of Wales Maternity & Neonatal Network	NHS Executive	

2	2.3 Local workforce planning and team structures ensure sufficient capacity and prudent use of skills for high quality care	D.Health Boards to undertake annual working patterns survey to explore inefficiencies and use results to review system waste and ensure prudent deployment of all roles, e.g., ensuring sufficient administrative staff.	Perinatal	Short term	Maternity services have recently undertaken working pattern survey in relation to 12 hours across the Health Board. Currently piloting 10 hours shifts in community. Review of admin support has created Roster creator within maternity services, freeing band 7 from undertaking this role. Self-rostering recently commenced in NICU. Pre-change satisfaction surveys completed. Post-change surveys planned for future. Roster manager in role to ensure roster is always updated and staffing levels are safe. Minimal admin staff at evenings and weekends for NICU Medical e-systems roll out and job planning around emergency workstreams	Health boards, HEIW	Minimal resource
		E.All NICUs to have a Clinical Director/Lead or equivalent post with a minimum of two funded sessions to deliver against recommendations.	Neonatal	Short term	NICU Clinical Director only has one funded session - 1 fundedsession for obstetric lead consultant and 2 funded sessions for CD in O&G	Health boards	Resource required All CD's have 1 standard session, not deemed to be unsafe.
		F.All Maternity Units to have a Clinical Director with sessional allocation in line with RCOG recommendations.	Maternity	Short term	Clinical Director in place for Maternity with sessional allocation	Health boards	Resource required note deemed unsafe
		G.All Health Boards must allocate adequate SPA time for consultants. This allocation should aim to adhere to the accepted standard of 7:3 DCC (Direct Clinical Care): SPA, with additional time allocated for specific extra lead roles undertaken (e.g., governance, data, Perinatal Mortality Review Tool).	Perinatal	Short term	Consultants have a ratio of 7.5:2.5 No extra time allocated for extra lead roles.)&G 2 allocated SPA and 3rd based on leadership roles. Additional given for governance and labour ward lead ect .	Health boards	Requires Job planning in line BMA and Welsh Contract terms - not deemed unsafe
		H.All NICUs should have a data manager with consideration of data management input for SCUs.	Neonatal	Medium term	No data manager for NICU.	Health boards	Resource required. Service improvement managers in place. Encompassed within roles within SPA and Nursing time to review data.
	2.4 Prioritise the wellbeing and safety of staff and patients through team culture and support mechanisms	I.NHS Wales to ensure provision of psychological support, within each maternity department and neonatal unit for all maternity and neonatal staff.	Perinatal	Short term	Wellbeing peer supporters within maternity supporting all grades. QR codes have been created and placed in all areas to report concerns with incivility. 2.4 WTE clinical supervisors for midwives in post to support staff with wellbeing, and a no blame culture Wellbeing information board visible for all (staff, parents & visitors) on NICU. No psychologist for NICU for parents or staff support. Support only available from charities etc. Organisational Well Being Support, Canopi, Melo. 2 WISH for parents, siblings and staff.	Health boards, WHSSC	Changed to amber as no psychologist (CP) would required resource
		J.Inform future workforce strategies and workforce planning by maximising standardised exit interview uptake, reporting and taking action to address themes both locally and at national level.	Perinatal	Short term	Exit interviews undertaken by line manager and /or clinical supervisor for midwives. Themes discussed with senior team for review and action. Discussion held & link for exit interview given to all NICU staff	Health boards, HEIW	Minimal resource
		K.All maternity & neonatal services to embed Psychological Safety and the principles of a Just Culture embedded as cultural norms.	Perinatal	Long term	Civility, culture and psychological safety incorporated in to mandated training. In addition, maternity have delivered an ongoing programme of civility saves lives. From September 2023 this work is included in neonatal mandatory training	Health boards, NHS Executive, HEIW	Minimal resource
		L.All maternity and neonatal units should appoint a Freedom to Speak Up Champion.	Perinatal	Short term	The Division actively promote a learning culture, providing feedback to staff following the raising of issues. Everyone has the freedom to speak, and this is the ethos we instil in all staff. Clinical supervisors for midwives visible in clinical areas supervision sessions well embedded within the service. We also have a reporting system called Datix to report issues, but Gratix is also in operation to report good practice. No freedom to speak champion per se would require investment, health board has large geographical cover for maternity. No Freedom to Speak up champion in NICU – will need investment.	Health boards	Minimal resource required
		M.All maternity and neonatal units should implement an annual validated psychological safety survey e.g., SCORE, SAFE, with results shared, discussed and acted on at local team, unit, Health Board and national levels.	Perinatal	Short term	Health Board staff surveys ongoing. Maternity staff surveys yearly including civility and wellbeing. Mandated training regarding civility culture and wellbeing.	Health boards, NHS Executive	Minimal resource

3	3.1 Develop a national maternity and neonatal workforce training strategy. 3.2 Deliver national strategy through local training plans. 3.3 Ensure training, competence and qualification records are complete and reportable. 3.4 Ensure sufficient service capacity and opportunity for all members of maternity and neonatal workforce to be able to fulfil all training and development requirements.	A.Define national training/competency requirements and standards for each role within the maternity & neonatal workforce: Which includes but is not limited to adherence to mandatory training in: a. Equality & Diversity b. FiCare (see 7J) c.Human Factors d.Lactation & Loss (see 13G) e.Leadership (see 1E) f.Multiprofessional Simulation g.Neonatal Life Support h.Patient Safety (see 11FF) i.Perinatal mental health (see 5L) j.Quality Improvement (see 12A & 12H) k.Situational Awareness (see 11P) l.Team Working (including communication) (see 11P) Which addresses current deficits in relation to: m.Enhanced Maternal Care (see 11S) n.Incident Investigation (see 11FF) o.Radiology (see 12K) Which creates a: p.Development Toolkit for Neonatal Nurse training, including Qualified in Specialty. q.Standardised multidisciplinary simulation training package for midwifery, obstetric and neonatal teams to supplement local Neonatal Life Support (NLS) training.	Perinatal	Medium term	In progress	Health boards, HEIW, WRP	Minimal resource	
		B.Establish local training plans in each organisation to ensure that every member of the maternity and neonatal workforce has allocated time, capacity and opportunity to meet all nationally and locally defined training needs.	Perinatal	Medium term	Training plans are reviewed yearly by PDF and senior team and HOM. Monitoring of training via senior midwifery managers team meeting and spotlight on ELM. Training compliance monitored via dashboard and currently under review for addition to ESR. Monthly operational meetings are held on NICU which monitor training needs and compliance. Medical staff complete mandatory training and can apply for study leave in line with the policy.	Health boards	No resouce required	
		C.Ensure adequate administrative support is in place to maintain records of all staff training, competencies, and qualifications. These should be held centrally with in the Health Boards, reportable and reviewed at least annually for all staff.	Perinatal	Medium term	Digital lead midwife has replaced the current data base with more accurate representation of staff training. Work ongoing with ESR e system to ensure that all mandated study is included within the system. Staff and line manager prompted when compliance requires renewal automatically. No admin support available to support this on NICU however PDF staff maintain electronic records of training not captured on ESR.	Health boards	Resource needed	?admin support
		D.Ensure that all additional personal and professional training needs are recorded using local appraisal processes.	Perinatal	Short term	PADR process embedded in practice, currently 72%. Clinical supervisors for midwives and line managers support PADR process and discussion regarding mandated and professional training. Yrarly appraisal in place for O&G. Monthly operational meetings are held on NICU which monitor PADR compliance which is currently at 80% for nursing. Doctors appraised using MARS.	Health boards	No resource required	
4	4.1 Establish & deliver a Maternity and Neonatal research strategy for Wales to improve both short term neonatal and longer term child and adult outcomes	A.Develop an NHS Wales Maternity & Neonatal Research Strategy which: a.Is led by a centrally funded maternity & neonatal academic lead for Wales in a central facility. b.Establishes research partnerships within Wales and internationally. c.Accesses current data repositories within Wales. d.Ensures primary data is available in a timely manner to drive high quality care.	Perinatal	Long term	a) National work b) Aneurin Bevan University Health board has a well-established midwifery research team facilitating local and national portfolio studies, commercial studies, structured service evaluations and national audit. In addition to two experienced research midwives, supported by the Consultant Midwife. There are midwifery, sonography and obstetric research champions in all areas who are all GCP trained (Good Clinical Practice in research) and who raise awareness of studies with colleagues and service users, disseminate results locally and are able to screen, take informed consent and collect data for studies. The ABUHB maternity research team link in with national work. NICU participate in relevant research trials with support from the research team within the Health Board. NICU doesn't have any dedicated research time – medical or nursing. c.– national work ?Badgernet, peri-prem dashboard & NNAP d. – national work ?Badgernet, peri-prem dashboard & NNAP	Welsh Government	Resource needed	
		B.Expand opportunities for Maternity and Neonatal Trainees in Wales to undertake research and higher degrees.	Perinatal	Medium term	National work	HEIW	Resource needed	
		C.Ensure that members of the perinatal team who wish to be active researchers have support from their Clinical Leads/Directors with consideration of recognised research time in their job plans.	Perinatal	Short term	In Maternity there is a designated consultant lead for research and a team of research midwives. Research roles to be considered for future development in NICU.	Health boards	Resource needed	

5	5.1 Every woman to be as well as possible for, and during, pregnancy and supported to give children the best start in life	A.Resource and maintain clear service pathways between maternity services, Public Health Wales and primary care to support women to: a.Achieve and maintain a healthy weight, b.Access smoking cessation support services, before, during and after pregnancy.	Maternity	Medium term	Healthy weight management service delivered by a dietician, 2 Band 4 Healthcare support workers, and public health lead midwife. across all sites. Smoking cessation support service in all areas, advisors attend antenatal clinics weekly, this is an opt out service for the woman/birth people. This service is extended to family members in the same household. CO monitoring has been re-introduced into all antenatal clinics and community settings.	Health boards, PHW	Resource needed, funding from PH Wales re healthy weight programme programme ends 2024. awaiting further review re continuation.
	5.2 Review access to maternity care for all women, regardless of ethnicity, geography or socio-economic status or other protected characteristic.	B.All Health Boards to a.co-produce communications tailored for ethnic minority women in their communities, b.ensure rapid access to advice if women from an ethnic minority background are concerned about their health, c.and ensure all staff have a lower threshold to review, admit and consider multidisciplinary escalation in women from an ethnic minority background.	Maternity	Short term	In relation to measures and systems to support effective communication, hearing loops, face to face and 'The Big Word' translation services are provided. These facilities are readily available to all women who require this support. We offer a bilingual service whereby documentation being provided to the women and is available in English and Welsh. An Equality and Diversity Midwife is in post to lead the multicultural agenda. All women and birthing people have access to healthier together page which offers support in multi languages.131 languages. Pregnant/New Baby : Healthier Together (cymru.nhs.uk) The Public Health Midwife works closely with ABUHB Health Inclusion Service, and third sectors to support those seeking sanctuary.	Health boards	No resource required
		C.Ethnicity must be accurately recorded at booking and data used to monitor outcomes for women of different ethnic origins.	Maternity	Short term	Data system currently in use has mandated field for recording data. Service moving to digitalised records in October 2023, mandated field, will have real time data available to support ethnicity.	Health boards, NHS Executive	Minimal resource
		D.All Health Boards to implement use of the 'Healthier Together' website, or similar product, to provide advice and information translated into many languages.	Maternity	Medium term	Fully adopted into service	Health boards	No resource required
		E.All women with limited English language skills should be provided with a co-produced, maternity access card to advise them on how/where to attend an obstetric unit in case of a concern.	Maternity	Short term	Maternity Services monitor any concerns regarding access to information and/or language choice issues through formal/informal concerns, social media, surveys and feedback from the Llais and ensure action if deficits are identified.	Health boards	No resource required
		F.All Health Boards to invest in portable visual interpreting systems (functionality similar, but not limited to, those provided by Language Line). These should be accessible 24 hours a day so that they can be used in clinic, theatres, and neonatal units.	Perinatal	Short term	Interpreter services utilised; language line embedded into service. Sign live in place within maternity to support women with additional needs. I pads incorporated across the service which will allow audio visual translation services	Health boards	No resource required
		G.Maternity Voices Partnerships in each Health Board should consider becoming Maternity and Neonatal Voices Partnerships to reflect the common goals of both services.	Perinatal	Short term	Maternity services and NICU have independent service user groups, consideration to work in partnership , though recognising the specific needs of each individual group	Health boards	No resource required
		H.Each Health Board should engage with their local Maternity Voices Partnership volunteers to create points of contact in harder to reach communities.	Perinatal	Short term	The ABUHB Maternity Services BABI group is a multidisciplinary forum established to ensure that Maternity Services throughout Aneurin Bevan Health Board are met. The BABI group encourage women and their partners to join the committee and help shape and evolve the maternity services by listening to their views and experiences as service users. It also looks at a variety of issues raised by both service users and health professional members. The ABUHB BABI meets every 6 weeks, taking a blended approach of virtual meetings and face to face. Between 10 and 20 committee members attend each meeting and our minutes are distributed via our email distribution list. We discuss issues to do with the maternity care offered within Aneurin Bevan from conception, antenatal care, birth, and post-natal care and propose changes and improvements where these are necessary. The Chair also attends the Maternity Services Board Meetings every 3 months and annual Maternity Performance meetings in Welsh Government.	Health boards	No resource required as long as charitable donation continues to support
		I.Each Health Board to establish paid Chair & Deputy Chair Maternity Voices Partnership positions to embed co-production of services.	Perinatal	Short term	A chair and vice chair are in post; however, these are unpaid roles.	Health boards	Resource required. Service improvement manages in place. Encompassed within roles within SPA and Nursing time to review data.
		J.Establish an All Wales Maternity and Neonatal Service User Framework Group to ensure the voices of women and families are central to national co-production of services	Perinatal	Medium term	In progress	NHS Executive	Minimal resource
		K.Consideration should be given to NHS Wales procurement of digital tools to assist in accurate risk assessment for adverse pregnancy outcome in early pregnancy.	Maternity	Long term	All care plans, risk assessment and guidelines and policies will be incorporated within BadgerNet from October 2023.	NHS Executive, Welsh Government	Resource needed
	5.3 Prioritise women's mental health in all areas of contact antenatally and postnatally	L.All Health Boards to embed the Wales perinatal mental health programme and ensure all staff are trained, (see 3A) feel competent to ask about mental health and recognise importance of recording PNMH data including medication use.	Maternity	Medium term	The multidisciplinary perinatal mental health team have clear criteria for referral of women. ABUHB perinatal mental health team are developing 'Perinatal Champion' roles in midwifery which evolved from the two-year project on birth trauma. This role would involve increasing the knowledge and awareness of perinatal mental health presentations, interventions and being a link with the team and with colleagues who might need advice on perinatal mental health. MECC training mandated into study days from September 2023	NHS Executive, Health boards	Recognising the need but prioritised to higher need. Would require additional resource

6	6.1 Ensure all Health Boards embed The All-Wales Midwifery Led Care Guidance into practice	A.Gather place of birth data as defined in Section16 of the 'Auditable Standards' in the All-Wales Midwifery Led Care Guidelines. a.Benchmark data with 2011 Birthplace Study results. b.Analyse findings to identify variation/risks and use data to inform quality improvement activity and implementation of sustainable practice changes.	Maternity	Medium term	a.) The All-Wales MLC guidance is embedded in practice and updates have been shared in numerous forums, including clinical governance, mandatory training, empowering leads, senior midwifery managers, specialist midwife meetings, birth centre forums and nationally. An infographic of updates to the All-Wales MLC Guidelines was created and circulated to all staff. The new badgerNet system, is receiving modifications to ensure all birth data as defined in section 16 is easily recorded for audit purposes. Data is also gathered on the maternity dashboard. b.) weekly transfer meetings are held to identify key themes and provide a learning environment in relation to births on the MLC pathway. As a result, a physiological birth session has been included in mandatory training from September 2023 to ensure learning and findings from transfer meetings are actioned.	NHS Executive, Health boards	Minimal resource
	6.2 Develop mandated standards for Midwifery led units in Wales	B.Benchmark Freestanding and Alongside Midwifery Units in Wales against the Midwifery Unit Network published standards. C.Analyse findings to: a.Support development of NHS Wales Midwifery Led Unit Standards. b.Identify variation/risks and use data to inform quality improvement activity.	Maternity	Medium term	a.) The team have mapped the midwifery units against the MUN standards using a piloted maternity unit self-assessment tool (MUSA). b.) The team have contributed to European work to develop this tool, so therefore have been able to utilise in ABUHB.	NHS Executive	Self assessment tool only completed as a pilot
	6.3 Implement standardised informed decision-making aids across Wales	D.Agree and implement standardised decision-making aids to support women and families in making informed choices. e.g. BRAN (Choosing Wisely) or BAPM Enhancing Shared Decision Making Framework.	Perinatal	Medium term	**National**	NHS Executive, Health boards	Minimal resource
7	7.1 Families to be supported and enabled to stay together (where possible) when their baby requires support, investigation, or treatment	A.Develop a standardised mechanism for multidisciplinary maternity & neonatal teams to review ATAIN (Avoiding Term Admissions into Neonatal) rates. B.Establish and ensure ongoing thematic analysis of ATAIN C.Share findings/learning nationally and use data to inform quality improvement activity and implementation of sustainable practice changes. e.g., where upstream (antenatal) contributory factors have been identified engage with Public Health Wales and other stakeholders (i.e., smoking/obesity to ensure equitable care).	Perinatal	Medium term	ATAIN data presented and analysed monthly at perinatal mortality & morbidity meeting. An ANNP is the NICU ATAIN lead and has dedicated SPA time. Data used to support business case for Transitional Care Scope to link Public Health data See 5.1	NHS Executive, Health boards	Would be achieved but no transitional unit.
		D.Ensure adequate facilities and support provision for wider family members, e.g., playrooms and additional support for siblings.	Neonatal	Short term	NICU have a reclining chair available at most cot spaces. there are also 8 special care spaces that have a sofa bed and 3 additional rooming-in parent bedrooms. In addition, there are two parent accommodation houses (1 currently functional and well used) with scope for siblings to stay. There is a parent's room on NICU and also a large waiting room with play facilities for siblings.	Health boards	No resource required
		E.Expand Neonatal Outreach services across NHS Wales to enable earlier discharge from neonatal units, Transitional Care, and postnatal wards. This should: a.Be available 7 days a week, b.Include access to Allied Health Professional Services. F.Include the ability to support short-term nasogastric tube feeding in the community for preterm infants.	Neonatal	Medium term	The NICU Outreach team are currently trialling discharging babies earlier by supporting them at home with short-term tube feeding. The Outreach team is currently only available Mon-Fri. Would need investment and a case to establish the need. Access to AHPs in the community to clarify the unmet need.	Health boards, WHSSC	Requires Resource for 7 days
		G.Where possible transcutaneous bilirubinometers to be used in the community alongside awareness of challenges for diagnosis of jaundice in ethnic minority babies. Explore introduction of home phototherapy.	Perinatal	Short term	All community teams have access to a bilirubinometer. Currently reviewing additional recourse to provide further meters, capital bid in place. Mandatory training session re equality diversity and inclusion to include awareness of identifying jaundice in non-white babies.	Health boards	Resource required. Service improvement manages in place. Encompassed within roles within SPA and Nursing time to review data
	7.2 Psychological support services should be accessible to all families during their stay in an NHS Wales neonatal unit with seamless links to	H.Nationally review funding and provision of psychology service ensuring it is in line with national UK guidance. I.Use review findings to share national learning, refine/create services and establish referral links to community maternity mental health services as appropriate.	Neonatal	Medium term	National although no psychological support on NICU. Overlaps with other recommendations	Health boards, WHSSC	Resource needed
	7.3 FiCare to be fully embedded in practice in all NHS Wales Neonatal Units	J.FiCare resources to be allocated and training to be facilitated for all units.	Neonatal	Short term	In progress / Bright spot Unsure of resources required. FiCare lead allocated on NICU.	Health Boards, NHS Executive	Clarification of resources
		K.All Neonatal Units to demonstrate >80% compliance with FiCare passport, and where not achieved, submit Board report describing barriers and action being taken to address on a 6 monthly basis.	Neonatal	Medium term	FiCare well established on NICU with parents fully participating in their baby's care. Documentation remains a challenge and passport has been locally amended with an aim of improving compliance with documentation to support the clinical FiCare findings.	Health boards	No resource required
	7.4 All Neonatal Units to adhere to Bliss Baby Charter Standards	L.All Neonatal Units to achieve Bliss Baby Charter accreditation. a.Resource and workforce capacity should be explicitly allocated to support achieving and maintaining accreditation.	Neonatal	Long term	Self-assessment of BLISS Baby Charter currently being undertaken. Financial implications of accreditation to be considered.	Health boards	Accreditation comes with a financial cost
	7.5 Embed a standardised family feedback process for NHS Wales	M.Agree and embed a standardised Maternity and Neonatal Feedback mechanism into NHS Wales services, during and following service use including Transitional Care. a.Ensure inclusion of feedback question/s about parental opinion on safety of care experienced. b.Ensure simplicity of process, communication materials to promote to families and information/training for staff, c.Make results available to parents, families, staff and senior leaders.	Perinatal	Long term	National	NHS Executive, Health boards	Minimal resource

8	8.1 Ensure opportunities for breastfeeding are optimised for all women to improve breastfeeding rates across Wales 8.2 Ensure early access to breast milk and sustaining numbers of both preterm and term babies receiving breast milk during their entire stay 8.3 Ensure NHS Wales has an infant feeding educated workforce 8.4 Ensure monitoring and evaluation of process and outcome indicators for successful breastfeeding	A.All neonatal units to employ at least one funded infant feeding lead post, who will work closely with the Health Board Strategic Infant Feeding Lead (as mandated in All Wales Breastfeeding 5 Year Action Plan 2019) to promote good breastfeeding practice.clxxvi a.High activity level units to consider employing 2 WTE Infant Feeding Leads.	Neonatal	Short term	NICU currently has 0.96wte breastfeeding advisors (x2 part-time nurses) As a Level 3 NICU consideration to increase to 2wte should be given Collaboratve work between maternity and neonates regarding infant feeding education	Health boards	Resource required. Service improvement manages in place. Encompassed within roles within SPA and Nursing time to review data
		B.NHS Wales to adopt the UNICEF Baby Friendly Initiative as a breastfeeding good practice accreditation. a.Resource and staff capacity should be explicitly allocated to support achieving and maintaining accreditation.	Perinatal	Medium term	Maternity Services has an infant feeding lead midwife. This specialist support provides leadership to all staff members, ensures maternity services are up to date with the best available evidence, and provides expert clinical advice in relation to breast feeding. Breastfeeding and responsive feeding are included in mandatory training days, and in addition all midwives, nursery nurse and maternity care support workers are supported to attend an in-house BFI study day as part of their yearly compliance.	Health boards	NHS Wales resource required to fund accreditation.
		C.All neonatal units to record expressed breastmilk volumes, as defined in the All-Wales Enteral Feeding Pathway for Preterm Infants. a.Report compliance with the pathway quarterly. D.Share findings/learning nationally and use data to inform quality improvement activity and implementation of sustainable practice changes, or reinforce action already being taken.	Neonatal	Short term	Breastmilk volumes are recorded on the pathway although compliance varies partly due to a vacancy of a breastfeeding advisor (now filled). Not currently reported – with increased breastfeeding support, this could be supported Regular sharing of data occurs	Health boards, NHS Executive	Minimal resource
		E.All units alongside their Infant Feeding Leads to develop unit-level plans to maximise early colostrum and early breast pump use in line with national guidance (BAPM MBM Toolkit). a.Ensure pathways and staff education on facilitation and recording of skin-to-skin rates. b.Ensure availability of breast pumps at each cot side. c.Monthly local monitoring of plan implementation. F.Share findings/learning nationally and use data to inform quality improvement activity and implementation of sustainable practice changes, or reinforce action already being taken.	Neonatal	Short term	Neonates a.) Skin to skin is recorded as a mandatory field on our data information system. The skin to skin for all mothers and babies is the default position. Skin to skin being facilitated wherever possible for all premature deliveries. b.) Breast pumps and sterile kits are available for all women. Women are also shown how to hand express. Breast pump not available at every space although NICU has a large number of mobile pumps that can be wheeled to individual spaces. c.) Standard agenda on ELM meetings. Oversight of the infant feeding lead f.) Breastfeeding statistics are recorded on the Maternity Dashboard for Welsh Government. Breast milk also features in the per-prem pathway and is collected by NNAP.	Health boards	No resource required
	8.5 Ensure equitable access to donor milk and options to donate milk across NHS Wales	G.Develop Milk Bank access for all women across Wales.	Perinatal	Long term	Currently women in the ABUHB catchment area can donate milk to Swansea and they are appropriately screened and supported by the Baby Milk Bank Team. NICU has access to DEBM according to local guideline.	PHW, Health boards	Resource needed
9	9.1 Develop Transitional Care in all maternity units, aligned with national BAPM standards	A.Implement Neonatal Transitional Care UK standards. a.Consider a single national data recording system to provide monitoring data and commissioning information. b.Ensure Transitional Care Service in all units is commissioned alongside all other neonatal services c.Ensure that all Neonatal Transitional Care standards are embedded by ensuring services are commissioned and. sustainably staffed to BAPM standards, including a designated nurse lead (band 7); a ratio of nursing/nursery staff to babies of 1:4; and all babies to have a named paediatric or neonatal consultant.	Perinatal	Medium term	Transistional care is provided although informal and unstaffed and does not meet the BAPM TC criteria. A business case is being worked through to further develop this case although space remains a concern.	Health boards, NHS Executive	Environmental capital cost required. Business case developed. Requires staffing
		B.Each baby to have clinical input at the same level of seniority as babies receiving special care on a Neonatal Unit.	Neonatal	Medium term	Transitional care babies are reviewed at least daily by NICU medical team supported by the Service 2 Consultant.	Health boards	Resource required
10	10.1 Review models of midwifery care to optimise continuity	A.Establish an agreed method of understanding the continuity of care that women in Wales currently receive. a.Use that method to collect baseline continuity of carer data b.Establish improvement plans where required.	Maternity	Medium term	a.) Actively monitor staffing challenges and the potential and actual impact on women and families if continuity of care is affected through Divisional Governance meetings and the Management and Leadership meetings. b.) ABUHB maternity have established a continuity of care and carer workstream to improve this area of practice. User surveys have been undertaken, supporting evidence that continuity improves care. A buddy model has been implemented, where staffing allows, and recent review shows signs of improved continuity. This is ongoing work. Caseloads have been closely reviewed, to ensure a fair and equitable workload.	Health boards	To achieve community midwifery would need to be up to establishment, which requires both resource and recruitment
		B.Health Boards to review community midwifery service provision to ensure that women see: a.No more than 2 midwives antenatally and postnatally, b.their named midwife for postnatal discharge.	Maternity	Medium term	Continuity of care is paramount to building a good relationship with the woman and the healthcare professional. Our aim is to ensure women have a named midwife, some may need a named obstetrician throughout the antenatal and postnatal period, which offers continuity in line with the All-Wales multi-professional work plan. See actions in 10.1 a) and b)	Health boards	Resource required
	10.2 Maximise continual risk assessment throughout pregnancy to ensure women birth in their place of choice	C.Health Boards to implement All Wales Midwifery-Led Care Guideline (6th Edition) guidance to ensure all women have the choice to birth in a Midwifery Led setting.	Maternity	Short term	Implemented and embedded into practice. All 4 place of birth options available for women within ABUHB. Strong ethos of supporting maternal choice including out of guidance/recommendation choices.	Health boards	No resource required
		A.Implement standard advice and pathways to support each Health Board, emergency service and clinician to provide optimal care for women experiencing acute pregnancy problems.	Maternity	Medium term	Though a National approach there are standard advice and pathways/ guidance in place	Health boards, WAST	Resource needed

	11.1 Develop and implement standardised advice for management of women with acute problems in pregnancy	B.Ensure that standardised clinical advice is made available to women and their families: a.Using Plain English principles b.Available via the most accessible channels c.Easily available at times of critical need d.Translated into multiple languages.	Maternity	Medium term	When women first access maternity services, they meet with their Community Midwife and language preferences/needs are highlighted on the Maternity Request for Care Form. If an interpreter is required, then arrangements are made, and the interpreter attends the women's dating appointment. In all antenatal clinics there is also access to 'The Big Word' Telephone Interpretation Service (which has replaced language line). This has not been identified as a local issue. In relation to measures and systems to support effective communication, hearing loops, face to face and 'The Big Word' translation services are provided. These facilities are readily available to all women who require this support. We offer a bilingual service whereby documentation being provided to the women i available in English and Welsh. The Healthier Together website has been created and embedded to provide information in 131 different languages proving good quality maternity, early years, and public health information. Consultant Midwife leads on equality diversity and inclusion. Leaflets and public information are reviewed by the maternity service user group (BABI) and Easy Read versions are created where appropriate.	Health boards, NHS Executive	Minimal resource
		C.Review information being given via 111 web pages and ensure: a.Alignment with the standard advice b.Published using Plain English principles c.Available in multiple languages.	Maternity	Medium term	National	WAST	Resource needed
		D.Establish telephone advice resources, based on the standard advice, and embed their use throughout NHS Wales maternity services.	Maternity	Medium term	In all antenatal clinics there is also access to 'The Big Word' Telephone Interpretation Service (which has replaced language line). This has not been identified as a local issue.	Health boards, WAST	Resource needed
		E.Create permanent midwifery posts within Welsh Ambulance Services Trust (WAST) to: a.Establish an expert link with maternity and neonatal services for clinical advice, information and partnership working, b.Provide expert input into development of a national 'Labour Line' telephone service. c.Provide expert input into consideration of a national 'Triage Line' telephone service. d.Provide specialist input into internal WAST training, paramedic undergraduate and post graduate education.	Perinatal	Medium term	National	Health boards, WAST	Resource needed
	11.2 Implement a standard approach to the detection of the sick or deteriorating woman in line with NICE guidance (NG133)	F.Develop an All-Wales Maternity Early Warning Score (MEWS) Chart and implement in every healthcare setting in Wales where a pregnant woman could receive care.	Maternity	Medium term	Currently using a localised version of MEWS while awaiting the All-Wales MEWS chart to be ratified.	NHS Executive	Using a localised . Awaiting an all wales
	11.3 Establish maternal medicine network access across NHS Wales	G.Establish a Maternal Medicine Network for South Wales, ensuring: a.Leadership from an obstetric physician, b.Senior midwifery coordination, c.Specialist advice from an obstetrician trained in maternal medicine.	Maternity	Medium term	These provisions are embedded in ABUHB with senior leadership in all of the mentioned roles. National	NHS Executive	Requires a resource.
		H.Develop and maintain a service level agreement (or equivalent) between NHS Wales services in North Wales with the Liverpool Maternal Medicine Centre.	Maternity	Medium term	N/A	Health boards	Resource required
		I.NHS Wales to consider if a Maternal Medicine Centre could/should be shared between Health Boards.	Maternity	Long term	National	NHS Executive	Resource needed
	11.4 Embed national guidance (NICE, RCOG, All Wales guidance) relating to pregnancy and birth across NHS Wales.	J.Refresh the NHS Wales Safer Pregnancy Campaign incorporating actions from Saving Babies' Lives Care Bundle version 3. This will require funding/implementation of: - a.Smoking cessation support readily available in all Health Boards. b.An improvement programme to ensure standardisation of carbon monoxide monitoring. c.Training to support provision of: a.Sufficient sonography services b.Uterine artery dopplers at 20 weeks c.Transvaginal cervical length in preterm birth clinics (NICE Guidance NG25) d.Computerised CTG (Cardiotocograph) to be made available in all units for women with reduced fetal movement or early onset fetal growth restriction. e.Preterm birth prevention clinics established in each Health Board.	Maternity	Medium term	a.) Smoking cessation support workers in post and working across the health board. b.) Carbon monoxide monitoring reinstated post covid, MECC training mandated for all staff. c.) Service has identified increased provision requirements, 2 x additional midwives in training 2023, a further 3 are being supported 2024 by HEIW a.) Consultant obstetricans are able to provide TV cervical length scans across the Health Board b) artery dopplers not routinely offered at 24/40 though offered to high risk women - Newly appointed band 8 governance lead for sonography. d.) Dawes Redman CTG cardiotocograph in place across Health Board. e) The service is provided but not in one dedicated clinic . ABUHB has a wide geographical spread with ANC services across the health board. Not feasible to have a prem clinic in 5 ANC, centralisation would mean women travelling from their locality to a central clinic, in view of soicio econominc deprivation not considered feasible Transvaginal scanning can be provided by a cohort of consultant.	Health boards, NHS Executive, HEIW	Resource needed premature clinics not prioritised or considered a safety risk
		K.All Health Boards to review existing complement of specialist midwives and ensure there are posts to cover diabetes and preterm birth	Maternity	Medium term	Birth rate plus has been undertaken and review of specialsit midiwfery team underway Support form Division to advertise for diabetic lead midwife- interview 22/08/2023, increase being considered for fetal surveillacne lead. Lead midwife for premature birth is notconsiderred a priority and is not viewed as a risk to the service. Any increase in specialist rolse would need to be financially resourced.	Health boards	No multiple birth or preterm . Not prioritised, not perceived as a safety risk.
		L.All Health Boards to implement Placental Growth Factor (PLGF) testing for women with suspected pre-eclampsia (NICE guidance NG133).	Maternity	Short term	Business case in development, will require additional funding. Require health economic benefits	Health boards, NHS Executive	Resource needed
		M.All Health Boards* to establish multiple pregnancy clinics with a specialist midwife, obstetrician, and sonographer as core staff (NICE guidance NG137). *Powys to consider specialist midwife to link with neighbouring clinics.	Maternity	Medium term	MCDA review in fetal medicine and DCDA uncomplicated in general ANC. Mulitple pregnancy service is in place, provision of sonography for multiples is undertaken by consultants or radiology. Extra training would be required for midwife sonographers to undertake scans of multiple pregnancies, this would require resource to be undertake, it is not felt that this currently poses a risk for women with multiple pregnancies.	Health boards	Resource required
		N.National guidance that is not followed should be reported by each Health Board to the NHS Executive Maternity and Neonatal Network	Maternity	Short term	Robust governance around this	Health boards	No respource required

11		O.NHS Wales to undertake a review of the effectiveness of GAP/GROW compared to alternative models for detecting small for gestational age babies.	Maternity	Long term	National	NHS Executive	Minimal resource
	11.5 Minimise variation in intrapartum care in line with NICE guidance	P.All Cardio Tocograph/Intermittent Auscultation training to consider using Each Baby Counts + Learn & Support toolkits and ensure inclusion of content relating to: a.Situational awareness, b.team working (including communication), c.and escalation (See 3A)	Maternity	Medium term	Designated fetal surveillance lead midwife in post coordinating training and training compliance in line with national FS standards. All wales work ongoing to review IFS standards and training scoping exercise in progress. Currently 0.4 WTE additional hours additional hours will require further resource..	Health boards, NHS Executive, WRP	Minimal resource
		Q.In suspected pre-term labour, all Health Boards to ensure all women have access to the most accurate preterm birth tests including: a.ultrasound machines to perform transvaginal cervical length, b.and quantitative fetal fibronectin.	Maternity	Medium term	USS machines with TVS available across the service Fetal fibronectin to assess preterm birth embedded into practice.	Health boards, HEIW	Resource needed
		R.In suspected pre-term labour, all Health Boards to ensure obstetricians are trained to perform transvaginal cervical length scans. (see 3A).	Maternity	Medium term	Transvaginal USS available across the Healthboard for women, provision by consultants. Would require additional resource training and education for all obstetricians to be competent.	Health boards, HEIW	Resource needed
		S.Enhanced maternal care training to be provided for enough midwives to ensure an appropriately qualified midwife on every shift in obstetric units. (See 3A). (E.g., PROMPT CiPP course)	Maternity	Medium term	PROMPT Wales is a maternity safety programme funded by Welsh Risk Pool. Its vision is to reduce avoidable harm and improve perinatal outcomes, through multi- professional training in obstetric emergencies enhancing safety, teamwork and communication. Data provided to PROMPT Wales demonstrates training has been successfully implemented. Welsh Risk Pool Safety and Learning programme will continue to provide quality assurance support to each faculty team, approve the planned programmes and monitor compliance against the PROMPT Wales standards to ensure training compliance is maintained. In addition training is provided in high dependency and a work book is currently being developed to support the programme.	Health boards, HEIW, WRP	Minimal resource
	11.6 Ensure evidence-based care and advice given to postnatal women on modifiable risks	T.Ensure all obese postnatal women can access the primary care obesity prevention programme (in development as of April 2023).	Maternity	Medium term	Healthy weight programme for pregnant women has been established in all areas across the Health Board.	Health boards, PHW	Minimal resource
		U.Ensure all postnatal women who have had gestational diabetes receive advice relating to: a.postnatal testing b.yearly HBA1C c.lifestyle modification to reduce development of type 2 diabetes and associated complications	Maternity	Medium term	All women with GDM are offered a postantal review and postnatal testing within maternity services, and are directed to primary care for follow up. Primary care collaboration required for yearly HBA1C, currenlty not supportinve of postnatal bloods. Public health midiwfe in post to support healthy lifestyle, HUBS being utilised to support education and information to women.	Health boards, NHS Executive, Primary Care	Resource needed
		V.Ensure all postnatal women who have had pre-eclampsia received advice relating to: a.lifestyle modification b.annual blood pressure checks.	Maternity	Short term	All women are directed to primary care for follow up or seen by obstetric team depending on clinical outcomes.	Health boards, NHS Executive, Primary Care	Resource needed
		W.Ensure all postnatal women who had a preterm birth under 34 weeks have an appointment with a specialist obstetrician to discuss implications for future pregnancies.	Maternity	Medium term	Postantal follow up is provided with consultant who is able to discuss implications for futrue pregnancy	Health boards	Resource not required/ however do not have a specialist obstetricain
	11.7 Develop and launch data dashboards which enable monitoring and benchmarking of clinical activity and outcomes 11.8 Ensure standardised approach to maternal and neonatal safety assurance and measurement throughout NHS Wales	X.NHS Wales to agree the content and output of a national standardised data dashboard which enables benchmarking against the NHS England Maternity Services and National Maternity and Perinatal Audit data sets.	Perinatal	Medium term	National	NHS Executive, DHCW	Minimal resource
		Y.Health Boards to collaborate and develop local dashboards, to include the standardised perinatal quality surveillance dashboard to enable real-time activity/outcome measurement and monitoring to support local improvements. a.A standardised perinatal quality surveillance dashboard would incorporate the following: •Clinical outcomes including stillbirths, neonatal deaths, HIE, ATAIN, SBLCBv2 progress and compliance. •Staffing vacancies for maternity and neonatal services for all relevant professional groups. •Training compliance. •Maternity and Neonatal Risk register	Perinatal	Short term	Structured dashboard in place within maternity services to record clinical outcomes, stillbirths, HIE, staffing vacancies, training compliance, and maternity risk register. Neonates – need for a standardised dashboard	Health boards, NHS Executive	Minimal resource
		Z.NHS Wales to implement annual assurance safety metrics which are aligned with safety actions elsewhere in the UK, including consideration of incentivisation.	Perinatal	Medium term	National	NHS Executive, WRP	Minimal resource
	11.9 Optimise and standardise maternity & neonatal governance systems across Health Boards	AA.Develop and implement NHS Wales Maternity and Neonatal Trigger Tools to guide standardisation of event/incident reporting.	Perinatal	Short term	National	NHS Executive	Minimal resource
		BB.Appoint national Maternity and Neonatal Safety Leads to support national learning and ensure implementation of learning from incidents.	Perinatal	Short term	National	NHS Executive	Resource needed
	11.10 Ensure local and national review of maternity & neonatal incidents to facilitate thematic analysis, learning and improvement 11.11 Ensure Executive Boards are aware of maternity & neonatal metrics, outcomes, safety and governance issues	CC.Align NHS Wales Datix fields with agreed national Trigger Tools and analyse data at Health Board and national level to identify themes and guide continual improvement.	Perinatal	Short term	National	NHS Executive, Health boards	Minimal resource
		DD.NHS Wales to develop and implement a standardised maternity & neonatal adverse event review process (E.g., NHS Scotland Perinatal Adverse Event Review Process).	Perinatal	Short term	In progress	NHS Executive, Health boards	Minimal resource
		AE.All maternity and neonatal units to have robust governance team structure, with accountability and line management to the DoM and CDs. The team should include: - e.a designated senior midwife/nurse and medical consultant leads for governance: f.with protected time allocated for fulfilling their roles including external review for PMRT, g.sufficient administrative support, h.and equitable allocation across both maternity and neonatal services.	Perinatal	Medium term	AE.) Maternity Services has a full-time lead midwife in post supporting the service with all aspects of governance who reports to the HOM and Clinical Director. Their time is protected to fulfil the role, in addition the lead midwife for bereavement supports review of PMRT, and there is a dedicated consultant to support. Weekly risk meetings with a multidisciplinary team approach with attendance from senior midwifery staff and a consultant obstetric, anaesthetic, and neonatal lead. There is no administrative support. NICU also has a nurse with dedicated time to manage governance. Protected time is allocated to the nursing team to complete the PMRT but this is taken from the clinical hours establishment. There is no administrative support for NICU regarding governance or PMRT.	Health boards	Resource required
		AF.All incident investigators to be fully trained and competent to undertake their roles, to include consideration of training in: a.Systems Engineering Initiative for Patient Safety (SEIPS) b.Patient Safety Investigation Response Framework (PSIRF). (See 3A)	Perinatal	Medium term	Internal training available for all incident investigators within ABUHB. Currently, staff waiting to attend course.	Health boards, HEIW	Resource needed

		AG.All Health Boards to ensure recorded justification and decision making to support any local deviation from nationally agreed protocols/guidance/best practice.	Perinatal	Short term	Process in place to support development of guidelines and integration of national guidelines. Any deviation would be highlighted within division via DMT/QPS and recorded on the risk register.	Health boards	No resource required
	11.12 Ensure all cases of maternal death, term intrapartum stillbirth, early neonatal death>37 weeks and hypoxic ischaemic encephalopathy (HIE) are reviewed by a fully trained independent investigation team	HH.NHS Wales to develop or commission a system for external independent review for all cases of: a.Maternal death, b.Term intrapartum stillbirth, c.Early neonatal death>37 weeks, d.Hypoxic ischaemic encephalopathy (HIE).	Perinatal	Medium term	A fully trained multi-professional team is involved in the reviews of all maternal deaths, term intrapartum stillbirths, early neonatal deaths >37 weeks with hypoxic ischaemic encephalopathy (HIE) at monthly Perinatal Mortality Review meetings. External reviews for NICU and maternity as part of Network mortality & HIE meetings.	Health boards, NHS Executive	Resource needed
12	12.1 Optimise Maternity & Neonatal Outcomes	A.Ensure that perinatal quality improvement is embedded and sustained as a cultural and behavioural norm throughout NHS Wales. Supporting implementation of: a.Local improvement activities in each unit and Health Board b.National improvement activities such as perinatal optimisation PeriPrem Cymru and MatNeoSSP Improvement Collaborative.	Perinatal	Short term	QUIP initiatives are shared to a multi-professional team at Clinical Governance meetings where learning and improvement is discussed prior to implementation. Maternity have established a QI and research forum for midwives and MCSWs. Multiple Improvement projects covering various subjects but including: The Golden Drops Project - The BAPM framework for early breastmilk in preterm babies has prompted a drive to give mothers' own breastmilk. The aim of the Golden Drops Project was to give the first drops of colostrum within the first six hours of life, to support the mother while expressing, to support and train staff, and to improve breastfeeding rates. Civility Saves Lives Service improvement project focussing on how kindness, respect and civility can create safer working environments. Education programme in maternity and neonates. Collaborative working with the PeriPrem and MatNeoSSP teams are welcomed to improve provisions for all pregnant women and birthing people. A new monthly Quality Improvement meeting has been introduced on NICU where all QI work can be discussed and monitored	NHS Executive, Health boards	Minimal resource
		B.Ensure all instances where babies were not born in the right place (e.g., <32 weeks) are subject to robust local and national review (including babies born prehospital under care of the Welsh Ambulance Services Trust).	Perinatal	Short term	Network level	Health boards, NHS Executive, WAST	Minimal resource
		C.All Health Boards to establish and sustain mechanisms for maternity and neonatal teams to work together across service boundaries, to: a.Create strong working relationships and strong communication pathways, b.Support changes in service development c.maximise multidisciplinary learning e.g., Sim training, d.Optimise clinical outcomes. (In line with national guidance)	Perinatal	Short term	Collaborative working continues to increase between maternity & neonatal teams including golden drops initiative, periprem passports, civility in teams, PANOM simulation sessions etc in addition to joint meetings, perinatal mortality & morbidity, risk etc. Clinical outcomes monitored for NICU with periprem pathway, NNAP etc.	Health boards	No resource required
		D.NHS Wales to implement the NHS Wales Probiotics Guideline	Neonatal	Short term	ABUHB NICU was the first Unit in Wales to introduce probiotics. These continue while working with Pharmacy to introduce the NHS Wales Probiotics Guideline.	NHS Executive, Health boards	Minimal resource
		E.Develop and implement an NHS Wales robust definition and process for review of all infections in babies on neonatal units. a.Health Boards to constantly record and monitor local instances. F.Report and publish infection rates nationally every 6 months. G.Consider use of established QI process for neonatal infection e.g., Vermont Oxford Network (VON)	Neonatal	Medium term	National Infection rates on ABUHB NICU are closely monitored by a consultant & nurse with a special interest in IPAC. Data is reported nationally every year rather than 6 monthly by NNAP, VON and also in our annual report. Close links with IPAC team continue.	Health boards, NHS Executive	Minimal resource
		H.Ensure neonatal teams embed national guidance on specialist neonatal respiratory care for babies born preterm.	Neonatal	Medium term	National guidance embedded on ABUHB NICU	Health boards	No resource required
		I.All NHS Wales maternity and neonatal units to ensure that a designated Quality Improvement Midwife/Nurse and senior consultant, with: a.The skills/competence to lead quality improvement activity in their unit. b.Time allocated to act as their unit's Quality Improvement Lead.	Perinatal	Short term	Quality improvement meetings are chaired by a designated nurse with allocated time. A lead is identified for each QI project identified. Available QI training is shared to the team.	Health boards	Resource required. Service improvement manages in place. Encompassed within roles within SPA and Nursing time to review data.
	12.2 Ensure Services are equitable for babies across Wales 12.3 Improve the pathway for babies presenting with bilious vomiting	J.All neonatal units to have a plan and to be allocated capacity to have early developmental intervention and to undertake developmental assessment at two years, using AHP input.	Neonatal	Medium term	ABUHB NICU is fully compliant with the 2-year developmental assessments	Health boards	No resource required
		K.Undertake a national review of care pathways for babies with bilious vomiting to enable close partnership working between surgical NICU's, transport services and all service providers to: a.Reduce unnecessary transfers b.Minimise mother-baby separation c.Consider drive-through options	Neonatal	Medium term	National	NHS Executive	Resource needed
		L.Develop a system of radiology support for neonatal units with no out of hours radiology services to reduce delays in access to surgical review and upper GI contrast study.	Neonatal	Medium term	9-5 support in ABUHB rather than the full support 24/7	NHS Executive, WHSSC	Resource needed

13	13.1 Minimise variation in bereavement care for all families who lose a baby, regardless of gestation or age	A.NHS Wales to explore commissioning options for perinatal pathology outside Wales to reduce waiting time for post-mortem results.	Perinatal	Medium term	Complete	WHSSC	Minimal resource
		B.NHS Wales to fully implement all five pathways within The National Bereavement Care Pathway (NBCP).	Perinatal	Long term	NHS Wales	Health boards, NHS Executive, Welsh Government	Resource needed
	13.2 All maternity and neonatal units to ensure specialist bereavement posts are created/sustained within workforce plans	C.Provide equitable bereavement care across Wales and services to ensure that all bereaved women receive care and advice from a Bereavement Midwife.	Perinatal	Medium term	Bereavement lead midwife in post, to incorporate all bereaved women ie those who have had a neonatal death or miscarriage would require additional hours for bereavement care. We have a fulltime bereavement Midwife in post supporting women across multiple geographically areas. We also have designated champion midwives have been allocated for bereavement care and support. Training is supported through sands training pathways. All midwives receive training to deliver bereavement care to all women and their families The service available for maternity pregnancy loss is led by the bereavement specialist midwife and support team who	Health boards	Partial resource needed
		D.Each Health Board to establish and sustain a Rainbow Clinic model which provides: a.Standardised debriefs for bereaved families, b.Specialist obstetric and midwifery care for women in future pregnancies to reduce risk of recurrent loss.	Maternity	Short term	All women are offered a debrief following baby loss with their obstetrician and bereavement lead midwife/ senior midwife. This would be in clinics close to home Individualised care is offered for all women in subsequent pregnancies. Reviewing provision for obstetric bereavement lead and exploring the possibility of a Rainbow clinic model however would be accross the Health Board and not centralsied.	Health boards	Resource required. Service improvement manages in place. Encompassed within roles within SPA and Nursing time to review data.
		E.Health Boards to review the caseload of all Bereavement Midwife posts to ensure appropriate use of skills, and plan for delivery of sustainable bereavement services in line with NBCP requirements.	Maternity	Short term	JD recently reviewed and appropriate skills for role.	Health boards	No resource required
		F.Health Boards to ensure each Neonatal unit has a named Bereavement Lead, with a.Protected time to fulfil the role. b.Potential for a single postholder to provide cover across multiple geographically adjacent units.	Neonatal	Short term	NICU has 2 nominated bereavement link nurses and a Consultant with a special interest. The nurses have dedicated time to review and improve the bereavement pathway and provide teaching etc. Although these hours come from the clinical establishment.	Health boards	Resource required. Service improvement manages in place. Encompassed within roles within SPA and Nursing time to review data.
	13.3 Create national and local implementation plans to embed the BAPM Lactation and Loss Framework across NHS Wales	G.Establish funding/resources, pathways, information and training to enable all Health Boards to embed the BAPM Lactation and Loss Framework for Practice.	Perinatal	Medium term	National	Health boards, NHS Executive	Minimal resource
14	14.1 Ensure resourcing for maternity services is transparent, and an alternative funding model urgently considered 14.2 Establish a care and funding model which fairly and adequately compensates Health Boards for delivering high quality care to all woman, whilst supporting personalisation, safety, and choice	A.Ensure that funding/resources follow the woman and her baby as far as possible, to a.Ensure women's choices are funded, b.Support organisations to work in close partnership to deliver services.	Maternity	Long term	The service supports care close to home the Head of Midwifery is the budget holder and therefore her focus is to ensure that women and birthing people and their needs are central. b.) Maternity services practice prudent healthcare to deliver effective and efficient services, by collaboration with other stakeholders.	NHS Executive	Minimal resource
		B.Incentivise the delivery of high quality and efficient care for all women, regardless of where they live or their health needs (also see 11Z).	Maternity	Medium term	ABUHB maternity are committed to Diverse Cymru Cultural competencies scheme and have a consultant midwife lead for addressing health inequalities, working closely with Public Health consultant and lead midwife for public health, and lead midwife for Safeguarding.	Welsh Government, WRP	Resource needed
15	15.1 Ensure there is joined up review of all perinatal services and that neonatal services encompass care from cot to community 15.2 Ensure efficient use of cot capacity across Wales 15.3 Ensure efficient flow of babies to their local hospitals or back home with their families 15.4 Ensure babies are born in the right place where possible 15.5 Ensure SCU teams are skilled in managing repatriated babies from NICUs 15.6 Maintain emergency care skills and confidence for all	A.Planning for neonatal services (such as reviews of flow and capacity) should be coordinated jointly with maternity services.	Neonatal	Medium term	Face to face handovers take place twice daily to give an overview of bed/cot status and acuity. Concerns over capacity within maternity raised by the neonatal team - Watch list in palce - needs refreshing	WHSSC	Minimal resource
		B.Transitional Care and Outreach services must be included where there is any review of maternity and/or neonatal services.	Perinatal	Long term	Consideration for Transitional care remains a priority for NICU	NHS Executive, WHSSC	Minimal resource
		C.Strategic planning and commissioning of maternity and neonatal services (from Cot to Community) should be coordinated jointly with commissioners and the NHS Executive and include representation from all members of the perinatal team.	Perinatal	Medium term	National	NHS Executive, WHSSC	Resource needed
		D.Undertake central review of the BAPM recommendations regarding NICUs admitting < 100 VLBW babies or carrying out <2000 intensive care days to develop plans to amalgamate NICUs to increase throughput or change designation.	Neonatal	Medium term	Need to identify flow pathways from Level 2 Units to other NICUs to protect the surgical cot availability at UHW. Should focus on respiratory care days rather than IC days due to improved respiratory management of preterm babies.	WHSSC	Resource needed
		E.Establish a system to electronically capture data relating to transfers and failed transfers of women and babies, in utero and ex-utero in both maternity and neonatal settings.	Perinatal	Medium term	Neonates are already operational with BadgetNet system. Digital System BadgetNet to be rolled out in ABUHB in October 2023. Digital Healthcare Wales are working on an All-Wales digital platform for full integration with all health boards. In-utero refusals are documented locally on both Maternity & NICU. A Network approach would be recommended.	NHS Executive, WHSSC	Resource needed
		F.Develop and implement a tool for monthly monitoring of each NHS Wales neonatal unit's non-special care days (coded HRG 3-5 on Badgernet). a.All units to share and discuss results regionally and nationally to identify improvements and share learning, e.g., barriers to delayed discharge, outreach support, Transitional Care facilities.	Neonatal	Medium term	National	Health boards, NHS Executive	Minimal resource

	skills and confidence for all neonatal clinical staff, particularly those working in SCUs	G.Establish and fund ongoing rotational experience for permanent medical staff from SCUs to NICUs.	Neonatal	Long term	NICU would support other staff rotating to the Unit.	HEIW, Health boards	Resource needed
16	16.1 Ensure compliance with all national neonatal transport guidance 16.2 Ensure 24/7 equitable transport service provision across Wales	A.Establish NHS All Wales guidance and toolkit to enable review of all clinical incidents related to transfers.	Neonatal	Medium term	National	NHS Executive	Minimal resource
		B.Maximise the ability of families to travel with their baby.	Neonatal	Medium term	Wherever possible, families are able to travel alongside their baby during neonatal transport	CHANTS, NWTS	Minimal resource
		C.Establish a Transport Service single point of contact for clinical advice and cot/maternal bed location. a.To include teleconferencing, call handling, and call recording functionality.	Perinatal	Medium term	In progress (South Wales)	NHS Executive, CHANTS, NWTS	Minimal resource

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**PQSOC/2504/3.3.2 - Pharmacy and Medicines Management:** RGH Pharmacy Robot Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge, Divisional Director, Primary & Community Division Jonathan Simms, Clinical Director of Pharmacy

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The PQSOC received the Medicines Management Annual Report at its meeting 25th April 2023. The report indicated concerns with the reliance of the RGH pharmacy robot that is responsible for the distribution of medication across the Health Boards southern hospitals.

The robot was installed in 2005 and had an estimated lifespan of 10 years. This is now the oldest pharmacy distribution robot still in use in the UK. A critical failure will result in significant disruption to the timely access of medicines across the Health Board with potential impact on patient safety and flow.

The Committee was informed that a business case to renew the robot had been developed which the Health Board was assessing.

The Committee requested an update of plans at a future meeting.

Cefndir / Background

The development of robotic dispensing technology allowed the redesign of pharmacy services to focus on patient facing activity at ward level, whilst also reducing the risk of dispensing errors through wrong product selection.

Replacement of the robot is an essential as part of the Pharmacy Clinical Futures delivery plan. The RGH site is the main pharmacy hub for the purchasing, storage, and distribution of medicines across the Health Board and therefore, the effective operation of the site is business critical.

In April 2023 it was reported that the RGH robot had suffered 2 (two) business critical breakdowns. Both incidents required pulling in our in-house expert to patch the systems to enable 1 of the 4 systems to work.

The frequency of breakdowns (major and minor) is increasing and the Directorate is extremely concerned that the issues will become non-repairable.

The issues and a revised PPD (approx. £710k) were escalated and capital funding is being explored to replace the robot.

This was discussed at the Executive Committee on the 7th September 2023. It was promoted to the Executive Risk Register and it was agreed that the robot replacement will be prioritised for next year's discretionary capital, and planning for the replacement should commence given the expected lead time for procurement.

Asesiad / Assessment

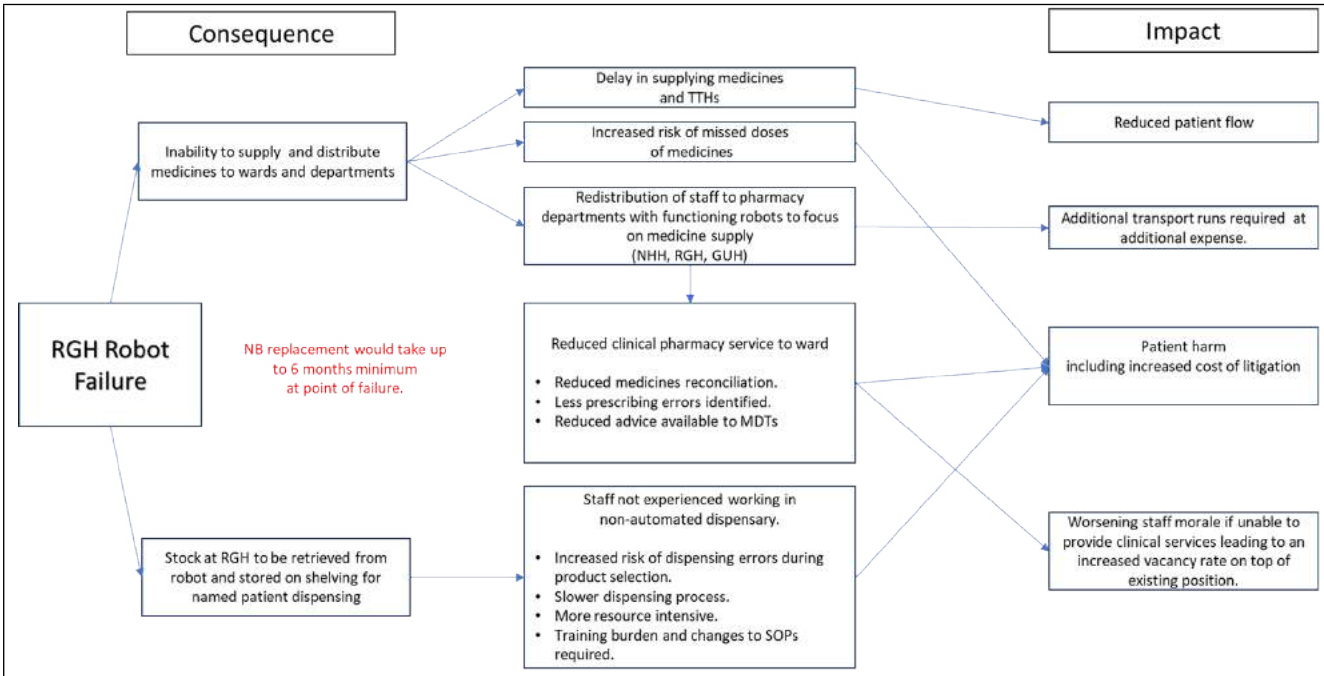
A risk assessment has been conducted and the risk of "Failure of the RGH Robot" is considered to be Very High with a score of 20. It is believed that the likelihood of failure is "Almost Certain" with a score of 5 as the robot has had two recent failures and is of an age that means break downs and failures will inevitably occur. The average annual number of failures/breakdowns requiring a full shutdown or technician visit is 23 per year (figure obtained from the RGH RDS breakdown data).

The consequence of the breakdown is considered to be "Major" with a score of 4. The minimum period for a major loss or interruption would be >1 week. If the RGH robot had catastrophic failure this would be a minimum of 12 months for recovery (including procurement and installation of new robot – assuming procurement agreement in place, tendering process complete and finance readily available). This would obviously, seriously hamper the Health Boards ability to deliver pharmaceutical care to patients.

There would be an impact on the Health Boards storage capabilities and procedures as the RGH service has over 20,000 pharmaceutical packs stored. These would need to be stored in a separate location to allow delivery as part of the contingency plan. At present there is no specific location identified at RGH or elsewhere that can these store the products.

It should be noted that space is already restricted in the Nevil Hall Pharmacy department due to presence of props in the robot room, in response to the reinforced autoclaved aerated concrete (RAAC) situation within the estate.

This provides an overall Risk score of 20 (5 x 4). An outline of the consequences and impact on patient care, staff and the Health Board are shown below.



The Directorate is currently updating its contingency plans in the event of a major failure of the robot. If required to be implemented, these plans will require other ABUHB pharmacy departments to provide mutual aid in order to maintain medicines supplies to our wards.

The implementation of the contingency plan will necessitate a reduced level of clinical pharmacy services across the Health Board, as staff would need to be redeployed to prioritise medicines supplies. This would expose patients to additional risk by a further reduction of pharmacy services at ward level over and above the current service, which is already compromised due to the current vacancy situation and a low historical baseline level of staff.

The risk of failure is listed on the Divisional Risk Register, an extract is attached as Appendix 1, and was escalated to Executive Committee where it was promoted to the Executive Committee Risk Register.

The contingency plans are expected to be completed by end September 2023; although, this doesn't imply that the robot will not fail before that date. The plans will require ratification by the other Pharmacy Site Leads as this will have implications on the service at all sites. The current business continuity and contingency plans are included as Appendix 2.

Argymhelliad / Recommendation

The Committee is asked to consider the report for assurance that the efforts to replace the Pharmacy robot are continuing and that plans are in place in the event of failure.

Appendix 1

Primary Care and Community Division: Extract of Divisional Risk Register – Pharmacy Robot only

Prim Care Div Risk Reg - pharmacy robo

A comprehensive maintenance contract with Omnicell Ltd. includes 3 routine maintenance inspections, 1 accident prevention per year with 4hr breakdown response.

Risk rating

Likelihood – Almost Certain (4):

- Lifespan of the robot should be 10 years (RGH is currently 20 years old).
- The average annual number failures/breakdowns requiring a full shutdown or Omnicell technician visit is 23. (Figure obtained from the RGH RDS breakdown data).

Consequence – Major (5):

- Loss or interruption would be >1 week (not permanent as new robot would eventually rectify the situation).
- If RGH robot had catastrophic failure likely this would be a minimum of 12 months for recovery of BAU (including procurement and installation of new robot – assuming procurement agreement in place, tendering process complete and finance readily available).
- Seriously hamper ability to deliver pharmaceutical care to patients:
  - less assurance of safety elements of dispensing linked to robotic picking.
  - Potential reduction in frequency of top-up deliveries – potential to reduce availability of medicines at ward level.
  - Reduced patient flow through RGH linked to reduced efficiency of dispensing.
- Impact on storage – RGH robot has 20,000 pharmaceutical packs stored – these would need to be stored in a separate location to allow delivery of contingency service. At present no specific ability to house these in RGH Pharmacy departmental footprint at present.

Appendix 2: RGH Robot Impact assessment

For the below assessment, a critical breakdown of the RGH robot is classified in terms of length of shutdown:

- **Immediate** – fix within a working day
- **Short term** – fix likely <1 week
- **Long term** – fix likely to take >1 week or is unfixable

Due to the breadth of causes of the breakdowns to the RGH robot it is not possible to scope each potential cause of a shutdown nor mitigate for each. Therefore, the assessment focuses on the likely impacts associated with a shutdown throughout the above timescales.

Timescale / Level of Escalation	Area / Potential Impact	Summary of Impact	Detail of Potential Impact / Issues Caused	Current Process Controls Measures / Mitigations
Immediate loss of RGH robot (1-2 day loss of service) **(Business Continuity Plan)**	**Bulk supply:** Short term inability to efficiently provide centralised distribution model to Southern ABUHB hospital sites (GUH, YYF, RGH, peripheral hospitals).	- Increased workload for local procurement teams at each site. - Reduced pharmacy assistant support to ward-based pharmacy service due to increased local demand for distribution. - Reduced efficiency of ward based service: Increased pull on pharmacist and pharmacy technician's to provide ward based service.	YYF and GUH to provide own bulk supplies from limited stockholding to cover interim needs. This will partially cover perceived impact however: - Limited pharmacy drug lines are held by each site, leading to an increased burden on local site procurement teams (with limited resource) to procure additional stocks. - Additional strain on Pharmacy System Team to ensure drug files allocated to additional sites. Staff (predominantly pharmacy assistants) at YYF, GUH would be diverted to support distribution service versus ward-based	GUH and YYF staff are trained to complete 'critical low' supplies for bulk items that fall below set PAR levels for onsite Omnicell's prior to top-up trigger from RGH. Sites receive automated daily report to trigger supply to maintain critical levels of stock across hospital sites in between centralised top-up from RGH. Within immediate timescale of 1-2 days there would be a limited number of top-up triggers (approx. 5-10 / day) as Omnicell top-up's are distributed throughout the week.

			pharmacy service. Leading to additional pressure on pharmacy technicians and pharmacists with potential for delayed provision of ward pharmacy services including discharges.	Band 4/5 pharmacy technicians trained to complete pharmacy assistant role at ward level. Require staff overtime to facilitate depending on perceived needs.
	Patient specific supply: Immediate lack of ability to retrieve stock for discharges and patient specific supplies at RGH and peripheral hospitals (County, Chepstow and St Woolos).	- Reduced patient flow due to reduced ability to access medication for discharge. - Increased need to procure patient specific medications in ad-hoc manner (reduced efficiency, increased workload, increased stockholding, increased costs e.g. off-contract purchasing etc). - Increased transport costs e.g. taxi use if urgent medication needed. - Increased transport time / reduced efficiency of transport runs due to need to respond to ad-hoc requests.	Lack of ability to access RGH robot stock in a timely manner resulting in reduced discharge profile to RGH and peripheral hospitals (namely County, Chepstow and St David's hospice) due to the nature of medication storage locations within robot (randomly assigned locations as opposed to alphabetical etc). Stock currently housed in RGH robot would be partially / minimally accessible resulting in a higher need to procure additional stock to meet named patient supplies for ward non-stock items or items for discharges. This is likely to result in an increase in the total stockholding at RGH pharmacy (beyond standard 10-14 days) with increased financial and waste impact associated with reduction in the lean nature of stockholding. In the immediate term this is likely to have a small impact. Increased need to transport medications between pharmacy sites where critical supply is needed in between wholesaler / manufacturer supply timelines.	Where possible, pharmacy teams endeavour to identify discharges ahead of time to allow sufficient time to process medication supplies. One-stop dispensing enables medication currently prescribed to be available on wards to meet patient needs and ward-based patient discharge. This will reduce number of medication lines impacted however will not fully mitigate the impact. Large number of stock lines available from wholesalers with direct delivery timelines as same or next day – enhancing availability of medications. This would be sufficient to allow patient specific 'to-follow' medications to be processed in a relatively timely manner to reduce missed doses or delays in discharges. Where appropriate and available ward stock / WP10(HP) could be used as an alternative method of discharge for acutely urgent discharges. Pharmacy has dedicated transport runs between RGH, GUH, NHH that run multiple times per day. This is likely to serve majority of supplies required during an immediate timescale, however may incur increased costs / delay in supply as per bulk issues.

	Workforce: Reduction in business-as-usual service and need to temporarily redeploy staff to meet mitigation and contingency measures.	- Increased staff costs – overtime / late working to facilitate fix of robot. - Distribution staff pulled to aid fix of robot / identify issues / work with manufacturers and engineers. - Procurement staff – increased workload to facilitate purchase of medications. - Patient services team – reduced ward based pharmacy service in short term to provide mutual aid to other pharmacy sections e.g. distribution / procurement. - Increased need for staff travel to support Systems Team response – increased costs.	Procurement staff – increased workload and pressure to procure immediate patient supplies for specific supplies (namely at RGH) due to reduced access to robot stock. Systems staff – additional requirement of Pharmacy Systems Team provide ad-hoc support for Omnicell and Pharmacy system changes to support temporary amendment of ward bulk issues supply arrangements and add drug files to specific supply locations. Distribution staff – additional pressure on site based distribution teams to provide supply of bulk items they would ordinarily have received during the Omnicell top-ups e.g. enhanced volume of critical low supplies.	Systems team SBAR presented to Pharmacy Management Team in May 2023 with ratification of plans in place to recruit 2 additional members of staff to the pharmacy systems team with associated training to allow additional resilience to be built into the team. Plans in place but recruitment has not yet commenced due to need to ring-fence funding. Distribution staff trained to process critical-low supplies. Automated reports generated daily. In the 'immediate' timeframe this is likely to be sustainable but may pull support from ward-based pharmacy services leading to reduced patient flow and potential for missed doses or reduction in the positive impact of ward based pharmacy medicines management processes e.g. identifying medicines reconciliation errors, medication advice to allied health care professionals etc.
Short Term loss of RGH robot (<1 week loss of service)	**Bulk supply:** Lack of ability to provide centralised distribution service for up to 1 week to	- Increased workload for local procurement teams at each site. - Short term reduction in patient flow across multiple sites (RGH,	Each Omnicell (approx. 50) will require a minimum of 1 top-up per week from RGH as the pharmacy distribution hub. If Omnicell's are unable to top-up for 1 week likely to place significant strain on local sites to process supply through critical low	To reduce impact and volume of Omnicell top-up's required to be diverted to other sites a risk stratified approach would be followed as per ABUHB Pharmacy Contingency plan. This would enable high risk and large

(Business Continuity Plan)	GUH, YYF, RGH and Peripheral Hospitals	GUH, NHH, YYF) due to pull on staff to support stock management service provisions to RGH and peripheral hospitals ~ Reduced pharmacy assistant support to ward-based pharmacy service due to increased local demand for distribution. ~ Reduced provision of ward-based service: Increased pull-on pharmacist and pharmacy technician's to provide ward based service. - Standard transport runs diverted to support delivery of bulk service continuity plans – increased costs / time – reduction in efficiency and potential for medication supply delays. - Increased medication supply issues and potential for missed doses from stock shortages.	processes. This would not be sustainable and would cause reduced availability of medications at ward level with potential for delay in patient doses and/or increased pressure on nursing staff to obtain supplies from adjacent wards. Increased need to transport medications between pharmacy sites where critical supply is needed in between wholesaler / manufacturer supply timelines. Additional transport runs between sites to transfer stock – use of current runs with additional taxi / ad-hoc transport required for urgent stocks (likely to rely heavily on NHH as there will be no or limited access to RGH robot stockholding during shutdown). Staff (predominantly pharmacy assistants) at YYF, GUH would be diverted to support distribution service versus ward-based pharmacy service. Lead to additional pressure on pharmacy technicians and pharmacists with potential for delayed provision of ward pharmacy services. Ward areas without automated supply provision (Omnicell's) lack ability to receive up-to-date stock holding analysis to allow maintenance of critical stock holding in same way as Omnicell wards. This could lead to lack of medication	volume areas to be topped up in priority order e.g. NICU, ICU, GUH ED, GUH MAU, RGH MAU, YYF MAU etc. Critical low process as detailed for immediate loss of RGH robot would be actioned to ensure critical stock levels within Omnicell areas are maintained. Additional transport for limited time period likely to be feasible however may incur additional costs and delay in timely supply of medications. Pharmacy has dedicated transport runs between RGH, GUH, NHH that run multiple times per day. This is likely to serve majority of supplies required during an immediate timescale. Band 4/5 pharmacy technicians trained to complete pharmacy assistant role at ward level. May require staff overtime to facilitate depending on perceived needs. Reduced ward cover would be enacted in line with pharmacy clinical service escalation pathways. Ward based pharmacy teams to attend ward as per usual process and aid pharmacy top-up service. Ward based teams in peripheral hospitals (without ward based pharmacy medicines management service) are provided

			supply or delay in medication stock supply with potential for missed doses to patients.	with access to WOREQ2 to allow ordering and supply. Usual timelines 48 hours likely to be extended to 72 hours during immediate RGH robot failure.
	Patient specific supply: Short term lack of ability to retrieve stock for discharges at RGH and peripheral hospitals.	- Increased medication supply issues and potential for missed doses from delayed patient specific supplies / need for patients to bring medication from home using relatives / carers etc. - Significant delays to discharges – potential for 24 hours delays. - Increased stockholding at RGH to support patient specific issues. - Lack of space to house additional stock – increased risk of picking errors. - Increased reliance on community pharmacies to support discharge processes – increased workload on already pressured system and reduced accuracy of information flow to GP's. - Increased costs and time associated with transport and urgent supply needs e.g. taxi's used. Reduced governance around medication transport.	Lack of ability to access RGH robot stock in a timely manner resulting in reduced discharge profile to RGH and peripheral hospitals (namely County, Chepstow, St Woolos and St David's hospice). Stock currently housed in RGH robot would be partially / minimally accessible resulting in a higher need to procure additional stock to meet named patient supplies for ward non-stock items or items for discharges. This is likely to result in an increase in the total stockholding at RGH pharmacy (beyond standard 10-14 days). Due to lack of space to house robot items external to robot at RGH Pharmacy dept likely to lead to increased risk of selection errors in dispensing process and increased time to dispense finding stock etc. Increased need to transport medications between pharmacy sites where critical supply is needed in between wholesaler / manufacturer supply timelines. Potential need to use ad hoc / taxi transport – currently no SLA / governance frameworks	Where possible, pharmacy teams endeavour to identify discharges ahead of time to allow sufficient time to process medication supplies. One-stop dispensing enables medication currently prescribed to be available on wards to meet patient needs and ward based patient discharge. This will reduce number of medication lines impacted. Large number of stock lines available from wholesalers with direct delivery timelines as same or next day – enhancing availability of medications. This would be sufficient to allow patient specific 'to-follow' medications to be processed in a relatively timely manner to reduce missed doses or delays in discharges. Where appropriate and available ward stock / WP10(HP) could be used as an alternative method of discharge for acutely urgent discharges. Limited timescale and use of stock procurement on individual patient basis may limit risk of selection errors. Pharmacy has dedicated transport runs between RGH, GUH, NHH that run multiple times per day. This is likely to serve majority of supplies required during an

			in place for these transport runs versus current pharmacy transport SLA.	immediate timescale. But there may be gaps where provision is not sufficient.
	Workforce: Reduction in business-as-usual service and need to temporarily redeploy staff to meet mitigation and business continuity measures will put additional strain on staff in other areas of the pharmacy workforce.	- Increased staff costs – overtime / late working to facilitate fix of robot or engineer visits throughout week (usually evenings and overnight). - Distribution staff pulled to aid fix of robot / identify issues / work with manufacturers and engineers. - Procurement staff – increased workload to facilitate purchase of medications. - Patient services team – reduced ward based pharmacy service in short term to provide mutual aid to other pharmacy sections e.g. distribution / procurement. - Increased need for staff travel to support Systems Team response – increased costs / pressure on staff.	Procurement staff at sites may lack additional capacity to cover tasks required to maintain service and procure additional medication stocks to enable supplies. Likely able to facilitate short term increases with reduction in 'pro-active' procurement processes e.g. chasing of outstanding orders, clearing 'to-follows', amending ordering parameters etc which may result in downline reduction in efficient procurement processes. Systems staff are likely to need to work on partial elements of change to the pharmacy system and Omnicell database to implement action mitigating actions. Currently systems team consists of 2 members of trained pharmacy staff. Clinical staff – additional stress and workload placed on reduced ward-based pharmacy staff team due to potential diversion of pharmacy assistant workforce to aid procurement and distribution processes.	Standardised procurement processes now in place following period of training. These processes have allowed for remote support to be a potential option in the short term from other sites. Systems team SBAR presented to Pharmacy Management Team in May 20023 with ratification of plans in place to recruit 2 additional members of staff to the pharmacy systems team with associated training to allow additional resilience to be build into the team. Distribution staff trained to process critical-low supplies. Automated reports generated daily. In the 'immediate'

			Distribution staff – likely increased workload to facilitate additional critical-low supplies and potential diverted Omnicell top-ups.	timeframe this is likely to be sustainable but may pull support from ward-based pharmacy services.
Long term loss of RGH robot (>1 week) **(Business Contingency Plan)**	**Bulk supply:** Lack of ability to provide centralised distribution service to GUH, YYF, RGH and Peripheral Hospitals. Omnicell top-ups to GUH, YYF and peripheral hospitals will not be fulfilled from RGH. These will need to be diverted to other sites – causing additional pressures on the procurement and distribution and clinical pharmacy teams at allocated sites.	Significant wholesale alterations to working practice across the HB. Impact likely at all sites – YYF, RGH, GUH, NHH. - GUH pharmacy not built for distribution – small robot, space and distribution staff: ~ Significant longer term pull of ward based staff required to support Omnicell stock top-up to GUH wards. Lack of pharmacy assistant and technician roles at ward level and heavy reliance on pharmacists to complete supply tasks. Not sustainable on background of current staffing vacancies therefore reduced ward provision. - RGH staff likely to be redeployed to aid other sites to support bulk distribution model – approx. x 3 WTE pharmacy assistants.	Lack of ability to provide centralised distribution model from RGH would have a significant impact on ability of the pharmacy teams across the HB to provide a clinical pharmacy service. In order to maintain ward stock supplies and provision to all required areas significant amendments would be required to the pharmacy service provision impacting procurement, distribution and clinical pharmacy teams. This would lead to reduced efficiency of pharmacy service provision and increased costs through redeployment of staff, enhanced requirements for transport between sites, overtime and agency staff requirements in addition to the likely reduction in clinical pharmacy services across all 4 HB sites. Omnicell top-ups for 25% of GUH wards to come from GUH using existing staff at GUH pharmacy. Potential need to add additional stock lines to GUH pharmacy stockholding, increased procurement direct to GUH pharmacy department, increased distribution involvement to book on and distribute stocks. This will result in redirection of ward based	Redirect Omnicell automation from RGH to GUH for assigned Omnicell's with least diverse stockholding. This will require approximately 1-2 pharmacy assistants to be redirected from ward-based pharmacy services. Due to the use of critical low processes distribution staff at GUH are trained to complete release of Omnicell orders. RGH staff (2 WTE Pharmacy assistants) to be redeployed to work from NHH to support distribution processes and release of Omnicell orders. Due to need to maintain current business-as-usual for NHH and limited additional capacity (both in terms of robot storage and working capacity of NHH robot during standard working hours) additional work shift patterns to be created to allow extended pharmacy opening at NHH e.g. 7am – 7pm) to facilitate. Overnight period of 'downtime' required to be able to load robot with additional stock to facilitate additional workload (NHH has the largest 'spare' capacity within its robot. At any one time there is the potential to add approximately 40% additional stockholding to the robot and therefore 40% would not meet the likely enhanced demand to purely run 9am-5pm service). RGH Pharmacy Procurement team to support GUH, NHH and YYF teams in terms of ordering of medications. This can be a blend of on-site and remote working. To support this a centralised task list and standardisation of

		- Reduced medication safety, increased missed doses, delayed discharge profile and flow across all sites. - Increased workload for local procurement teams at each site will necessitate diversion of staff to support and reduced proactive procurement processes e.g. medication shortage management, contract purchasing etc – increased costs of procurement process. - Significant disruption to NHH pharmacy department – relocate bulk issues (RGH & 50% GUH). Likely to require extended opening hours and shift working to facilitate whilst maintaining NHH service. - May require renegotiation of Powys SLA with associated costs. - Standard transport runs diverted to support delivery of bulk service contingency plans – increased costs / time – reduction in efficiency and potential for medication supply delays.	pharmacy assistants to assist the processing of orders. Omnicell top-up's for 75% of GUH requirement and 50% of RGH requirement to be rediverted. This is likely to rely on NHH pharmacy department which at present has limited scope due to structural issues around NHH hospital estate. NHH need to maintain supply to NHH ward areas and Powys as part of their WDA agreement to supply. Procurement service at any given site unlikely to meet increased demand in terms of volume and variety of stockholding. YYF Pharmacy department to service YYF ward top-up service. ABUHB pharmacy transport timelines are scheduled to meet current needs of centralised distribution service. These are unlikely to meet the needs of a disseminated distribution model. There would be additional routine and ad-hoc required transport runs requiring the pharmacy service to revisit and re-negotiate the terms of the current SLA in place with likely enhanced costs in	the procurement function has been developed and implemented in July 2023 to allow fluid movement of staff as required. YYF Pharmacy department to service YYF ward top-up service. During implementation of new pharmacy system YYF pharmacy team completed own ward-top up service. Likely need to divert pharmacy assistant from ward-based pharmacy service to facilitate. Pharmacy transport between RGH, GUH, NHH is provided solely for the purpose of the pharmacy service. This will allow flexibility of service to meet changing needs as currently 1 driver dedicated all day to pharmacy transport runs. Despite this, transport runs would likely need to diverge outside of the current SLA with NWSSP and therefore renegotiation of terms and payment is likely.

		- Increased medication supply issues and potential for missed doses from stock shortages.	addition to the need to use taxi services to meet acute demands.	
	Patient specific supply: Long term lack of ability to access robot stock and need to relocate stock at RGH for manual dispensing of patient specific supplies, including discharges for RGH and peripheral hospitals.	- Significant disruption to ward based pharmacy service with reduced patient flow. - Increased risks of medication safety incidents and dispensing errors through manual picking of stock for patient specific supplies from RGH in particular. - Lack of adequate medication storage – currently no option for external storage of robot medications within RGH Pharmacy footprint, and associated security issues potential. - Increased staff costs – overtime / late working to facilitate fix of robot or engineer visits throughout week (usually evenings and overnight). - Distribution staff pulled to aid fix of robot / identify issues / work with manufacturers and engineers. - Procurement staff – increased workload to facilitate purchase of medications.	Lack of ability to access RGH robot stock in a timely manner resulting in reduced discharge profile to RGH and peripheral hospitals (namely County, Chepstow, St Woolos and St David's hospice). In the event of a longer term shutdown there would be the need to remove all stock from the RGH robot and relocate to enable access and dispensing based on manual picking model from shelves where stock is arranged in alphabetical order. This would include need to: - Manually pick stock from shelves. Pharmacy staff are not trained to do this on large scale and therefore would lead to increased risk of picking and dispensing errors leading to potential for medication safety issues and patient harm. - Manual picking of stock is significantly less efficient than embedded automated practices using robot dispensing. This will increase the pharmacy staff requirement to complete dispensing activities and require redeployment of staff, increased costs linked to agency staff and overtime and a reduction in	In order to mitigate some of the impact caused there is the need to proactively identify a location and complete any enabling works ahead of a long term breakdown which will likely incur refurbishment costs in addition to the opportunity costs of use of an area within the hospital. Limited mitigating actions for a long term shutdown are feasible to completely manage risks and associated impacts.

		- Patient services team – reduced ward based pharmacy service in short term to provide mutual aid to other pharmacy sections e.g. distribution / procurement. - Increased need for staff travel to support Systems Team response – increased costs / pressure on staff. - Significant negative effects on staff morale – background of short staffing and increased pressures throughout pharmacy.	dispensing efficiency which will impact patient flow. - Need for dedicated space outside of RGH Pharmacy department footprint. Currently no sufficient storage location identified at RGH however lack of available space in RGH Pharmacy to remove and relocate within current footprint. St Woolos location identified location (during RGH Pharmacy refit scoping) required significant investment (approx. £200K) to make fit for purpose. Without robot the inefficiency of dispensing and adverse impact on patient flow may require diversion of additional patient specific workload to alternative sites e.g. NHH and GUH who do not have the current capacity to do so.	
	Workforce: Long term reduction in business-as-usual service and need to redeploy staff to meet mitigation and contingency measures will put additional strain on staff in other areas of the		Procurement staff at sites may lack additional capacity to cover tasks required to maintain service and procure additional medication stocks to enable supplies. Long term robot failure likely to require additional staff to be trained to complete procurement processes to support staff at other sites. A centralised distribution hub at RGH currently allows economies of scale that would not be feasible in a fragmented distribution model.	Procurement processes have been standardised to allow potential for cross-site working as needed. Procurement team have developed a training pack that would allow staff to be trained to complete elements of the procurement process in a timely manner if required. The pharmacy system now allows adapted ordering levels to be set by the system itself based on historical usages which aids automation and reduces needed for manual interpretation.

	pharmacy workforce.		Systems staff are likely to need to work on partial elements of change to the pharmacy system and Omnicell database to implement action mitigating actions. Currently systems team consists of 2 members of trained pharmacy staff. Clinical staff – additional stress and workload placed on reduced ward-based pharmacy staff team due to potential diversion of pharmacy assistant workforce to aid procurement and distribution processes. Distribution staff – likely increased workload to facilitate additional critical-low supplies and potential diverted Omnicell top-ups.	
	Other: Availability of replacement parts for RGH robot repairs	Inability to fix issues as parts are no longer the manufactured	The lack of availability of mechanical parts for robot repairs is an ongoing issue to the ceasing of manufacture due to age of robot. Previous mechanical fixes have used second hand parts or patch fixes from DIY store purchases due to the lack of availability. As the robot gets older these issues are compounded.	Current mitigation around robot breakdowns involved routine servicing of RGH robot by Omnicell through service contract (£31,062 / annum exc. VAT) with servicing every 4 months by engineer visit to site. Despite the routine servicing the robot still incurs regular breakdowns. The average number of breakdowns per month is 2.3 (data January – July 2023) compared to average of 1.4 breakdowns per month in 2020. During each breakdown in 2023 there have been significant disruptions at an average of 6 days between the opening and closure of the call / ticket.
	Other: Lead time for replacement robot	Procurement of robot is unlikely to be quick and therefore procurement during acute breakdown scenario likely to delay resolution.	Current lead time for replacement robot in region of 3-6 months when planned. If robot was to breakdown this is likely to be extended due to procurement timelines to approximately 12 months leading to at	

			least 12 months of disruption to the pharmacy service.	
	Other: Pharmacy stockholding		Depending on timeline of RGH robot failure and resolution likely to be risk of expiry of stock in RGH robot leading to significant risk of financial losses. RGH robot holds £1.2M stock at any given time. This stock will be required to be removed from the RGH robot manually. There is an ongoing need to store this stock in an additional location at RGH for named patient supply and RGH site bulk issues. There is no current specified location that provides the required security or space to store this stock.	Currently no sufficient storage location identified at RGH however lack of available space in RGH Pharmacy to remove and relocate within current footprint. St Woolos location identified location (during RGH Pharmacy refit scoping) required significant investment (approx. £200K) to make fit for purpose.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	On P&CC Divisional Risk Register score = 20
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.6 Medicines Management 3.1 Safe and Clinically Effective Care 5.1 Timely Access 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
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)**	
Resource Assessment:	Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	No does not meet requirements

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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Adequacy of controls	Approval status	Consequence (Target)	Consequence (current)	Controls in place	Date first identified	Description	Division	Handler	ID	Last updated	Likelihood (Target)	Likelihood (current)	Location (type)	Manager	Rating (Target)	Rating (current)	Review date	Risk Subtype	Risk Type	Risk level (Target)	Risk level (current)	Site	Title	Health & Care Standard Theme	RISK - Date of last update	Risk / Issue	Risk Owner	Risk Register	Risk Register Sites	Standard	Trend	Capital Risk - Has a PPD
Inadequate	Current	Major (4)	Major (4)	Funding for robot and/or refurbishment not forthcoming in current capital programme. Without the RGH refurbishment and robot case progressing, this service will continue to deteriorate and lead to missed doses at ward level, delay TTHs and have a negative effect on patient flow throughout ABUHB. Comprehensive maintenance contract with Omnicell Ltd. This includes 3 routine maintenance inspections, 1 accident prevention per year with 4hr breakdown response. Contingency plan – this is due to be completed by end of September 2023 as stipulated in the report and will require ratification by the other Pharmacy Site Leads as PMT as would have implications on the service at all sites.	24/07/2019	Current department layout/robot is over 18yrs old and service is not fit for purpose. Robot has a constantly high number of breakdowns, rendering supply erratic and leading to medication stock issues across South Gwent. RGH department not fit for purpose and significantly inferior to other sites, consequently unable to perform role as Medicines Distribution Hub.	Primary Care & Community	Thomas, Jane	3762	Jane Thomas 22/8/23	Almost Certain (5)	Almost Certain (5)	Pharmacy - Acute hospitals	Webber, Jo	20	20	31/10/2023	Medicines Management	Patient Safety	High risk	High risk	Royal Gwent Hospital	Dispensing and Ward Box Robot	Safe Care	22/08/2023	Risk	Jonathan Simms	Divisional Risk Register	Royal Gwent Hospital	2.6 Medicines management (safe care)	No change to risk	Yes

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee Self-Assessment
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to inform the Committee of the annual self-assessment process and to discuss the self-assessment template, which is appended to the report as Appendix 1.

Cefndir / Background

As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

Asesiad / Assessment

Traditionally, the self-assessment is completed at the end of every financial year to determine committee members' opinions on the effectiveness of the committee throughout the year; however, it has been agreed that the self-assessment process will be completed midway through the year, (October/November) on the basis, that this will inform the Committee Annual Report, Annual Accountability Report and Governance Statement. This will also inform the Board's overall evaluation of its effectiveness.

Following discussion, if the Committee considers the self-assessment template (appendix 1) is a useful tool, which is based on the Committee's terms of reference, the template will be shared with members by the first week of November for a period of four weeks. Following this, the Corporate Governance Team will compile the responses into charts for the December Patient Quality, Safety and Outcomes Committee's consideration and discussion.

Argymhelliad / Recommendation

The Committee is asked to:

- NOTE the report,
- CONSIDER the self-assessment template for completion in order to inform areas of development for the forthcoming year, and;
- AGREE to the Committee undertaking the self-assessment as per the timescales set out.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The self-assessment of committee effectiveness ensures risk is appropriately monitored and managed.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
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:	None

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**	Not Applicable
• **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	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

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

Patient Quality, Safety and Outcomes Committee Self-Assessment Checklist

Introduction

The self-assessment tool is a way for our Patient Quality, Safety and Outcomes Committee (PQSOC) to develop its effectiveness. The Board and its sub-Committees should aim to assess their effectiveness against these questions on an annual basis.

To gain an overall view of PPC effectiveness, it is important that the individual views of all members are considered as a whole, therefore, each area of the effectiveness tool allows space for comments. This provides an important opportunity to expand on any considerations relating to that section of the effectiveness tool and to highlight any concerns about the Committee's performance.

At the end of the self-assessment there is an opportunity for you to provide an overall score on the Committee's effectiveness using the scoring scale below.

Score	Measure	Description
1	**Room for improvement**	The PQSOC is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The PQSOC is performing to the required standard in this area. There may be room for improvement, but the PQSOC can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the PQSOC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

The completed self-assessments will enable the Corporate Governance Team to: -

1. generate an overall view of PQSOC effectiveness; and
2. drill down and analyse specific areas of strength or improvement on a section, sub-section, and individual question level.

The results of which will be reported to the Committee in December 2023 and used to inform the Committee Annual Report, Annual Accountability Report and Governance Statement.

Section 1 - Committee Processes: Composition, Establishment, and Ways of Working				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
1	Does the Committee have written terms of reference and have they been approved by the Board?			
2	Are the terms of reference reviewed annually?			
3	The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?			
4	Has the Committee been quorate for each meeting this year?			
5	In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?			
6	Members who have recently joined the PQSOC have been provided with induction training to help them understand their role and the organisation?			
7	The Committee is clear about its role in relationship to other Committees that play a role in relations to patient quality and safety matters?			
8	Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?			
9	The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor?			
10	The Committee has an established a plan of matters to be dealt with across the year?			

11	Does the Committee consider issues at the right time and in the right level of detail?			
12	The Committee ensures that the relevant executive director(s) attends meetings to enable it to understand the reports and information it receives?			
13	Are the Committee's papers distributed in sufficient time for members to give them due consideration?			
14	The quality of the Committee's papers received allows Committee members to perform their roles effectively?			
15	Committee meetings are chaired effectively?			
16	The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?			
17	The Committee environment enables people to express their views, doubts, and opinions?			
18	The Committee challenges management and other assurance providers to gain a clear understanding of their findings?			
19	Members hold their assurance providers (management) to account for late or missing assurance?			
20	Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored?			

21	At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc?			
22	Decisions and actions are implemented in line with the timescale agreed?			
23	Are the outcomes of each meeting and any issues of concern reported to the next Board meeting?			
24	Does the Committee prepare an annual report on its work and performance for the Board?			
25	The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.			
26	The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?			

Section 2 – Clinical Quality Governance				
	Question	**Response Yes/No**	**Comments**	**Suggested Improvement Actions**
27	Is the Committee satisfied that there is a credible process for assessing, measuring and reporting on Clinical Quality Governance			
28	Is the Committee assured that the Health Board's Clinical Quality Governance Arrangements remain appropriate and aligned to the National Quality Framework			
29	Is the Committee assured that Clinical Quality Governance is embedded in practice?			
30	Does the Committee receive sufficient assurance that the systems, processes and plans to measure, monitor and enhance the quality of our healthcare services are fit for purpose			
31	Does the committee effectively scrutinise the quality performance issues and key performance indicators (6 pillars):			

	1. Person Centred			
	2. Safe			
	3. Timely			
	4. Effective			
	5. Efficient			
	6. Equitable			

Section 3 – Patient Experience and Involvement				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
32.	Does the Committee receive assurance that the arrangements for capturing the experience of patients, citizens and carers are sufficient, effective and robust?			
33.	Does the Committee review progress against the Patient Experience and Involvement Strategy			
34.	Does the Committee receive and consider sufficient information on compliance with Putting Things Right Regulations, including trends and ensuring lessons are learned?			

Section 4 – High Quality, Safe and Effective Healthcare				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
35	Does the Committee receive assurance that commissioning arrangements are in place to ensure the efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on behalf of ABUHB?			

36	Is the Committee satisfied that arrangements are in place to undertake, review and act on clinical audit activity which responds to local and national priorities?			
37	Does the Committee consider recommendations made by internal and external review bodies and ensure that action is taken in response?			
38	Does the Committee received sufficient assurance that arrangements are in place to ensure that there are robust infection prevention and control measures in place in all settings?			
39	Does the Committee contribute to the development of the Health Board's Annual Quality Priorities?			
40	Does the Committee consider performance against key quality outcomes focussed indicators and metrics?			

Section 5 – Research and Development and Improvement and Innovation				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
41	Does the Committee receive assurance in respect of the research and development activity within the organisation?			
42	Does the Committee receive assurance in respect of improvement and innovation projects to improve the quality and safety of services?			

Section 6 – Compliance with Health and Safety Regulations and Fire Safety Standards				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
43	Does the Committee receive assurance in respect of arrangements in place for compliance with Health and Safety Regulations and Fire Safety Standards, including operating practices in respect of: • Staff Health and Safety • Stress at Work • Patient Health and Safety (ie falls, patient manual handling violence and aggression) • Fire Safety • Risk Assessment processes • Safe handling of loads • Hazardous substances			

Overall Assessment		
Score	**Measure**	**Description**
1	**Room for improvement**	The PQSOC is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The PQSOC is performing to the required standard in this area. There may be room for improvement, but the PQSOC can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the PQSOC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.
Comments:		

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 October 2023
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Aneurin Bevan University Health Board Patient Safety Incident Reporting & Management Policy (Duty of Candour: Moderate/Severe Harm)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Garvin Jones – Head of Legal Services

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Boards 'Policy & Procedure for the Management of Serious Concerns (Severe or Catastrophic) was issued in 2012 and due for review in 2015. This is now significantly outdated. There have been numerous developments and changes of focus over the intervening period:

- Significant changes in national legislation and policy, including the introduction of Duty of Quality and Duty of Candour.
- Changes to the methodology for National Reportable Incidents (NRI's), moving away from prescriptive 'trigger lists' to 'judgement' and 'analysis'.
- An embracing of new concepts, including 'Safety 11 culture' and 'Just culture'.
- Alongside 'good' incident investigations, ever important need to embed learning & improvement from our investigation findings, to reduce patient safety incidents and prevention of future occurrence.
- 'Rich stream' of learning/improvement/actions now formally submitted and assessed for assurance via the Welsh Risk Pool (WRP).
- Increased recognition of the ever important need to ensure our systems put patients, families and staff at the heart of our process.

The Health Board's policy has been updated and refreshed to reflect the changing landscape. As a Health Board we must ensure that our processes and approaches to this complex and sensitive area of healthcare are aligned, to ensure the quality of

our Patient Safety investigations, that our patients are at the heart of that process, and to maximise learning opportunities for the benefit of patients, service users, their families, our staff and other NHS organisations.

In addition to Patient Safety Incident investigations, focussed on an adverse event causing moderate or severe harm, the Health Board will invoke other types of investigations as determined, including thematic reviews, look back reviews, joint investigations, concise reviews and rapid learning. These will be discussed and taken forward via the Executive Huddle.

Going forward, the Health Board will look to incorporate patient wishes/ concerns/ expectations from the outset directly into the Terms of Reference for the intended investigation. The Health Board will share the draft TOR with the patient/ representative and look to agree these wherever possible.

Accountability for tracking and implementing learning and actions

The central Patient Safety Incident Team will monitor and track identified Divisional actions and learning from incident investigations. Whilst the central team will assist with this quality assurance, ultimately each Division will be responsible and accountable for the delivery of its learning, actions and ongoing monitoring, audits and assurance around compliance. Accountability Agreements will be developed for each Division. An Escalation process will be invoked if required.

Actions arising from moderate/severe investigations to be shared with Executives and Divisional Triumvirate.

The Health Board strives to be an all-encompassing learning organisation where people continually expand their capacity to improve.

Cefndir / Background

On 11th May 2023 the NHS Wales Executive published NHS Wales National Policy on Patient Safety Incident Reporting & Management. The purpose of this Policy is to set out clear expectations and standards for patient safety incident reporting and management across NHS Wales, superseding the previous guidance on Serious Incidents within the 2013 Putting Things right guidance document. The Health Board's policy, and processes going forward, have been updated to reflect the National policy and approach.

For context, this updating of our policy should be seen in the wider landscape of current works underway at the Health Board. Patient Safety Incidents are increasing. We currently have a high number of significant/severe harm investigations underway. We are seeing repeated incidences and themes. Whilst these are being managed and local learning occurs, this does not appear to translate into organisational learning.

With this in mind, a significant piece of work is underway to realign QPS resources in a new central model, to include ABCi improvement colleagues, and so better align our ability to drive and embed learning and improvement. The central Patient Safety Incident team, alongside a new alignment to the legal services team, will see increased specialism, to include dedicated Investigating Officers, ensuring required

skills and independency for our most complex/involved/sensitive and reputational patient safety incident investigations.

Through these combined, cost-neutral changes, we hope to make more effective use of our available resources and skilled staff, reduce variation in practices, achieve a more unified consistent approach, being more adaptable and responsive to our most sensitive and complex incidents, promoting the Health Board's reputation as a truly learning organisation.

Asesiad / Assessment

The Health Board's Patient Safety Incident Reporting & Management Policy supports the NHS Wales National Policy which endeavours to empower all NHS organisations in Wales to take more ownership and accountability for incident reporting and management, and thereby learning & improvement from our investigation findings, to reduce patient safety incidents and prevention of future occurrence.

A summary of key changes outlined in the chart below:

2012 Policy	2023 Policy
Referred to as a Serious Incident	Redefined as Patient Safety Incident
Severe and Catastrophic harm considered	Moderate and severe harms considered in addition to thematic reviews of lower harm incidents
Safety I culture	Safety II culture
Focusing on 'What went wrong'	Examining 'what went right' in addition to 'what went wrong'
Focus on incident in isolation	Focus on themes and wider learning from these.
Incidents categorised as Red 1 (Corporate led) and Red 2 (Divisional led) investigations	Incidents categorised as Moderate and Severe investigations

New components of 2023 policy:

Duty of Candour obligations explicit
Aligns to the All-Wales National policy on patient safety incident reporting and management – previously local arrangement responsibility.
Harm is due to healthcare exposure ('but for')
Just Culture introduction
Outlines National Reporting process
Aligned to new legislation - Health and Social Care (Quality and Engagement) (Wales) Act 2020, The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023, Putting Things Right guidance document (v3, 2013), The Duty of Candour Procedure (Wales) Regulations 2023 and The Duty of Candour Statutory Guidance 2023.
Inclusion of definitions of terms
Removal of H+S and child protection sections (links to supporting policies)
Removal of Coronial reporting categories
Importance of timely patient and family engagement in setting and agreeing Terms of Reference
Clarity of Executive sign off process.
Clarity upon lead divisional/organisational responsibility for action plan production and dissemination of organisational learning.
Introduction of incident review by Division within 2 working days.
Presentation of incident to weekly pre-executive huddle.
Recognised importance of securing CCTV/ other evidence where relevant

Argymhelliad / Recommendation

The Committee is asked to review and provide comment on the revised policy prior to presentation to the Board for approval.

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):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 6. Individual care
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	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NHS Wales National Policy on Patient Safety Incident Reporting & Management.
Rhestr Termau: Glossary of Terms:	Within Policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No, not needed

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.

Aneurin Bevan University Health Board

Patient Safety Incident Reporting & Management Policy

(Duty of Candour: Moderate/Severe Harm)

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 1 | Issue date: dd/month/year
Approved by: | Review by date: dd/month/+ 3 years
Owner: Head of PTR | Policy Number: ABUHB/Category/Number

Contents

1 Introduction and Background

Patient Safety Incidents have the potential to cause harm to those in receipt of healthcare. It is inevitable that healthcare systems and processes will have weaknesses and that sometimes, these may result in errors or near misses. Patient Safety Incidents not only impact upon patients, services users, their families, and Health Board staff but can affect the reputation of the organisation, eroding public trust. Therefore, being able to respond effectively and appropriately when things go wrong is fundamental to improving patient safety and the quality-of-service provision. In an increasingly complex health care system, it is impossible to prevent all risks associated with healthcare. Aneurin Bevan University Health Board (ABUHB) is committed to the health and safety of its patients, service users, staff, visitors and contractors by promoting a culture of openness and honesty, focusing on improving practice and creating a safer environment. It thereby aims to proactively report and manage all patient safety incidents to reduce future risks and mitigate further recurrence.

This Patient Safety Incident Reporting & Management Policy forms part of the Health Board's governance and risk management process for managing, reporting, analysing and learning from patient safety incidents.

Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. Incident reports can be a valuable source of data about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. Patient safety incident reporting has changed across NHS Wales as our understanding of how to best use intelligence from incident data continues to evolve. This includes triangulation with other data sources (for example, patient experience and compliance data) and moving from a Safety I to a Safety-II approach will help organisations to shift the narrative from focusing purely on "what went wrong?" and balance this with learning from "what goes right".

Applying these new approaches will enable the Health Board to think differently about this complex and sensitive area of healthcare and ensure that these maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, and ABUHB staff. Incident reporting and management can highlight specific weaknesses in our healthcare system or processes that need to be addressed to prevent future incidents leading to avoidable death or serious harm.

The Patient Safety Incident Reporting & Management Policy seeks to promote an open reporting culture which encourages staff to look critically at their own actions and those of their teams, with an emphasis on learning and not blame, and where Health Board staff feel supported to identify, report, manage and learn from patient safety incidents, without the fear of punitive response or action. The Health Board are fully committed to embedding Speaking Up Safely as part of our culture. Speaking up Safely: A Framework for the NHS in Wales (gov.wales)

ABUHB's Patient Safety Incident Reporting & Management Policy supports the NHS Wales National Policy (effective from 11 May 2023) which endeavours to empower all NHS organisations in Wales to take more ownership and accountability for incident reporting and management.

2 Policy Statement

This Patient Safety Incident Reporting & Management Policy covers the reporting, management and investigation of patient safety incidents. These will be facilitated by the Patient Safety Incidents Team, in conjunction with and support from, the Executive team, Divisions and Directorates, the Health & Safety Team, and Health Board staff

While many patient safety incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- Highlighting existing risks so that early safety actions can be implemented to reduce the likelihood of recurrence.
- Reviewing of current measures, the Health Board has in place to prevent incidents.
- Fulfilling the Health Board's legal and statutory obligations to record and report certain defined incidents as set forth by NHS Wales Executive.
- Acting as a mechanism for oversight and assurance particularly where significant harm has occurred in the delivery of healthcare, in line with The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 - also known as 'Putting Things Right' (referred to forthwith as 'the Regulations').
- Enabling the monitoring of trends, themes and patterns of incident types or in certain areas, departments or hospital sites and helps to facilitate thematic review for wider learning.
- Learning from what has gone wrong and what could have been done differently, ensuring the sharing of lessons learnt from appropriate levels of investigation and providing a springboard for onward system improvements for the safety of patients.

- Ensuring that all learning is disseminated among key members of the Health Board to inform and improve future practice.
- Providing assurance to patients, service users, their families that lessons have been learned.

There are several routes within the Health Board for learning opportunities to ensure an open and positive learning culture. These include, but are not limited to, patient safety incident investigations, patient experience and complaints alongside established Health Board panels such as Medical Examiner, Falls Review, and Redress. These should be managed collaboratively and thoroughly to determine root causes, contributory factors and actions where appropriate to improve services. ABUHB is committed to ensuring that all actions for learning and improvement from patient safety incidents should be disseminated across the whole organisation to ensure the safety of patients, service users and staff.

3 Aims

ABUHB aims to ensure that all staff can identify Patient Safety Incidents, take appropriate actions and mitigate risks of avoidable harm to patients, staff and service users. Integral to this is the development of an organisational culture which supports incident reporting in an open and fair environment in line with a 'just culture.' Efforts to resolve system failures to support staff in delivering a quality service will be prioritised to improve service delivery. Analysis and learning from incidents are a critical part of patient safety including learning from when things go well. ABUHB is committed to the development of a positive learning culture throughout the organisation.

4 Objectives

- Ensure a clear and consistent Health Board approach to incident reporting, management and investigation aligned to the All-Wales National Policy.
- Provide support and guidance regarding the reporting and investigation of patient safety incidents within ABUHB.
- Provide clear guidance on what types of incidents should be nationally reported to the NHS Executive, and how this should occur.
- To ensure that all incidents (including incidents of near miss) are appropriately reported, and recorded, and an appropriate and proportionate level of investigation is undertaken.

5 Scope

This policy replaces the ABUHB Serious Incident Policy (2012). This policy applies to all permanent and temporary employed staff working within ABUHB, including primary care contractors, who have a responsibility to report and/or investigate and co-operate with Patient Safety Incidents. This policy only applies to patient safety incidents which are to be reported, managed and investigated by ABUHB.

The Policy links and may also need to be considered in conjunction with the following documents:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns,
  Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- Putting Things Right guidance document (v3, 2013)
- The Duty of Candour Procedure (Wales) Regulations 2023
- The Duty of Candour Statutory Guidance 2023

6 Definitions

6.1 Patient Safety Incident

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

This also extends to;

"A situation in which one or more patients or staff are involved, has or could result in significant harm or death; is likely to produce significant legal, or media interest; could damage the Health Board's (HB) reputation or assets and may have significant HB wide implications for practice and delivery of care"."

Policy Term	Applicable Definition
Concern	As defined in the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011,* a concern is any complaint, claim or reported patient safety incident.
Patient Safety Incident	Refers to an incident occurring during the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/ occupational health services.
Action	Something done intentionally or unintentionally.
Inaction	Something **not** done intentionally or unintentionally including because of indecision, unnecessary delay, failure to act.
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy.
"Must report"	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy.

6.2 Harm definitions

The following definitions align with the definitions set out in the Duty of Candour Statutory Guidance.

No harm	Any patient safety incident that had the potential to cause harm, but impact resulted in no harm having arisen.
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care.
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care.
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition.
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition.

A near miss is an incident that did not result in harm, loss or damage, but could have.

7 Roles and Responsibilities

7.1 Chief Executive

The Chief Executive has overall responsibility and accountability to ensure that effective reporting and management of the risks associated with Patient Safety Incidents within ABUHB and is consistent with good practice throughout the Health Board. This responsibility has been delegated to the Executive Director of Nursing (Responsible Officer).

The Chief Executive is responsible for ensuring that ABUHB meets its mandatory reporting obligations to external bodies including the NHS Executive, Wales and Health and Safety Executive (HSE). This is achieved

through the development of robust incident reporting and investigation mechanisms. The Chief Executive and the Executive Team are committed to improving patient outcomes and patient safety and increasing patient satisfaction as well as workplace health and safety of staff. Timely and effective reporting, investigation and analysis of incidents are important constituent parts in achieving this commitment.

7.2 Responsible Officer

The Executive Director of Nursing has an overall responsibility for quality and patient safety. They are responsible for and overseeing the day-to-day management of these arrangements and will provide leadership and support in achieving the aims of this policy and procedures.

The Responsible Officer ensures arrangements are in place to:

- Ensure that concerns (patient safety incidents, complaints and claims) are dealt with under a single arrangement.
- Manage concerns in line with the Putting Things Right (PTR) Regulations (2013).

The responsibilities of the Executive Director of Nursing are delegated to the Head of Patient Safety Incidents but remain under the direct control and supervision of the Executive Lead.

7.3 Head of Patient Safety Incidents

The Head of Patient Safety Incidents, with the support of the central Patient Safety Incident team, is responsible for the handling and consideration of patient safety incident investigations (Duty of Candour: Moderate/ Severe/ Death) and their role requires them to undertake other functions in relation to dealing and cooperating with other persons or organisations, e.g., primary care providers. The Head of Patient Safety Incidents provides leadership and advice to the Executive Board, clinicians and managers on the handling and management of Patient Safety Incident investigations. This includes implementing a system across the Health Board to ensure the remedial actions of Divisions and Directorates are tracked and implemented, with escalation if required, to avoid recurrence of incidents and the sharing of lessons learnt across the organisation and beyond.

All Patient Safety Incidents raised will be discussed via the weekly Executive Safety Huddle. Details of the subject and nature of the incident together with the outcome of the investigation must be recorded. Compliance with the stated time periods for response are monitored and reported. The Board are made aware of Patient Safety Incidents which may adversely affect the reputation of Board.

7.4 Patient Safety Incidents Team

The central Patient Safety Incident team will provide an Annual Report to the Board. This report will include the number of Patient Safety Incidents. The report will focus on providing assurance to the Board that lessons identified during the investigation of an incident are actioned and that appropriate remedial action is implemented, monitored and evaluated for effectiveness.

7.5 Divisional Directors

Are responsible for establishing structures to ensure that Patient Safety Incidents are reported in a timely manner and appropriately investigated within their division. This includes establishing reporting and monitoring arrangements within the Division with a focus on lessons learnt.

7.6 Divisions

Each Division will establish a Quality and Patient Safety forum which includes in its terms of reference the need to review monitor and audit its management of Patient Safety Incidents.

7.7 Redress

If the investigation identifies that there is a possibility that the Health Board may have breached its duty of care to the patient, and that as a result this has caused harm to the patient, and assessed to be within the financial threshold for Redress, the division/locality will need to submit their investigation findings to the Health Board's Redress Panel. In addition to the investigation papers, clinical opinions on harm, and a draft CEO response, the Division will need to complete an LFER to summarise the case and submit to the Redress Panel – Learning from Events Report.

Further information on the required process can be obtained from the Legal Intranet pages: Legal Services - Home (sharepoint.com)

The Redress Panel will formally review the information provided and make a determination as to whether a breach of duty and harm has occurred – a 'Qualifying Liability'

It is possible that the Panel will require further information before a determination can be made. Once the further information has been gathered the case will be represented to the Panel.

The findings of the Redress Panel will be layered into the draft CEO response and send to the CEO for final approval and sign off.

Each division will produce a robust and measurable action plan related to Patient Safety Investigations that occur within their division.

7.8 Investigating Officers

Investigating officers are required to:

- Undertake all patient safety incident investigations and produce written reports in accordance with this policy when appointed by the Divisional Management/QPS team or on occasions the corporate team to do so.
- Seek and undertake the Health Board Investigating Officer training to perform this role.
- Communicate with other key staff involved in the investigation and ensure confidentiality, integrity, sensitivity, courtesy and professionalism throughout their investigation.
- Act in the best interests of patients and their families in the course of their patient safety incident investigation. Seek advice from specialist departments where necessary.
- In cases where information is provided by a member of staff or employee (e.g., from their statement) is referenced in the report, the member of staff or employee must be shown a copy of the report before it is approved.

7.9 Responsibility of All Staff

- Work to the principles and aims outlined in this policy and the All-Wales National Policy.
- To identify, report and review all patient safety incidents (regardless of harm).
- To learn from Patient Safety Incidents and use opportunities to share learning among colleagues.
- To fully co-operate in an investigation to ensure that there is no unreasonable delay in providing information to the investigating officer. Where appropriate to provide statements and attend meetings to give information. Employees are encouraged to seek assistance or advice from their employee's representative. Staff with any literacy issues, must be supported to complete statements from their line manager.

7.10 Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations.
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. (The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting).
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

8 Nationally Reportable Incidents

8.1 Governance and Assurance Requirements

Aneurin Bevan University Health Board must ensure that it has robust systems and processes in place in relation to local and national incident reporting, including:

- Systems and processes to enact this policy in all areas of the organisation.
- All incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirements.
- Being responsible and accountable for their judgements and decisions in line with the policy.
- Integration with other relevant clinical and corporate governance processes e.g., management of complaints and claims, mortality review processes etc.
- Internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms.
- Clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board.
- Mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate.
- Systems for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate

investigation methodology. Organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes.
- Capturing and demonstrating shared learning.
- Ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

8.2 Types of Incidents

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident, and the Health Board will need to apply judgment when considering what should be reported, both at a local and a national level.

Examples of incidents which must be reported include but not limited to:

- Unexpected death
- Clinical error
- Equipment failure
- Unexpected outcome of clinical intervention
- Absence of records
- Self-harm/suicide/overdose
- Delays in diagnosis or treatment
- Slips, trips and falls (patients, public & Staff)
- Information Governance issues
- Staffing/resource related
- Medication errors (prescribing, administration, anaphylaxis)
- Never Events (see Appendix for further guidance)

Incident Reporting should not be used as a means for staff to register a point of view, highlight a situation they were unhappy with or raise a 'political' issue. There are other, more appropriate, means of raising and dealing these within ABUHB. The Health Board also has other policies that may be the more appropriate avenue for raising a concern.

8.3 Complaints as Patient Safety Incidents

The Health Board may be alerted to a Patient Safety Incident raised via the Complaints process. On receipt of a concern raised by a patient, their carer or representative, the Complaints Manager will conduct an initial review and grade the incident in terms of level of harm to the patient. It is acknowledged that the complaint letter is based on the perspective of the

patient/family and facts will need to be verified. Therefore, for concerns graded as serious (severe or catastrophic) the complaints manager will check whether there is a serious incident investigation underway and send the concern to the Locality/Divisional Director to arrange for a rapid review (within 3 working days) to verify the grading. If grading is verified the complaint will be managed via the serious concerns process.

8.4 Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees should have access to report directly into the system. Relevant clinicians should register on the Datix Cymru system to access and review incidents within it also assign and be assigned actions as well as being able to send and receive e-mails out of Datix Cymru thereby creating an audit trail.

The use of Datix Cymru ensures a consistent approach to data collection and analysis. This should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

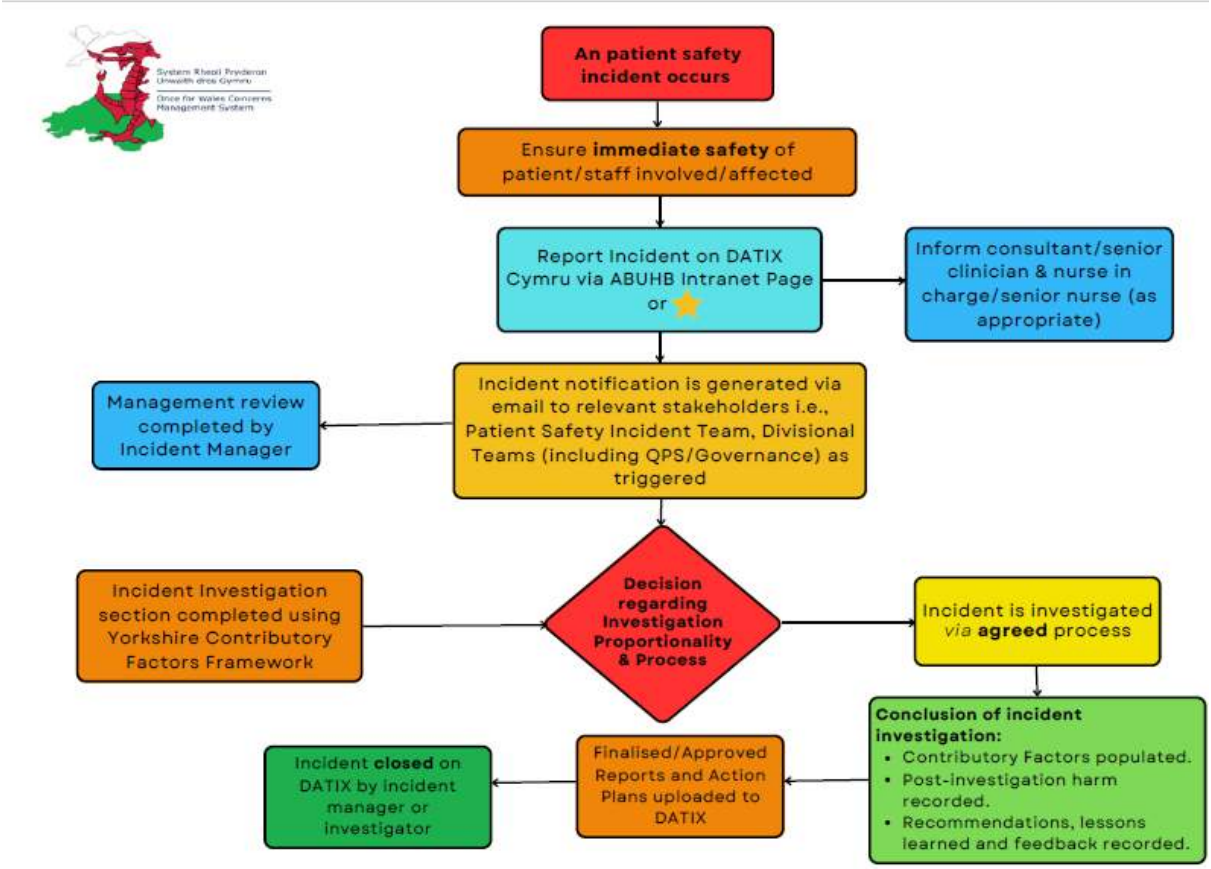
- Secondary and acute care settings
- Primary and community care, including community pharmacy, optometry, dentistry services urgent and emergency services including emergency departments & ambulance services
- Out of hours' services
- Public health services
- Relevant IT services
- Prisons
- Commissioned services, and
- Incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the Health Boards' governance and assurance mechanisms, ensuring clear reporting of relevant information.

The Health Board will ensure that local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

Guidance for Reporting an Incident can be found in the Appendices.

Figure 1: Process for reporting and investigation of a Patient Safety Incident within ABUHB



9 Review of Patient Safety Incidents to ascertain if they are Nationally Reportable Incidents (NRIs)

As part of the initial assessment process the Health Board will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable:

- Never Events, as specified within this Policy, even where no harm has occurred. (The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy);

- Suspected mental health homicides;
- Suspected suicide or self-inflicted death
    - in any clinical setting; or
    - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge
- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** during a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm** or **death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded later.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- Screening services
- IT failures
- Data breaches
- National system failures, and/or
- Service disruptions

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- Near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations

to help raise awareness and mitigate risks for other patients or service users; and/or
- Incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources to inform the discussion.

9.1 Reporting Process for Patient Safety Incidents as NRIs

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in **Appendices**.

9.1.1 Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems which are overseen and managed by the NHS Wales Executive.

AN EWN should be considered with regards to incidents which may or may not have resulted in direct harm to patients, but may have an impact on service provision, organisational reputation, adverse media coverage or political embarrassment.

An EWN will be submitted to Welsh government via PTR only and requires Executive sign off prior to submission.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, both processes must be followed.

9.2 Initial assessment to determine risk management and next steps

All patient safety incidents will require an initial assessment to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident (within first 72 hours) has occurred or otherwise been identified by the Health Board.

This initial assessment must include:

- Review of known information about the incident and consideration of further information to be obtained to inform the next steps;
- Assessment of risk and determination of make safe actions in relation to:
  - All patient(s) or service user(s) affected by the incident; and
  - The organisation, or other safety systems, to prevent recurrence in similar circumstances;
  - Consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

The initial assessment must be undertaken by a member of staff of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. This should ideally be undertaken by the incident manager or an ABUHB appointed member of staff identified to complete an incident investigation.

The incident will be presented to a pre-executive huddle panel made up of Assistant Director level representatives form Nursing, Medicine and Therapies and Health Sciences.

9.3 Just Culture and Staff Wellbeing

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way. ABUHB in conjunction with NHS Wales endorses the use of the NHS England Just Culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff

member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should not be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The Just Culture guide, along with supporting reference materials, can be found on the NHS England website - www.england.nhs.uk/patient-safety/a-just-culture-guide/.

If staff are involved in an incident, the investigating officer assigned to undertake an investigation might want to talk to all staff involved about what happened. Staff may be asked to provide a formal statement of their involvement or what they witnessed. This helps to understand the events leading to and during the incident. Staff who are asked for this type of information should receive support from their clinical supervisor/line manager and should be kept informed of what is happening with any investigation.

Being involved in a patient safety incident can be upsetting for any member of staff.

Staff who are worried or distressed by what has happened or need someone to talk to can access support via their clinical supervisor, or local education centre. They can also self-refer to Employee Wellbeing Service.

9.4 Corporate Responsibilities

The ABUHB Patient Safety Incidents Team will escalate patient safety incidents of potential concern, and which meet the criteria of national reportable incidents to the Executive team via the weekly Executive Safety huddle to:

- Determine the depth and parameters of an appropriate investigation;
- Consider, where required, escalation e.g.:
  as a Nationally Reported Incident (NRI) or
  Early Warning Notification
- Determine reporting to relevant national frameworks (e.g., multiagency safeguarding processes); Reporting to relevant external bodies (MBRACE/HSE/RIDDOR/SHOT);
- Any relevant communications handling required;
- Next steps in terms of incident management.

10 Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the statutory guidance, can be found on the Welsh Government website.

Incident reporting, management and investigation is intertwined with the principles of Being open: communicating patient safety incidents with patients and their carers and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- An adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is:

  - Unintended or unexpected, and
  - More than minimal e.g., moderate, severe or death, and
  - The provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 occur after the date on which Section 3 was brought into force (i.e., 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

- The Duty of Candour Statutory Guidance 2023 – see **Appendices**
- Duty of Candour Datix Process – see **Appendices**

11 Investigation

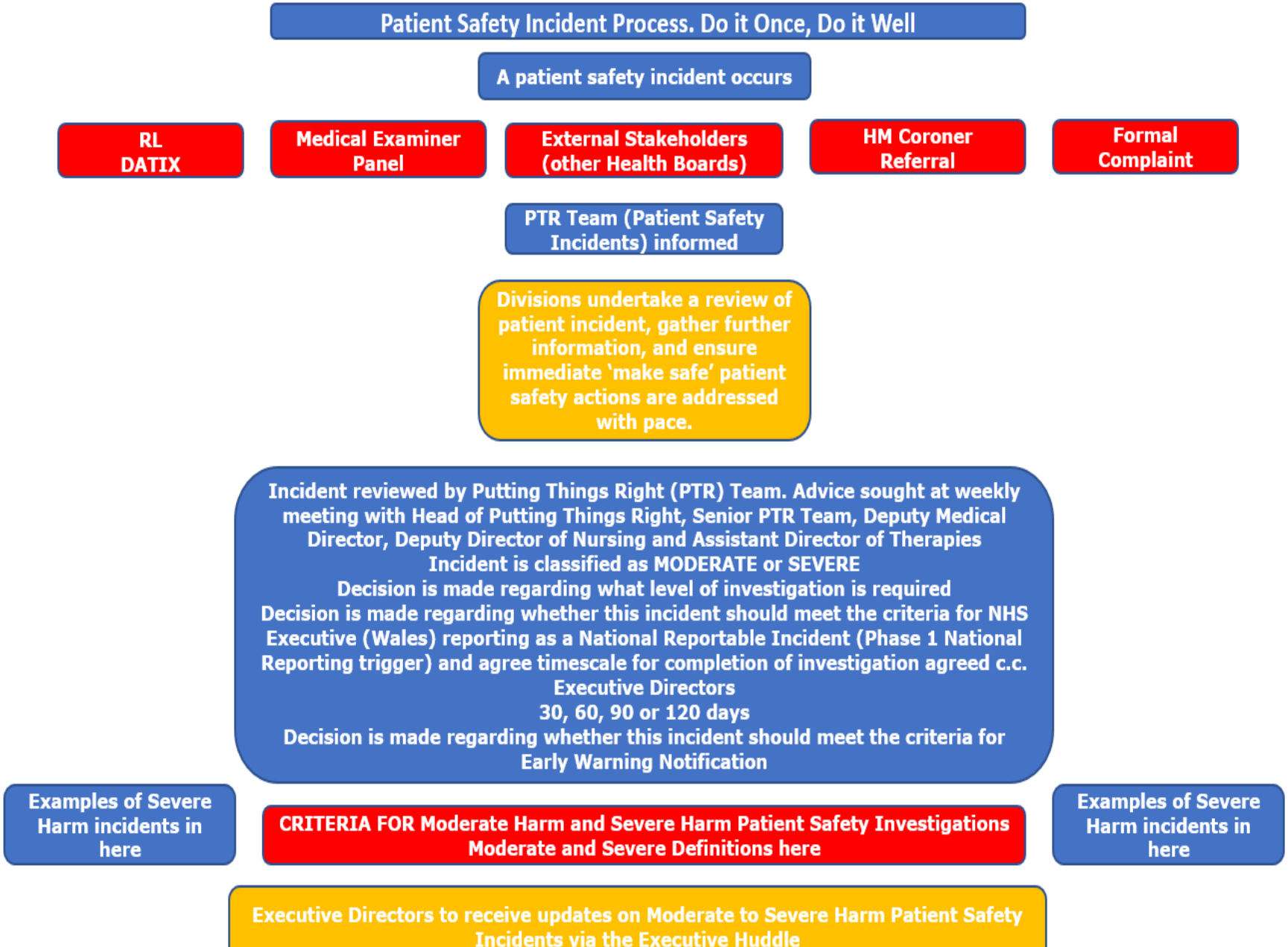
All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2023.

Regulation 23 outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

In addition to Patient Safety Incident investigations, focussed on an adverse event causing moderate or severe harm, the Health Board will invoke other types of investigations as determined, including thematic reviews, look back reviews, joint investigations, concise reviews and rapid learning. These will be discussed and taken forward via the Executive Huddle.

Patients and/or their representatives/family will be engaged from the beginning of the investigation. If the Duty of Candour has been triggered this will commence at that point. Patients must be contacted to ascertain any concerns, explain the intended investigation and its purpose, to ascertain the patient's wishes and expectations. The Health Board will incorporate this input from the patient directly into the Terms of Reference (TOR) for the intended investigation. The Health Board will share the draft TOR with the patient/representative and look to agree these wherever possible. The ultimate determination of the TOR will rest with the Health Board to ensure investigations progress and wider opportunities for learning/prevention of future harm are not lost through delay.

Appendix 1


Patient Safety Incident Process. Do it Once, Do it Well
A patient safety incident occurs
RL DATIX
Medical Examiner Panel
External Stakeholders (other Health Boards)
HM Coroner Referral
Formal Complaint
PTR Team (Patient Safety Incidents) informed
Divisions undertake a review of patient incident, gather further information, and ensure immediate 'make safe' patient safety actions are addressed with pace.
Incident reviewed by Putting Things Right (PTR) Team. Advice sought at weekly meeting with Head of Putting Things Right, Senior PTR Team, Deputy Medical Director, Deputy Director of Nursing and Assistant Director of Therapies
Incident is classified as MODERATE or SEVERE
Decision is made regarding what level of investigation is required
Decision is made regarding whether this incident should meet the criteria for NHS Executive (Wales) reporting as a National Reportable Incident (Phase 1 National Reporting trigger) and agree timescale for completion of investigation agreed c.c. Executive Directors
30, 60, 90 or 120 days
Decision is made regarding whether this incident should meet the criteria for Early Warning Notification
Examples of Severe Harm incidents in here
CRITERIA FOR Moderate Harm and Severe Harm Patient Safety Investigations Moderate and Severe Definitions here
Examples of Severe Harm incidents in here
Executive Directors to receive updates on Moderate to Severe Harm Patient Safety Incidents via the Executive Huddle

Appendix 2

Moderate to Severe Harm Patient Safety Incident Process

- **Appointment of Chair** of Investigation process **(list as appendix)**
- A **trained** Investigating Officer (IO) is appointed by the Division in advance of the **initial** meeting (consideration of multiple IOs if cross-divisional)
- Timeline of events completed by the Division **and clinical notes secured.**
- List of key stakeholders to attend is agreed (including any external).
- **Dates for initial and outcome meetings are arranged.**
- Standard PTR Incident Agendas are used.

Initial Meeting
1 week

Purpose of meeting (Initial meeting agenda used):

- Division present overview/timeline of patient safety incident.
- Agree Terms of Reference and Scope of Investigation.
- Nominate a Patient/Family Liaison Officer for Patient/family. ***Need discussion about minutes***
- Appoint an Action Plan Lead.
- Consider if incident meets the criteria for National Reporting.
- Gain assurance that immediate patient safety actions undertaken.
- Identify support for staff.
- Assurance of immediate Patient Safety actions undertaken **and added to Action Plan**
- **Any early learning for sharing to be presented.**

Family Liaison Officer Contacts Patient/Family and asks if they have any questions/concerns to be investigated as part of the process.

Investigation Period
6 weeks

- Investigating Officer undertakes investigation based on Terms of Reference and Scope, including any additional Patient/Family questions and drafts investigation report (+/- Fishbone Diagram)
- Investigating Officer meets with PTR Incidents Team and the draft investigation report is reviewed against Terms of Reference. Consider if any other areas of investigation need to be explored.
- The Investigating Officer meets with Action Plan Lead, shared key areas of learning and improvement and the draft action plan is developed.
- The Investigating Officer considers any Breach of Duty and if Learning from Events (LFER)/Redress required.

Investigating Officer shares Investigation Report and Action Plan (+/- Fishbone Diagram) and sends to Divisional Management for Divisional Approval.

Outcome Investigation Meeting
10 weeks

- Divisionally Approved Investigation Report and Action Plan is presented and Chair Approval is completed.
- Agree monitoring of Actions and ABUHB learning.
- Consider if Incident meets the criteria for National Reporting (if reported, an NHS Executive Outcomes Form is completed by PTR (Incidents) Team.
- Confirm arrangements for sharing report with relevant staff and family/patient.
- Confirm arrangements for sharing report and action plan with Legal Services (for HM Coroner)

Approved Investigation Report and Action Plan (+/- Fishbone Diagram) are formatted and saved in Word and PDF. PDF copies are uploaded to RL DATIX as Approved and PTR (Incidents) Team will email Divisional QPS out of RL DATIX to request closure of the incident.
Investigating Officer emailed final Exec Approved Report as copy.

Sharing of Approved Reports with Patient/Family

11.1 Guidance for Investigating a Concern

The investigating officer will undertake several steps in the thorough investigation of a Patient safety Incident.

Purpose of the Investigation

1. **To find out the full facts** with respect to sequence of events that led to concern
2. To determine **what, if anything, went *wrong*** – and what went well
3. To find out **why it went wrong**
4. To Identify what actions are required to **prevent it happening again**

Planning the Investigation

Take time to plan your investigation

- Be clear of the issues
- Make a list of the people you will need to speak to/contact and what information you need from them
- Remember other people may emerge as you gather information
- Identify the documentation you will need to look at, e.g.
    - Medical and nursing records
    - Incident form
    - CWS / Myrddyn
    - Staff rotas, etc
- Remember time scales
- Factor in:
    - Availability of medical records
    - Availability of key staff
    - Time to draft the report
    - Time for the corporate review

Finding out the Facts

Gather the information - this is the lifeblood of any investigation and will take 60% of your time. Facts will be obtained from:

- Documentation
- Interviews/or information gained from the staff involved in the concern/witnesses
- Examination of equipment records, where necessary
- Examination of the location of the incident may relevant
- A review of appropriate policies and procedures
- **Consider whether CCTV exists and if it aids the investigation N.B. it will require securing within 28 days**

Determine what, if anything, went wrong

- What service/care should have been provided?
- What was provided and what happened?
- Map and analyse the information gathered by using relevant tools (e.g., timeline, tabular timeline, narrative chronology, time person grid)
- Compare sequence of events with relevant standards, protocols and guidelines

Determining why it went wrong

- Were suitable standards in place to control what went wrong?
- If standards in place, were they appropriate or sufficient?
- If standards were good enough, were they applied in practice?
- Look at the influencing factors, such as:

    - Staff factors
    - Patient factors
    - Environmental factors
    - Task factors
    - Equipment factors
    - Team factors
    - Organisational and Management factors

Use appropriate tools dependent on severity and complexity of concern. Remember, some tools help gather information, some help to analyse information and some help to draw conclusion. (ABUHB Patient Safety Incident Toolkit).

More information on the ABHB Toolkit can be found on: Putting Things Right - Web Page Tool Kit.pdf - All Documents (sharepoint.com) and within the Appendices.

Preventing it happening again

- What lessons can be learnt?
- Are there any recommendations?
- Think about failures that have led to concern, e.g.

    - Human error or inappropriate behaviour by staff
    - Procedural or administration problems
    - Communication problems
    - Recommendations to be practical, proportionate and constructive

Involving patients, families, service users and carers

Involvement begins with a genuine apology. The principles of honesty, openness, and transparency (Being Open) must be used. All ABUHB staff involved in liaising with patients, families, service users and carers must have the necessary skills, expertise, and knowledge to explain what occurred comprehensively and compassionately. The appropriate person must be identified for each incident in accordance with the Duty of Candour.

- Patients and/or their representatives will be engaged from the beginning of the investigation. They must be contacted to ascertain any concerns and to help inform the Terms of Reference for the investigation.
- Patients and their families will know what they can expect from the investigation. They will be informed of realistic and achievable timescales and outcomes.
- Patients and their families will be made aware of the rationale and purpose of the investigation.
- Patients and their families will be provided with the opportunity to express any concerns and questions
- Patients and their families will be provided with a draft final patient safety incident report inclusive of the findings. The Health Board will consider any further comments or questions before finalisation of the report.
- Patients and their families will be signposted to any identified appropriate support services.
- Patients and their families will be provided with the opportunity to meet with representatives from the Health Board to discuss the findings and explore any further concerns.

11.2 Methodologies

Methodologies used should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are several focussed review tools built into Datix Cymru which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage (All Wales Pressure Ulcer/PU tool)
- Extravasation

Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents (see Appendices).

11.3 Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and
- where services have been commissioned, including relating to social care.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Appendices.

The Health Board currently holds weekly joint investigation meetings with Welsh Ambulance Service Trust (WAST) to review collaboratively cross organisational incidences.

Commissioned Services

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
   - NHS England; or
   - NHS Scotland; or
   - NHS Northern Ireland; and

2. NHS Wales funded healthcare provided by an 'independent provider', either:
   - Provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
   - Provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does or may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare (CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

- The investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
- There is no requirement on the provider to consider a QL as part of the investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

11.4 Investigation outcomes

Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

Completing an incident investigation

The accountability for supporting and engaging with an incident investigation sits within the Division who undertook the investigation.

To allow the Executive Board to be assured that incidents within the organisation have been dealt with appropriately, the Health Board must ensure robust processes are in place to inform and assure their Boards that:

- The quality of their investigation processes is of a high standard;
- Investigations are being undertaken and completed in a timely manner;
- Patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- Appropriate actions are being taken and learning is being shared across the organisation.

All Patient Safety incident investigations and their accompanying action plan, resulting in Moderate and above harm, in addition to all Never Events will receive Senior Executive sign off.

Learning, and ongoing monitoring and assurance of actions, will be presented at the Quality and Patient Safety Operational Group by Divisions and Directorates through to Patient Quality Safety Outcome Committee.

Accountability for tracking and implementing learning and actions

The central Patient Safety Incident Team will monitor and track identified Divisional actions and learning from incident investigations. Whilst the central team will assist with this quality assurance, ultimately each Division will be responsible and accountable for the delivery of its learning, actions and ongoing monitoring, audits and assurance around compliance. Accountability Agreements will be developed for each Division. An Escalation process will be invoked if required.

Actions arising from moderate/severe investigations to be shared with Executives and Divisional Triumvirate.

The Health Board strives to be an all-encompassing learning organisation where people continually expand their capacity to improve.

12 Process for reporting outcomes of a National Reportable Incident investigation

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Appendices.

This function will be undertaken by the Patient Safety Incident SI team.

13 Training

Staff undertaking the Investigating Officer Role Should attend the Putting Things Right Serious Incident Investigation and Complaints Training. This workshop is held over a full day and should be attended by Senior Health Board staff involved in the handling and response to Complaints and Serious Incidents received within the Health Board.

The workshop focuses upon developing an understanding of Serious Incident and Complaints investigation and response in line with the Putting Things Right regulations and provides:

- An understanding of the PTR process and the framework for investigating concerns.
- Roles and responsibilities of the IO.
- An overview of the necessary tools and knowledge required in the execution of an investigation.
- Signposts to the resources used to support investigations.

14 Review

This Policy will be reviewed every 3 years or in line with any National or Local Policy change.

15 References

Health and Social Care (Quality and Engagement) (Wales) Act 2020

The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023

Putting Things Right guidance document (v3, 2013)

The Duty of Candour Procedure (Wales) Regulations 2023

The Duty of Candour Statutory Guidance 2023

16 Appendices/Supporting information

1. NHS Wales Never Events list
2. Nationally Reportable Incident (NRI) reporting processes & flow chart
3. Guidance on nationally reporting specific incident types
4. Joint investigation process
5. Guidance on Safety-II principles
6. Commissioned Services flowchart
7. Cause and effect diagram (fishbone diagram)
8. Yorkshire Contributory Factors Framework - Improvement Academy
9. Systems Engineering Initiative for Patient Safety (SEIPS)
10. Guidance for Reporting an Incident
11. Datix Cymru Incidents Module User Guide
12. Health and Safety Intranet pages
13. Safeguarding Intranet pages
14. Putting Things Right Intranet pages
15. Duty of Candour Datix Process
16. The Duty of Candour Statutory Guidance 2023

Aneurin Bevan University Health Board

Clinical Standards Effectiveness Group

Minutes of the Meeting of the Clinical Standards Effectiveness Group held on Thursday, 20th July 2023 at 14:00-16:00, via Microsoft Teams

In attendance:

Dr Leo Pinto (LP)	Asst Med. Dir. for Clinical Effectiveness & Consultant Physician (Chair)
Leeanne Lewis (LL)	Asst. Dir. of Quality & Patient Safety (Vice Chair)
Joanne Stimpson (JSt)	Quality & Patient Safety Lead for NCA
Dr Stephen Edwards (SE)	Consultant Anaesthetist, & Deputy Med. Director
Gareth Morgan (GMo)	Senior Information Manager, QPS Team
William Batten (WB)	Clinical Effectiveness & Formulary Pharmacist
Glenys Mansfield (GMa)	General Manager, Scheduled Care
Carly Cole (CC)	Divisional Operations Manager, Scheduled Care
Dr Liam Taylor	Deputy Medical Director
Caroline Rowlands (CR)	Deputy Head of Nursing, QPS and Nurse Education Locality Offices
Dr Tom Morgan-Jones (TMJ)	Consultant Anaesthetist & Scheduled Care Div. Dir.
Kylie Crooks	Senior Nurse Quality & Patient Safety, USC
Susan Dinsdale	Assistant Divisional Nurse, Family and Therapies
Dawn Baker Lari (DBL)	Directorate Manager, Scheduled Care
Sara Garland (SG)	General Manager, Family and Therapies
Craig Roberts (CR)	Asst Dir. of Therapies and Health Science, Corporate Services

Observing:

Roopashree Mandyam	Coordinator Quality and Patient Safety, QPS Team
Alla Rybak	Coordinator Quality and Patient Safety, QPS Team

Apologies:

Dr Seema Sindhakar (SS)	Consultant Anaesthetist
Dr Clifford Jones (CJ)	Primary Care Clinical Director Division
Jonathan Simms (JSi)	Clinical Director of Pharmacy
Sarah Cadman (SC)	Head of Quality & Improvement, MH&LD

Guests:

Mr K Swarnkar (KS)	Consultant Surgeon
Dr Davida Hawkes	Consultant Paediatrician

Daniel Jones Radiographer

CSEG 20/07/01 Welcome and Introductions

Dr Pinto (Chair) welcomed all attendees to the meeting and requested a round of introductions.

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

Apologies for Absence

As above.

Declarations of Interest

There were no declarations made of potential conflicts of interest by those attending the meeting.

Draft Minutes of the Meeting held on 23rd May 2023

Dr Pinto stated that he was not present at the last meeting and requested the group's approval on the notes from 25th May 2023, which were deemed to be an accurate account of the meeting.

CSEG 20/07/02 – National Bowel Cancer Audit – Annual Report 2022
Clinical Lead – Mr Swarnkar
Key Points:
The Clinical Lead stated the importance of the context of the report. Data from April 2020 to March 2021 is heavily influenced by the pandemic where services were drastically reduced. It was requested that laparoscopic surgery is halted due to being an aerosol generating procedure, this was the same for endoscopies. Stopping laparoscopic surgery due to the pandemic impacted on the results compared to the national achievement of 71%, also impacting this rate is that ratio of clinicians able to carry out the laparoscopic surgery. 3 out of the 8 surgeons, will not be adding data to this target which will impact on the Health Board compliance.

Also, during this timeframe there were two MDTs, in the Royal Gwent Hospital and Nevill Hall Hospital, this has since become one combined MDT. The audit expectations are around data quality, treatment given and the outcomes in terms of quality of surgery and quality of the survival period. KS highlighted

that oncological treatment outside of surgery is managed by Velindre Cancer Centre.
KS stated that the Health Board collects data real time within the MDT and entering to CANISC, this is then exported to the NBoCA platform from CANISC. **The Health Board is amongst the best for 2-year survival rate and the 90-day survival rate.** Overall, the data quality is in the green parameters.
Nationally and within the Health Board adjuvant chemotherapy rates are under the target, oncologists are part of the MDT, and this measure is within their remit, and this has been raised with oncologist within the Health Board's MDT.
KS stated that the complexities of rectal cancer management across the UK make this almost its own specialty and this impacted the rates for Nevill Hall Hospital MDT, however with a combined MDT this will improve in the next reporting period.
The outcome measures around the 30-day unplanned admissions data comes from PEDW (Patient Episode Data Wales) the Welsh equivalent of England's HES (Hospital Episode Statistics), included inter site step down transfers and wound infection patients being reviewed, not admitted to SAU (Surgical Assessment Unit) as separate admissions. The area of concern is the 18-month loop ileostomy closure, due to the pandemic and the backlog. This has been discussed at MDT and requires an action plan.

Report: National Recommendations:

1. All hospitals/trusts/MDTs should review the individual local outcomes provided by NBOCA and agree on three targeted local quality improvement initiatives for 2023. These should focus on areas where local QI metrics are not being met or are close to falling short of the target **– The Health Board is not meeting the targets suggested in recommendation 2.**
2. Participation and engagement with the NBOCA quality improvement plan to focus on improving cancer outcomes targeting the areas most relevant to the hospital/trust/MDT, with particular emphasis on the performance measures with the most national variation:
    a. 18-month diverting ileostomy closure
    b. 30-day unplanned return to theatre
    c. Administration of adjuvant chemotherapy following major resection for stage III colon cancer
3. Bowel cancer charities should continue to raise awareness and educate patients, particularly about the symptoms and signs of bowel cancer. They should also promote engagement with the NHS England Bowel Cancer Screening Programme and Bowel Screening Wales, highlighting the advantages of early diagnosis – **Bowel Screening Wales are doing a good job with this, although variation on localities, and increase of the age range for screening will increase numbers into the pathway.**
4. Hospitals/trusts/MDTs should support local developments in the implementation of diagnostic and surgical hubs in order to help to mitigate the impacts of COVID-19 on elective diagnoses and treatments **– The Health Board currently has Rapid Diagnostic Clinics using**

Radiologists and GPs which is escalated to the colorectal team for further tests.

5. Review and take action to improve participation, coding, data quality, and timely reporting for NBOCA, in particular for:
    a. >70% completeness for risk adjustment variables (particularly TNM staging and ASA grade) for patients undergoing surgery **– there has been ongoing issue with regards to staffing within Cancer Services, which hopefully will improve along with the participation of the QPS (Quality and Patient Safety) Team liaising with Cancer Services.**
    b. Completion of genomics data for all patients including MMR/MSI status – **KS is confident that the completeness of this will improve in the next reporting period.**
    c. In addition, Lynch germline testing should be ordered where MMR deficiency is identified and referral to clinical genetics for those where Lynch syndrome is diagnosed **– this is already being carried out as part to the MDT and are automatically referred to the genetics unit for advice.**
    d. Completion of data item relating to patients being seen by a Clinical Nurse Specialist (CNS) – **KS stated that he has no doubt that all patients are seen by CNS and results from this reporting period for the two MDTs shows a higher than national rate and this has only improved moving into one MDT.**
    e. Improved completion and accuracy of pre-treatment TNM staging **– TNM staging is given by the radiologists at MDT.**

National Level QI targets:

- KS stated that the Health Board already has input from liver surgeons as part of the MDT.
- All cancer patients with stage four disease get these genetic tumour profiling now as a standard.
- All patients who have a histology report given should mention the microsatellite instability or MMR status.

LL asked KS if the issue with regards to clinicians not doing laparoscopic surgery was across Wales. KS stated that the Health Board has far greater numbers of cancers than other units therefore our rates will always look worse(as a percentage of large denominator), however KS stated that the rates for the Health Board are already improving and thinks this will be evidenced in the next report which is more in keeping with current practices.
KS stated that there is a 5-10% conversion rate from laparoscopic to open, which isn't wrong or evidence of complications, however laparoscopic surgery improves patients LoS (length of stay), reduced postoperative complication and pain.
SE asked if there are any PREM's (Patient Recorded Experience Measures), which is not being captured and LL suggested this could be looked at in the future.

RM asked about the 18-month stoma unclosed and the LoS for open versus laparoscopic, KS stated that there are many reasons for this delay, such as chemotherapy treatment, the pandemic and reduced cancer operating lists which is still an issue currently. These patients with previously removed cancers awaiting Closure of loop stoma are deemed cancer free. **The limited operating spaces must be utilised for those with cancers in situ and remaining available spaces used for closure of loop ileostomies.** It is important that we increase the availability of semi elective operating spaces at RGH to try and meet the 18-month targe. The LoS difference between the two types of operations(Open and laparoscopic) is about 24 hours, which isn't much in terms of one patient but across the UK with 30,000 cancers being operated on, this would be a massive saving of bed occupancy.

Actions: ***(Specific, Measurable, Achievable, Relevant, Timely)***

- To look at the data relating to 2021/2022 and 2022/2023 18-month stoma unclosed rates to see there has been an improvement and to analyse the data to identify what the current causes might be.
- To liaise with MDT oncologists regarding Adjuvant Chemotherapy rates, for 2021/2022 & 2022/2023 data and discuss methods for improvement.
- Identify Laparoscopic rates for 2021/2022 & 2022/2023 for those clinicians carrying out laparoscopic surgery.

Please see AMaT summary Report for NLCA -

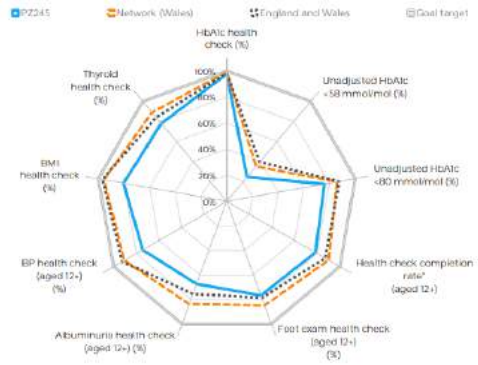
NBoCA - ClinicalAuditSummary

CSEG 20/07/03 - National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2021/2022
Clinical Lead – Dr Davida Hawkes

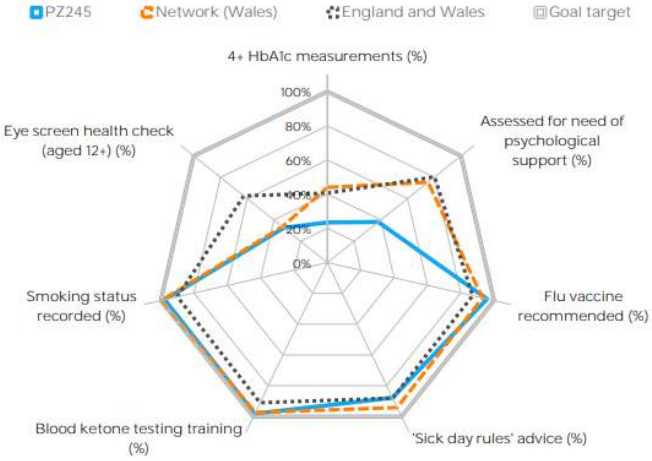
Key Points: The Clinical Lead (CL) stated that the report was reflective of data form 2021/2022 and is therefore retrospective. Data is entered to a platform called 'Twinkle' which is uploaded to the NPDA platform; therefore, data entry accuracy is vital. There is a large diabetes team consisting of five consultants, four nursing staff, three dieticians and a psychologist.

The current report looks at the number of children receiving paediatric diabetes care in 2021/2022, however it reports on the Grange University Hospital which only provides data from 2020/2021 (Nov 2020). The report looks at what percentage of children are receiving all six key health checks that are the key components to a successful service, the data below shows that the Health Board performance against the Welsh network and nationally and the Health Boards performance from 2020/21 and 2021/22. Caution is required when comparing

the two years of data and during 2020/21 services saw a dramatic changes due to the pandemic. The Health Board falls short compared to the Welsh Network and England and Wales rates, however, does indicate that performance for 2021/22 has improved.



The report also focuses on the additional health checks as shown in the plot graph below:



Eye screen health checks are out of the control of the Health Board as this service is managed centrally by the Welsh Screening Service.

Albuminuria health check performance is not good, due to the lack of samples being provided by the age group required.

The Funnel Plot charts below demonstrates the negative outlier status for health check completion rates with a full year of care (ALERT) and those receiving all six health checks (ALARM), which is making the team feel despondent. The HbA1c is a measure of how well the patient's diabetes is being controlled and an indicator of blood glucose levels and is a marker for the patient longer term health as the children transition into adults and therefore impacting adult health services, this is an example of the need for a more prudent healthcare and the crossover of two divisions does not help make for joined up working.

Figure 12: Health check completion rate for children and young people with Type 1 diabetes aged 12 or older who completed a full year of care

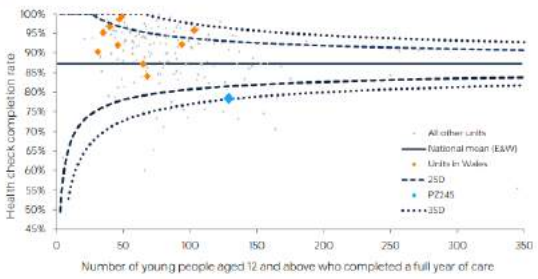
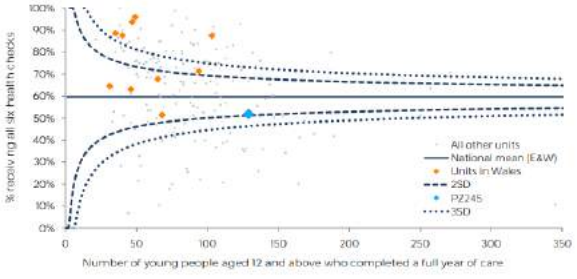
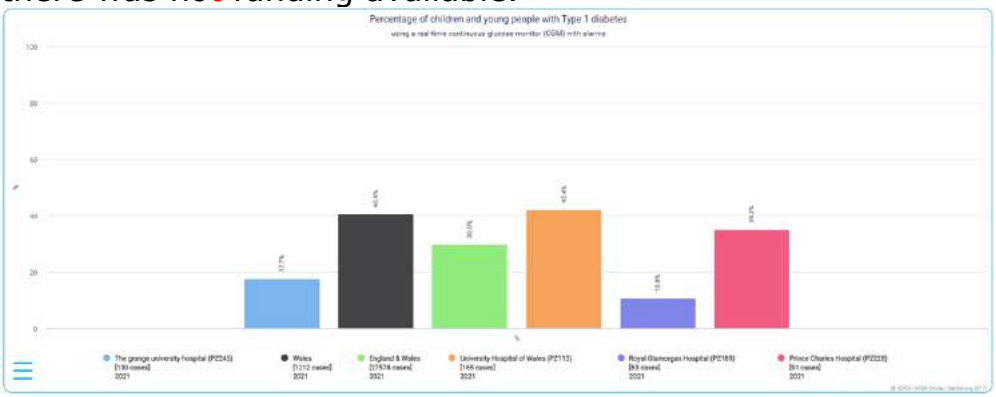


Figure 13: Percentage of young people aged 12 years and above who received all six health checks



The CL explained the value in the patients using technologies to assist with looking after their diabetes and the report focuses on the rates of children using diabetes related technologies. The graph below demonstrates the low usage of technologies for the Health Board compared to Wales. A business case was submitted 18 months ago and although recognised as being a requirement there was not funding available.



The report looks at the risk of macrovascular and microvascular complications, which isn't so much of an issue in children, however, does impact the patient moving into adult services.

There is also screening of additional psychological support required, with 0.6 WTE (whole time equivalent) psychologist support and with the majority of the children requiring this, is demonstrates the need for a psychology service within the team.

The CL wanted to highlight the level of deprivation across the health board is the highest across Wales making harder work for the team and that the team run events or the patient and their families which prove to be very successful. It brings families together and children can mix with other children going through the same experiences. The team also educate school staff to administer insulin and the importance of food, to ensure children are safe in school. It was also noted that 2022-2023 has seen and increase in newly diagnosed diabetes in children (30-50% increase).

SG noted the hard work being undertaken by the team and stated that the business case had been taken to the executive team due to its high priority however, a more succinct report is being pulled together and re-submitted. SG stated that this is highlighted on the Divisional Risk register. CR stated he was part of the PIP and explicit detail is needed for a re-submission. SD noted that nursing staff had reduced, and the needs are great for the children's health within the Health Board. The group all acknowledged the importance of this service for the children now and as they grow into adults and use the adult services, placing further pressure, when it could be addressed and be prudent healthcare. The CL stated that approximately one third of children are using the hybrid closed loop technology which is the Gold Standard.

Report National Recommendations:

1. Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies.

2. Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential differences in outcome with different modalities of insulin delivery and blood glucose monitoring.
3. Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year.
4. Awareness of diabetes symptomatology amongst the public should be enhanced to avoid newly diagnosed children and young people presenting with Diabetic ketoacidosis (DKA).
5. Studies should be funded to derive evidence for interventions supporting pre-diabetic children and young people to avoid progression to Type 2 diabetes.

Actions: ***(Specific, Measurable, Achievable, Relevant, Timely)***

- To reiterate the importance of the previously submitted business case for staffing, resource, and technologies for re-submission.

Please see AMaT summary Report for NLCA -

NPDA - ClinicalAuditSummary

CSEG 20/07/03 - Safety Memo - Recording Evidence Based Guidance on Web-Based Audit Management and Tracking (AMaT) at ABUHB

LL stated that the QPS team had presented the Clinical Audit Strategy to the Divisional Management Team. This incorporate evidence-based guidance usage and tracking this using AMaT. Guidance such as NICE and HTW, where the Clinical Director of a service will need to look at the guidance to see if the Health Board is working within those guidelines and if not, what can be implemented. It has been brought to the attention of this group so that the information can be taken back to the Clinical Directors within the Divisions, so they are aware that there may be correspondence relating to guidance's sent to them going forward.

Annual Clinical Audit Activity report
LL informed the group that the QPS team had produced a 'Clinical Audit Activity' report for National Clinical Audits, that are brought to this group for scrutiny of the action plans based on the report recommendations. This is to be produced annually and feedback form the group is welcomed. All the relevant information and data is placed into the audit on AMaT, and this automates the AMaT Summary, which is then used to populate the papers for Patient Quality and Safety Outcomes Committee (PQSOC) and be added the activity report for that year.

Clinical Audit Plan 2023/2024
LL informed the group of the completion of the Clinical Audit plan by the QPS team. This is the forecast of National Clinical Audits as published by Health Quality Improvement Partnership (HQIP) and this plan also identifies local audits where they are known at this present time and building this in line with audits registered on AMaT. This also incorporates studies managed by NCEPOD (National Confidential Enquiries into Patient Outcome and Death). Feedback would be welcomed from the group on these reports. These reports will be published annually to give that accountability to the Audit and Risk Assurance Committee (ARA) and reported to Patient Quality and Safety Outcomes Committee (PQSOC).

Qure AI trial: Chest X-ray and Head CT
LL stated that the introduction the Artificial Intelligence (AI) into Health Care brings with it questions as to whether it is viable, accurate and what the impacts are on the services and the users. As new techniques and procedures come to this group for approval, it is the expectation that the request to use AI would also come via this group and the group had accessed the policy and framework.

Daniel Jones (DJ) form Radiology joined the group to explain the use of AI in radiology. The company used is experience in data from various projects and is widely used in NHS England (NHSE). Currently there can be a wait for chest x-ray reporting, whereas the AI can analyse the reports and feedback almost instantly flagging any significant findings and email notifications to certain people. The plan is to use this to speed up cancer pathways as diagnosis would be much quicker. This will not replace a set of eyes on the report; however, it will highlight the report of higher importance, much more quickly. The speed of reporting will bring its own implications which require further work up. Dr Pinto asked whether the reports would get reviewed and signed off by a human, which DJ confirmed was accurate.

DJ stated that initially this would lengthen the waiting times for routine, as highlighting urgent case as a priority will place them ahead of the routine cases, however over time this would ensure that pathway lengths can be reduced.
CR voiced concerns over the newness of this and asked if it was similar to a triage tool at present, which DJ confirmed. DJ confirmed that human eyes will still look at the reports.
DJ also informed the group of an AI option to use to measure bone age for pathologies.
CR stated there is a project ongoing at present in histopathology looking at prostate biopsies which maybe should come to this group in retrospective time. There requires linkage with pathology and retrospective approval. It was discussed that this was low risk and that it had been approved by Information.

Next meeting Thursday 21st September 2023 @ 14:00 – 16:00

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 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 (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

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. This now includes ensuring there are sufficient governance processes around the implementation of Artificial Intelligence (AI). 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 20th July 2023, the audit reports reviewed were:

- National Bowel Cancer Audit (NBoCA) – Annual Report 2022
- National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2021/2022

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 Bowel Cancer Audit (NBoCA) – Annual Report 2022
- Appendix Two - National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2021/2022

As part of our clinical audit plan and strategy we are committed to participating in the National Clinical Audit Outcome Review Plan (NCAORP). The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has several studies at various stages within the process.

- Testicular Torsion - the Health Board has fully participated in this study and a report is expected in winter 2024. See Appendix Three.
- Endometriosis – the study is supported by the Division and it remains active. A Clinical Lead has been identified.
- Juvenile Idiopathic Arthritis – Health Board data has been submitted and cases are being uploaded to the NCEPOD platform. A Clinical Lead has been identified.
- End of Life Care – Health Board data has been submitted and cases are being uploaded to the NCEPOD platform. Currently this study does not have a Clinical Lead.

CSEG also overseas governance behind introduction of new devices and clinical procedures. At the July meeting, the 'Policy: Artificial Intelligence use in Clinical Practice' was tested for:

- Qure AI trial Chest X-ray and Head CT –
  - Appendix 5 – Application form

The application form was discussed to ensure that the AI project had a robust governance process around its implementation. The Group agreed the approval of Qure AI. The Policy is now ready for approval at the next Clinical Standards and Policy Group.

Audit Management and Tracking (AMaT) is being widely used across the Health Board for the use of local audits, as specified in the audit plan. The volume of audits being undertaken and number of action plans being allocated is rising. See attached Appendix 6 for more information.

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

Appendix One

National Clinical Audit reporting template (AMaT) - NBoCA

Title: **National Bowel Cancer Audit Annual Report 2022**

Date registered: **16/02/2023**

Category: **National (NCAORP)**

Speciality: **General Surgery**

Division: **Scheduled Care**

Lead participant: **Keshav Swarnkar**

Audit lead: **Usman Khan**

Rationale
The NBOCA aims to describe and compare the quality of care and outcomes of patients diagnosed with bowel cancer in England and Wales

Objectives
The NBoCA collects data on items which have been identified as good measures of clinical care

Guidance	Title
NG151	Colorectal cancer (January 2020)

• Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	20/07/2023 14:00	Teams	Awaiting approval

Results - Key Findings

Chapter 3 – Quality Improvement (QI)

- The proportion of hospitals/trusts/MDTs meeting each local NBoCA QI target has reduced for 7 out of 10 targets during the COVID-19 pandemic compared to the previous audit period. This is most marked for the 18-month unclosed diverting ileostomy QI target.
- The local QI targets with the highest proportion of hospitals/trusts/MDTs meeting the targets are 2-year survival (98%) and 90-day post-operative mortality (96%).
- The local QI target with the lowest proportion of hospitals/trusts/MDTs meeting it is "the proportion of patients seen by Clinical Nurse Specialist (CNS)" (31%).

QI Metric	Local Target	RGH	NHH
Proportion of patients seen by Clinical Nurse Specialist (CNS)	< 10%	89%	97%

- In the last audit period (2019/20), of those hospitals/ trusts/MDTs with information for all 10 local QI targets, 8% met all 10 targets, 44% met 9 or more targets and 72% met 8 or more targets. During this audit period (2020/21), 3% met all 10 targets, 18% met 9 or more targets and 53% met 8 or more targets.

Key:
> 80%
50 - 80%
< 50%

Data Submission- Quality

Data Quality	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021
Total number of patients	300	302	140	71
Case Ascertainment	Good	Good	Good	Good
TNM staging	100%	81%	100%	92%
Performance status	100%	100%	100%	100%
Major Resections	176	190	83	49
7 audit items for risk adjustment	100%	100%	100%	100%

Management of ALL patients

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Seen by Keyworker	97%	89%	99%	97%	86%
Potentially curative	69 (86% resected)	57 (89% resected)	30 (90% resected)	26 (100 resected)	83% resected

Major resections- QA

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Total number	176	190	83	49	
Distant Metastasis (%)	9%	13%	5%	6%	7%
At least 12 LN resected	87 %	91%	83%	73%	86%
Attempted Lap Surgery	48%	56%	49%	31%	71%

Stage 3 Colon cancer management

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Number of patients	52	109	44	54	
Adjuvant Chemotherapy	54%	47%	48%	50%	63%

Key:
> 80%
50 - 80%
< 50%

Rectal Cancer management -QA

Key:
- > 80%
- 50 - 80%
- < 50%

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
Total number of pts	43	47	17	11	
CRM recorded	93%	96%	94%	91%	90%
CRM negative	81%	89%	94%	64%	84%
APER	30%	30%	24%	61%	39%
Permanent stoma	36%		61%		37%

Outcomes

	RGH 2019/20	RGH 2020/21	NHH 2019/20	NHH 2020/2021	National
30 day unplanned admissions	14%		9.1%		13.9%
30 day unplanned return to theatre	12.8%		4.3%		12.9%
90 day mortality	4.1%		1.2%		4%
2 year mortality	22.1%	17%	27.7%	29%	27.4%
18 month stoma unclosed	40.9%		56.1%		40%

National level QI targets
The current national level QI targets are summarised below, according to the five CQC domains:

Well-led:
1. All trusts/hospitals/MDTs with >80% case ascertainment
2. All trusts/hospitals/MDTs with >70% data completeness of seven items for risk adjustment in patients having surgery
3. >95% of trusts/hospitals/MDTs undertaking rectal cancer surgery to participate in and recruit to at least one NIHR portfolio trial in rectal organ preservation

Responsive:
4. >95% of trusts/hospitals/MDTs with annual resectional rectal cancer surgery volume of more than 20 patients
5. Increase proportion of patients with synchronous liver metastases at time of diagnosis with colorectal cancer discussed at specialist liver MDT
6. All trusts/hospitals/MDTs with >80% of patients with Stage IV disease with genetic tumour profiling (KRAS, NRAS, BRAF)
7. All trusts/hospitals/MDTs with >90% patients with mismatch repair immunohistochemistry or microsatellite instability

Caring:
8. All trusts/hospitals/MDTs with >95% of colorectal cancer patients seen by Clinical Nurse Specialist (CNS)

Effective: - Reduce variation between trusts/hospitals/MDTs in:
9. risk-adjusted unplanned return to theatre after colorectal cancer resection
10. rates of neoadjuvant treatment in rectal cancer patients undergoing resection
11. rates of adjuvant chemotherapy after colon cancer resection
12. colorectal cancer operations via laparoscopic approach
13. risk-adjusted 30 day unplanned readmission rates after colorectal cancer resection
14. rates of diverting ileostomies after rectal cancer surgery unclosed by 18 months
15. risk-adjusted survival at 2 years after colorectal cancer resection
16. patients referred to palliative care or enhanced supportive care clinic in last year of life
17. patients receiving palliative systemic treatment in final 30 days of life

Safe:
18. Reduce variation between trusts/hospitals/MDTs in riskadjusted mortality after colorectal cancer resection

Local QI targets

The local QI targets selected to deliver on the national targets are:

1. >80% case ascertainment
2. >70% data completeness of seven items for risk adjustment in patients having surgery
3. Participation in and recruitment to at least one NIHR portfolio trial in rectal organ preservation
4. Annual resection rectal cancer surgery volume of more than 20 patients
5. >95% of patients with synchronous liver metastases discussed at specialist liver MDT*
6. >80% patients with Stage IV disease with genetic tumour profiling (KRAS, NRAS, BRAF)
7. >90% patients with mismatch repair immunohistochemistry or microsatellite instability
8. >95% colorectal cancer patients seen by Clinical Nurse Specialist (CNS)
9. <10% risk-adjusted unplanned return to theatre after colorectal cancer resection
10. 10% to 60% rate of neoadjuvant treatment in rectal cancer patients undergoing resection
11. >50% rate of adjuvant chemotherapy after colon cancer resection
12. >50% colorectal cancer operations via laparoscopic approach
13. <15% risk-adjusted 30 day unplanned readmission rates after colorectal cancer resection
14. <35% diverting ileostomies rectal cancer surgery unclosed by 18 months
15. >70% risk-adjusted survival at 2 years after colorectal cancer resection
16. >95% patients referred to palliative care or enhanced supportive care clinic in last year of life
17. <20% patients receiving palliative systemic treatment in final 30 days of life
18. <6% risk-adjusted mortality after colorectal cancer resection

Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Key successes & concerns

Successes
Good diagnostics to date with cancer cases.

Concerns
Lack of capacity with operating space for high loop ileostomy cases. Failure to book number of patients in for theatre and a concern of waiting lists increasing.
Patients waiting for chemotherapy with Velindre is out of our control of the Health Board. Need to escalate time to be seen by oncologists to cancer lead (Dr Williamson) to discuss concerns with caecal cancers.
Current job plans for colorectal surgeons requires providing cover for emergency surgery, reducing capacity for cancer cases.
With number of on calls provided by surgeons who have to cover at GUH for one week, this leads the Health Board approx. 84 cases short.

Action Plan

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG
1	Participation and engagement with the NBoCA quality improvement plan to focus on improving cancer outcomes targeting the areas most relevant to the hospital/trust/MDT, with particular emphasis on the performance measures with the most national variation: a) 18-month diverting ileostomy closure, b) 30- day unplanned return to theatre, c) Administration of adjuvant chemotherapy following major resection for stage III colon cancer	18-month closure of loop diverting ileostomy needs targeted action. This will require more theatre space under current conditions (i.e less theatre access to non cancer cases.)	Dr Tom Morgan-Jones	09/06/2023	15/07/2023	

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG
2	Participation and engagement with the NBoCA quality improvement plan to focus on improving cancer outcomes targeting the areas most relevant to the hospital/trust/MDT, with particular emphasis on the performance measures with the most national variation:	Audit the stage 3 colon cancers for adjuvant chemotherapy and investigate reasons for having not been offered chemotherapy.	Mr Keshav Swarnkar	09/06/2023	01/09/2023	

	a) 18-month diverting ileostomy closure, b) 30- day unplanned return to theatre, c) Administration of adjuvant chemotherapy following major resection for stage III colon cancer					

Appendix Two
National Clinical Audit reporting template (AMaT) - NPDA

Title: **National Paediatric Diabetes Audit (NPDA) report on Care and Outcomes 2021/2022**

Date registered: **05/07/2023**

Speciality: **Paediatric Diabetes**

Division: **Family and Therapies**

Category: **National (NCAORP)**

Reported type(s): **Clinical Standards Effectiveness Group**

Lead participant: **Ramya Venkataramakrishnan**

Audit lead: **Davida Hawkes**

Rationale

The NPDA is part of the National Clinical Audit Outcome Review Plan and is part of the NHS Digital directory of audits relating to Diabetes care. The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological well-being, and assessment of diabetes- related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and well-being of children and young people with diabetes. In 2021/22, 100% of paediatric diabetes teams participated in the NPDA.

Objectives

Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.

Aims and priorities

- Build on and improve the previous joint adult and paediatric audit
- Collect a clinically meaningful dataset
- Engage clinicians, patients and parents
- Improve awareness of NPDA findings and maximise their use to drive national policy
- Develop the use of NPDA data in local and national quality improvements
- Use a regional network approach to data collection
- Capture patients' experiences
- Collaborate with the suppliers of the adult audit to ensure information around transition to adult care is captured
- Report at timely and regular intervals
- Develop user-friendly tools to interrogate the dataset
- Support centres wishing to develop local action plans to improve diabetes care
- Maximise the use and availability of data for research

Guidance

Code	Title
NG18	Diabetes (type 1 and type 2) in children and young people: diagnosis and management (August 2015)

Results

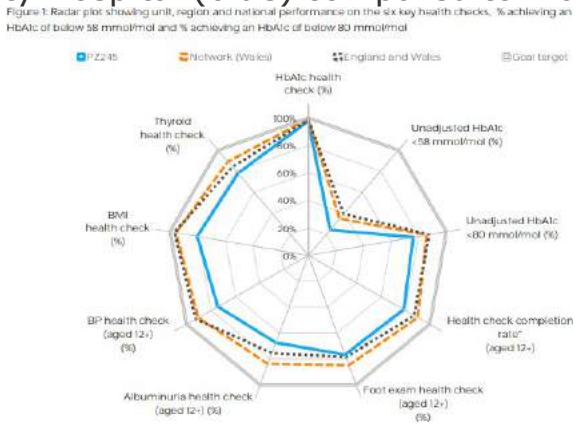
- How many children and young people were receiving care from paediatric diabetes services in England and Wales in 2021/22?

The chart below shows Grange University Hospital (GUH) data only.

Figure 8: Number of children and young people according to diabetes type by audit year

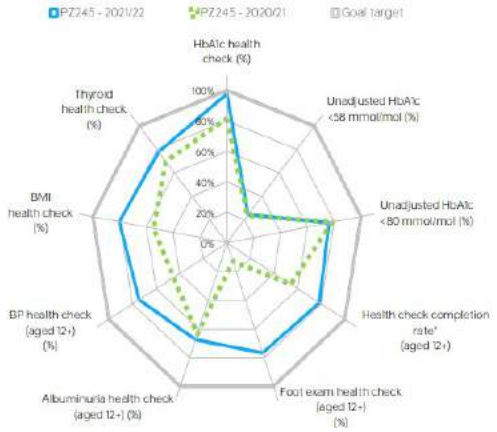
- What percentages of children and young people received all six recommended health checks in 2021/22?

The plot below shows The Grange University Hospital (blue) compared to Wales (orange) and UK (black dotted line).

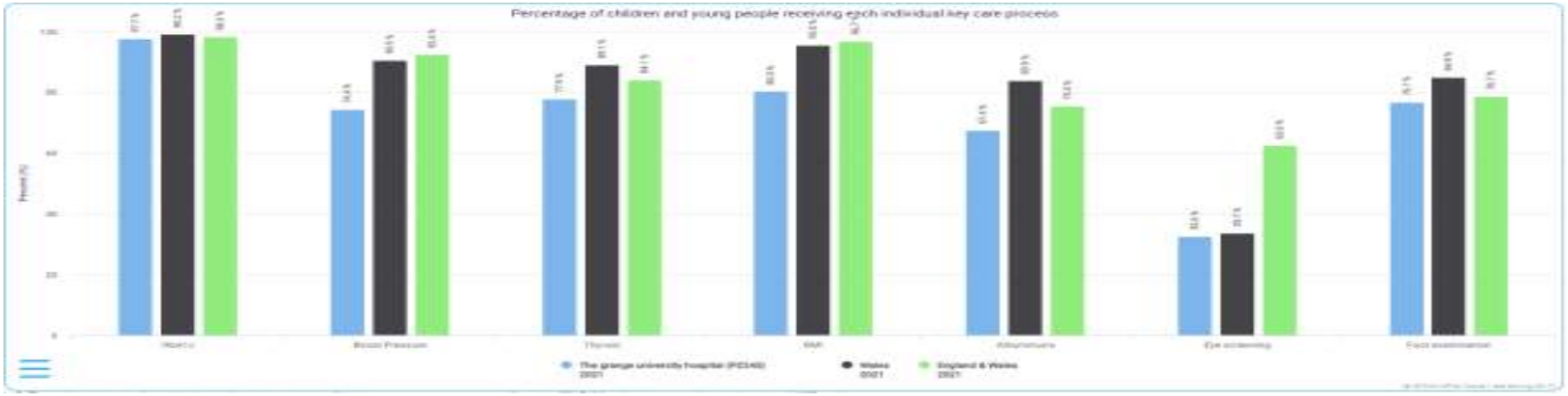


The below plot shows an improvement in 5 of the 6 key health checks (64.7% 2020/2021 & 67.4% 2021/2022).

Figure 2: Radar plot showing unit performance in 2020/21 and 2021/22 on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol

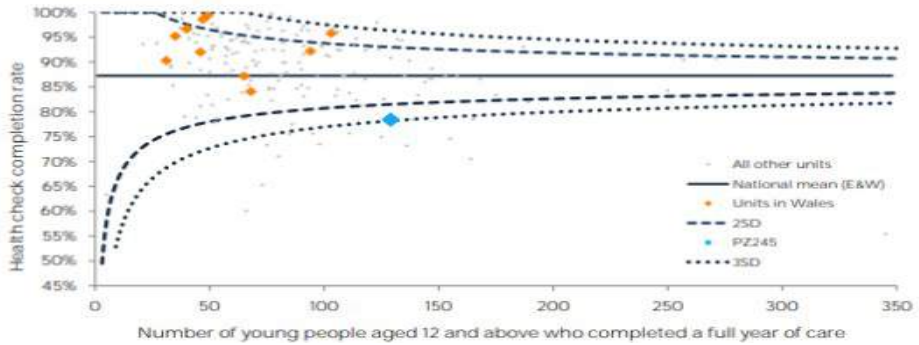


The graph below demonstrates the key care process results for 2021/2022. GUH compared to Wales and UK by health Check. Please note that Eye Screening is managed by The Diabetic Retinopathy Screening Service for Wales which means the management of target sis outside of the health boards control.



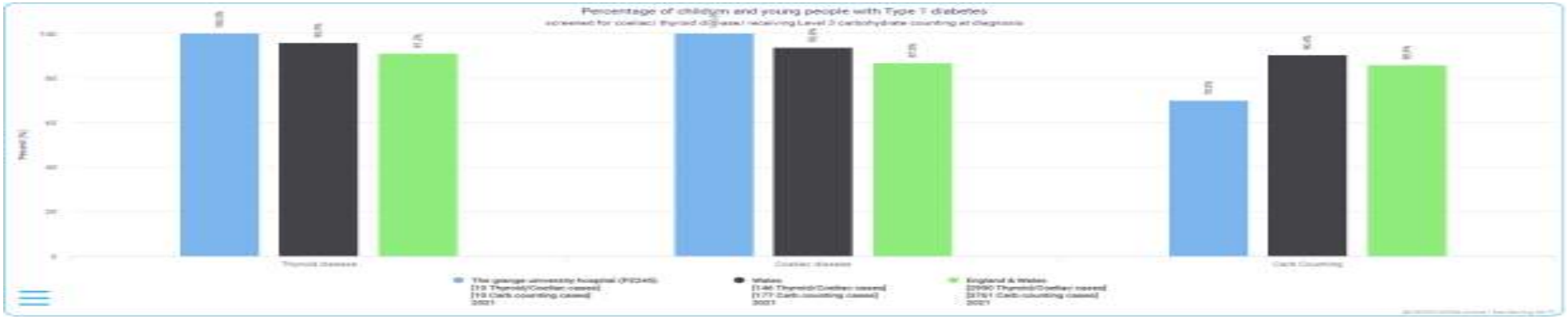
The below funnel chart outlier status of GUH, on the performance indicator for health check completion rate for 2021/22 is: ALERT.

Figure 12: Health check completion rate for children and young people with Type 1 diabetes aged 12 or older who completed a full year of care



The Clinical Lead (CL) presented the 2020/2021 report to the Standards and Effectiveness Group (CSEG) in September 2022 informing that the lack of face-to-face clinics resulting from the pandemic, was impacting on this result. During 2023 the face-to-face clinics have resumed and the impact should be seen in the next report.

- What percentage of all recommended health checks were delivered by PDUs in 2021/22? Outlier
- What percentages of children and young people with Type 1 diabetes received recommended checks at diagnosis in 2021/22?



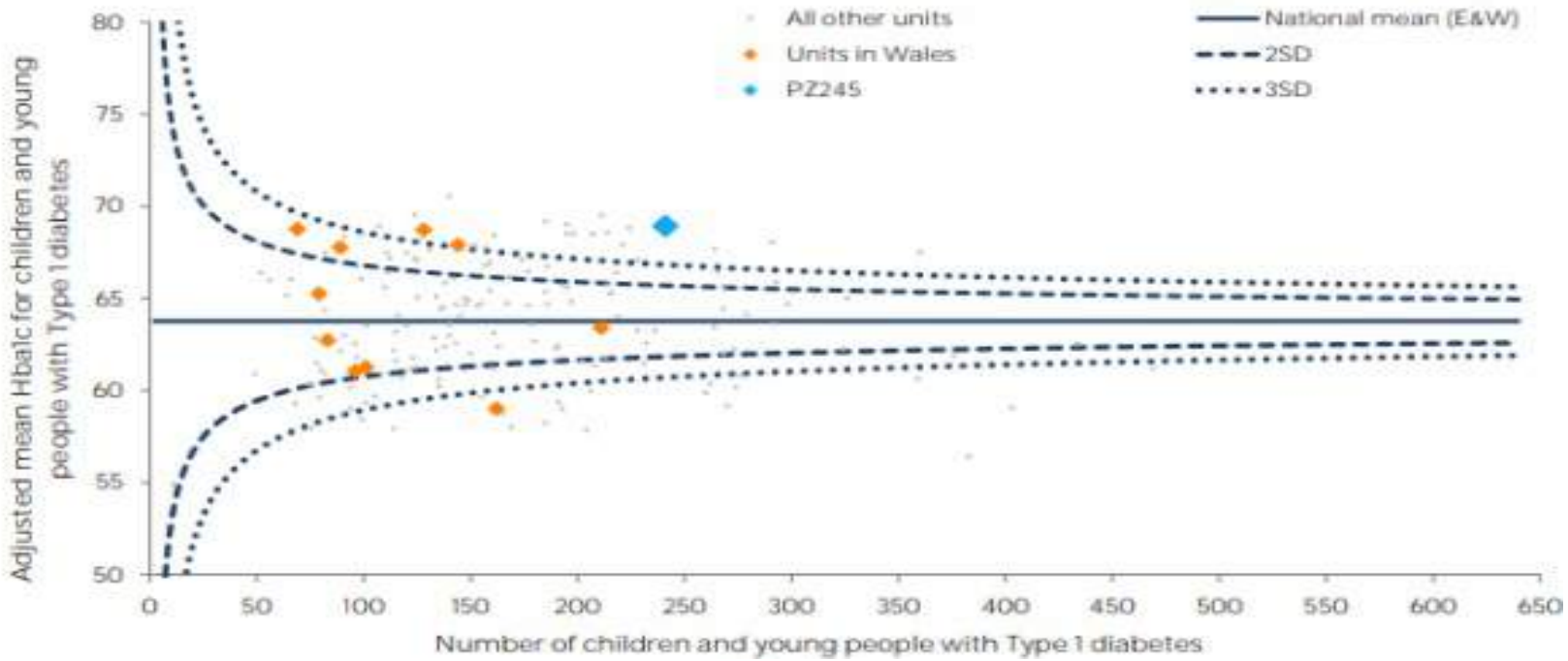
In CSEG September 2022, the CL stated that the Carb Counting at diagnosis was a data entry error as this is commenced at diagnosis. This remains an issue and requires an action to ensure the data reflects accurately.

- Has there been longitudinal improvement in national HbA1c?

  The GUH mean HbA1c for children and young people with Type 1 diabetes was 69.7 mmol/mol. The adjusted mean was 68.9 mmol/mol. The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: ALARM.

The CL stated in September 2022 that the lack of resource funding to manage the technologies for controlling HbA1c is impacting this target and the Health Board will remain an outlier until the cost for consumables linked to vital technologies needed for children to reduce their HbA1c, therefore improving their health as children and as they grow into the adult diabetes service. A collaborative business case submitted by adult services and the paediatric diabetes team which was supported however not funded.

Figure 21: Adjusted mean HbA1c

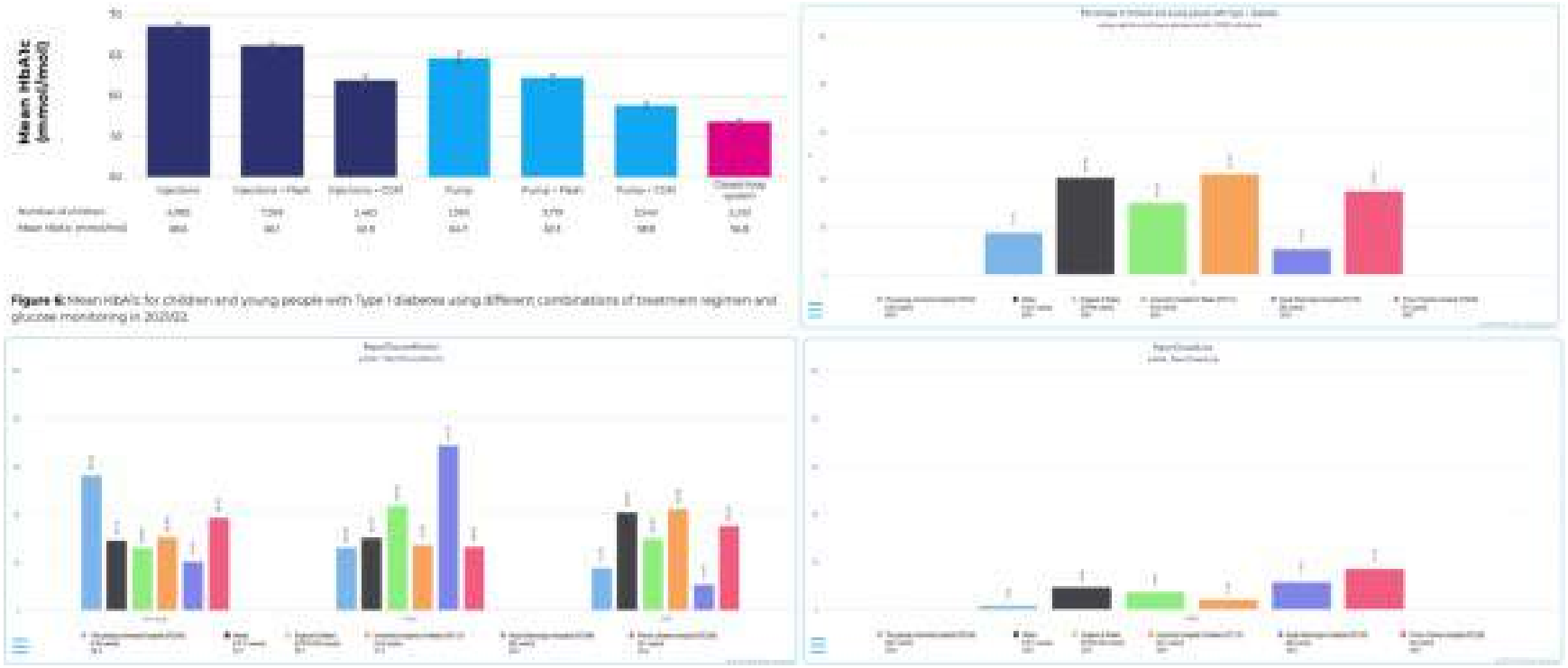


- What percentages of children and young people with Type 1 diabetes were using diabetes-related technologies in 2021/22?

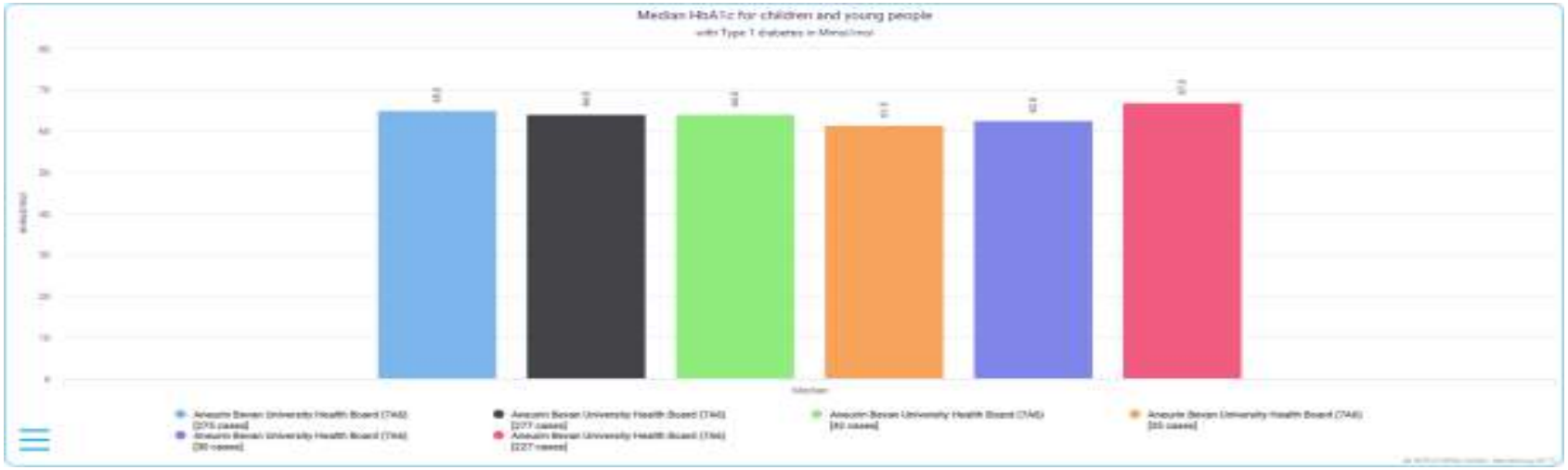
Graphs above demonstrate the link between CYP not using technologies and the reduction in the Health Boards HbA1c measure making the Health Board ALARM status.

- What was the average HbA1c for children and young people with Type 1 diabetes using different diabetes-related technologies in 2021/22?

The graphs below demonstrate the lower HbA1c when using advanced technologies across the UK and The Grange University Hospital displays low use of the technologies, therefore increasing and HbA1c and contributing to the ALARM status. This will not improve without the resources to obtain and manage the technologies.

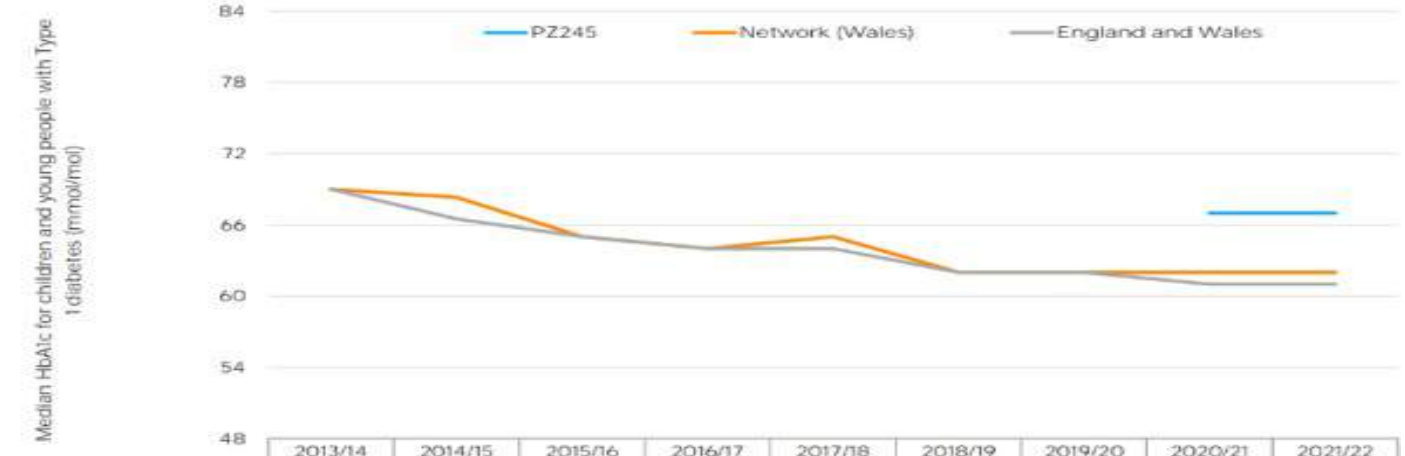


The graph below, shows the reduction in the Health Boards HbA1c recent years.



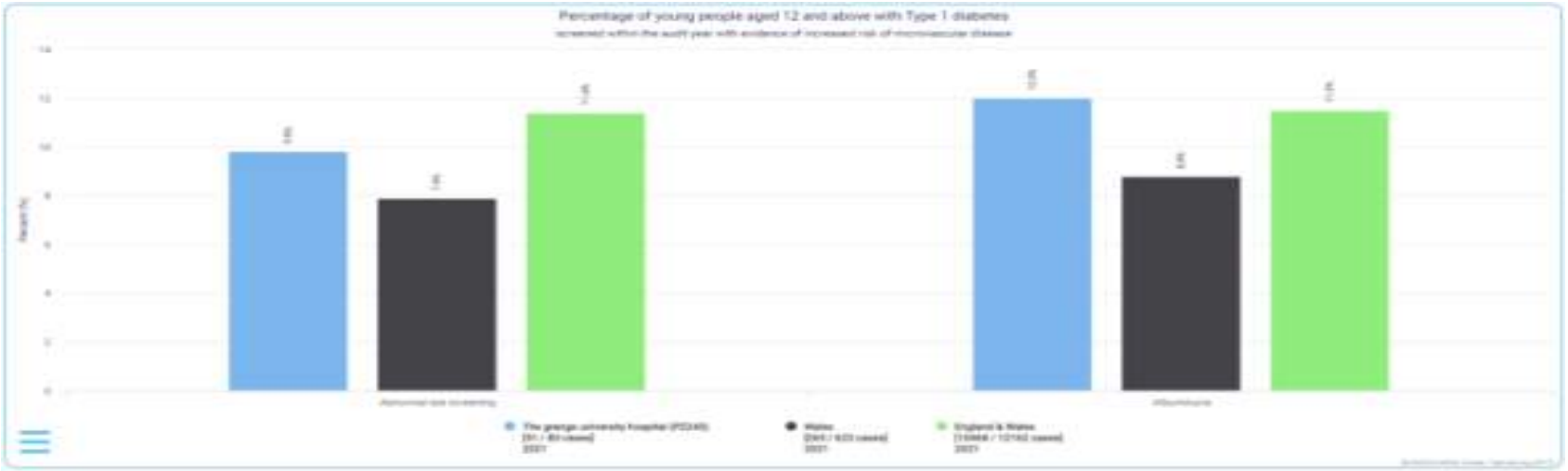
Below is only The Grange University Hospital for 2 years.

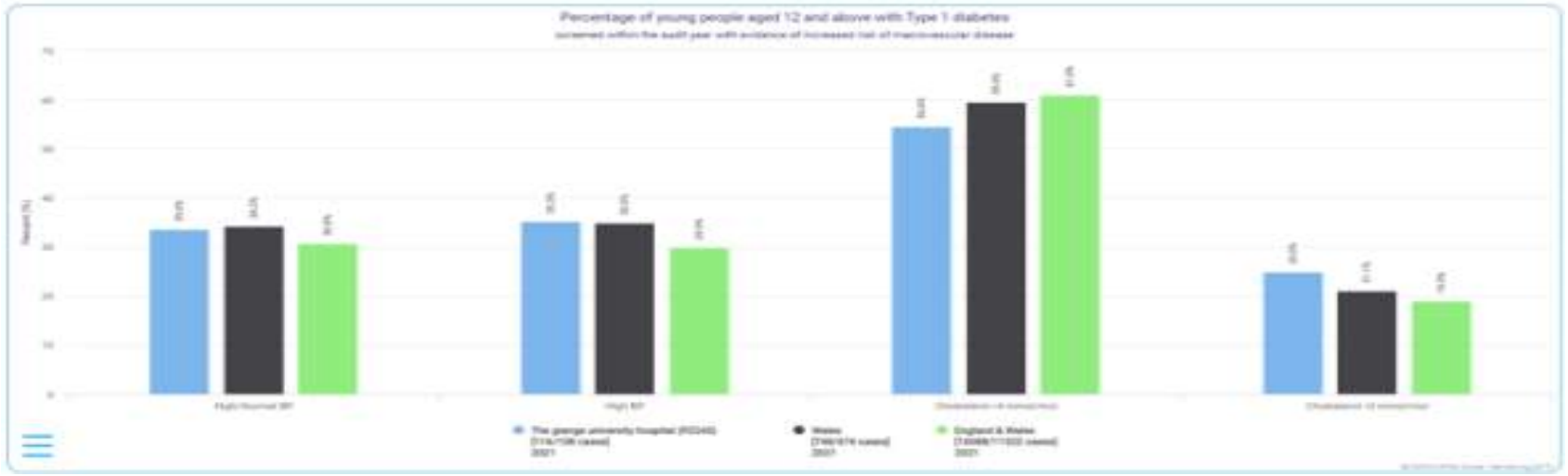
Figure 18: Median HbA1c for children and young people with Type 1 diabetes



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
PZ245								67.0	67.0
Network (Wales)	69.0	68.3	65.0	64.0	65.0	62.0	62.0	62.0	62.0
England and Wales	69.0	66.5	65.0	64.0	64.0	62.0	62.0	61.0	61.0

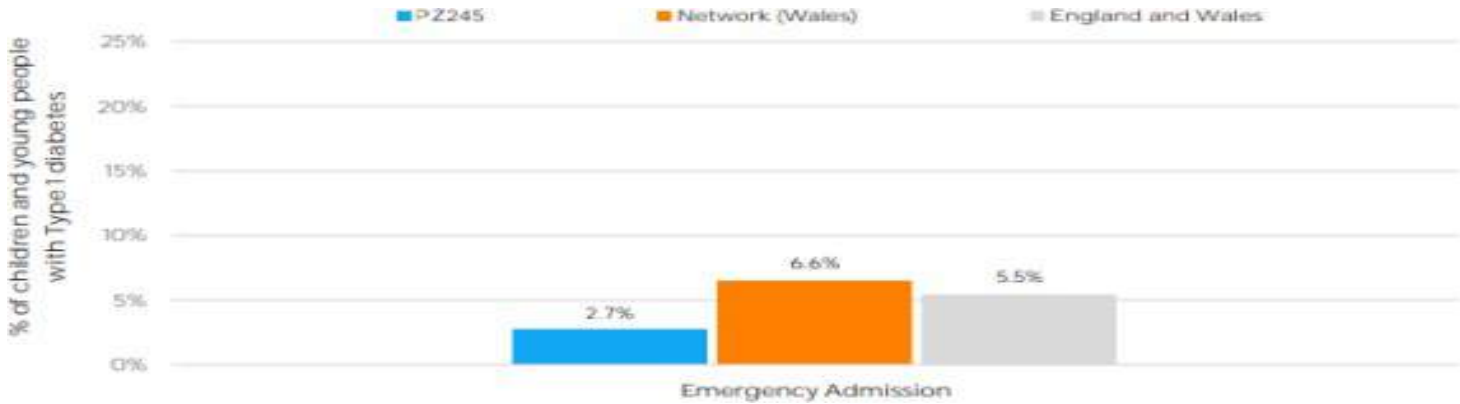
- What percentages of children and young people with diabetes were at risk of macrovascular and microvascular complications in 2021/22?



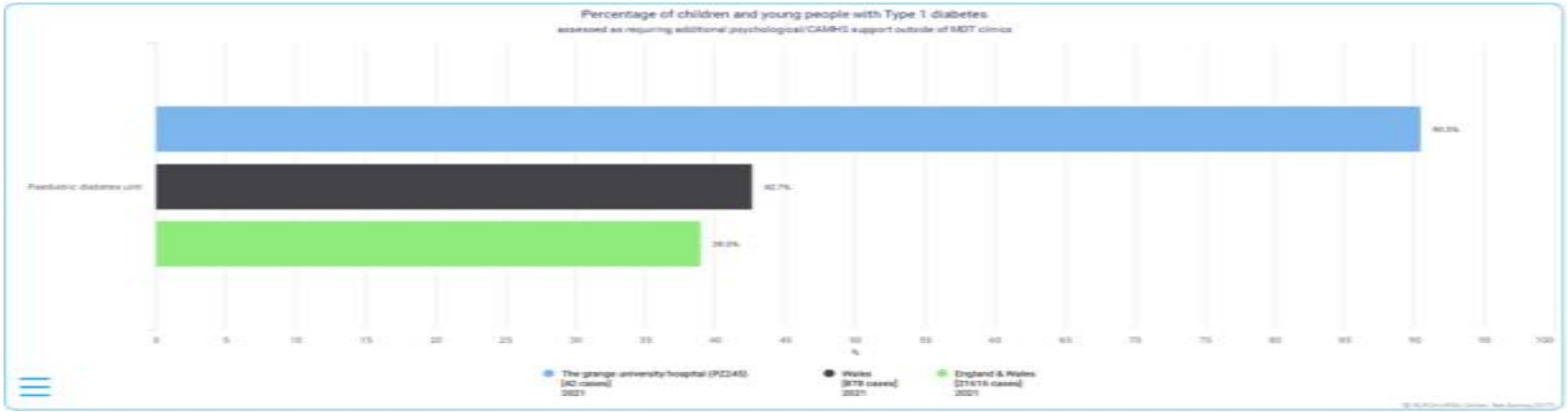


- What percentages of children and young people with Type 1 diabetes had diabetes-related hospital admissions in in 2021/22?

Percentage of children and young people with Type 1 diabetes who had at least one diabetes-related emergency hospital admission during the audit period, that was not associated with diagnosis.

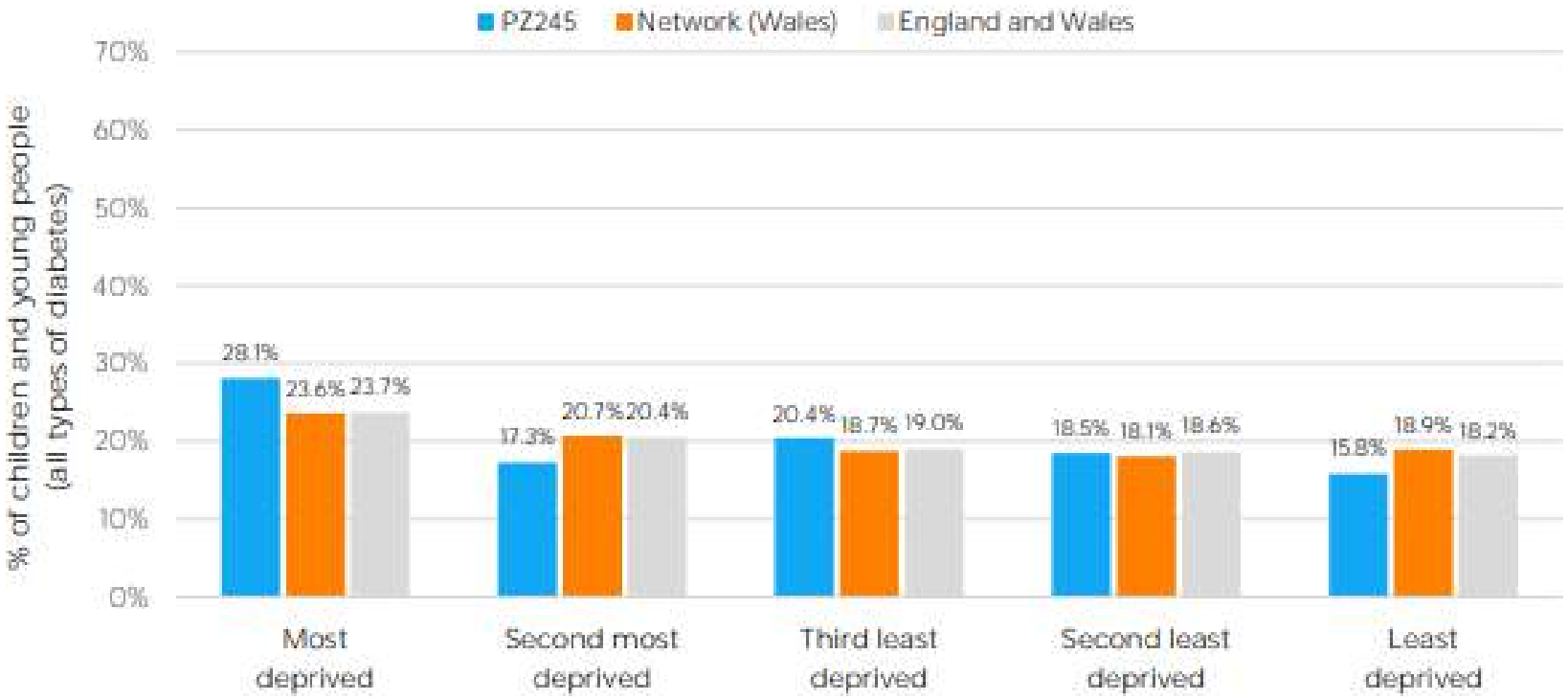


- How many children and young people with diabetes were assessed as requiring additional psychological support following assessment in 2021/22?



Also noted is that Aneurin Bevan University Health Board a higher rate of CYP in the deprived areas compared to the rest of Wales and the UK.

Figure 6: Percentage of children and young people within each deprivation quintile by unit, region and overall



Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Risk level	Description
Major	Non-compliance with national standards/Significant risk to patients if unresolved

This has been added to the Divisional Risk Register.

Key successes & concerns

Successes
The Paediatric Diabetes Team attended the Gwent Children's Diabetes Family Evening 2023. Attendees: Thirty-two families (80 people) initially confirm their attendance, with approximately 60 people attending on the evening. Great feedback, document attached in the results page.

Concerns
A business case was submitted to PIP for the required funding for the diabetic pumps. The case was approved, but there has been a lack of funding and has contributed to the outlier status. This Health Board, Standard Operating Procedure for outlier status has been followed and there has been acknowledgement of the outlier status.
There is a noticeable gap in access to pump technology for Gwent children and young people with diabetes.
The outlier status of The Grange University Hospital, on the performance indicator for health check completion rate for 2021/22 is: Alert. It is noted that this will continue to be an outlier and remain on the risk register with the lack of funding for the devices.
The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: Alarm.

Action plan

	Recommendation(s)	Actions	Responsible	Date raised	Due date	Action RAG
1	**National recommendations 1.** Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Health Boards and Regional Partnership Boards across Wales. **National recommendations 2.** Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential	The alarm status related to diabetes technologies, for the audit has been on the Divisional F&T risk register for some time. A joint business case submitted to PIP by adults and F&T was supported but not funded. Unfortunately, there has been no change to finances to be able to put in any additional workforce to improve this situation. Issues flagged at F&T Divisional Assurance meetings. The costs for consumables was reflected and the gap in ability to improve HbA1C levels still stand.	Sara Garland	01/08/2023	21/09/2023	

	differences in outcome with different modalities of insulin delivery and blood glucose monitoring. Action by: Integrated Care Boards across England in line with the aims for diabetes care set out within Core20PLUS5 – the national NHS England approach to reducing health inequalities for children and young people. Health Boards and Regional Partnership Boards across NHS Wales and Public Health Wales. The RCPCH, to provide a better understanding of ethnic and social deprivation variability. **National recommendations 3.** Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year. Action by: Clinical teams within Paediatric Diabetes Units in NHS Health Boards and Trusts across England and Wales.	Further actions from this is to submit the costs associated to diabetes to be submitted to Chief Operating Officer (LW). This will be undertaken jointly by both adults and paediatric finance teams.				

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
2	**National recommendations 1.** Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Health Boards and Regional Partnership Boards across Wales. **National recommendations 2.** Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential differences in outcome with different modalities of insulin delivery and blood glucose monitoring. Action by: Integrated Care Boards across England	Risk to remain of register and further work as above. PQSOC to be made aware of risk when submitting audit activity report Work underway to address the gap in access to pump technology for Gwent children and young people with diabetes.	F&T Division working with Exec lead for diabetes	01/08/2023	21/09/2023		New

	in line with the aims for diabetes care set out within Core20PLUS5 – the national NHS England approach to reducing health inequalities for children and young people. Health Boards and Regional Partnership Boards across NHS Wales and Public Health Wales. The RCPCH, to provide a better understanding of ethnic and social deprivation variability. **National recommendations 3.** Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year. Action by: Clinical teams within Paediatric Diabetes Units in NHS Health Boards and Trusts across England and Wales.						

Appendix Three – NCEPOD Study – Testicular Torsion

Name of Study:	**Testicle Torsion**		
Date of initial correspondence from NCEPOD	19/08/2022	Has inclusion specifics been provided?	Yes
Date NCEPOD request data returned?	21/09/2022	Date inclusion specifics sent to informatics:	
Date Division informed of pending study:	04/09/2022	There was an error in the first ICD10 codes	

Has a Clinical Lead been requested by QPS?	Yes/[redacted]	Name of Clinical Lead:	Michael Pollitt

Date data returned from informatics:	12/12/2022	Date data sent to NCEPOD: (via secure portal)	12/12/2022
Date added to NCEPOD platform:	14/12/2022		

Is there and Organisational Questionnaire	Yes/[redacted]	How many OQ? (Site dependant)	1 GUH
Deadline for OQ(s):	03/03/2023	Date Sent:	13/04/2023
Are there Clinical Questionnaires?	Yes/[redacted]	How many CQ? (No. of patients in study)	4
Deadline for CQs:	21/12/2022	Submitted	19/04/2023

Have all patients been allocated to a clinician?	Yes/[redacted]	By whom in QPS CAT?	Joanne Stimpson
Date allocated to a clinician:	14/12/2022	Has the Division and CL been informed?	Yes[redacted]
All case notes securely sent	Yes/[redacted]		
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:			
Some of the cases selected by NCEPOD did not meet the criteria and changes to many of the clinicians required to complete the reviews.			

Appendix Four

Application Form for the use of Artificial Intelligence as part of clinical practice

SECTION 1 – OVERVIEW	
Title of AI application or software or project:	Qure AI trial (6 months)

Brief description of the AI application – purpose, which patients will it benefit, how will it work? Provide a copy of the Intended Use Statement	We are currently looking to utilise AI to assist in diagnosis and prioritise patients with pathologies the AI picks up to assist in a speedy diagnosis and treatment in line with many pathways. We have at this point commenced a month trial with Behold AI or will be soon at the point of this. Qure AI also have a Chest X-ray AI and have offered 6-month trial along with their CT Head AI product.

Reasons for use – potential benefits? How will it affect existing ways of working?	Currently in terms of chest reporting we have a significant backlog which is around 85 days for certain referral sources to have their Chest X-ray reported. These would sit there without being reviewed also and could possible be sat there with a significant pathology where time is of the essence. The AI would analyse the Chest X-rays as soon as they have been performed and send a result back into PACS as a secondary capture image. Any urgent findings would also be flagged allowing us to report them urgently rather than wait the possible 85 days to appear on a reporters list.

Strategic or operational goals or objectives that its use will help to meet?	This will help the lung cancer pathway by picking up any suspected lung cancers minutes after the examination has been performed. Either allowing for a report as soon as possible or flagging the patient for specified imaging or pathways. There is also the possibility to allow the AI to put auto reports against the X-rays that have high confidence normal which would reduce the waiting times for chest X-rays to be reported. This is what it can do but will not be utilised like this anytime soon without having the appropriate data and documentation to support.

Submitting clinician	Daniel Wyn Jones	**Designation**	PACS Manager

Assessed by Division?	☒ Yes	☐ No
Approved as suitable to go forward for implementation by Division?	☒ Yes	☐ No
Assessed by Informatics?	☒ Yes	☐ No
Approved as suitable to go forward for implementation by Informatics?	☐ Yes	☒ No

Supported by	Dr Ishan Gunatunga	**Designation**	**Clinical Director**
Supported by	Arvind Kumar	**Designation**	**General Manager**

SECTION 2 – CONTACT DETAILS & SUBMITTING DIVISION / DIRECTORATE i.e. where the AI will be used and who will be the responsible staff for implementation and monitoring?			
Division	Clinical Support Services	Specialty	Radiology
Directorate	Radiology		
Lead Clinician	Dr Ishan Gunatunga	Designation	Consultant Radiologist/CD
E:Mail	Ishan.gunatunga@wales.nhs.uk	Tel	01633 234312
Lead Manager	Arvind Kumar	Designation	General Manager
E:Mail	Arvind.kumar@wales.nhs.uk	Tel	01633 234326

SECTION 3 – ABOUT THE PROCESS/CLINICAL PROCEDURE OR TECHNIQUE WITHIN WHICH AI WILL BE USED**:**			
1. Title / Name of the AI application:	Qure AI trial		
2. Clinical Procedure in which AI will be used?	Chest X-ray and CT Head		
3. Will the AI be used to make decisions about a patients care or treatment? e.g.the AI will "automatically" generate medication prescriptions, decide the next steps in the care or treatment plan		☐ Yes	☒ No
(a) If yes, describe how this will be done.			
For the trial the AI will be there as a diagnostic tool to assist reporters.			
4. Will the AI be used as a decision making support tool? e.g. create a suggested treatment plan based on the information it has obtained		☐ Yes	☒ No
(a) If yes describe how this will be achieved.			
5. Will it replace an existing clinical process or procedure?		☐ Yes	☒ No
(a) If yes, please describe the process or procedure it will replace:			
All studies for the purpose of the trial will be reported as usual			
6. Will it be used to support existing processes or procedures?		☒ Yes	☐ No
(a) If yes, please describe its role in supporting existing processes:			
The AI will be there as a assistance when reporting or as a second set of eyes to an extent			
7. Will training in its use be required?		☐ Yes	☒ No
(a) If yes, please describe what training, for whom and how this will be achieved:			
8. Has a new Digital Service Request been made?		☒ Yes	☐ No
(a) If yes, please provide Reference number:			
The request has gone to front of house and supporting documentation has been submitted for review.			

SECTION 4 – EVIDENCE BASE		
1. Entirely new to ABUHB i.e. it is not used elsewhere in the Health Board?	☐ Yes	☒ No
(a) If No, where in the Health Board is it used?		
2. In use elsewhere in the UK?	☒ Yes	☐ No
(a) If Yes, where in the UK is it used?	NHS East Kent,	

	NHS Milton Keynes, NHS Frimley and 20 other NHS sites	
3. In use elsewhere in the world?	☒ Yes	☐ No
(b) If Yes, where is it used?	70+ countries	
4. Similar to an existing use of AI in the Health Board?	☐ Yes	☐ No
(a) If Yes, what similar use is there in the Health Board?		
5. Listed or approved by NICE?	☒ Yes	☐ No
(a) If yes, provide NICE Registration reference		
6. Has the AI / application had a clinical evaluation as required under the Medical Devices Regulation?	☒ Yes	☐ No
(a) If yes, give details		
I have got CER, Risk management file and hazard logs relevant to Qure AI.		
7. Subject to regulatory requirements other than NICE or Medical Devices Regulation?	☐ Yes	☒ No
(a) If yes, what are the regulatory requirements?		
The products are CE MDR Class IIB Cleared		

SECTION 5 – RISK ASSESSMENT (provide separate Risk Assessment documentation)		
1. Has the potential ethical risk been assessed?	☒ Yes	☐ No
(a) If Yes, describe how risk was assessed and details of how it will be addressed?		
- Qure actively monitors the GRC i.e., Governance, Risk, Compliance and discusses any potential risks and mitigation with the Regulatory body. - A Risk Framework and a Risk Assessment is created that defines all potential risks and vulnerabilities and their mitigation techniques and is updated regularly. - We provide a complete transparency on Patient's data privacy and encryption with Clients to avoid any nonconsensual action. Any patient's data is completely encrypted to avoid any tampering. - Qure actively trains and conducts multiple security and risk awareness programs and trainings to encourage the employees about AI ethics and Cyber Security. - Qure strongly believes in incentivizing their employees on their sincere contribution. - Every product deployment is quantitatively researched on and has been calculated with potential risks and failures along with the potential backup solutions, including the risk impact on the stake holders.		
2. Has the supplier provided evidence of how it addressed potential system bias?	☒ Yes	☐ No
(a) If Yes, give details of how it will be addressed?		
- As Qure uses only image data for training (no clinical history, patient demographics, or free text fields), the probability of this bias occurring is limited to the characteristics that are present or can be inferred from image data. Further, the wide distribution of training datasets from multiple image source sites helps limit this risk. - Potential sources of bias were identified during development of the algorithms, and training data was checked to ensure a balanced distribution of the known factors. For any unusual trends towards increased or decreased likelihood of abnormalities in certain population subgroups (gender, age, device type) were checked through processing X-ray/CT Scan metadata and natural language processing of reports before adding data to the training database. Test data results were similarly verified to check for unusual correlations between population subgroups and software results. Systemic Bias introduced by Ground Truth: The ground truth for training was derived largely using natural language processing (NLP), and partly using expert manual annotations. The probability that expert manual annotations have a systematic bias is low, because of the number of experts performing the annotations, and because the annotations were performed with direct reference to a radiology report. The possibility that NLP labels were inaccurate or incomplete was mitigated by performing extensive research into natural processing algorithms for medical report data (http://blog.qure.ai/notes/teaching-machines-read-radiology-reports) and by testing the performance of these NLP algorithms.		

3. Have the potential information security risks been assessed?	☐ Yes	☐ No
(a) If Yes, describe how risk was assessed and details of how they will be addressed?		
Data integrity Self-Tests conducted on real time basis to be done periodically using CRC checks during system set up. Qure internal team also has standard system monitoring in place for disc utilization, CPU usage etc.		
4. Have other potential technical security risks been assessed?	☒ Yes	☐ No
(b) If Yes, describe how risk was assessed and details of how it will be addressed?		
To avoid this the qure.ai team performs the account set up and authentication for each user account and the credentials are associated are linked through user's PACS To avoid this all logins are to be done via public/private key pairs only. Servers are not open for public access Bitdefender IDS/IPS is used where in the agents scan the monitored systems looking for malware, rootkits and suspicious anomalies.		
5. Is there any potential or actual commercial interest risk?	☐ Yes	☒ No
(a) If Yes, provide details of the risk and how this will be mitigated.		
6. Are there any potential or actual intellectual rights?	☒ Yes	☐ No
(a) If Yes, provide details of the concern and how this will be mitigated.		
Qure has ownership of all IP pertaining to its AI products, including multiple patents and trademarks. Details of some of the patents are mentioned below. If required Qure can provide additional information to define its background IP. Trademark Name: qXR Application Number: 88885839 Jurisdiction: US Classes: 9, 38, 42, 44 Trademark type: Wordmark Trademark Name/ Title of Invention: Predicting Lung Cancer Risk Photon ref.: 1319 Application Number: 17/383,845 Patent Number: US11276173 Country: USA Filed date: 23/07/2021		

7. Are there any potential or actual conflicts of interest?	☐ Yes	☒ No
(a) If Yes, provide details of the conflict and how this will be mitigated.		
8. Have other risks been assessed?	☒ Yes	☐ No
(a) If Yes, what are these and how they will be addressed??		
If Yes, what are these and how they will be addressed?? We have a comprehensive risk management file which addresses all risk associated with the product. Which is shared as well		

SECTION 6 – PATIENT INFORMATION GOVERNANCE & CONSENT		
1. Will the patient be informed about the use of this specific AI as part of their care or treatment?	☐ Yes	☒ No
(a) If Yes, what information will be provided? (Where available the use of EIDO leaflet must be used)		
We will look into notices and information being available for AI being utilised within ABUHB Radiology.		
(b) If No, describe the reasons for this		
2. Is patient consent required to use this AI?	☐ Yes	☒ No
(a) If No, describe the reasons for this		
The AI won't be making any decision and will be a diagnostic tool for the purpose of the trial and the research lead for Radiology has discussed amongst her peers include Prof Chris Edwards and concluded there was no requirement for the trial to seek consent. Though we will be putting poster in the departments for patients to read along so they can ask any question if they require.		
3. Will the patient be informed about the efficacy of using AI as part of their care or treatment?	☐ Yes	☒ No
(a) If Yes, what information will be provided?		
(b) If No, describe the reasons for this		
The AI will only be utilised to assist diagnosis for the purpose of the trial and all studies will still receive a report as they normally would.		
4. Has Information Governance been consulted about its use and provided advice on patient consent?	☒ Yes	☐ No
5. Describe how the use of AI will be included in the patient notes?		
The AI will analyse the image and send a secondary capture image with the results overlayed on the additional image going to PACS. The results of the AI will be included in the same image packet as the original imaging.		

SECTION 7 – PROCUREMENT / SUPPLIER CHAIN DILIGENCE		
1. Has a preferred supplier been identified?	☐ Yes	☒ No
(a) If Yes, provide details		
2. Does the preferred supplier have the appropriate accreditation e.g. Cyber Essentials Plus?	☒ Yes	☐ No
(a) If Yes, provide details		
3. Is the preferred supplier registered with MHRA and certified for ISO 13489 and the application UKA / CE marked	☒ Yes	☐ No
(a) If Yes, provide details		
4. Is the preferred supplier registered with the ICO?	☒ Yes	☐ No
(a) Provide details		
Will attach		
5. Can the preferred supplier provide a Clinical Safety Case Report and Hazard Log	☒ Yes	☐ No
(a) Provide details		
Will attach		
6. Has the preferred supplier got post market surveillance monitoring in place?	☒ Yes	☐ No
(a) Provide details		
Will attach		

SECTION 8 – MONITORING PERFORMANCE AND EFFECTIVENESS (THIS IS MANDATORY)
1. Describe how the outcomes of the use of the AI application be audited.
All the chest X-rays will be reported as normal for the purpose of this trial and the AI will be used as a diagnostic tool to assist diagnosis and prioritize studies to be reported over studies the AI find without any significant pathologies.
2. Describe how the accuracy of the AI application will be monitored.
The images will be reported as normal and the AI will be there as a diagnostic tool but any discrepancies will be fed back to Qure to review. Also a part of the integration the AI will analyse a certain number of our studies which we will review to adjust the sensitivity to our needs and specifically calibrate the AI for ABUHB.
3. What is the process to monitor any adverse events where the AI application potentially forms part of the event?
The images will be reported as normal so the reporter will still liable as they will be reporting the examination and not the AI. Any discrepancies will be fed back to Qure and they will investigate.

SECTION 9 – RESOURCES		
1. Is there a requirement to meet costs of implementation (capital / revenue)?	☒ Yes	☐ No
(a) If Yes, provide details		
There will be no license cost but there will be a £15,000 implementation fee along with the cost of building a VM to host.		
(b) If No, provide reasons why not.		
2. Is there a requirement for more staff?	☐ Yes	☒ No
(a) If Yes, provide details		
(b) If No, provide reasons why not.		
The AI should automatically analyse the images with no intervention required.		
3. Are there any other cost or resource requirements?	☒ Yes	☐ No
(a) If Yes, provide details of what and how this will be met.		
We will require a VM to be installed on the ABUHB network by IT to host the software that will handle the imaging like a gateway to Qure AI's external datacenter. There will also be a £15,000 implementation cost. This will also require Cyber and Networks time to set up and approve the firewall rules.		

SECTION 10 – APPROVAL		
1. Is this application granted?	☐ Yes	☐ No
(a) If Yes, provide reasons to support		
(a) If No, provide reasons why it isn't supported		

Signed off by		Designation	Chair of CSEG

Appendix Five

Progress on Audit Management and Tracking (AMaT) system, for five months (March 2022 to August 2023)

This report demonstrates the current usage of AMaT since it was purchased and implementing in March 2022. To date, there are 875 registered users on AMaT within the Health Board.

Clinical Area

Since its commencement within the Health Board, AMaT has been used to gather audit-based data and for the management of National Clinical Audit and Local Audit across all wards. This includes all hospital sites within the Health Board.

Since March 2022 there have been 122 audits registered in the Clinical Audit Area, being a mixture of retrospective and prospective:

Audit Period	Number
2019-2020	6
2020-2021	6
2021-2022	8
2022-2023	70
2023-2024	32
Grand Total	122

This is attributable to 39 national audits, and 83 local audits. This demonstrates the positive engagement with Divisions when presenting the Clinical Audit Strategy. It also illustrates the time invested by the clinical audit team in training users for AMaT over the last twelve months.

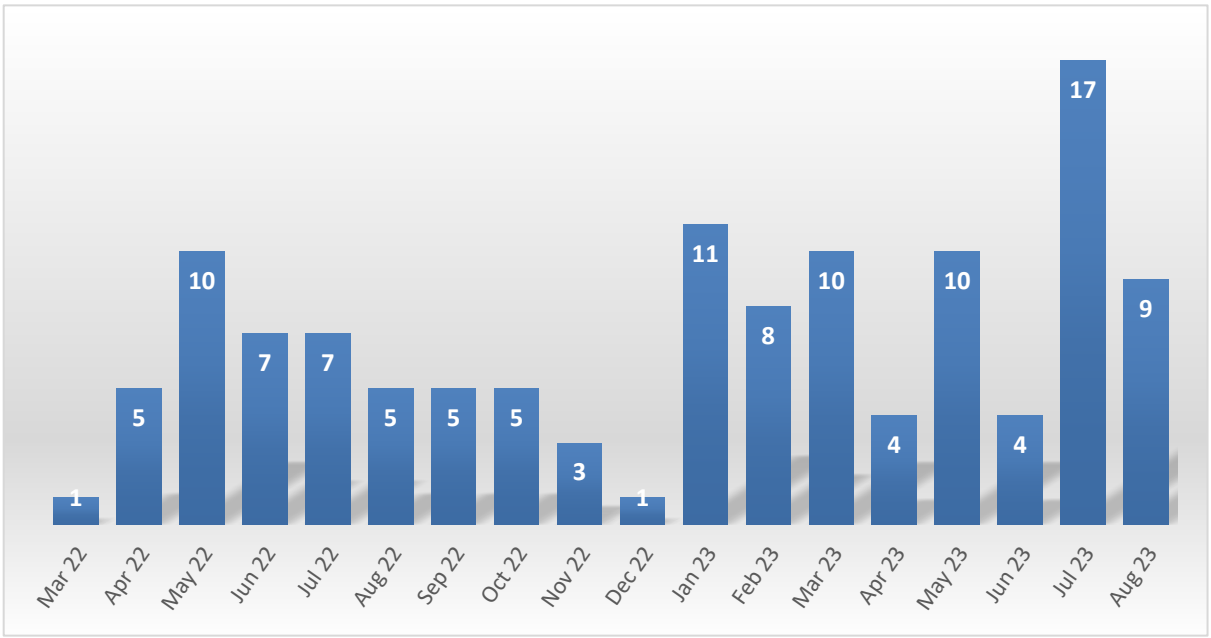


Figure 1.1 Chart to show the number of audits registered to Clinical Areas

There are a vast number of clinical specialities that are now using AMaT throughout the Health Board.

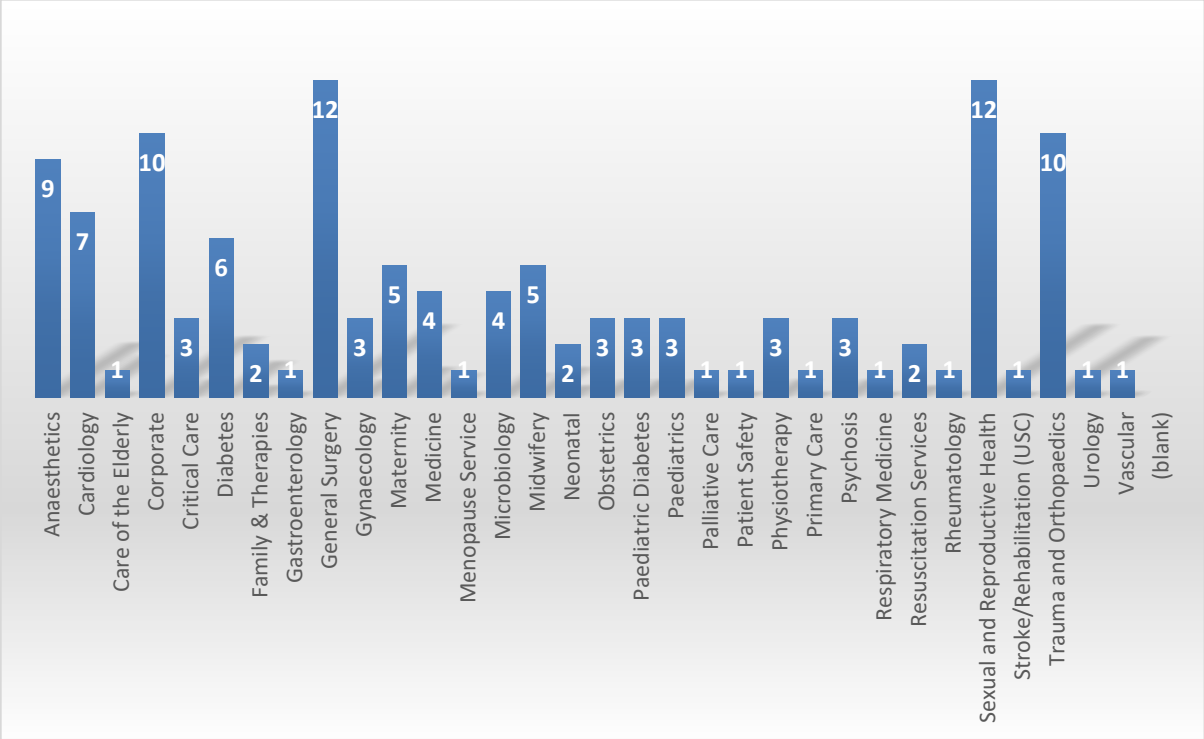


Figure 1.2 Audits in Clinical Area by Specialty

The internal audit report issues in November 2022 reported limited assurance for the local audit process within the Health Board. AMaT has helped improve the reporting of local audits. These audits have completed actions which are tracked in AMaT. The clinical audit team are reviewing the processes and governance structure in relation to users of AMaT. This will allow overdue actions to be followed up.

There are a number of action plans linked to National Clinical Audits which are part of the National Clinical Audit Outcome Review Plan (NCAORP). The management of registered audits is also being reviewed ensuring this links to the standardised registration form.

The clinical audit team are currently establishing links with hospital pharmacy audits and working with 61 GP practices in Primary Care.

The current license for AMaT expires in February 2024. The number of clinical areas, specialities and variety of health professionals that use this system demonstrates that investment in the system has been worthwhile. It is also currently being utilised for ward accreditation audits. Given its uptake and utilisation, ongoing funding will be pursued to ensure the system can continue to be used.

Ward Area

Within the Ward Area there are 12 registered projects containing 56 individual audits. The audits can be registered to any number of wards or all wards.

Project overview

Project	Number of audits	Current compliance	Improvement	Overdue actions
Cardiac Arrest	1	R 14.3%	▲	
Controlled Drugs	1		N/A	
Corporate	1		N/A	
DECi	3	A 76.3%	▼	
Dietetics	4	R 46.4%	▼	
ED Nursing	1	R 0.0%	▲	
Haematology	1		▲	
Health & Safety Monitoring	1		N/A	205
IPC Annual Audits	31	A 89.3%	▲	282
Oral Hygiene	1	R 69.4%	N/A	0
Thrombolysis Audit	1	R 73.1%	N/A	
Ward Accreditation Audits	10	A 75.4%	▼	1

As with the actions in the Clinical Area, there are trial processes underway to ensure governance relating to the overdue actions within ward area.

WHSSC Joint Committee
19 September 2023
Agenda Item 4.8.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Kate Eden**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**16 August 2023**

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

- **WHEELCAIR SERVICES DEEP DIVE PRESENTATION AND PATIENT STORY**

A presentation outlining the functions of the Posture and Mobility service and the services it provides for children, young people and adults who require long term wheelchair use was received. Members noted the actions in place to reduce the current waiting times of over 52 weeks to zero by December 2023. The increased waiting times were a direct result of the COVID Pandemic and the backlog created due to the service being closed during that period.

Members received an informative patient story about a young girl, Ellen, who presented to the service initially with extremely complex issues and no experience of independent movement having never rolled, crawled or operated a wheelchair by herself. Despite this, Ellen was insistent on trying a powered wheelchair to gain more independence in her everyday life. Members noted the challenges Ellen faced due to her presentation, posture and dyskinesia and how the services used innovative thinking to overcome the issues by adapting a wheelchair to suit her posture and using the Drive Deck Platform to assess the best way she could drive it independently.

The presentation;

- Explored Referral to Treatment Time (RTT) between 2019/2022 and 2022/2023 and the first quarter of 2023/2024; and
- Explained the actions that were being taken to help reduce waiting lists.

QPSC noted;

- The Welsh Government RTT performance measures,
- Trajectories for 2023/2023,
- Key Performance Indicators; and
- Quality standards.

The challenges and achievements across the three centres were highlighted.

2.0 WELSH KIDNEY NETWORK (WKN) PRESENTATION

Members received a presentation outlining the impact of kidney disease and treatment options for patients with advanced kidney failure. Members noted the significant commitment required for patients undergoing Haemodialysis in the Dialysis Unit and the work that the WKN had undertaken to increase the uptake of home therapy using value based healthcare to improve access for patients as well as employing welfare benefits officers to assist patients in navigating the benefits system to access available financial assistance.

Members also noted the main role of the WKN as the commissioner for all adult kidney specialised services in Wales. The presentation explained the structure and role of WKN and highlighted the current commissioning responsibilities as;

- Haemodialysis (HD),
- Home HD,
- Peritoneal dialysis,
- Transplantation,
- Vascular access

3.0 WELSH KIDNEY NETOWRK REPORT

Members received a report outlining the current Quality and Patient Safety 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 5 July 2023 and WKN Board meeting on 3 August 2023. There were 11 items on the current WKN risk register. One risk related the pressure on the Transplant Follow up Service had been closed.

Members noted that the Network Manager post would be advertised shortly which should decrease the current staffing risk and the updates to the limited outpatient dialysis capacity risk in Swansea which should be resolved once the new units open.

The Patient Story attached as an appendix to the report provided an account of a renal patients experience with the services following two failed transplants and how the team supported them to carry out self-care dialysis at home despite initial anxieties.

4.0 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 tables at the end of the report.

- **Cancer & Blood**

The main issue to note was the improved traction on the performance issues within the All Wales Lymphoma Panel service. The Escalation meetings continue to monitor progress against the action plan. It is anticipated that during the next escalation meeting in September 2023 there will be a recommendation to reduce the level of escalation due to the good work being undertaken.

North Wales Plastic Surgery service remains an area of concern and WHSSC continue to work with the Welsh Government escalation arrangements. WHSSC continue to attend the Task and Finish Group as an advisor and members noted that the Harm review is progressing. Members noted that as part of the harm review patients had been categorised and prioritised and those categorised as urgent have already been seen.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continue to breach maximum waiting times for treatment at Swansea Bay UHB and this remained a concern for WHSSC. The service remains in escalation Level 2 with a delivery plan in place.

- **Neurosciences**

Members noted that two new risks scoring above 15, both relating to Deep Brain Stimulation commissioned from North Bristol NHS Trust, had been added since the last report. A progress meeting has been scheduled for 21 September 2023 and a further update will be provided at the next QPSC meeting.

- **Cardiac**

Members noted the updates against the two services which currently remained in escalation level 2; Cardiff and Vale UHB (CVUHB) Cardiac Surgery Service;

- The planned repatriation of Cardiothoracic Surgery to UHW, initially scheduled for September 2023, is likely to be delayed and the actions that had been paused pending the relocation have been discussed with the HB at the July Cardiac Service Risk, Recovery and Assurance meeting.
- A formal escalation review is scheduled to take place in October 2023 when the outstanding actions will be discussed.

Swansea Bay UHB (SBUHB) Cardiac Surgery Service;

- Escalation monitoring continues to take place via bi-monthly meetings,
- SBUHB continue to make excellent progress against the action plan and the team will be considering the potential for further de-escalation at the next meeting in October 2023 subject to the National Adult Cardiac Surgery Audit Report (NACSA 2023).

- **Women & Children**

Members noted the five service areas with risks scoring 15 and above;

  - Paediatric Intensive Care,
  - Paediatric Surgery,
  - Neonatal,
  - Paediatric Cardiac Surgery; and
  - Wales Fertility Institute (WFI) – IVF.

- Mitigating actions are in place for each of the services with Paediatric Surgery, Paediatric Intensive Care and the Wales Fertility Institute all being managed through the WHSSC escalation process.

- **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. The first escalation meeting is due to be scheduled and further feedback will be shared subsequently.

- **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 they will meet the contract volumes by December 2023 and they have provided a revised demand and capacity plan and waiting times trajectory and this is being monitored on a weekly basis. Members expressed their continued concern in relation to Paediatric Surgery waiting times and requested further assurance.

Overall waiting times have decreased to meet the Ministerial waiting time of 104 weeks. However, because this relates to children WHSSC have requested further significant reduction to 52 weeks 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 on 1 June 2023. Further investigations into pressure damage sustained on the unit are on-going. WHSSC have written to CVUHB requesting further assurance regarding the concerns raised into the pressure damage incidents. A response from the Executive Nurse Director (END) has been received advising that the Executive team in CVUHB had been sighted on the full report which is due to be presented to the HB Quality, Patient, Safety and Experience (QPSE) Committee on 26 September 2023. The full assurance report with relevant actions will then be shared with WHSSC and submitted to WHSSC QPSC in October 2023.

Health Inspectorate Wales has written to the Chief Executive Officer (CEO) of CVUHB after a whistle blowing letter outlining concerns relating to the Paediatric Critical Care Unit (PICCU). Members noted the response provided by the Executive Director of Nursing confirming that detailed analysis was being undertaken and highlighting the significant pressures the services are currently experiencing. Once that analysis has been completed the results will be shared with QPSC.

- **Mental Health & Vulnerable Groups**

Members noted that there was currently only one Mental Health service in escalation. Ty Llidiard has been de-escalated to Level 2 and FACTS has been de-escalated completely. Ty Llidiard in particular had made excellent progress over the last 12 months.

The committee received an update regarding the rise in Eating Disorder (ED) adult placements, many of them being placed out of area. A review with the Clinical Gate Keepers is taking place to understand the rationale for the significant increase over the last six months. A Deep Dive into ED services will be brought back to QPS for further discussion.

WHSSC continue to participate in the Children and Young People's Gender Identity Service transformation programme and NHS England (NHSE) have prepared letters to issue jointly from NHSE and NHS Wales to all those on the waiting list relevant by age. These will be available bilingually.

Members noted that the First Minister made a visit to the Mother and Baby Unit in Tonna in July which received positive feedback.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members noted the improved position concerning the risk related to sustainability and delivery of the IF service in CVUHB due to workforce issues. The HB remain committed to providing this services.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

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 2 in July 2023,
- Paediatric Surgery C&VUHB remains in escalation level 3 since March2023,
- Wales Fertility Institute (WFI) – IVF has been escalated to 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 at ***Appendix 1***

4.2 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.

4.3 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 June to July 2023 was presented to the committee.

4.4 Incident and Concerns Report
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. Members noted the 8 new incidents that had been reported since the last update and the actions taken in line with the governance process within the relevant HBs.

An in-depth review of the women and children's incidents was included. Members noted the additional detail following the Deep Dive into Women and Children's services outlined within the report, as requested by members during the last QPSC meeting for further assurance. No themes or issues were identified.

A public report has been issued from the Ombudsman looking at how complaints are handled and the recommendations will be considered at the QPSC Development Day to ensure it ties into the Duty of Candour and Quality going forward.

Members noted the content of the report.

4.5 Report from the WHSSC Policy Group
A report outlining the summary of activity of the Policy Group was received and members noted the 40 policies currently in development across the services. The Policy Group also reports this to Management Group for further assurance.

4.6 Quarterly Newsletter
The WHSSC Quarterly Newsletter in Welsh and English versions was received and members noted the work outlined within the paper. The newsletters are attached as ***Appendix 2.***

4.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 18 July 2023,

- Welsh Health Circulars on Research Matters and Withdrawal of WHC Annual Quality Standards,
- 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. Members continued to express their concern over Paediatric Surgery waiting times and requested more information in relation to the waiting times trajectories. Further assurance was requested on pressure sores in CVUHB Paediatric Intensive Care Unit.

Members also wanted to highlight the inspiring patient story received and the comprehensive update received on the work of ALAC. In addition a very informative presentation from the WKN was provided.

Carolyn Donoghue new Independent Member (IM) for WHSSC has been appointed as the new WHSSC QPSC Chair.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

- Quality Newsletter English and Welsh (***Appendix 2 & 3***)

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	24 October 2023 at 10.00hrs

Comisiynu Gwasanaethau Iechyd Arbenigol Cymru

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

CYLCHLYTHYR

4ydd Argraffia, Gwanwyn/ Haf 2023

Dyma'r 4ydd rhifyn o'r cylchlythyr Ansawdd gan dîm Gwasanaethau Iechyd Arbenigol Cymru yng Nghymru. Ein cynllun yw cyhoeddi'r rhain bob chwarter i ategu adroddiadau a data a ddarparwyd eisoes drwy wahanol fforymau i Fyrddau Iechyd Cymru.

This Newsltter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

Mae hwn yn rhoi trosolwg o rywfaint o'r gwaith yr ydym yn ymwneud ag ef, ac yn cyflwyno rhai o'r uchafbwyntiau o safbwynt comisiynu. Darperir gwasanaethau a gomisiynir gan PGIAC yng Nghymru ac yn Lloegr; bydd hwn yn rhoi cipolwg ar ein gwaith yn unig. Rhoddwyd caniatâd ar gyfer y cynnwys sydd wedi'i gynnwys.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

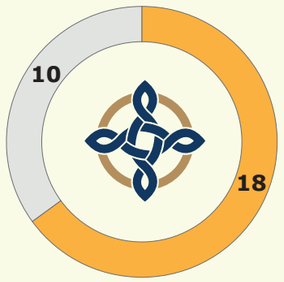
Cynnwys

PGIAC - Cylchlythyr 4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023

Adrodd

Nid yw PGIAC yn ymchwilio i ddigwyddiadau ond mae'n gyfrifol am gefnogi'r ymchwiliadau i'r rhain ochr yn ochr â monitro ac adrodd i'r Byrddau Iechyd. Mae PGIAC yn gyfrifol am sicrhau bod gwasanaethau diogel yn cael eu darparu a sicrhau bod gan dueddiadau neu themâu sy'n codi o bryderon gynlluniau gweithredu sy'n cael eu cwblhau ac sy'n cefnogi dysgu. Mae PGIAC yn hwyluso monitro parhaus gwasanaethau a gomisiynir ac yn gweithio gyda darparwyr pan fydd materion yn codi.

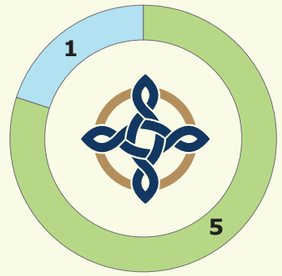
Rhwng y cyfnodau o fis Ionawr i fis Mehefin 2023, cofnodwyd ***18*** Digwyddiad Diogelwch Cleifion a ***10*** Hysbysiad Rhybudd Cynnar.



10 Hysbysiadau Rhybudd Cynnar

18 Digwyddiadau

Rhwng y cyfnodau o fis Ionawr i fis Mehefin 2023, cofnodwyd ***5*** Digwyddiad Diogelwch Cleifion a ***1*** Hysbysiad Rhybudd Cynnar.



1 Hysbysiadau Rhybudd Cynnar

5 Digwyddiadau

Pryderon

Digwyddiadau

Gweithio i Wella

Cwynion

Gall pryderon a godir gyda PGIAC gynnwys ymateb uniongyrchol gan y sefydliad neu gynnwys ymateb ar y cyd â'r Bwrdd Iechyd sy'n comisiynu neu efallai y bydd angen i PGIAC ofyn i'r Bwrdd Iechyd ymateb yn uniongyrchol.

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Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Diweddariad gan y Tîm Gofal Cleifion IPFR (Ceisiadau Cyllido Cleifion Unigol)

Mae'r Tîm Gofal Cleifion yn derbyn ac yn rheoli ceisiadau cyllido cleifion unigol am ofal iechyd sydd y tu allan i'r ystod gytunedig o wasanaethau.

Trosolwg o Geisiadau Cyllido Cleifion Unigol a broseswyd yn Chwarter 4 2022-23 a Chwarter 1 2023-24:

	Nifer y Ceisiadau a drafodwyd fel Camau Gweithredu Cadeiryddion	Nifer y Ceisiadau a drafodwyd gan Banel IPFR Cymru Gyfan
Ionawr 2023	7	9
Chwefror 2023	2	12
Mawrth 2023	1	12
Ebrill2023	0	14
Mai 2023	8	12
Mehefin 2023	7	11

Diwrnod Clefydau Prin - 28ain Chwefror 2023

Ar Ddiwrnod Clefydau Prin, dadorchuddiwyd Ap newydd gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Eluned Morgan. Datblygwyd yr ap Gofal ac Ymateb yng Nghymru gan Science & Engineering Applications Ltd, mewn cydweithrediad ag amrywiol grwpiau cleifion a'r GIG, gyda chyllid gan Lywodraeth Cymru i gefnogi'r broses o wneud penderfyniadau clinigol mewn achosion o argyfwng a sefyllfaoedd eraill sy'n hanfodol o ran amser.

Ar hyn o bryd mae Llywodraeth Cymru yn gweithredu Cynllun Gweithredu Clefydau Prin Cymru, ac yn ariannu Clinig SWAN (Syndrome Without a Name) cyntaf y DU, sydd wedi'i leoli yn Ysbyty Athrofaol Cymru, yng Nghaerdydd.

Care and Respond

Cliciwch ar y llun i fynd â chi i wefan Care and Respond.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i Gynllun Gweithredu Clefydau Prin Cymru 2022-2026.

Dyfeisiau Meddygol Uned Peirianneg Adsefydlu Bae Abertawe (MPCE)/ Gwasanaeth Aelodau Artiffisial a Chyfarpar (ALAS)

Yn ddiweddar, cyhoeddwyd erthygl yn Scope, sef cylchgrawn aelodau'r Sefydliad Ffiseg a Pheirianneg mewn Meddygaeth (IPEM) gan Uned Peirianneg Adsefydlu Bae Abertawe.

Mae'r erthygl yn adlewyrchu'r dull yn Abertawe o gyflawni cydymffurfiaeth Rheoliadau Dyfeisiau Meddygol (MDR) drwy weithredu systemau rheoli ansawdd o fewn gwasanaethau unigol (gan gynnwys Gwasanaeth Aelodau Artiffisial a Chyfarpar (ALAS), a chyfeiriad a chydlynu drwy 'Grŵp Sicrwydd MDR' ledled y Bwrdd Iechyd.

Cyfeirir hefyd at waith Grŵp MDR Addysg a Gwella Iechyd Cymru (AaGIC), yn ogystal â sut mae Abertawe wedi cydweithio'n ddiweddar â Bwrdd Iechyd Prifysgol Betsi Cadwaladr (BIPBC) ynghylch 'Parodrwydd ar gyfer MDR' a manteision cydweithredu ar draws Byrddau Iechyd (h.y. rhannu gwybodaeth arbenigol, ffyrdd effeithlon o weithio, dulliau cyd-alinio) i leihau'r risgiau corfforaethol a gweithredol, gan gynnwys gwasanaethau a gomisiynwyd.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i rifyn yr Haf o Scope sy'n cynnwys yr erthygl ardderchog hon (tudalen 32)!

QuicDNA

O'r chwith i'r dde: Charles Janczewski, Dr Magda Meissner, Eluned Morgan MS, Sian Morgan

Mae QuicDNA yn dreial clinigol a fydd yn gwerthuso buddion prawf biopsi hylif arloesol mewn pobl sydd ag amheuaeth o ganser yr ysgyfaint. Bydd y treial yn edrych ar sut y gallai defnyddio'r prawf biopsi hylif yn gynharach yn y broses ddiagnostig wella a chyflymu'r diagnosis, lleihau'r amser rhwng diagnosis a thriniaeth, ac yn y pen draw hysbysu sut y gellir defnyddio'r dechnoleg ar gyfer mathau eraill o ganser.

Ymwelodd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Eluned Morgan AS, â'r Sefydliad Geneteg Feddygol yn Ysbyty Athrofaol Cymru i ddysgu mwy am lansiad treial clinigol QuicDNA.

Cyflwynwyd QuicDNA gan Sian Morgan yn y Digwyddiad Addysg Thorasig a gynhaliwyd gan Rwydwaith Canser Cymru ar 19 Mai. Yn y dyfodol, mae gan QuicDNA y potensial i ddarparu dull syml, hygyrch a dibynadwy o ymchwilio i ganser a amheuir, sgrinio cleifion canser asymptomatig a monitro llai ymledol ar gyfer dychweliad canser.

PGIAC - Cylchlythyr *4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023*

Trawsblaniad Rhoddwyr Byw

Mae Dr Doruk Elker, Arweinydd Clinigol Trawsblannu wedi rhannu llwyddiant gwych Rhaglen Trawsblannu Rhoddwyr Arennau Byw (LKD).

Cwblhawyd 41 trawsblaniad rhoddwyr arennau byw ym mlwyddyn ariannol 2021/22 a dyma'r nifer uchaf o drawsblaniadau rhoddwyr byw y mae'r tîm wedi'u gwneud yng Nghaerdydd mewn degawd! Yn ogystal, cwblhawyd 5 neffrectomi rhoddwr byw, ac roedd pedwar ohonynt yn rhoddwyr anhunanol heb eu cyfeirio. Cafodd dau o blant eu trawsblannu ym Mryste ar ôl i'r rhoddwyr a'r derbynnydd gael eu datblygu yng Nghaerdydd. Anogir y tîm y bydd y gweithgaredd cryf hwn yn parhau gan fod 14 trawsblaniad LKD eisoes wedi'u bwcio tan ganol mis Gorffennaf gyda llawer mwy yn y camau cynllunio.

"Llongyfarchiadau i'r tîm Rhoddwyr Byw a'r tîm trawsblannu ehangach am eu hymroddiad a'u hymrwymiad i wneud i hyn ddigwydd i'r cleifion a'u teuluoedd."

Rydym hefyd yn diolch i'n cydweithwyr Neffroleg am addysgu cleifion clefyd cronig yn yr arennau (CKD) a'u teuluoedd am fanteision rhoi arennau byw a'u cyfeirio mewn modd amserol. Adlewyrchir hyn yn adroddiad diweddaraf Gwaed a Thrawsblaniadau'r GIG (NHSBT) sy'n dangos mai Uned Trawsblannu Caerdydd sydd â'r gyfradd uchaf o drawsblaniadau arennau rhoddwyr byw rhagataliol yn y DU."

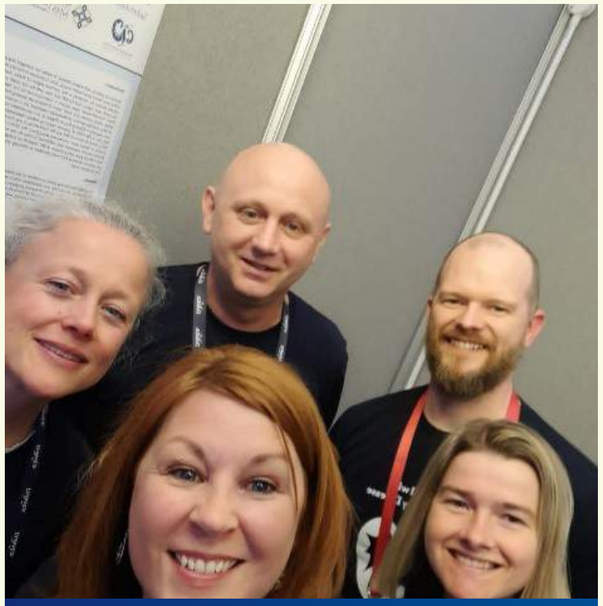
Dr Elker

Cyflawniad anhygoel, rydym yn siŵr y byddwch yn cytuno!

Cynhadledd UK Kidney

Roedd Rhwydwaith Arennau Cymru yn un o'r nifer o stondinau arddangos a gynrychiolir yn nigwyddiad 'UK Kidney Week' (UKKW) Cymdeithas Arennau'r DU sy'n ddigwyddiad blynyddol a'r digwyddiad Cynhadledd fwyaf yn y DU ar gyfer Gweithwyr Proffesiynol Arennau. Cynhaliwyd digwyddiad 2023 yn ICC Casnewydd ar 5 - 7 Mehefin.

Dyma'r tro cyntaf i'r digwyddiad cenedlaethol hwn gael ei gynnal yng Nghymru a gallodd nifer o arweinwyr clinigol y Rhwydwaith Arennau Cymru (WKN) hyrwyddo'r gwaith rhagorol sy'n digwydd ar draws ein cenedl, o Drawsblannu i Therapïau Cartref, Seilwaith Digidol i archwiliadau Gweithlu. Arweiniodd hyn, ochr yn ochr â Phrif araith Gweinidog Iechyd a Gofal Cymdeithasol Cymru, lle canmolwyd WKN yn fawr, at nifer o gynrychiolwyr yn ymweld â stondin arddangosfa'r Rhwydwaith yn ystod y digwyddiad.



O'r chwith i'r dde: Sarah McMillan, AnnMarie Pritchard, Richard Davies, Jonathan Matthews, Jennifer Holmes

Mae ein rhwydwaith arennau wedi'i adeiladu ar ansawdd, arfer gorau, technoleg ac arloesedd, gan osod cleifion wrth wraidd popeth a wneir gennym.

Rhwydwaith Arennau Cymru
Wales Kidney Network

Diwrnod Rhyngwladol y Nyrsys a Diwrnod Rhyngwladol y Fydwraig

Roedd timau Gofal ac Ansawdd Cleifion PGIAC yn arddangos trugareddau o'r gorffennol i ddathlu Diwrnod Rhyngwladol y Nyrsys a Diwrnod Rhyngwladol y Fydwraig. Diolch yn fawr iawn i Theresa Williams o'r Tîm Gofal Cleifion am bobi cacennau bach a chacennau cri!

Canolfan Walton

Mae Canolfan Walton wedi lansio proses chwe cham, sef 'The Six WALTON Steps' sy'n tynnu sylw at eu gweledigaeth o Daith Cleifion a Theuluoedd rhagorol. Trwy adborth, maent wedi datblygu gweledigaeth ar y cyd ar gyfer y profiad delfrydol i gleifion a'u teuluoedd yng Nghanolfan Walton ac wedi cynnwys mentrau fel therapi anifeiliaid anwes ar draws yr Ymddiriedolaeth, sesiynau cerddoriaeth ac wyau Pasg a ddarperir gan yr uwch dîm nyrsio ar Sul y Pasg.

Dyletswydd Ansawdd

Mae'r Ddyletswydd Ansawdd yn rhan o Ddeddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 ac mae PGIAC yn dangos sut maent yn bodloni'r Ddeddf:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i Ganllawiau Statudol y Ddyletswydd Ansawdd 2023 a Safonau Ansawdd 2023.

Domains of Quality (**STEEEP**)
Framework to assess quality and guide improvement.

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person- centred

Evidencing the Duty of Quality

- Make use of existing performance, outcome and delivery indicators and measures where possible
- Patient and staff experience, information and stories
- Reports from inspectorate and licensing bodies
- Consideration of national clinical audits, reports, inquiries

Reporting to support Annual Quality Report

- Bimonthly QPS Chairs Report to Joint Committee
- Summary of Services in Escalation Trajectory
- Quarterly bilingual Quality newsletter
- Six monthly Innovation & Improvement Report
- QPS & WHSSC Annual Report
- Integrated Commissioning Plan (ICP)
- Incorporate STEEEP into all reporting templates
- Quarterly report to QPS to monitor progress

Rhaglen Trawsblannu Gwaed a Mêr Esgyrn De Cymru (SWBMT)

Roedd Dydd Gŵyl Dewi 2023 yn nodi 40 mlynedd ers y trawsblaniad bôn-gelloedd cyntaf a berfformiwyd yng Nghymru ar 1af Mawrth 1983.

Cynhaliwyd digwyddiad dathlu ar 24 Mehefin i anrhydeddu Dr Jack Whittaker a ddechreuodd y rhaglen drawsblannu, yn ogystal â sefydlwyr allweddol eraill.

Dathlu 40 mlynedd: 1983-2023
Celebrating 40 years: 1983-2023
TGMDC SWBMT 40

Ymgyrch Strôc FAST

Cynhaliwyd ymgyrch ymwybyddiaeth ddiwedd mis Ebrill ac roedd yn cynnwys y teledu, fideo ar alw, hysbysebu ar y radio a chyfryngau cymdeithasol, yn ogystal â darllediadau yn y cyfryngau yng Nghymru. Nod yr ymgyrch oedd codi ymwybyddiaeth o arwyddion strôc a chynyddu gwybodaeth am strôc fel argyfwng meddygol.

Strôc yw'r pedwerydd prif achos marwolaeth yn y DU a'r achos unigol mwyaf o anabledd cymhleth. Dangoswyd bod mwy o ymwybyddiaeth o'r acronym FAST yn arwain at gleifion yn gofyn am gymorth prydlon ar gyfer symptomau strôc. Mae triniaeth gynnar nid yn unig yn achub bywydau ond yn arwain at fwy o siawns o wellhad.

Digwyddiad Addysg Thorasig

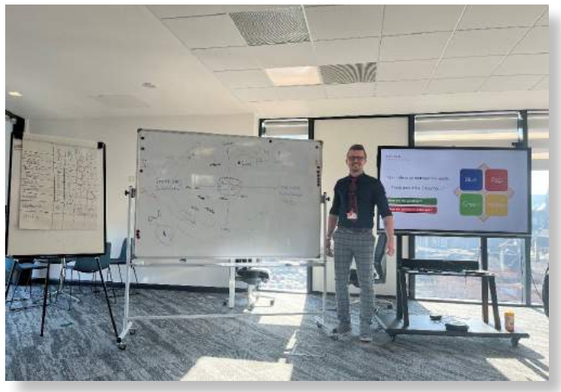
Cynhaliodd Rhwydwaith Canser Cymru Ddigwyddiad Addysg Blynyddol Grŵp Oncoleg Thorasig Cymru ddydd Gwener 19 Mai a mynychodd ystod eang o aelodau'r tîm amlddisgyblaethol (MDT). Ymhlith y pynciau a gyflwynwyd oedd Sgrinio Canser yr Ysgyfaint, Echdoriad Is-labedol, Roboteg a Genomeg.

Diolch yn fawr iawn i Rhiannon Parker, Rheolwr Digwyddiadau Rhwydwaith Canser Cymru am ddarparu'r lluniau!

GIG CYMRU NHS WALES | Rhwydwaith Canser Cymru | Wales Cancer Network

Diwrnod Datblygu Tîm Gofal ac Ansawdd Cleifion

Mynychodd Timau Gofal Cleifion ac Ansawdd PGIAC Ddiwrnod Datblygu Tîm ym mis Chwefror mewn cydweithrediad â Thrafnidiaeth Cymru (TrC). Roedd Mark Hector, Rheolwr Hyfforddi a Datblygu TrC yn Hwylusydd ardderchog yn yr Offeryn Jigsaw Discovery ac mae'r Tîm yn edrych ymlaen at gyfleoedd i gydweithio yn y dyfodol!

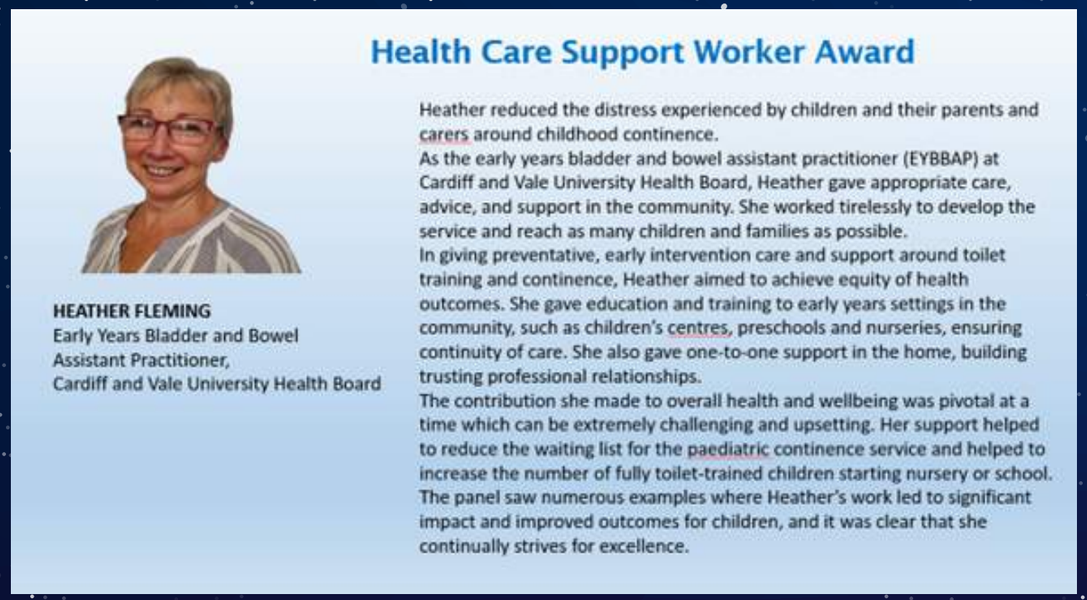


Gwobrau RCN 2023

O'r Dde i'r Chwith: Krysta Hallewell, Emma King, Debra Davies, Kate Eden, Leanne Amos, Jason Mohammad, Vicki Dawson-John, Kirsty John

Cynhaliwyd gwobrau'r Coleg Nyrsio Brenhinol blynyddol ar 29 Mehefin yn Neuadd y Ddinas, Caerdydd. Mae PGIAC yn noddi'r wobr Gweithiwr Cymorth Gofal Iechyd (HCSW) ac mae nifer o staff PGIAC yn mynychu'r seremoni wobrwyo ynghyd â Kate Eden (Cadeirydd). Mae'r wobr yn agored i unrhyw Weithiwr Cymorth Gofal Iechyd sy'n cael gwaith wedi'i ddirprwyo'n uniongyrchol gan Nyrs Gofrestredig, Bydwraig neu Ymwelydd Iechyd mewn unrhyw leoliad, sydd wedi dangos ymrwymiad i ddarparu safonau uchel o ofal nyrsio a bydwreigiaeth.

Llongyfarchiadau mawr i'r enillydd, Heather Fleming, a hefyd i'r ail, Kelly Brown!



Newyddion Cyflym o'r Timau Comisiynu

Iechyd Meddwl a Grwpiau Agored i Niwed

Strategaeth iechyd meddwl 5 mlynedd parhaus. Adolygiad o'r gwasanaethau presennol a datblygiad pellach o'r rhain ar y gweill.

Menywod a Phlant

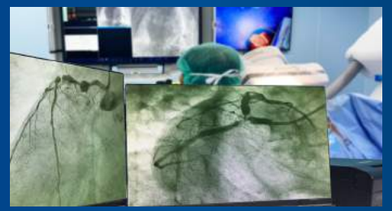
Diwrnod Gwella ac Arloesi'r Gwasanaeth IVF yn cael ei gynllunio ar hyn o bryd.

Niwrowyddorau a chyflyrau hirdymor

Strategaeth Cymru gyfan i wella canlyniadau a phrofiad cleifion sy'n cael adsefydlu arbenigol ar y gweill.

Canser a'r Gwaed

Diwrnodau Gwella ac Arloesi'r Gwasanaeth Thorasig, Anhwylder Gwaedu Etifeddol ac Imiwnoleg yn cael eu cynllunio ar hyn o bryd.



Cardiaidd

Gwerthusiad a chamau gweithredu yn cael eu datblygu o ddatblygiadau gwasanaeth fel dangosfyrddau ar gyfer adrodd ar ymarfer clinigol.

Methiant y Coluddyn

Gwaith parhaus yn cael ei wneud gyda'r tîm comisiynu Methiant y Coluddyn a ffurfiwyd yn ddiweddar ac o ganlyniad i'r adolygiad Methiant y Coluddyn a'r Diwrnod Gwella Gwasanaeth ac Arloesi.

Gwasanaethau Arbenigol

Strategaeth ar y gweill.

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Cydnabod Digwyddiadau Sylweddol a Diolchiadau

Cyhoeddwyd stori newyddion rhagorol – Mae Gwasanaeth Glasoed Gogledd Cymru (NWAS) wedi derbyn Nod Barcud!

Gellir cyflawni'r Nod Barcud Safonau Cyfranogiad Cenedlaethol, a ddyfernir gan bobl ifanc, ar gyfer sefydliadau sy'n profi eu bod yn cyflawni yn erbyn y Safonau Cenedlaethol.

Sganiwch y cod QR/cliciwch arno i fynd â chi i'r stori newyddion!

Cafodd Dr Thomas Hoare gydnabyddiaeth gan yr Arglwydd Raglaw o Orllewin Morgannwg a Penny Nurse, Rheolwr Prosiect Straen Trawmatig Cymru.

"Llongyfarchiadau i Tom - mae hyn yn haeddiannol iawn a dylech fod yn falch IAWN."

Mae'r holl dîm yma yn PGIAC yn cytuno!


IN RECOGNITION

of the valuable contribution made by

DR THOMAS HOARE
TRAUMATIC STRESS WALES

to supporting and caring for
Ukrainian Refugees in the Welcome Centre, Neath Port Talbot
and for making a positive difference to their lives

Dated this 23rd day of February, 2023

LOUISE HUETT, CStJ, JP
HIS MAJESTY'S LORD-LIEUTENANT of WEST GLAMORGAN

Dolenni defnyddiol

Cylchlythyr Clefyd Cynhenid y Galon Oedolion (ACHD)

Mae fersiynau Gaeaf a Gwanwyn o'r Cylchlythyr ACHD ar gael yma:

Cliciwch ar y PDF i agor y ddogfen.

Cylchlythyr Cynllun Gweithlu Nyrsio AaGIC

Mae AaGIC yn cynhyrchu Cylchlythyr chwarterol Cynllun Gweithlu ac mae rhifyn y Gwanwyn bellach ar gael.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Cylchgrawn Mesothelioma UK

Mae Mesothelioma UK yn grŵp cymorth sy'n cyhoeddi cylchgrawn chwarterol ac mae modd cael mynediad i'r rhifyn a'r archif diweddaraf yma:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Cylchlythyr Rhwydwaith Iechyd Meddwl Amenedigol

Mae cylchlythyr Rhwydwaith Iechyd Meddwl Amenedigol Ebrill ar gael yma:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Partneriaeth Cydwasanaethau
Shared Services Partnership

Comisiynu Gwasanaethau
Iechyd Arbenigol Cymru

CYLCHLYTHYR

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Whssc.nhs.wales

Gwanwyn/Haf 2023

Ar gyfer ymholiadau neu fanylion am unrhyw agwedd o fewn y Cylchlythyr hwn, cysylltwch ag **Adele Roberts,** Pennaeth Diogelwch Cleifion ac Ansawdd neu **Leanne Amos**, Swyddog Cymorth Gweinyddu Ansawdd.

E-bost: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

Partneriaeth Cydwasanaethau
Shared Services Partnership

Cynlluniwyd gan Gyfathrebu Partneriaeth Cydwasanaethau GIG Cymru

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: 14/06/2023

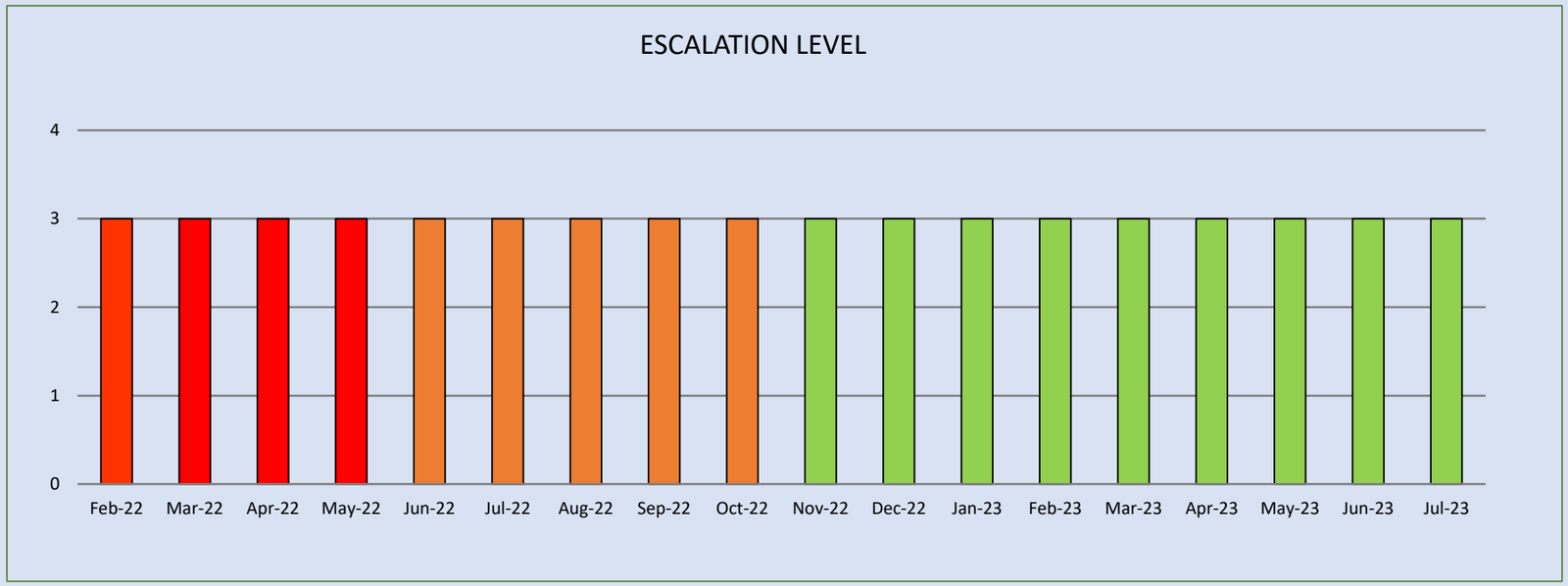
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



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 may be delayed to the initial intended timeline as the case goes through the scrutiny process.

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 went to their Investment in Infrastructure Board on 22nd June; 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 5th June, 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:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22 2023 the outcome is not confirmed as yet.**
- **There may be delay to the initial intended timeline as the case goes through the scrutiny process. Once the outcome of the WG process is known, the timeline can be confirmed.**

Executive Director Lead: David Roberts
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: 14/06/2023

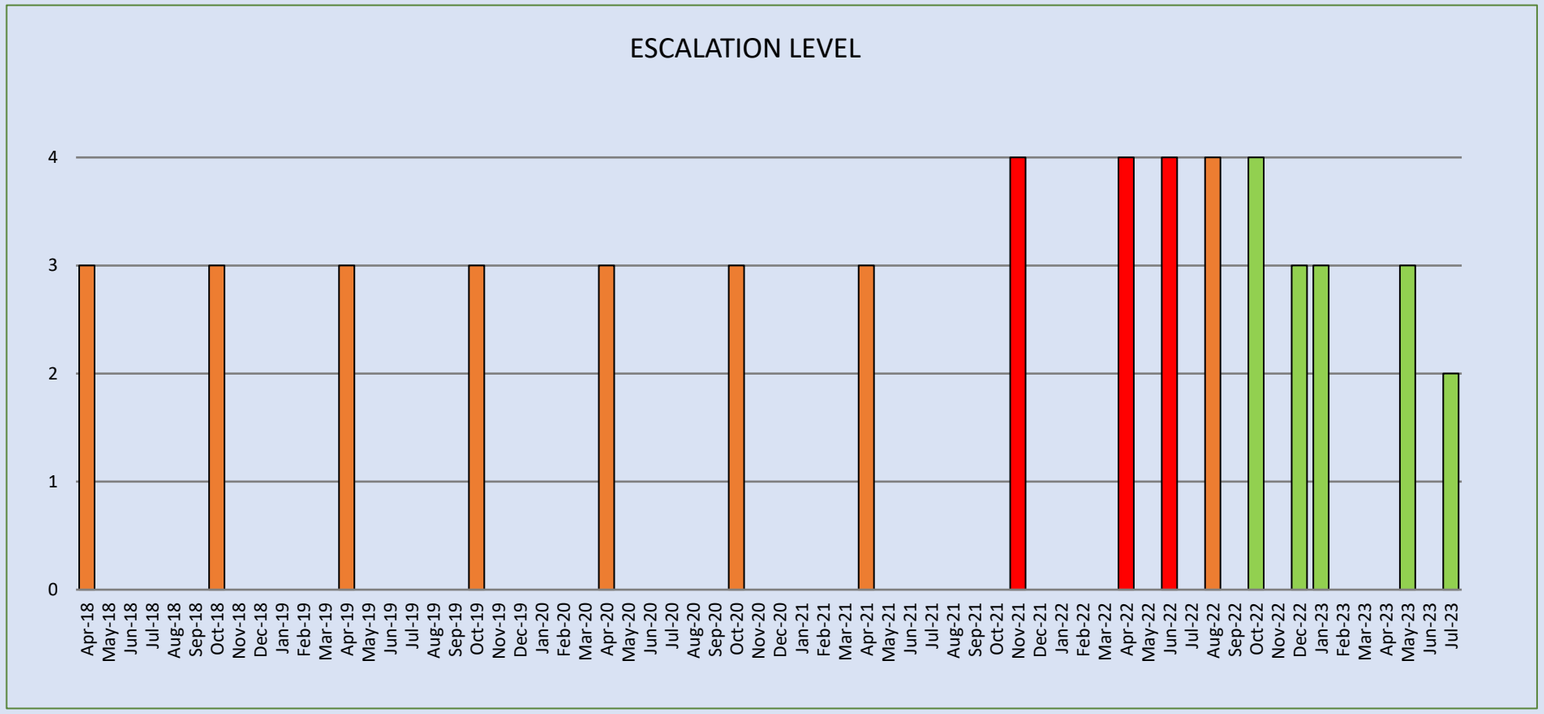
Service in Escalation: Ty Llidiard

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



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
July 2023 - WHSSC escalation	De-escalated to level 2

Rationale for Escalation Status :
De-escalated to level 2.

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.
July 2023 – The Service has been de-escalated to Level 2 in June 2023

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	Actions outstanding to be completed by Sept 23
Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Completed June 23

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 12th.
July 23 – Report received from NCCU and resulted in de-escalation Level 2 in June 2023. 6 Actions outstanding to be completed by September 2023. Further escalation meeting scheduled for 7th August 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023 & 26/07/23
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

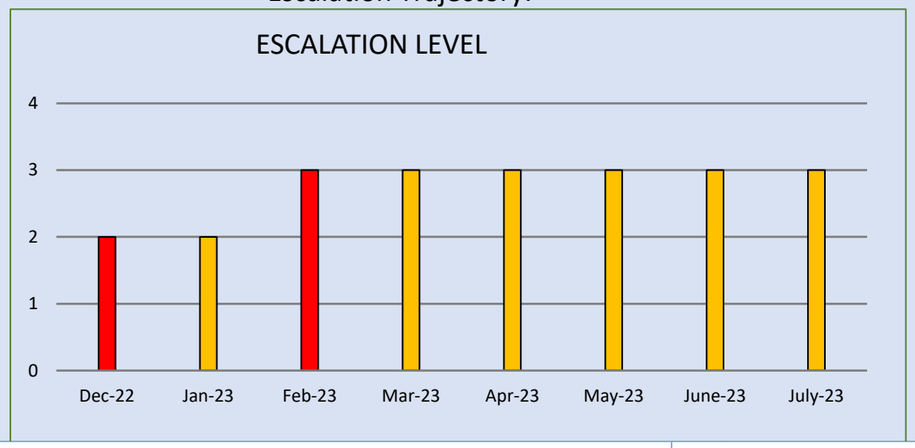
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



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.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan does not deliver contracted volume,
• 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. Service is on-track to meet contracted volumes by December 2023. Reprofiling the waiting times projections is being undertaken by the HB for sharing in August.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
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	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
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.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:

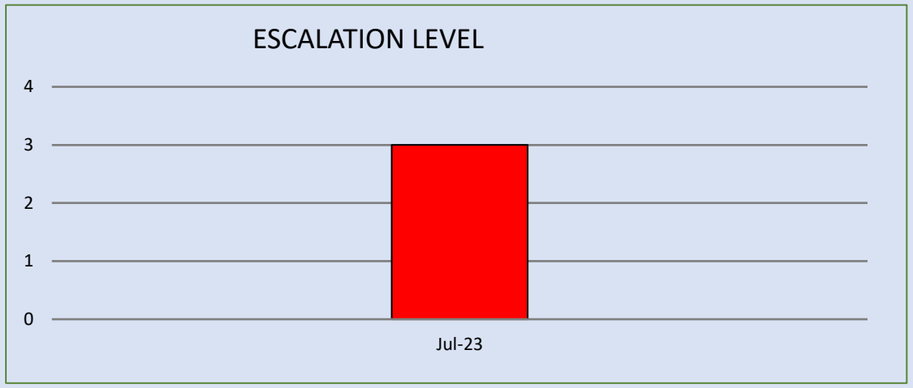
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.

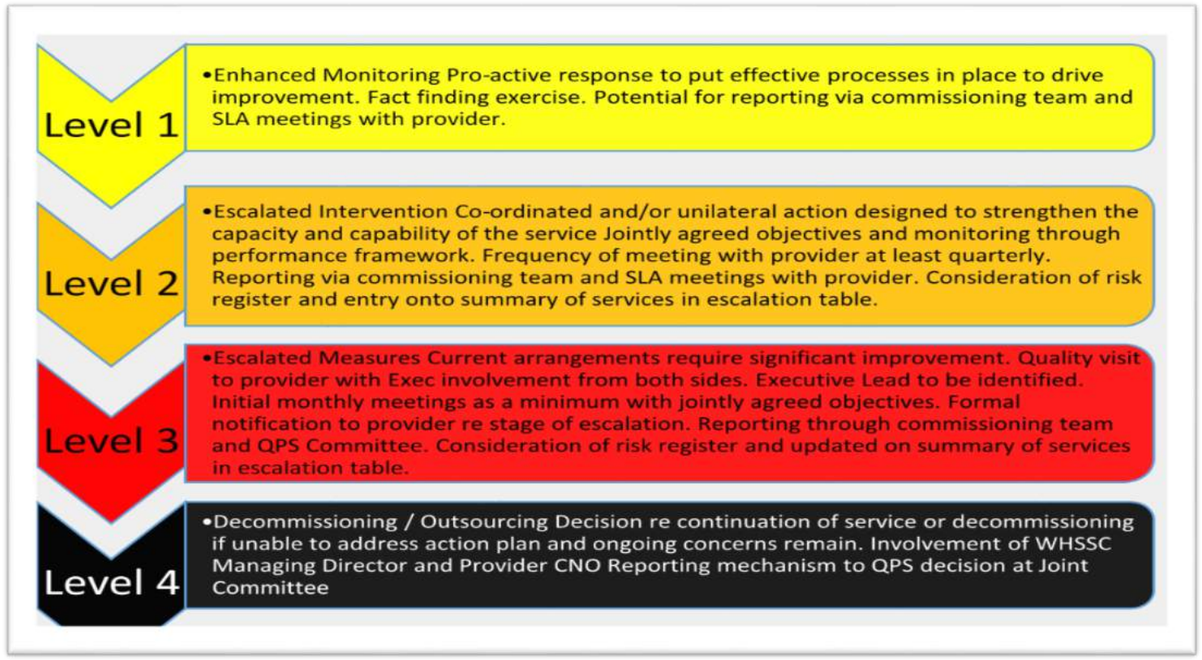
Actions:

Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to exec	Assistant Specialised Planner	7th August 2023	
Monthly escalation meeting	Assistant Specialised Planner	Monthly	
Quality visit	Assistant Specialised Planner	September 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

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

Welsh Health Specialised Services Commissioning

NEWSLETTER

4th Edition, Spring/ Summer 2023

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

This is the 4th edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This Newsltter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from WHSSC are provided both in Wales and in England; this will only provide a snapshot of our work. Permission has been provided for the content included.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

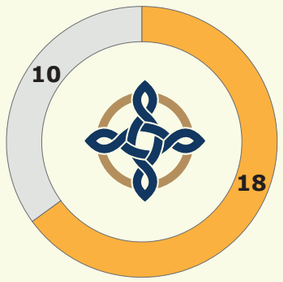
Contents

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Reporting

WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and ensure that trends or themes arising from concerns have actions plans which are completed and support learning. WHSSC facilitates the continued monitoring of commissioned services and work with providers when issues arise.

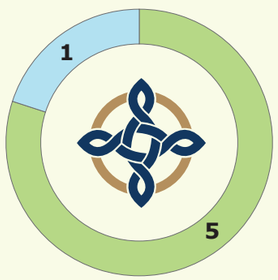
Between the periods of January to June 2023, there were ***18*** Patient Safety Incidents and ***10*** Early Warning Notifications logged.



10 Early Warning Notifications

18 Incidents

Between the periods of January to June 2023, there were ***5*** Patient Safety Incidents and ***1*** Early Warning Notifications logged.



1 Early Warning Notifications

5 Incidents

Concerns

Incidents

Putting Things Right

Complaints

Concerns raised with WHSSC may involve a direct response from the organisation or involve a joint response with the commissioning Health Board or WHSSC may need to ask the Health Board to respond directly.

GIG CYMRU NHS WALES

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarter 4 2022-23 and Quarter 1 2023-24:

	Number of Requests discussed as Chairs Actions	Number of Requests discussed by All Wales IPRF Panel
January 2023	7	9
February 2023	2	12
March 2023	1	12
April 2023	0	14
May 2023	8	12
June 2023	7	11

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Rare Disease Day - 28th February 2023

On Rare Disease Day, a new App was unveiled by Health and Social Services Minister Eluned Morgan. The Care and Respond app has been developed in Wales by Science & Engineering Applications Ltd, in collaboration with various patient groups and the NHS, with Welsh Government funding to support clinical decision making in cases of emergency and other time critical situations.

The Welsh Government is currently implementing the Wales Rare Diseases Action Plan, and funding the UK's first SWAN (Syndrome Without a Name) Clinic, based at the University Hospital of Wales, in Cardiff.

Care and Respond

Click the picture to be taken to the Care and Respond website.

Scan the QR code/ click on it to be taken to the Wales Rare Diseases Action Plan 2022-2026.

Medical Devices Swansea Bay's Rehabilitation Engineering Unit (MPCE)/Artificial Limb and Appliance Service (ALAS)

Swansea Bay's Rehabilitation Engineering Unit (MPCE) recently had an article published in Scope, the member magazine of the Institute of Physics and Engineering in Medicine (IPEM).

The article reflects the approach in Swansea to achieving Medical Devices Regulations compliance through implementation of quality management systems within individual services (including Swansea's Artificial Limb and Appliance Service), and direction and coordination through the Health Board wide 'MDR Assurance Group'.

The work of the Health Education and Improvement Wales (HEIW) MDR Group is also referenced, plus how Swansea has recently collaborated with BCUHB regarding 'MDR Preparedness' and the benefits of cross-Health Board collaboration (i.e. sharing of specialist knowledge, efficient ways of working, aligned approaches) to reduce the corporate and operational risks, including of commissioned services.

Scan the QR code/ click on it to be taken to the Summer edition of Scope which features this excellent article (page 32)!

QuicDNA

From left to right: Charles Janczewski, Dr Magda Meissner, Eluned Morgan MS, Sian Morgan

QuicDNA is a clinical trial that will evaluate the benefits of an innovative liquid biopsy test in people with suspected lung cancer. The trial will look at how the use of the liquid biopsy test earlier in the diagnostic process could improve and speed up diagnosis, reduce the time between diagnosis and treatment, and eventually inform how the technology can be used for other types of cancer.

The Minister for Health and Social Services Eluned Morgan MS visited the Institute of Medical Genetics at University Hospital of Wales to learn more about the launch of the QuicDNA clinical trial.

QuicDNA was presented by Sian Morgan at the Thoracic Education Event hosted by Wales Cancer Network on 19th May. In the future, QuicDNA has the potential to provide a simple, accessible and reliable means of investigating suspected cancer, screen asymptomatic cancer patients and less invasive monitoring for cancer recurrence.

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Living Donor Transplant

Dr Doruk Elker, Clinical Lead for Transplantation has shared the fantastic success of the Living Kidney Donor (LKD) Transplant Program.

41 living kidney donor transplants were completed in the 2021/22 financial year and is the highest number of living donor transplants the team have done in Cardiff in a decade! In addition, 5 living donor nephrectomies were completed, of which four were non-directed altruistic donors. Two children were transplanted in Bristol after the donor and recipient work-ups were completed in Cardiff. The team are encouraged that this strong activity will continue as there are 14 LKD transplants already booked until mid-July with many more in the planning stages.

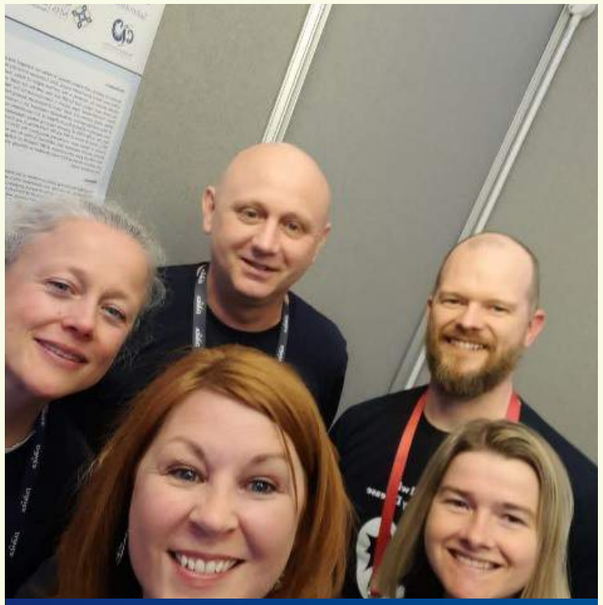
> “Congratulations to the Live Donor team and the wider transplant team for their dedication and commitment to make this happen for the patients and their families.”
>
> We also thank our Nephrology colleagues for educating CKD patients and their families about the benefits of living kidney donation and referring them in a timely fashion. This is reflected in the latest NHSBT report which demonstrates that Cardiff Transplant Unit has the highest rate of pre-emptive living donor kidney transplants in the UK.”
>
> **Dr Elker**

An amazing achievement, we are sure you will agree!

UK Kidney Conference

The Welsh Kidney Network were one of the many exhibition stands represented at the UK Kidney Association's 'UK Kidney Week' (UKKW) event which is an annual occurrence and the largest UK Conference event for Kidney Professionals. 2023's event was hosted at the ICC Newport on the 5th-7th June.

This was the first time that this national event had been hosted in Wales and a number of the WKN's clinical leads were able to promote the excellent work going on across our nation, from Transplantation to Home Therapies, Digital infrastructure to Workforce audits. This, alongside the Welsh Minister for Health and Social Care services' Key Note speech in which the WKN were highly commended, led to a number of delegates visiting the Network's exhibition stand during the event.



From left to right: Sarah McMillan, AnnMarie Pritchard, Richard Davies, Jonathan Matthews, Jennifer Holmes

Our Kidney Network is built on quality, best practice, technology and innovation, placing patients at the heart of everything we do.

Rhwydwaith Arennau Cymru
Welsh Kidney Network

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

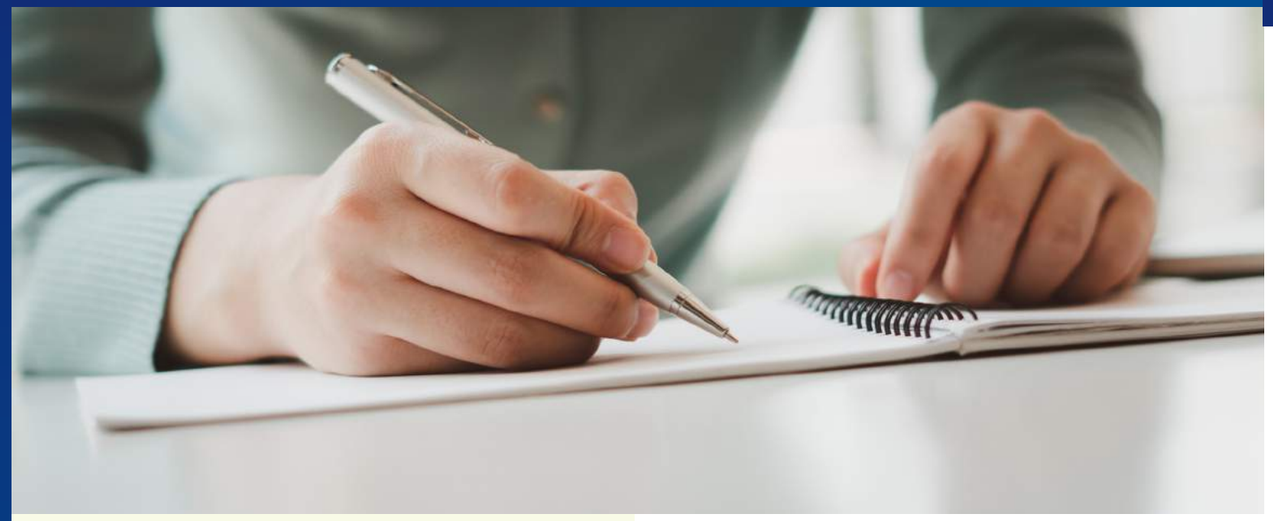
International Nurses Day and International Day of the Midwife

WHSSC Patient Care and Quality Teams displayed memorabilia to celebrate International Nurses Day and International Day of the Midwife collectively. A massive thank you to Theresa Williams of the Patient Care Team for baking cupcakes and Welsh cakes!

The Walton Centre

The Walton Centre have launched a six stage process The 'Six WALTON Steps' highlighting their vision of an excellent Patient and Family Journey. Through feedback, they have developed a shared vision for the ideal patient and family experience at The Walton Centre and included initiatives such as pet therapy across the trust, music sessions and Easter eggs delivered by the senior nursing team on Easter Sunday.

Duty of Quality



The Duty of Quality forms part of The Health and Social Care (Quality and Engagement) (Wales) Act 2020 and WHSSC demonstrate how they are meeting the Act:

Domains of Quality (**STEEEP**)
Framework to assess quality and guide improvement.

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person- centred

Evidencing the Duty of Quality

- Make use of existing performance, outcome and delivery indicators and measures where possible
- Patient and staff experience, information and stories
- Reports from inspectorate and licensing bodies
- Consideration of national clinical audits, reports, inquiries

Reporting to support Annual Quality Report

- Bimonthly QPS Chairs Report to Joint Committee
- Summary of Services in Escalation Trajectory
- Quarterly bilingual Quality newsletter
- Six monthly Innovation & Improvement Report
- QPS & WHSSC Annual Report
- Integrated Commissioning Plan (ICP)
- Incorporate STEEEP into all reporting templates
- Quarterly report to QPS to monitor progress

Scan the QR code/ click on it to be taken to The Duty of Quality Statutory Guidance 2023 and Quality Standards 2023.

South Wales Blood and Marrow Transplant (SWBMT) Programme

St David's Day 2023 marked the 40th anniversary of the first stem cell transplant performed in Wales on 1st March 1983.

A celebratory event was held on 24th June to honour Dr Jack Whittaker who started the transplant programme, as well as other key founding members.

Dathlu 40 mlynedd: 1983-2023
Celebrating 40 years: 1983-2023
TGMDC SWBMT 40

FAST Stroke Campaign

Awareness campaign ran at the end of April and included TV, video on demand, radio and social media advertising, as well as coverage in the Welsh media. The campaign aimed to raise awareness of the signs of stroke and increase knowledge of stroke as a medical emergency.

Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability. Increased awareness of the FAST acronym has been shown to lead to patients seeking prompt help for stroke symptoms. Early treatment not only saves lives but results in a greater chance of a better recovery.

Thoracic Education Event

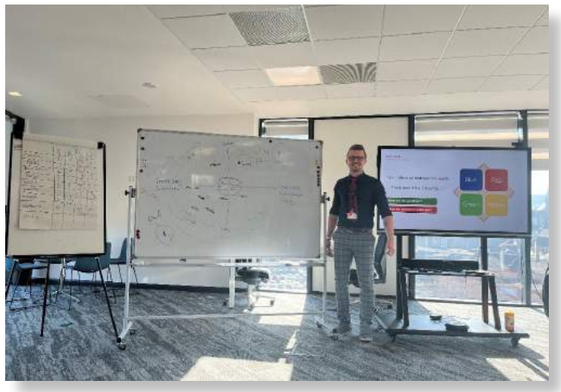
The Wales Cancer Network held the Annual Welsh Thoracic Oncology Group Education Event on Friday 19th May and was attended by a wide range of MDT members. Among the topics presented were Lung Cancer Screening, Sublobar Resections, Robotics and Genomics.

A big thank you to Rhiannon Parker, Events Manager for The Wales Cancer Network for providing the pictures!

GIG CYMRU NHS WALES | Rhwydwaith Canser Cymru | Wales Cancer Network

Patient Care and Quality Team Development Day

WHSSC Patient Care and Quality Teams attended a Team Development Day in February in collaboration with Transport for Wales (TfW). Mark Hector, Training and Development Manager at TfW was an excellent Facilitator in the Jigsaw Discovery Tool and the Team look forward to future collaboration opportunities!

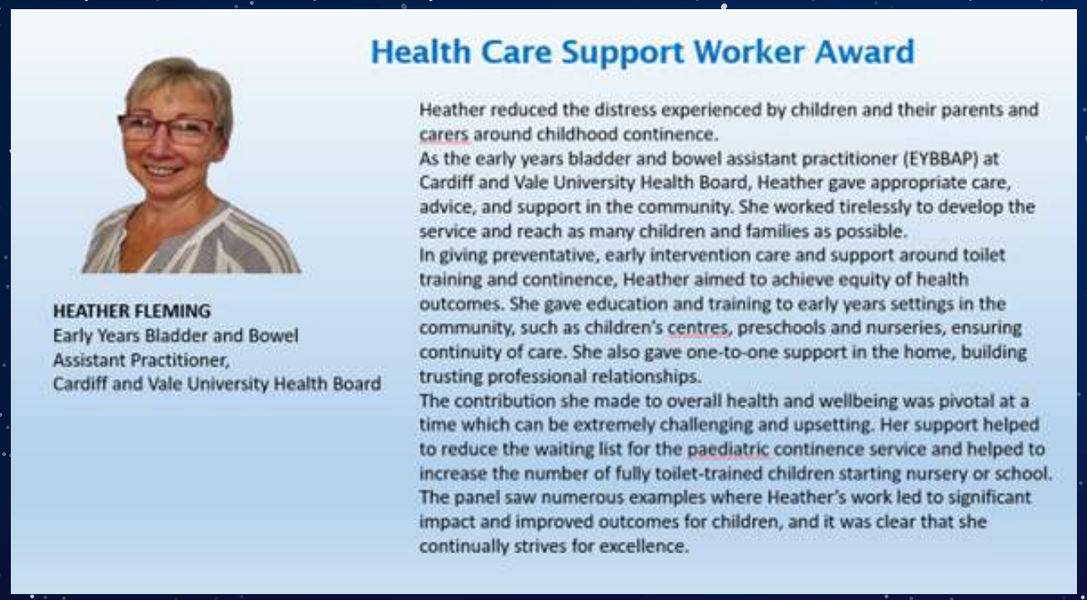


RCN Awards 2023

From left to right: Krysta Hallewell, Emma King, Debra Davies, Kate Eden, Leanne Amos, Jason Mohammad, Vicki Dawson-John, Kirsty John

The annual Royal College of Nursing awards took place on 29th June at City Hall, Cardiff. WHSSC sponsors the Health Care Support Worker (HCSW) award and a number of WHSSC staff attend the award ceremony along with Kate Eden (Chair). The award is open to any Health Care Support Worker who is delegated work directly by a Registered Nurse, Midwife or Health Visitor in any setting, who has demonstrated commitment to providing high standards of nursing and midwifery care.

A huge congratulations to the winner, Heather Fleming, and also to the runner-up, Kelly Brown!



Health Care Support Worker Award

HEATHER FLEMING
Early Years Bladder and Bowel Assistant Practitioner,
Cardiff and Vale University Health Board

Heather reduced the distress experienced by children and their parents and carers around childhood continence.
As the early years bladder and bowel assistant practitioner (EYBBAP) at Cardiff and Vale University Health Board, Heather gave appropriate care, advice, and support in the community. She worked tirelessly to develop the service and reach as many children and families as possible.
In giving preventative, early intervention care and support around toilet training and continence, Heather aimed to achieve equity of health outcomes. She gave education and training to early years settings in the community, such as children's centres, preschools and nurseries, ensuring continuity of care. She also gave one-to-one support in the home, building trusting professional relationships.
The contribution she made to overall health and wellbeing was pivotal at a time which can be extremely challenging and upsetting. Her support helped to reduce the waiting list for the paediatric continence service and helped to increase the number of fully toilet-trained children starting nursery or school.
The panel saw numerous examples where Heather's work led to significant impact and improved outcomes for children, and it was clear that she continually strives for excellence.

Quick Round up of Commissioning Teams

Mental Health and Vulnerable Groups

5 year Mental health strategy ongoing. Review of current services and further development of these underway.

Women and Children's

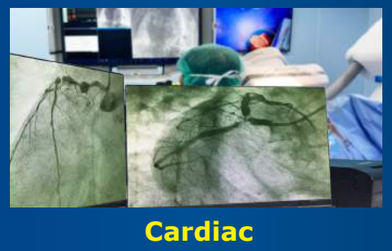
IVF Service Improvement and Innovation Day currently being planned.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic, Inherited Bleeding Disorder and Immunology Service Improvement and Innovation Days are currently being planned.



Cardiac

Evaluation and actions being taken forward from service developments such as dashboards for clinical practice reporting.

Intestinal Failure

Ongoing work being undertaken with the recently formed IF commissioning team and as a result of the IF review and Service Improvement and Innovation Day.

Specialised Services

Strategy is underway.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Recognition of Significant Events and Thank you's

"

An excellent news story was published - The North Wales Adolescent Service (NWAS) has been awarded a Kitemark!

The National Participation Standards Kitemark, which is awarded by youngsters, is achievable for organisations who prove they are achieving against the National Standards.

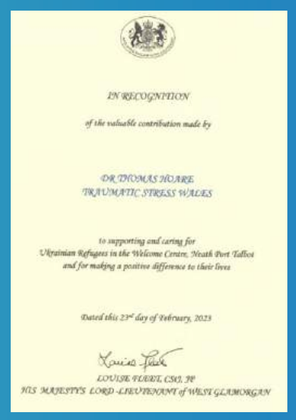
Scan the QR code/click on it to be taken to the news story!

"

Dr Thomas Hoare received recognition from the Lord Lieutenant of West Glamorgan and Penny Nurse, Project Manager for Traumatic Stress Wales said

"Congratulations Tom – this is well deserved and you should be VERY proud."

The entire team here at WHSSC agree!


IN RECOGNITION
of the valuable contribution made by
DR THOMAS HOARE
TRAUMATIC STRESS WALES
to supporting and caring for
Ukrainian Refugees in the Welcome Centre, Heath Port Talbot
and for making a positive difference to their lives
Dated this 23rd day of February, 2023
LOUISE FURTT, CSO, JP
HIS MAJESTY'S LORD-LIEUTENANT of WEST GLAMORGAN

Useful Links

Adult Congenital Heart Disease (ACHD) Newsletter

The Winter and Spring versions of the ACHD Newsletter are available here:

PDF

Click the PDF to open the document.

PDF

HEIW Nursing Workforce Plan Newsletter

HEIW produce a quarterly Workforce Plan Newsletter and the Spring edition is now available.

Scan the QR code/ click on it to be taken to the newsletter.

Mesothelioma UK Magazine

Mesothelioma UK are a support group who publish a quarterly magazine and the latest edition and archive can be accessed here:

Scan the QR code/ click on it to be taken to the newsletter.

Perinatal Mental Health Network Newsletter

The April Perinatal Mental Health Network Newsletter is available here:

Scan the QR code/ click on it to be taken to the newsletter.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Welsh Health Services
Specialised Commissioning

NEWSLETTER

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Whssc.nhs.wales

Spring/Summer 2023

For queries or detail on any aspect within this Newsletter, contact **Adele Roberts,** Head of Patient Safety and Quality, or **Leanne Amos**, Quality Administration Support Officer.

Email: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	National Organ Donation Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The latest NHSBT Annual Report regarding Actual and Potential Deceased Organ Donation for Aneurin Bevan University Health Board has been produced and covers the period 1 April 2022 - 31 March 2023.

The covering letter, full report and summary report is attached as Appendix 1.

Cefndir / Background

- Health Board organ donation performance reports are produced biannually by NHSBT and include a summary report, a detailed report and a covering letter highlighting key figures and issues.
- This latest report has been reviewed at our most recent Organ Donation Committee (ODC) meeting held on the 13th July 2023.
- These reports are generated using data from the National Potential Donor Audit (PDA) and the UK Transplant Registry.
- The PDA reviews all deaths in critical care and emergency department of patient's aged 80 and under to investigate the potential for missed opportunities for donation.

- Data from the PDA also provides information on the quality of care in our health board at key stages of organ donation.
- This is then reviewed by the ODC to investigate where there might be opportunities for care improvement.
- The ODC has input from a number of stakeholders. Key individuals include the Organ Donation Committee Chair (Shelley Bosson – Independent Member ABUHB), the Clinical Lead for Organ Donation/CLOD (Dr Matthew Carwardine – Critical Care Consultant ABUHB) and the Specialist Nurse for Organ Donation/SNOD (Sharon Keightley - NHSBT).

Asesiad / Assessment

- There were 4 solid organ donors over the year which resulted in 11 patients receiving a transplant.
- 1 further donor was consented but did not proceed to donation. This was due to a prolonged time to asystole once withdrawal of life sustaining treatment took place.
- There were no missed referrals this year and in fact there have been no missed referrals since 2019. This is a key indicator to aim to maintain as low as possible as it has the greatest impact in terms of avoiding missed opportunities for organ donation.
- A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families as this has been shown to increase consent rates. This occurred in 6 organ donation discussions but there was 1 occasion where a SNOD was not present. This case has been reviewed by the ABUHB Organ Donation team and felt there were no specific actions to be learnt from this and of note consent for organ donation was obtained in this particular case.
- Currently ABUHB is exceptional (gold) for referral rates when compared with UK performance and average (bronze) for SNOD presence and consent rates.
- Another goal is that neurological death tests are performed wherever possible in appropriate patients. This was not done for 1 out of 5 potential patients as it was not felt to be appropriate at the time. This has also been reviewed by the health board organ donation team who agree that this was entirely reasonable given the circumstances and do not feel any specific action need be taken. I have also discussed this with the regional NHSBT team who agree there was a clear explanation in these cases. We have discussed this issue at the ODC meeting and agreed that we need to monitor instances such as these and we have also provided feedback to NHSBT in that we feel their inclusion in the audit is not beneficial.
- Since our health board became an alliance site for tissue donation we have seen a significant increase in tissue donation referrals and this now appears to be a well-established process within Critical Care and the nursing team should be commended for this. Conversion rates unfortunately remain low (although this is true nationally) however over the year 30 corneas were donated by ABUHB patients to the NHSBT Eye Banks.

The Organ Donation Committee will be:

- Finalising policy document for withdrawal of life sustaining treatment in theatres for donation after circulatory death with theatre management.
- Updating the Organ Donation Policy for ABUHB.
- Liaising with the Health Board Arts Development team to investigate the possibility of commissioning artwork in GUH to commemorate organ donors from our community.
- Exploring the possibility of organ donation SIM training being facilitated internally.
- Working with Tissue Donation Specialist Nurse to rollout tissue donation referrals across all other wards in the health board (currently only occurs in Critical Care and Emergency Department).
- Meeting to discuss possible future projects and initiatives regarding organ donation within the health board and once identified apply for funding from regional funds.
- Considering processes for investigations into patient deaths within commissioned services.

Argymhelliad / Recommendation

The Committee is asked to receive the report for information.

Appendix 1

Summary Report – Actual and Potential Deceased Organ Donation
1 April 2022 – 31 March 2023

Actual and Potential
Deceased Organ Donation
1 April 2022 - 31 March 2023

NHS Blood and Transplant

Aneurin Bevan University Health Board

ORGAN DONATION AND TRANSPLANTATION 2030: MEETING THE NEED

In 2022/23, from 5 consented donors the Health Board facilitated 4 actual solid organ donors resulting in 11 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

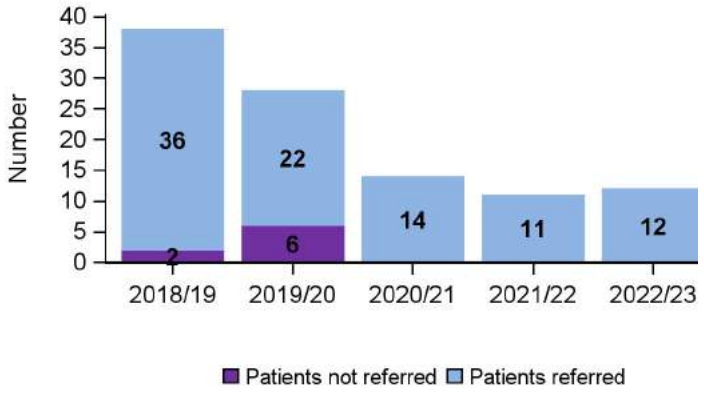
In addition to the 4 proceeding donors there was one consented donor that did not proceed.

Best quality of care in organ donation

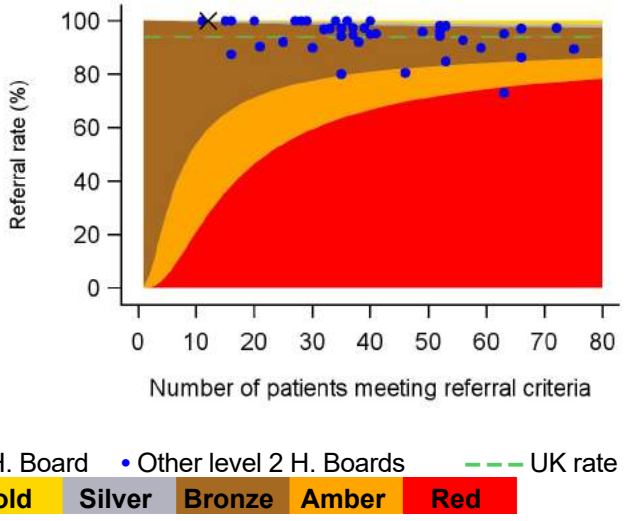
REFERRAL OF POTENTIAL DECEASED ORGAN DONORS

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold



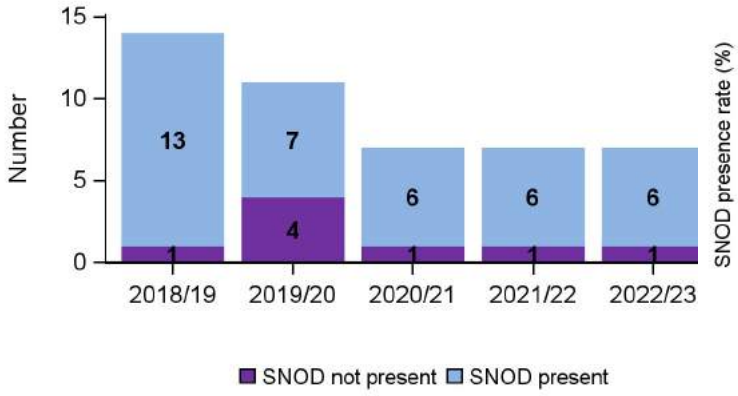
The Health Board referred 12 potential organ donors during 2022/23. There were no occasions where potential organ donors were not referred.

When compared with UK performance, the Health Board was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant.

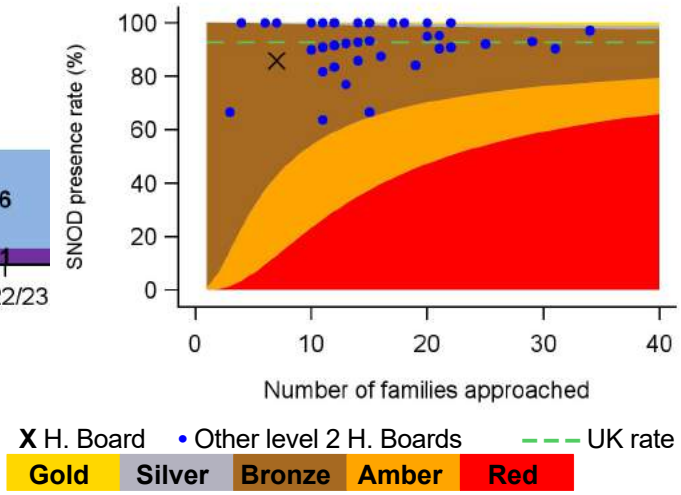
PRESENCE OF SPECIALIST NURSE FOR ORGAN DONATION

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 6 organ donation discussions with families during 2022/23. There was 1 occasion where a SNOD was not present.

When compared with UK performance, the Health Board was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2022 - 31 March 2023		
Deceased donors	64	1,429
Transplants from deceased donors	155	3,589
Deaths on the transplant list	25	441
As at 31 March 2023		
Active transplant list	243	6,959
Number of NHS ODR opt-in registrations (% registered)**	1,402,291 (45%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Health Board are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	5	1980	8	5307	12	6910
Referred to Organ Donation Service	5	1965	8	4886	12	6482
Referral rate %	99%	92%	94%			
	G 100%		G 100%		G 100%	
Neurological death tested	1556		4			
Testing rate %	79%					
	B 80%					
Eligible donors[2]	1439	3467	4906			
Family approached	1244	1691	2935			
	4		7		11	
Family approached and SNOD present	1190	1526	2716			
	4		3		7	
% of approaches where SNOD present	96%	90%	93%			
	G 100%		2		6	
Consent ascertained	846	959	1805			
			B 67%		B 86%	
Consent rate %	68%	57%	61%			
	4		1		5	
- Expressed opt in	3	476	1	578	4	1054
	G 100%		B 33%		B 71%	
- Expressed opt in %	*100%*	*95%*	*50%*	*84%*	*80%*	*89%*
- Deemed Consent	1	284	0	306	1	590
- Deemed Consent %	*100%*	*63%*	*N/A*	*52%*	*100%*	*57%*
- Other*	0	86	0	74	0	160
- Other %*	*N/A*	*60%*	*N/A*	*38%*	*N/A*	*47%*
Actual donors (PDA data)	4	783	0	636	4	1419
% of consented donors that became actual donors	*100%*	*93%*	*0%*	*66%*	*80%*	*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at: https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Appendix 2

Detailed Report Actual and Potential Deceased Organ Donation 1 April 2022 – 31 March 2023

NHS
Blood and Transplant

Detailed Report
Actual and Potential Deceased Organ Donation
1 April 2022 - 31 March 2023

Aneurin Bevan University Health Board

PROVISIONAL

TABLE OF CONTENTS

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Health Board metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued April 2023 based on data meeting PDA criteria reported at 11 April 2023.

1. DONOR OUTCOMES

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2022 and 31 March 2023, Aneurin Bevan University Health Board had 4 deceased solid organ donors, resulting in 11 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2021/22. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

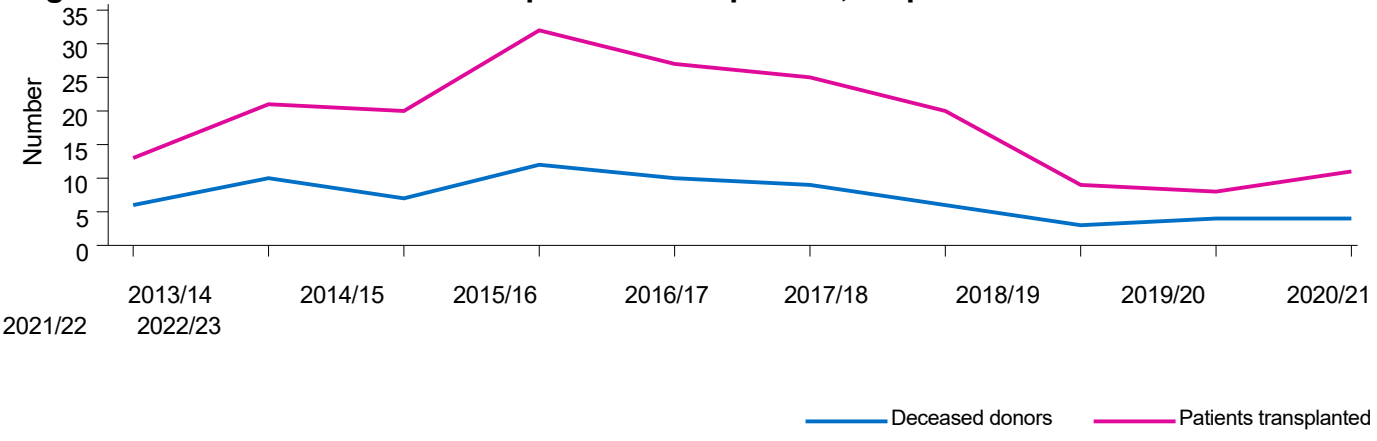
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Health Board		Average number of organs donated per donor: UK	
DBD	4	(1)	11	(3)	3.3	(3.0)	3.5	(3.4)
DCD	0	(3)	0	(5)	-	(1.7)	2.9	(2.7)
DBD and DCD	4	(4)	11	(8)	3.3	(2.0)	3.2	(3.1)

In addition to the 4 proceeding donors there was one additional consented donor that did not proceed, where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	8	(2)	1	(0)	2	(1)	1	(0)	0	(0)	0	(0)
DCD	0	(5)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	8	(7)	1	(0)	2	(1)	1	(0)	0	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2013 - 31 March 2023



2. KEY RATES IN POTENTIAL FOR ORGAN DONATION

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Aneurin Bevan University Health Board.

Performance in your Health Board has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2021/22 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2022 - 31 March 2023

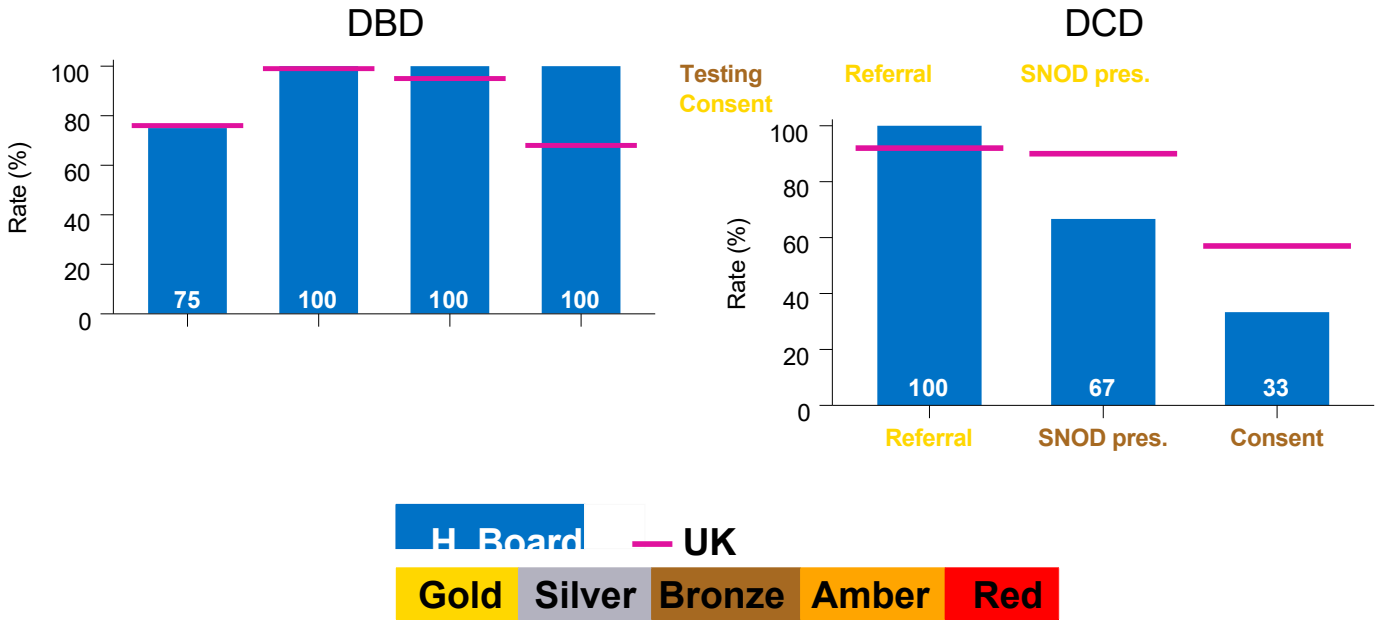


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2018 - 31 March 2023

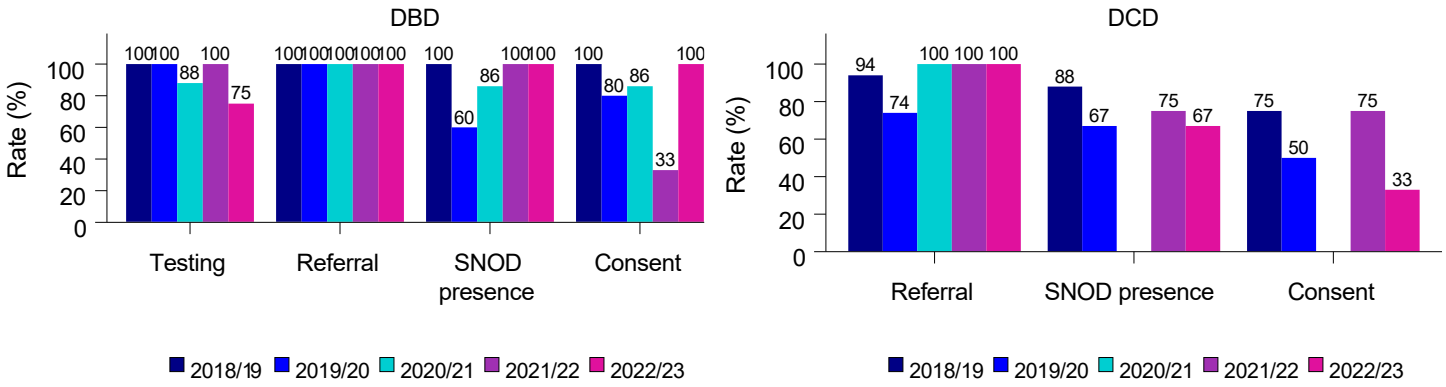


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2022 - 31 March 2023

	DBD				DCD				Deceased donors	
	H. Board		UK		H. Board		UK		H. Board	UK
Patients meeting organ donation referral criteria[1]	4		2032		8		5284		11	6908
Referred to Organ Donation Service	4		2010		8		4859		11	6470
Referral rate %	99%	92%	94%		G 100%				G 100%	
Neurological death tested	1	5	5	1	3					
Testing rate %	76%									
Eligible donors[2]	1	4	3	4	1	4	4	1	B 75%	
Family approached	1	2	4	3	1	6	2	3	7	10
Family approached and SNOD present	1	1	8	6	1	5	0	9	3	6
% of approaches where SNOD present	95%	90%	92%		3				2	5
Consent ascertained	8	4	3	9	5	1	1	7	B 67%	
Consent rate %	68%	57%	61%		G 100%				3	
- Expressed opt in	2		473	1			572		B 33%	3
1045					G 100%					B 67%
- *Expressed opt in %*	100%		95%	50%			84%		75%	89%
- Deemed Consent	1		284	0	303		1	587		
- *Deemed Consent %*			100%	63%	N/A		52%	100%	57%	
- Other*	0		86	0	75	0	161			
- *Other* %*		N/A		59%	N/A	39%	N/A	47%		
Actual donors (PDA data)					3		780		0	630
% of consented donors that became actual donors					100%		93%		0%	66%

					3		780		0	630	3	1410
% of consented donors that became actual donors					100%		93%		0%	66%	75%	79%

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold Silver Bronze Amber Red

3. BEST QUALITY OF CARE IN ORGAN DONATION

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Health Board at the key stages of organ donation. The ambition is that your Health Board misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2018 - 31 March 2023

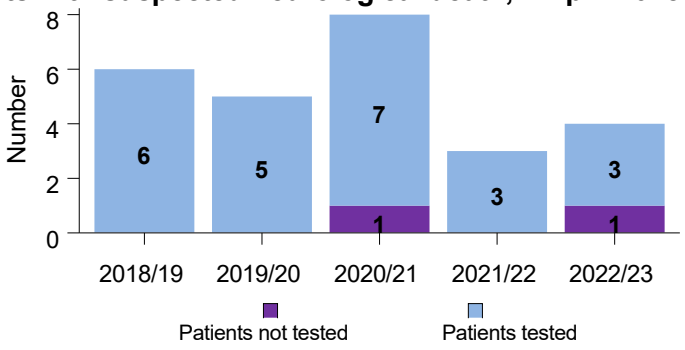


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2022 - 31 March 2023

	Health Board	UK
Biochemical/endocrine abnormality		-
31		
Clinical reason/Clinician's decision	-	69
Continuing effects of sedatives	-	6
Family declined donation	-	27
Family pressure not to test	-	49
Inability to test all reflexes	-	22
Medical contraindication to donation	-	6
Other	-	52
Patient had previously expressed a wish not to donate		1
	2	
Patient haemodynamically unstable	-	182
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	10
Treatment withdrawn	-	21
Unknown	-	3
Total	**1**	**481**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2018 - 31 March 2023

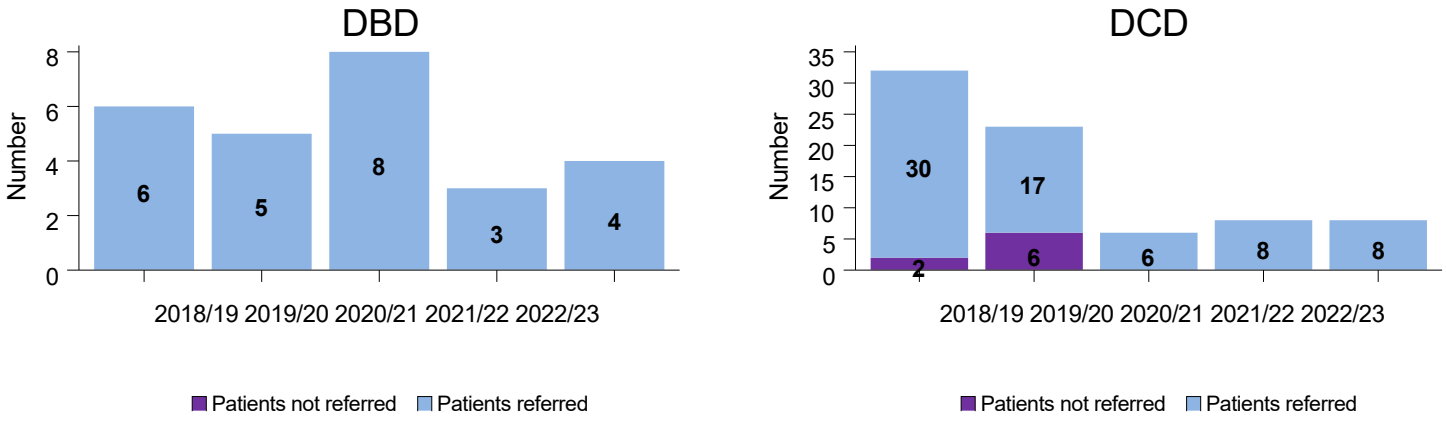


Table 3.2 Reasons given why patient not referred to SNOD 1 April 2022 - 31 March 2023	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Family declined donation following decision to remove treatment	-	1	-	14
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	-	-	28
Not identified as potential donor/organ donation not considered	-	7	-	26 9
Other	-	-	-	27
Patient had previously expressed a wish not to donate	-	-	-	3
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	1	-	2
Thought to be medically unsuitable	-	2	-	57

Uncontrolled death pre referral trigger	-	10	-	19
Total	**-**	**22**	**-**	**425**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2022/23 there was 1 potential donor in your Health Board with an ACI reported, 0 DBD and 1 DCD donor. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

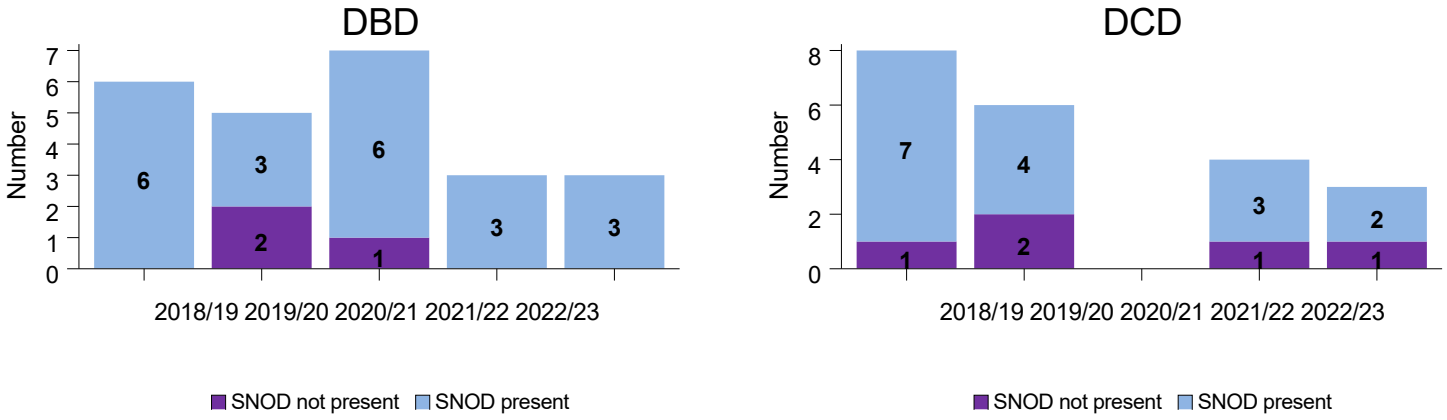
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2022/23, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 32% and 18%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 61%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2018 - 31 March 2023



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 11 April 2023]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 11 April 2023]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance [accessed 11 April 2023]

3.5 Consent

In 2022/23 less than 10 families of eligible donors were approached to discuss organ donation in your Health Board therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2018 - 31 March 2023

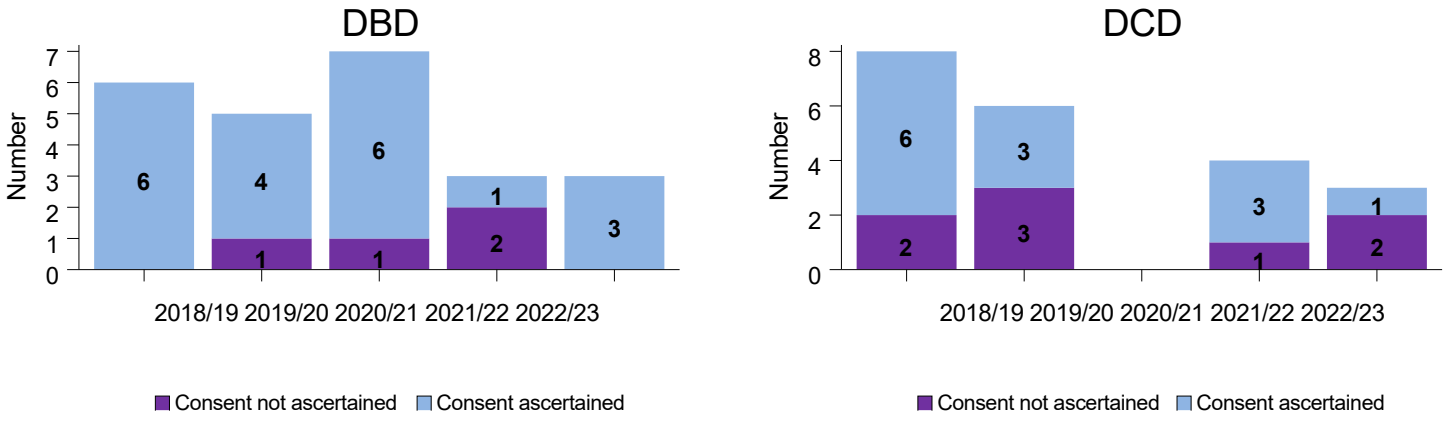


Table 3.3 Reasons given why consent was not ascertained, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	2	-	1
Family concerned other people may disapprove/be offended	-	1	-	2
Family concerned that organs may not be transplantable	-	1	-	7
Family did not believe in donation	-	4	-	12
Family did not want surgery to the body	-	38	-	51
Family divided over the decision	-	21	-	17
Family felt it was against their religious/cultural beliefs	-	42	-	23
Family felt patient had suffered enough	-	22	-	61
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	20	-	13
Family felt the length of time for the donation process was too long	-	17	-	123
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	2	-	16
Family were not sure whether the patient would have agreed to donation	-	45	-	90
Other	-	22	1	73
Patient had previously expressed a wish not to donate	-	120	-	173
Patient had registered a decision to Opt Out	-	22	1	32
Strong refusal - probing not appropriate	-	17	-	31
Total	**-**	**400**	**2**	**725**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2022 - 31 March 2023	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinical - Absolute contraindication to organ donation	-	10	-	7
Clinical - Cardiac arrest during referral	-	2	-	-
Clinical - Considered high risk donor	-	7	-	8
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	6	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	10	-	52
Clinical - Organs deemed medically unsuitable on surgical inspection	-	7	-	3
Clinical - Other	-	3	-	9
Clinical - PTA post WLST	-	-	1	163
Clinical - Patient actively dying	-	4	-	20
Clinical - Patient asystolic	-	1	-	-
Clinical - Patient's general medical condition	-	2	-	3
Clinical - Positive virology	-	1	-	3
Clinical - Predicted PTA therefore not attended	-	-	-	3
Consent / Auth - Coroner/Procurator fiscal refusal	-	5	-	10
Consent / Auth - NOK withdraw consent / authorisation	-	5	-	24
Logistical - Other	-	-	-	3
Total	**-**	**63**	**1**	**321**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. COMPARATIVE DATA

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Health Board with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Health Board is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Health Board, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

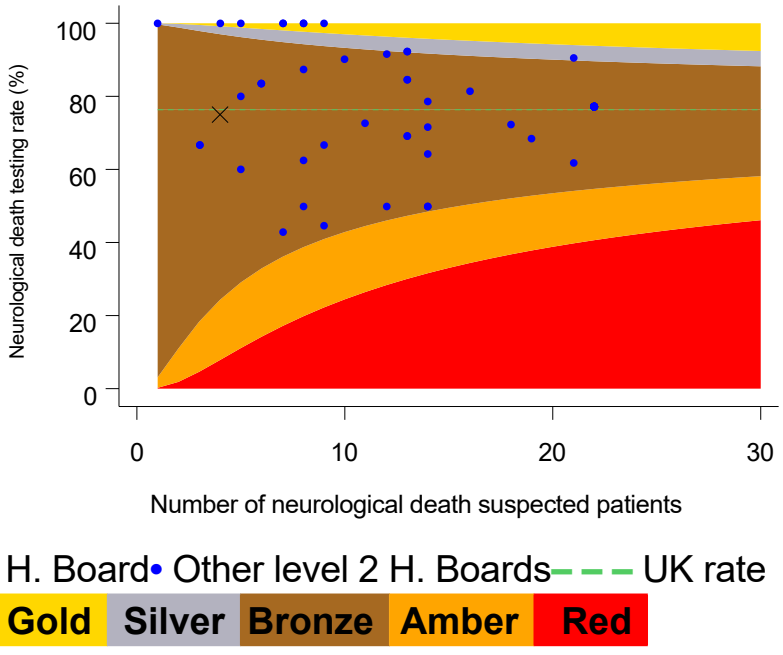
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2022 - 31 March 2023

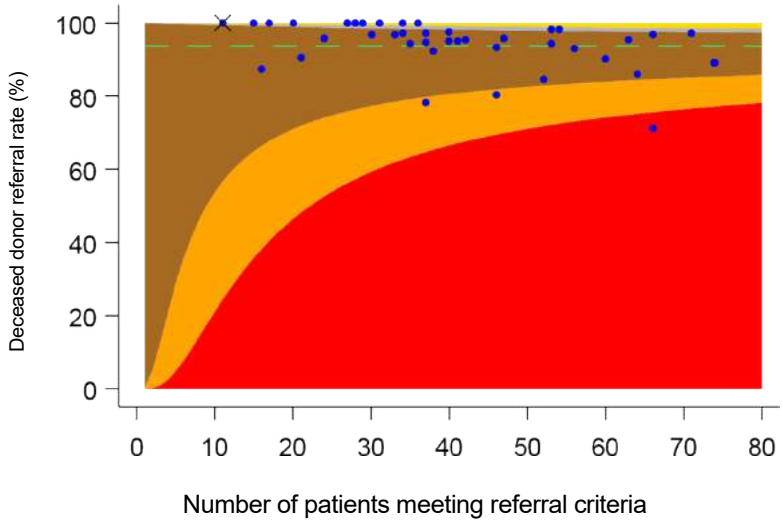


When compared with UK performance the neurological death testing rate in Aneurin Bevan University Health Board was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2022 - 31 March 2023



X H. Board • Other level 2 H. Boards – – – UK rate

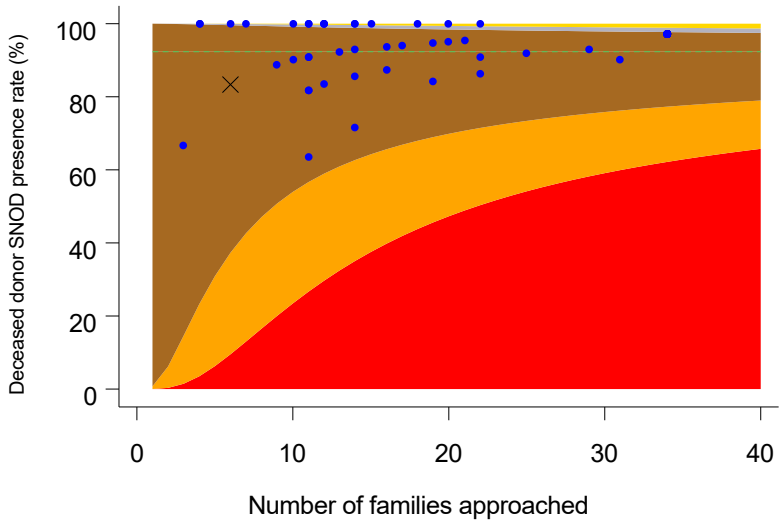
Gold **Silver** **Bronze** **Amber** **Red**

When compared with UK performance Aneurin Bevan University Health Board was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2022 - 31 March 2023



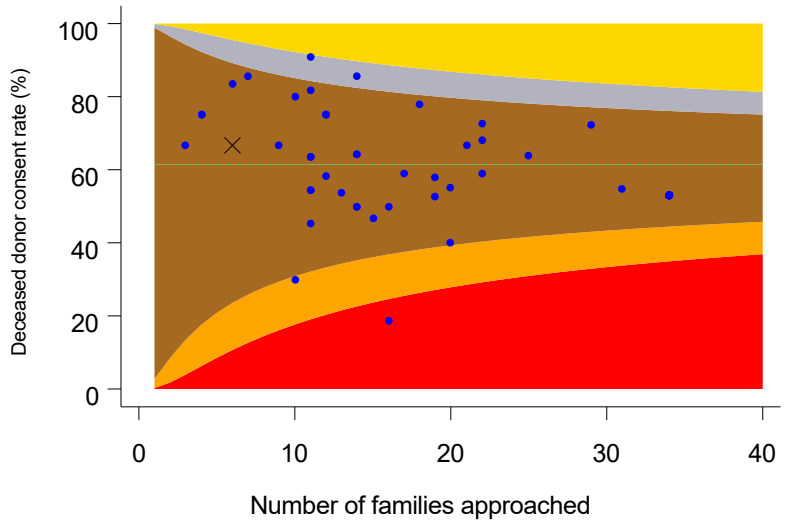
X H. Board • Other level 2 H. Boards – – – UK rate

Gold **Silver** **Bronze** **Amber** **Red**

When compared with UK performance Aneurin Bevan University Health Board was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2022 - 31 March 2023



X H. Board• Other level 2 H. Boards– – – UK rate

Gold **Silver** **Bronze** **Amber** **Red**

When compared with UK performance the consent rate in Aneurin Bevan University Health Board was average (bronze).

5. PDA DATA BY HOSPITAL AND UNIT

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where death was suspected	Patients where neurological patient died	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Llanfrechfa, The Grange University Hospital													
A & E	1	0	-	1	-	0	0	0	0	-	0	-	0
ICU - general	3	3	-	3	-	3	3	3	3	-	3	-	3
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0

Table 5.2 Patients who met the DCD referral criteria – key numbers and rates 1 April 2022 - 31 March 2023

Patients anticipated	Patients for whom imminent death was DCD referral	Unit where patient died rate (%)		Patients for whom treatment was withdrawn	Eligible donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate DCD (%)	Actual DCD donors from eligible donors
Llanfrechfa, The Grange University Hospital											
A & E	1	1	-	1	1	1	0	-	0	-	0
ICU - general	7	7	-	7	6	2	2	-	1	-	0
Other, please specify	0	0	-	0	0	0	0	-	0	-	0

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Aneurin Bevan University Health Board in 2022/23 there were 0 such patients. For more information regarding the Emergency Department please see Section 6.

6. EMERGENCY DEPARTMENT DATA

A summary of key numbers for Emergency Departments

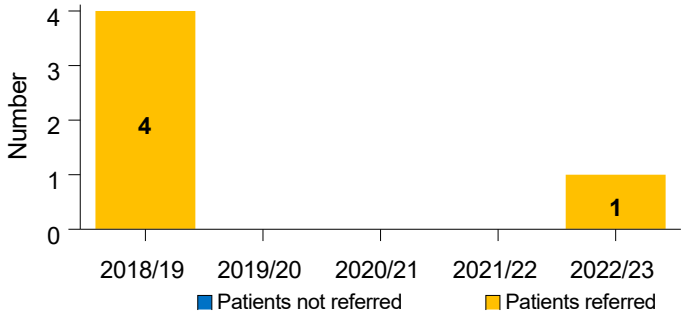
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [1] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service. Aim: There should be no blue on the following chart.

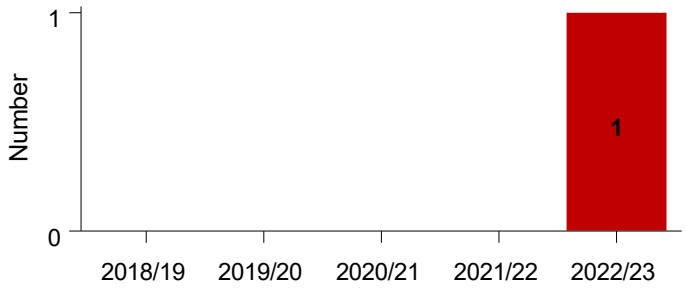
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2018 - 31 March 2023



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present. Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2018 - 31 March 2023



[1] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 11 April 2023]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2022 - 31 March 2023		
Deceased donors	64	1,432
Transplants from deceased donors	155	3,589
Deaths on the transplant list		24
430		
As at 31 March 2023		
Active transplant list	243	6,959
Number of NHS ODR opt-in registrations (% registered)**		1,402,291 (45%)
	28,567,574 (44%)	

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

7.2 Trust/Board Level Benchmarking

Aneurin Bevan University Health Board has been categorised as a level 2 Health Board. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD Key numbers and rate by Trust/Board level, 1 April 2022 – 31 March 2023

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	4	3	-	4	-	3	3	3	3	-	3	-	3
Level 1	1165	894	77	1152	99	879	831	715	677	95	474	66	438
Level 2	446	337	76	441	99	328	304	265	257	97	180	68	169
Level 3	297	229	77	293	99	225	217	188	183	97	134	71	123
Level 4	124	91	73	124	100	90	85	75	69	92	55	73	50

Table 7.4 National DCD Key numbers and rate by Trust/Board level, 1 April 2022 – 31 March 2023

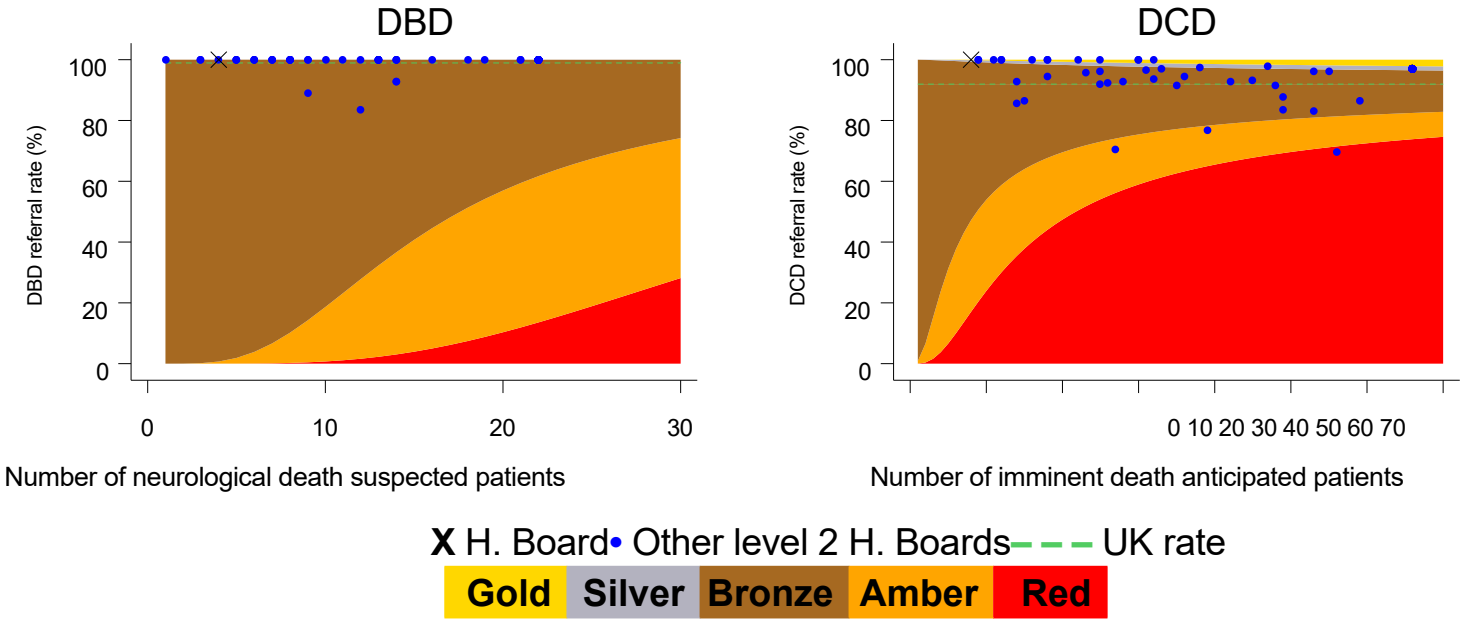
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	8	8	-	8	7	3	2	-	1	-	0
Level 1	2554	2361	92	2452	1765	935	849	91	535	57	366
Level 2	1333	1227	92	1296	832	368	329	89	207	56	132
Level 3	987	912	92	950	570	266	237	89	152	57	94
Level 4	410	359	88	399	274	107	94	88	57	53	38

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Health Board against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

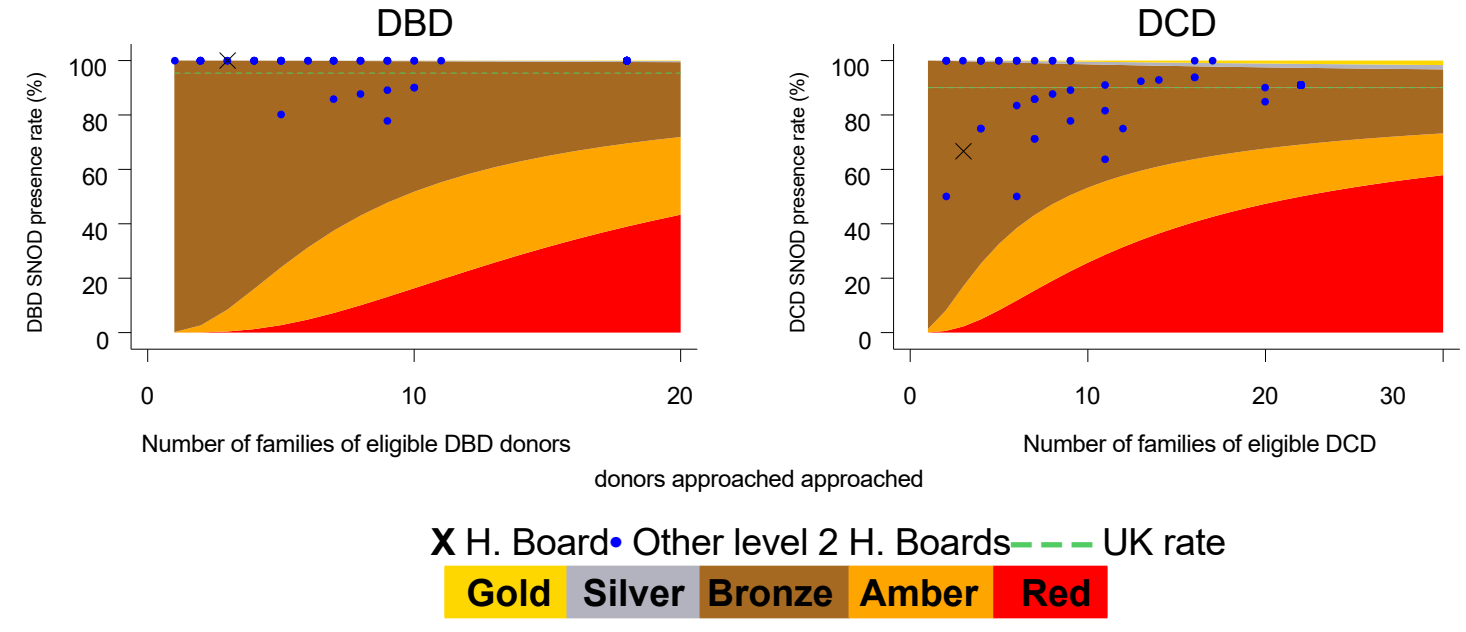
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2022 - 31 March 2023



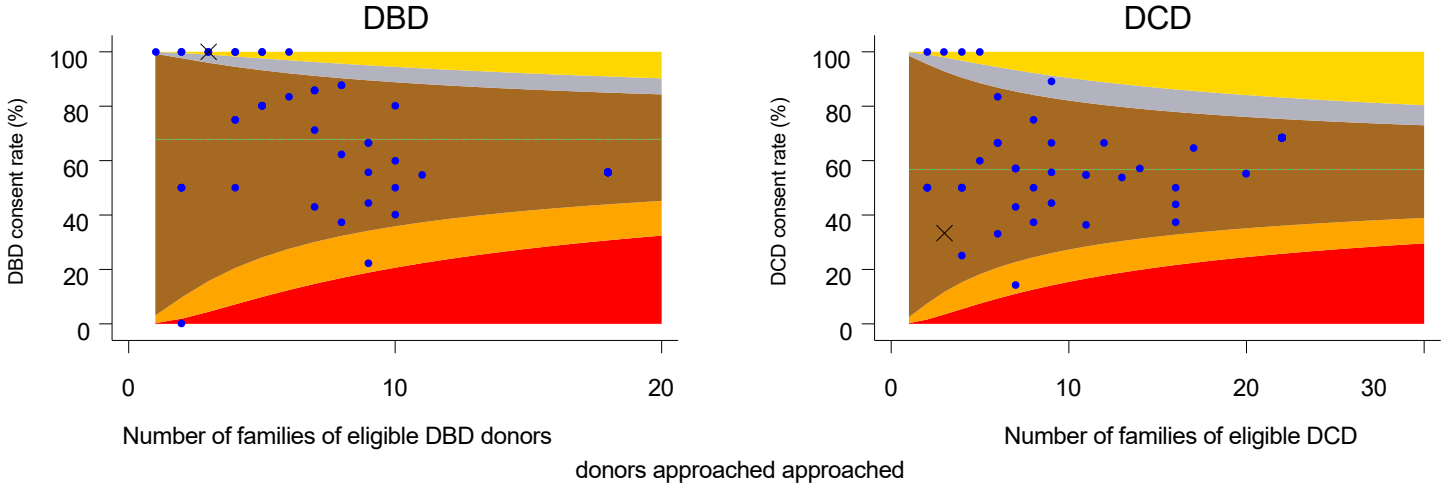
When compared with UK performance Aneurin Bevan University Health Board was exceptional (gold) for referral of potential DBD organ donors and exceptional (gold) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2022 - 31 March 2023



When compared with UK performance Aneurin Bevan University Health Board was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in Aneurin Bevan University Health Board was exceptional (gold) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-p ol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD

Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-p ol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD
Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision

Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.
2 Key rates in potential for organ donation Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).
3 Best quality of care in organ donation Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
5 PDA data by hospital and unit Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
6 Emergency department data Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

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):	3.1 Safe and Clinically Effective Care 4.1 Dignified Care 5.1 Timely Access Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
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)**	
Resource Assessment:	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
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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

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Ask for: Communications
01656 641150
Communications
@ombudsman.wales

Date: 17 August 2023

Ann Lloyd CBE
Aneurin Bevan University Health Board
By Email only: ann.lloyd@wales.nhs.uk

Annual Letter 2022/23

Dear Ann

I am pleased to provide you with the Annual letter (2022/23) for Aneurin Bevan University Health Board which deals with complaints relating to maladministration and service failure, and the actions being taken to improve public services.

This letter coincides with my Annual Report – "A year of change – a year of challenge" – a sentiment which will no doubt resonate with public bodies across Wales. My office has seen another increase in the number of people asking for our help – up 3% overall compared to the previous year, and my office now receives double the number of cases we received a decade ago.

Last year, I met with public bodies across Wales last year – speaking about our casework, our recommendations, and our proactive powers. The current climate will continue to provide challenges for public services, but I am grateful for positive and productive way which Health Boards communicate with my office.

Colleagues from my Improvement Team meet regularly with Aneurin Bevan University Health Board to discuss compliance with our recommendations and our complaints standards work, and we would like to pass on our thanks to Jane Rowlands-Mellor and her team for the constructive and candid way these discussions are conducted.

926 complaints were referred to us regarding Health Boards last year – an increase of 21% compared to the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 30% of Health Board complaints - a similar proportion to previous years.

Supporting improvement of public services

Our *Groundhog Day 2: An opportunity for cultural change in complaint handling?* report issued in June, highlighted the complaint handling failings we identified in cases involving health boards across Wales during the preceding 12 months. Our recommendations to the Health Board were aimed at ensuring that, as the new Duties of Candour & Quality are introduced within your organisation, that the opportunity for a cultural change is taken - to promote openness and candour with service users and ensure there is systemic learning when things have gone wrong.

I trust that, in line with our recommendations to the Health Board, the report has or will soon be considered by your Quality & Patient Safety Committee and it will:

- review the resources available to your complaints team
- review arrangements for accurately compiling complaints data
- 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.

Despite the challenges of last year, we have pushed forward with our proactive improvement work and launched a new Service Quality process to ensure we deliver the standards we expect.

Last year, we also began work on our second wider Own Initiative investigation – this time looking into carers assessments within Local Authorities. This investigation will take place throughout the coming year, and we look forward to sharing our findings.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year, with more than 50 public bodies now operating our model policy. We've also now provided more than 400 training sessions since we started in September 2020.

We continued our work to publish complaints statistics into a second year, with data now published twice a year and we included information about Health Boards for the first time in 22/23. This data allows us to see information with greater context – for example, last year 6% of Aneurin Bevan University Health Board's complaints were referred to PSOW.

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I would encourage Aneurin Bevan University Health Board, to use this data to better understand your performance on complaints.

Further to this letter can I ask that Aneurin Bevan University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Update my office on how the Health Board has complied with the recommendations in our report: *Groundhog Day 2: an opportunity for cultural change?* by **1 December 2023**.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.

Yours sincerely,

MM. Morris.

Michelle Morris
Public Services Ombudsman

cc. Nicola Prygodzicz, Chief Executive, Aneurin Bevan University Health Board.
By Email only: Nicola.prygodzicz@wales.nhs.uk

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

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Appendix B - Received by Subject

Aneurin Bevan University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	2	1%
Clinical treatment in hospital	91	55%
Clinical treatment outside hospital*	8	5%
Complaints Handling	31	19%
Confidentiality	0	0%
Continuing care	0	0%
COVID19	5	3%
De-registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	4	2%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
Mental Health	7	4%
NHS Independent Provider	0	0%
Non-medical services	2	1%
Nosocomial COVID	1	1%
Other	11	7%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	3	2%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	1	1%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Total	**166**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Aneurin Bevan University Health Board		**% Share**
Out of Jurisdiction	36	23%
Premature	19	12%
Other cases closed after initial consideration	53	33%
Early Resolution/ voluntary settlement*	30	19%
Discontinued	0	0%
Other Reports - Not Upheld	4	3%
Other Reports Upheld*	18	11%
Public Interest Reports*	0	0%
Special Interest Reports*	0	0%
Total	**160**	

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	48	160	30%
Betsi Cadwaladr University Health Board	80	231	35%
Cardiff and Vale University Health Board	30	129	23%
Cwm Taf Morgannwg University Health Board	37	141	26%
Hywel Dda University Health Board	41	100	41%
Powys Teaching Health Board	5	23	22%
Swansea Bay University Health Board	33	134	25%
Total	**274**	**918**	30%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2022/23. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2022/23. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Heath Boards in 2022/23. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our ref: AL/JRM Direct line: 01633 435957 20 September 2023

Ms Michelle Morris
Public Services Ombudsman for Wales
1 Fford yr Hen Gae
Pencoed
CF35 5LJ

Dear Ms Morris

RE: Annual letter 2022/23

Thank you for your letter dated 17 August 2023 which was received by the Health Board on 18 August 2023.

In response to your letter, the information provided is intended to provide assurance, and to demonstrate that the Health Board is delivering against the actions outlined below,

1. Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
2. Update my office on how the Health Board has complied with the recommendations in our report: *Groundhog Day 2: an opportunity for cultural change?* by **1 December 2023**.
3. Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
4. Inform me of the outcome of the Council's considerations.

Firstly, I can confirm that the Annual Letter will be presented at the Patient Quality Safety Outcomes Committee on 11 October 2023. This will assist Board members in their scrutiny of the Health Board's performance and to consider any further actions required as a result of information included.

To provide assurance, I would like to advise that your '*Groundhog Day 2: an opportunity for cultural change*?' Report has already been presented at the Health Board's Quality Patient Safety Outcomes Committee on 26 July 2023, along with a supporting Action Plan, which will be monitored and actioned accordingly through the Committee.

Pencadlys
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: 01633 436700

Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: 01633 436700

The Corporate PTR team continue to meet quarterly with Mathew Harris, the Head of Complaints Standards and Lowri Russell the Compliance and Improvement Officer. These meeting are both informative and supportive and have ensured relationships are further strengthened. I would like to thank you for your kind acknowledgement of the positive relations that have been fostered, and I am aware that this is reciprocated by Jane Rowlands-Mellor and her team.

I am pleased to advise that since February 2023 the Health Board's Investigating Officer (IO) training, has been delivered face to face, resulting in improved feedback. A more 'hands on' practical approach is proving beneficial to attendees. Alongside this, the Health Board continues to engage with the PSOW delivered complaints training. These sessions run once a month, and feedback is positive. Since August 2022, 43 Health Board colleagues have participated in these valuable sessions.

Management of complaint handling continues to receive organisational and Executive focus. All concerns are now reviewed by the Executive Director of Nursing (EDoN) or one of her Nursing team, prior to Chief Executive (CEO) sign off. This additional scrutiny ensures a compassionate, well written response, with the EDoN sighted first hand, on relevant learning and service improvements. Since May 2023 there has been a focussed approach to closing historic concerns. This has received Executive and Health Board through PQSOC oversight, with delays reported upon. As an organisation there can always be improvements, acknowledging that 19% of the complaints received by the Ombudsman are affiliated to poor 'complaint handling'.

A multifaceted approach is being adopted to support improvements and to facilitate learning. This includes, a scoping exercise of Quality, Patient Safety resource across the Corporate, Divisional and Quality Improvement Teams and detailed review of the Health Boards improvement and learning systems. It is anticipated that a change in process, along with the introduction of a PALS Team in October 2023, will ensure, where appropriate, concerns will be managed under Early Resolution, allowing for a more person-centred approach, which will ultimately improve the experience of the complainant and staff involved.

I hope the information provided in relation to the actions being undertaken is helpful in terms of assurance, but also serves as an update on the Health Boards progress against the Complaints Standards work.

Please do not hesitate to contact me should you require any further information.

Your Sincerely

Ann Lloyd
Chair/Cadeiryd