Patient Quality, Safety and Outcomes Committee

Tue 20 June 2023, 09:30 - 12:30

Microsoft Teams

Agenda

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 25th April 2023

Attached *Chair*

1.4 Draft Minutes PQSOC Committee 25_04_23 V2 PB Approved.pdf (14 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 PQSOC Action Log June 2023 (JW).pdf (4 pages)

2. Items for Approval/Ratification

2.1. Clinical Audit

For approval

2.1.1. Annual Clinical Audit Activity Report 2022/23

Attached *Medical Director*

2.1.1a Annual Clinical Audit Activity Report 2022.23.pdf (5 pages)
2.1.1b Annual Clinical Audit Activity Report 2022.23 (1) updated.pdf (76 pages)

2.1.2. Clinical Audit Plan

Attached *Medical Director*

2.1.2a Clinical Audit Plan.pdf (6 pages)
2.1.2b Clinical Audit Plan.pdf (24 pages)

3. Items for Discussion

3.1. Patient quality and Safety Outcomes Performance Report, June 2023

Attached *Clinical Executive Directors*

- Patient and staff experience and stories
- Incident reporting- falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding
- Additional Risks and Issues

3.1 PQSOC Performance Report - June 2023(1).pdf (82 pages)

3.2. EMBRACE UK Perinatal Mortality Data

Attachment *Director of Nursing*

3.2 ABUHB - SBAR MBRRACE 2021 - Health Board response (1).pdf (7 pages)

4. Items for Information

4.1. Highlight Reports

4.1.1. Quality & Patient Safety Operational Group

Attached *Clinical Executives*

4.1.1 QPSOG Report.pdf (4 pages)

4.1.2. Children's Right Participation Forum

Attached *Clinical Executive Directors*

4.1.2 QPS - Children's Rights Update (June 2023)(1).pdf (26 pages)

4.1.3. Safeguarding Group Highlight Report

Attached *Clinical Executive Directors*

4.1.3 Safeguarding Highlight Report - May 2023.pdf (3 pages)

4.1.4. Clinical Effectiveness and Standards Committee Report

Attached *Clinical Executives*

4.1.4 Clinical Effectiveness and Standards Committee Report.pdf (24 pages)

4.1.5. WHSSC QPS Committee Report

Attached *Clinical Executives*

4.1.5 WHSSC Joint Committee- QPSC Chairs report 18 April 2023.pdf (32 pages)

4.1.6. ABUHB Community PROMPT Wales Quality Assurance Report

Attached *Clinical Executives*

4.1.6 ABUHB - FINAL COMMUNITY PROMPT WALES QA REPORT 23MAY16.pdf (15 pages)

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 is Wednesday 26th July 2023

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

MINUTES OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD PATIENT, QUALITY, SAFETY & OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 25th April 2023
VENUE	MS Teams

PRESENT	Pippa Britton, Independent Member (Chair)
	Louise Wright, Independent Member
	Paul Deneen, Independent Member
	Helen Sweetland, Independent Member
.IN ATTENDANCE	Jennifer Winslade, Director of Nursing
	Rani Dash, Director of Corporate Governance
	Peter Carr, Director of Therapies & Health Science
	James Calvert, Medical Director
	Nicola Prygodzicz, Chief Executive
	Bryony Codd, Head of Corporate Governance
	Tracey Partridge-Wilson, Assistant Director of Nursing
	Leanne Lewis, Assistant Director of Quality & Patient Safety
	Jonathan Simms, Clinical Director of Pharmacy
	Jeanette Wells, Research and Development Director
	Sue Bale, Research and Development Director
	Tanya Strange, Head of Nursing for Person Centred Care
	Nathan Couch, Performance Audit Lead (Health), Audit Wales
	Linda Joseph- Deputy Regional Director- Llais
	Stephen Chaney- Deputy Head of Internal Audit
	Rebecca Atkinson, Meeting Secretariat

PQSOC/2504/1.	**PRELIMINARY MATTERS**
PQSOC/2504/1.1	**Welcome and Introductions** Pippa Britton (PB), Committee Chair welcomed and noted the guest attending for specific agenda items.
PQSOC/2504/1.2	**Apologies for Absence** There were no apologies.
PQSOC/2504/1.3	**Declarations of Interest** There were no Declarations of Interest.
PQSOC/2504/1.4	**Draft Minutes of the last Meeting held on 7th February 2023** The draft minutes of the meeting held on 7th February 2023 were **APPROVED** and **ACCEPTED** as an accurate record.
PQSOC/2504/1.5	**Committee Action Log** The PQSOC noted the updated action log. **PQSOC – 0702/3.1** Jennifer Winslade (JW), Director of Nursing reported that this action had been completed and data for the Health Board's Compliance of Nursing Staffing Wales Act 2016 is contained in the PQSOC Report. The Patient, Quality & Safety Outcomes Committee **NOTED** the updates.
PQSOC/2504/2.	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**
PQSOC/2504/2.1	**Committee Annual Report 2022/23** Rani Dash (RD), Director of Corporate Governance provided an overview of the PQSOC Annual Report for 2022/23. The Annual Report seeks to provide a comprehensive evaluation on the business undertaken by the Committee over the course of the 2022-23 financial year including any issues, and gaps in assurance that have required escalation to the Board. RD asked the Committee to consider and endorse the report prior to submission to the Board on 24th May 2023. The Committee thanked the Corporate Governance Team for its work and **ACCEPTED** the report.

PQSOC/2504/3.	**ITEMS FOR DISCUSSION**
PQSOC/2504/3.1	**Patient Quality and Safety Outcomes Measures Report, March 2023** Jennifer Winslade (JW), Director of Nursing introduced the presentation and thanked her team for all the work in putting it together. JW presented data on the Workforce Nursing Staffing Levels (Wales)Act 2016 and advised the Committee that the data provided was that required to be reported under the Act. JW advised the Committee that between November 2022 to January 2023 11 complaints about nursing care had been received. Pippa Britton (PB) Independent Member, requested an improvement plan progress report and it was agreed that a progress report would be reported to the next Committee meeting. ***Action: Director of Nursing*** JW outlined an update on the Pillars of Quality. The Strategy document had been approved at the last Board Meeting and the data was currently being reviewed. PB asked how feedback from the Independent Member's walkaround sessions was captured. Committee Members agreed that these walkaround sessions were of great value but they needed a purpose and clear briefing of Independent Members needs to take pace prior to visits. Leeanne Lewis (LL) Assistant Director for Quality and Patient Safety advised the Committee that they were currently planning walkaround visits and a member of admin support would accompany members on the visits to document and follow-up actions. Tracey Partridge-Wilson (TPW), Assistant Director of Nursing outlined an update on National Reportable Incidents (NRI's). A meeting was being planned with the Delivery Unit to streamline the process and provide clear guidance for staff on the categorisation of an NRI. This meeting would bring ABUHB into line with other Health Boards. James Calvert (JC), Medical Director reassured the Committee that conversations were being held to prevent Never Events. PB asked if the missing months in the graph showed that staff learnt from training after a never event had occurred. JC confirmed that the graph shows common never events.

	Paul Deneen (PD) Independent Member questioned whether security was an issue in Mental Health and whether the patient in question was appropriately placed. TPW reassured the Committee that the General Manager of Mental Health was reviewing and producing a report to bring to the next committee meeting regarding this issue and that the patient concerned was appropriately placed. Peter Carr (PC), Director of Therapies and Health Sciences further reassured the Committee that a full review of security was now taking place to include external partners, as part of a wider Health and Safety plan. An action plan had been developed and was currently being worked through. JW reported on Complaints and SI's, highlighting that work was underway to improve the current process and ensure that response times were improved. All data and process issues were being improved which was a huge task. TPW further reported that work was being undertaken collaboratively with other Health Boards as to their processes and a plan was underway to bring all the PTR teams within our Health Board under one directorate. PD asked if there was any correlation between complaints received from solicitors following media campaigns. JW reported that nothing had been highlighted and complaints were mainly from patient experience. PD asked if any trends that were identified were brought to the attention of the Committee and it was confirmed that this was already happening. TPW outlined Claims, Redress and Inquests data and context and assured the Committee that this information would be reported at every PQSOC Meeting. PD asked how our data compares with the rest of Wales. It was agreed that benchmarking data would be provided. ***Action: Assistant Director of Nursing*** Helen Sweetland (HS) Independent Member welcomed the significant progress with Claims, Redress and Inquests and complaints to streamline processes. PD noted the good relationship with the Coroner and questioned the high number of 30% and whether, given training to staff this number would reduce. TPW confirmed that this would be monitored and reported back to the Committee. PB asked for information regarding the role of the Coroner be sent to the Committee for information. ***Action: Director of Nursing***

	JC reported that the coroner agrees that having complete information within reports and working with families was key. The Health Board has done this well and included, within the report to the coroner, questions from the family. The Coroner for the Health Board will call more cases as this is her approach. JW further reported that as the reporting has improved, less work is needed by staff. The process was improving and quarterly meetings were taking place to move the process forward. PC provided an overview on Health, Safety and Security and work with the Health and Safety Executive to resolve issues relating to two ongoing cases. PC further reported that Violence and Aggression was now being reported and staff have confidence that the Health Board is taking this matter seriously. There had also been an awareness campaign to the public reinforcing the Health Board's zero-tolerance approach to Violence and Aggression within the Health Board and directed towards staff. PD asked whether members should be concerned with 50 incidents a week and whether staff wore cameras and how the police supported these incidents. PC reported that we were capturing more incidents now and the range of incidents vary. A breakdown would be included in future reports. PC reported that security wear body cameras and there is CCTV on site but the Health Board needs to be mindful of patient confidentiality. The Health Board maintains a positive relationship with Gwent Police. ***Action: Director of Therapies and Health Sciences*** PD further asked for clarification on the definitions of verbal and physical abuse. PC reported that this information would be included in the Health and Safety Annual report which will be presented at the next Committee meeting. JW outlined the current position on Infection Prevention. The main areas of concern were C.difficile and Klebsiella sp bacteraemia. There were 32 covid cases in the hospitals last week so the undercurrent of covid-19 was still present. Covid-19 testing guidance had recently changed and it was becoming a seasonal illness. JW reported that Wave 1 of the Covid-19 Investigations was 100% complete and wave 2 and 3 were underway. ABUHB now had one of the best completion of Investigations. A Board level report would be produced

for Covid-19 Investigations and would include early learning themes.

TPW provided an overview of safeguarding activity. The Health Board were currently supporting 3 Child Practice Reviews, 2 Domestic Homicide Reviews and 1 Adult Practice Review.

PD asked how the Health Board and Committee reassured itself that all locum, contractor and agency staff were trained to our safeguarding standards. TPW reported that all bank and agency staff were required to complete Statutory and Mandatory training and Safeguarding is part of the contract signed by Locum, Agency and contracting staff.

JW outlined the progress made with implementation of the Welsh Nursing Care Record which had been fully implemented at the Grange University Hospital. The Royal Gwent Hospital will be next. The WNCR provides reassurance around falls and nutrition and consolidates data around quality of care.

PC provided an overview of inpatient falls, highlighting a significant increase in December 2022 when hospitals were under extreme winter demand and pressure. PC reported that a new policy released in 2021 and improved training has had a significant impact on reducing the numbers of falls.

The Committee noted the information provided in relation to urgent care and planned care. Nicola Prygodzicz (NP), Chief Executive provided updated data for March 2023 reporting that there were huge numbers but that staff did extremely well to cope.

Helen Sweetland (HS) Independent Member noted that she was pleased that, despite the pressures, the SDEC had managed to keep its functionality.

JC that suspected cancer referrals continue to increase with numbers expected to rise. There had been reductions in the numbers of 62 and 104 waits and focus would be on 3 main areas of work:-

1. First contact within 14 days
2. Reducing waits and delays for Radiology and Pathology. Pathology being outsourced.
3. Updating information that GP's give to patients with a cancer diagnosis.

	PD welcomed the helpful presentation and asked if the Board could do anything else to assist. JC confirmed that the Board was supportive and that that support encourages openness and transparency. It was felt that the Board currently provides the right amount of constructive challenge. HS asked if the urgent rate for Cancer patients had seen an increase if patients felt that other routes were slow. JC advised that there are more urgent cases as a result of Covid. Bowel Cancer rates had seen a reduction in threshold due to poor screening rates. The Health Board would be working with the Moondance Cancer Initiative to help with the take up of screening in Wales. PB thanked everyone for their input to the performance report. The Patient, Quality, Safety Outcomes Committee Performance Report March 2023 was **RECEIVED.** The report provides the Committee with an overview of the Health Boards Quality and Safety Metrics and Summary of Performance **for ASSURANCE.**

PQSOC/2504/3.2	**Committee Risk Report, March 2023** Rani Dash (RD) Director of Corporate Governance provided an overview of the Committee's Strategic Risk Report for March 2023. 10 risks had been allocated to this Committee from the main Health Board Risk Register and the risks had not changed since previous reports. The Patient, Quality & Safety Outcomes Committee **RECEIVED** the overview of the Strategic risks which routinely report to the PQSO Committee and **NOTED** the update in respect of risk CRR028 as requested by the Committee.
PQSOC/2504/3.3	**Annual Reports:** The following Annual Reports were received by the PQSOC Committee for information and Discussion.
PQSOC/2504/3.3.1	**Blood Management** James Calvert (JC), Medical Director welcomed Stacey Wetherell (SW), Haematology Department Manager to the meeting. SW outlined the report which provided assurance of the Health Board's delivery of Health and Care Standard 2.8 Blood Management and its various components and sets out the priorities and actions which will be progressed through the Hospital Transfusion Committee (HTC). SW reported on one issue regarding traceability. Figures were usually 100% but were currently 98%. This was mainly due to the transfer to an electronic reporting system which some staff were not using. This was mainly Bank and Agency staff and there was a training plan in place to address these issues. The PQSOC Committee referred the matter of this training to the People and Culture Committee for further follow up. ***Action: Refer to People and Culture Committee*** The Patient Quality, Safety and Outcomes Committee **ACCEPTED** this report as **ASSURANCE** against the Health & Care Standard 2.8 Blood Management.
PQSOC/2504/3.3.2	**Pharmacy and Medicines Management** James Calvert (JC), Medical Director welcomed Jonathan Simms (JS), Clinical Director of Pharmacy who outlined the report. The annual report provided an update on the Welsh Government requirements that an annual prescribing report showing progress in the four priority

areas of safe prescribing; antimicrobial stewardship; cost efficiency; and access to medicines is scrutinised by the Board or the Quality and Safety committee.

JS highlighted that there were references to the pharmacy teams' involvement in the Covid Immunisation Programme throughout the report. Judith Paget, Director General. had presented an award to the team to recognise their involvement and contribution in the Programme.

Pippa Britton (PB) Independent Member acknowledged the contribution on behalf of the Board and the Committee and thanked everyone involved.

JS outlined the following risks:

1. Storage of IV Fluids at the Royal Gwent Hospital.
2. Concern regarding the functionality of the RGH pharmacy robot, responsible for the distribution of medicines to all wards, including The Grange University Hospital.

Nicola Prygodzicz (NP), Chief Executive reassured the Committee that a business case to renew the robot had been developed and they would be looking at costs associated with this.

Paul Deneen (PD), Independent Member asked for an update on this situation as it was a concern to the Committee and it was agreed that an action plan would be presented to a future meeting.
Action – Medical Director

PD asked if the Committee could help with any issues regarding e-prescribing. JS reported that a business case was being developed and 3 contractors were being considered to facilitate e-prescribing. JC reported this was a high-risk procurement as a Company employed for a pilot in Swansea Bay failed to deliver. A new Government Framework will be produced to give clear guidelines.

The Patient Quality, Safety and Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the Pharmacy and Medicines Management Annual Report.

PQSOC/2504/3.3.3	**Research and Development** James Calvert (JC), Medical Director welcomed Professor Sue Bale (SB) to the meeting. SB outlined the report noting that Research was a function of a University Health Board. JC noted that research and development will produce an annual report to showcase the work being undertaken. Helen Sweetland (HS) Independent Member congratulated SB on the new research and development space and asked for a list of all research being undertaken to be produced. Paul Deneen (PD) Independent Member asked if all funding options had been explored. After discussion it was agreed that PD and HS (Research Champion) would meet outside the meeting to discuss this further. The Patient Quality, Safety and Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the Research and Development Annual Report.
PQSOC/2504/3.3.4	**Dementia Care** Jennifer Winslade (JW), Director of Nursing welcomed and introduced Tanya Strange (TS), Head of Nursing for Person Centred Care who outlined a presentation on the work carried out to date. TS further presented a video that had been circulated to the public. Pippa Britton (PB) Independent Member asked for the video link or presentation to be sent to Independent Members and a link to the invitation for the Dementia Conference. ***Action: Head of Nursing for Person Centred Care*** Louise Wright (LW), Independent Member asked if the team were linking in with the new Equality Officer regarding Dementia Care. TS assured the Committee that the new Equality Officer was being invited to all their events. The Committee thanked TS and her team for the report. The Patient Quality, Safety and Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the Dementia Care Annual Report.

PQSOC/2504/3.3.5	**Falls & Bone Health Committee** Peter Carr (PC), Director of Therapies and Health Sciences outlined current work and noted the priority for the next 12 months is to deliver on our work programmes and develop a Falls strategic intent. Pippa Britton (PB) Independent Member thanked PC for a comprehensive report and welcomed the emphasis on the Community. Louise Wright (LW), Independent Member asked about foot wear for inpatients in hospital and making sure they had the correct footwear. PC reported that footwear was part of the multi factorial risk assessment with prompts to add to care plan; it is then everyone's responsibility to know what the care plan is. Paul Deneen (PD) Independent Member asked how we can advise patients to use aids to prevent falls. PC reported that work was ongoing around intergenerational awareness for falls. The Patient Quality, Safety and Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the Falls and Bone Health Committee Annual Report.
PQSOC/2504/3.3.6	**Nutrition & Hydration Group** Peter Carr (PC), Director of Therapies and Health Sciences outlined the work currently being undertaken within the Health Board and provided an update to the Committee regarding standards and compliance. Themes to take forward are: • Re-establish the Nutrition and Hydration Group. • Action plan to achieve greater compliance with the Dining Review action plan, opportunities for rolling out the Ward Based Nutrition Support Workers and a Corporate approach to escalating a dedicated Nutrition Support Team. Pippa Britton (PB) Independent Member thanked PC for the report and suggested linking in with the Dementia Team as to how we can move forward with nutrition and hydration for vulnerable patients. Paul Deneen (PD) Independent Member suggested looking at Nutrition and Hydration as part of the Independent Member visits.

	The Patient Quality, Safety and Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the Nutrition & Hydration Group Annual Report.
PQSOC/2504/3.4	**National Audit of Care at the End of Life (NACEL) Management** Leeanne Lewis (LL), Assistant Director for Quality & Patient Safety outlined the report and informed the committee that this paper had been presented to the Executive committee as during the fourth round of the National Audit of Care at the End of Life (NACEL) outputs, Aneurin Bevan University Health Board was flagged as a potential outlier under the NACEL Management of Outliers Policy, relating to the Community data submission. LL reported that the Health Board's score was low due to a lack of documentation but reassured the Committee that care of patients was good, but this had not been appropriately documented. The Patient Quality, Safety and Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the National Audit of Care at the End of Life (NACEL) Management Report.
PQSOC/2504/3.5	**National Review of Consent to Examination and Treatment Standards in NHS Wales: Welsh Risk Pool Report and Management Response** Leeanne Lewis (LL), Assistant Director for Quality & Patient Safety reported that this had already been presented to the Executive Team, signed off and an action plan developed. This report outlines how the Health Board comply and benchmark with standards. There was a robust action plan in place with realistic timeframes to ensure compliance with these standards. The Health Board had fallen behind following the opening of the Grange and the pandemic and staff were currently being trained via an e-learning package. Helen Sweetland (HS), Independent Member, asked about patient information leaflets being available and up to date. LL confirmed that she would be looking to form a citizens group to review all patient information leaflets and create a database to manage the process. The Committee were asked to note the ongoing work on Consent to Examination & Treatment Standards.

	The committee asked for an update on the action plan to be brought to a future meeting. ***Action: Medical Director*** The Patient, Quality & Safety Outcomes Committee **RECEIVED** and **NOTED FOR ASSURANCE** the National Review of Consent to Examination and Treatment Standards in NHS Wales: Welsh Risk Pool Report and Management Response
PQSOC/2504/3.6	**Clinical Audit Activity Report (March)** Leeanne Lewis (LL), Assistant Director for Quality & Patient Safety outlined the report. It was noted that the use of AMaT had improved monitoring audit activity and a standardised template would be created for all audits to use and a timeline produced to ensure that all audit activity was captured. The Committee noted that good progress was being made. The Patient, Quality & Safety Outcomes Committee **RECEIVED FOR ASSURANCE** the Clinical Audit Activity Report for March.
PQSOC/2504/4.	**ITEMS FOR INFORMATION**
PQSOC/2504/4.1	**Highlight Reports** The Patient Quality Safety Outcome Committee received the following reports for information: a) Quality and Patient Safety Operational Group b) Children's Rights Participation Forum c) Safeguarding Group Highlight Report d) Clinical Effectiveness and Standards Committee Report e) WHSSC QPS Committee Report Paul Deneen (PD) Independent member asked if WHSSC could be prioritised earlier in the agenda to enable a proper discussion of the work being undertaken. Rani Dash (RD) Director of Corporate Governance reported that the information regarding commissioned services will be picked up on the performance report slides in the future. The Patient, Quality & Safety Outcomes Committee **RECEIVED FOR ASSURANCE** the Highlights Reports

PQSOC/2504/4.2	**Committee Workplan 2022/23** Pippa Britton (PB) Independent Member reported that there had been no significant changes to this workplan. Rani Dash (RD) Director of Corporate Governance reported that this was the closing report for 2022/23 and a new plan would be prepared for 2023/24. The Patient, Quality & Safety Outcomes Committee **RECEIVED FOR INFORMATION** the PQSOC Programme of Business 2022/23
PQSOC/2504/5.	**OTHER MATTERS**
PQSOC/2504/5.1	**Items to be Brought to the Attention of the Board and Other Committees** **2504/3.3.1 -** SW reported on one issue regarding traceability. Figures were usually 100% but were currently 98%. This was mainly due to the transfer to an electronic reporting system which some staff were not using. This was mainly Bank and Agency staff and there was a training plan in place to address these issues. The PQSOC Committee referred the matter of this training to the People and Culture Committee for further follow up. ***Action: Refer to People and Culture Committee***
PQSOC/2504/5.2	**Any Other Urgent Business**
PQSOC/2504/5.3	**Date of Next Meeting** The date of the next Patient Quality & Safety Outcome Committee was noted as Tuesday 20th June 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
6th December 2022	**PQSOC 0612/14**	**Health & Safety Compliance Report:** Members requested a detailed report on violence and aggression, including comparative data across Wales and the impact of negative social media comments on the health and safety of staff members.	**Head of Health and Safety/ Secretariat**	**Q1, 2023/24**	To be added to the PQSO Committee Workplan for 2023/24
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023**: Health Board's Compliance of Nursing Staffing Wales Act 2016 to be presented bi-monthly.	**Director of Nursing**	June 2023	Complete
7th February 2023	**PQSOC 0702/3.3**	**HIW Inspection Review to include Tracking of Improvement Actions Arising from Inspections and Review**: Committee Chair to discuss with Health Board Chair if a review of different patient record systems	**Committee Chair**		Discussion held with Chair. Board briefing to be scheduled to discuss quality of clinical record keeping.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		was required and if this should be presented to the Board.			
7th February 2023	**PQSOC 0702/3.4**	**Clinical Audit**: The Committee Chair requested this report is provided at each PQSOC Committee meetings.	**Director of Nursing/Meeting Secretariat**	June 2023	To be included within the PQSO Committee workplan for 2023/24 as a routine assurance report.
7th February 2023	**PQSOC 0702/3.5**	**Annual Reports – Health Board Organ Donation Report**: In line with the ToR the National Organ Annual Report will need to be presented to the August/October PQSOC	**Medical Director/Meeting Secretariat**	June 2023	To be scheduled within the PQSO Committee workplan for 2023/24.
25th April 2023	**PQSOC/2504/3.1**	**Patient Quality and Safety Outcomes Measures Report, March 2023:** Nurse Staffing Levels Improvement Plan/ progress report to be reported to the next Committee meeting.	**Director of Nursing**	June 2023	This is in progress; improvement actions are reported with the PQSOC report.
25th April 2023	**PQSOC/2504/3.1**	**Patient Quality and Safety Outcomes Measures Report, March 2023:** Claims, Redress and Inquests benchmarking data to be provided	**Assistant Director of Nursing**	June 2023	Complete. There is no current all-Wales comparison data which makes it difficult to fairly compare Health Boards in this area. With the

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					advent of RLDatix Cymru this may progress
25th April 2023	**PQSOC/2504/3.1**	**Patient Quality and Safety Outcomes Measures Report, March 2023:** Information regarding the role of the coroner be sent to the Committee for information.	**Director of Nursing**	June 2023	Complete. An all-Wales Guide to the role of the Coroner is under development. A copy of the draft has been sent to Committee
25th April 2023	**PQSOC/2504/3.1**	**Patient Quality and Safety Outcomes Measures Report, March 2023:** A breakdown of Violence and Aggression incidents to be provided in future reports	**Director of Therapies and Health Sciences**	June 2023	To be included within future reports
25th April 2023	**PQSOC/2504/3.3.1**	**Blood Management:** Training requirements for use of the electronic reporting system, particularly for Bank and Agency Staff, and associated action plan to be monitored by People and Culture Committee	**Medical Director**	June 2023	Transferred to People and Culture Committee

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
25th April 2023	**PQSOC/2504/3.3.2**	**Pharmacy and Medicines Management:** Action Plan in relation to Pharmacy Robot to be presented to future meeting	**Medical Director**		To be included in work programme 2023/24
25th April 2023	**PQSOC/2504/3.5**	**National Review of Consent to Examination and Treatment Standards in NHS Wales: Welsh Risk Pool Report and Management Response:** Update on the Action Plan to be presented to a future meeting	**Medical Director**		To be included in work programme 2023/24

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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 June 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Clinical Audit Activity Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Simpson, Quality and Patient Safety Lead for National Clinical Audit Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation The Aneurin Bevan University Health Board's Annual Clinical Audit Activity Report provides documentation of the Health Board's participation in the National Clinical Audit and Outcomes Review Plan for the financial year, April 2022 to March 2023. 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.
Cefndir / Background Aneurin Bevan University Health Board has four priorities for Clinical Audit: • To ensure scrutiny of national clinical audit performance at directorate and divisional level, overseen by the Clinical Standards and Effectiveness Group (CSEG), to ensure development, monitoring, and completion of improvement plans.

- Divisions to identify clinical audits which provide scrutiny and assurance associated with quality and safety risks identified from Datix, complaints and outcomes of care.
- Trainees are supported to participate in high quality clinical audits that support clinical governance.
- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

The Health Board's strategic focus has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan (NCAORP). This confirms the list of National Clinical Audits and outcome reviews that all Health Boards and Trusts are expected to participate in, where the service is provided. The plan is refreshed annually. The plan also confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of health care services in Wales.

The focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy by engaging with Divisions. With the Audit Management and Tracking system (AMaT) there has been a focus on training staff to utilise the system. There has also been a push to ensure local audit plans are being developed by Directorates. AMaT is being used to build the audit proforma, capture data and produce results with an action plan.

Asesiad / Assessment

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. When 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 guideline defined standards of care. It also improves the quality of care and patient outcomes.

The Annual report provides a detailed report for each of the NCAORPs the Health Board participated in for 2022/23. There are examples of successes and challenges faced by the Clinical Audit team, with reference to the findings from the Internal Audit report in November 2022. Goals for 2023/24 are being set to ensure there is an ongoing workplan for Clinical Audit for the Health Board.

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided by reporting to the Patient Quality and Safety Outcomes Committee, providing scrutiny of National Clinical Audit performance with robust development and monitoring of improvement plans. The Clinical Audit Plan will be monitored by CSEG, to ensure lessons are learnt across the Health Board and that the plan is being delivered effectively. Actions and findings from national and local clinical audits will be monitored by this Group and will be utilised to inform future planning within the Health Board.

Working alongside Risk and Governance will ensure the appropriate governance structures and arrangements are in place for Clinical Audit. The development of a Risk Management Strategy and Board Assurance Framework will address how risks

from Clinical Audit are escalated. This will provide assurance from each applicable divisions / directorate. This is being developed as part of the Quality Strategy and will be finalised in the next six months.

Identification of relevant clinical risks from audits will be discussed at CSEG and Divisions asked to incorporate in the Divisional risk register. Results of all clinical audits undertaken need to be triangulated and inform future planning. The development of this annual audit report by the clinical audit team will allow the learning from clinical audit to be fed back to clinical areas.

Where the Health Board has been identified as an outlier on a national audit, we have produced a standard operating procedure, which will ensure a standardised approach is undertaken in reviewing, investigating and responding to outlier notification in relation to national clinical audits. This will be undertaken by the clinical audit lead and be signed off by CSEG and a summary will be provided for the Executive team. This allows an escalation process for actions raised within audits, as advised by Internal Audit. This process started in January 2023 and will be utilised going forward.

The current report reflects clinical audit reporting and scrutiny over the last 12 months. Next year's annual report with utilise the standardised reporting template available in AMaT. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. AMaT will be used to track and monitor actions raised in local and national clinical audits. An action plan will be produced with measurable improvements within a specified timeframe. Production of SMART action plans and confirmation of their completion will be overseen by divisions reporting to CSEG. Data can be presented using dashboards and easy-to-read graphical presentations. This will facilitate an effortless presentation of results at Clinical Standards and Effectiveness Group (CSEG).

Patient experience, quality, and safety is at the centre of our work to secure improvements in the quality of care and services we deliver and to improve outcomes for the population we serve. Clinical audit is an important component of our effective commitment over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system in the wake of the Covid-19 pandemic.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team in producing an annual clinical audit report for the last financial year.

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):	3.3 Quality Improvement, Research and Innovation 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care Choose an item.
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 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. Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse 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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

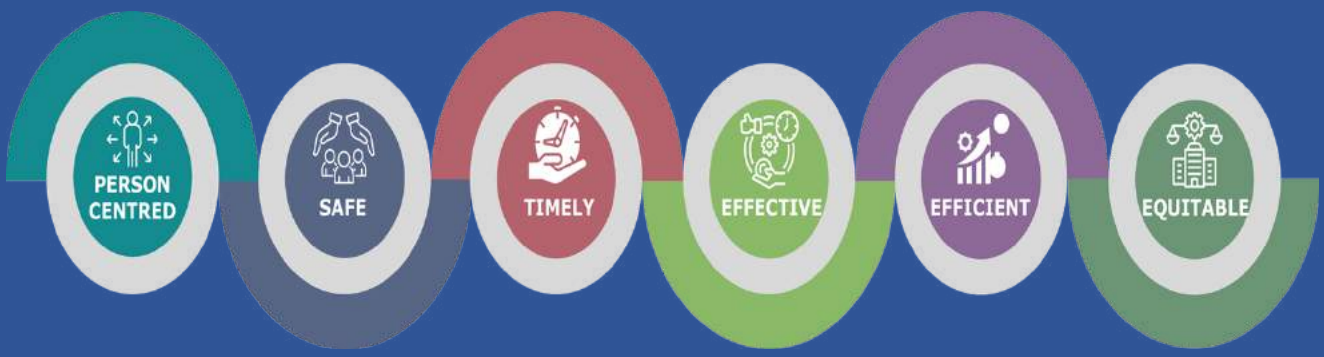
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Quality and Patient Safety

Clinical Standards and Effectiveness Group

Annual Clinical Audit Activity Report 2022/2023



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2023/2024 National clinical Audit Plan

Introduction

Welcome to the Aneurin Bevan University Health Board's Annual Clinical Audit Activity Report. 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. This report will cover the National Clinical Audits (NCA)s the Health Board participated in for the financial year, April 2022 to March 2023.

For the past few years, the pressures of Covid-19 have placed continued demands on all departments within the NHS. There has been competing priorities with delivering patient facing services whilst working throughout the pandemic. The Heath Board also had to overcome additional hurdles when undertaking the Clinical Futures transformational plan on opening the Grange University Hospital. Our recent Internal Audit report highlighted the challenges placed on staff in participating in clinical audits throughout these testing times.

The Health Board's strategic focus on National Clinical Audit has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan. This confirms the list of National Clinical Audits and outcome reviews that all Health Boards and Trusts are expected to participate in, where they provide the service. The plan is refreshed annually. The plan also confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of health care services in Wales.

The focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy by engaging with Divisions. With the addition of the Audit Management and Tracking system (AMaT) in June 2022 there has been a focus on training staff to utilise the system. There has also been a push to ensure local audit plans are being developed by Directorates. AMaT is used to build the audit proforma, capture data and produce results with an action plan.

Aneurin Bevan University Health Board has four priorities:

- To ensure scrutiny of national clinical audit performance at directorate and divisional level, overseen by the Clinical Standards and Effectiveness Group, to ensure development, monitoring, and completion of improvement plans.
- Divisions to identify clinical audits which provide scrutiny and assurance associated with quality and safety risks identified from Datix, complaints and outcomes of care.
- Trainees are supported to participate in high quality clinical audits that support clinical governance.
- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

What is Clinical Audit?

What is clinical audit?

Clinical Audit forms part of the system for improving standards of clinical practice. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

Clinical audit takes place as part of a quality improvement cycle that measures the concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and implemented before being re-audited with the aim of improving reliability and outcomes of care.

Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way. When clinical audit is conducted well it enables the quality of care to be reviewed objectively. Benefits of clinical audit include:

- Promotes awareness of guideline defined standards of care.
- Provides opportunities for education and training.
- Builds relationships between clinicians, clinical teams, managers, and patients.
- Leads to improvements in service delivery and patient outcomes.

Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage.

Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice. Welsh Government supports Welsh NHS Bodies to deliver 'The Duty of Quality'. The duty of quality, is part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and came into force on 1 April 2023.

This provides statutory guidance that aims to help organisations deliver high quality care through better decision making and planning to ensure better outcomes for people using health services. The Duty also encourages Value-Based health care by focusing on patient defined goals for care, to allow the Health Board to better meet patients' needs.

What is the audit cycle?

When a clinical audit reveals the need for improvements to a service it is important that re-audit takes place following implementation of agreed changes. Sometimes it will take several re-audits to improve a service and "close the loop".

Embedding Clinical Audit into NHS Operational Delivery

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. When 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 guideline defined standards of care. It also improves the quality of care and patient outcomes.

Governance Structure

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided by reporting to the Patient Quality and Safety Outcomes Committee, providing scrutiny of National Clinical Audit performance with robust development and monitoring of improvement plans.

Each Division, via the divisional triumvirate and the clinical lead for each NCA are invited to present the audit findings, recommendations and action plans to the bi-monthly Clinical Effectiveness and Standards Group (CSEG). CSEG is to be attended by the quorate, three out of five divisional representatives who will be challenging the report outcomes to ensure compliance.

Each Division should present their clinical audit findings within their Directorate meetings, as part of their Quality and Governance meetings. This allows for an appropriate escalation process for actions raised with audits.

Successes and Challenges

Successes

- **Implementation of the Clinical Audit Strategy underway**

In October 2022, implementation of the Clinical Audit Strategy started. For the past six months, engagement meetings with the Divisions have taken place.

- **Participation in the Annual Programme, detailed in the NHS Wales National Clinical Audit and Outcome Review Plan.**

The Health Board has participated in the National Clinical Audit and Outcome Review Plan (NCAORP), a mandated programme of national audit commissioned by the Health Quality Improvement Partnership (HQIP). National Clinical audits are being completed and results noted in an effective system via CSEG.

- **Use of the Audit Management and Tracking System (AMaT)**

Implementation of AMaT is underway. We are successfully training staff to use the system for registering audits, designing proformas, capturing data and results. This will form part of the Clinical Audit Plan for the Health Board. AMaT has allowed standardisation of documentation for reporting audits. Further utilisation of AMaT will ensure clinical audits provide sufficient assurance to the Board over the management of associated risks.

Challenges

- **Internal Audit Report**

The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance. The publication of Clinical Audit Internal Audit Report in November 2022 issued limited assurance in this area. Each of the recommendations in the report have been reviewed and an action plan has been developed to provide the necessary improvements.

- **Local audit plans**

An appropriate local clinical audit plan is being developed by working with Directorates to register audits via AMaT, using a standardised template. The system will be used to record and track local audits, and conclusions and actions will be monitored by the appropriate forum / committee.

- **Risk registers**

The internal audit report highlighted inappropriate governance structure /arrangements in place for clinical audits. This has been improved by ensuring there is an effective reporting pathway for clinical audit results, this is via escalation of the governance structure from CSEG to PQSOC. This will highlight the need for ensuring adequate risk registers and identification of relevant risks are in place.

- **Resources**

The Health Board is carrying out a data acquisition exercise to ensure it has the correct resource at an operational level to ensure clinical audit is carried out to a high standard and any resulting actions are implemented.

Goals for 2023/24

Over the next 12 months the Patient Safety and Quality Clinical Audit team will work collaboratively Divisions to achieve the following:

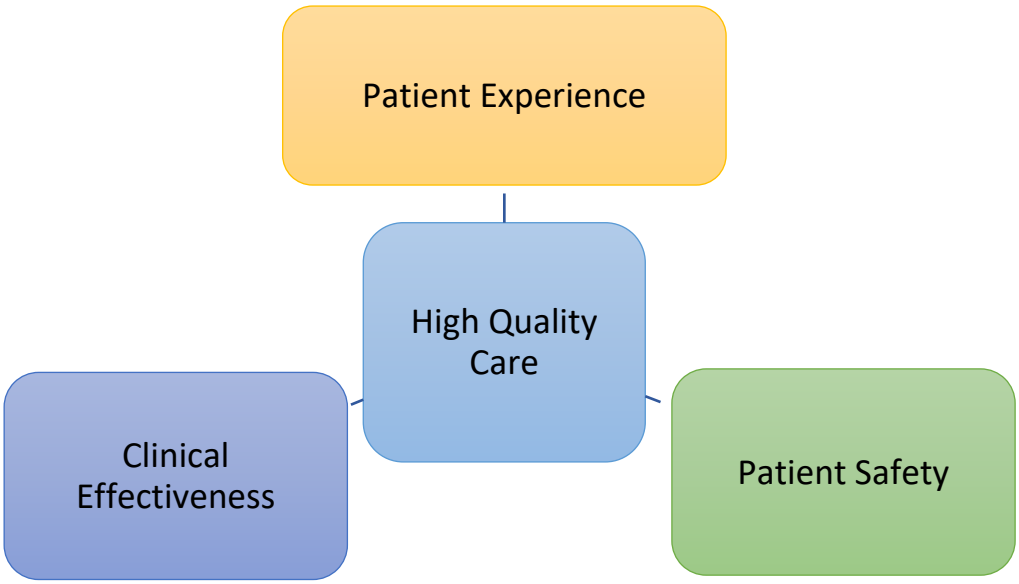
- Fully implement the Clinical Audit Strategy throughout the organisation.
- Implement the Internal Audit recommendations and action plan.
- Continue to ensure mandatory participation in National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) & NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR) and engagement at a local level.
- Develop local audit plan with Divisions.
- Continue to full embed AMaT, working on governance structure and future funding stream.
- In line with the Duty of Quality ensure the Health Boards delivers on its commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality care, patient safety, patient experience and clinical effectiveness.
- Ensure actions and findings from national and local clinical audits are monitored at an appropriate forum and should be utilised to inform future planning within the Health Board.
- As part of Quality Planning, ensure that national clinical audits inform the Health Board's future planning and forms part of the Health Board's and Divisional Integrated Medium-Term Plan (IMTP).
- Triangulate the learning from clinical audits to improve services.
- Complete data acquisition project to review the resources for effective participation in Clinical Audit.

Conclusion

It has been a challenging few years for the Health Board, recognising participation in audit was demanding whilst managing service pressures and focusing on delivering patient facing services. Throughout 2022/23 the Clinical Audit team have endeavoured to promote the importance of Clinical Audit and attempted to make it part of core services and business as usual.

The Divisional Triumvirates have been engaged with the launch of the Clinical Audit Strategy and the use of AMaT. AMaT will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to CSEG and PQSOC. We will ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

Patient experience, quality, and safety is at the centre of our work to secure improvements in the quality of care and services we deliver and to improve outcomes for the population we serve. Clinical audit is an important component of our EFFECTIVE commitments over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system in the wake of the Covid-19 pandemic.



Our EFFECTIVE Commitments 2023-2026	
To deliver care that is effective, reliable, and based upon the best evidence available. To increase the proportion of patients who receive evidence-based care. To reduce variations in the quality of care. To identify and implement evidence-based best practice guidance. Deliver consistently effective and reliable care.	
Aim	**Objective**
Provide effective care.	▪ Deliver consistently effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to Improve outcomes. ▪ To ensure that the care delivered to patients is both effective and based upon the best evidence available. ▪ Support Divisions to drive improvement priorities from learning.
Implement the mandatory National Audit Programme.	▪ Participate in the relevant national audits to provide assurance of effective care delivery. Use the findings from the relevant national audits to support the continued improvement of quality outcomes by sharing learning and good practice across the organisation. ▪ Produce action plans to monitor the actions needed from audits, ensuring the are measurable and achievable.
Building audit capability across the organisation through skills development.	▪ Developing an organisational training offer covering all staff groups. ▪ Build audit capability across the organisation through the implementation of the web-based Audit Management and Tracking System (AMaT). ▪ Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives.
To increase engagement with audit and effectiveness work.	▪ To improve the visibility of Clinical Audit Results by implementing the Clinical Audit Strategy. developing an internal registry ▪ Develop and embed GIRFT processes within the central team, supporting the Divisions to drive improvement priorities from learning.
Implement NICE Guidance and adoption of Health Technology Wales guidance.	▪ Ensure the relevant NICE (National Institute for Health and Care Excellence), and specialist national guidance are regularly assessed and implemented to deliver interventions based upon the best possible evidence. ▪ Utilise best practice evidence and benchmark data to improve outcomes.

APPENDICES

Clinical Audit reports

The following reports have been presented to CSEG during 2022/2023. The following actions have been recorded in AMaT and require the Clinical Lead to complete action achievable dates or identify areas where actions remain outstanding, which can be put forward to the divisional risk register. In the future CSEG will ensure that action plans from divisions are SMART so that completion can be reliably monitored:

Appendix One - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Primary Care (PC) – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report**		
Audit period	April 2020 and July 2021	**Case Ascertainment:**	COPD – 482 Asthma - 91
Local data available:	Yes	**Number of cases:**	331 (One of the largest services)
Audit Rational:	The primary role of NACAP is to support individual clinical teams to make improvements in the quality of care they deliver. The data included in this report reflect a period during which the COVID-19 pandemic stretched respiratory staff and services to their limits, therefore, direct comparisons with previous reports should be interpreted with caution. The findings enable us to reflect and identify opportunities to restore and strengthen the provision of care for people living with asthma and COPD.	**Audit Objectives:**	State of the Nation is a view of the care of people with asthma and COPD in England and Wales. This report is the first to combine data on asthma, COPD and pulmonary rehabilitation across primary and secondary care services to underpin key messages, optimising respiratory care across the pathway. More than 9 million people are living with a diagnosis of asthma or COPD in the UK. The National Asthma and COPD Audit Programme (NACAP) aims to improve the quality of their care, services and clinical outcomes. We do this by supporting and training clinicians, empowering

			people living with asthma and COPD and their carer's and informing policy.
Clinical Lead:	Natalie Janes - Deputy Head of Service-Primary Care, Primary Care and Community Division	**Division/Specialty**	Primary Care and Community Division Respiratory

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:
• For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care • Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• Early and accurate diagnosis can only be achieved by conducting physiological diagnostic testing across hospital specialist and primary and community care services. • Over 90% of patients being diagnosed with Asthma or COPD by primary care clinicians. • 61.8% of hospitals across Wales have access to both Fractional exhaled Nitric Oxide (FeNO) and Spirometry as diagnostic tools for children and young people with asthma, FENO is limited across primary care, with only specialist nursing teams having the device. • The data was recorded when COVID-19 rates were high (April 2020 to July 2021) and infection controls measures were stringent, indicated that 43.9% of adults diagnosed with asthma had a record of any objective diagnostic measurement. 1.9% of adults had a record of receiving a gold standard diagnostic test for COPD of post-bronchodilator spirometry, within the past 2 years in primary care across Wales. • Only 6% of people with COPD and Medical Research Council (MRC) grade 3–5 breathlessness were offered pulmonary rehabilitation in the past 3 years in primary care across Wales. The national issue with regards to the delivery of Spirometry and concerns

regarding pulmonary rehabilitation have been highlighted through the Respiratory Alliance Wales group to Welsh assembly Government and health minister.

- A small scoping exercise was carried out regarding spirometry coding on clinical systems, 2 out of 5 practices were coding incorrectly. The concerns have been discussed since report at an All-Wales Respiratory Health Implementation Group and has been highlighted as one of the top priorities. The goal is to review and develop an interactive all Wales Template for both COPD and Asthma which will link with All Wales prescribing and management guidelines, referral forms and APPS.

- The Spirometry Hubs at ABUHB based in the North and South of the HB, during COVID-19 were a huge success with over 400 patients reviewed over 140 patients had a change in referral diagnosis, 52 patients were reviewed from Secondary Care (SC) waiting lists.

- Hubs provided an opportunity to provide education and training for staff who had become deskilled requiring revalidating or staff new to spirometry due to the withholding of Spirometry for 2 ½ years during the pandemic. Due to changes/shortages in staff and equipment issues 40 out of 71 practices across ABUHB are currently performing spirometry due to staff with skills etc training and education workshops have since been arranged through the primary and community care academy to upskill the workforce.

- Collaborative working with Paediatrics and Neonatal nursing, regarding training education and All Wales Oxygen Service to replicate the gold standard that have been developed for adults continues. The division have also supported two innovative projects working alongside GSK and AstraZeneca (pharmaceutical industry) reviewing patients at high-risk on asthma/COPD registers in collaboration with signed up general practices.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>

- Education and training 3-day programme delivered by the Primary Care Respiratory Nurse Team via the Primary and Community Academy
- Level 1, 2 and 3 Spirometry training delivered by the Primary Care Respiratory Nurse Team via the Primary and Community Academy
- GSK and AstraZeneca (pharmaceutical industry) joint working and donated goods and services projects review of identified high-risk asthma/COPD patients.
- Housebound patient annual reviews Project supported by the Respiratory specialist nursing team in managed practices.
- Spirometry diagnostic Hubs supporting COVID-19 recovery position.
- PCRSN team providing support, education/training, Face to face training/mentorship in GP surgeries.
- Intranet site
- Gold standard O_2 service with clinical and operational SOP
- Prison in-reach

Aneurin Bevan University Health Board Concerns:
• Only 40/71 practices completing spirometry on scoping review. • Spirometry equipment needed in 9 practices. • Inaccurate data recording across general practice, review of templates required. • Staffing demand for in-house training outweighs nurses who can offer support and education. • Health care professionals not trained to manage Paediatric asthma patients' annual reviews or provide spirometry testing if deemed appropriate. • Respiratory Training/funding for ARTP and re accreditation some practices not supporting ongoing costs. • Some practices not following all Wales management and prescribing guidance • Not always providing good inhaler technique • Time for assessment reviews, variable • Promotion of Apps text dump bundles costs. Uptake poor. • Pre-screening for COPD. Smokers. • Asthma/Lung UK expert patient programmes, were previously supported with lottery funding. • Housebound reviews/care home/residential home/Homeless not always on annual review but when there is an acute episode.

SECTION C - to be completed by Clinical Lead pre CSEG

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Clinical leads to investigate all issues around spirometry and support training and education over the next six months. • Investigate concerns with coding and develop templates over the next few months. • Continue ongoing work for respiratory pathway/asthma pathway with team. • Training and education to continue and develop via Academy.

When making your action plan, ensure the objectives are:

SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Two- Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**Eighth Patient Report of the National Emergency Laparotomy Audit Dec 2020-Nov 2021 Royal College of Anaesthetists**		
Audit period	Dec 2020 - Nov 2021	**Case Ascertainment:**	100%
Local data available:	Yes	**Number of cases:**	331 (One of the largest services)
Audit Rational:	This report is the eighth annual report of the National Emergency Laparotomy Audit (NELA). It examines care received by NHS patients in England and Wales undergoing emergency laparotomy (emergency bowel surgery) between 1 December 2020 and 30 November 2021. The COVID-19 pandemic continued to have a significant impact on patients, staff, and hospitals during this period, and maintaining adequate staffing levels was a major challenge for many healthcare organisations. It is right to recognise and applaud the degree to which standards of care were maintained for patients. The dedication of clinical teams in achieving this is commended.	**Audit Objectives:**	Specific concerns remain around delays in pathways of care for many patients between time of arrival in hospital and definitive surgical intervention ('door-to-surgery time'). Both time to administration of first antibiotics, and overall time to arrival in theatre are unacceptably long and detrimental for many patients with suspected intra-abdominal infection. Surgeons, emergency and general physicians, radiologists, anaesthetists, intensivists and geriatricians, together with their respective hospital management teams, are encouraged to work together near address these delays.
Clinical Lead:	Helen Williams - Anaesthetics Babu Muthuswamy - Intensivist Charlotte Thomas – General Surg Sara Long - Geriatrician	**Division/Specialty**	Anaesthetics, Intensivist, General Surgery, CotE

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:	
1.1	Hospitals should continue to engage further with NELA data collection. In particular, make use of real-time data and resources available from NELA to drive clinical and service quality improvement. These include quarterly hospital, regional and national data reports; excellence and exception case-reporting tools; and process measure and mortality monitoring tools available via the NELA website.
1.2	Funded time within consultant job plans should be available to support invaluable work and contributions by members of clinical teams in collecting data, and coordination and service improvement overseen by NELA surgical, anaesthetic, radiology and emergency medicine local clinical leads. This requires trust/health board recognition of the value of this work.
1.3	Trusts and health boards should support NELA data collection and analysis with funded audit and governance assistance.
2.1	Ensure NELA leads for radiology are appointed in each department, with specific job planned time to facilitate coordination of multidisciplinary review meetings and radiology events and learning meetings (REALM). Conclusions should be shared where applicable with providers of outsourced reporting services.
3.1	Multidisciplinary teams in emergency, surgical, perioperative, acute and critical care should work to produce and implement locally agreed optimised pathways of care, with the aim of streamlining diagnosis with as little delay for patients as possible.
4.1	Clinical teams should be supported by management teams to work together to identify where and why existing standards around antibiotic administration are not being met.
4.2	Clinical teams should establish and introduce locally agreed pathways for administration of antibiotics preoperatively for those with suspected intra-abdominal infection or sepsis, following guidance around timeliness from the Academy of Medical Royal Colleges and the Surviving Sepsis Campaign.
4.3	Clinical/nursing teams should ensure that locally agreed pathways support the administration of antibiotics, without delay, at the time of prescribing.

5.1	Surgeons, anaesthetists and intensivists should ensure a formal assessment of mortality risk has been performed around the time of decision to operate, taking into account the significant impact of frailty.
5.2	Clinical teams should not hesitate to refer a high-risk patient for postoperative monitoring in critical care, even if not currently critically ill.
5.3	Trusts/health boards should ensure critical care capacity is able to meet demand. Any critical care capacity shortfall should be reviewed as part of departmental and hospital-level clinical governance.
6.1	A formal assessment of frailty should be performed for all patients aged 65 or over.
6.2	Surgeons, anaesthetists and intensivists should ensure frailty has been taken into account when assessing the mortality risk of their patients as the NELA risk score does not take frailty into account.
6.3	Trusts/health boards should work towards improving capacity for experts in elderly care to review all elderly, frail and vulnerable patients postoperatively. This liaison work on surgical wards should happen on a systematic and consistent basis rather than in an ad hoc manner. In many hospitals this goal is likely to require specific trust/ health board support and funding.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• The in-hospital mortality rate has not been published in the report; however, we can see our numbers for year 8 was 28 deaths and year 9 recorded 32 deaths. All deaths are reviewed with no areas of concern. The deaths are high risk patients with other co-morbidities. • During 2022 set up bi-monthly M&M meetings and the Health Board is fortunate to also have an ED Lead, Dr James where ED have been doing some QI work to improve sepsis screening, also inviting staff from SAU to the M&M meetings to learn from their experiences. • Single site working has improved results, but there is still room for further improvement. • Require better flow plans, with patient transfers for Critical Care Unit (CCU).

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>
• Documented risk factors recorded preoperatively for the Health Board are green at 88.5% year 8 and expected higher at 94.9% for year 9 data.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Preoperative CT with Year 7 data reported by in house consultant 63.2%, Year 8 reduced to 53.8%. Year 9 not expected to show any better. • Access for theatre for the Health Board 61.3%, below the National Average (NA) of 71.8%. • Preoperative input by clinical staff – Cons Surg & Anaes - 74.5%, Surgeon only – 81.2% (expected over 95% for yr 9), Anaes only – 80% (expected over 95% for yr 9) and intensivist 50.9% (expected yr 9 73%). • 55.6% of ABUHB patients had a decision to operate within 24 hours of admission. This is difficult to interpret as some patients are managed medically initially and then develop to requiring surgical intervention. • High risk patients who have a risk of death >5% with consultant surgeon (84.2%), consultant Anaesthetist (88.5%) or both (77.6%) in theatre for year 8 (all set to improve for yr9). • Older patients or those assessed as high risk seen by a geriatrician is 7% for this reporting period, however due to the input of Dr Sara Long, Consultant Geriatrician, this has increased to 64% for year 9 data. • Admissions to critical care for patients with an estimated mortality of >5%, with the NELA target 80% and the Health Board year 8 result is 70% with year 9 increasing to 74%. • Length of Stay (LoS) deteriorated within the Health Board however remains better than the NA.

SECTION C - to be completed by Clinical Lead pre CSEG

ACTION PLANS:
1. Business case being explored for Dr Long's role to continue improving >65 and frail and >80-year Multidisciplinary Team meeting (MDT).
2. ICU lead is to write to the CD for critical care lead and divisional director for scheduled care outlining our concerns.
3. QI work on antibiotic administration in patients with suspected sepsis

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Three- Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Neonatal Audit Programme (NNAP) Summary report on 2021 data**		
Audit period	2021	**Case Ascertainment:**	100%
Local data available:	Yes	**Number of cases:**	
Audit Rational:	It assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes	**Audit Objectives:**	The audit reports key outcomes of neonatal care (mortality, bronchopulmonary dysplasia, late onset bloodstream infection, necrotising enterocolitis and preterm brain injury), measures of optimal perinatal care (birth in the right place, antenatal steroids, antenatal magnesium sulphate, deferred cord clamping and normal temperature on admission), maternal breastmilk feeding (during admission and at discharge), parental partnership, neonatal nurse staffing levels, and other important care processes (screening for retinopathy of prematurity and follow-up at two years of age).
Clinical Lead:	Dr Sunil Reddy – Consultant Neonatologist Dr Susan Papworth – Consultant Neonatologist	**Division/Specialty**	Neonataology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:			
The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care and identifies areas for improvement. The 12 measures reported are:			
1	Antenatal steroids	**7**	Neonatal Nursing staffing
2	Antenatal magnesium sulphate	**8**	On time screening of retinopathy of prematurity (ROP)
3	Deferred cord clamping	**9**	Bronchopulmonary Dysplasia (BPD)
4	Temperature on admission	**10**	Breast milk at 14 days
5	Parental consultation within 24 hours	**11**	Breastfeeding at discharge
6	Parental presence at consultant ward rounds	**12**	Medical Follow up (F-Up) at two years

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:	
1	The Health Board has been effective at ensuring antenatal steroids are administered to women who deliver at 23-33 weeks gestation, with GUH at 95% compared the National Average (NA) of 92.1%.
2	Mothers receiving Magnesium Sulphate within 24 hours of delivery of babies born at less than 30 weeks, the Health Board is behind the NA at 81.1% compared to the NA of 86.9%. The Health Board has improved approx. 18% from the previous year due to good team working with midwifery colleagues and Quality Improvement (QI) measures put in place.
3	Health Board Cord Clamping rates for the Health Board have always been on the low side which is negative.
4	Babies' temperature is important for their successful outcomes and the Health Board has completed QI work to raise the level, which is now and improved 80% compared the NA of 73.2%.
5	Interaction and communication between Health Board staff and the parents is vital. The Health Board has always performed well, currently 95.1% a little behind the NA of 96.3%.
6	Communication as part of the ward round is important the Health Board has improved obtaining 96.1%, more than 10% above the NA of 85.8%. The Health Board is focusing on integrated care with parents such as QI projects called 'delivery room cuddles'.

7	Staffing levels appropriate to guidelines is 59.7% compared to NA 73.9% and there are currently plans to look at this.
8	A colleague Ophthalmologist visits the ward to carry out retinopathy screening of babies born less than 32 weeks which has a target of 4 weeks, and when babies are discharged without screening, they are seen in clinic, which does impact Health Board performance. The NA is 95.4% and GUH 89.2%.
9	The Health Board has always had low Bronchopulmonary Dysplasia (BPD) rates and has been commended for this and asked to present data with advice on how this is maintained. This NNAP report shows the Health Board at approx. 35% which is below the NA of 38%.
10	The Health Board has scope for improvement in terms of babies receiving mothers' milk. Currently at 51.9% compared the NA of 60.6% there are QI projects called 'Golden Drops'.
11	The Health Board and All Wales has always been behind the NA for early breast feeding and breast milk at discharge however the Health Board is moving in the right direction although remain behind the NA of 60.6% at 51.9%.
12	Babies born before 30 weeks who receive a follow up at gestational age of 2 years is 100% within the Health Board and the NA is 72.5%. The Health Board has been recognised as a positive outlier by NNAP for this measure.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>

- Antenatal steroids NA 92.1% - ABUHB - 95%
- Temperature on admission NA 73.2% - ABUHB 80%
- Parental presence at consultant ward round NA 85.8% - ABUHB 96.1%
- Parental consultation within 24 hours of admission NA 96.3% - ABUHB 95.1%
- Bronchopulmonary Dysplasia (BPD) NA 38.8% - ABUHB 34.9% (low result indicates success)
- Follow up at 2 years NA 72.6% - ABUHB 100%7.
- Cystic Periventricular Leukomalacia (cPVL) another brain injury from preterm births which can be linked to Cerebral Palsy, the Health Board is approx. 13% and again in the upper half of units reporting.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Concerns:</u>

- Antenatal Magnesium Sulphate NA 86.9% - ABUHB 91.1%
- Early breast-feeding NA 80.5% - ABUHB 70.3%
- Breast milk feeding at discharge NA 60.6% - ABUHB 51.9%
- On time screening of retinopathy of prematurity NA 95.4% - ABUHB 89.2% (due to discharge before screening, so seen in clinic)
- Neonatal nursing staffing levels NA 73.9% - ABUHB 59.7%
- Cord Clamping rates NA 43% - ABUHB 30.2% (the Health Board has always been on the low side which is negative, and the blood stream infection rates have also been low which is a positive).

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
1. Scope for improvement in breast feeding 2. Scope for improvement in deferred cord clamping 3. Scope for improvement in retinopathy screening 4. Maternity Badgernet- commencing 2023 5. Perinatal optimisation program adoption

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Four - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Paediatric Asthma Secondary Care – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report**		
Audit period	April 2020 and July 2021	**Case Ascertainment:**	
Local data available:	Yes	**Number of cases:**	211
Audit Rational:	The primary role of NACAP is to support individual clinical teams to make improvements in the quality of care they deliver. The data included in this report reflect a period during which the COVID-19 pandemic stretched respiratory staff and services to their limits, therefore, direct comparisons with previous reports should be interpreted with caution. The findings enable us to reflect and identify opportunities to restore and strengthen the provision of care for people living with asthma and COPD.	**Audit Objectives:**	State of the Nation is a view of the care of people with asthma and COPD in England and Wales. This report is the first to combine data on asthma, COPD and pulmonary rehabilitation across primary and secondary care services to underpin key messages, optimising respiratory care across the pathway. More than 9 million people are living with a diagnosis of asthma or COPD in the UK. The National Asthma and COPD Audit Programme (NACAP) aims to improve the quality of their care, services and clinical outcomes. We do this by supporting and training clinicians, empowering people living with asthma and COPD and their carer's and informing policy.
Clinical Lead:	Dr Marcus Pierrepoint - Paediatrician in Child Health	**Division/Specialty**	Respiratory

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:
• For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care • For care to be provided to people with asthma and COPD within the recommended timeframe after hospital admission, to support optimal outcomes. • For people with asthma and COPD to receive care by appropriately trained healthcare professionals, at each stage of their care pathway. • Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
Recommendation 1: The majority of children are not diagnosed in hospital and are diagnosed before they capable of performing objective bedside tests on clinical grounds. Lack of facilities for spirometry in paediatrics outside our special assessment clinics and is not a diagnostic tool within paediatrics. The Team only recently had access to a Fractional exhaled Nitric Oxide (FeNO) machine as part of a multicentre research project, it is used in tertiary respiratory service assessments. **Recommendation 2:** Shared asthma pathway with ED and has been working well for some time. Requirement to prescribe Prednisolone (steroid) within the first hour, core data shows 33% of patients receive within one hour for ages 6-18 years old. One possible explanation is the clock starting on arrival at ED reception. There are delays with triage due to current pressures, education with junior doctors in the ED is being addressed. The smoking status is not asked routinely across Wales, as the expectation of a child admitting to smoking in front of the parents is not likely, this isn't currently part of the education pack, this will also be addressed and included in the education pack. **Recommendation 3:** Children being discharged 24/7 after respiratory attacks, current specialist nursing staff availability is not 24/7. The Health Board has 2.5WTE respiratory/allergy nurses to cover all aspects of respiratory medicine so can only support outpatients and cascade training. 98% of children with acute asthma get appropriately trained, with staff supervising inhaler techniques. Children requiring 3 courses of steroids or who have been through HDU and those that need >step 3 care get referred to respiratory clinics. **Recommendation 4:** Different pressures on the care settings in relation to paediatric respiratory conditions. Dr Pierrepoint has run educations sessions, predominately attended by primary care nursing staff, with only 1 or 2 GP's attending. Acknowledged the need to train more GP's. In terms of transition to adult services, these numbers are low with more

manageable disease and varying profiles of the disease. Transition meetings have been explored however availability is a challenge and meetings have been held to discuss a way forward. Welsh Government transition tools are being used and the Health Board will educate more broadly via the asthma hub. There are available QR codes advertised widely and there is a 'wheezy' pathway for young children who are not define as asthmatic.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:
• High number of children receive training for inhaler techniques.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Time to receive prednisolone within the first hour if attendance within the Emergency Department. • Lack of resource for specialist nursing staff 24/7.

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:

• Promulgate the asthma hub for parents.
• Asthma paediatric specialist meetings to review benchmarks.
• Planning an update of the asthma pathway:
  ○ Push for steroids in the first hour.
  ○ Highlight the smoking documentation.
  ○ Develop/utilize smoking advice for parents.
  ○ Sign off formally on the asthma education each time.
• Meet with the adult service to discuss transition.
• Explore FeNO.
• Look for opportunities to liaise with primary care.
• Ensure all CYPs with asthma get follow up, this is unlikely to be within 1 month.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Five- Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Hip Fracture Database (NHFD) 2021: Improving Understanding Published Sept 2022 – Royal College of Physicians – NICE QS 16 & CG124**		
Audit period	2021	**Case Ascertainment:**	
Local data available:	Yes [redacted]	**Number of cases:**	685
Audit Rational:	The National Hip Fracture Database (NHFD) is an online platform that uses real-time data to drive Quality Improvement (QI) across all 163 hospitals that look after patients with hip fractures in England and Wales.	**Audit Objectives:**	The NHFD supports work in all domains of hip fracture operative care, including audit and QI activities across perioperative care, transfusion practices, analgesic interventions, and assessment of prosthesis use. Rehabilitation and postoperative care again feature strongly in the use of NHFD information to assess care. As an evolving area of focus within the NHFD, it is vital that more investigators ask questions around the impact of care pathways within physiotherapy in patients following surgery.
Clinical Lead:	Dr Allen Wilson Presented on behalf of the team involved.	**Division/Specialty**	Scheduled Care/Orthopaedics/Orthogeriatrics

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action

Recommendations:	
R1	Hip fracture teams should use quarterly governance meetings to review the quality and outcome of the care they provide.
R2	Where performance is significantly below average (red in the caterpillar plots), units should formally discuss possible reasons for this within their regular MDT meeting and plan a QI project to address it.

R3	Quarterly governance meetings should be taken as an opportunity for team members and trainees from all disciplines to make use of the NHFD website as a driver for QI; the new Quarterly Governance Tool is designed to help them do this.
R4	The NHFD recommends that governance meetings of surgical, orthogeriatric, anaesthetic, nursing, therapy and management leads should take place on at least a monthly basis.
R5	Monthly governance meetings should be used to plan appropriate QI interventions, and to monitor the impact of these using the real time data reported in the NHFD run charts.
R6	Hip fracture teams should use their KPI caterpillar plots to identify better-performing neighbouring units, so they can share best practice and network with them in designing QI work.
R7	Hip fracture teams should use KPI 0 as a marker of initial care and a driver to improve the provision of local anaesthetic nerve blocks and fast-tracking of patients to an appropriate ward. Performance should be considered alongside the figures for their unit in the Anaesthesia run chart and Assessment benchmarking table.
R8	To help patients avoid further fragility fractures, hip fracture team governance meetings should review KPI 7 alongside their Bone Medication Table and arrangements for 120-day follow-up.
R9	Hip fracture teams should signpost patients, their families, and carers to the NHFD website resources designed to help them understand their care and recovery following a hip fracture.
R10	Hip fracture teams should use monthly governance meetings to review their policies and protocols, and to compare these with those in other units as described in the Facilities Survey.
R11	Hip fracture teams should minimise inequalities in health care; specifically, by reviewing whether support and information are provided in formats and languages appropriate to their patients.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
ABUHB is performing well in: • KPI 1 – Prompt Orthogeriatric review – 93% ABUHB, 86% NA • KPI 3 – NICE compliant surgery ABUHB 72%, compared to NA 69% • KPI 5 – Not delirious Post-Op – Prompt delirium assessment after operation ABUHB 79%, NA 62% • KPI 6 – Return to original residence, ABUHB 72%, NA 70% • KPI 7 – Bone Medication – given suitable bone strengthening treatment with a 120-day follow-up, 62% ABUHB and NA 34% Comparable in: • KPI 0 – Admission to a specialist ward – 5% ABUHB and 6% nationally, reflective of the pressure on the NHS • KPI 2 – Prompt surgery 57% ABUHB and NA Not performing well: • KPI 4 – Prompt mobilisation isn't where we want it to be 74% compared to NA 80%

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:
• KPI 1 – Prompt Orthogeriatric review – 93% ABUHB, 86% NA • KPI 3 – NICE compliant surgery ABUHB 72%, compared to NA 69% • KPI 5 – Not delirious Post-Op – Prompt delirium assessment after operation ABUHB 79, NA 62% • KPI 6 – Return to original residence, ABUHB 72%, NA 70% • KPI 7 – Bone Medication – given suitable bone strengthening treatment with a 120-day follow-up, 62% ABUHB and NA 34%

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• KPI 4 – Prompt mobilisation isn't where we want it to be 74% compared to NA 80%

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Orthogeriatrician Governance meeting to commence within the next month. • Currently have one ring fenced bed for #NoF within ED. • Review of Policies and Protocols with comparison to other units. • Review the inequalities in healthcare relating to the information literature available to patients.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Six - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Early Inflammatory Arthritis Audit (NEIAA) year 4 2021/2022 Published Oct 2022 – British Society for Rheumatology**		
Audit period	2021-2022	**Case Ascertainment:**	57.4% records completed. 40.7% records incomplete
Local data available:	Yes	**Number of cases:**	159
Audit Rational:	The purpose of the NEIAA is to improve the quality of care for patients with inflammatory arthritis. The audit will assess care provided to people with new diagnosis of early inflammatory arthritis. The audit is also assessing how inflammatory arthritis affects people's day to day function, mobility, sleep, wellbeing and ability to work (where applicable).	**Audit Objectives:**	The aim of NEIAA is to assess the provision of care and the impact of that care on outcomes for people with EIA in England and Wales. NEIAA determines whether the care provided is consistent with current recommended best practice defined by NICE QS 33. It provides information to support multidisciplinary healthcare professionals, NHS managers, chief executives, service commissioners, regulators, policy makers, patients, their carers and families to improve quality of care, service delivery and outcomes.
Clinical Lead:	Dr Non Pugh	**Division/Specialty**	Scheduled Care/Rheumatology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:	
Rheumatology service providers	
1	Collect and submit comprehensive audit data into **NEIAA**, removing barriers to audit participation where applicable (key finding 1)
2	Use NEIAA data to evaluate service performance and identify areas for improvement (all key findings).

3	Set up **EIA** referral pathways with the aim of removing barriers to early referral, effective triage and rapid specialist review (key findings 2 and 3).
4	Establish systems to support rapid and safe initiation and escalation of **cDMARDs** (key finding 4).
5	Provide regular patient education and self-management support in a format suitable for each patient, utilising and signposting to charities (e.g., **NRAS**) (key finding 5).
6	Set up or maintain access to specialist advice within 24 hours for people with EIA (key finding 7).
7	Support patients with submitting **PRO** data, where possible (key finding 8).
8	Develop follow-up care pathways aimed at increasing the proportion of patients achieving remission within three months of diagnosis (key finding 9).

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
See appendix 1 **Key Metrics** • How quickly do primary care and other health professionals refer people suspected to have inflammatory arthritis? • How soon after referral are people seen in specialist secondary care services? • How long does it take to start treatment? • Do patients receive prompt education about their condition? • Are treatment targets set and agreed? • Do patients have access to emergency advice? • Are annual reviews taking place?

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>
QS 1 - Nationally 54% of patients were referred within three working days - ABUHB – 69 % referred within 3 working days.
QS 3 - Nationally 65% of patients with a diagnosis of RA pattern EIA were established on a cDMARD within six weeks of referral. The Welsh rate is approx. 65% - ABUHB is performing well at 83 %

QS 4 - Nationally, 95% of patients with confirmed EIA were offered access to education and information on self-management - ABUHB Baseline: 87% ABUHB 3 months: 100%
QS 6 - Nationally 95% of patients were provided with access to rheumatology specialist advice (e.g., a telephone advice line). Wales is performing well, above the national average - ABUHB – 94%

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
QS 2 - Nationally 42% of patients referred with suspected EIA were seen within three weeks. Wales is below the national - ABUHB is below the national and Welsh average at 22%
QS 5 - Nationally 90% of patients with confirmed EIA had a treatment target set and agreed - Wales along with ABUHB under the NA at 77%.
QS 7 – Delays in 3 and 12 month follow up appointments in ABUHB - 12-month target for ABUHB 25% - 50% reduction on previous years

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Improve clinic booking processes – to be discussed at Directorate/DPSQ meetings and with BSR Regional Audit Champion. • Report booking issues for DATIX entry going forward. • CNS and registrar to be involved in audit follow up.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Seven - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Vascular Registry (NVR) 2022 Annual Report** Published Nov 2022 – Royal College of Surgeons				
Audit period	2019-2021	**Case Ascertainment:**			
Local data available:	Yes	**Number of cases:**		**2021**	**2022**
			NVR Cases	12	25
			No. of EVAR	7	11
Audit Rational:	The 2022 National Vascular Registry Annual Report highlights the important outcome data for vascular procedures performed in the period between 2019 and 2021. For the majority of this period, vascular clinician's practice came under unprecedented pressure from the Covid-19 pandemic. It is of great credit to the vascular community that despite these pressures, case ascertainment rates in the NVR remain extremely high. Furthermore, vascular surgeons and interventional radiologists have embraced the innovative changes introduced to the datasets aimed at gaining a greater understanding of variations in practice and patient outcomes and ultimately aimed at improving patient care.	**Audit Objectives:**			
Clinical Lead:	Mr David McLean	**Division/Specialty**	Vascular – Surgery		

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:
1) Ensure that pathways for patients with aortic aneurysms avoid undue delays for both standard and complex repair. Units should regularly aim to meet the recommended 8-week standard pathway for elective AAA repair
2) Evaluate whether the organisation of vascular services is consistent with the VSGBI 2022 "Provision of Vascular Services" document and the GIRFT 2018 Vascular Services report, with particular attention to: • Improving network pathways for vascular surgery • Providing 24/7 access to hybrid operating theatres • Developing teams with the expertise to deliver in and out of hours care including nursing staff and radiographers • Levels of staffing in vascular surgery and interventional radiology.
3) Ensure that patients with CLTI receive care as recommended in the VSGBI Quality Improvement Frameworks (QIF) for peripheral arterial disease. Vascular units should: • aim for 60% of patients to have a revascularisation procedure within 5 days, in keeping with the 2022-23 CQUIN • have access to (ring-fenced) urgent interventional radiology slots, potentially within a day case unit • provide access to a supervised exercise programme • have sufficient capacity on diabetic foot MDT ward rounds for inpatients and a diabetic foot MDT clinic for outpatients
4) Ensure that patients who have major lower limb amputation receive care as recommended in the VSGBI Quality Improvement Framework (QIF). Vascular units should: a) investigate the causes of long delays to surgery b) review levels of consultant presence in theatre c) ensure access to a specialist amputee rehabilitation team including psychological support and rehabilitation medical or AHP consultant.
5) Commissioning of vascular units to perform complex AAA repair should be conditional on the unit submitting data on all cases to the NVR

6) Ensure timely referral and expedited surgery for patients with symptomatic carotid disease with measures to reduce waiting times to carotid endarterectomy
7) Continue to review the COVID-19 vaccine status of patients requiring vascular procedures and ensure the necessary precautions are offered
8) Improve the completeness of data entered into the NVR by ensuring the provision of administrative support for vascular surgeons and interventional radiologists. NHS trusts should review levels of completeness in relation to: a. Details of implanted medical devices b. 'Hybrid' lower limb revascularisation procedures c. Complex repair of aortic aneurysms and aortic dissection d. Frailty among patients aged 70 years or over undergoing AAA repair.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• Some data issues with regards to Anaesthetic review the report shows 93%, when ALL patients are reviewed by an anaesthetist in MDT meetings. • Revascularisation is an ambitious target set within 5 days, however the Health Board is at approx. 61% in target compared to Cardiff at 31%. • Angioplasties carried out as day cases for the Health Board was lower than the NA of 60% at 44% whereas Cardiff were at 0% due to organisational issues. ABUHB angioplasty suite remains functioning in GUH, therefore are supporting Cardiff with these cases. Case ascertainment was low due to not being mandatory. • Bypass case ascertainment for both the Health Board and Cardiff are good, and both good outcomes with ABUHB patients having a reduced LoS, although the Health Board mortality rate was slightly higher but not a concern and lower re-admission rates. • Amputation time, decision to surgery, often can't be done too quickly as patients need to be prepared for such an outcome, however waiting too long can lead to further medical issues. The Health Board delay was 8 days to amputation and Cardiff significantly higher at 11 days, with a much higher LoS of 21 days compared to the Health Board 11 days LoS. Cardiff issues due to theatre usage. The Health Board 100% patients' amputation within 30 days and Cardiff are at 76%. No issues with outcomes for either site • Data issues with Carotid Endarterectomies (CEA) in Cardiff so no result, however ABUHB Symptom to Surgery rate is 12 days with NA being 13 days • The Health Board v's National shows a slightly lesser rate of referral within 7 days but significantly better rate for patients receiving surgery within 7 days of referral and slightly better than NA in patients receiving surgery with 14 days of symptoms, with a much lower LoS than Cardiff at 1 days compared to 6. See Appendix 1 •

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>
• Overall ABUHB performing well in 2021 compared to Cardiff, so moving services there without additional radiology support. • Mr McLain noted that the radiology services that were provided at GUH were outstanding. Cardiff has lesser theatre capacity, relaying on emergency theatre space, which is causing delays. This will be evidenced in the next report. • Radiology in GUH still providing an excellent service all round for patients being seen in GUH.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Concerns:</u>
• Cardiff has a solely vascular ward with dedicated vascular nurses, which is proving better for the patients, however repatriation causes issues with bad availability in Cardiff, also a bottleneck moving patients to the lakeside wing of Cardiff from the acute vascular ward. • Theatre provision and hyrd-theatre has no progress and junior Dr's ratio is the single highest risk for the network, losing more Dr's in February 2023. • IT co-ordination remains challenging between the 3 HB involved. 6/7 months into the centralisation and it is going well.

References: n/a

Appendix Eight - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Diabetes Audit 2020/2021 Care Processes and Treatment Targets**		
Audit period	2020-2022	**Case Ascertainment:**	
Local data available:	Yes	**Number of cases:**	
Clinical Lead:	Dr Clifford Jones	**Division/Specialty**	Primary Care Diabetes

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:

Key Recommendation 1
Diabetes care providers and local systems should restore routine diabetes review (9 annual care processes) and work to reduce geographic variation. The data dashboard for 2020-21 and the quarterly data releases can be used for benchmarking and tracking progress.

Key Recommendation 2
Diabetes care providers and local systems should work with people who have type 2 and other types of diabetes to help them achieve individualised targets for blood glucose and blood pressure control. For people with type 1 diabetes they should build on the 2020-21 improvement in glucose control as per recommendations in the NDA Type 1 Report and improve achievement of blood pressure control.

Key Recommendation 3
General practices should identify the small number of people with type 2 or other diabetes and severe frailty, who are treated with sulphonlyureas and/or insulin, and have evidence for low average glucose levels (HbA1c ≤ 53 mmol/mol) and consider de-intensification of glucose-lowering treatment.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

Although not included in this audit data, achievement of care process in ABUHB has returned to pre-pandemic levels.
Focus on individualised targets.
Focus on frailty and hypoglycaemia.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:

HbA1c shows steady improvement.
Primary Care (PC) Specialist Nurse service have done a lot of work to improve the care provided and to participate in the Diabetes Enhanced Service.
PC Nurse Specialists providing education programmes for other Healthcare professionals.
Data is gathered direct from the PC Information Portal which means we can get live data.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:

Treatment Targets for ABUHB have mostly seen a reduction, HbA1c, 58mmol/mol has increased slightly for Type I from 2019/20 to 2020/21. The same pattern is demonstrated at a Welsh National level.
All 3 treatment targets saw a downward turn across Wales

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:

- Diabetes service to continue to promote and support Diabetes NES (national Enhanced Services) and improvement of diabetes care.
- Diabetes service to continue education for HCSW's and Diatips (diabetes theory into practice).
- Discuss NDA (National Diabetes Audit) and ongoing achievement of outcomes with NCN leads and generate strategies to reduce variation.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Nine - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Audit for Percutaneous Coronary Intervention (NAPCI) 2022 Summary Report** Published June 2022 by NICOR in partnership with HQIP		
Audit period	2022	**Case Ascertainment:**	
Local data available:	Yes	**Number of cases:**	
Audit Rational:	NICOR is a partnership of clinicians, IT experts, statisticians, academics and managers who, together, are responsible for six cardiovascular clinical audits (the National Cardiac Audit Programme – NCAP) and a number of new health technology registries, including the UK TAVI registry. Hosted by Barts Health NHS Trust, NICOR collects, analyses and interprets vital cardiovascular data into relevant and meaningful information to promote sustainable improvements in patient well-being, safety and outcomes.	**Audit Objectives:**	It covers the financial year 2020/21, during which the COVID-19 pandemic has challenged the capacity of healthcare systems around the world, including substantial disruptions to cardiovascular care across key areas of healthcare delivery. This has included reductions in percutaneous coronary intervention (PCI) activity, both in elective and acute settings. The report focuses on a number of specific quality improvement (QI) metrics in relation to the delivery of PCI services derived from national and/or international standards and guidelines.
Clinical Lead:	Dr Shawmendra Bundhoo	**Division/Specialty**	Scheduled Care/Cardiology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action) ***(Please highlight)***	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:	
1.	It is recommended that operators undertaking Left Main Stem PCI use intravascular imaging to guide interventional strategy and optimise stent expansion and apposition, in line with international consensus statements around best practice. improvements can be made.
2.	Hospitals should seek to modify their pathways and ward structures to reduce unnecessary overnight stays for patients undergoing elective PCI. The explanation for the wide variation seen between hospitals will include differences in the management of wards and day units, pressure on beds from emergency admissions and differences in patient pathways.
3.	Hospitals not meeting the standards for the use of drug-eluting stents during primary PCI should review their cases to see where improvements can be made.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

- The Health Board does not provide a 24/7 Primary PCI service and all patients are referred to University Hospital of Wales (UHW) and self-presenting patients to GUH can be offered a Primary PCI between the hours of 08:30 & 17:00 Mon-Fri and 09:00 & 13:00 on Saturdays. The number of patients admitted to the Health Board has increased since the setup of Cardiology services in GUH. Presented were the figures of ratio of IP v OP over recent years which showed 2019/20 just under 400 and roughly 50/50, with 2020/21 over 400 however with roughly 85% OP activity and an increase of over 700 patients in 2021/22 with approx. 80% OP activity.

- The use of ICI during PCI of the unprotected LMS was affected by the drive for not performing open heart surgery however complex the case, and UHW Surgical Dept. had a large outbreak of C-19 followed by the entire service moving to University Hospital of Llandough (UHL) causing delays for patients requiring revascularisation and increasing the numbers Left Main Angioplasty to be carried out and it is recommended that patients should undergo an intracoronary imaging with the intravascular ultrasound or there's another modality called optical coherence tomography to ensure that the stent is well apposed, however complexities with the dataset (protected/unprotected left main) requirements show the Health Board is unfairly underperforming and dissecting our data shows that we were 89% (26/29 cases) using Intravascular Ultrasound (IVUS) performing about the NICOR and British Cardiac Intervention Society target of 75%. A peer review journal published in August showed the Health Board with very good outcomes compared to the national and the worldwide benchmarks in terms of the outcome and Dr Bundhoo was one of the paper authors.

- Variation of day case elective activity is compromised due the data capture and further analysis proves the Health Board is performing at 89%. When patients are not discharged same day often this is due to a change in processes where the patient used to come back in time for a stent however now these are admitted for stent next day.

- Drug eluting stents have been used in the Health Board since 2015.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>
• PCI activity has increased in the Health Board after Cardiology Services were centralised at GUH. • Elective PCI cases are gradually increasing in the Health Board following the peaks of the Covid pandemic. • Left main PCI cases have good outcomes when compared with national and worldwide benchmarks. • The proportion of IVUS use in left main PCI cases is at 89% which follows the BCIS Guidelines. • Majority of day case PCI patients are discharged the same day GUH 38.89% & RGH 59.38%. • Drug eluting stents are universally used in all stenting cases. • Compliance has improved with the appointment of Cardiology PACS Manager and regular submission of data to NICOR. • The Health Board PCI services comply with national guidelines in delivering a safe and effective PCI service. • Data report is 2020/2021 and the Health Board outcomes have improved since this data capture.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Concerns:</u>
• Data capture remains incomplete leading to inaccurate representation of the Health Board PCI practice.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Ten - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Maternity & Perinatal Audit – Clinical report 2022** Published June 2022 by Royal College of Obstetricians and Gynaecologists.		
Audit period	2018/2019	**Case Ascertainment:**	
Local data available:	Yes [redacted]	**Number of cases:**	
Clinical Lead:	Jayne Beasley	**Division/Specialty**	Family and Therapies/Maternity

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Awaiting plan of action	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:	
1	Improved Availability & quality of information regarding interventions
2	Offer episiotomy for instrumental birth
3	Review case of PN readmissions
4	Data Reviews for completeness, user feedback to support
5	Epidural/spinal GA / analgesia should be separate for data collection
6	National maternity data set with pre-existing conditions
7	Review meaningful data such as skin to skin

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
ABUHB Clinical Summary report: • Majority of women birthed between 37-41+6/40. • 12.3% Instrumental birth, 27.6% Caesarean section (old data and CS rates currently around 33% comparable to other HB's. • 24.6% vaginal birth had episiotomy. • 33.5% women had Induction of Labour.

- 61% who opted for VBAC were successful.
- OASI rates 3.1%.
- Post-natal readmission higher following Caesarean birth.
- 50% SGA babies born after due date.
- Data completeness issues: - anaesthesia/augmentation/BMI/ethnicity/comorbidities.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:
Date is pre GUH so difficult to compare current service.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Lack of data for birth without intervention

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• BRAN - Benefits, Risks, Alternatives, do Nothing used in ABUHB and expanding antenatal education working with early years framework to put in place.
• Moving to digitalised of maternity health records to improve data capture (delayed) to 2023.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Eleven - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Clinical Audit of Psychosis - National report for Wales - Early Intervention in Psychosis Audit**		
Audit period	2021-2022	**Case Ascertainment:**	
Local data available:	Yes [redacted]	**Number of cases:**	
Audit Rational:	To promote quality improvement in patient outcomes, and, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales.	**Audit Objectives:**	Aims to improve the quality of care that NHS MH Trusts in England and HBs in Wales provide to people with psychosis which was 5-year programme until July 2022. The report is a Spotlight on Early Intervention in Psychosis (EIP) teams in Wales – specialised services that aim to provide prompt assessment and evidence-based treatment to people with First Episode Psychosis (FEP) with standards based on EIP Access & Waiting Time Standard guidance which details NICE recommended management and treatment.
Clinical Lead:	Sarah Cadman	**Division/Specialty**	MH&LD/MH

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action

Recommendations:
Standard 1: Timely Standard 2: Cognitive behavioural therapy for psychosis Standard 3: Family intervention Standard 4: Prescribing of clozapine Standard 5: Supported employment and education programmes

Standard 6: Physical health screening Standard 7: Physical health interventions Standard 8: Carer-focused education and support programmes

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• ABUHB are leading the way in this service across Wales. • 100 case notes for under the age of 65 and receiving FEP and open to Children and young people, were looked at by NCAP. • In Wales, 85% had their employment status documented and 8% were in paid employment. 63% were unemployed and seeking work leaving 7% did not want to work or seek education/training to support obtaining employment. Of the people employed and seeking work, 43% were offered employment support and 2% were specifically offered individual placement and support (IPS). • Trends of data discussed at CSEG, over the last 4 years of the 8 standards which mostly showed a gradual increase. ABUHB had higher compliance in 6 out of 8 on the standards compared to Total National Standards (TNS) and 5 out of 8 were higher than the English TNS and highest in Wales in 3 standards. England has had established EIP services far longer than Wales.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:
• Timely Access – seen within 2 weeks of referral – 21% compliance achieved (ABUHB believe this should be 100% as everyone is seen within 2 weeks of referral). • Prescribing of Clozapine – for people who have tried 2 other anti-psychotic drugs with limited success. Clozapine is a drug that requires in-patient admission to commence and requires significant monitoring (blood tests) thus isn't acceptable to all people. • Supported employment and education programmes – 36% (affected by the pandemic) There is now a full time OT in post who is developing vocational opportunities within the team. • Physical health screening – previously scored poorly but have hugely improved at 85%.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Cognitive behavioural therapy for Psychosis (CBTp) - at least one session of a course delivered by a person with the relevant skills, experience and competencies – ABUHB 60% - the NICE Stds are very specific about the required skills and currently only one clinician in Wales meets this. ABUHB are training all EIP staff to deliver CBTp-informed interventions. • Family Intervention (FI) – 57% compliance achieved. This was impacted by the pandemic as FI is usually a face-to-face intervention. • Physical health interventions – reacting to health screening, 48%. • Carer-focused education and support programmes – 35%, this was affected by the pandemic.

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
1. Screen and intervene – better access 2. Think family – better links with families 3. Equitable access – reaching out to communities possibly experiencing FEP 4. Outcome focused – ARMS – At Risk Mental State, working to prevent people slipping into psychosis, ABUHB does not have the capacity currently to work with people with ARMS. There is a national steering group which monitors activity and service development of FEP teams across Wales. ABUHB is a part of this group and standards continue to be monitored via this group too.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Twelve - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**Myocardial Infarction National Audit Project (MINAP) 2020-2021**		
Audit period	2020-2021	**Case Ascertainment:**	It must also be noted that there was no MINAP Coordinator in post and this reflects in the case ascertainment. Previously rates for ABUHB were 100% stringent data and 85% non-stringent data and this report shows 58.2% and 46.7%.
Local data available:	Yes	**Number of cases:**	
Clinical Lead:	Dr Nigel Brown	**Division/Specialty**	Cardiology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:	
1	In the management of STEMI, staff in hospitals where Call-To-Balloon time standards are not being met should work with partner Ambulance Trusts, emergency departments, neighbouring non-interventional hospitals and cardiologists to better understand delays in provision of primary PCI. This may include making improvements to the hospital response to the arrival of a patient but may also focus on ways to improve pre-hospital Call-To-Door times. Since the end of the present annual audit cycle significant pressures on the ability of Ambulance Trusts to hand over care of patients upon arrival at hospital may further adversely affect this metric.
2	In the management of both STEMI and NSTEMI, staff in hospitals with lower rates of provision of an echocardiogram should undertake a review of data collection processes – to ensure that the reported rate accurately reflects practice – and then review the patient pathway to identify opportunities for echocardiography during the index admission. Consideration should be given to performing a limited 'bedside' echocardiogram if there are difficulties obtaining timely detailed 'departmental' studies. Where patients are discharged early to another hospital before an echocardiogram can be performed there must be a clear request to perform the test at the receiving hospital.

3	Those hospitals not reaching recommended levels for admitting patients with heart attack to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those nursed outside cardiac facilities.
4	Those hospitals with low rates of cardiology involvement in the care of patients with heart attack should undertake a review of their data collection processes – to ensure that the submitted data reflects practice. If it does, there should be consideration of improved provision of cardiac care during admissions. This might require increased staffing or more flexible use of members of the cardiology team – for example Nurse Specialists and Physician Associates.
5	Those hospitals with low rates of angiography in eligible NSTEMI patients should perform a review of their systems of data collection and submission, and their systems for managing acute coronary syndromes (ACS).
6	In those hospitals where the 72 hour quality standard for angiography following admission with NSTEMI is not met, commissioning groups, managerial and clinical leaders should engage in a process of system review, economic appraisal and quality improvement. This may require changes within hospitals, across referral networks and/or in the overall commissioning of services. There should be an emphasis on early reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals; this may involve weekend angiography lists for such patients. Anecdotal reports suggest that since the end of the present annual audit cycle the improvements seen here have not been maintained. Any lessons regarding more timely care that have been learned during the pandemic should be incorporated within plans for postCOVID recovery of services.
7	In the management of both STEMI and NSTEMI, staff in hospitals not meeting the standard for prescription of all secondary prevention medication prior to discharge should first explore data completeness and ensure that their data are a valid representation of practice. If suboptimal performance is confirmed quality improvement programmes should be implemented. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or 'ACS nurse specialists'.
8	Staff in those hospitals with lower rates of prescription of aldosterone antagonists should ensure that patients with impaired LV function are identified by echocardiography (or some other reliable assessment method) and that such patients are considered for appropriate treatment. This might require the use of discharge pro-forma or checklists and the direct involvement of specialist cardiac pharmacists, 'ACS nurse specialists' and specialist sonographers.
9	Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI should review the provision of services and identify early patients who might benefit. This could include routine distribution of cardiac rehabilitation information/invitation leaflets to all patients admitted to cardiac facilities, and the inclusion of such information in discharge

	checklists. All hospitals should ensure equitable access to cardiac rehabilitation. Rehabilitation staff who were redeployed to ward-based duties during the pandemic should return to their original practices.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

- There is a caveat to the report as the data was during the pandemic.
- It must also be noted that there was no MINAP Coordinator in post and this reflects in the case ascertainment.
- Previously rates for ABUHB were 100% stringent data and 85% non-stringent data and this report shows 58.2% and 46.7%.
- Recently realised MINAP haven't recorded some of the data and this is trying to be realigned but will take some time.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:

- The data is RGH as pre-transition to GUH. 100% of all NSTEMI patients seen by a Cardiologist and all NSTEMI admitted to a Cardiac Ward/Unit just above 90%.
- Almost 90% of patients underwent an angiogram and just short of 60% within 72 hrs. NA is 66% and legitimate delays such as other medical issues, must be considered.
- Almost 100% of ABUHB patient are discharged all secondary prevention medication. Post cardiac event referred to Cardiac Rehab, the pandemic has given an opportunity to reflect on how the service is delivered. There are offers of virtual or F2F service, which has improved the compliance which is 92% take up from 76%.
- What limited data there is for RGH prior to centralisation on GUH site is reassuring.
- New appointment – Louise Croxford, RN (cardiac) – up to date – not an audit that can be done away from the service.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:

- Significant fall in activity reflected in the data as a result of:
  a. Significant disruption due to COVID-19 in 2020/21 and staff absence
  b. Possible confusion NICOR as mid-year switch in hospitals

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Directorate planning strategies to improve performance for NST-ACS and BC for repatriation of PPCI (element of) to address delays in transfer patients who present to GUH

References: n/a

Report key messages	
Project title: Myocardial Ischaemia National Audit Project (MINAP)	
Report ref. and name: *Management of Heart Attack: analyses from the Myocardial Ischaemia National Audit Project (MINAP) and the National Audit of Percutaneous Coronary Intervention (NAPCI): 2022 Summary Report (2020-21 data)*	
Date of publication: *16th June 2022*	
Key message 1:	Effect of COVID-19: • the first 'lockdown' was associated with a substantial fall in the number of heart attack admissions, which was most marked for non-ST-segment elevation myocardial infarction (NSTEMI) and among older people, leading to a 14.8% reduction in cases over the year; • for ST-segment elevation myocardial infarction (STEMI), during the first lockdown fewer primary PCI procedures were performed, and the timeliness of these procedures *worsened*; • for NSTEMI, during the first lockdown a smaller proportion of eligible patients underwent angiography, and there were fewer PCI procedures performed, but timeliness of angiography and PCI *improved* – a substantially larger percent received angiography within the 72-hour quality standard for angiography following admission; • Length of stay in hospital was shorter than before, by a day
Key message 2:	With respect to STEMI, the proportion who receive immediate reperfusion treatment was at the highest recorded level during the last ten years, and the proportion who undergo an echocardiogram during admission showed a year-on-year increase, now also at the highest recorded level. However, there is a continuing trend towards less timely Primary Percutaneous Coronary Intervention (PPCI), associated with increasing delays both before and after arrival at hospital, and with the lowest ever recorded proportion of patients treated within the standard 'Call-To-Balloon' interval.
Key message 3:	With respect to NSTEMI, there were fewer patients, a slightly higher proportion were admitted to a cardiac unit and cardiologists (and their teams) continued to be involved in caring for the majority. The proportion of eligible patients who underwent a coronary angiogram during their admission fell slightly, but the proportion of these who received an angiogram within the standard 72 hours showed a significant improvement during the peak waves of COVID-19 admissions. This improvement is likely to reflect changes in practice that were peculiar to the COVID-19 pandemic, and so may not be maintained.

Key message 4:	For both STEMI and NSTEMI there is consistently good performance in the prescription of drugs to prevent subsequent heart attacks and improvement in the proportion of patients referred to cardiac rehabilitation.

Appendix Thirteen - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Paediatric Diabetes Audit (NPDA) results 2020/21** Published April 2022 by the Royal College of Paediatrics and Child Health		
Audit period	2020-2021	**Case Ascertainment:**	
Local data available:	Yes	**Number of cases:**	
Audit Rational:	The NPDA is designed to measure and motivate change at local, regional network and national levels across England and Wales. It also has a role in assuring patient safety, as data from the audit are used to inform hospital inspections by the Care Quality Commission (CQC) in England and by the Healthcare Inspectorate Wales in Wales. The audit encourages everyone with an interest in improving the lives of children and young people with diabetes to work together including healthcare managers, commissioners, children, young people, and their families as well as all members of the multi-disciplinary team.	**Audit Objectives:**	This report aims to address a series of questions relating to paediatric diabetes care, which include: • Are numbers of children and young people with Type 1 and Type 2 diabetes receiving care from PDUs increasing? • What proportion of children and young people with diabetes are reported to be receiving key age-specific processes of diabetes care, as recommended by NICE? • How many children and young people achieve outcome measures within specified treatment targets? • Are children and young people with diabetes demonstrating evidence of small vessel disease (microvascular) and/or abnormal risk factors associated with large vessel disease (macrovascular) prior to transition into adult services? • Are there inequalities in care and outcomes between PDUs, regional networks, or between different patient groups?
Clinical Lead:		**Division/Specialty**	

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:	
Trusts and Health Boards should:	
1	Ensure PDUs have appropriate staffing levels in paediatric multi-disciplinary teams (MDT) to provide excellent care to young patients with diabetes in the context of increasing numbers of children and young people with diabetes being diagnosed and managed within PDUs. This must include: • Dedicated admin and IT support for recording good quality data • Provision for all children and young people for whom multiple daily insulin injections are not appropriate to use an insulin pump from diagnosis, and to be trained and able to do so.
2	Ensure that alternative arrangements for delivering and recording routine paediatric care are in place when in person hospital visits are suspended.
3	Support paediatric diabetes services to reset, restore and recover following disruption to services caused by the COVID-19 pandemic, with reference to RCPCH principles for doing so.
4	Ensure that parents and patients have access to appropriate psychological support as required and in line with NICE guidance.
Paediatric diabetes teams and hospital commissioners should:	
5	Ensure that a real time continuous glucose monitor is available to all children and young people with diabetes who wish to use one, supported by an education programme to ensure optimal use.
Paediatric diabetes teams should:	
6	Review their annual NPDA results as a team within a month of receipt, and work together to identify priorities for on-going quality improvement activities.
7	Regularly upload data collected as part of routine diabetes care (monthly) by members of the paediatric diabetes (MDT) into the NPDA data capture system. Data uploaded should be:

	• Checked for completeness and quality. • Used to monitor performance against HbA1c and health check completion targets throughout the audit year. • Used to identify patients at risk of missing key health checks by the end of the audit year, so that they may be followed up at their next clinic appointment.
8	Ensure that they produce consistent messages about glucose and HbA1c targets and have a mechanism to ensure all team members are aware of and are communicating the same targets to their families.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
The 6 Key health checks are: 1. HbA1c 2. Blood Pressure 3. Thyroid function 4. BMI 5. Albuminuria 6. Foot examination The NPDA recommends tracking year-on-year unit level HbA1c results using the median, as this is less affected by extreme high or low values and since local case mix is unlikely to vary significantly between audit years.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:
• The Sick Day Rules is affected by data entry and should be 100% so discussions are required with the team, all children have Ketone monitors, and the smoking status is completed by the nurses and the Influenza Immunisation is on the clinic letters so this should also be 100%. • Carb Counting is a data entry deficit as all children carb count from diagnosis.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:

- Children and Young people with T1D should have at least 4 HbA1c recorded, which below demonstrates that ABUHB are 0.4% compared to Wales 15.3% and UK rate of 14.9%, this is linked with not seeing the patients F2F.
- Thyroid and Celiac Disease blood screening has been worked on by community nurses, however our performance has reduced from the previous year (2019 100% for both measures) and behind the Welsh standard for 2020.
- The data below shows Eye Screening was drastically reduced during 2020 and outside of ABUHB control as managed by the Diabetic Retinopathy Screening Service who halted screening during the pandemic.
- The % of children and young people with Type 1 diabetes with a complete year of care who were offered an additional dietetic appointment, who attended an additional dietetic appointment, and the proportion who were offered and subsequently attended an appointment (take-up rate) ABUHB are lower than Wales and UK.
- 19.1% of Children and young people in GUH were recorded as having a psychological screening assessment, of those 96.1% were recorded as requiring additional support, however this is impacted by the psychologists not being available.

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:

- Reinstate Face to Face clinics over the coming months.
- Offer technologies to all children as per NICE Guideline and this will need HB funding for the Insulin Pump business case that was approved in 2021.
- Look to complete data on a quarterly basis.
- Increase staffing levels, including Psychology, Dietetics and Nursing. Business case needed.

When making your action plan, ensure the objectives are:

SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Fourteen - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Heart Failure Audit (NHFA) 2022 Summary Report (2020/21 Data)** Published June 2022 by NICOR		
Audit period	202/2021	**Case Ascertainment:**	107%
Local data available:	Yes	**Number of cases:**	678 Heart Failure admissions
Audit Rational:	This report summarises selected key findings from the National Heart Failure Audit (NHFA), part of the National Cardiac Audit Programme (NCAP). It deals with a specific and crucial phase in the disease trajectory of patients admitted to hospital with heart failure (HF) in England and Wales. There is a particular focus on a set of quality improvement (QI) metrics, based on standards and guidelines, which aim to drive up standards of care during the acute admission phase to achieve better patient outcomes.	**Audit Objectives:**	
Clinical Lead:	Consultant Nurse, Linda Edmunds	**Division/Specialty**	Scheduled Care/Cardiology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:

1	Hospitals not achieving the recommended standard of the use of in-patient echocardiography for patients with acute heart failure should urgently review their clinical pathways and ensure that echocardiography is performed and ideally within the first 48 hrs of admission.
2	Hospitals should ensure that high-risk cardiac patients have access to a cardiology ward. Heart failure patients are often those in the highest risk groups.
3	Hospitals not achieving the standards for ensuring a patient with acute heart failure is managed on a cardiology ward or seen by a heart failure team should review their pathways of care and consider a quality improvement programme to improve on their current performance.
4	Greater attention is needed to ensure all patients with HFrEF receive the disease-modifying drugs that they should be on unless there is a contraindication. This can be increased by patients being managed on cardiology wards or being seen by a HF specialist team, early during an admission. Those hospitals not meeting the expected standards should perform a clinical pathway review to investigate where improvements can be made.
5	More attention to follow-up arrangements is required so that patients are referred for Cardiology & Specialist Heart Failure Nurse follow-up, ideally leaving hospital with their first appointment. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for heart failure patients.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• Only recently have patients been referred to the inpatient Heart Failure Nurse specialists, previously referral was not made until time of discharge

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>
• Heart Failure admissions nationally have reduced; however, numbers have risen in the Health Board from 662 in 2019/20 to 678 in 2020/21

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Concerns:</u>
• Nationally patients diagnosed with Echocardiography is 85%, with the Health Board at 79% for 2020/2021 compared to 84% for the previous year. • Input by a Consultant Cardiologist for the Health Board is 32% however increases to 53% when expanded to input from any specialist, although significantly underperforming compared to the national rate.

- 34% of patients in 19/20 were Cardiology Inpatients compared to 35% in 2020/2021.
- GUH is performing well at 48.8% compared to the national level of 51% for patient discharged on all 3 disease -modifying drugs, however overall Health Board is underperforming at 36%.
- Referral to Cardiology Follow up has reduced from 41% to 31% for the Health Board which is at 39% nationally.
- Cardiac rehabilitation is 12% nationally, with the Health Board sites lower than this, although NHH was 13.3% for 2020/21, GUH was 3.9% and RGH 5%.

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Commencement an inpatient heart failure nurse service to ensure echocardiography is performed within 48 hours to provide diagnosis to aid accurate treatment – one site initially for roll out once taken onboard any learning. • High risk cardiac patients have access to the cardiology ward – right treatment at the right place. • Pathway of care to ensure patients are seen by the heart failure team with a dedicate Consultant cardiologist lead. • Seeing patient face to face in the ward area ensure that patients are being discharged on the correct medications. • Follow up pathways providing a 2-week appointment at the point of discharge. • Improved access to cardiac rehabilitation.

When making your action plan, ensure the objectives are:

SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Fifteen - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Hip Fracture Database (NHFD) 2020** Published Nov 2021 by The Royal College of Physicians		
Audit period	2020	**Case Ascertainment:**	
Local data available:		**Number of cases:**	GUH 583 NHH 98
Audit Rational:	Since the National Hip Fracture Database (NHFD) was established in 2007 it has pioneered a system of collaborative multidisciplinary care driven by continuous quality improvement (QI) that is the envy of countries around the world. Anaesthesia, surgery, nursing and rehabilitation after hip fracture are so successful that clinical staff continued delivering them, even when conservative approaches were being considered for many other injuries, and in spite of the personal challenges they faced in doing so.	**Audit Objectives:**	A multidisciplinary team (MDT) is a cornerstone of modern medical management. To receive the benefit of the MDT the patient needs to be admitted promptly to the right place; wards have staff with the particular skills best suited to care for those patients they are expecting to admit. In general, the rate of admission to an appropriate ward within 4 hours is poor, the proposed new KPI 'zero' is designed to encourage this to change. This report uses six NHFD key performance indicators (KPIs) to describe how the quality of care varies between hospitals and changes over time. The impact of COVID-19 on patient care and the organisation of trauma services are also described.
Clinical Lead:	Mr John Lloyd & Dr Usman	**Division/Specialty**	Scheduled Care

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)
Recommendations:			
1	Clinical leads should examine their mortality run charts as soon as they are released each quarter.		

2	If mortality run charts show a major difference between crude and casemix-adjusted mortality, clinical leads should examine their casemix run charts to ensure the data they provide are complete and high quality.
3	Clinical leads should examine their position regarding 'prompt orthogeriatric review' on the KPI 1 caterpillar plot for 2020.
4	Sites should examine their position regarding 'prompt surgery' on the KPI 2 caterpillar plot for 2020.
5	Clinical leads should examine their position regarding 'NICE compliant surgery' on the KPI 3 caterpillar plot for 2020.
6	Clinical leads should examine their position regarding 'prompt mobilisation' on the KPI 4 caterpillar plot for 2020.
7	Clinical leads should examine their position regarding 'prompt delirium assessment; on the KPI 5 caterpillar plot for 2020.
8	Clinical leads should examine their position regarding 'return to original residence' on the KPI 6 caterpillar plot for 2020.
9	All sites should consider how they might signpost these NHFD patient and carer resources in posters and in the written information that they should be routinely providing to patients and their families.
10	Clinical leads should study their assessment benchmark table and their anaesthesia run chart to examine these aspects of the care offered in the earliest stages of patients' time in hospital. The orthogeriatric clinical lead should also look at the bone protection table to consider how their approach compares with other units in their local networks. They should also consider the follow-up they offer to support patients' persistence with medication, and any potential for links with local Fracture Liaison Services to improve the secondary prevention care and information their patients receive.
11	Hospitals should ensure that patients admitted with non-hip femoral fractures receive the same prompt multidisciplinary care afforded to those with hip fracture, to allow them to benefit from the well-evidenced improved outcomes this brings.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
The current KPI's at GUH favourable to NHFD: • Prompt Orthogeriatric review – 90% (NHFD 88%) • Prompt surgery – 66% (NHFD 65%) • NICE compliant surgery – 74% (NHFD 70%) • Prompt mobilisation – 77% (NHFD 80%)

- Not delirious post-op – 77% (NHFD 62%)
- Return to original residence – 75% (NHFD 70%)

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:

- Benchmarked data against comparable hospitals in the region and the Health Board is preforming favourably against these. With the largest volume of patients compared to other Welsh Health Board's.
- Numbers dropped during the pandemic and have subsequently returned to pre-covid rates.
- 3 of the 4 metrics in bottom quartile have action plans.
- Hours to surgery have improved and in Feb 2022 the Health Board was performing better than the NA.
- Operations and anaesthetic always carried out by an appropriate trained staff, and this is shown in the low return to theatre numbers.
- 30-day mortality – The Health Board was 1 std dev outside however now it is 6% with along with the National Average.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:

- Day of surgery has varied numbers of lists across the week and lose lists to accommodate other lists, such as Paeds and there are issues with laminar air flow theatres required for implants and only available in two theatres in GUH
- Acute LOS is around 5/6 days with step down at day 2 if medically stable, but overall, LOS impacted by social reasons

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:

- Admission to Orthopaedic Ward within 4 hours: QI Project being led by Dr Muhamad Usman to explore ringfencing of a #NOF bed on Ward A0 to prioritise patients through A&E and bed allocation process – significant time spent in the ambulance prior to arriving on A0 ward at GUH – other procedures can be allocated the ringfenced bed.
- Physiotherapist assessment by the day after surgery & Mobilised out of bed the day after surgery: Audit ongoing between Physiotherapy and Anaesthetics to investigate how current Anaesthetic practice can affect this metric and provide recommendations to improve. Reports to be provided at the May #NOF meeting – not always a seven-day service at all sites, a business plan has been submitted, and this will help reduce LOS.
- Looked at longer operating lists and work more out of hours, however there remains staffing issues even though there is a lot of goodwill at present – infrastructure does not allow for this.

References: n/a

Appendix Sixteen - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

SECTION A

Title of Audit & Governing body:	**National Neonatal Audit Programme Annual Report on 2020 data** Published March 2022 by the Royal College of Paediatrics and Child Health		
Audit period	2022	**Case Ascertainment:**	
Local data available:		**Number of cases:**	RGH 98 NHH 12 GUH 2
Audit Rational:	National Neonatal Audit Programme (NNAP) is a national clinical audit of care for babies admitted to neonatal services. Approximately 1 in 7 babies will require neonatal care because they are born too early, have too low a birth weight or have a medical condition that needs specialist treatment. The audit reports on key measures of the processes and outcomes of neonatal care and supports professionals, families and commissioners to improve the care provided to babies requiring specialist treatment.	**Audit Objectives:**	NNAP aims 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.
Clinical Lead:		**Division/Specialty**	

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action

Recommendations:

1	Neonatal units and networks with high rates of adverse outcomes (bronchopulmonary dysplasia, necrotising enterocolitis and late onset infection) should: • Identify potentially better practices from neonatal units with lower rates of adverse outcomes. • Implement identified best practice, including any identified from the NICE guideline [NG124] Specialist neonatal respiratory care for babies born preterm. •
2	Neonatal networks and their constituent neonatal units should, following a review of local mortality results, the national neonatal Getting It Right First Time (GIRFT) report and the Neonatal Critical Care Review, take action to: • Consider whether changes to network structure, clinical flows, guidelines or staffing might be helpful in reducing local mortality rates. • Consider a quality improvement approach to the delivery of evidence-based strategies in the following areas to reduce mortality: timely antenatal steroids, deferred cord clamping, avoidance of hypothermia and management of respiratory disease. Such quality improvement activity should pay due regard to relevant guidance and resources, such as the NICE guideline for specialist respiratory care and the BAPM and NNAP quality improvement toolkits. • Ensure that shared learning from locally delivered, externally supported, multidisciplinary reviews of deaths (including data from the local use of the Perinatal Mortality Review Tool) informs network governance and unit level clinical practice.
3	Perinatal teams, neonatal units and Local Maternity and Neonatal Systems (in England) should: • Identify babies who did not receive delivery in the optimal location, antenatal steroids, antenatal magnesium, deferred cord clamping and/or did not achieve post-delivery normothermia, and review records to identify opportunities for improvement. • Adopt evidence-based practices, using the following guidance and methodologies to support improvement: – Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). – BAPM and NNAP quality improvement toolkits, including; Antenatal Optimisation Toolkit, Normothermia Toolkit, and Optimal Cord Management Toolkit. – Prevention of Cerebral Palsy in PreTerm Labour (PReCePT) quality improvement programme. – Preterm Wellbeing Package, Maternity and Children's QI Collaborative, Scottish Patient Safety Programme. – Perinatal Excellence to Reduce Injury in Premature Birth (PERIprem) quality improvement programme.
4	Neonatal units and networks with low rates of breastmilk feeding at 14 days and/or at discharge should introduce focused quality improvement initiatives in these areas, making use of the following tools and resources: • BAPM and NNAP Maternal Breast Milk Toolkit • UNICEF Neonatal Baby Friendly Initiative • Bliss Baby Charter

5	Neonatal units should look for learning from other units and from adaptations made in response to the COVID-19 pandemic to improve opportunities for parental partnership in care and decision making. This may include: • Using video conference for parental consultation on admission or for attendance on the ward round if it is not possible for parents to attend in person. • Working with local parent groups, parents, staff and other stakeholders to create a culture which actively promotes parent partnership in care, and to manage barriers to change such as concerns about confidentiality and barriers to parents attending the unit. • Ensuring that the service is following the latest guidance on parent and family access to the unit and involvement in care and not inappropriately restricting parents' access to their babies.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

The Health Board Neonatal team enters all babies admitted to the neonatal unit(s) to BadgerNet the neonatal database. It also captures data on Peri-natal outcomes. Captured are measures relating to birth, treatment, parent interaction, nurse staffing and 2 year follow ups.
There is a New measure relating to the deferred clamping of the umbilical cord, which is an incomplete dataset for 2020.

- Temperature of babies <32 weeks within 1 hour, the Health Board has struggled previously to meet NA of normothermia of 36.5-37.5 degrees with low numbers of babies delivered below 32 weeks at NHH and caution required interpreting the result of 28.6%, although RGH 67.3% compared to NA of 70.6%.
- With NEC (necrotising enterocolitis) below NA and doing well.
- Nurse staffing levels for the Health Board are comparable to the NA.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:

- Antenatal Steroids NHH (91.7%) and RGH (95.9%) performed well in 2020, National Ave (NA) 90.9%, however caution required with the limited data for GUH for 2020 and improvement shown for 2021.
- Interaction with parents and neonatal team, NHH (86.9%) slightly below NA and RGH (96.9%) above NA of 95.5%
- Adjusted proportion of BPD/Death in very preterm babies, doing well compared to networks.
- ROP 100% across the Health Board, credited to the good work done by ophthalmology colleagues.
- F-Up at 2 years based on BadgerNet entries, the Health Board doing very well.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Magnesium Sulphate, NNAP informed the Health Board of being an alarm level outlier and which has been investigated, both sites lower than the NA of 84.6%, NHH 66.7% & RGH 63.2%. • Breast milk at discharge and breast milk going home, sadly this remains an issue from previous years, caution required with results for GUH. • Breast milk at discharge and breast milk going home, remains an issue from previous years, caution required with results for GUH. • Separation days not performed well previously, various factors such as lack of transitional care impacting this.

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
Introduction of several QI projects • Magnesium Sulphate reinforcement and focus on data entry bringing results from outlier status at 69.2% to 91.1% • Temperature <32 weeks – commenced a programme of work called 'Mind the Gap' taking the results from 67.3% to 80.3% in 2021. • Breast feeding team working on a programme called 'Golden Drops', dedicated breastfeeding team, midwifery team involvement. • Cord clamping commenced a programme called 'Life Start' previously at 12% and for 2021 increased to 20.9% and 2022 showing approx. 60%. • Midwifery and Obstetric perinatal team working awareness and implementation. • Breast milk at D/C has improved from 46.2% to 52% • Separation days remains outside our control.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References:

1. Ref.-300-NNAP-report-Report-on-2020-data-FINAL.pdf (hqip.org.uk)
2. NNAP Online (rcpch.ac.uk)

Appendix Seventeen - National Clinical Audit Activity

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2023/03/09	PICANet - Paediatric Intensive Care Audit	PICANet: State of the Nation Report 2022	https://www.hqip.org.uk/resource/picanet-mar-2023/#.ZAoBEnbP1PY	The Health Board is not included in this report; however, our Paediatrics do have an invested interest the key metrics when relevant to HB services. Due to present July 2023 CSEG
2023/03/09	NPDA - National Paediatric Diabetes Audit	NPDA: Report on Care and outcomes 2021/22	https://www.hqip.org.uk/resource/npda-mar-2023/#.ZAruxHbP1PY	Clinical lead for Paediatric Diabetes has presented to CSEG in 2022 data from the 2020/2021 report and is invited to present the 2021/2022 to the July 2023 CSEG.
2023/03/09	CVDPREVENT-Cardiovascular Disease Prevention Audit	CVDPREVENT: Third Annual Audit Report	https://www.hqip.org.uk/resource/third-annual-report-cvdprevent/#.ZAoBAnbP1PY	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2023/03/09	Mental Health Clinical Outcome Review Programme	NCISH: Annual Report: UK patient and general population data 2010-2020	https://www.hqip.org.uk/resource/ncish-mar-2023/#.ZAoBDXbP1PY	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2023/03/09	NACAP - National Asthma and COPD Audit Programme	NACAP: Clinical outcomes Summary report	https://www.hqip.org.uk/resource/nacap-mar-2023/#.ZAoBBnbP1PY	QPS team liaising with Secondary Care Asthma and COPD leads to attend CSEG in July 2023.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2023/02/09	NELA - National Emergency Laparotomy Audit	NELA: Eighth Patient Report of the National Emergency Laparotomy Audit	https://www.hqip.org.uk/resource/eighth-patient-report-emergency-laparotomy-nela/#.Y-S6cXbP1PY	Presented at CSEG March 2023 – update in QPSOC Clinical Audit Report April 2023. Results above.
2023/01/12	NACAP - National Asthma and COPD Audit Programme	NACAP: Drawing breath - The state of the nation's asthma and COPD care and recommendations for improvement	https://www.hqip.org.uk/resource/drawing-breath-jan23/#.Y7_neHbP1PY	Primary Care and Children's Asthma presented at CSEG March 2023 – update in QPSOC Clinical Audit Report April 2023. Results above.
2023/01/12	NPCA - National Prostate Cancer Audit	NPCA Annual Report 2022 Prostate Cancer services during the COVID-19 Pandemic (published January 2023)	https://www.hqip.org.uk/resource/npca-annual-report-2022/#.Y8AUB3bP1PY	Clinical Lead for this service presented to CSEG in May 2023 and actions plans currently being developed.
2023/01/12	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA: An audit of the care received by people with oesophagogastric cancer in England and Wales	https://www.hqip.org.uk/resource/oesophago-gastric-cancer-2022/#.Y8APwHbP1PY	QPS team arranging with clinical Lead to present to the CSEG July 2023.
2023/01/12	NBoCA - National Bowel Cancer Audit	NBoCA: Annual Report 2022	https://www.hqip.org.uk/resource/nboca-annual-report-2022/#.Y8AZ1XbP1PY	Clinical Lead for this service presented to CSEG in May 2023 and actions plans currently being developed.
2022/12/08	Medical and Surgical Clinical Outcome Review Programme	Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure	https://www.hqip.org.uk/resource/ncepod-disordered-activity-2022/#.Y5G0IHbP1PY	QPS Team working with Divisional Triumvirates to ensure NCEPOD studies receive full participation.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/12/08	NVR - National Vascular Registry	National Vascular Registry: Short Report - Use of implantable medical devices in aortic aneurysm repair	https://www.hqip.org.uk/resource/nvr-short-report-dec22/#.Y5G0CnbP1PY	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023. Results above.
2022/11/10	SSNAP - Sentinel Stroke National Audit Programme	The Road to Recovery: The Ninth SSNAP Annual Report	https://www.hqip.org.uk/resource/sentinel-stroke-audit-programme-annual-report-2022/	Report discussed at Stroke MDT
2022/11/10	NVR - National Vascular Registry	National Vascular Registry 2022 Annual Report	https://www.hqip.org.uk/resource/national-vascular-registry-2022-annual-report/#.Y2z-v3bP1PY	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023. Results above.
2022/11/10	FFFAP - Falls and Fragility Fracture Audit Programme	National Audit of Inpatient Falls (NAIF) Annual report 2022: Working together to improve inpatient falls prevention	https://www.hqip.org.uk/resource/national-audit-of-inpatient-falls-annual-report-2022/#.Y2z-knbP1PY	Report discussed at Falls panel
2022/11/10	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme : Saving Lives, Improving Mothers' Care Report 2022	https://www.hqip.org.uk/resource/maternal-newborn-and-infant-clinical-outcome-review-programme-saving-lives-improving-mothers-care-report-2022/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/11/10	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme (NNAP): Summary report on 2021 data	https://www.hqip.org.uk/resource/national-neonatal-audit-programme-summary-report-on-2021-data/	Presented at CSEG March 2023 – update in QPSOC Clinical Audit Report April 2023. Results above.
2022/10/13	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit - Year 4 Annual Report	https://www.hqip.org.uk/resource/national-early-inflammatory-arthritis-audit-year-4-annual-report/	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023. Results above.
2022/10/13	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance Report	https://www.hqip.org.uk/resource/mbrrace-uk-perinatal-mortality-surveillance-report-2020/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/09/30	PMRT - Perinatal Mortality Review Tool	PMRT - Learning from Standardised Reviews When Babies Die	https://www.hqip.org.uk/resource/perinatal-mortality-review-tool-annual-report/#.YzahI3bMJPY	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/09/08	FFFAP - Falls and Fragility Fracture Audit Programme	Improving understanding: The National Hip Fracture Database report on 2021	https://www.hqip.org.uk/resource/the-national-hip-fracture-database-report-on-2021-improving-understanding/	Presented at Falls Panel
2022/09/08	NPCA - National Prostate Cancer Audit	NPCA Short Report 2022: Patient and Tumour Characteristics Associated with Metastatic Prostate	https://www.hqip.org.uk/resource/national-prostate-cancer-audit-short-report-patient-and-tumour-characteristics-associated-with-metastatic-prostate-cancer-diagnoses-in-england/	England only – no local data

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
		Cancer at Diagnosis in England		
2022/08/11	NAD - National Audit of Dementia	National Audit of Dementia - Memory Assessment Services Spotlight Audit 2021	https://www.hqip.org.uk/resource/national-audit-of-dementia-memory-assessment-services-spotlight-audit-2021/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/08/11	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA short report - Postoperative nutritional management among patients with oesophago-gastric cancer in England	https://www.hqip.org.uk/resource/national-oesophago-gastric-cancer-audit-short-report-2022-postoperative-nutritional-management-among-patients-with-oesophago-gastric-cancer-in-england/	England only – no local data
2022/07/14	NDA - National Diabetes Audit	National Diabetes Audit, 2020-21 Report 1: Care Processes and Treatment Targets	https://www.hqip.org.uk/resource/national-diabetes-audit-2020-21-report-care-processes-and-treatment-targets/	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023. Results above.
2022/07/14	NDA - National Diabetes Audit	Non-Diabetic Hyperglycaemia, 2020-21 Diabetes Prevention Programme	https://www.hqip.org.uk/resource/national-diabetes-audit-diabetes-prevention-programme-non-diabetic-hyperglycaemia-report-2020-21/#.Ys_lY3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/07/14	NDA - National Diabetes Audit	National Diabetes Inpatient Safety Audit-England and Wales	https://www.hqip.org.uk/resource/national-diabetes-inpatient-safety-audit-an-annual-survey-of-girft-recommended-staffing-systems-and-pathways/#.YtAzkHbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/07/14	NACEL - National Audit of Care at the End of Life	National Audit of Care at the End of Life - Third round of the audit (2021/22) report, England and Wales	https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-third-round-of-the-audit-2021-22-report/#.Ys_lQHbMKUk	Presented at EoLB
2022/07/14	NACEL - National Audit of Care at the End of Life	Mental Health Spotlight Audit Summary Report, England and Wales (2021/22)	https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-mental-health-spotlight-audit-summary-report-2021-22/#.Ys_WVXbMKUk	Presented at EoLB
2022/07/14	Ep12 - National Audit of Seizures and Epilepsies	National Clinical Audit of Seizures and Epilepsies for Children and Young People	https://www.hqip.org.uk/resource/national-clinical-audit-of-seizures-and-epilepsies-for-children-and-young-people-epilepsy12-report-england-and-wales-2019-21/#.Ys_WO3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/07/14	NACAP - National Asthma and COPD Audit Programme	Pulmonary rehabilitation 2021 organisational audit - Summary report	https://www.hqip.org.uk/resource/pulmonary-rehabilitation-2021-organisational-audit-summary-report/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/07/14	NACAP - National Asthma and COPD Audit Programme	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Wales primary care clinical audit 2021	https://www.hqip.org.uk/resource/national-asthma-and-chronic-obstructive-pulmonary-disease-audit-programme-wales-primary-care-clinical-audit-2021/#.YtAjz3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/07/14	NCAP - National Clinical Audit of Psychosis	Early Intervention in Psychosis Audit - National report for England 2022	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-early-intervention-in-psychosis-audit-report-england/#.Ys_lkHbMKUk	England only
2022/07/14	NCAP - National Clinical Audit of Psychosis	National report for Wales - Early Intervention in Psychosis Audit	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-early-intervention-in-psychosis-audit-report-wales/#.Ys_lfHbMKUk	The Clinical Lead presented local data to CSEG in November 2022, an update was given in QPSOC Clinical Audit Report for the February 2023. Results above.
2022/07/14	NCMD - National Child Mortality Database	National Child Mortality Database: The Contribution of Newborn Health to Child Mortality across England	https://www.hqip.org.uk/resource/national-child-mortality-database-the-contribution-of-newborn-health-to-child-mortality-across-england/#.Ys_WJ3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	NMPA - National Maternity and Perinatal Audit	National Maternity and Perinatal Audit Annual Clinical Audit Report	https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-clinical-report-2022/#.YrCOjXbMKUk	The Clinical Lead presented local data to CSEG in November 2022, an update was given in QPSOC Clinical Audit Report for the February 2023. Results above.
2022/06/16	NACAP - National Asthma and COPD Audit Programme	Adult Asthma and COPD Organisational Audit Report	https://www.hqip.org.uk/resource/adult-asthma-and-copd-2021-organisational-audit-summary-report/#.YrCDmHbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/06/16	NACAP - National Asthma and COPD Audit Programme	Children and Young People Asthma Report	https://www.hqip.org.uk/resource/child-and-young-person-asthma-2021-organisational-audit-summary-report/#.YrCJVnbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	CVDPREVENT-Cardiovascular Disease Prevention Audit	Cardiovascular Disease Prevention Audit 2022 Annual Report	https://www.hqip.org.uk/resource/cvdprevent-second-annual-report/#.YrCOr3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	NICOR - National Cardiac Audit Programme	National Cardiac Audit Programme Annual Report	https://www.hqip.org.uk/resource/national-cardiac-audit-programme-2022-report-the-heart-in-lockdown/#.YrCO1HbMKUk	PCI & MINAP – Nov 2023 CSEG and update Feb 2023 QPSOC. Results above. Heart Failure – Sept 2022 CSEG. Results above. Cardiac Rhythm – not presented
2022/06/16	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme Acute Organisational Audit	https://www.hqip.org.uk/resource/sentinel-stroke-national-audit-programme-acute-organisational-audit-2021/#.YrCO-nbMKUk	Stroke Board
2022/06/16	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme Stroke Mimics Report	https://www.hqip.org.uk/resource/sentinel-stroke-national-audit-programme-mimic-audit-2021-short-report/#.YrCPGHbMKUk	

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/06/16	NDA - National Diabetes Audit	National Diabetes Audit Transition Audit Report	https://www.hqip.org.uk/resource/national-diabetes-audit-2017-21-adolescent-and-young-adult-type-1-diabetes/#.YrB2w3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	NDA - National Diabetes Audit	National Diabetes Audit (Type 1 Diabetes) Audit Report	https://www.hqip.org.uk/resource/national-diabetes-audit-2020-21-type-1-diabetes/#.YrB31XbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/05/12	Medical and Surgical Clinical Outcome Review Programme	A Picture of Health Bridging the gap between physical and mental healthcare in adult mental health inpatient settings	https://www.hqip.org.uk/resource/national-confidential-enquiry-into-patient-outcome-and-death-a-picture-of-health/#.YnzWpNrMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/05/12	NABCOP - National Audit of Breast Cancer in Older Patients	National Audit of Breast Cancer in Older Patients 2022 Annual Report	https://www.hqip.org.uk/resource/national-audit-of-breast-cancer-in-older-patients-2022-annual-report/#.YnzNwdrMKUk	Clinical lead presented the 2021 Annual Report in February 2022 and is invited to present the 2022 report to the CSEG in May 2023.
2022/05/11	NDA - National Diabetes Audit	National Diabetes Foot Care Audit Interval Review: July 2014 - March 2021	https://www.hqip.org.uk/resource/national-diabetes-foot-care-audit-interval-review/#.YnzN5trMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/04/14	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit Annual report 2020-21: Care processes and outcomes	https://www.hqip.org.uk/resource/national-paediatric-diabetes-audit-annual-report-2020-21/#.Ylfc0ejMKUk	The Clinical lead presented the 2020/2021 Annual Report to the Sept 2022 CSEG 2020/2021.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/04/14	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Safety in Mental Health	https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report/#.YlflwujMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/04/14	Child Health & Medical and Surgical Clinical Outcome Review Programmes	How data captured by NCEPOD supports the identification of Healthcare Inequalities: A review - 2022	https://www.hqip.org.uk/resource/national-confidential-enquiry-into-patient-outcome-and-death-review-of-health-inequalities-short-report/#.YlgQ1ujMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 June 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Plan 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. 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 are.

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 guideline defined standards of care. It also improves the quality of care and patient outcomes.

The Health Board has Four Priorities:

- That there is scrutiny of national clinical audit performance at directorate and divisional level (overseen by the Clinical Effectiveness Committee) with robust development, monitoring, and completion of Improvement plans.
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risks identified from datix, complaints and outcomes of care.
- Trainees are supported to participate in high quality clinical audits that support clinical governance.

- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

Cefndir / Background

Clinical audit is one tool in a wider quality improvement strategy aimed at providing assurance with respect to delivery of best practice care. National Clinical Audits are mandatory audits set out by Welsh Government which all health boards must participate in. Aneurin Bevan University Health Board complies with the requirements of Welsh Government by participating in all mandatory national clinical audits.

As suggested by the Healthcare Quality Improvement Partnership (HQIP), Aneurin Bevan University Health Board clinical audit team will update the following organisational documents, ensuring they are linked and read together to ensure the effective management of clinical audit:

- **Clinical Audit Policy** – the current Policy is being updated to reflect the use and conduct of clinical audit: the document sets out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice, and improving the quality of services to meet the needs of patients, healthcare commissioners, healthcare regulators, and others.
- **Clinical Audit Strategy 2022-25** – The Clinical Audit Strategy sets out the principles of when clinical audit should be used. How an audit is identified as required and planned and how this links with the Quality Management System under development in ABUHB. It describes how the Health Board will implement the strategy, and increase the impact of audit on improvement in clinical services.
- **The clinical audit plan** has been developed for the next 24 months: this will provide a prioritised summary of planned clinical audit activity and outcomes, that is regularly updated and scrutinised in accordance with the above clinical audit policy and strategy.
- **A clinical audit report template** has been developed using the web-based Audit Management system (AMaT): this will provide consistency in clinical audit reporting and will allow completion of audit actions to be visible to the corporate and divisional team.

Our clinical audit plan will reflect national and local drivers for quality improvement. It will aim to balance key drivers with directorate/division/service/ clinician priorities. Using AMaT will ensure there is a system for prioritisation of clinical audit and enable monitoring to ensure clinical audits selected for the programme are completed.

Asesiad / Assessment

Development of 2023/24 Plan

In developing the Aneurin Bevan University Health Board audit plan the Clinical audit team has ensured the following has been considered:

- Ensuring that directorates participate in all national clinical audits, national confidential enquiries and service reviews relevant to the services that it provides.
- Participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

- National audits, which are not on NCAPOP, but which are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls).
- Clinical audits identified or required for Board Assurance Framework.
- NICE guidance and HTW adoption. Audit is not mandatory but implementation and audit of NICE guidance can be subject to external review.
- Projects requiring re-audit after changes in practice.
- Ensuring that all clinical audit activity within directorates is registered.
- Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).
- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads are being asked to confirm their list of audits and identify any other projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits that are required from clinical incidents, complaints or risks.

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by the Welsh Government (WG) annually. This plan is one of the foundation cornerstones in the drive to improve the quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of the healthcare provided to patients and to assess year on year improvements. The plan also details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided.

The Health Board's clinical audit plan will be updated electronically and provide a list of all the clinical audit projects planned or undertaken. The nine-month publication schedule for the NCAPORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) will be shared with Directorates. This will be updated on a rolling month basis to ensure the nine months are captured within the plan. This will align with presentation of results at Clinical Standards and Effective Group (CSEG) and dates for Operational Groups and Outcome Committees. The Clinical Audit intranet page will host the publication list.

We are have engaged with Divisions to facilitate implementation of the Clinical Audit Strategy by presenting at meetings throughout January and February 2023. The Clinical Audit Plan will be shared after approval. The Clinical Leads and Divisional Triumvirate will be contacted ahead of the proposed date the reports

will be issued. A link to the HQIP site will be available on the clinical audit intranet page. The clinical audit team will produce an annual audit report.

Clinical Audit for Assurance

Clinical audit is a quality improvement tool aimed at providing assurance on delivery of best practice. In its review of clinical audit, the Healthcare Quality Improvement Partnership (HQIP) suggested that clinical audit should be integral to Board assurance of quality and improvement. To be able to provide this assurance the Clinical Audit Plan should meet external commitments and expectations and internal priorities. The Plan should be able to provide confirmation that clinical practice compares favourably with evidence of good practice but, where this is not the case, that changes are made to improve the delivery of care.

Improved communication and encouragement of audit

Audit results presented at CSEG will enable feeding back on the benchmarked performance of individual providers within clinical audits and reviews to organisations as appropriate for reflection and action. From April 2023 audit reports will be standardised using AMaT to ensure successes and challenges are documented and a detailed, CSEG agreed, action plan is visible on AMaT.

The regular publication of a National Clinical Audit and Outcome Review e-bulletin highlighting developments and findings from recent reports will be made available to clinicians via CSEG. The ambition of the clinical audit team is to raise the profile of clinical audit with boards, patient groups, clinicians and all staff working within the health board. AMaT is enabling closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.

The introduction of the web-based system AMaT (Audit Management and Tracking) will make auditing easier, faster, and more effective. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe. Using AMaT, Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data using a dashboard and easy-to-read graphical presentations. This will improve engagement with clinical directors, QPS audit team and CSEG.

ABUHB is in the process of training staff to use AMaT. The Clinical Audit Strategy states that all NCA's will be registered on AMaT with relevant documentation uploaded and allocated an audit lead. The Clinical Lead is the audit lead for the specialty of the NCA. Defined objectives are identified and are time specific for the audit period. Local audits are being registered in the Clinical Audit area on AMaT.

AMaT will facilitate effective clinical audit and provide an oversight of audit data. This will improve accountability for clinical audits, visibility of action plans and allow tracking of actions, providing assurance to the Committee and Executive Board.

The National Clinical Audit and Outcome Review Plan is a mandated programme of national audit commissioned by the Health Quality Improvement Partnership. It is published by Welsh Government annually and confirms the list of NCAs that require mandatory participation by the Health Board. It specifies how findings from audits should be used to measure and drive forward improvements in healthcare in Wales. This will form part of the new Clinical Audit Plan. Our ambition is to ensure clear

lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.
Argymhelliad / Recommendation Note the assurance provided by the clinical audit team to develop a clinical audit programme for the next 12-24 months. Work is underway to implement the clinical audit strategy, update the Health Board policy on clinical audit, produce a clinical audit programme and produce an annual Health Board audit report. AMaT is being implemented. Engagement with Divisions on clinical audit is planned.

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. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
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 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 Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse 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	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.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Clinical Standards and Effectiveness Group

Quality and Patient Safety

Clinical Audit Plan 2023/2024

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Appendices:

Introduction

The Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. 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.

Clinical audit when conducted in accordance with best practice standards, provides assurance of compliance with clinical standards, identifies and minimises risk, waste, and variation in clinical practice from guideline defined standards of care. It also improves the quality of care and patient outcomes.

Aneurin Bevan University Health Board has four priorities:

- To ensure scrutiny of national clinical audit performance at directorate and divisional level, overseen by the Clinical Standards and Effectiveness Group, to ensure development, monitoring, and completion of improvement plans.
- Divisions to identify clinical audits which provide scrutiny and assurance associated with quality and safety risks identified from Datix, complaints and outcomes of care.
- Trainees are supported to participate in high quality clinical audits that support clinical governance.
- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

This Clinical Audit Plan should be read in conjunction with other Health Board Policies, namely:

- 'Clinical Audit Policy' – describes the use and conduct of clinical audit: the document sets out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice and improving the quality of services to meet the needs of patients, healthcare commissioners and healthcare regulators.

Clinical Audit Policy Issue 1.1.pdf

- 'Clinical Audit Strategy 2022-25' sets out the principles for when clinical audit should be used. How an audit is identified and planned and how this links with the Quality Management System under development in Aneurin Bevan University Health Board. It describes how the Health Board will implement the strategy, and increase the impact of audit on improvement in clinical services.

Clinical Audit Strategy 2022 - 2025.pdf

Together these documents demonstrate how clinical audit will be developed, delivered and outcomes put into practice through service improvement.

Clinical Audit

What is clinical audit?

Clinical Audit forms part of the system for improving standards of clinical practice.

Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

Clinical audit takes place as part of a quality improvement cycle that measures the concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and implemented before being re-audited with the aim of improving reliability and outcomes of care.

Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way. When clinical audit is conducted well it enables the quality of care to be reviewed objectively.

Benefits of clinical audit include:

- Promotes awareness of guideline defined standards of care.
- Provides opportunities for education and training.
- Builds relationships between clinicians, clinical teams, managers, and patients.
- Leads to improvements in service delivery and patient outcomes.

Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage.

Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice. Welsh Government supports Welsh NHS Bodies to deliver 'The Duty of Quality'. The duty of

quality, is part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and came into force on 1 April 2023.

This provides statutory guidance that aims to help organisations deliver high quality care through better decision making and planning to ensure better outcomes for people using health services. The Duty also encourages Value-Based health care by focusing on patient defined goals for care, to allow the Health Board to better meet patients' needs.

What is the audit cycle?

The diagram below sets out the steps involved in a complete audit cycle. When a clinical audit reveals the need for improvements to a service it is important that re-audit takes place following implementation of agreed changes. Sometimes it will take several re-audits to improve a service and "close the loop".

Figure One: The audit cycle

Principles of the clinical audit plan

In developing the Aneurin Bevan University Health Board audit plan the following principles have been considered:

Ensuring that directorates participate in all National Clinical Audits (NCAs), National Confidential Enquiries (NCEPOD) and service reviews relevant to the services that it provides.

National audits, which are not on NCAPOP, but which are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls).

Clinical audits identified or required for Board Assurance Framework.

NICE guidance and HTW adoption. Audit is not mandatory, but implementation and audit of NICE guidance can be subject to external review.

Projects requiring re-audit after changes in practice.

Ensuring that all clinical audit activity within directorates is registered.

Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.

Ensure healthcare professionals are enabled to participate in clinical audit to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.

Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

Clinical Audit Plan

This clinical audit plan will be added to and refined over a two year cycle. It provides a prioritised list of planned clinical audit activity. This will be regularly updated and scrutinised in accordance with the principles above and in line with emerging insights obtained from review of complaints, concerns, SUI investigations and evolving clinical guidance.

In its review of clinical audit, the Healthcare Quality and Improvement Partnership (HQIP) suggests that clinical audit should be integral to Board assurance of quality and improvement. To be able to provide this assurance a clinical audit plan should developed which provides confirmation that clinical practice compares favourably with external standards of good practice and where this is not the case, that changes are made to improve the delivery of care.

Aneurin Bevan University Health Board's clinical audit plan reflects national and local drivers for quality improvement. It aims to balance the requirement to undertake national audit with directorate/ division/ service/ clinician priorities. The audit plan will ensure that necessary resources, governance and organisational structures are in place to support engagement in audits, reviews and national registries included in the annual plan.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads have been asked to confirm their list of local audits. They have also been asked to identify any other projects relating to clinical priorities where audit work will support the improvement of patient care.

Audit Management and Tracking System (AMaT)

Audit completion will be tracked using a specialised audit management system (AMaT). Key benefits include facilitation of audit management, management of re-audits, and visibility of noncompliance and logging of areas of focus for future improvement projects. This will allow tracking of results and an action plan to be produced within a specified timeframe.

Creation and delivery of actions arising from audit are an opportunity to improve safety and patient experience. Use of AMaT will ensure there is a system for prioritisation of clinical audit and will enable monitoring and tracking of actions. AMaT will facilitate effective clinical audit reporting of audit data. As part of CSEG, Audit Leads will provide Audit reports, using a standardised template, which will 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.

National Clinical Audits

Participation is mandatory in all National Clinical Audits (NCAs) (Appendix One). The list of NCAs is updated on a rolling nine-month programme and will be updated on the Quality and Patient Safety Clinical Audit Intranet Page monthly.

All (NCA's) reports will be discussed at Directorate and / or Divisional level. Results are presented to the Clinical Standards and Effectiveness Group (CSEG) held bi-monthly who oversee and agree audit action plans and monitoring of their completion.

Following the conclusion of data collection for an audit and subsequent publication of results a reporting template will be completed with collaboration between the Quality and Patient Safety (QPS) Clinical Audit Team and the Clinical Lead for the audit (Appendix Two). This will involve recording the results and actions directly onto AMaT and utilising the pre-populated proforma on the system and enable visualisation of the report.

The standardised clinical audit report template in AMaT is being tested to provide consistency in the reporting of clinical audit and will allow completion of audit actions to be visible to the corporate and divisional team. See Appendix Two.

Local Audits

Local audits will be registered with the QPS Clinical Audit Team by using the 'Local Audit Registration Form' (Appendix Three). They will be approved in advance of registration by the specialty Audit Lead and Audit Facilitator, Lead Participant and Audit Mentor if Applicable.

The Divisional Management Triumvirate will be informed of Directorate audits being undertaken. The QPS Clinical Audit Team will ensure that all processes are carried out and completed.

Local audits must be registered via AMaT using the Local Audit Registration and sent to the QPS Clinical Audit Team via the email that is supplied on the form. This will allow organisational oversight of the results of all audit activity.

The current list of local audits that have been registered in AMaT can be seen in Appendix Four. This will be updated as AMaT training continues throughout the Health Board and whilst Divisions are switching to registering audits electronically.

The National Clinical Audit and Outcome Review Plan (NCAORP)

The annual National Clinical Audit and Outcome Review Plan (NCAORP) sets out the list of National Clinical Audits and Outcome Reviews which all health boards are expected to participate in each year.

The agreed NHS Wales programme of audits includes audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) managed by the Healthcare Quality Improvement Programme (HQIP).

The Health Board's clinical audit plan provides a list of all the clinical audit projects planned or undertaken.

This will be updated monthly to ensure the rolling nine-month NCAORP is reflected in the plan. Appendix One lists NCAs and CORP for 2023. The scheduling function on AMaT will align reporting with CSEG meetings and include dates for Operational Groups and Outcome Committees. This will be evaluated after six months.

NCAORP is published by the Welsh Government (WG) annually. This plan is one of the cornerstones in the drive to improve the quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements. The plan also details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The objectives of NCEPOD are to assist in maintaining and improving standards of healthcare by undertaking confidential reviews of patient care and publishing national recommendations.

NCEPOD invites individuals/organisations to propose future studies and once agreed these studies are implemented nationally. See Appendix Five for Proforma that needs to be completed by the QPS Clinical Audit Team and the Division Triumvirate.

Appendix One – National Clinical Audit and Outcome Review Plan

This is published on a rolling nine-month programme and will be updated monthly on the Quality and Patient Safety Clinical Audit Intranet Page.

National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) and NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). Publication notification date 12th April 2023 –All the NCA's will be management in AMaT using the Clinical Area.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
373	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme (Data only) Oct-Dec 2022	NCA	Kings College London	Wed 12/04/2023	N/A
377	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation Report	NCA	Royal College of Surgeons	Wed 12/04/2023	25/5/23
387	NDA - National Diabetes Audit	National Diabetes Audit (Data only) Q3 data - Core & Diabetes Prevention Programme, DPP (Non-Diabetic Hyperglycaemia, NDH)	NCA	NHS Digital	Wed 12/04/2023	Invite to July CSEG
400	NVR - National Vascular Registry	National Vascular Registry Short Report: Impact of the Covid-19 pandemic on the provision of vascular surgery in the UK	NCA	Royal College of Surgeons	Thu 11/05/2023	Annual report presented Jan 2023

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
		National Health Service - March 2023 update				
246	NDA - National Diabetes Audit	National Diabetes Audit Core: Report 2 Complications and Mortality	NCA	NHS Digital	Thu 08/06/2023	Invited to July CSEG
396	GI-NBoCA - Gastro-Intestinal Cancer Audit Programme - National Bowel Cancer Audit	National Bowel Cancer Audit Short Report: Capturing transfer of bowel cancer patients from theatre to critical care in linked national clinical datasets	NCA	Royal College of Surgeons	Thu 08/06/2023	Will be invited to Sept 2023 CSEG.
401	GI-NOGCA - Gastro-Intestinal Cancer Audit Programme - National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit Short Report -"Socioeconomic differences in the impact of OG cancer on life expectancy"	NCA	Royal College of Surgeons	Thu 08/06/2023	Yet to present annual report - Will be invited to Sept 2023 CSEG.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
417	Child Health Clinical Outcome Review Programme	Transition from paediatric to adult services (cohort 1 October 2019 and 31 March 2021)	CORP	National Confidential Enquiry into Patient Outcome and Death	Thu 08/06/2023	N/A as did not complete the study.
262	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit Admissions report	NCA	Royal College of Paediatrics and Child Health	Thu 13/07/2023	Will be invited to Sept 2023 CSEG.
385	NDA - National Diabetes Audit	National Diabetes Audit Core State of the Nation report (Y1) - Care Processes and Treatment Targets 2021-2022	NCA	Royal College of Obstetricians and Gynaecologists	Thu 13/07/2023	Will be invited to Sept 2023 CSEG.
380	NACEL - National Care at the End-of-Life Audit	National Care at the End-of-Life Audit Annual Report	NCA	Royal College of Surgeons	Thu 13/07/2023	Discussed at EOLB.
404	NCMD - National Child Mortality Database	National Child Mortality Database Thematic report - trauma	N/A	University of Bristol	Thu 13/07/2023	For Division
416	Medical and Surgical Clinical Outcome	Medical and Surgical Clinical Outcome Review Programme Crohn's disease	CORP	National Confidential Enquiry into	Thu 13/07/2023	For Division

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
	Review Programme			Patient Outcome and Death		
420	Ep12 - National Audit of Seizures and Epilepsies	Epilepsy12 state of the nation report (cohort 2020-22)	NCA	Royal College of Paediatrics and Child Health	Thu 13/07/2023	Not participating
388	NDA - National Diabetes Audit	National Diabetes Audit Type 1 State of the Nation report (Y1) 2021-2022	NCA	NHS Digital	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.
389	NDA - National Diabetes Audit	National Diabetes Audit Young Type 2 State of the Nation report (Y1)	NCA	NHS Digital	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.
403	NAD - National Dementia Audit	National Dementia Audit National Report 2023	NCA	Royal College of Psychiatrists	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.
418	NPCA - National Prostate Cancer Audit	National Prostate Cancer Audit Short Report - Utilisation of the Rapid Cancer Registry Data in the NPCA and how to report this data (topic TBC)	NCA	Royal College of Surgeons	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
412	FFFAP - Falls & Fragility Fracture Audit	National Hip Fracture Database (NHFD) State of the Nation 2023 report	NCA	Royal College of Physicians	Thu 14/09/2023	Will be invited to Nov 2023 CSEG.
407	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit (NEIAA) State of Nation Annual Report	NCA	British Society for Rheumatology	Thu 12/10/2023	Will be invited to Nov 2023 CSEG.
409	NDA - National Diabetes Audit	National Pregnancy in Diabetes (NPID) State of the Nation report	NCA	NHS Digital	Thu 12/10/2023	Will be invited to Nov 2023 CSEG.
421	MNI - Maternal, Newborn and Infant CORP	Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal surveillance (cohort 2020-22)	CORP	University of Oxford	Thu 12/10/2023	For Division
398	NVR - National Vascular Registry	National Vascular Registry 2023 Annual Report	NCA	Royal College of Surgeons	Thu 09/11/2023	Will be invited to Jan 2024 CSEG.
408	SSNAP - Sentinel Stroke	Sentinel Stroke National Audit Programme (SSNAP) State of the Nation Annual Report 2023	NCA	Kings College London	Thu 09/11/2023	N/A
415	FFFAP - Falls & Fragility Fracture Audit	National Audit of Inpatient Falls (NAIF) 2023 Annual Report	NCA	Royal College of Physicians	Thu 09/11/2023	N/A

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
423	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme maternal mortality surveillance (cohort 2020-22)	CORP	University of Oxford	Thu 09/11/2023	For Division
424	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme maternal mortality confidential enquiry (cohort TBC)	CORP	University of Oxford	Thu 09/11/2023	For Division
405	NCMD - National Child Mortality Database	National Child Mortality Database Thematic report - infection	N/A	University of Bristol	Thu 14/12/2023	For Division
422	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme MNI Perinatal confidential enquiry (cohort TBC)	CORP	University of Oxford	Thu 14/12/2023	For Division

Further audits added as of 11/05/2023

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
426	PICANet - Paediatric Intensive Care Audit	Paediatric Intensive Care Audit State of the Nation Report (Jan-Dec 2022)	NCA	University of Leeds	Thu 14/12/2023	Will be invited to Jan 2024 CSEG.
427	NDA - National Diabetes Audit	National Diabetes Audit Core underlying data, 01/01/2022-31/03/2023, Eng & Wal	NCA	NHS Digital	Thu 14/12/2023	Will be invited to Jan 2024 CSEG.
406	NOA - National Obesity Audit	National Obesity Audit Preliminary Report (cohort TBC)	NCA	NHS Digital	Thu 11/01/2024	N/A
419	FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLSDB) 2024 State of the nation report (cohort TBC)	NCA	Royal College of Physicians	Thu 11/01/2024	Will be invited to Mar 2024 CSEG.
410	NCISH - Mental Health CORP	Mental Health Clinical Outcome Review Programme Alcohol and Drug report (cohort TBC)	CORP	University of Manchester	Thu 08/02/2024	Will be invited to Mar 2024 CSEG.
411	NCISH - Mental Health CORP	Mental Health Clinical Outcome Review Programme Annual Report 2024 (cohort TBC)	CORP	University of Manchester	Thu 08/02/2024	Will be invited to Mar 2024 CSEG.

CLINICAL STANDARDS & EFFECTIVENESS GROUP (CSEG)

Appendix Two – Standardised Audit Reporting Template

ALL National Clinical Audit (NCA) results will be added to AMaT and presented at CSEG. Completion of an action plan is essential.
When making your action plan, ensure objectives are SMART: Specific, Measurable, Assignable, Realistic, Time-related.

Standardised template below, data added to AMaT and will be printed as a report

Project Details	
Title	Date registered:
Speciality:	Date at CSEG:
Division:	
Lead Participant:	Audit Lead:
Rationale:	Guidance:
Objectives:	

Project progress

- **Results**
- **Conclusions**
- **Assurance & risk**
- **Key successes & concerns**
- **Action plan**
- **Re-audit**

Appendix Three – Local Audit Registration Template

LOCAL AUDIT REGISTRATION

All audits to be entered onto AMaT (Audit Management and Tracking)

To be completed by ALL Divisions

Title of audit	
Date of application:	
Is this a re-audit?	Yes/No
Which area will be used for this audit?	**Clinical Area**
	Ward Area
Specialty Audit Lead: (Required in both Clinical and Ward Areas)	
Name:	
Designation:	
E-mail:	

Specialty Audit Facilitator: (Required in both Clinical and Ward Areas)	
Name:	
Designation:	
E-mail:	

Lead Participant: (Required in both Clinical and Ward Areas)	
Name:	
Designation:	
E-mail:	

Audit Mentor: (Clinical Area Only)	
Name:	
Designation:	
E-mail:	

Division:	
Specialty(s):	
Division approval granted	Yes/No
Approving name:	
Approving designation:	
Will the audit subject cross over into another division?	Yes/No
If yes, which other Division?	
Is the above Division signed up to the audit?	Yes/No
Rationale for the audit:	

Please identify which of the following best fits your application: (Yes/No)	
Project in relation to Health Board Objectives/risk/incident/NICE	Yes/No
If above is Yes, please detail:	
Divisional priority	Yes/No
Individual (specialty) Priority	Yes/No
Individual (CPD) Priority	Yes/No
Other:	
Project Planning	
Will a proforma be required in AMaT to collect the data?	Yes/No
If no, which professional body will be collecting the data?	
Is support from the QPS Team required:	Yes/No
If Yes, please e-mail: abb.clinicalaudit@wales.nhs.uk	
PLEASE ENSURE A SIGNED COMPLETED COPY OF THIS FORM IS E-MAILED TO THE ABOVE CLINCIAL AUDIT ADDRESS	

Appendix Four – Local Audit Plan

Currently there are 38 local audits registered in the AMaT Ward Registration Area for 2023/2024. Once the audits have been undertaken, they are available in a results table (see below), by audit frequency with the overall audit score. In the insight dashboard each question within the audit can be looked at the view the question score.

Results (table)

Label	Division	Business Unit	Speciality	Ward	Project	Audit	Submissions	Result
ABUHB - PVC Bundles Compliance Audit Tool - 01 Jan 2023 to 31 Jan 2023	Medicine	General Medicine	Care of the Elderly (COTE) (archived), Medicine	3/2 Usk Ward - NHH, Acute Medical Ward - RGH	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	11	36.4%
ABUHB - PVC Bundles Compliance Audit Tool - 01 Feb 2023 to 28 Feb 2023	Family and Therapies, Medicine, Primary Care and Community, Scheduled Care	Family and Therapies, General Medicine, General Surgery, Primary Care	Care of the Elderly (COTE) (archived), ENT, Family & Therapies, Gastroenterology, Medicine, Primary Care, Respiratory Medicine, Stroke/Rehabilitation (USC)	3/3 Duffryn Ward - NHH, 3/4 Tretower Ward - NHH, 4/2 Crickhowell Ward - NHH, 4/4 Llanellen Ward - NHH, A/3 Ward - GUH, A/4 Ward - GUH, C/0 Ward - GUH, C/4 Ward - GUH, Medical Assessment Unit - GUH, Sirhowy Ward - YAB, Tyleri Ward - YAB	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	41	72.0%
ABUHB - PVC Bundles Compliance Audit Tool - 01 Mar 2023 to 31 Mar 2023	Medicine, Scheduled Care	General Medicine, General Surgery	General Surgery, Medicine	C6 East Ward - RGH, D3 East Ward - RGH, D3 West Ward - RGH	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	12	83.3%
ABUHB - PVC Bundles Compliance Audit Tool - 01 Apr 2023 to 30 Apr 2023	Medicine, Primary Care and Community	General Medicine, Primary Care	Cardiology, Medicine, Primary Care	A/1 Ward - GUH, A/2 Ward - GUH, C6 West Ward - RGH, D4 East Ward - RGH, Ruperra Ward - SW	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	22	70.5%

The tables below identify the number of wards within a specialty that the audit has been registered to. For example, PVC Bundles audit is registered on 6 Acute Care wards. The audit has been registered to 138 wards across ABUHB.

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Primary Care	Radiology	Rheumatology	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Annual	**24**	**48**	**10**	**4**	**20**	**170**	**85**	**4**	**37**	**2**	**4**	**7**	**12**	**4**	**36**	**24**	**13**	**8**	**4**	**8**	**10**	**16**	**550**
ABUHB - PVC Bundles Compliance Audit Tool	6	12	3	1	6	42	21	1	10		1	1	3	1	9	6	3	2	1	2	3	4	**138**
All Wales Adult Mouth Care Assessment Audit	6	12	2	1	4	39	21	1	9		1	1	3	1	9	6	3	2	1	2	2	4	**130**
Health & Safety Inspection: Respiratory Protective Equipment (RPE)	6	12	3	1	6	43	21	1	9	2	1	3	3	1	9	6	4	2	1	2	2	4	**142**
Provision of Snacks and Beverages						6	1					1									1		**9**
Treatment Escalation Plan	6	12	2	1	4	39	21	1	9		1	1	3	1	9	6	3	2	1	2	2	4	**130**
Weekly Stroke Thrombolysis Audit						1																	**1**
Grand Total	24	48	10	4	20	170	85	4	37	2	4	7	12	4	36	24	13	8	4	8	10	16	**550**

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Primary Care	Radiology	Rheumatology	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Quarterly	**6**	**12**	**3**	**1**	**6**	**51**	**33**	**1**	**12**	**1**	**26**	**9**	**2**	**9**	**6**	**4**	**2**	**7**	**2**	**3**	**18**	**214**
ABUHB - IPAC - Theatre Audit - Section 4 - Anaesthetic Rooms						3	3		2		4	1	1			1		1			3	**19**
ABUHB - IPAC - Theatre Audit - Section 5 - Theatre							1				4	1						1			1	**8**
ABUHB - IPAC - Theatre Audit - Section 6 - Scrub Room							1				4	1						1			1	**8**
ABUHB - IPAC - Theatre Audit - Section 7 - Dirty Utility / Sluice							1				4	1						1			1	**8**
ABUHB - IPAC - Theatre Audit - Section 8 - Recovery / Resuscitation							1				3	1						1			1	**7**
ABUHB - IPAC - Theatre Audit - Section 9 - Dirty Utility (Recovery)							1				3	1						1			1	**7**
ABUHB - IPAC- CAUTI Bundle Compliance Audit	6	12	3	1	6	42	21	1	10	1	1	3	1	9	6	3	2	1	2	3	4	**138**
ABUHB - IPS - Decontamination Dashboard (Scopes) (Urology & Endoscopy)						4	2				1										4	**11**
ABUHB - IPS - Endoscopy - Decontamination						2	2				2										2	**8**
Grand Total	6	12	3	1	6	51	33	1	12	1	26	9	2	9	6	4	2	7	2	3	18	**214**

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Pathology	Primary Care	Radiology	Rheumatology	Sexual and Reproductive Health	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Monthly	**112**	**192**	**56**	**30**	**96**	**726**	**346**	**24**	**160**	**16**	**24**	**156**	**48**	**16**	**146**	**12**	**96**	**62**	**32**	**12**	**16**	**32**	**50**	**64**	**2524**
ABUHB - IPAC - (IPS) - Isolation Precautions	16	24	8	4	12	90	42	4	20	4	4	28	6	2	18	2	12	8	4	2	2	4	6	8	**330**
ABUHB - IPAC - Hand Hygiene Audit	16	24	8	4	12	90	42	2	20	4	4	22	6	2	18	2	12	8	4		2	4	6	8	**320**
ABUHB - IPAC - HCAI Audit - (Covid-19)	12	24	6	4	12	86	42	2	20		2	18	6	2	18	2	12	8	4		2	4	6	8	**300**
ABUHB - IPAC - HOUDINI Audit Tool	16	24	8	4	12	98	46	4	20	4	4	32	6	2	18	2	12	8	4	4	2	4	6	8	**348**
ABUHB - IPAC - Infection Prevention Quality Dashboards	16	24	8	4	12	98	46	6	20	4	4	36	6	2	20	2	12	8	4	6	2	4	6	8	**358**
ABUHB - IPAC - PVC Bundle Compliance Audit	12	24	6	2	12	84	42	2	20		2	6	6	2	18		12	6	4		2	4	6	8	**280**
Dignity and Essential Care Inspection (DECi) - Inpatient Care	12	24	6	4	12	84	42	2	20		2	6	6	2	18		12	8	4		2	4	6	8	**284**
Dignity and Essentials Care Inspection (DECI) - Ward Area	12	24	6	4	12	84	42	2	20		2	6	6	2	18		12	8	4		2	4	6	8	**284**
Malnutrition Screening for Inpatients (Updated)						12	2					2											2		**18**
Prothrombin Complex Concentrate use in ABUHB																2									**2**
Grand Total	112	192	56	30	96	726	346	24	160	16	24	156	48	16	146	12	96	62	32	12	16	32	50	64	**2524**

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Pathology	Primary Care	Radiology	Rheumatology	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Weekly	**30**	**12**	**18**	**12**	**30**	**240**	**120**	**6**	**60**	**6**	**12**	**18**	**6**	**54**	**1**	**18**	**24**	**12**	**6**	**6**	**12**	**24**	**727**
2222/Cardiac Arrest Audit	30	12	18	12	30	240	120	6	60	6	12	18	6	54		18	24	12	6	6	12	24	**726**
Prothrombin Complex Concentrate use in ABUHB															1								**1**
Grand Total	30	12	18	12	30	240	120	6	60	6	12	18	6	54	1	18	24	12	6	6	12	24	**727**

AMaT training is currently underway to register local audits on AMaT, build a proforma, collect results and develop action plans.

The current list of local audits registered for April 2023

Division	Project type	Title
Family and Therapies	Clinical Audit Project	Adherence of appropriate investigations and counselling for women with POI
Family and Therapies	Service Evaluation	An evaluation of emergency contraception provision within ABUHB
Family and Therapies	Clinical Audit Project	BASHH (British Society of Sexual health and HIV) National Clinical Audit 2022: management of Mycoplasma genitalium (Mgen)
Family and Therapies	Clinical Audit Project	Menopause counselling in women undergoing bilateral salpingo-oophorectomy +/- hysterectomy before the age of 45
Clinical Support Services	Quality Improvement Project	An audit of the management of Staphylococcus aureus bacteraemia
Scheduled Care	Staff Questionnaire (feedback, satisfaction, etc.)	ICU nurses' decision-making around measuring gastric residuals to guide enteral feeding
Scheduled Care	Clinical Audit Project	The effect of oral anticoagulant use on surgical delay and mortality in older hip and femoral fracture patients
Corporate QPS	Peer review and Clinical Audit Project	Local Review Consent to Examination & Treatment Standards in Aneurin Bevan University Health Board

The local audit plan will be updated every six months as Directorates continue to add local audits on AMaT.

Appendix Five - National Confidential Enquiry into Patient Outcome and Death

Improving the quality of healthcare

National Confidential Enquiry into Patient Outcome and Death

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

ANEURIN BEVAN UNIVERSITY HEALTH BOARD NCEPOD PROCESSES

Name of Study:			
Date of initial correspondence from NCEPOD		Has inclusion specifics been provided?	Yes/No
Date NCEPOD request data returned?		Date inclusion specifics sent to informatics:	
Date Division informed of pending study:			

Has a Clinical Lead been requested by QPS?	Yes/No	Name of Clinical Lead:	

Date data returned from informatics:		Date data sent to NCEPOD: (via secure portal)	
Date added to NCEPOD platform:			

Is there and Organisational Questionnaire	Yes/No	How many OQ? (Site dependant)	
Deadline for OQ(s):			
Are there Clinical Questionnaires?	Yes/No	How many CQ? (No. of patients in study)	
Deadline for CQs:			

Have all patients been allocated to a clinician?	Yes/No	By whom in QPS CAT?	
Date allocated to a clinician:		Has the Division and CL been informed?	Yes/No
Once a CQ has been completed by a clinician, this triggers and email to the QPS CAT who will collect relevant case notes and submit to NCEPOD via the secure portal			
Comments:			

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Patient Quality, Safety and Outcomes Committee

Performance Report

JUNE 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

- Incident reporting and severity of harm
- Duty of Candour, Falls, Thematic reviews and learning
- Next steps - pressure ulcers, medicines management and mortality
- Patient Experience and Staff Feedback, will include compliments
  - Civica in place
  - Patient Experience and Involvement Strategy being implemented
  - Business case to PIP for PALs (June 2023)
- Complaints and concerns
- Health, Safety and Security
- Infection Prevention and Control, Covid-19 investigations
- Safeguarding

Urgent Care

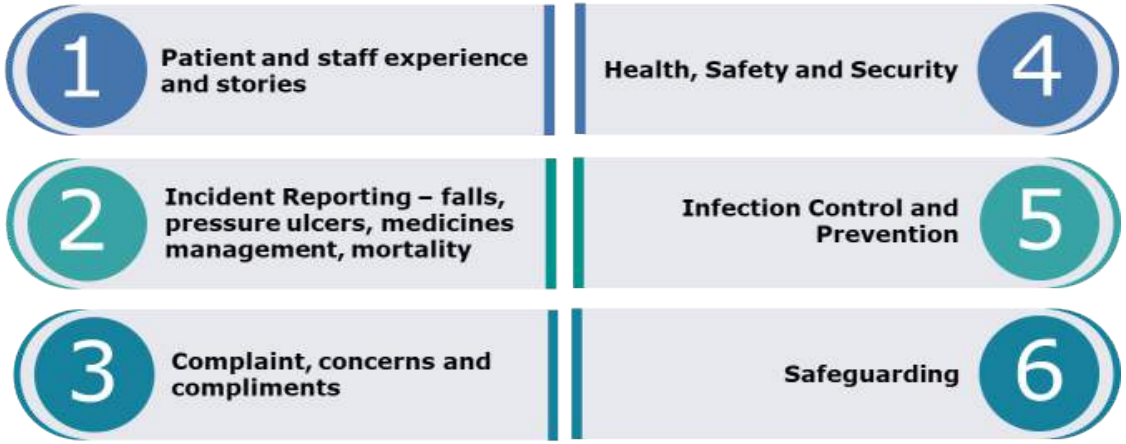
Planned Care

Cancer

Quality Strategy Implementation Plan

- Quality & Engagement Act from 1st April 2023 encompassing Duty of Candour and Duty of Quality.
- Approved - Quality Strategy and Patient Experience & Involvement Strategy.
- Board session delivered in March 2023 and workstreams meeting in April 2023.
- Implementation plan underway.
- Workplan being refined, including deteriorating patients, NRIs and never events in theatres and radiology.
- Patient experience and involvement forms part of the pillars of quality, using Civica to include stories and thematic experience data.
- Establish a forum for learning from triangulation of data, including thematic reviews, develop action plans and shared learning.
- Safe Care Collaborative ongoing.

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.

Next Steps

- Person centred approach – 'what matters to me' directly involve our patients and staff in improvement, service delivery and change
- Review and monitor WG Quality & Engagement Act deliverables as part of the delivery of the Quality Strategy
- Key objectives for Quality & Safety outlined for the next twelve months for monitoring, review and evaluation.
- Delivery plan as part of Quality Strategy will map goals and timeframes with SMART objectives and a Quality Outcomes Framework
- Safety walk arounds being reinstated
- Review of QPS/ QI resources
- 'Big conversation' around Quality Improvement
- Safety First - a redesigned approach to incident/ serious incident management and decision making
- PTR and QPS teams working together to develop a plan for learning and sharing of incidents. Strengthened Divisional learning / reporting through Governance structures
- Embed an open and transparent learning organisation, with a just culture, incorporating psychological safety, human factors and wellbeing.

Pillars of Quality

Section 1

Good Practice and Learning

Spotlight on Primary Care & Community Division

Section 2

Listening and Learning from Feedback

Examples from 22/23 PC&C Division

Common Themes across Investigations/Outcomes

End of life care and MDT communication (identified in Mortality Reviews and Serious Incident investigations)
Action taken: Prompt consideration of End-of-Life drugs for deteriorating patients. Clear communication of patient plan for OOH management.

Lack of empathetic and compassionate communication between staff and patients/relatives/carers. Consideration of individual need including supporting visiting and communication between patients and loved ones.

Discrepancies in pressure ulcer classification when moving between services.
On admission/discharge from hospital, patients should receive body map with grading, signed off by Registrant. Any discrepancies escalated to Team Leader.

Action taken: SOP developed (awaiting ratification) to utilise clinical photography to improve identification/grading of pressure ulcers. The importance of providing pressure damage prevention information to patients, relatives and carers has been reiterated. There has been significant improvements in the prevention of avoidable pressure ulcers across the DN service.

Listening and Learning from Feedback

Examples from 22/23 PC&C Division

Concerns regarding lack of family involvement in discharge planning: Families are integral part of providing support at home and should be involved in discharge planning.

Actions taken:

- ✓ Ensure all ward staff are aware of the importance of completion of discharge checklists and clear concise documentation regarding communication with families.
- ✓ Family members should be consulted regarding Community Care Provision availability as part of discharge planning.
- ✓ All discharge risks should be explored, discussed, documented and relevant risk assessments completed.
- ✓ Communication breakdown - new process implemented to ensure families are fully informed and engaged with discharge planning
- ✓ Information documentation being produced for families regarding care providers.

Listening and Learning from Feedback

PREMS Audit SWH PC&C Division

PREMS audit 10/2/23 – themes and improvements

Themes relating to patient experience:

- Lack of televisions in bed areas
- Limited ability to interact with other patients and converse
- Staff sometimes take a prolonged period to answer a call bell
- Maintaining privacy and dignity within the ward environment
- Staff have limited time to interact and support independence
- Uncomfortable furniture
- No continuity of staff impact staff knowledge of individual conditions/capabilities

Actions taken:

- Urgent development of day rooms identified as essential to covert the space into a resource and introduce structured activities, increase patient activity levels, reduce patients' risk of deconditioning, increase physical activity levels and boost mental well-being through interaction with staff and other patients.
- Every effort to be made to answer call bells in a timely manner, with explanation and documentation if delay. Call bell audit undertaken.
- Staff reminded to ensure patients dignity and privacy is always protected and adopt a zero tolerance to any deviation to standard.
- Patient independence encouraged at every opportunity. RTD used to record any exceptions to plans to support independence (e.g. mobility plans)
- Audit of bed side chairs to ensure fit for purpose. Capital Bid considered requiring investment to purchase patient chairs/ chairs that enable rehabilitation activities. Unfortunately bid not supported and therefore chairs not purchased.
- Ward Manager to aim staff allocation into respective teams to provide continuity of care and promote consistency.

Examples of Learning from Feedback

Issue	Cause	Remedial Action	Who	When
ID1091 – concerns raised by profoundly deaf patient unable to access 111 for advice	Lack of standardisation of systems to support patient access with sensory loss	Discussions with 111 and partner HBs across Wales demonstrated systems not standardised from user's perspective to support ease of access for patients with sensory loss. Explored Nationally and proposals for a standard system to provide seamless, timely access in line with Equality Act 2010. (Urgent Primary Care)	National 111 service	Ongoing
ID2107-Incorrect information for OOH pharmacy services	Information available on website not updated	Action implemented to ensure duty pharmacies OOH information is updated to enable service users access to correct information.	Pharmacy directorate	Completed
Potential for confusion when GPs selecting medications with similar names from dropdown list.	Failure to consider similarities in drug names and cross referencing with BNF	Utilise BNF and BNF app and double check prescription with similar name medications. Communicated to all GP practices for action and learning.	Medical Director	Completed
ID773 - Concern regarding UPC 24/7 GP review and assessment - potential delay in diagnosis of Diabetic Ketoacidosis.	Euglycaemic DKA is difficult to diagnose early due to nonspecific symptoms. Individual did not exhibit classic DKA symptoms when assessed by GP OOH. Condition subsequently deteriorated making DKA more evident.	GPs advised of potential for Euglycaemic DKA in unwell diabetic patients treated with dapagliflozin or similar drugs, and to ensure blood ketones are measured to rule out this rare condition. Feed back recommending improvements in comprehensive clinical examination in patients presenting with nonspecific symptoms as well as clinical documentation, including providing details of symptoms/management/safety netting and follow up advice.	Medical Director	Completed

County Hospital listened to their patients and heard feelings of loneliness and isolation.

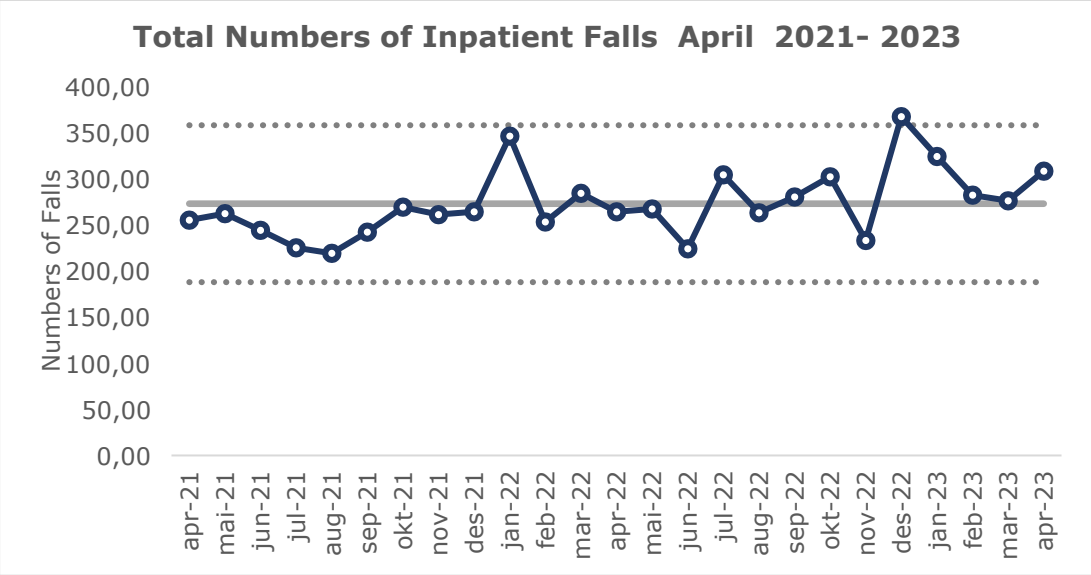
They developed schedule of intergenerational activities for patients and their families. The staff fully embraced the activities and have a daily ward activity schedule with positive feedback from patients and their families. This has been rolled out to all community hospitals.

Meaningful Occupation Activities

Total Numbers of Inpatient Falls

April 2021-’23

Total = Sum of the falls related incidents reported for the given period



April 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 April 2021-2023.

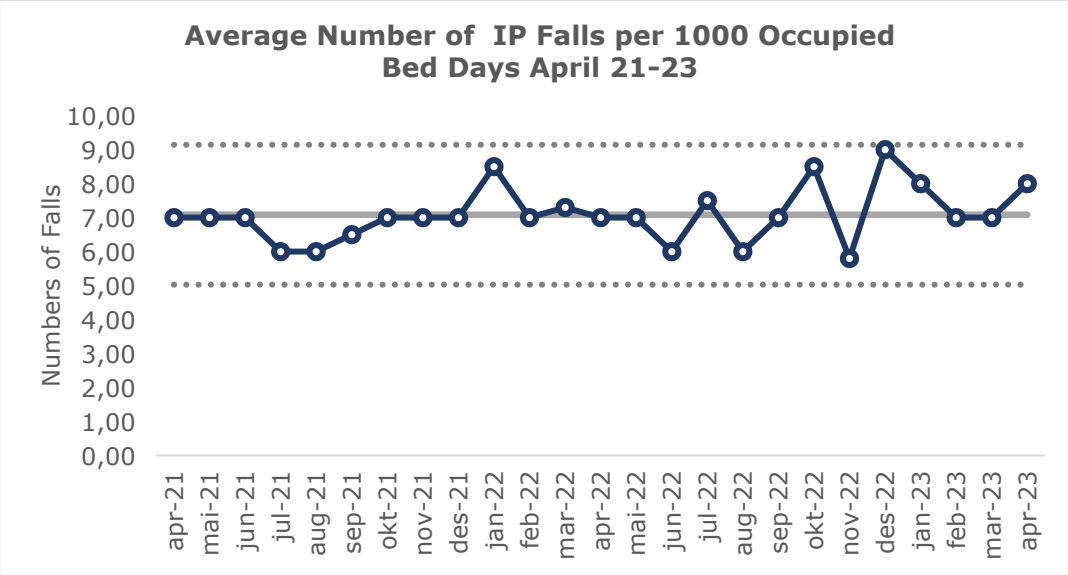
A review of areas of concern is being undertaken to establish reasons and learning associated with the April change in trajectory.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• The mean average number of monthly falls for ABUHB has seen a marginal increase from 270 to 272. • For the year 2022-23 incident reporting numbers remain subject to a greater degree of variation as compered to 2021-22. Since December 2022 there has been a downwards trajectory to March 2023. April has seen an increase in reported incidents to a value of 308.	December 2022 saw the highest numbers of reported falls incidents since January 2022 at 369. April 2023 represents the second highest value for reported incidents in the given period.

Average Number of IP Falls per 1000 Occupied Bed Days (OBD)

April 2021-’23

OBD = The sum of the number of beds occupied for the given period



April 2023 - Context

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

The data represents the collective information for ABUHB and refers to the average numbers of Inpatient falls per 1000Occupied Bed Days (OBD).

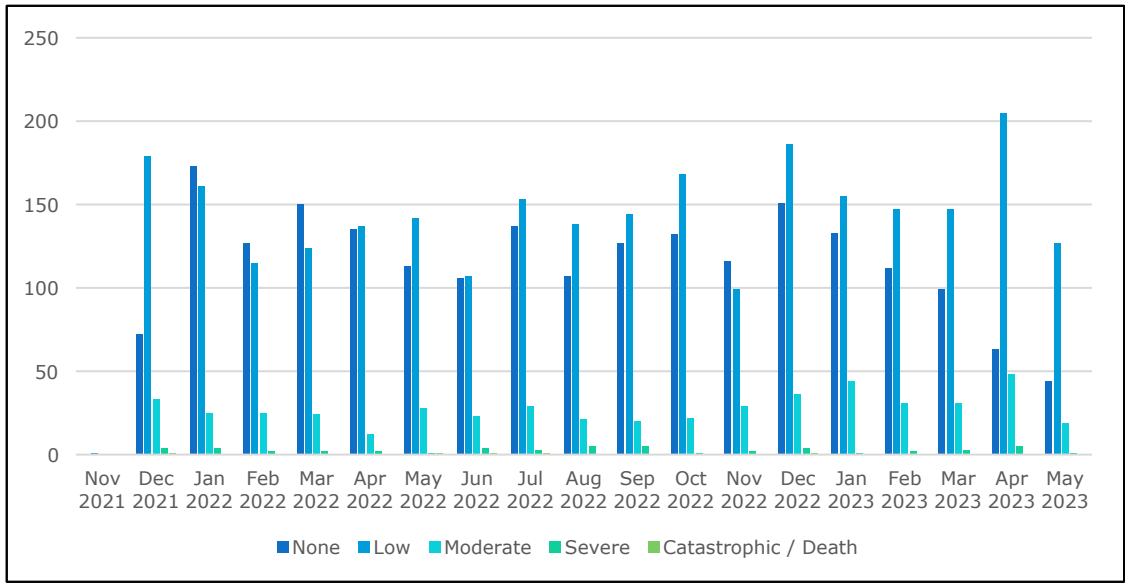
1000 OBD’s represents a national standard unit of measure.

December 2022 figure is the highest since January of the same year.

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 per 1000 OBD’s for the period April 2021- 2023 was 7.1. This is marginally above the value of 6.97 as detailed for the period March 2021-23. • Aligned to the National average for the given period the following is demonstrated: – 24% above National Average – 26% below National Average – 50% More closely aligned to the value of 6.6	Again 2022-23 saw a greater degree of variation as compared to 2021 across the corresponding periods. As compared to the previous reporting period March 2021 -23 an analysis of the data for the given period has identified with an increase in the number of months in which the value is more closely aligned to the national figure.

Falls Data

Severity of Harm



May 2023 - Context

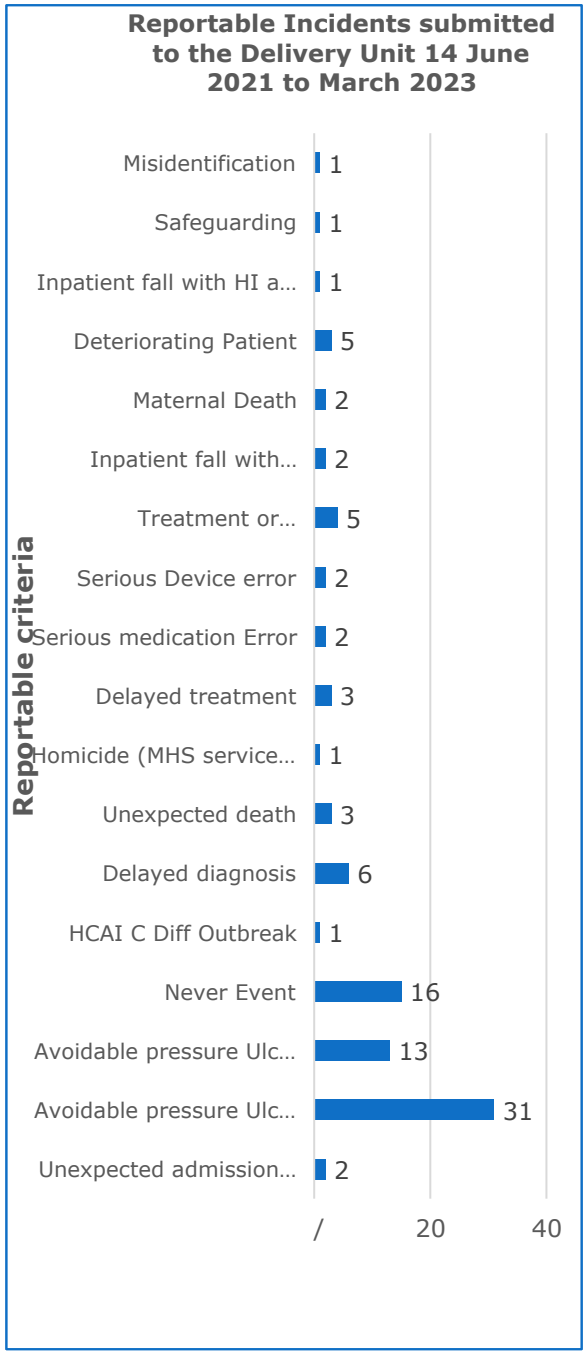
The data used in this chart has been retrieved from Datix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period December 2021 to February 2023.

The 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.	The information provided details the distribution of the levels of severity of harm as reported for falls incidents a period of 15 months to February 2023. Of the total numbers of falls incidents reported the severity of harm is categorised as follows: • 40% - No harm • 50% - low harm • 9.5% - Moderate harm • 0.4 % Severe harm • 0.1 Catastrophic	

National Reportable Incidents



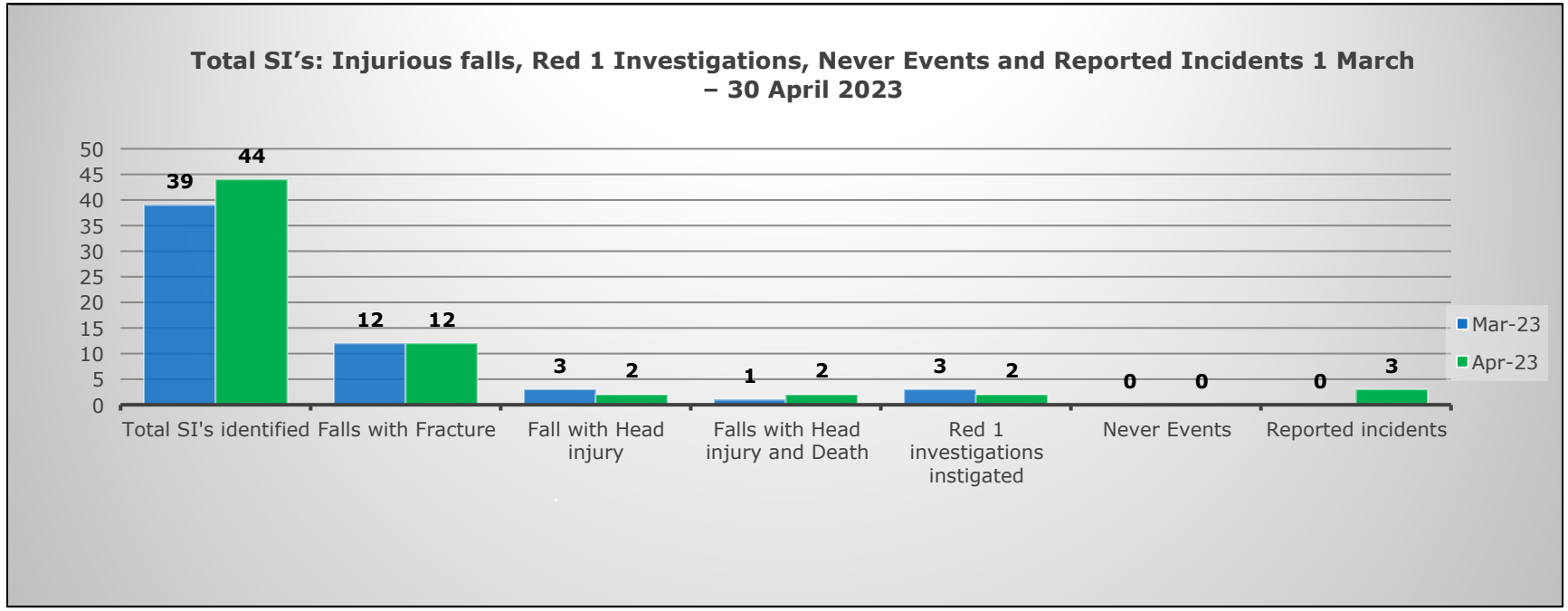
A total of **98** incidents were considered to meet reporting criteria and were submitted during this period.

Currently ABUHB benchmarks below comparator organisations for reporting of NRIs. Data has been supplied by the DU and an internal benchmarking

Review of the framework and the approach in ABUHB will have been completed by July. This will be a fundamental review of process, decision making, reporting and assurance, this will also embed learning and improvement as part of the end to end process.

Learning	Improvement
Investigation has highlighted that there is no security presence at YYF which would have been helpful in supporting AMU with a sectioned patient that kept absconding.	• A review of security across key sites within the Health Board has been undertaken by a security maintenance specialist, the recommendations will follow.
Site teams are expected to respond to unwell self-presenters in the Minor Injury Units (MIU) and to be reminded of their role and responsibilities when patients present.	• Self-presenting deteriorating patient Action Cards to be reinforced with the medical teams. • Roles and responsibilities are discussed at medical induction and are repeated at each changeover.
Poor compliance with/lack of fluid balance.	• Being addressed via care bundles at bedside.
Urea as a stand-alone option on e-blood test requesting led to a full electrolyte profile not being performed.	• This option has now been removed.
Poor handover and comms between teams - nursing staff not on ward rounds and handover between medical teams.	• Being addressed by Senior Nurse and Clinical Director.
Lying and standing BP's not completed in many cases, therefore highlighting additional risk of falls.	• Regular audits by Senior Nurses.
A review of the step-down process to eLGH's was required.	• A step-down transfer documentation tool has been developed to improve the safety of the patient handover process. This will ensure that key clinical information remains with the patient and informs their ongoing care when they are moved geographically and across Divisions.

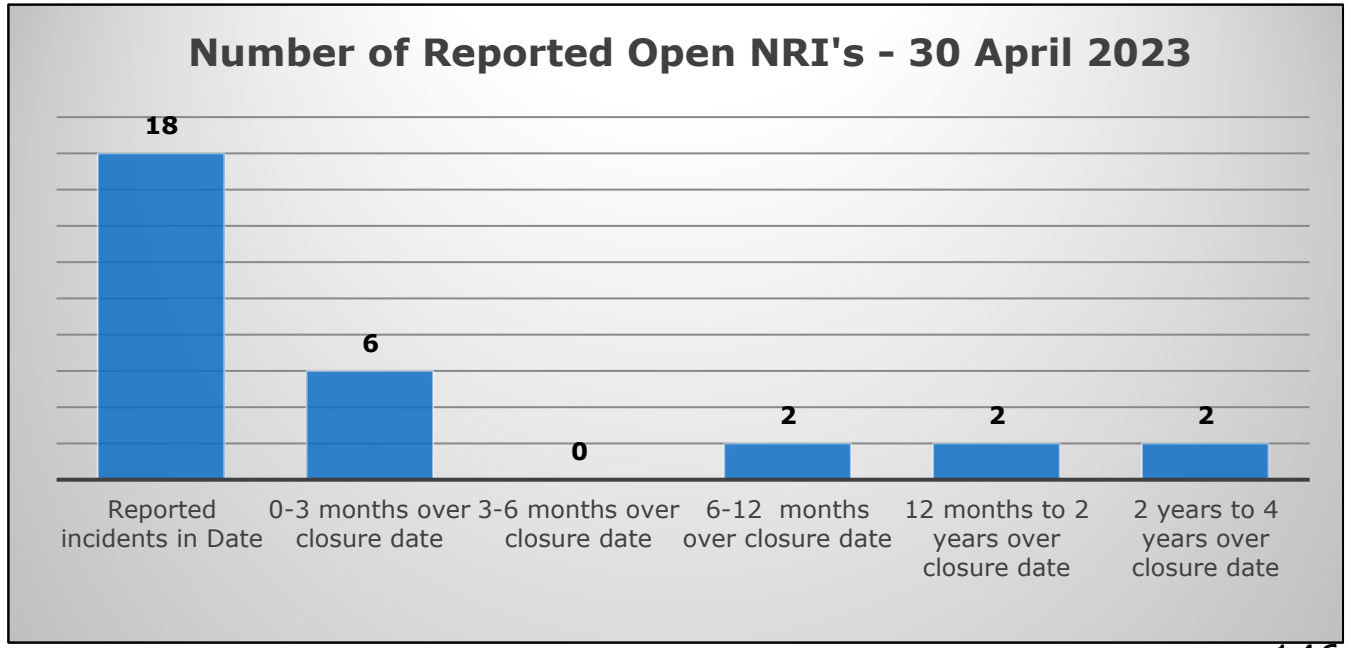
Serious Incidents



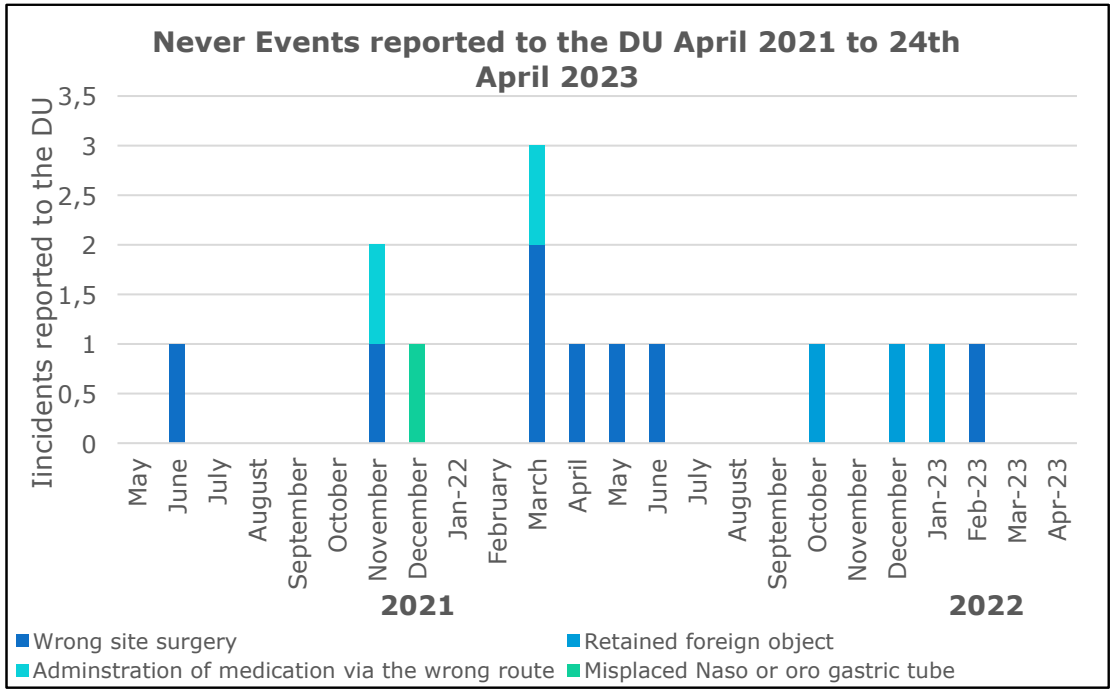
Total SI's: Injurious falls, Red 1 Investigations, Never Events and Reported Incidents 1 March – 30 April 2023

	Mar-23	Apr-23
Total SI's identified	39	44
Falls with Fracture	12	12
Fall with Head injury	3	2
Falls with Head injury and Death	1	2
Red 1 investigations instigated	3	2
Never Events	0	0
Reported incidents	0	3

As of the May 2023 the Corporate Serious Incidents Team were managing 36 live Red 1 SI's, with 17 in meeting stages. Discussion with the NHS Executive highlighted an issue with incidents being reported. The incidents were being appropriately managed, but not reported, due to interpretation of the amended Policy as of June 2021. This learning has been addressed. The SI process is subject to review currently



Never Events



- There have been no reported Never Events during March and April 2023
- One Never Event has been closed with the DU for this reporting period- ABU11320-Patient underwent a diagnostic angiogram that they did not require. See below for learning
- ABUHB aware of its high number of wrong site procedure Never Events. A large amount of improvement work has gone into making processes more robust, using systems thinking lens for investigations, training IOs using Human Factors and the introduction of the Theatre Safety Collaborative Group for education, sharing and learning.
- There is a Health Board wide wrong site procedure action plan.
- In response to thematic reviews around deteriorating patients, Never Events, and missed/unacted upon radiological findings, these themes have been assigned Senior Exec leads to oversee improvements.

Issue	Cause	Remedial Action	Who	When
Since July 2022 NHS Wales Never Event reporting criteria have changed	Directive from Welsh Government in line with NHS England Removed incidents: Wrong tooth extraction Oesophageal intubation Intravenous administration of medicines intended for epidural route -during implementation of NRfit	SI Team still monitor RLDATIX for these incidents	PTR SI Team	Ongoing
		Improved search capability on DATIX for key words in these incidents	ABUHB H&S Team	
		Liaise with Divisions when these incidents are identified	Divisional QPS leads	
ABU11320- A Patient underwent a diagnostic angiogram that they did not require	The root cause has been identified as a breakdown in multidisciplinary communication to clearly make explicit what procedure the patient was to have.	There must be an improved process for the completion of the Angiography request forms.	CD and Senior Nurse	May 2023 and ongoing
		There must be development of an online request form for cardiac angiography.		
		The generic term "Angio" should not be used when referring to the range of angiography procedures. Staff must refer to the full procedure that the patient is listed for by name.		
		There must be improved MDT communication regarding patients undergoing procedures in Cardiology		
		There must be an improved processes and documentation used within Cardiac Catheter lab to ensure positive patient identification and clear communication during all Angiography Procedures to ensure safe practice		

Duty of Candour

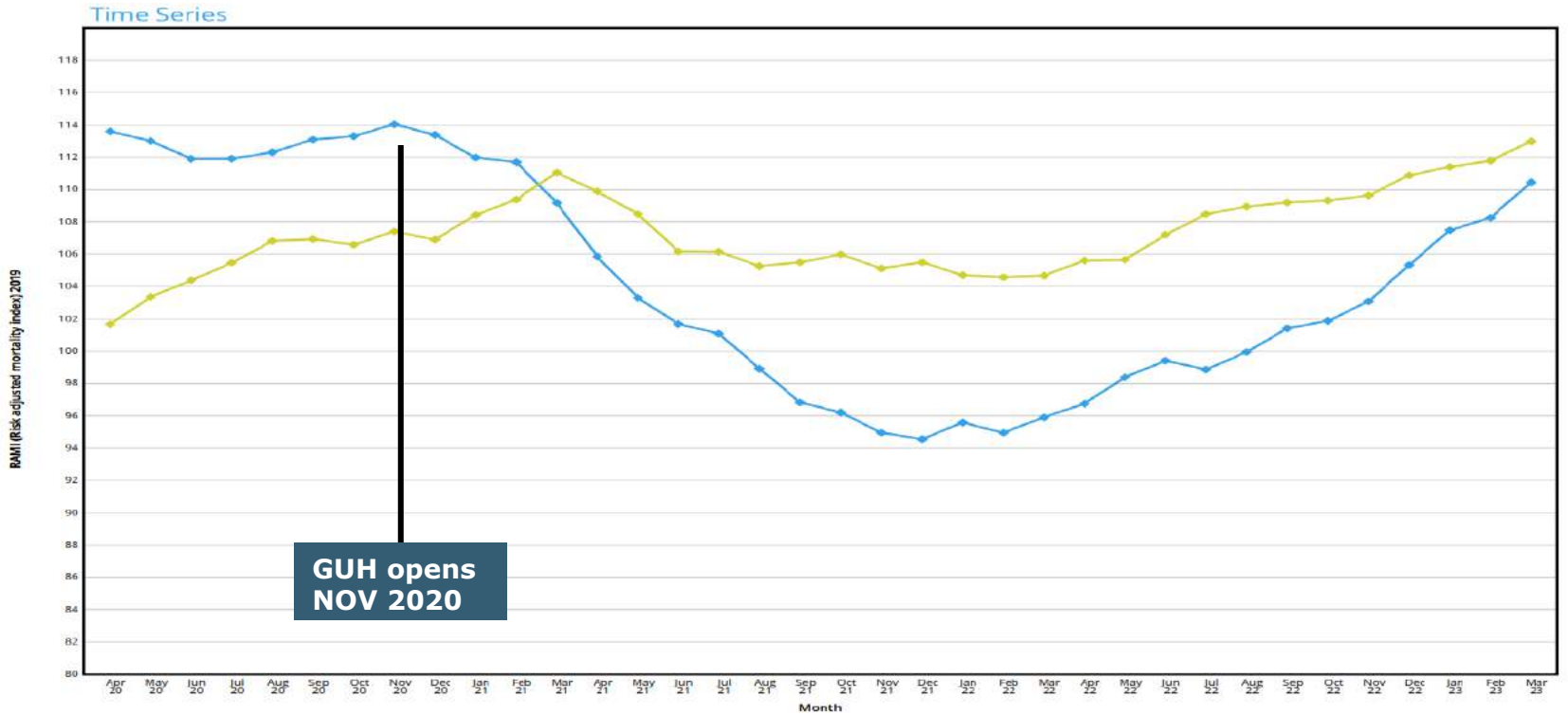
The image below illustrates the DoC dashboard in the Datix system.

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
ABCi	0	0	0	0	0	0	1	1
Complex & Long Term Care	0	6	7	4	1	0	21	39
Director of Public Health	0	5	7	0	0	0	1	13
Estates & Facilities	0	11	15	0	0	0	19	45
F&T	2	74	177	6	0	0	190	449
Medical Director	0	0	1	0	0	0	1	2
Mental Health & Learning Disabilities	0	249	357	3	0	0	14	623
Nursing Director	1	4	3	0	0	0	6	14
Planning, Performance & ICT	0	2	4	0	0	0	4	10
Primary Care & Community Division	5	134	373	24	4	0	198	738
Scheduled Surgical & Critical Care	1	153	406	9	1	0	31	601
Medicine	2	304	863	6	2	2	231	1410
Workforce & OD	0	1	1	0	0	0	2	4
Urgent Care	0	93	168	0	0	0	6	267
Clinical Support Services	0	22	33	0	0	0	26	81
Total	11	1058	2415	52	8	2	751	4297

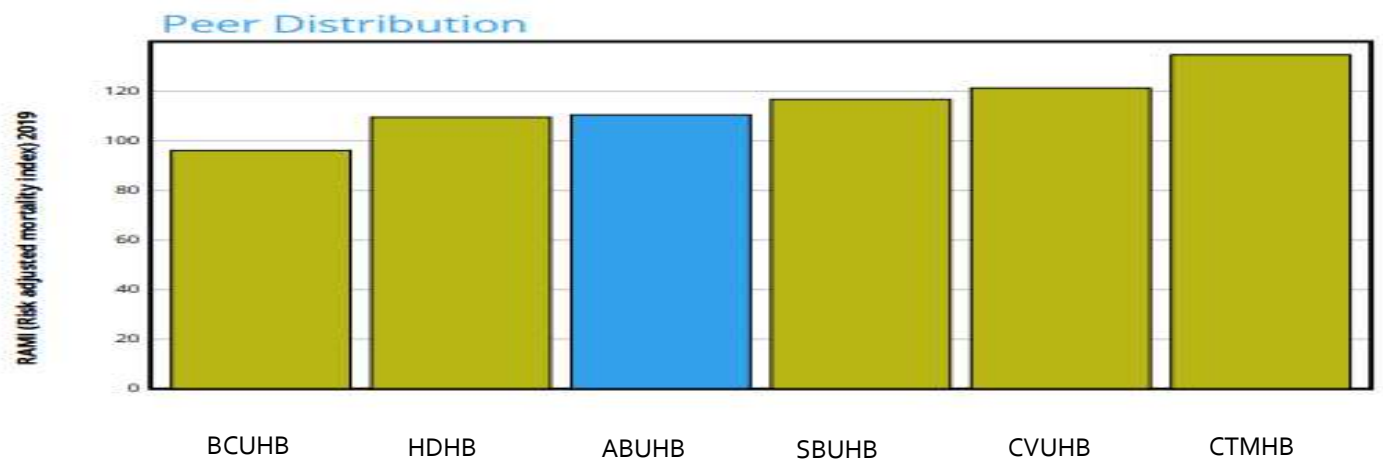
Duty of Candour

- Good strategic engagement within the Health Board leading to identified Duty of Candour (DoC) leads within the Divisions. Regular meetings are being held to monitor the implementation of DoC.
- To assist Divisions, a DoC Dashboard has been created within the Datix system. The dashboard highlights incidents that have triggered the duty and those that need to be reviewed.
- The Putting Things Right Team are validating the DoC data within the dashboard.
- Strong engagement in the national implementation programme
- Next steps is to further embed DoC and performance reporting, including against DoC timeframes

RAMI (Risk adjusted mortality index)



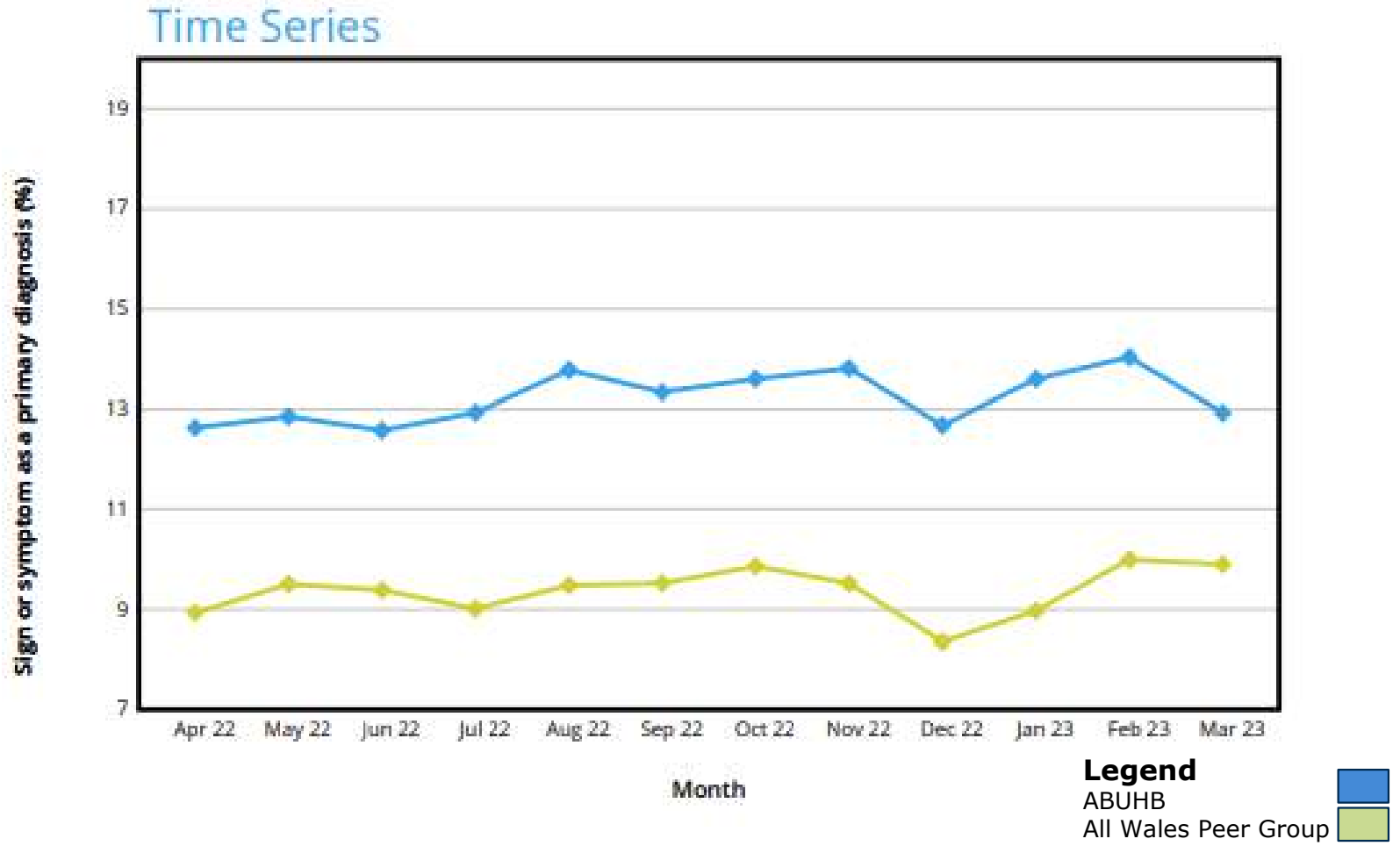
Significant decrease in RAMI post GUH opening (Nov 2020) until Dec 21 before gradually increasing in-line with the rest of Wales



Currently performing 3rd of 6 within peer group

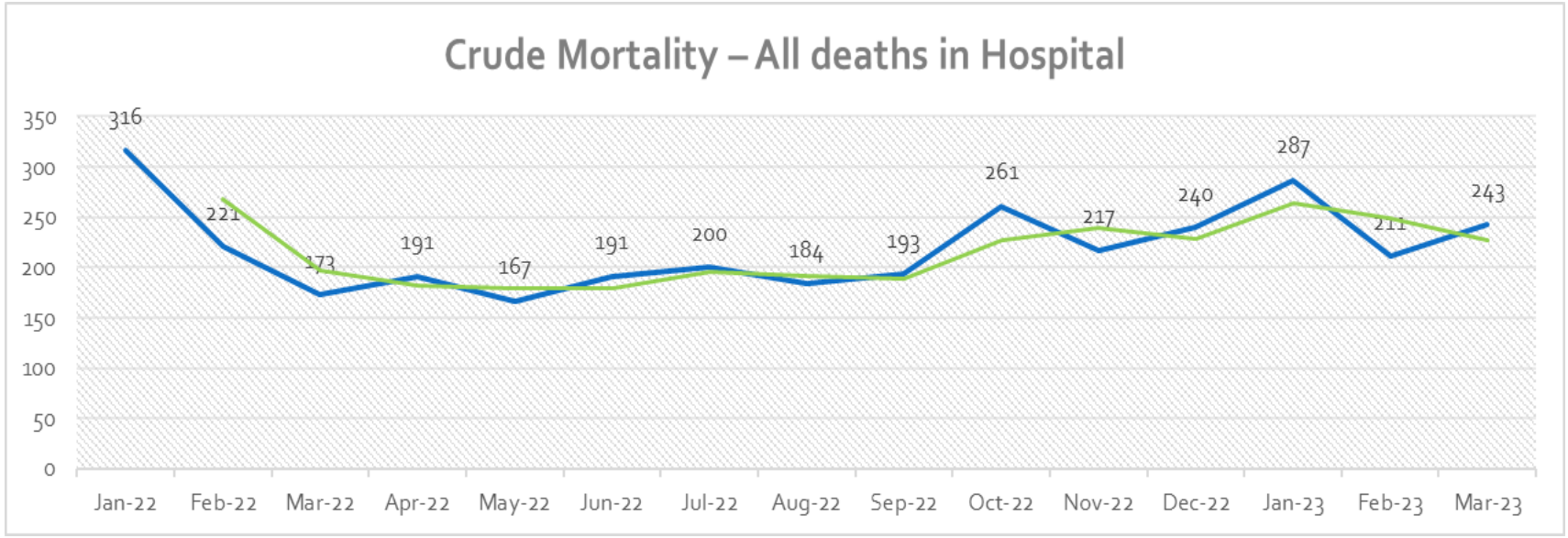
Legend
ABUHB
All Wales Peer Group

RAMI (Risk adjusted mortality index)

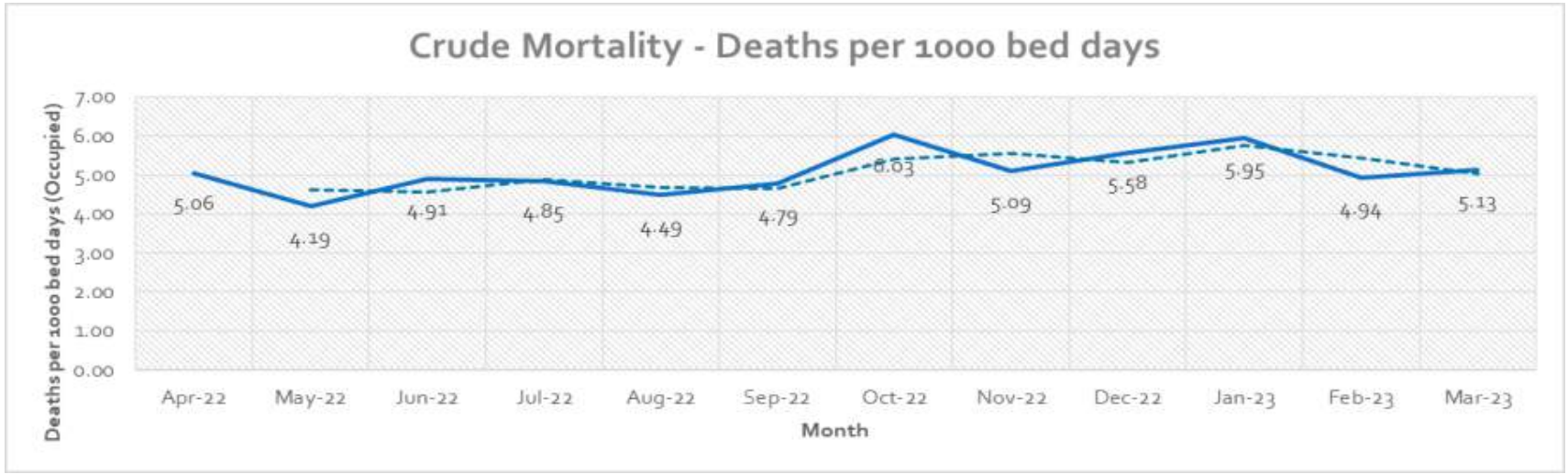


The above graphs shows the ABUHB (blue line) has a significantly higher amount of symptoms coded as a primary diagnosis than our peers within Wales (yellow line). For example, instead of an actual Respiratory Diagnosis, it is coded as "Difficulty breathing". This effects the accuracy of the data as a sign or symptom will make the calculation of RAMI less reliable.

Crude Mortality in Hospital



The above graphs shows the ABUHB Crude Mortality data (Deaths in Hospital). There has been an increase of deaths within Hospital since Oct 22, as expected with seasonal variance. This peaked in January 23 and followed the same pattern as the previous year.



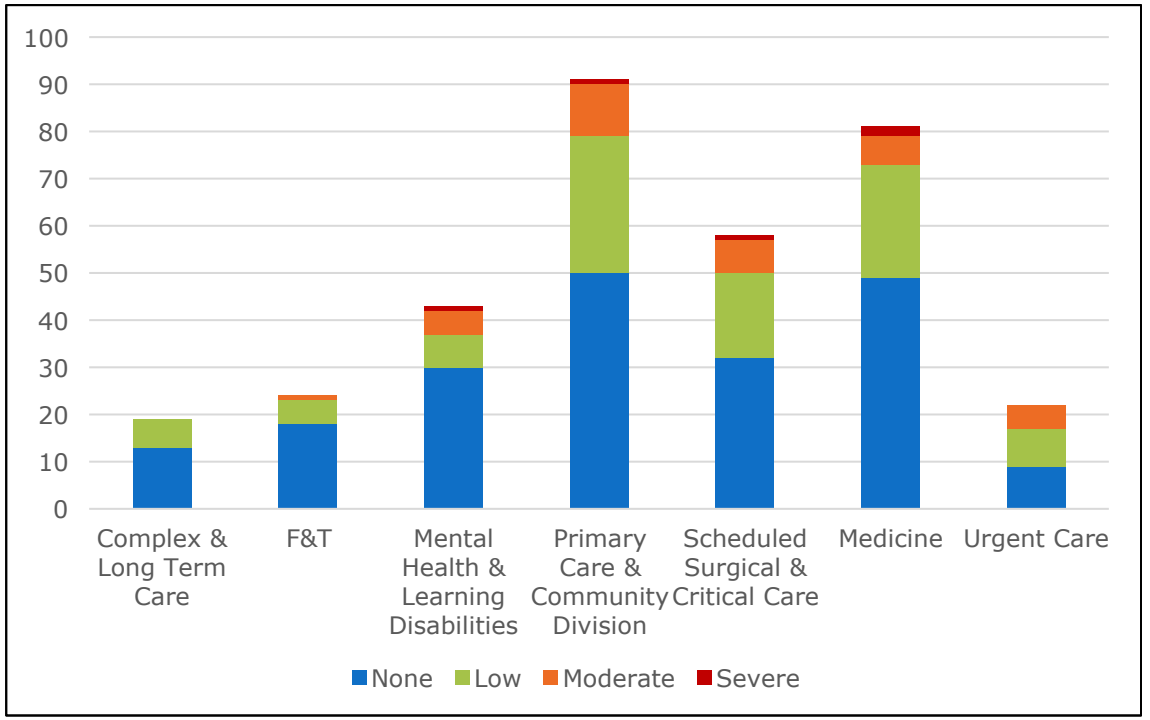
The above graphs shows the ABUHB Crude Mortality data per 1000 bed days, this peaked in October 22 and the trendline suggests, this is gradually decreasing.

Legend
ABUHB
All Wales Peer Group

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. Inconsistencies within the coding (Sign or symptom as a primary diagnosis) this affects the accuracy of calculating RAMI	Coding has now moved under the management of the Information Team Liaising with CHKS to identify coding lag effect on RAMI Work with clinicians to ensure classification is correct to increase coding accuracy and improve RAMU data.	Information Team Information Manager	Ongoing
Mortality Data	Understanding mortality data and interrogation of CHKS	Information Manager now in post	Information Manager	Ongoing
	Dedicated resource to review CHKS data	Information Manager reviewing reports in CHKS and looking at clinical outcomes		
		Developing mortality framework looking at mortality reported to Board, Divisions and Directorates		
		Drill down to specialty data to understand outliers of performance		
CHKS data	The Mortality per bed day visual has identified under performing areas against the peer specialty within Wales. Current lack of understand of how to drill down into the data of areas that are performing well and under performing areas.	Liaising with CHKS to identify the most relevant drill down methods to extract information to ensure these measurements are most relevant and also to identify positive and negative performance going forward.	Information Team	Ongoing

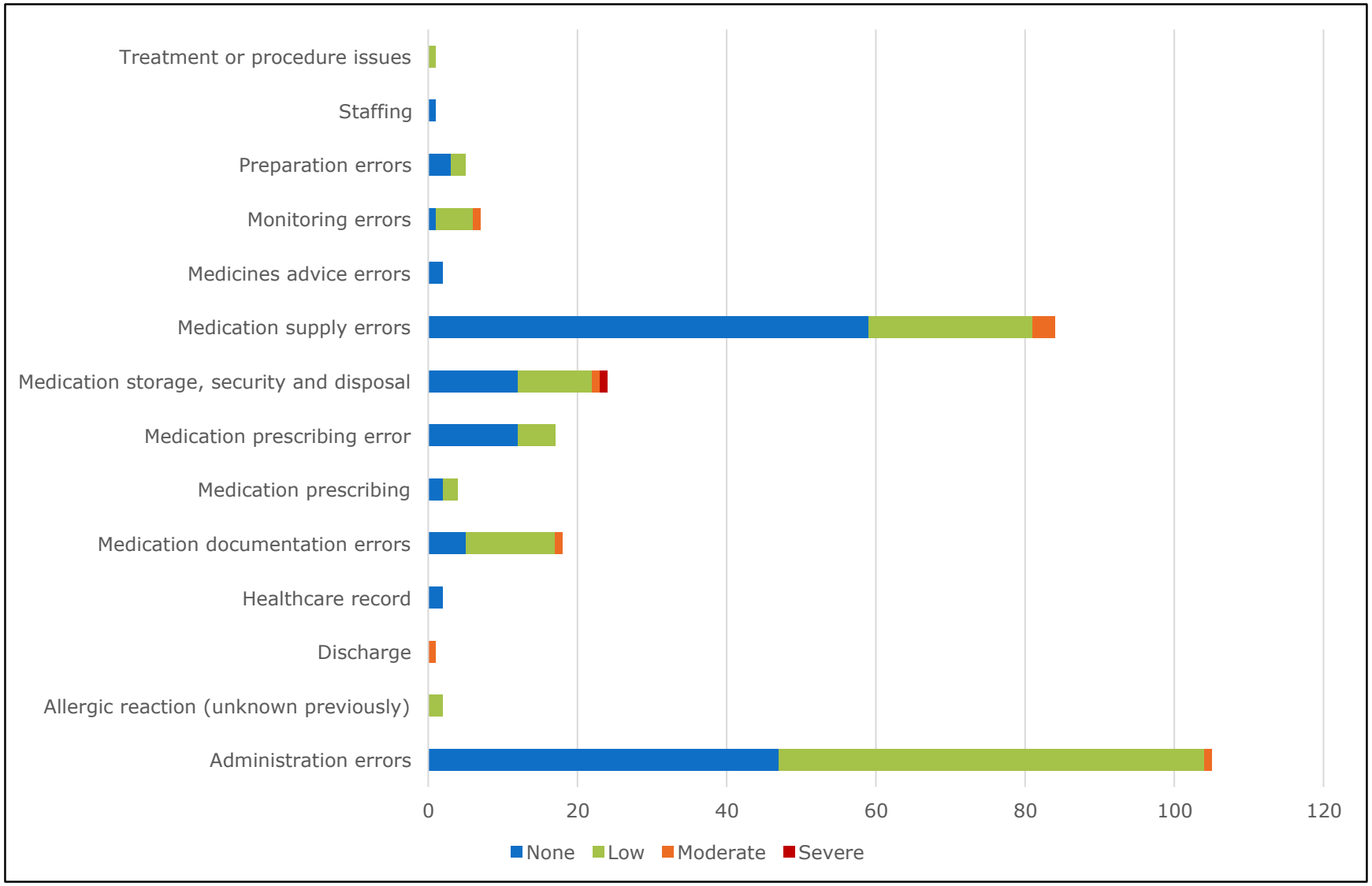
Medication Incidents by Severity and Division



2022-23	Q1	Q2	Q3	Q4
None	235	224	226	208
Low	96	95	95	98
Moderate	25	41	32	35
Severe	7	0	7	5
Catastrophic	0	1	0	0
Total	363	361	360	346

- Total 346 incident reported January to March 2023
- Total 275 incidents reviewed and investigated January to March 2023
- Graph relates to total number of incidents by division and "Reporters view on level of harm"

Medication Incidents by Sub Type and Severity



Medication Incidents by Sub Subtype and Moderate/ Severe harm (post investigation)

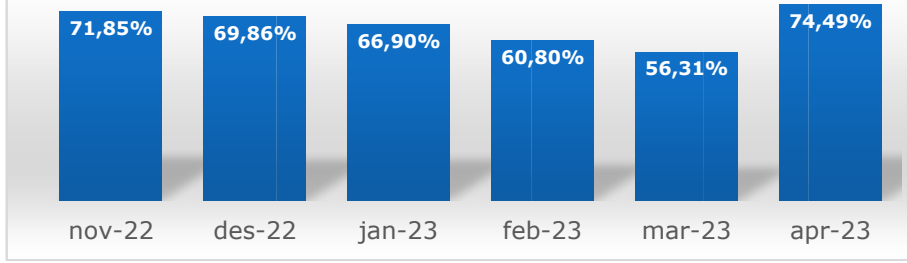
Incidents by Sub Subtype and Severity of Incident Post Investigation	Moderate	Severe
Delay - Unavailable equipment / medical device	1	0
Delay in medication supply	1	0
Drug content errors - Incorrect medication (Tramadol CD LIN)	1	0
Drug content errors - Incorrect strength (Pregabalin CD LIN)	1	0
Failure to undertake appropriate monitoring	1	0
Incorrect patient/service user	1	0
Incorrect quantity/running balance (Oxynorm CDLIN)	1	0
Lost/misplaced medicines	1	1

Summary of Progress

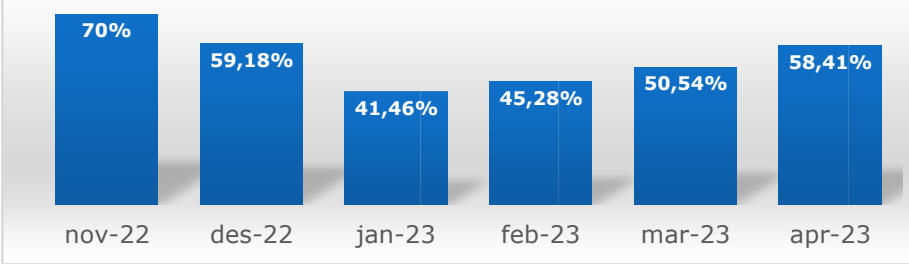
- Report for medicine safety incidents presented at Aneurin Bevan Medicines Safety Group (ABMSG) for every quarter.
- Moderate severity and above are discussed and themes reviewed.
- Medicines Safety Newsletter developed to share learning and awareness of incidents.
- Assurance / Exception reports from the Divisions as part of ABMSG:
  - Looks at Divisional Medicines Safety Incidents and trends
  - Actions taken
  - Lessons learnt and organisational learning
- Medicines Safety Strategy approved by QPSOG and being implemented as part of the 3-year plan
  - Goal 1 - Improve reporting and learning from medication incidents and good practice
  - Further goals see strategy
- MSG-Medication-Safety-Strategy-March-2022--Final--2.pdf

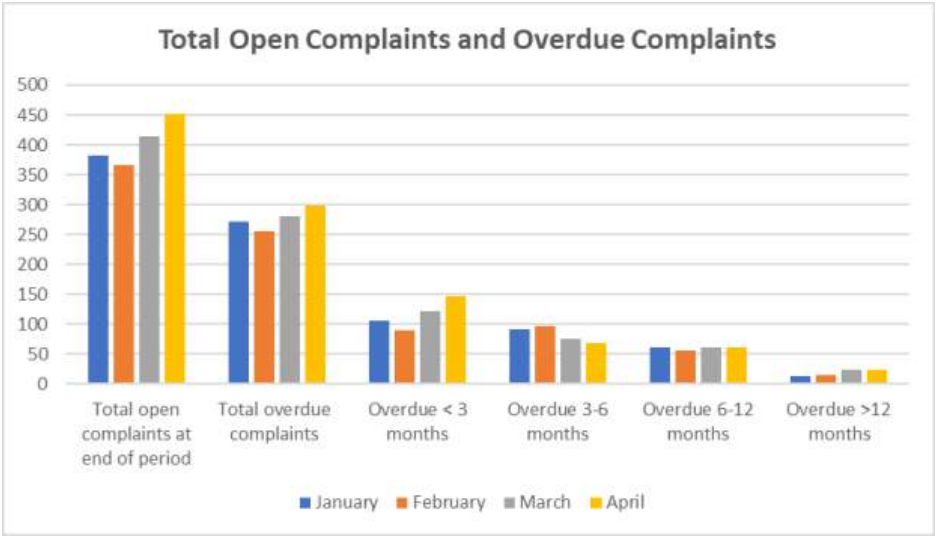
Complaints

Early Resolution Performance

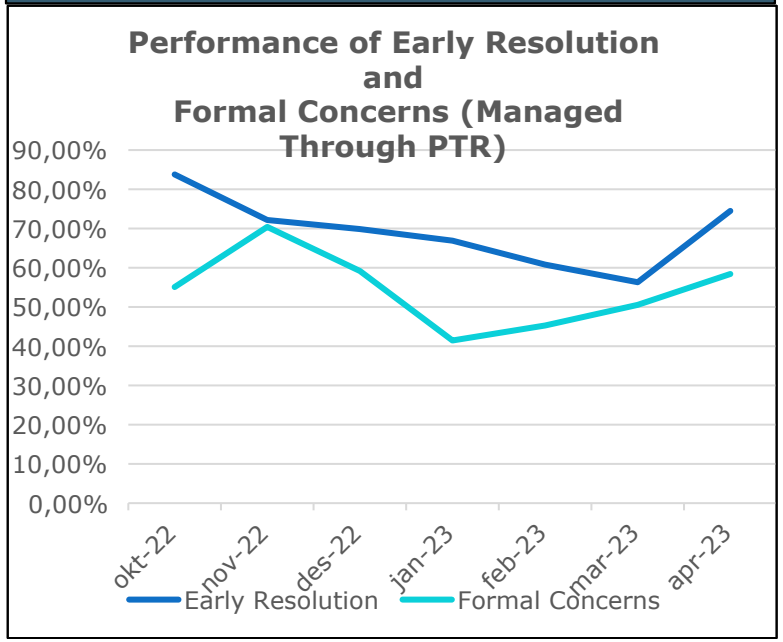


Formal Complaints Performance

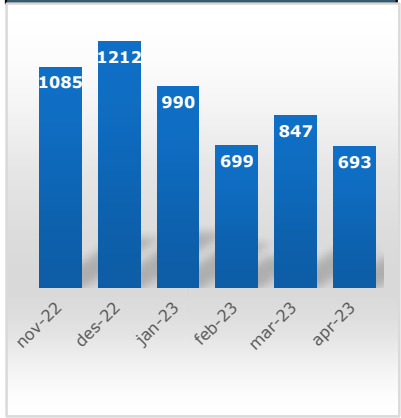




Complaints Data



Enquires Recorded by Patient Liaison Officers



Historic Concerns

A focused piece of work will be led corporately working with divisional colleagues to close historic concerns more than 12 months old, e.g. pre May 2022.

Learning from Complaints

Issue	Cause	Remedial Action	Who	When
As non urgent case patients cardiology procedure was delayed	Priorities managed according to clinical need	This booklet 'The Waiting Game' had been developed for cardiology patients to help them understand why there is often a wait to undergo procedures, how patients our prioritised and why procedures may be cancelled or put on hold etc. Senior Nurse advised to re circulate.	Cardiology team	Previously developed but had not been embedded fully, now being circulated to all patients
Concern raised could not be properly investigated (PSOW case closed April 2023)	Records lost following A&E attendance	An extensive action plan has been produced to ensure that the risk of losing records is minimised. To offer assurances of this, there is a Standard Operating Procedure (SOP) for Breach Reporting in place, which includes an ICO Risk Assessment matrix, to ensure the process for reporting to them is followed. A recent internal audit review was completed of the IG processes and some of those findings have been used to support the action plan.	Head of Health Records	February 2023
Inappropriate discharge	Poor communication between the Health Board and family	As part of the Six Goals work all Senior Nurses across the Health Board have been asked to review and audit the "board rounds" that currently take place daily in every area where the discharge needs are discussed for all patients. It is evident that these board rounds can be utilised more effectively and there is a request that changes are made, so that pertinent questions are asked and discussed in relation to discharge. As part of the same initiative all wards will be implementing "afternoon huddles". Ward staff will be asked to provide an update on the plans for each patient to the nurse in charge. This will provide senior oversight to decisions being made so that plans are carried out safely and in a timely manner.	Senior Nurses	Baseline audits undertaken and training of ward staff took place May 2023
Cardiac arrest and subsequent death	Care afforded by GP and ED	In future, in addition to a 999 call being made, should an emergency vehicle be available, it will be freed and dispatched from the ED. A call will also be made through the internal 2222 medical emergency line which will trigger the appropriate cardiac arrest team to attend the incident. This team will have appropriate equipment with them to prevent a delay in treatment. An Oxygen Cylinder, mask and an Automated External Defibrillator (AED) were placed in the GUH reception area.	ED- GUH	immediately following the events on the August 2022

Claims, Redress & Inquests

ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests

Total clinical negligence claim numbers are up slightly this period **375,** this being **60%** of the overall portfolio

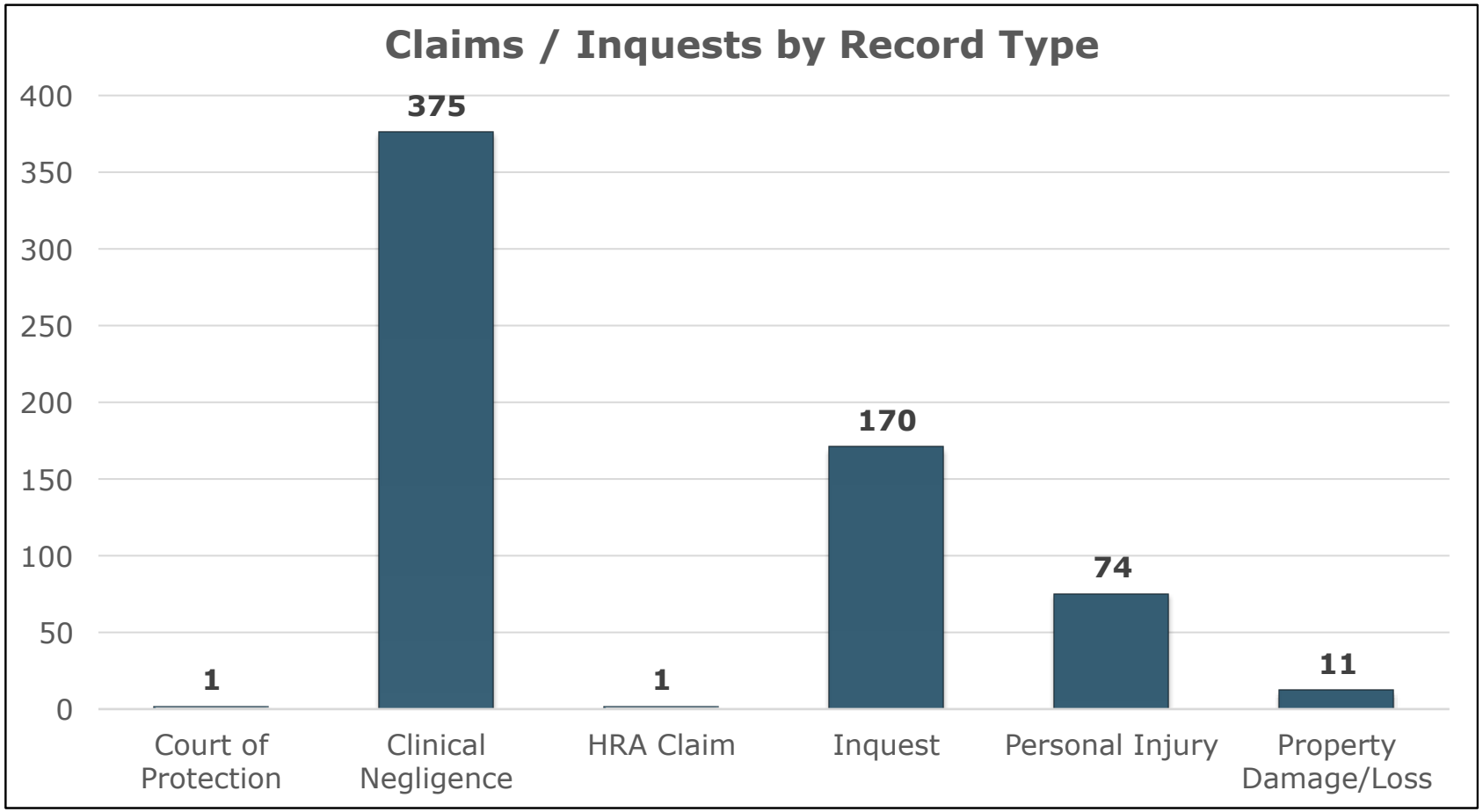
Inquest numbers are down slightly, but only as a result of inquests held keeping pace with new cases coming in

Live' Coroner inquests remain high at **170,** this being **30%** of the overall portfolio.

Personal injury claims continue a year on year reduction, **71,** representing only **10%** of the claims portfolio, and a **10 year low**.

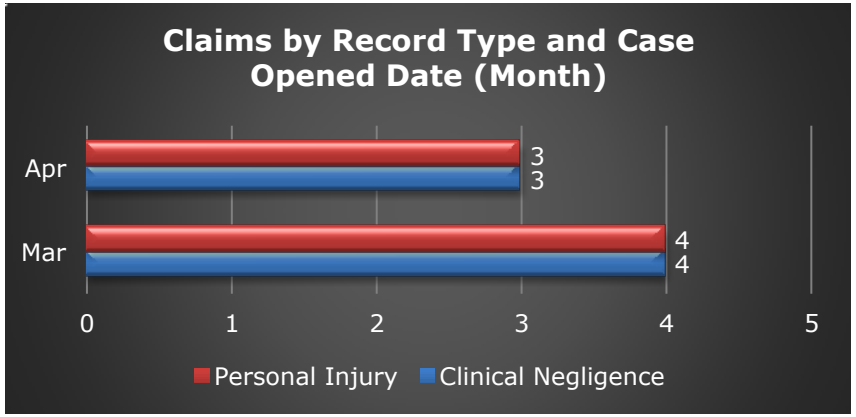
Claims, Redress & Inquests

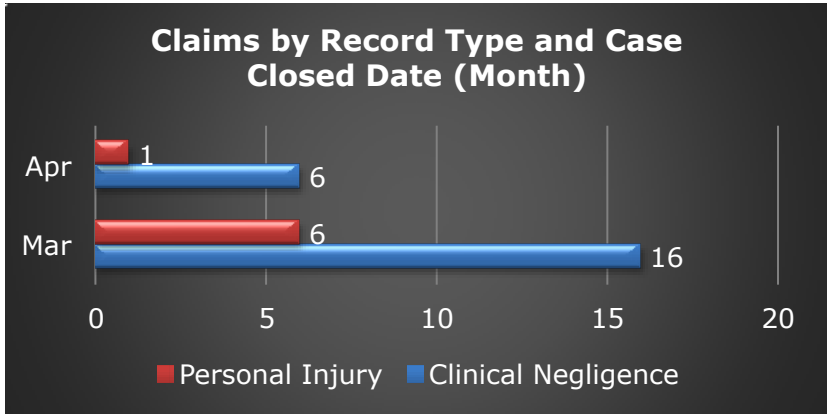
For the period to **30 April 2023** there are **631** live claims and inquests across the Health Board.

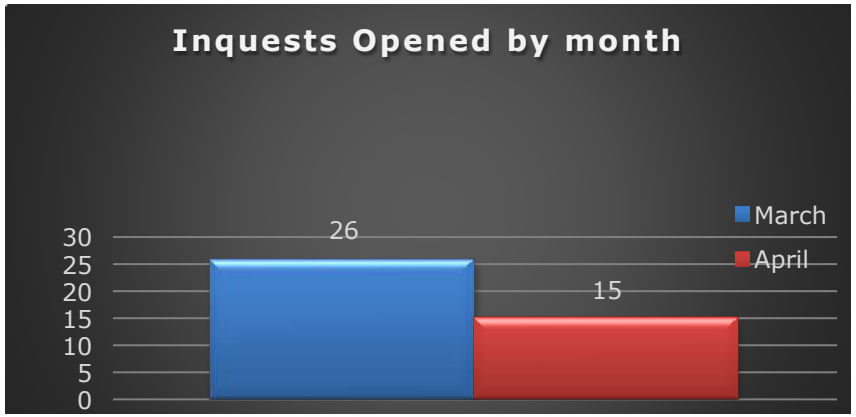


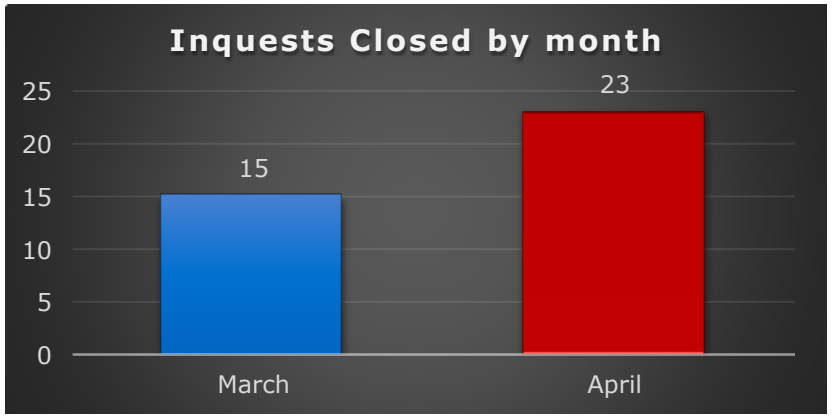
Claims, Redress & Inquests

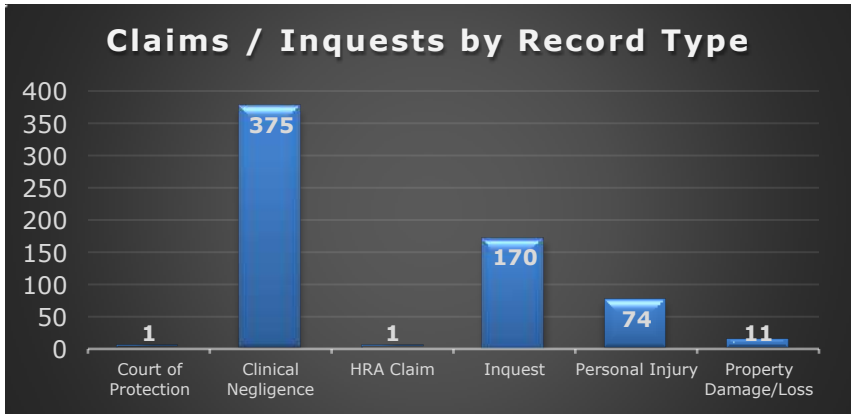
March – April 2023

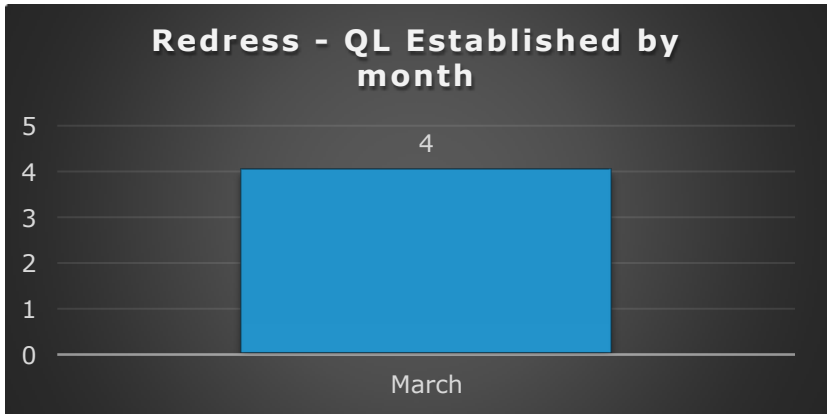




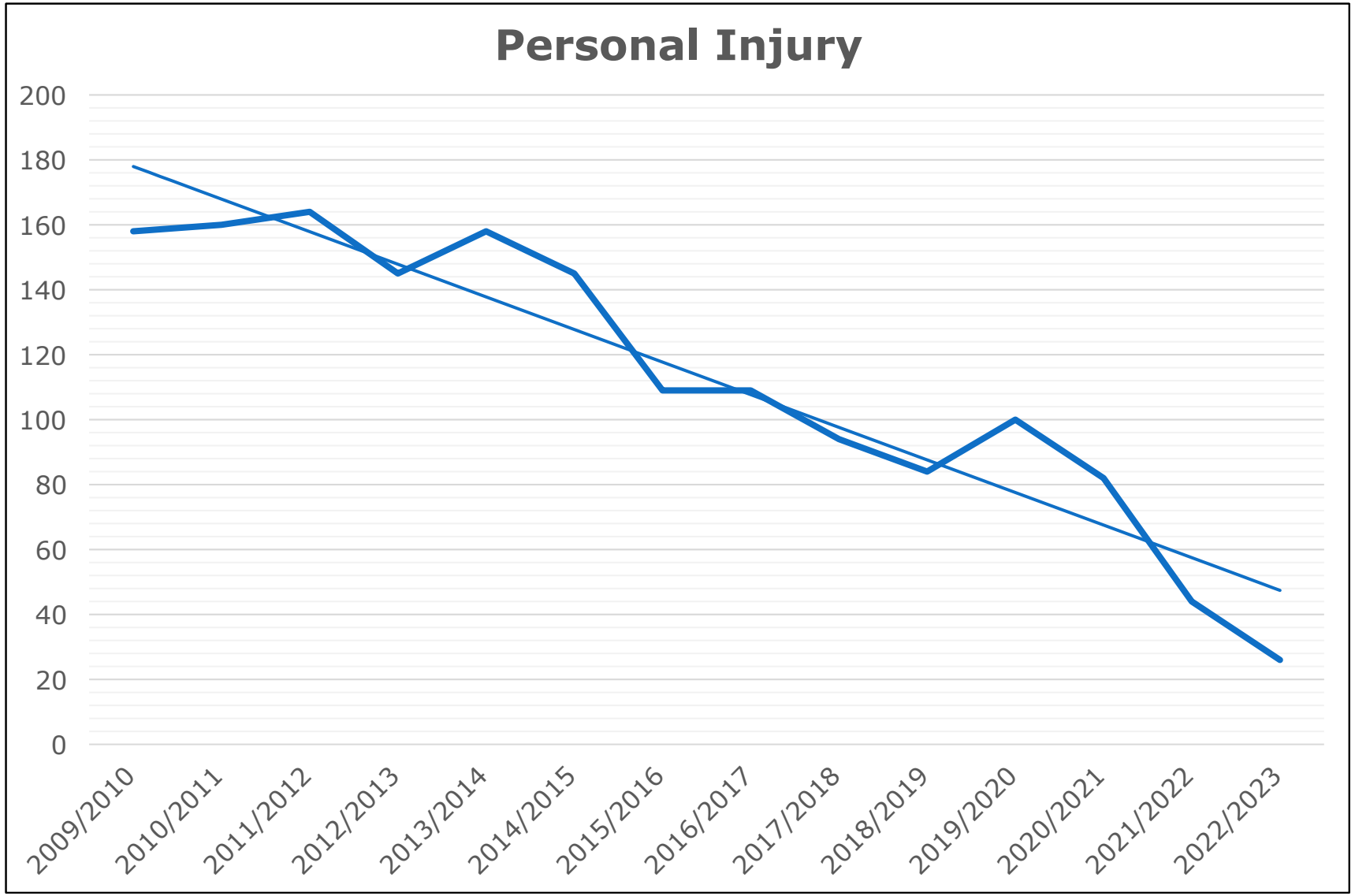








Claims, Redress & Inquests



Claims, Redress & Inquests

Learning and Improvement

- Over the period we have seen a significant number of IIW's (Inquests In Writing). These can only take place where HM Coroner for Gwent is satisfied with the quality of witness statements and Serious Incident reports from the Health Board, leading to timely answering of questions from families, and reducing the number of staff required to attend inquests in person.

- Only 1 Regulation 28 Report from Coroner this period (assurance re prevention of future deaths). Concern re paper referrals between services. ABUHB response in hand and due early June.

- All Claims and Redress matters require submission of *Learning From Events Reports* to the Welsh Risk Pool (WRP). Our learning/assurance/actions are scrutinised by a clinically led *Learning Advisory Panel.*

- Following approval of ABUHB learning and improvements at the WRP Committee on 15 March, £12 million was approved for reimbursement to the Health Board.

Claims, Redress & Inquests

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

Health, Safety & Security

Health and Safety Executive Engagement

The Health and Safety Executive (HSE) have **two ongoing cases** within the Health Board.

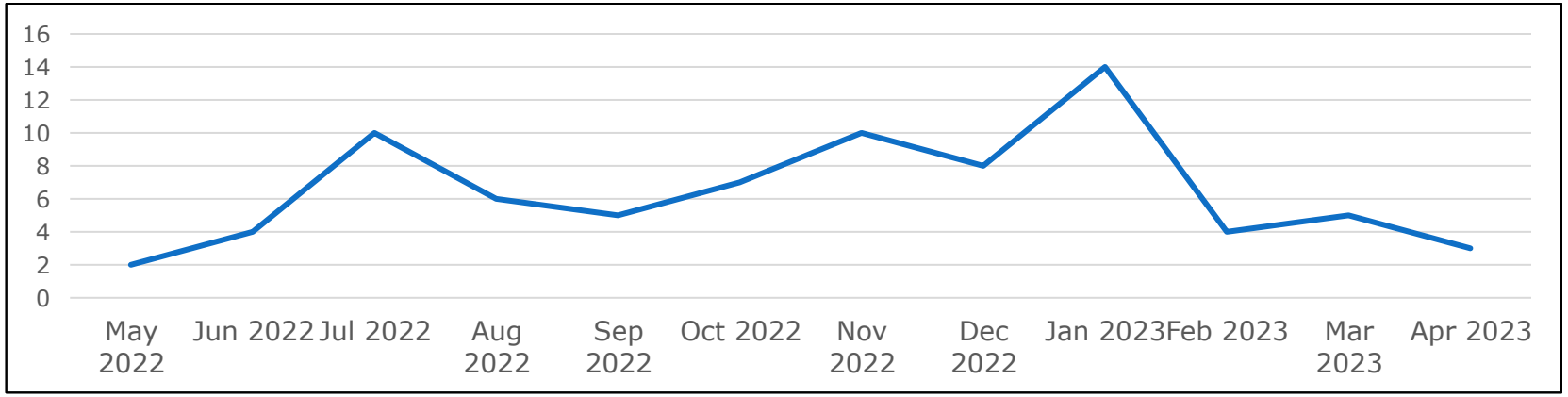
A patient fall at Nevill Hall Hospital (*HSE visit planned for 15 June 2023*) and an inspection of Pathology at Royal Gwent Hospital. (*Awaiting evidence of validation to provide assurance to the HSE and close the file*)

An internal audit relating to the Monitoring of Health and Safety Executive (HSE) Action Plans provided reasonable assurance, however, an SOP needs to be developed to provide clarity on the process for managing HSE engagement.

Health, Safety & Security

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period May 2022 to April 2023 the Health Board reported **78 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).



49% of these cases were reported within the legal timeframes within the legislation. However, since February 2023 there has been an improvement with only 2 incidents (out of 12) being reported late.

Health, Safety & Security

Health and Safety Statutory and Mandatory Training

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

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

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

Health, Safety & Security

Stress at Work Risk Assessment & Guidance

A working group in relation to Health at Work has been developed to review various topics of health hazards across the Health Board.

Stress at Work is part of the working group and a draft Stress risk assessment and guidance has been developed, aligned to the HSE Stress Management Tool.

The assessment and guidance will provide individuals with tools to identify possible causes of Stress but also have those discussions with their Line Managers to put measures in place to manage it.

#BeKind Campaign

As part of the #BeKind Campaign a staff survey was made available between 16 and 31 March 2023. A total of 364 survey responses were received.

The information collated from the survey will support an awareness campaign on reducing violence at work.

The campaign will aim to increase knowledge of Health Board policies and procedures for managing violence and aggression.

Infection Prevention

ABUHB – Reduction Expectation Goals

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

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

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

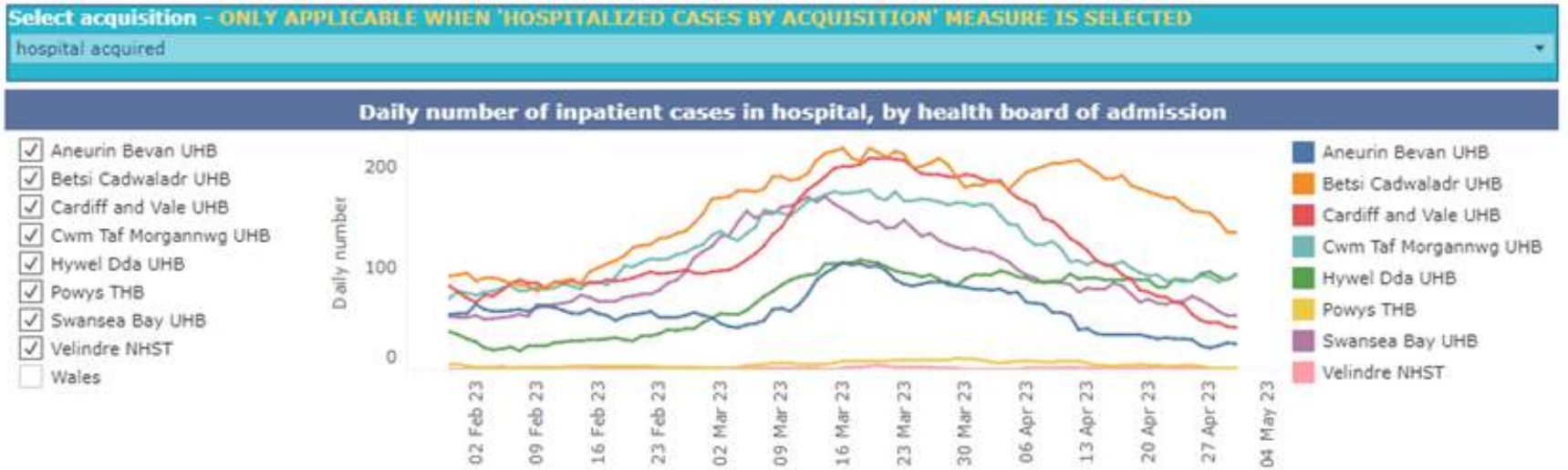
	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	193	32.26	12	2.01	126	21.06	138	23.07	315	52.66	118	19.73	18	3.01	451	75.39
Betsi Cadwaladr UHB	301	42.79	17	2.42	171	24.31	187	26.59	511	72.65	144	20.47	38	5.40	693	98.53
Cardiff and Vale UHB	139	27.55	12	2.38	134	26.56	144	28.54	306	60.65	134	26.56	25	4.96	465	92.17
Cwm Taf Morgannwg UHB	114	25.34	4	0.89	143	31.79	147	32.68	382	84.92	85	18.90	40	8.89	507	112.71
Hywel Dda UHB	204	52.35	14	3.59	99	25.40	113	29.00	335	85.96	117	30.02	29	7.44	481	123.42
Powys THB	12	9.02	0	0.00	0	0.00	0	0.00	1	0.75	1	0.75	1	0.75	3	2.26
Swansea Bay UHB	201	51.41	12	3.07	139	35.55	151	38.62	264	67.53	107	27.37	44	11.25	415	106.15
Velindre NHST	3		0	0.00	2		2		11		1		0		12	
Wales	1,167	36.82	71	2.24	814	25.68	882	27.83	2,125	67.04	707	22.31	195	6.15	3,027	95.50

Current Position

E Coli	314 cases of E coli reported from Apr 2022 to Mar 2023. This is -9% fewer than the equivalent period 2021/22. Provisional rate is 52.66 per 100,000 population. 30 cases of E coli reported from Apr 2023 main source remains UTI
C diff	192 cases of C diff reported from Apr 2022 - Mar 2023. This is -6% fewer as than the equivalent period 2021/22. Provisional rate is 32.26 per 100,000 population. 11 cases of C diff reported from Apr 2022 .
Klebsiella	118 cases of Klebsiella reported from Apr 2022 to Mar 2023. This is 27% more than the equivalent period 2021/22. Provisional rate is 19.73 per 100,000 population. 11 cases of Klebsiella reported from April 2022
Staph aureus	137 cases of Staph aureus bacteraemia reported from Apr 2022 - Mar 2023. This is 3% more than the equivalent period 2022/22. Provisional rate is 32.26 per 100,000 population. 5 cases of Staph aureus bacteraemia reported from Apr 2023
Pseudomonas	18 cases of Pseudomonas reported from Apr 22 to Mar 23. This is -42% fewer than the equivalent period 2021/22. Provisional rate is 3.01 per 100,000 population. 2 cases of Pseudomonas reported from April 2023

Infection Prevention

ABUHB – Covid-19



Current Position

Inpatients	Currently 10 inpatients testing symptomatic patients only, staff risk assessment updated and aligned to sickness policy. Respiratory patient pathway reviewed and transferred from A1 to MAU 2
Outbreaks	No wards or bays closed (17.05.23)
Care Homes	1 outbreak, 5 care homes with incidents reported, 111 covid free (11.05.23)

Infection Prevention

Reduction Expectation Goals

Issue	Cause	Remedial Action	Who	When
Reduction of healthcare associated infections (awaiting WG update 2023/24)	• Antimicrobial stewardship & resistance • Slippage with proactive deep clean • Fundamental Infection Prevention measures not sustained at 95% • High acuity of patients • Secondary infections post Covid-19 • Patients presenting septic in secondary care • Ongoing waiting times for elective surgery for biliary conditions • Capacity and boarding patients	• Refreshed action plan developed ongoing monitoring via RNTG • Roll out of Antimicrobial risk kit (ARK) • Aseptic Non Touch Technique (ANTT) roll out with the aim of achieving bronze accreditation • Focus on care bundles & device management • Proactive HPV programme developed and monitored via RNTG • RCA process reviewed to incorporate duty of candour • Successful hand hygiene campaign • Promote awareness for admission screening for MRSA and CPO	Divisional Management Team Antimicrobial pharmacist Infection Prevention Team	Monthly review via Reducing Nosocomial Transmission Group

COVID-19 Investigations

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

No. cases referred to Legal & Risk

Wave 1: 100% complete

Wave 2: 15.18% complete

Wave 3: 53.58% complete

Wave 4: 26.19% complete

Data as of 30 April 2023

Highlights:

- No cases referred to Legal & Risk
- Non-Clinical Investigator strategy increasing team performance
- Incoming enquiries from patients and/or relatives extremely low
- No increase in support requests to Llais

Challenges:

- Team performance currently tracking below required trajectory to complete programme on time.

Mitigating Actions:

- Further Recruitment of 3 x Full Time Non-Clinical Investigators in progress
- Further Recruitment of 2 x Full Time Clinical Investigators in progress

COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Delayed start to programme & resource to complete programme on time.	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 outcome positive. Further recruitment in progress.	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
Availability & time to locate clinical notes.	Clinical notes sparse for COVID-19 identification & management. Locating pertinent notes due to non-chronological back scans. Mental Health notes in off-site storage facilities.	N/A N/A Liaising with Health Records colleagues	COVID-19 Investigation Team (CIT)	On going

Safeguarding

Data Analysis

The Corporate Safeguarding Team developed a number of data collection tools, to capture themes and trends.

These areas of data include: -

- Child and Adult Duty to Reports
- Child Protection Medicals
- PRUDiC's
- Child Strategy Discussions
- Section 5 Practitioner Concerns

Now these data collection systems are in place, the CST is developing a dashboard to capture themes and trends and inform future reports.

Safeguarding System Assurance

- 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.

- Conversations are already underway with colleagues in Primary Care to determine how we can clarify expectations, strengthen policy/process within GP Practices and monitor their compliance.

- Whilst work across Primary care is a priority, further consideration will need to be given to similar processes for all other independent contractors in due course.

Safeguarding

Current Practice Review

The Corporate Safeguarding Team are currently supporting Safeguarding Boards with:

- 3 Child Practice Reviews
- 2 Domestic Homicide Reviews

In addition the Adult Practice Review for Adult A has recently been published by the Gwent Safeguarding Board.

This case related to an Adult who was cared for in their own home, was open to several agencies and died following a fall.

The review highlighted good practice by ABUHB District Nurses, Mental Health Services and General Practice, adding that this was clearly patient centred.

Whilst there are no specific recommendations made to ABUHB, the over arching theme is that in cases where patients are open to multiple agencies, there is no formal role for case/care co-ordination.

A multi agency recommendation has been made to establish how agencies can ensure effective a proactive communication/sharing of information where no Care Co-Ordinator is in place. This recommendation will be taken forward by the Safeguarding Board, with ABUHB being active participants.

Safeguarding

Training and Development

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

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

- Safeguarding level 3 training packages have been revised and commenced in April 2023. Evaluating well at the current time.
- Divisional leads urged to support the training plan by encouraging staff to book on to training. To ensure this is manageable it has been suggested that higher banded staff (6-7s) attend first then gradually working down to their Band 5 staff.

Safeguarding

Issue	Cause	Remedial Action	Who	When
Timeliness and Quality of Child Safeguarding Referrals from ABUHB Professionals	Practitioners are not always recognising the requirement to refer or prioritising the completion of the DTR forms, despite recent steps to simplify the process through introduction of online forms.	• Remedial plan offered by Senior Nurse in ED. • Education and support continuing from CST. • Regular meetings between CST and ED Management Team to monitor progress • Recent (May 2023) feedback from LA suggests an increase in frequency of referral, though highlights further work is required in regard of quality/completeness	Corporate Safeguarding Team Emergency Care Team	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
Partner concerns relating to ABUHB engagement in MARAC meetings	Due to workload pressures and shortages in the team, a trial was arranged to share MARAC research and receive actions by return, but not attend the meetings.	• Changes to staff establishment, from existing funding, to increase CST Admin resources to prepare research (interviews June 2023) • Re-engagement of Safeguarding Leads in attending MARAC meetings.	Corporate Safeguarding Team	July 2023

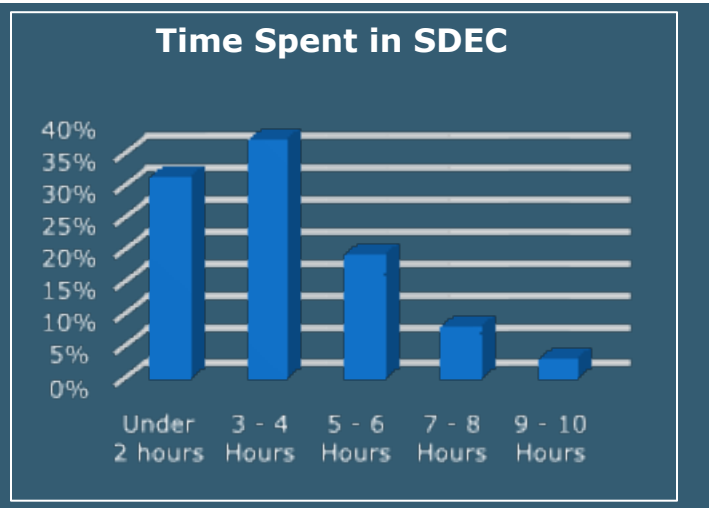
Escalated risk concerns outside of the pillars

Section 3

Escalated Risk Concerns

- Deprivation of Liberty (DoLS) assessments and waiting lists
- Health Inspectorate Wales - Ty Lafant Inspection Report/South Wales Argus article
- Notification of outlier status for National Clinical Audit - Standard Operating Procedure being followed for outlier process
- Dashboards have been developed within the Datix system to provide managers with relevant information relating to incident management. This includes open incidents, themes and trends and more recently tracking systems to support the Duty of Candour.

SDEC GUH at a Glance 8/8/22 – 19/5/23



4553 Patients seen

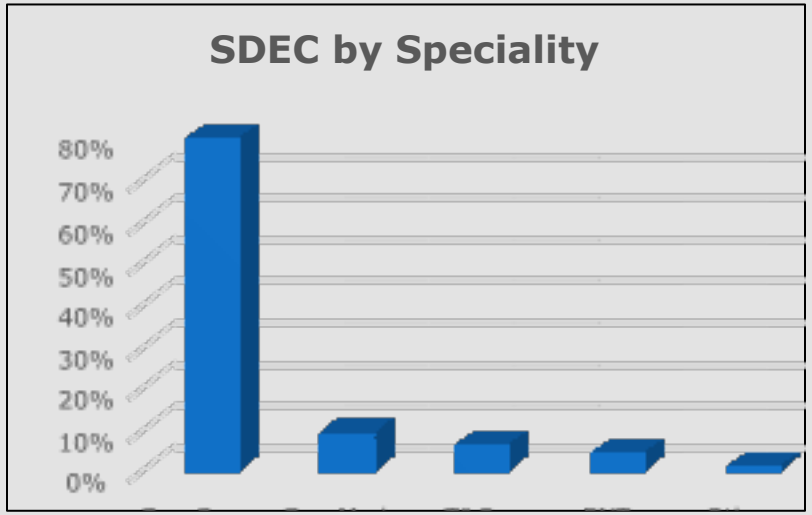
Average 29 Patients per day

434 Next day Returners

Median time 4 hours

3824 patients Discharged Same Day (84%)

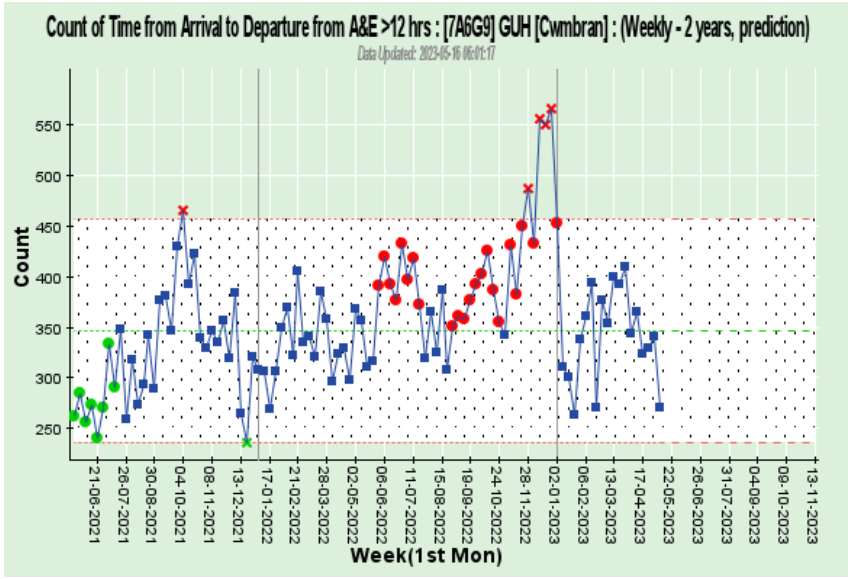
729 Admissions

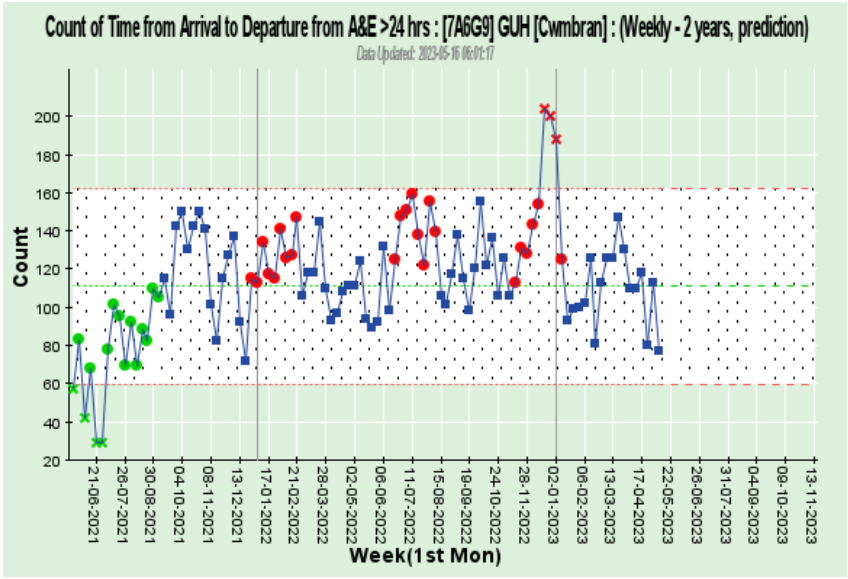


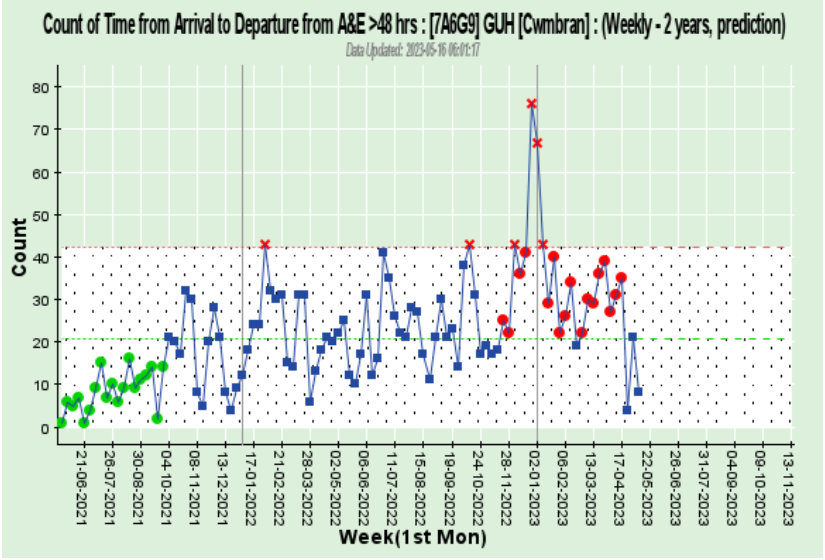
Progress Summary:

- Average daily patient throughput up from 26 to 29
- Surgical model working very well:
  - Established GP referral process via Flow Centre
  - T&O pathway established
  - ENT Pathway in pilot for 3 months
- Consistent Positive feedback from patients and SAU staff
- General medicine utilization continues to increase since Jan 23
- Pathway for Maxfax, Gynae and Gastro also established
- SDEC has never been used for in-patient capacity

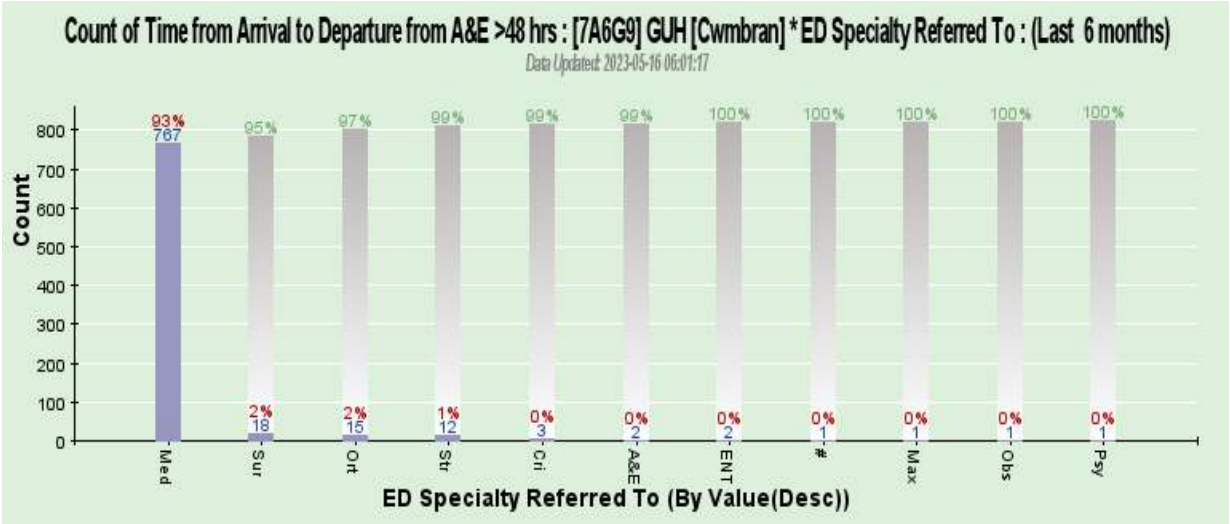
Urgent & Emergency Care

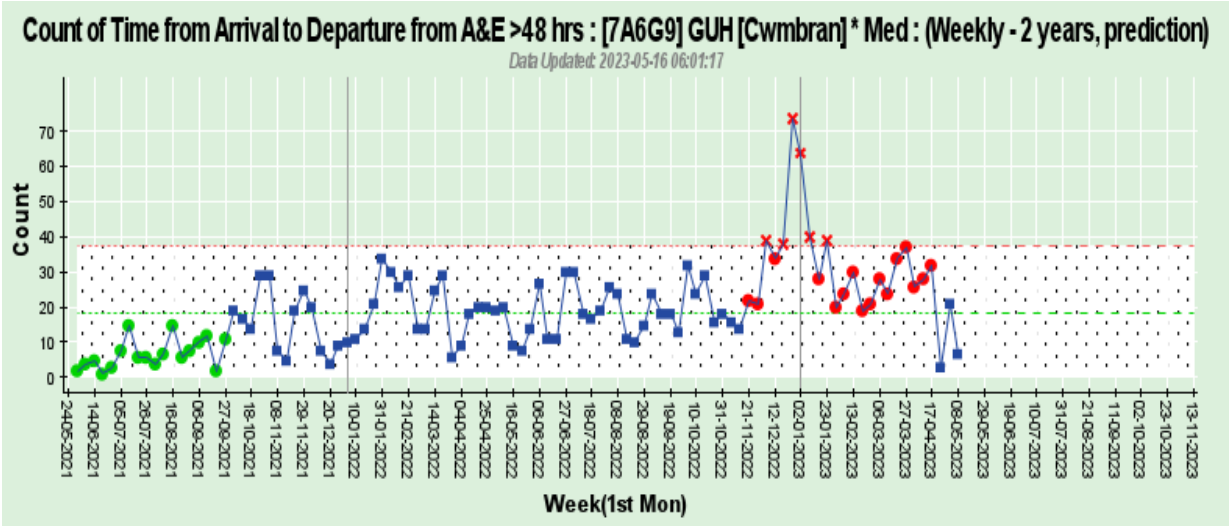






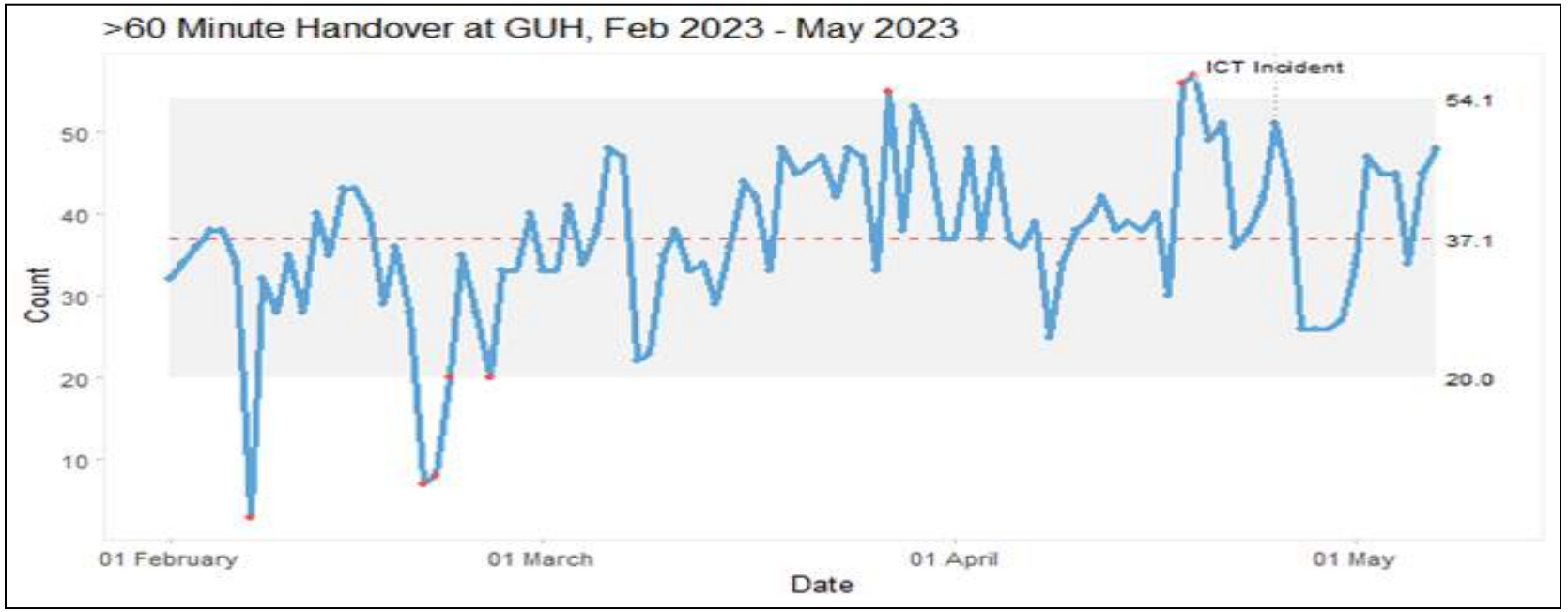
Urgent and Emergency Care

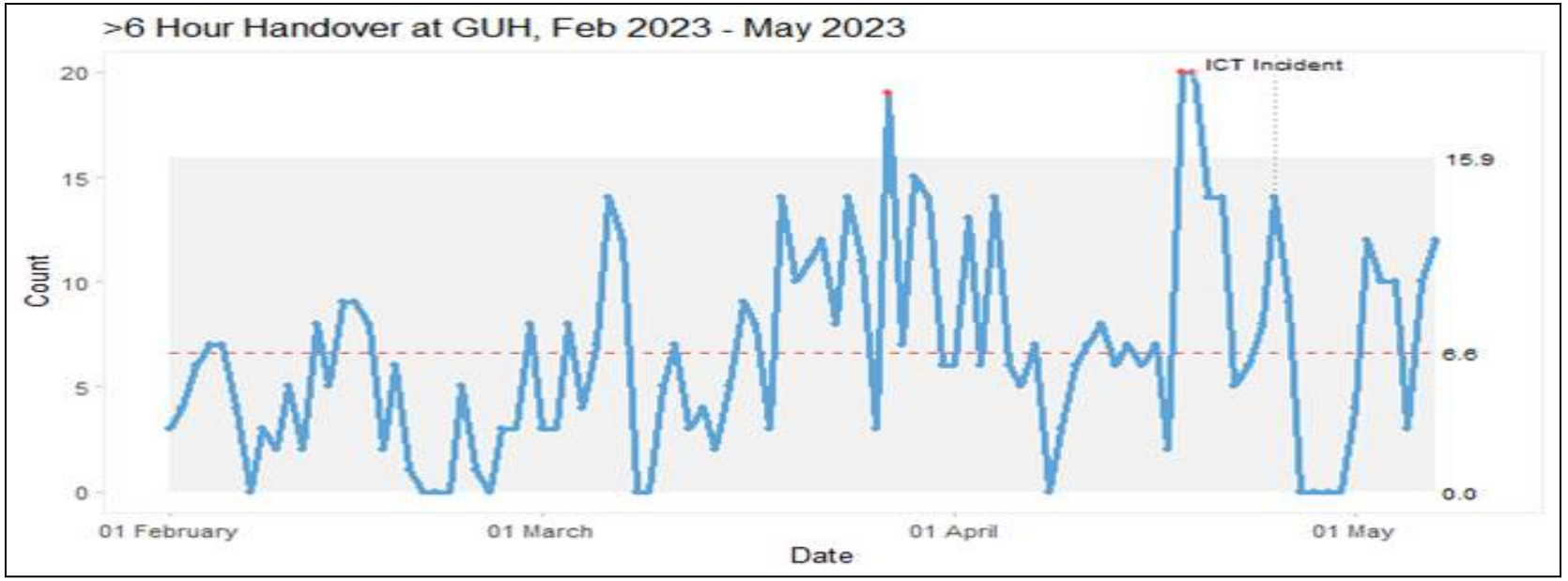




93% of the 48+ hour waits in ED are for medical specialties. The time to departure for medical specialties over 48 hours are normally occurring at around 18. Numbers were ranging from 20-37 from 30th January until 17th April, but have been lower for the past 3 weeks.

Urgent & Emergency Care

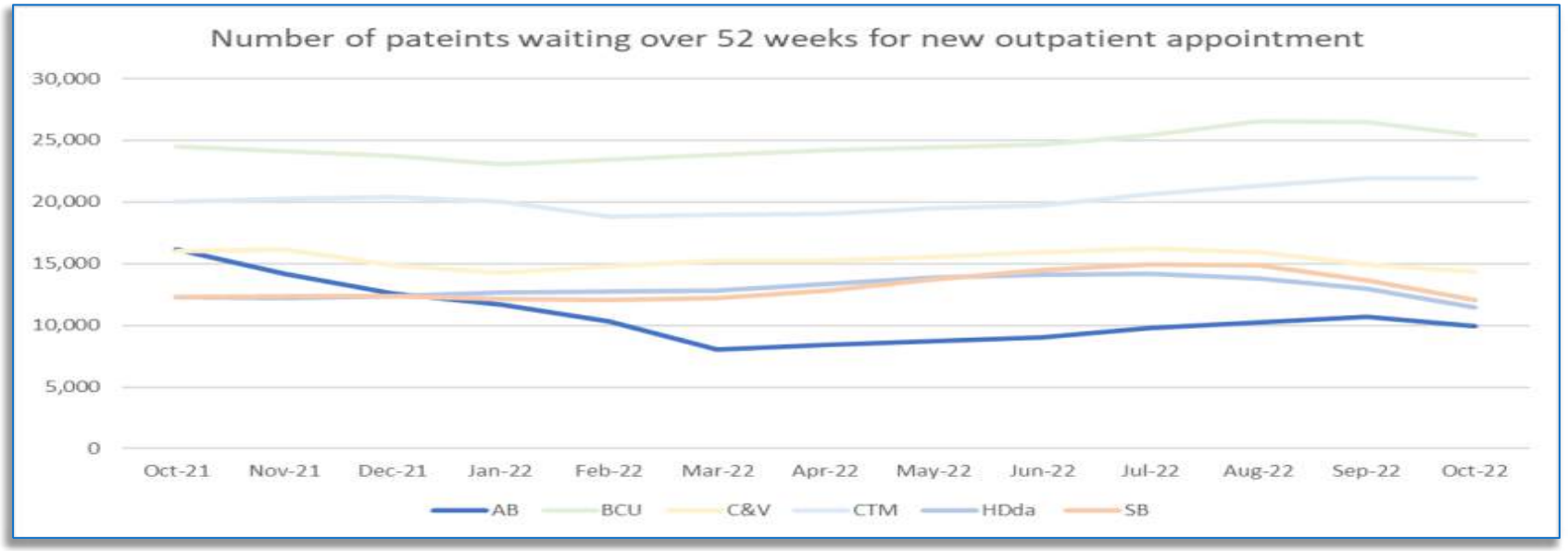


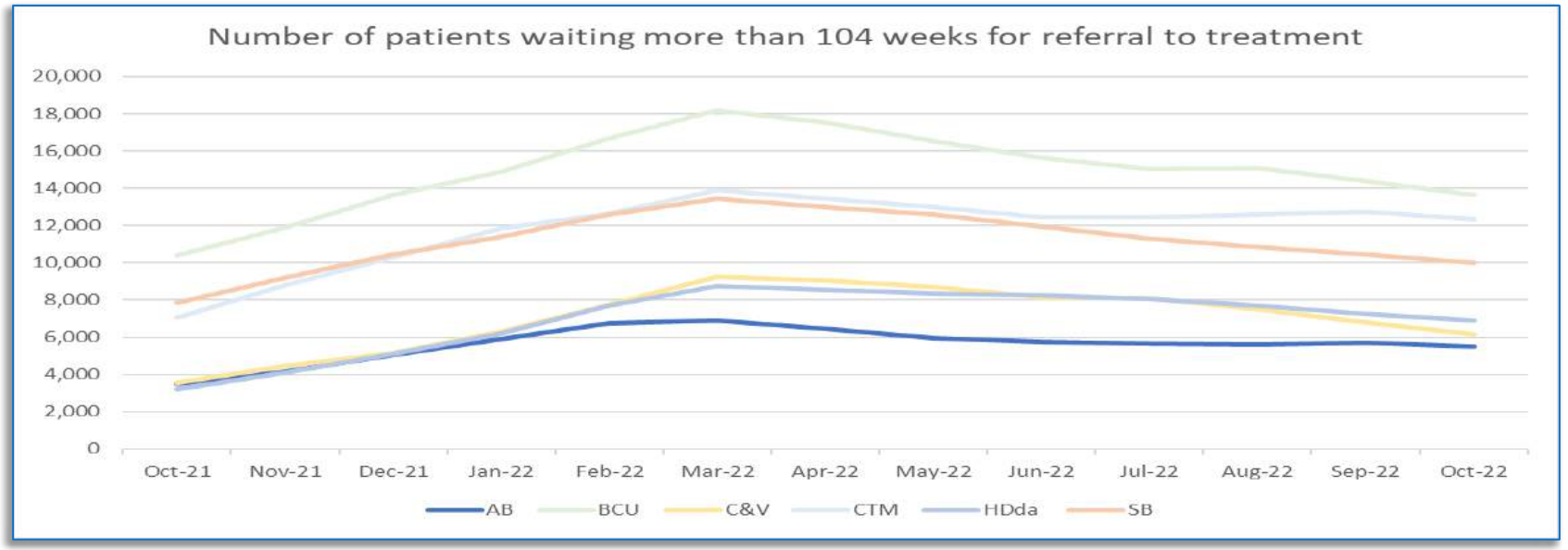


Urgent & Emergency Care

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

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

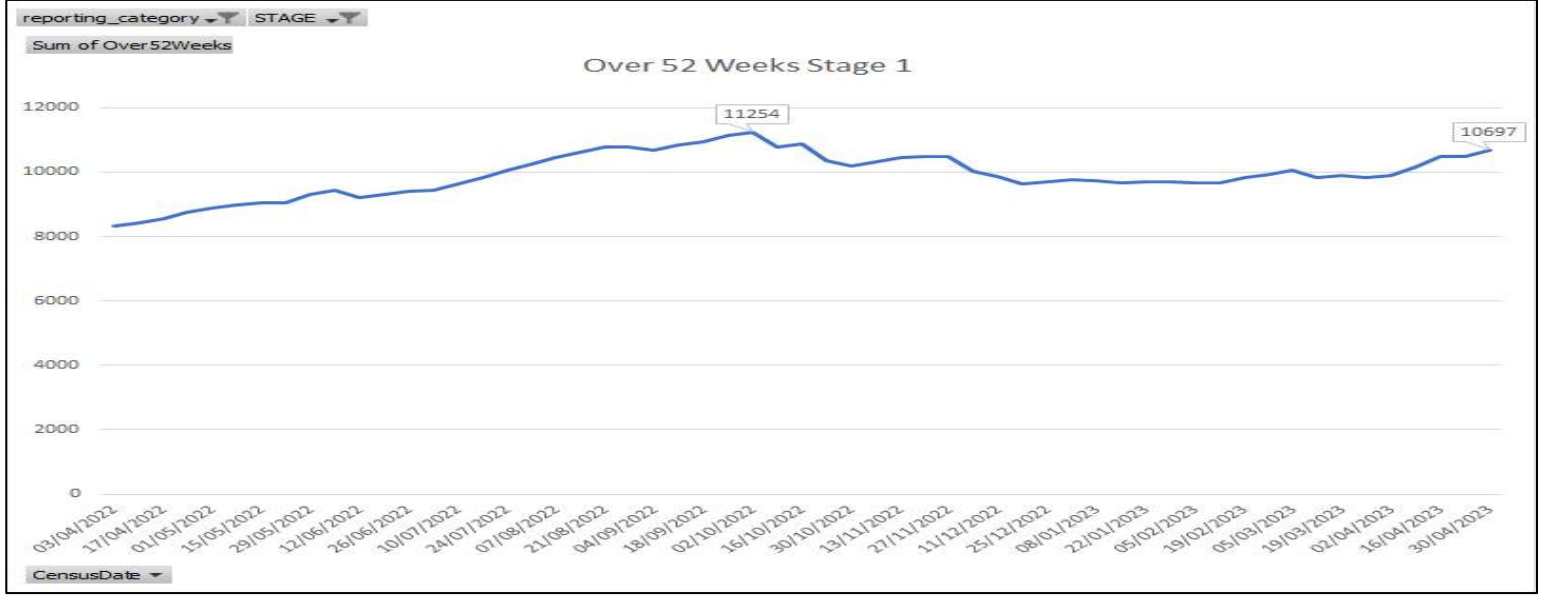




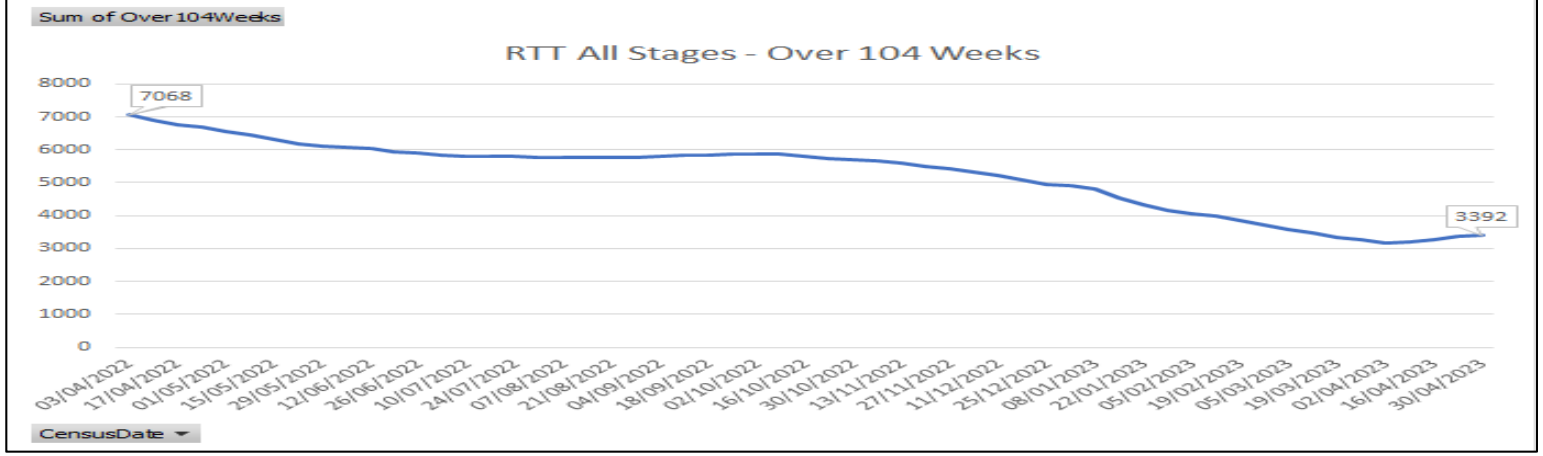
Planned Care

RTT Weekly Snapshot *(reportable activity only)*

RTT – Stage 1 (New Outpatients) Over 52 Weeks



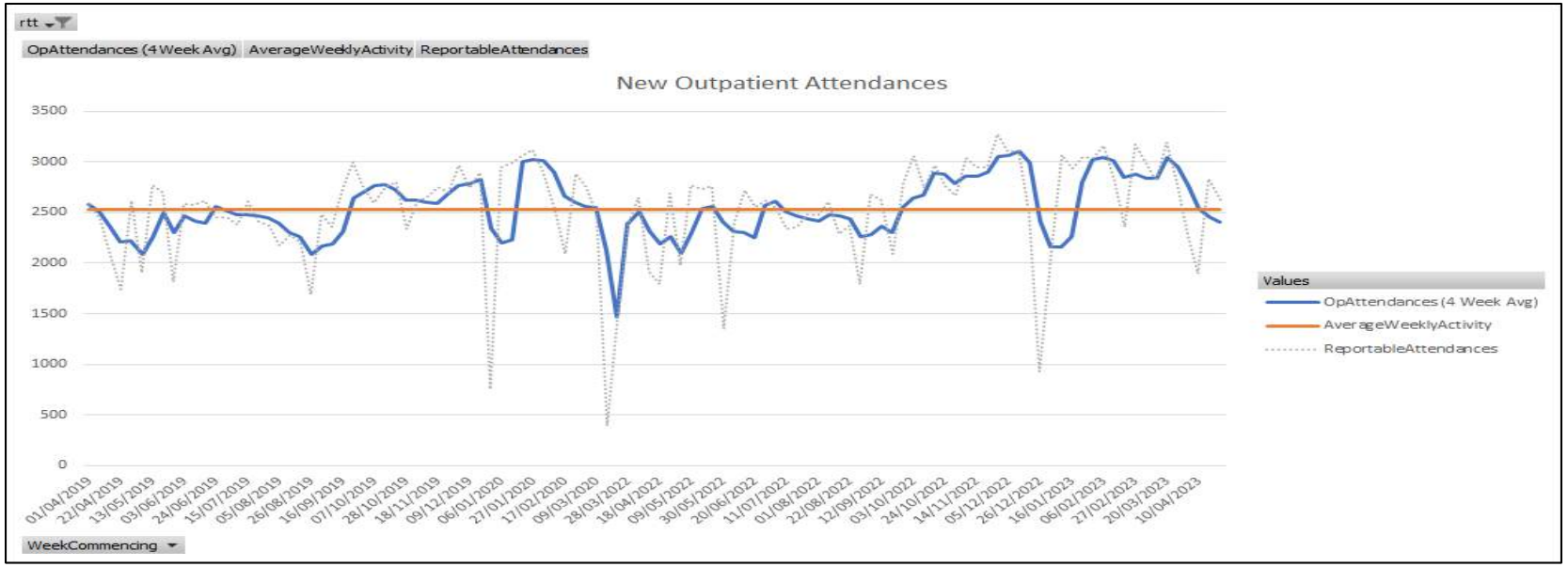
RTT – All Stages Over 104 Weeks



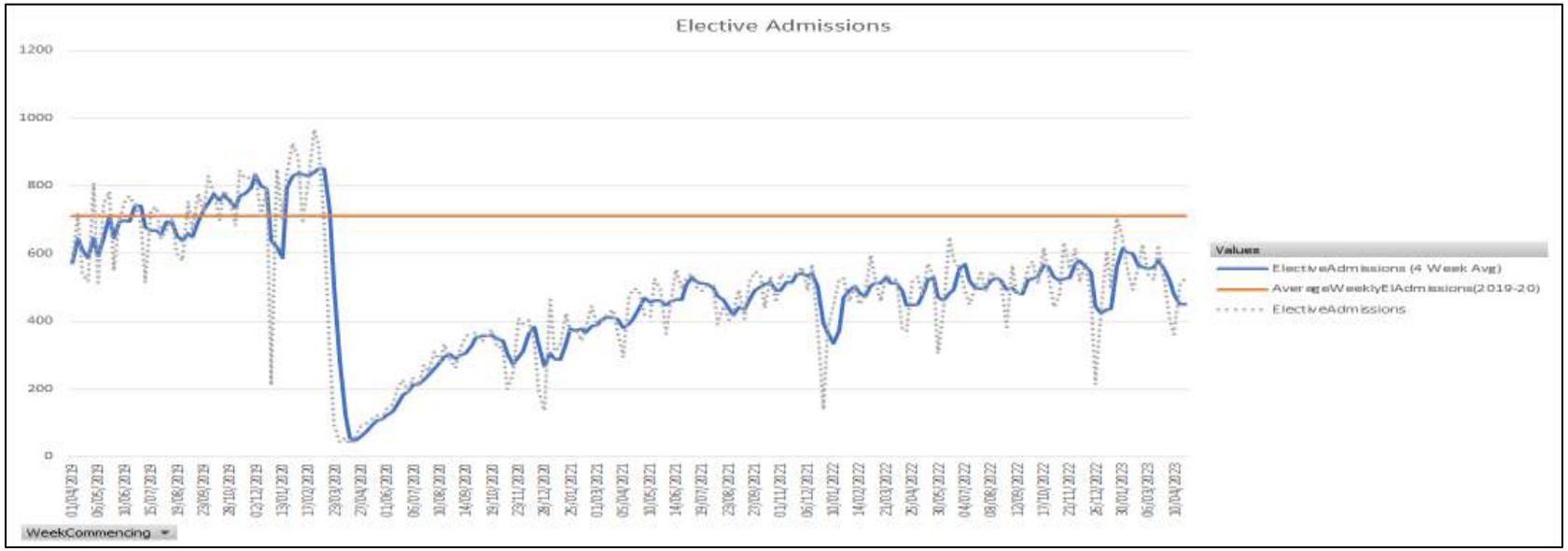
Planned Care

Activity Summary

Outpatients



Elective Admissions



Planned Care

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

Outpatients

reporting_category	RTT Reportable

Over 52 Weeks Stage1(Current Week)	Change Stage 1 Over 52 Weeks (past 5 weeks)	Model Forecast Over 52 Weeks St 1 (CurrentMonth)
10697	861	9966
		731

Over 104 Weeks Stage1 (Current Week)	Change Stage 1 Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks St 1 (CurrentMonth)
1000	214	405
		595

Division/specialty	Over 52 Weeks Stage1 (CurrentWeek)	Model Forecast Over 52 Weeks St 1 (CurrentMonth)	Variance Against Model 52 Weeks Stage 1	% Var Againt Model St 1 52W Status	Change Stage 1 Over 52 Weeks (past 5 weeks)
Clinical Support Services					
Chemical Pathology	36		36		4
Family and Therapies					
Gynaecology	20		20		-23
Medicine					
Diabetes & Endocrinology	1		1		-5
Gastroenterology	1		1		-3
Scheduled Care					
Dermatology	1		1		0
Ear Nose & Throat	3668	3290	378		309
General Surgery	22		22		21
Maxillo-Facial	379	354	25		38
Ophthalmology	3696	3771	-75		380
Orthodontics	136		136		-7
Trauma & Orthopaedic	1881	1746	135		38
Urology	856	805	51		109
Grand Total	**10697**	**9966**	**731**		**861**

Stage 4 Treatment

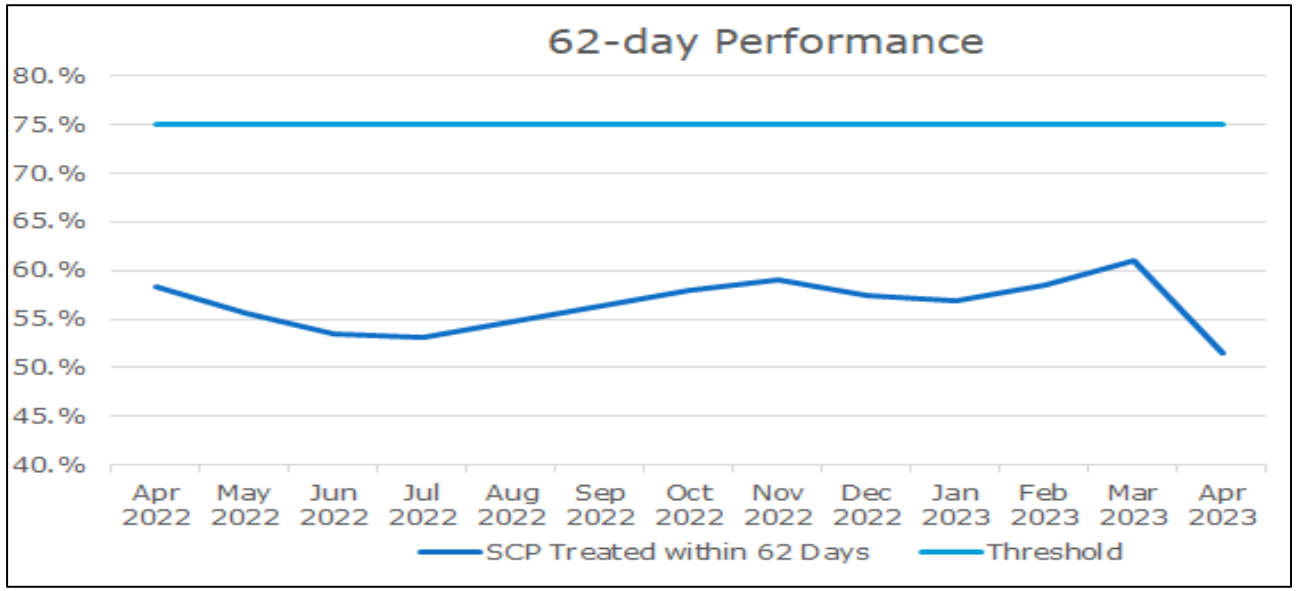
reporting_category	RTT Reportable
STAGE	(Multiple Items)

Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks (CurrentMonth)
1787	-116	1837
		-50

Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)	Model Forecast Over 156 Weeks (CurrentMonth)
653	-122	500
		-153

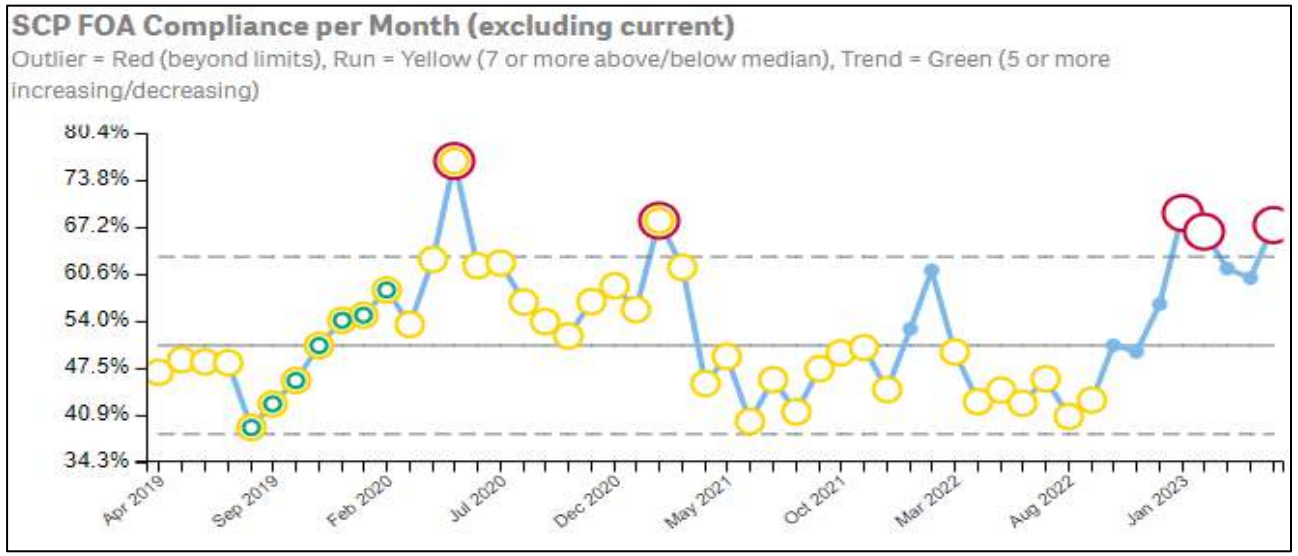
Row Labels	Over 104 Weeks (Current Week)	Model Forecast Over 104 Weeks (CurrentMonth)	Var Against Model Over 104 Weeks		Change Over 104 Weeks (past 5 weeks)
Scheduled Care					
Ear Nose & Throat	275	285	-10		-22
General Surgery	82	65	17		14
Maxillo-Facial	9		9		0
Ophthalmology	4		4		4
Trauma & Orthopaedic	1200	1271	-71		-100
Urology	217	216	1		-12
Grand Total	**1787**	**1837**	**-50**		**-116**

Cancer – 62 Day Performance



The provisional view of April performance suggests a drop in compliance.

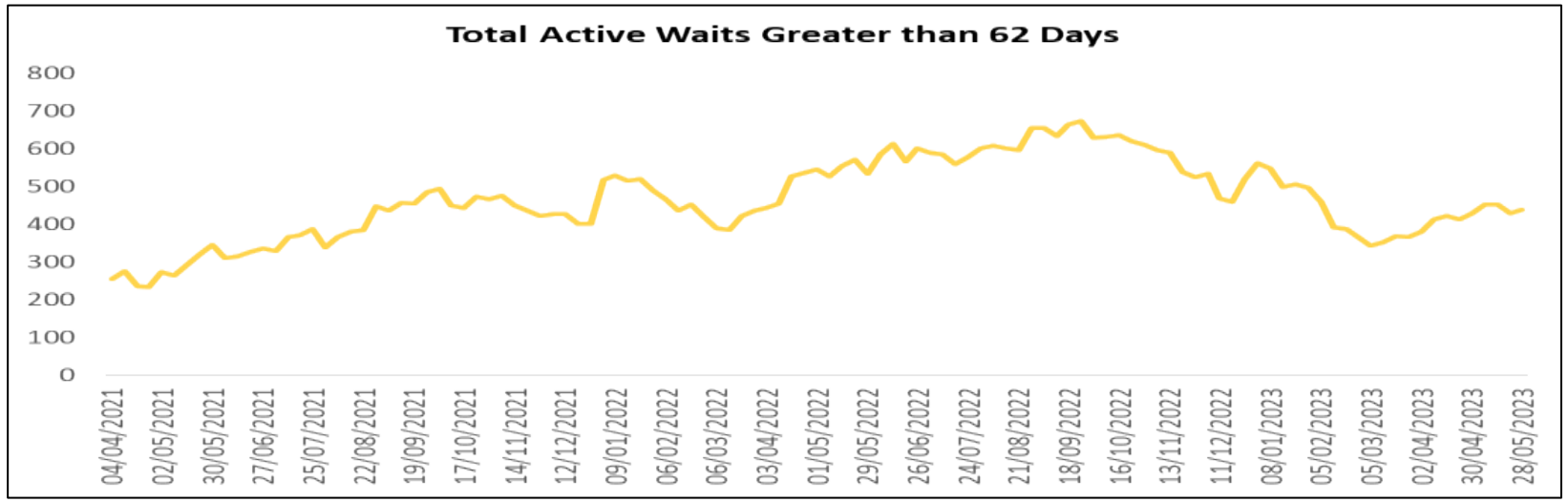
Treatments dropped quite considerably in April due to the Easter break and annual leave. Tumour sites continue to struggle with theatre capacity.

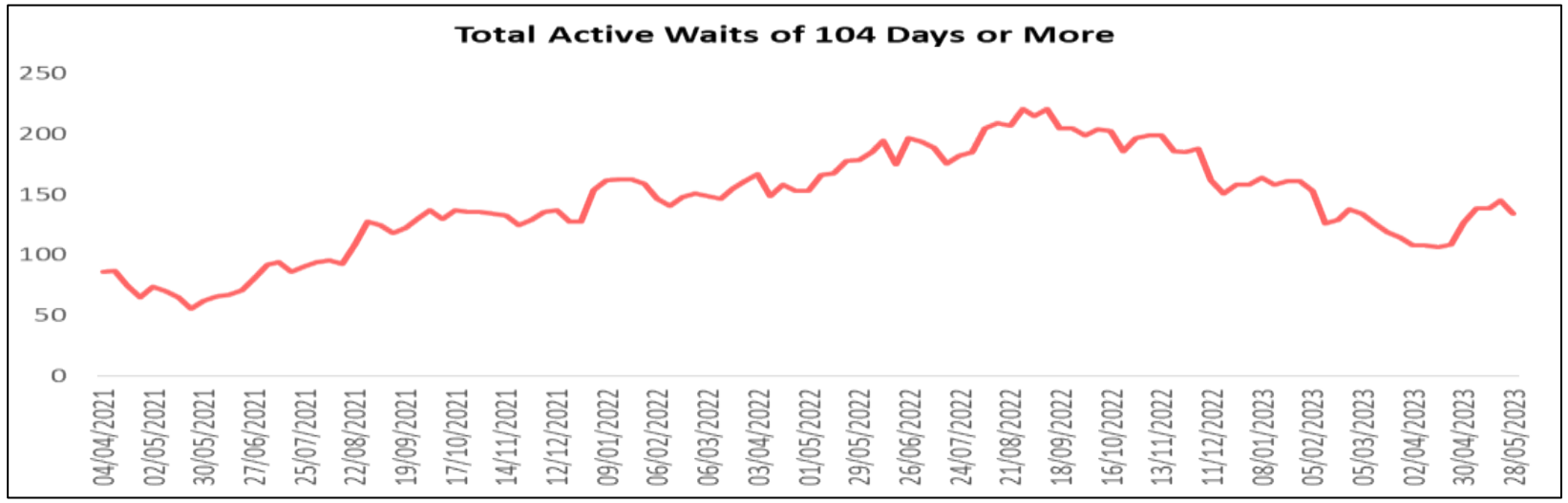


Focus on the front end of the pathway has resulted in a positive increase in the number of patients starting their pathway within 14 days.

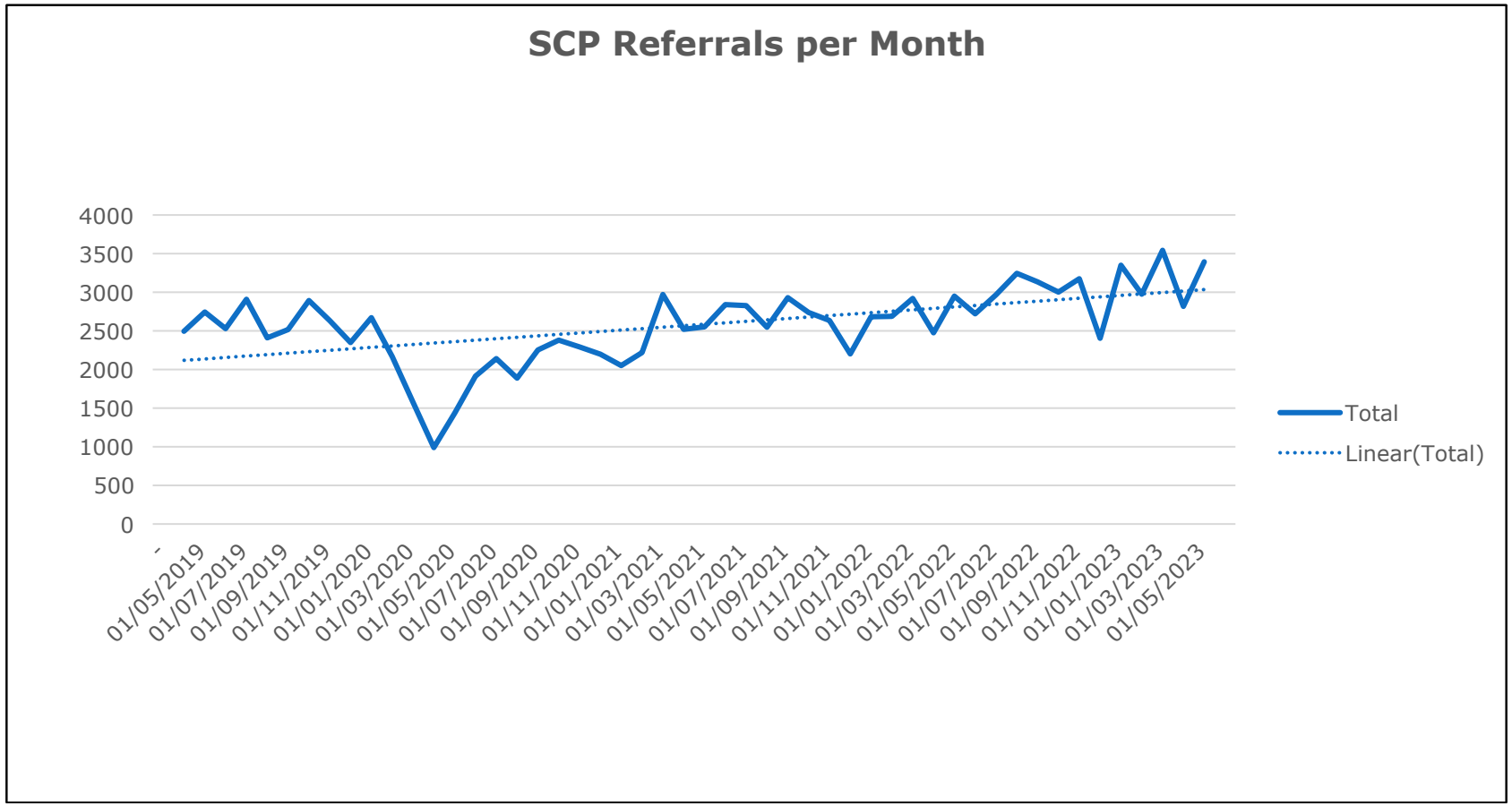
Cancer Backlog

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





SCP Demand



Demand continues to remain high with another spike in referrals in May in most tumour sites but primarily in Head & Neck, Skin, UGI and Urology.

Recovery Challenges

Issue	Cause	Remedial Action	Who	When
Colorectal theatre waiting times	Demand/Capacity shortfall	New job plans created to redistribute cancer workloads evenly amongst clinicians. Additional locum appointed however will not be undertaking Cancer work to begin with.	Dawn Baker-Lari	30/5/23
Delays in referral vetting in OMFS	On-call consultant only vets once a week on a Friday. Booking clerk not in work until Monday, can delay pathway up to 10 days	On-call consultant to undertake referral vetting every day.	Teresa Allcock	30/5/23
Rising Cancer Backlog	Loss of activity over end of financial year, Easter holidays and May Bank holidays	Backlog scrutiny exercise being undertaken in all major tumour sites. Renewed push on start of pathway to prevent further growth	Cancer Services & all tumour sites	30/5/23

For Information

Section 4

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 – March/ April 2023**	**Number of closed incidents/ complaints – March/April 2023**	**Total number of incidents/ complaints <u>not closed</u> and to be reported on/during the <u>next</u> 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)	**14**	**6** *(4 of which deemed unavoidable)*	**8**	**1** *(out of the 4 closed in March)* **1** *(out of the two closed in April)*	**2**
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	**7**	**4**	**3**	**0**	**0**
Medication errors never events	**0**	**0**	**0**	**0**	**0**
Any complaints about nursing care	**9**	**4**	**5**	**0** *(requires validation)*	**0** *(requires validation)*
Infiltration/ extravasation injuries	**14 adults 1 paeds**	**3**	**11 Adult 1 paeds**	**2** *(out of 3 closed)*	**0**

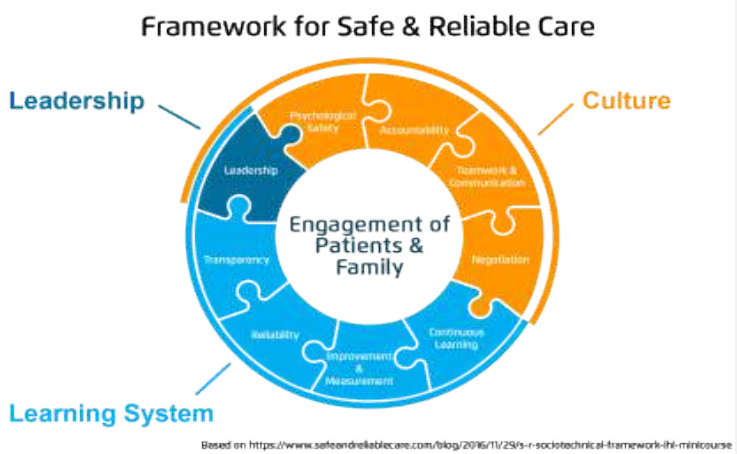
Nursing Staffing Levels Wales Act 2016

Issue	Cause	Remedial Action	Who	When
Incorrect categorisation of HAPU's resulting in inaccurate reporting.	Following RCA – categorisation not revisited and re-categorised to reflect outcome of RCA.	Further education and training for divisions on correct process.	Divisional Nurses Nurse Staffing Programme Lead	On-going
Focused review not been undertaken to determine if HAPU avoidable or unavoidable.	Staff unfamiliar with requirements of the new system to meet NSLWA requirements. Continue to populate RCA which requires manual pull through.	Further education and training for divisions on correct process.	Divisional Nurses Nurse Staffing Programme Lead	On-going
Investigation section not fully completed to determine nurse staffing levels and whether this contributed to the incident.	Staff unfamiliar with requirements of the new system to meet NSLWA requirements. The question "Is this related to nursing care" -if the investigator enters NO in the drop-down box- the NSLWA questions do not open.	Further education and training for divisions on correct process.	Divisional Nurses Nurse Staffing Programme Lead	On-going
Requirement to report nurse staffing levels aligned to complaints is ambiguous.	Complaints often multifaceted, spanning different wards, specialities, divisions and hospitals.	Staff reminded of the requirement to determine the root cause of a complaint and to complete the NSLWA component on Datix to determine nurse staffing levels at the time and whether this was considered a contributing factor.	Divisional Nurses Nurse Staffing Programme Lead	On-going
Validation of metrics in a timely manner.	The nature of the level of harm relating to the NSLWA means there is often a delay in validating the data as each incident requires a thorough RCA.	Divisions asked to review incidents in particular HAPU's and falls at the earlies opportunity and whilst the patient is still within our care to improve accurate and timely validation.	Divisional Nurses Nurse Staffing Programme Lead.	On-going

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	29/09/2023	This alert continues to be an issue for all Health Boards in Wales. HBs have just taken receipt of a letter from Welsh Gov which outlined the work that had been undertaken by a Task and Finish Group assembled specifically for PSA008. A new workplan for ABUHB to declare compliance with this alert is in progress.	**Non-compliant (work in progress)**
PSN065 The Safe Use of Ultrasound Gel to Reduce Infection Risk Compliance deadline: 28/03/2023	28/03/2023	The notice concerns best practice when using ultrasound gel, choice of sterile or non-sterile gel and specific infection control concerns associated with non-sterile ultrasound gel. The notice outlines the situations where sterile gel should be used in place of non-sterile gel.	**COMPLIANT** **Declared 23/03/2023**
PSA015 Safe use of oxygen cylinders in areas without medical gas pipeline systems Compliance deadline: 27/01/2023	01/03/2023	This alert outlines the best practice for the safe use of O2 cylinders, especially during periods of extreme pressures, when the demand for oxygen is greater, and patients might be placed in surge or escalation areas which do not have access to medical gas pipeline systems. The alert tackles the risks associated with using O2 cylinders with the following; • Patient safety • Fire safety • Physical safety Risk assessments are currently being undertaken in areas WITHOUT piped gas.	**COMPLIANT** **Declared 12/05/2023**
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients Compliance deadline: 29/09/2023	29/09/2023 **(in progress)**	Providing a unique identity for any unknown patient ensures safe and prompt diagnostic testing and treatment. The main risk here is blood test results being allocated to the wrong patient which could result in administration of an blood component. 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.	**In progress** **Aim: Sept 2023**



Safe Care Collaborative - update

Organisational Update:

- Learning Session: Individual Coaching sessions with each workstream
- Leadership programme of work scoping and workplan setting including commencement of the Exec walkarounds
  - Stage – Action Period 3
- Commencement of the capability and capacity building programme; Junior Dr's Improvement Forum, QPS leads.
- Data lead working with coaches and teams identified measures and baseline for the Acute and Ambulatory workstream.

Team Update:

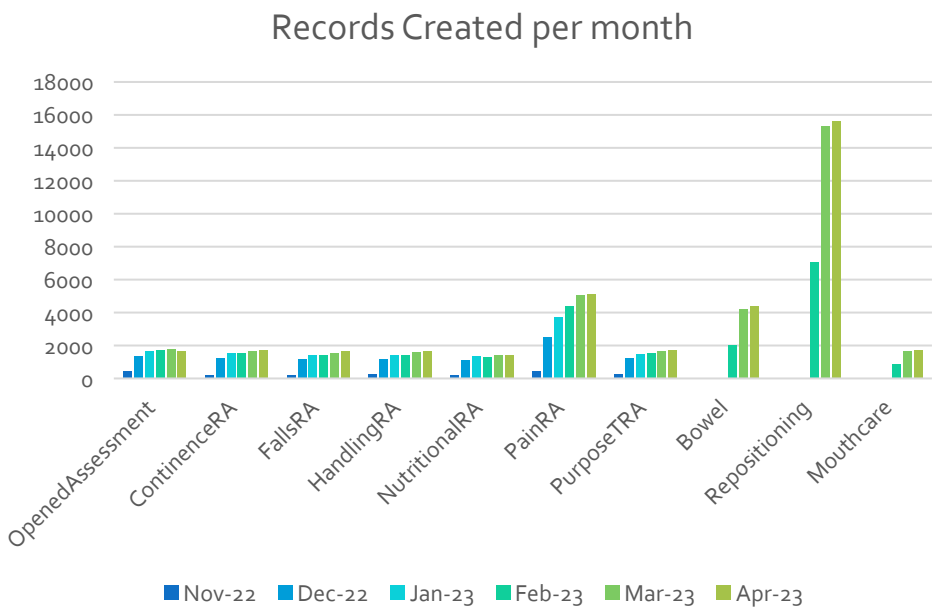
- 70% of teams identified specific SMART aim for their respective workstreams.
- Development of the organisational storyboard for Learning session 2.
- Key family of measures to be updated by next Learning Session – June. Includes outcome, process and balancing measures.
- Review of CATCH Team capacity and the potential to bring on new care home team.
- Recruitment of Theatres Quality and Patient Safety to the Collaborative

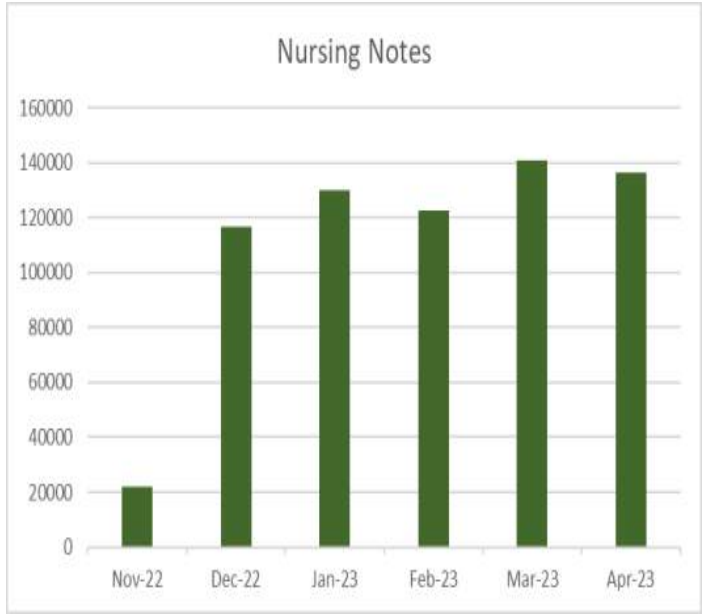
Workstream	ABUHB Team	IHI Score
Acute	Medical Assessment Unit at GUH	1.5
	Ward C0 (ENT surgical ward) at GUH	1.5
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU) at RGH	1.5
	Monmouthshire Integrated Team	1.5
Community	Clinical Assessment & Treatment in Care Homes (CATCH) at County	Team structure under review
	Mental Health OT Team	1.0
Leadership	Executives, Leaders for Safety, Faculty	1.5

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

Welsh Nursing Care Record

- Rollout commencing in Royal Gwent Hospital from 5th June 2023.
- YYF / St Woolos to follow the RGH implementation plan.
- Version 2.3 release due Sept 2023 with a single instance across Wales; no new form released but several key changes requested e.g. falls assessment.
- Positive news: significant uptake of the repositioning chart.





Welsh Nursing Care Record

Issue	Cause	Remedial Action	Who	When
Delay in getting a WNCR record started on two wards	Two 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	Work not started on creating dashboard output from data warehouse	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

Person Centred Care

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Equality and Diversity **(Stroke Services)**	People who have experienced stroke wish to have an opportunity to volunteer.	Meeting held with Head of Services Neurological Rehab to have an initial discussion about patients becoming volunteers and supporting stroke patients	Co-production will allow people who have experienced a stroke to gain an opportunity in volunteering	Neurological Rehab Team to forward PCCT details to those patients interested. Volunteer manager to meet with Neurological Rehab support group to discuss volunteering opportunities.
Equality and Diversity **(Alcohol Services)**	People who are recovering from alcohol misuse would like the opportunity to volunteer	Initial discussion with Assistant Practitioner Gastroenterology on volunteering opportunities to support patients	Offering volunteer opportunities will provide people who are recovering from alcohol misuse the opportunity to volunteer and gain a sense of purpose.	Volunteer manager to meet with patient group to discuss volunteering opportunities.
Equality and Diversity **(Aspergers)**	Contact from a mother whose daughter has Aspergers seeking a work experience placement for her	Met with young lady with Asperger's, sight and hearing impairment who would like a career in Admin. This young lady had been advised by her work coach this career is not appropriate. PCCT able to offer a Work experience placement. Contact made with Work Experience team and awaiting paperwork to be finalised for her to commence.	Defining a pathway to allow work experience for people with Aspergers will allow more people with the condition to gain work experience.	To commence placement and provide support so that the individual can gain a work experience and improve confidence.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Improved Signposting in Haematology	Request from Cancer Services to develop meet and greet volunteers to improve signposting.	Meeting held with Cancer Project Manager to 'meet and greet' volunteers to support patients that have multiple appointment on the same day at different departments. Emails sent to existing volunteers for expression of interest.	Signposting across Haematology will improve.	Await contact from exiting volunteers. Recruitment of meet and greet volunteers
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
Endoscopy DNA Rates in Cancer Services	There are high numbers of DNA's with endoscopy.	Discussion held with Cancer Project Officer to discuss establishing telephone befrienders to contact patients with upcoming Endoscopy appointments as a reminder. Aim is to reduce DNA rates (proof of concept) Emails sent to existing volunteers for expression of interest.	Telephone 'befrienders' will contact patients to remind them of their appointments at endoscopy.	Await contact from existing volunteers. Ongoing discussions around peer support through the Cancer Covid Recovery Steering Group

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Welsh Cancer Patient Experience Survey and Patient Story	Following the National Welsh Cancer Patient Experience Survey in which 1233 cancer patients gave overall rating 9/10, both areas of excellence and areas for improvement have been identified. **Areas of excellence:** • Patients felt they were told sensitively that they had cancer. • Information pre surgery is good. **Areas to improve:** • Prepare patients for the impact of cancer. • Opportunity to discuss individual concerns including emotional wellbeing.	Staff training and education in psychological support Wellbeing workshops on uncertainty, fatigue, mindfulness. Increase in expert by experience. Inclusion of wider communication methods, virtual face to face, BSL. Improved awareness of protected characteristics. Improved access and confidence for digital resources.	Work programmes identified and services designed to reach more cancer patients.	Implement and embed programme evaluate against benchmark.
PSA (Prostate specific antigen) self-management portal	Evaluation Evidence. Patients with prostate cancer require PSA monitoring for 5 years. Currently this is done via an outpatient clinic, but evaluation shows that other than receiving the blood results patients have few health concerns.	Introduction of *mymedical* record a digital platform that will manage PSA monitoring remotely. Patients meeting criteria, will attend workshop re self-management and then enrol on platform.	Reduces outpatient appointments, increases capacity. Gives patients control, increasing their ability to manage their health and reduces anxiety. Increases assurance in follow up.	Go live is 29/5/2023 Evaluation of services with learning cycles.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Cancer services: optimising health for cancer patients	GPs at referral for cancer struggle to consistently optimise health due to time constraints.	Development of a digital patient self-assessment tool sent by Drdoctor, to assess health behaviours, i.e., smoking, exercise, diet, and emotional wellbeing, sent to patients referred with suspected cancer.	Potential to reach 35000 cancer referrals a year, with 468 sent to date, and 600 responses. Indicating that patients are accessing the information more than once. Examples of the impact are: 22% of respondents smoke, and 53% would like to quit, 55% of patients would like to increase physical activity, 32% would like to improve their diet. The platform directs to information for self-management.	Evaluation form being sent to patients to assess the usability and benefits of the tool. Learning from this will influence next steps.
Volunteer to Career	People with additional learning needs and those who have not worked in the NHS need support to gain work experience.	Met with Additional Learning Needs Tutor from Coleg Gwent to support pathway 3 students in patient experience. Met with Workforce to update with work plan who in turn signposted personnel to discuss volunteer Wellbeing Assistant.	People with additional learning needs and those with no experience of working in the NHS will be provided with volunteer opportunities to gain experience.	Ongoing collaboration with WOD, colleges and job centres. Promotion of the Volunteer to Career Programme.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Staff Wellbeing **Chaplaincy Service**	Feedback from Staff Chaplaincy conversations and encounters with staff during ward visits, responsive calls, and other chance encounters. Common themes of tiredness, fatigue, working under pressure, feeling of not being valued.	Chaplaincy have provided pastoral support and listening for individuals as requested. Signposting as appropriate help. Responding with practical support through wellbeing sessions, (chill-out and Pop-Up wellbeing). Focusing support in areas of specific expressed need and responding to requests.	Evaluation of sessions very positive. Always requests for more and regular sessions. Scheduling sessions for staff groups where specific need is identified or expressed.	Planning and scheduling sessions each month across H.B. as manageable. Re-launch of Chill Out sessions across sites including more remote areas such as community clinics.
Religious Needs of Staff **Chaplaincy Service**	Engagement sessions with Muslim staff about facilities to support them in the work environment so that they can fulfil their religious obligations at various hospital sites.	Meetings arranged to listen and understand the concerns and needs of the staff group. In consultation with the accommodation request group and capital projects, a room was set aside and renovated for Muslim staff. The setting up of the new space also allowed for the existing small room to become a dedicated female Muslim prayer space, as requested.	Very positive feedback from staff. Muslim staff network (doctors) has promoted ABUHB as a 'good place' to work with good provision for Muslim staff when considering the obligations of faith.	Continued listening and learning with staff who have specific religious needs

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Bereavement and Grief and Loss Following Suicide **Chaplaincy Service**	Feedback from Staff Chaplaincy is regularly called to support staff with the care of families following death, but increasingly to support staff, when they themselves face loss of family or the death of a colleague.	Provide a range of training and practical support around bereavement and loss, also respond to specific situations as they arise, for example, staff suicide. Annual training event facilitated by chaplaincy that addresses current issues. This year, a training day about grief and loss following suicide has been arranged at GUH on the 26-05-2023. Guest lecturer, Dr Bill Webster	Previous training sessions have looked at sudden and expected death, supporting E.D. Baby loss and Neo-natal death, supporting our maternity and NICU wards. Sessions appreciated and evaluated well.	Continue to offer support for staff who experience loss/grief.
Patient Education **(Endometriosis)**	Feedback from Clinical Nurse Specialist Patients who experience endometriosis would benefit from self-management education.	Meeting with CNS Endometriosis to discuss options to raise awareness this condition and self-management of condition.	Patients with endometriosis will have better access to self-management education.	CNS to attend existing OAK sessions and to develop the training plan. Another meeting to take place once these sessions have been attended and discussion with Endo team. Meetings continuing. To look at patient education around consent in the future.

Person Centred Care: Listening and Learning from Feedback

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

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Dementia Care in Hospitals	Relative feedback supports the need to raise awareness of Dementia Standards and Hospital charter.	Presentation to Communication Champion Network of Dementia Standards, including hospital charter animation. Medicine Induction Day session on "How ABUHB supports Dementia Care". Met with Carer, responded to concerns. Actions for improvement agreed with ward teams, and senior MDT.	More awareness amongst ward-based staff on person centred dementia care	Roll out to all other wards over coming year.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Mental Capacity Act (MCA)	Concerns identified relating to compliance to the Mental Capacity Act across the Health Board.	Programme of training available to all staff • ESR • Short virtual sessions MCA and DoLS joint session x19 sessions = 80 staff MCA x22 sessions =223 staff DoLS x22 sessions = 155 staff Bespoke short sessions provided at various location including number of sessions: • YAB X5 • YYF X3 • County Hospital X5 • RGH X2 • Ty Siriol X5 • YTC X3 • St Woolos • CCU X10 • Rhymney Integrated Centre • Mass vaccination clinic staff Workshop for staff involved in decision making (full day) x 16 sessions = 155 Bespoke Workshop sessions provided on request. • Community LD Team • SaLT • Scheduled and Unscheduled Care x4 sessions • ED and Minor Injuries x2 sessions Rolling programmes: • JoE • QPS • Dementia Champions • Band 4 Assistant Practitioners • Doctors lunchtime • Rotational doctors • Grand Round ➢ MCA Practitioners make themselves available in clinical areas to support staff to implement MCA into clinical day-to-day practice. ➢ Advice and support completing capacity assessments. ➢ Advice and attending BIM eg. Discharge and medical treatment ➢ Advice relating to the eligibility for DoLS. ➢ Mental Capacity Act Policy reviewed and amended. ➢ New capacity assessment and Best Interest form developed – awaiting feedback to circulate. ➢ Quarterly MCA forum staff across the health board opportunity for individual case discuss and raise areas of concern that team can approach and offer training and support. ➢ Collaborative working with LA's and WG to prepare for the implementation of LPS – currently postponed.	By improving organisational compliance with MCA, patients who lack capacity will receive the appropriate care and treatment through the principles of the Act. Training will support staff to develop their knowledge and skills.	Continue to provide training both open sessions and requests for bespoke training. Promote training via media and during visits to clinical areas. Engagement events at various locations sites to promote the training and support that the team can provide. Due to the delay in LPS implementation to continue to educate staff in relation to the current DoLS framework. Practitioners to continue to provide support in clinical areas. Animation video relating to consent. Team to attend training to develop their own knowledge in specialist areas. Team have received AMaT training to support auditing compliance with the Act.

Questions

Document Title:	**MBRRACE-UK PERINATAL REPORT 2021**
Date of Document:	**1ST June 2023**
Author	**Jayne Beasley Head of Midwifery & Gynaecology**

Summary / Situation:

Aneurin Bevan University Health Board perinatal mortality rates for births in 2021 have been released ahead of the full MBRRACE-UK report to be published in September 2023. This report highlights the findings and recommendations outlined by MBRRACE-UK regarding all stillbirths and neonatal deaths for births of babies born after 24 weeks gestation, within Aneurin Bevan University Health Board, during 2021.

Background:

Aneurin Bevan University Health Board reports all stillbirth and neonatal deaths to MBRRACE-UK. Excluding births before 24 weeks and terminations of pregnancy MBRRACE-UK analyses and reports the mortality data to seek improvements in health care for mothers and babies.

For purposes of MBRRACE-UK definitions: -

Stillbirths: A baby born after 24 weeks gestation showing no signs of life.
Neonatal deaths: A live born baby who died up to 28 completed days after birth.
Extended perinatal deaths: Includes stillbirths and neonatal deaths.

The yearly reports provide analysis of the mortality data, demonstrates crude data of deaths per 1000, and the stabilised and adjusted rate, which is a more reliable estimate of mortality rates, considering socio economic factors, maternal and gestation age and ethnicity. The data is analysed by comparing Aneurin Bevan University Health Board with other trusts and health boards with a level 3 Neonatal intensive care unit.

In addition to annual data and comparator ratings, this year, MBRRACE-UK has used the data from the previous years to develop a trend analysis across a three-year period.
An increase in mortality is noted by:-

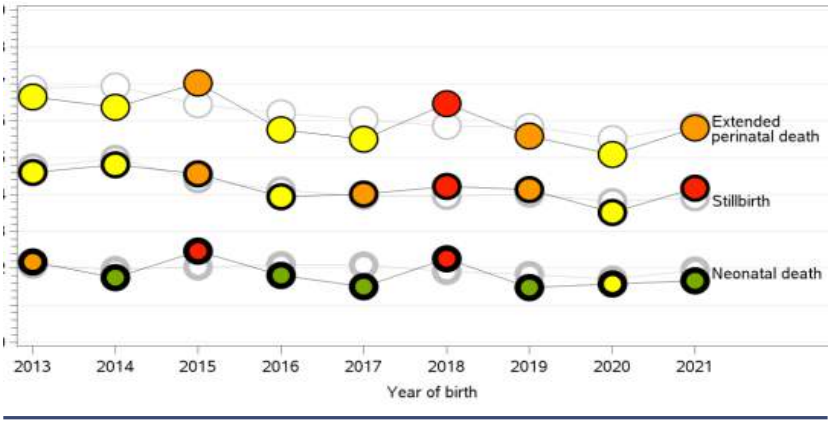
- A worsening rate over a 3-year period.
- Rate more than 5% higher for each of the last 3 years.
- Rate worsened by 2 or 3 categories since the previous report.

It is considered that this will provide enhance reporting, and opportunities for improvements in care. In line with recommendations for Aneurin Bevan University Health Board data has been reviewed, and utilisation of the perinatal mortality review tool has been undertaken to explore themes and learning.

Assessment:

Aneurin Bevan University Health Board's perinatal mortality rates for years 2013-2021 demonstrate an overall downward trajectory with all rates falling in 2020.

However, to note the stillbirth rates for 2021 reports 5% higher than similar Trusts and Health Boards.



- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

The Stillbirth rate for the previous 3 years:
2021: 4.17/1000
2020: 3.52/1000
2019: 4.14/1000
The Neonatal Death rate for the previous 3 years:
2021 1.66/1000
2020 1.58/1000
2019 1.48/1000

Crude data for 2022 would suggest a stillbirth rate of 4.1/1000.

In 2021 there were 24 Stillbirths and 5 Neonatal deaths out of 5398 births

Stabilised and Adjusted Stillbirth rate	**4.17/1000**	Stabilised and Adjusted Neonatal Mortality rate	**1.66/1000**	Stabilised and Adjusted Perinatal Mortality rate	**5.81/1000**

Excluding anomalies	**3.73/1000**	Excluding anomalies	**1.4/1000**	Excluding anomalies	**5.12/1000**
5% higher than similar Trusts and Health Boards		**15% lower than similar trusts and Health boards.**		**Similar to other trus and health boards**	

Review of the Data

Analysis of the data for 2021 demonstrates that for births occurring in Aneurin Bevan University Health Board there are associated risks for higher perinatal mortality. Such as higher rates of births to mothers under 25 years of age (17.7% vs 14.5% for UK), and almost a third of births occur to mothers who reside in high deprivation areas (29.5%).

It also highlights: -

- 91.6% of stillbirths occurred during the antenatal period.
- Most deaths occurred during the third trimester.
- 0 deaths occurred after 42 weeks gestation.
- For most deaths the cause was unknown (62.5% stillbirth and 60% neonatal deaths)
- Post mortem was offered in 100% cases where there has been a stillbirth and in 50% cases when there has been a neonatal death.
- Good rates of compliance with data (98% key data received)
- Notification of deaths within 7 days to MBRRACE-UK is 22% for stillbirths and 10% for neonatal deaths. An improvement on 2020 (0%)

Stillbirth and Neonatal Death 2021 Summary Review.

All cases of stillbirths and neonatal deaths for 2021 had a complete review via:

- Monthly MDT Perinatal Mortality meetings
- Perinatal Mortality Review Tool (PMRT) MDT review
- Retrospective audit 2021 completed.
- Incident reviews and investigation

Whilst 62% had no risk factors for still birth or neonatal death a number of themes and actions have been identified following review:

Themes Identified	Action	Date	Resource needed
Growth restriction significant factor	Aspirin to be administered to women with previous SFGA and stillbirth.	Completed 2022	
	Third trimester scan to identify late growth restriction.	Completed 2022	Increased scanning capacity
	Review of SFGA guideline to consider symphysis fundal height measurement from 24/40 and serial growth scans from 24/40.	All Wales guideline developed 2023	Will require increase Ultrasound scanning 2 midwife sonographers in training 2023 and 1 for 2024.
Scanning not always detecting SFGA	Audit to measure detection rates. All SFGA DATIX	Ongoing	Obstetrician and midwife sonographer leading.
	Develop role for Governance Lead for obstetrics and Gynaecology scanning.	To commence employment June 2023.	0.8 Band 8a lead sonographer, financed within maternity.
Inaccuracies in plotting Symphysis Fundal Height on customised growth chart	Mandated Gap and Grow online training.	Complete 44% - 6 month position.	
	Monitoring via Senior management team at monthly meetings.	Complete	

	Face to face gap and grow training.	September 2023	Additional training requirement
Smoking	Public Health Midwife in post Healthier together website Smoking in pregnancy :: Healthier Together (cymru.nhs.uk) Referral to help me quit during AN MECC training Reintroduction of Co2 monitoring. Increase public health messages via social media site. Consideration for band 4 to support the PH agenda	Complete Complete Complete September 2023 Complete July 2023 September 2024	Currently seconded into post substantive post out to advert 16.6% of women smoke at booking Training resource for all staff Additional staffing resource
Prematurity greatest factor for neonatal death	Midwife and Neonatal lead in place for PeriPrem.	Complete	Funded 0.2 band 7 maternity and neonates till March 2024
Majority of cases no cause identified	Increase PM Uptake Bereavement lead midwife post. Post-mortem consent training update. Timely completion of Perinatal	Ongoing Complete Ongoing Ongoing	 Funded from maternity budget Training requirements

	Mortality review tool, letters and follow up to families. Audit of stillbirth cases for 2022	 Ongoing	
Timely referral to MBRRACE	Bereavement lead midwife post reporting responsibility handed to maternity.	Complete 2022	Funded from maternity budget

Conclusion and Recommendation:

MBRRACE report for 2021 demonstrates that Aneurin Bevan University Health Board has:

- An increased rate for stillbirths (5% higher than similar Trusts and Health Boards).
- Neonatal deaths are 15% lower than similar Trusts and Health boards.

All cases were reviewed utilising the Perinatal Mortality Review Tool, and in addition local audit and incident review completed. Themes and trends have been identified and action taken. Almost a third of women that birth within the Health Board reside in areas of high deprivation, a known risk factor for poor pregnancy outcomes. Public health issues, such as smoking, and growth restriction were key themes identified during review of cases. An increase in care provision such as additional scanning would require consideration regarding funding.

It is recommended that there is a commitment to:

- Continue to monitor all cases of small for gestational age babies through audit.
- Ongoing work re PeriPrem
- Ongoing work re Gap and Grow training.
- Ensure continued use of PMRT, case review and audit of 2022 cases.
- Public Health agenda.

Thus, working to reduce rates and improve outcomes for mothers and babies.

Agenda Item:4.1a

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 June 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Highlight Report from the Quality and Patient Safety Operational Group meeting 31/5/2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of Therapies and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Carr, Executive Director of Therapies and Health Science

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is asked to note the information contained in the highlight report from the Quality and Patient Safety Operational Group meeting held on 31/5/2023

Cefndir / Background

The Quality and Patient Safety Operational Group meets bimonthly and has cross-Divisional and multidisciplinary membership. This highlight report is part of routine reporting to the Committee.

Asesiad / Assessment

Divisional Risks and Issues

The Divisional Quality and Patient Safety Leads were given the opportunity to share / update by exception on Divisional risks and issues related to quality and

patient safety, with an explanation of action being taken. Written reports from each Division were also shared in advance of the meeting.

All the Divisional risks and issues raised are included in the Divisional risk and issue registers with information detailing the mitigation action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the current risks to ensure the quality and safety of services. No new risks were escalated for additional assistance from the Operational Group.

In addition, an update was provided from the Heads of Putting Things Right, and Corporate Health & Safety.

The group also received an update on the planned introduction of Liberty Protection Safeguards by Welsh Government which has been delayed now until the next Government term i.e., sometime between 2025 and 2027. Therefore, the existing Deprivation of Liberty Safeguards (DoLS) arrangements remain in place in NHS Wales. There was discussion about access to restraint training.

Future role and function of the QPSOG

A facilitated discussion was held with the group, to explore opportunities to reshape and repurpose the QPSOG to deliver the requirements of the Health Board's new Quality Strategy, in particular to meet the requirements for a Health Board cross-Divisional learning forum. This discussion will feed into ongoing discussions at Divisional level, with the intention of informing the development of a revised Terms of Reference for the QPSOG, ahead of the next scheduled meeting in July 2023.

Argymhelliad / Recommendation

The Committee is asked to note the information contained in the highlight report from the Quality and Patient Safety Operational Group meeting held on 31/5/2023.

Matters requiring Committee consideration:

- Items raised and discussed in the meeting will feed into the Patient Quality and Safety Outcomes Measures Report (scheduled for the Committee meeting in April 2023)

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	NA

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Not Applicable
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:	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** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Children and Young People's Rights and National Participation Standards

Quality and Patient Safety Update
June 2023

Introduction

- Since the last update provided to the Quality and Patient Safety Group, no Children's Rights Forums have taken place
- The next event is scheduled to take place in July, following which a written report will be provided to the Group
- Whilst no forum has taken place, a briefing was provided to Board to share the approach, developments and plans in relation to Children's Rights and Participation on 5th April 2023, along with a facilitated discussion to support continued development of our approaches.
- The facilitated discussion points (included on slide 25 of this pack) resulted in a small number of actions shown overleaf.

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Actions following Board Discussion

1. Meeting with Workforce and OD to progress on opportunities for involving YP in recruitment/volunteering/apprenticeship/work experience etc
2. Meeting to discuss Children's rights impact assessment in our organisational policies
3. Looking at options to weave in work on transition into this forum

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Children and Young People's Rights and National Participation Standards Board Briefing 5th April 2023

Plan for session

- Introductions
- Background and Purpose
- Overview of key areas of focus
  - Children and Young People's National Participation Standards
  - Involving young people in the recruitment process
  - Additional Learning Needs & Nest implementation
- What next

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Children's Rights – Wales position

- Policy and legislation on children in Wales is underpinned by the UNCRC.
  - Rights of Children and Young Persons (Wales) Measure 2011,
  - Social Services and Well-being (Wales) Act 2014
  - Well-being of Future Generations (Wales) Act 2015
- All establish duties on public authorities that contribute toward the realisation of children's rights.
- A Children's Rights Approach is consistent with these duties, and will help public sector bodies to meet their statutory duties.

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Embedding children's rights

- At the core of planning and service delivery at every level
- Into every aspect of decision-making
- Recognise the importance of CYP having a say
- Great examples across services
- Working in partnership with Reginal Youth Forum

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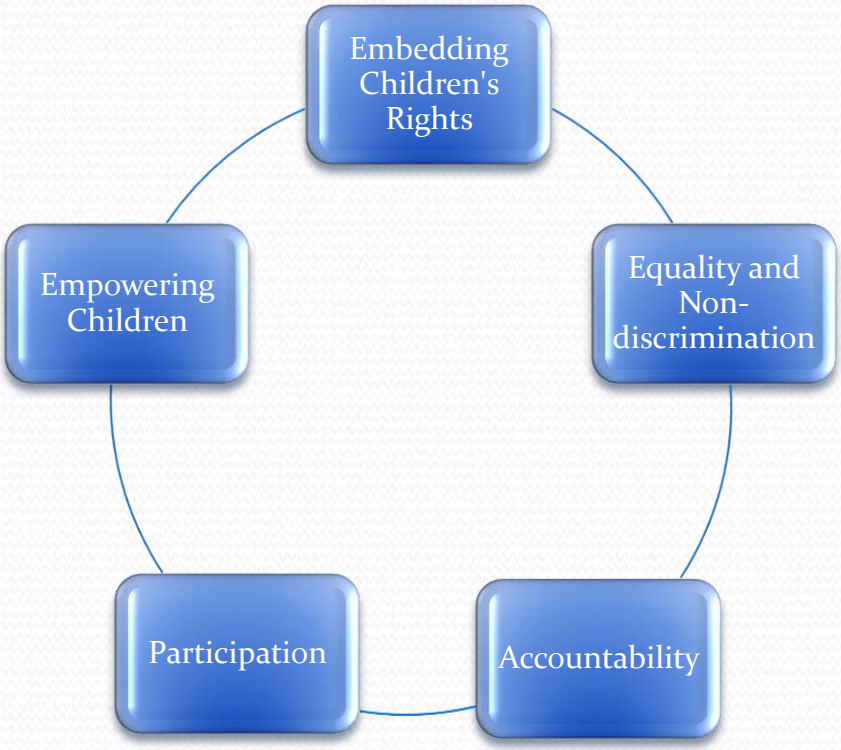
A Children's Rights Approach

- *"A Children's Rights Approach means that organisations will prioritise children's rights in their work with children and families to improve children's lives."*



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Safonau Cyfranogiad Cenedlaethol dros Blant a Phobl ifanc

Children and Young People's National Participation Standards

"Mae gan blant hawl i roi eu barn ynghylch beth ddylai ddigwydd, pan fydd oedolion yn gwneud penderfyniadau sy'n effeithio arnyn nhw, ac i gael sylw i'w barn"

Erthygl 12: Confensiwn y Cenhedloedd Unedig ar Hawliau'r Plentyn (CCUHP)

"Children have the right to say what they think should happen, when adults are making decisions that affect them, and to have their opinions taken into account"

Article 12: The United Nations Convention on the Rights of the Child (UNCRC)

Mae hyn yn golygu:	Byddwn ni:		This means:	We will:
• Mae gennych chi'r hawl i wybodaeth sy'n hawdd ei deall ac sy'n gadael i chi wneud penderfyniad gwybodus.	• Yn darparu gwybodaeth o safon dda, yn glir ac yn hawdd mynd ati. • Yn rhoi gwybod i chi pwy sy'n mynd i wrando a gadael i chi wybod pa wahaniaeth gallai'ch cyfranogiad chi ei wneud.	1 Gwybodaeth Information	• You have the right to information that is easy to understand and allows you to make an informed decision.	• Provide information that is good quality, clear and accessible. • Inform you about who's going to listen and let you know what difference your involvement could make.
• Mae gennych chi'r hawl i ddewis cymryd rhan a gweithio ar bethau sy'n bwysig i chi.	• Yn rhoi digon o gefnogaeth ac amser i chi ddewis a ydych chi eisiau cymryd rhan.	2 Chi biau'r dewis It's your choice	• You have the right to choose to be involved and work on things that are important to you.	• Give you enough support and time to choose if you want to get involved.
• Mae plant a phobl ifanc i gyd yn wahanol ac mae ganddyn nhw'r hawl i gael eu trin yn deg.	• Yn herio gwahaniaethu. • Yn cynnig amrediad o gyfleoedd a chefnogaeth i fodloni anghenion plant a phobl ifanc.	3 Dim gwahaniaethu No discrimination	• Children and young people are all different and have the right to be treated fairly.	• Challenge discrimination. • Provide a range of opportunities and support to meet the needs of children and young people.
• Mae gennych chi'r hawl i leisio barn. Mae'ch safbwyntiau chi'n bwysig a chânt eu parchu.	• Yn gwrando ar eich barn, eich profiadau a'ch syniadau ac yn eich cymryd chi o ddifri. • Yn gweithio gyda chi ar bethau rydych chi'n dweud eu bod nhw'n bwysig. • Yn gwerthfawrogi beth sydd gennych chi i'w gynnig.	4 Parch Respect	• You have the right to have a say. Your opinions are important and will be respected.	• Listen to your views, experiences and ideas and take you seriously. • Work with you on things you say are important. • Value what you have to offer.
• Mae gennych chi'r hawl i ddysgu a bod y gorau y gallwch chi fod. • Bydd gennych chi gyfleoedd i weithio gyda phobl eraill a gwneud gwahaniaeth. • Rydyn ni eisiau i chi gymryd rhan mewn profiadau positif.	• Yn gweithio gyda chi mewn ffordd ddiogel, hwyl a phleserus. • Yn manteisio i'r eithaf ar beth rydych chi'n ei wybod ac yn gwneud pethau sy'n meithrin eich hyder a'ch sgiliau chi.	5 Bod ar eich ennill You get something out of it	• You have the right to learn and be the best you can be. • You will have opportunities to work with others and make a difference. • We want you to be involved in positive experiences.	• Work with you in safe, fun and enjoyable ways. • Make the most of what you know and do things that build your confidence and skills.
• Mae gennych chi'r hawl i wybod pa wahaniaethau rydych chi wedi eu gwneud a sut mae rhywun wedi gwrando ar eich syniadau chi.	• Bob amser yn sicrhau eich bod chi'n cael adborth o fewn amser sydd wedi'i gytuno. • Yn dweud wrthych chi sut mae'ch syniadau wedi cael eu defnyddio a pham. • Yn dweud wrthych chi both sy'n digwydd nesaf.	6 Adborth Feedback	• You have the right to know what differences you have made and how your ideas have been listened to.	• Always ensure you have feedback in an agreed time. • Tell you how your ideas have been used and why. • Tell you what happens next.
• Dylai'r bobl sy'n gwneud penderfyniadau sy'n effeithio ar blant a phobl ifanc roi hawliau plant yng nghanol popeth maen nhw'n ei wneud.	• Yn gweithio gyda chi ac yn dysgu sut i wneud pethau'n well. • Yn gwneud yn siŵr bod eich barn yn gwneud gwahaniaeth i'r ffordd rydyn ni'n gwneud cynlluniau a phenderfyniadau.	7 Gweithio'n well drosoch chi Working better for you	• Those who make decisions that affect children and young people should put children's rights at the centre of everything they do.	• Work with you and learn how we can do things better. • Ensure your views make a difference to the way we make plans and decisions.

Y Safonau hyn sy'n cynnal tair colofn CCUHP - Diogelu, Darpariaeth a Chyfranogi
The Standards underpin the three pillars of the UNCRC – Protection, Provision & Participation

Cymru Ifanc Young Wales

Ariennir gan Lywodraeth Cymru Funded by Welsh Government

Our journey in Aneurin Bevan …..

- June 2017/18 – Annual Health Seminar - a pledge to the Children's Commissioner for Wales : *'to promote and embed a children's rights approach across ABUHB'*
- Summer 2018 - establishment of Children's Rights and Participation Forum
- December 2018 – ABUHB Board Development session
- April 2019 – Chief Exec & Chair sign the Charter with a commitment to achieving the Participation Standards Kitemark (30th Anniversary UNCRC – 20/11/19)

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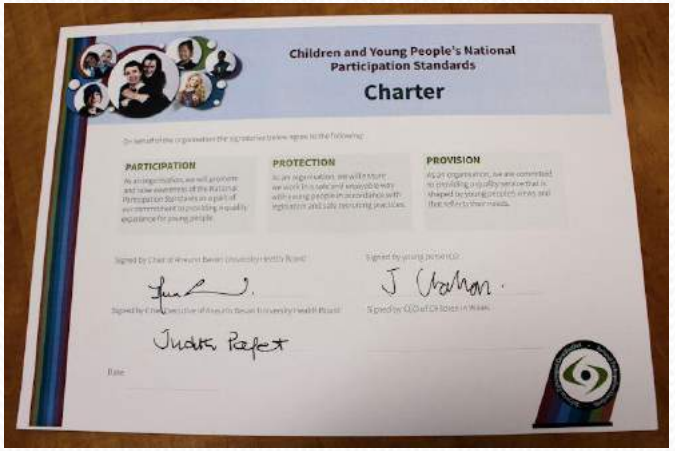

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Young People's Inspection - Kitemark

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Kitemark achieved

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Children and Young People's Rights & Participation Forum

- Chair - Dr Kavitha Pasunuru (taken over from previous Divisional Director in April 2022)
- Exec Sponsor – Exec Director of Nursing
- Membership - led by the Family & Therapy Division on behalf of HB
  - Aim to have a broad representation from all areas that CYP access
- Meet quarterly
- Reporting process – Patient Quality, Safety & Outcomes Committee (PQSOC)
- Work plan

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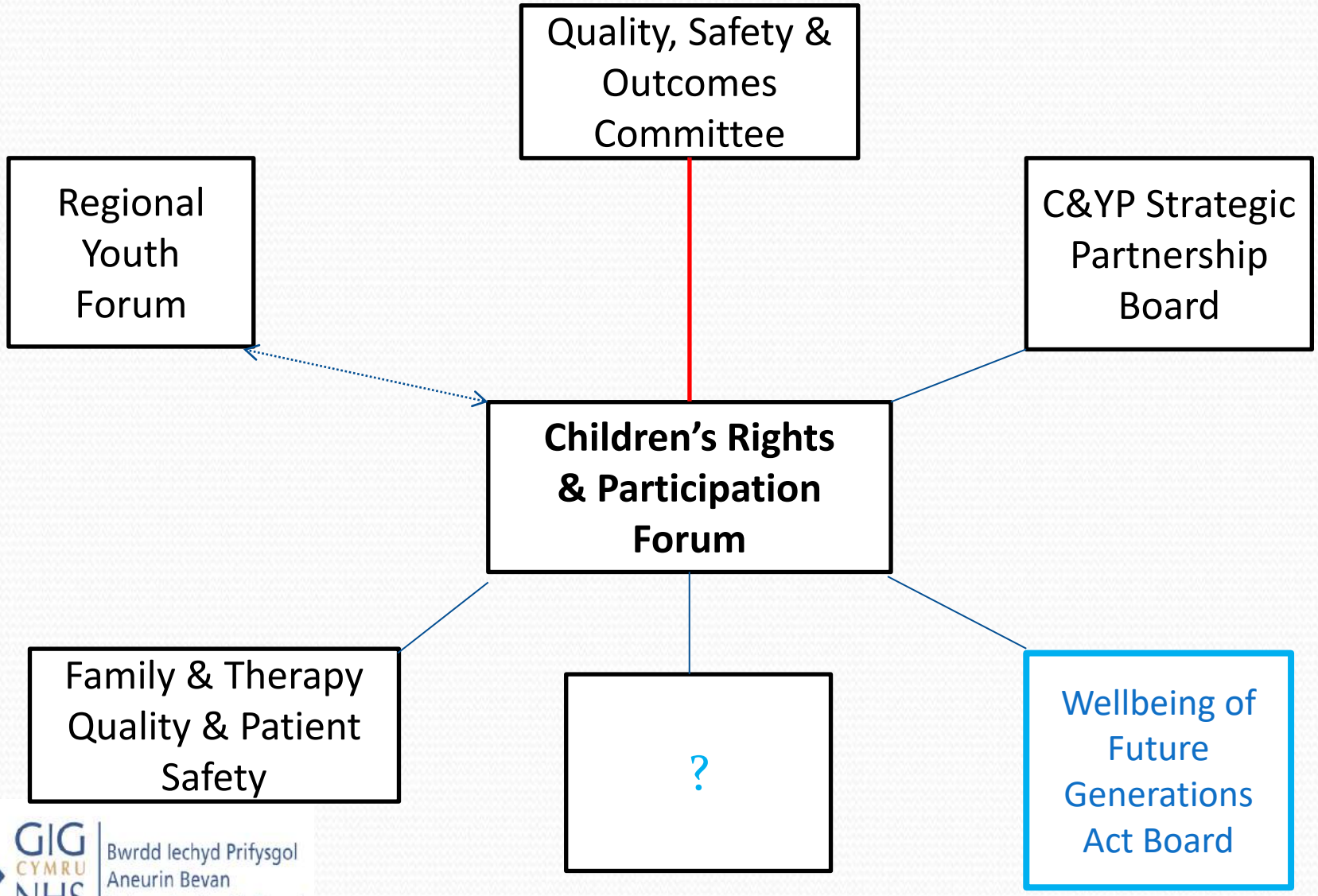

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Grange University Hospital - Youth Forum visit

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Guideline - Involving young people in the recruitment process

- Recognised the need to develop resources to support implementation
- Task and finish group to develop guideline
- Development of ABUHB guideline – Involving Young People in the Recruitment Process
- Pilot to evaluate process

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NEST/NYTH

- A planning tool to ensure mental health and well being is at the heart of all services and to create a whole system approach.

N	rhoi **N**erth (Give strength / empower)	**N**	Nurturing (taken care of and cherished)
Y	**Y**mddirie (Trust)	**E**	Empowering (feeling strong and listened to)
T	Tyfu'n ddiogel (Growing safely)	**S**	Safe (protected and able to be yourself)
H	Hybu (Encourage)	**T**	Trusted (reliable and there for you)

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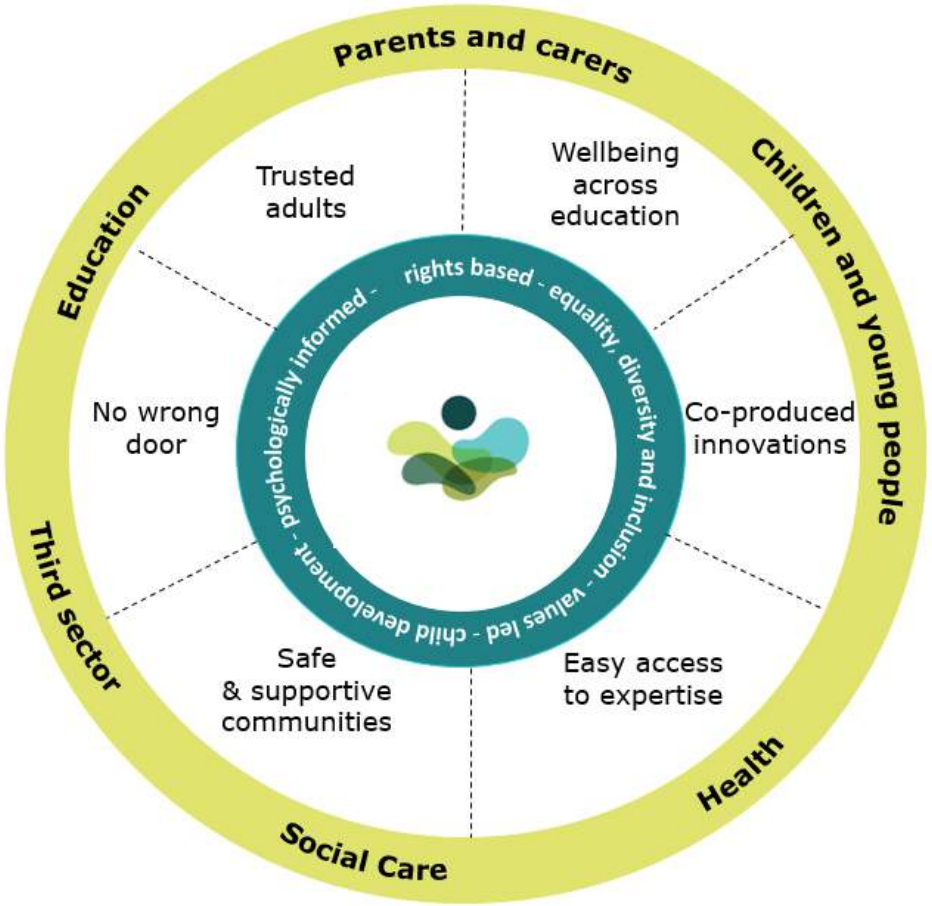
NEST/NYTH



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Children's Rights/NEST

- Working with the Children's Commissioner Office and WG NEST lead to establish an ESR module
- Connectivity between Children's Rights and NEST
- Piloted within Gwent, with scope to share on a national level
- In discussions with HEIW to share the training further
- Increase awareness and promote good practice

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Children's Rights /ALN

- Person Centred Planning around children's needs
- DECLO role and support
- Education/health interface

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Children's Rights/Partnership

- Active stakeholder engagement events on specific themes- Neurodiversity, whole school approach etc
- Identifying opportunities to evidence Children's Rights approach in Gwent
- Engagement with CHC/Llais

GIG CYMRU NHS WALES
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Prioritised work plan December 2022

- Awareness/training package for Children and Young people's Rights
- Membership and participation of the forum
- Involving CYP in the recruitment of staff
- Invite the Children's Commissioner to our forum
- Develop a communications strategy for our group

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Other priorities

- Focus on progressing advocacy offer for CYP within ABUHB
- Development of the coproduction groups
- Sharing of practice -an update or short report
- To develop 'Children's Rights champions'

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Discussion points

- Raise the profile of the work done by this group
- Training opportunities
- Communication strategy/Digital support
- Funding opportunity – to support Projects
- Rewards for young people
- Children's Rights Impact Assessment – CRIA
- Toolkit for recruitment
- Mapping of activities that uphold CYP's Rights

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Diolch yn fawr

-

Thank You

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Highlight Report

Group Name:	**ABUHB Safeguarding Committee**		
Group Aim:	The Safeguarding Committee has delegated authority to establish and implement the strategic direction of safeguarding activity across the Health Board, providing assurance that legal requirements and national guidance are incorporated in to policy.		
Date Completed:	12 June 2023	**Date of last meeting:**	10 May 2023
Completed By:	Howard Stanley – Head of Safeguarding		
Distribution:	PQSOC		
Summary:	This highlight report contains a brief summary of discussions at the ABUHB Safeguarding Committee.		

National Referral Mechanism

The National Referral Mechanism (NRM) is the national framework for identifying and referring victims of modern slavery and ensuring they receive the appropriate support. The Single Competent Authority (SCA) administers it, which is part of the Home Office.

Due to a severe backlog of NRMs, where children were waiting approximately 2 years following referral to receive a decision, in 2020 the Home Office proposed a pilot study asking Local Authorities to bid for monies to enable panels to run within localities. Gwent developed a successful bid and received funding for a co-ordinator and joined the pilot in 2021. Each NRM panel has representation from Health, Social Services and Police (as a minimum) and are held on a fortnightly basis. 5 staff within Health currently sit on the panel, on a rotational basis. Feedback from the Single Competency Agency has been very positive for the Gwent pilot, recognising how beneficial the co-ordinator role has been.

The Home Office has extended the pilot to 2024 and are looking to expand throughout the UK.

Case Review - LM

A Child Safeguarding Practice Review (previously known as a Serious Case Review) is undertaken when a child dies or the child has been seriously harmed and there is cause for concern as to the way organisations worked together. The purpose of a child safeguarding practice review is for agencies and individuals to learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.

The Committee received a presentation on the Child Practice Review in respect of Logan Mwangi (LM), who died in July 2021. An independent review identified a 'significant missed opportunity', following LM's inpatient stay where significant injuries were identified. This was a CTMUHB case, however actions have been identified locally and are being progressing within the Health Board. An internal Learning Event will be organised, to include engagement from Local Authorities.

Safeguarding Training

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

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

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

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

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

Publication from Women's Right Network

- Sexual Safety SBAR

The Women's rights network (WRN) published an article titled "**When we are at our most vulnerable – the sickening extent of rapes and sexual assaults in hospitals**" on April 16, 2023. Furthermore, the article was shared on Twitter and the Health Board was tagged. The Daily Mail has since reported on the topic, omitting Gwent but citing the WRN article.

The report focuses on patients who were sexually assaulted or raped while

in hospital. The statistical table is based on freedom of information request (FOI) from individual police forces across the United Kingdom (UK). Gwent police recorded 40 allegations of sexual assault and 11 alleged rapes between January 1, 2019 and October 31, 2022.

An internal data validation exercise has been undertaken and an SBAR will be presented to the Executive Committee with recommendations for consideration.

Safeguarding Risk Register

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

Items for Escalation

- Ongoing monitoring of Safeguarding Training Compliance.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 June 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Effectiveness and Standards Group Clinical Audit Activity Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson – Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

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

CSEG is held bi-monthly. On 23rd March 2023, the audit reports reviewed were:

- National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Primary Care (PC) – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report
- National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care & Primary Care
- National Neonatal Audit Programme (NNAP) Summary report on 2021 data
- Eighth Patient Report of the National Emergency Laparotomy Audit Dec 2020-Nov 2021. Royal College of Anaesthetists

- New Procedures Policy request:
    - SEM Scanner
    - Trans-Nasal Endoscopy (TNE)

For future 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 to present National Clinical Audit results. The template provides information on:

- Title of the audit and time period
- Audit rationale and objectives
- Clinical Lead and Division/ Speciality
- Recommendations
- Summary of results
- Successes
- Concerns
- SMART action plan

The clinical lead is requested to discuss this with Directorate and Division in a timely manner, before or after CSEG.
Going forward we will be utilising the full capability of AMaT to record all audit information and using the reporting functionality.

The attached Appendices provides the above information for all National Clinical Audits.

- Appendix One - National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Primary Care (PC) – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report
- Appendix Two - National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care & Primary Care
- Appendix Three - National Neonatal Audit Programme (NNAP) Summary report on 2021 data
- Appendix Four - Eighth Patient Report of the National Emergency Laparotomy Audit Dec 2020-Nov 2021. Royal College of Anaesthetists

CSEG also overseas governance behind introduction of new devices and clinical procedures.

A new procedure using a handheld SEM scanner was presented. The scanner provides a visual skin assessment to prevent pressure ulcers, as part of the current skin bundle. Whilst other organisations had questioned the quality of the evidence for its use, a pilot has shown 100% reduction in pressure ulcers, although the pilot numbers were low. NICE claimed this is beneficial for patients but suggested a longer research base. A quotation for community use was £284,000 per annum.

The Chair confirmed that evidence for robust cost effectiveness is lacking. Whilst this may provide benefits in a community setting for certain packages of care, there remains the knowledge, skill and experience of nursing staff being sighted on the patients' skin, which risks de-skilling staff. The group agreed that the best care for the patients is by clinical examination by skilled and trained staff and the costs of the equipment would be better used to increasing nursing resources. This was not approved for use. The Chair advised that it may be useful to review via a technology funding process and additional information would be needed.

A new procedures request was received for Trans-Nasal Endoscopy (TNE). The presenting Consultant confirmed that the procedure was NICE approved and unlike the current Oesophageal Gastro Duodenoscopy (OGD) which is performed via the mouth, this procedure uses a thinner scope so can gain access via the nose, which benefits the patients that cannot tolerate mouth access. Planned trial dates had been arranged from May to June 2023 over an 8-week period and if successful a business case will be submitted with funding from the Cancer Pathways.

The group agreed to approve the procedure and it was requested to ensure completion of the form with signatures from Clinical Director and Divisional Director as the Directorate Manager (which had already signed).

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 - Clinical Audit Report

Presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

All audits MUST be registered and updated on AMaT

SECTION A

Title of Audit & Governing body:	National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Primary Care (PC) – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report		
Audit period	April 2020 and July 2021	**Case Ascertainment:**	COPD – 482 Asthma - 91
Local data available:	Yes	**Number of cases:**	331 (One of the largest services)
Audit Rational:	The primary role of NACAP is to support individual clinical teams to make improvements in the quality of care they deliver. The data included in this report reflect a period during which the COVID-19 pandemic stretched respiratory staff and services to their limits, therefore, direct comparisons with previous reports should be interpreted with caution. The findings enable us to reflect and identify opportunities to restore and strengthen the provision of care for people living with asthma and COPD.	**Audit Objectives:**	State of the Nation is a view of the care of people with asthma and COPD in England and Wales. This report is the first to combine data on asthma, COPD and pulmonary rehabilitation across primary and secondary care services to underpin key messages, optimising respiratory care across the pathway. More than 9 million people are living with a diagnosis of asthma or COPD in the UK. The National Asthma and COPD Audit Programme (NACAP) aims to improve the quality of their care, services and clinical outcomes. We do this by supporting and training clinicians, empowering people living with asthma and COPD and their carer's and informing policy.

Clinical Lead:	Natalie Janes - Deputy Head of Service- Primary Care, Primary Care and Community Division	**Division/Specialty**	Primary Care and Community Division Respiratory

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:
• For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care • Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• Early and accurate diagnosis can only be achieved by conducting physiological diagnostic testing across hospital specialist and primary and community care services. • Over 90% of patients being diagnosed with Asthma or COPD by primary care clinicians. • 61.8% of hospitals across Wales have access to both Fractional exhaled Nitric Oxide (FeNO) and Spirometry as diagnostic tools for children and young people with asthma, FENO is limited across primary care, with only specialist nursing teams having the device. • Data recorded when COVID-19 rates were high (April 2020 to July 2021) and infection controls measures were stringent, indicated that only 43.9% of adults diagnosed with asthma had a record of any objective diagnostic measurement. 1.9% of adults had a record of receiving a gold standard diagnostic test for COPD of post-bronchodilator spirometry, within the past 2 years in primary care across Wales.

- 6% of people with COPD and grade 3–5 Medical Research Council (MRC) breathlessness were offered pulmonary rehabilitation in the past 3 years in primary care across Wales. The national issue with regards to the delivery of Spirometry and concerns regarding pulmonary rehabilitation have been highlighted through the Respiratory Alliance Wales group to Welsh assembly Government and health minister.

- Following a small scoping exercise regarding spirometry coding on clinical systems, 2 out of 5 practices were coding incorrectly. The concerns have been discussed since publication of the report via the All-Wales Respiratory Health Implementation Group. This has been highlighted as one of the top priorities. The goal is to review and develop an interactive all Wales Template for both COPD and Asthma which will link with All Wales prescribing and management guidelines, referral forms and APPS.

- The Spirometry Hubs at ABUHB based in the North and South of the HB, during COVID-19 were a huge success with over 400 patients reviewed over 140 patients had a change in referral diagnosis, 52 patients were reviewed from Secondary Care (SC) waiting lists.

- Hubs provided an opportunity to provide education and training for staff who had become deskilled requiring revalidating or staff new to spirometry due to the withholding of Spirometry for 2 ½ years during the pandemic. Due to changes/shortages in staff and equipment issues 40 out of 71 practices across ABUHB are currently performing spirometry due to staff with skills etc training and education workshops have since been arranged through the primary and community care academy to upskill the workforce.

- Collaborative working with Paediatrics and Neonatal nursing, regarding training education and All Wales Oxygen Service to replicate the gold standard that have been developed for adults continues. The division have also supported two innovative projects working alongside GSK and AstraZeneca (pharmaceutical industry) reviewing patients at high-risk on asthma/COPD registers in collaboration with signed up general practices.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>

- Education and training 3-day programme delivered by the Primary Care Respiratory Nurse Team via the Primary and Community Academy.
- Level 1, 2 and 3 Spirometry training delivered by the Primary Care Respiratory Nurse Team via the Primary and Community Academy.
- GSK and AstraZeneca (pharmaceutical industry) joint working and donated goods and services projects review of identified high-risk asthma/COPD patients.
- Housebound patient annual reviews Project supported by the Respiratory specialist nursing team in managed practices.
- Spirometry diagnostic Hubs supporting COVID-19 recovery position.

- PCRSN team providing support, education/training, Face to face training/mentorship in GP surgeries.
- Gold standard O_2 service with clinical and operational SOP.
- Prison in-reach.

Aneurin Bevan University Health Board <u>Concerns:</u>
• Only 40/71 practices completing spirometry on scoping review. • Spirometry equipment needed in 9 practices. • Inaccurate data recording across general practice, review of templates required. • Staffing demand for in-house training outweighs nurses who can offer support and education. • Health care professionals not trained to manage Paediatric asthma patients' annual reviews or provide spirometry testing if deemed appropriate. • Respiratory Training/funding for ARTP and re accreditation some practices not supporting ongoing costs. • Some practices not following all Wales management and prescribing guidance • Not always providing good inhaler technique • Time for assessment reviews, variable • Promotion of Apps text dump bundles costs. Uptake poor. • Pre-screening for COPD. Smokers. • Asthma/Lung UK expert patient programmes, were previously supported with lottery funding. • Housebound reviews/care home/residential home/Homeless not always on annual review but when there is an acute episode.

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	NA
Outlier information: (if appliable)			

Audit discussed at Directorate level:	Yes/No	**Date:** Scheduled for 30/5/23
Audit discussed at Division level	Yes/No	**Date:** Scheduled for 30/5/23
Action Plans agreed with Division/Directorate?	Yes/No	**Date:** Scheduled for 30/5/23
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date:** 30/5/23

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Clinical leads to investigate all issues around spirometry and support training and education over the next six months. • Investigate concerns with coding and develop templates over the next few months. • Continue ongoing work for respiratory pathway/asthma pathway with team. • Training and education to continue and develop via Academy.

When making your action plan, ensure the objectives are:
SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Two - Clinical Audit Report

Must be completed and presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

All audits MUST be registered and updates on AMaT

SECTION A

Title of Audit & Governing body:	National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Paediatric Asthma Secondary Care – This forms part of the National Asthma and Chronic Obstructive Pulmonary Disease Programme (NACAP) Drawing Breath Report		
Audit period	April 2020 and July 2021	**Case Ascertainment:**	
Local data available:	Yes	**Number of cases:**	211
Audit Rational:	NACAP supports individual clinical teams to make improvements in the quality of care they deliver. This report included a period during the COVID-19 pandemic, which stretched respiratory staff and services to their limits. Direct comparisons with previous reports should be interpreted with caution. Findings enable us to reflect and identify opportunities to restore and strengthen the provision of care for people living with asthma and COPD.	**Audit Objectives:**	State of the Nation - a view of the care of people with asthma & COPD in England & Wales. Combining data on asthma, COPD & pulmonary rehabilitation across primary and secondary care services for the first time. More than 9 million people are living with a diagnosis of asthma or COPD. NACAP aims to improve the quality of their care, services and clinical outcomes. By supporting and training clinicians, empowering people living with asthma and COPD and their carer's and informing policy.
Clinical Lead:	Dr Marcus Pierrepoint - Paediatrician in Child Health	**Division/ Specialty**	Respiratory

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	2. Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:
• For every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care. • For care to be provided to people with asthma and COPD within the recommended timeframe after hospital admission, to support optimal outcomes. • For people with asthma and COPD to receive care by appropriately trained healthcare professionals, at each stage of their care pathway.

- Primary, secondary and community services to implement ways to work together, offering people with asthma and COPD a seamless pathway of care.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:

Recommendation 1: Most children are not diagnosed in hospital and are diagnosed before they are capable of performing objective bedside tests on clinical grounds. Lack of spirometry facility in paediatrics outside special assessment clinics and is not a diagnostic tool within paediatrics. The Team recently had access to a Fractional exhaled Nitric Oxide (FeNO) machine as part of a multicentre research project, it is used in tertiary respiratory service assessments.

Recommendation 2: An asthma pathway has been shared with ED and has been working well for a number of months. The requirement to prescribe Prednisolone (steroid) within the first hour forms part of the core data and was 33% for ages 6-18 years old. One possibility is due to the clock starting on arrival at ED reception. There are delays with triage due to current pressures. Education with junior doctors in ED is being addressed.
The smoking status is not asked routinely across Wales, as the expectation of a child admitting to smoking in front of the parents is unlikely, this will also be addressed and included in the education pack.

Recommendation 3: Children being discharged 24/7 after respiratory attacks and lack of resource for specialist nursing staff available 24/7. The Health Board has 2.5WTE respiratory/allergy nurses to cover all aspects of respiratory medicine so can only support outpatients and cascade training. 98% of children with acute asthma get appropriately trained staff supervising inhaler techniques. Children requiring 3 courses of steroids or who have been through HDU and those that need >step 3 care get referred to our respiratory clinics.

Recommendation 4: There are different pressures on the care settings in relation to paediatric respiratory conditions. Educations sessions have taken place, predominately attended by primary care nursing staff, with only 1 or 2 GP's attending. Acknowledged more training of GP's needed. In terms of transition to adult services, these numbers are low with more manageable disease and varying profiles of the disease. Transition meetings have been explored however availability is a challenge and meetings have been held to discuss a way forward but not confirmed yet. Welsh Government transition tools are being used and we will educate to be more broadly used also used is an asthma hub, available via QR codes advertised widely and there is a 'wheezy' pathway for young children who are not define as asthmatic.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Successes:
• High number of children receive training for inhaler techniques.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board Concerns:
• Time to receive prednisolone within the first hour if attendance within the Emergency Department. • Lack of resource for specialist nursing staff 24/7.

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	No
Outlier information: (if appliable) Alert/Alarm			

Audit discussed at Directorate level:	Yes/No	**Date: TBC**
Audit discussed at Division level	Yes/No	**Date: TBC**
Action Plans agreed with Division/Directorate?	Yes/No	**Date: TBC**
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date:**

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
• Promulgate the asthma hub for parents. • Asthma paediatric specialist meetings to review benchmarks. • Planning an update of the asthma pathway: ○ Push for steroids in the first hour.

    - Highlight the smoking documentation.
    - Develop/utilize smoking advice for parents.
    - Sign off formally on the asthma education each time.
- Meet with the adult service to discuss transition.
- Explore FeNO.
- Look for opportunities to liaise with primary care.
- Ensure all CYPs with asthma get follow up, this is unlikely to be within 1 month.

When making your action plan, ensure the objectives are:
SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Three – Clinical Audit Report

Must be completed and presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

All audits MUST be registered and updates on AMaT

SECTION A

Title of Audit & Governing body:	National Neonatal Audit Programme (NNAP) Summary report on 2021 data		
Audit period	2021	**Case Ascertainment:**	100%

Local data available:	Yes	**Number of cases:**	
Audit Rational:	It assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes	**Audit Objectives:**	The audit reports key outcomes of neonatal care (mortality, bronchopulmonary dysplasia, late onset bloodstream infection, necrotising enterocolitis and preterm brain injury), measures of optimal perinatal care (birth in the right place, antenatal steroids, antenatal magnesium sulphate, deferred cord clamping and normal temperature on admission), maternal breastmilk feeding (during admission and at discharge), parental partnership, neonatal nurse staffing levels, and other important care processes (screening for retinopathy of prematurity and follow-up at two years of age).
Clinical Lead:	Dr Sunil Reddy – Consultant Neonatologist Dr Susan Papworth – Consultant Neonatologist	**Division/Specialty**	Neonatology

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	2. Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action (consider local audit)

Recommendations:			
The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care and identifies areas for improvement. The 12 measures reported are:			
1	Antenatal steroids	**7**	Neonatal Nursing staffing
2	Antenatal magnesium sulphate	**8**	On time screening of retinopathy of prematurity (ROP)
3	Deferred cord clamping	**9**	Bronchopulmonary Dysplasia (BPD)

4	Temperature on admission	**10**	Breast milk at 14 days
5	Parental consultation within 24 hours	**11**	Breastfeeding at discharge
6	Parental presence at consultant ward rounds	**12**	Medical Follow up (F-Up) at two years

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:	
1	The Health Board has always been good at ensuring antenatal steroids are administered to women who deliver at 23-33 weeks gestation, with GUH at 95% compared the National Average (NA) of 92.1%.
2	Mothers receiving Magnesium Sulphate within 24 hours of delivery of babies born at less than 30 weeks, the Health Board is a little behind the NA at 81.1% compared to the NA of 86.9%. However, the Health Board has improved 16 approx. 18% from the previous year due to good team working with midwifery colleagues and Quality Improvement (QI) measures put in place.
3	Health Board Cord Clamping rates for the Health Board have always been on the low side which is negative.
4	Babies' temperature is important for their successful outcomes and the Health Board has completed so QI work to raise the level, which is now and improved 80% compared the NA of 73.2%.
5	Interaction and communication between Health Boards staff and the parents is vital and the Health Board has always performed well, currently 95.1% a little behind the NA of 96.3%.
6	Communication as part of the ward round is important the Health Board has improved obtaining 96.1%, more than 10% above the NA of 85.8%. The Health Board is focusing on integrated care with parents such as QI projects called 'delivery room cuddles'.
7	Staffing levels appropriate to guidelines is 59.7% compared to NA 73.9% and there are currently plans to look at this.
8	A colleague Ophthalmologist visits the ward to carry out retinopathy screening of babies born less than 32 weeks which has a target of 4 weeks, and when babies are discharged without screening, they are seen in clinic, which does impact Health Board performance. The NA is 95.4% and GUH 89.2%.

9	The Health Board has always had low Bronchopulmonary Dysplasia (BPD) rates and has been commended for this and asked to present data with advice on how this is maintained. This NNAP report shows the Health Board at 17pprox.. 35% which is below the NA of 38%.
10	The Health Board has scope for improvement in terms of babies receiving mothers' milk. Currently at 51.9% compared the NA of 60.6% there are QI projects called 'Golden Drops'.
11	The Health Board and All Wales has always been behind the NA for early breast feeding and breast milk at discharge however the Health Board is moving in the right direction although remain behind the NA of 60.6% at 51.9%.
12	Babies born before 30 weeks who receive a follow up at gestational age of 2 years is 100% within the Health Board and the NA is 72.5%. The Health Board has been recognised as a positive outlier by NNAP for this measure.

Aneurin Bevan University Health Board <u>Successes:</u>

- Antenatal steroids NA 92.1% - ABUHB - 95%
- Temperature on admission NA 73.2% - ABUHB 80%
- Parental presence at consultant ward round NA 85.8% - ABUHB 96.1%
- Parental consultation within 24 hours of admission NA 96.3% - ABUHB 95.1%
- Bronchopulmonary Dysplasia (BPD) NA 38.8% - ABUHB 34.9% (low result indicates success)
- Follow up at 2 years NA 72.6% - ABUHB 100%
- Cystic Periventricular Leukomalacia (cPVL) another brain injury from preterm births which can be linked to Cerebral Palsy, the Health Board is approx. 13% and again in the upper half of units reporting.

Aneurin Bevan University Health Board <u>Concerns:</u>

- Antenatal Magnesium Sulphate NA 86.9% - ABUHB 91.1%
- Early breast-feeding NA 80.5% - ABUHB 70.3%
- Breast milk feeding at discharge NA 60.6% - ABUHB 51.9%
- On time screening of retinopathy of prematurity NA 95.4% - ABUHB 89.2% (due to discharge before screening, so seen in clinic)
- Neonatal nursing staffing levels NA 73.9% - ABUHB 59.7%

- Cord Clamping rates NA 43% - ABUHB 30.2% (the Health Board has always been on the low side which is negative, and the blood stream infection rates have also been low which is a positive).

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	[redacted] No	**Has outlier processes commenced:**	[redacted] NA
Outlier information: (if appliable) Alert/Alarm			

Audit discussed at Directorate level:	Yes/No	**Date: TBC**
Audit discussed at Division level	Yes/No	**Date: TBC**
Action Plans agreed with Division/Directorate?	Yes/No	**Date: TBC**
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date: TBC**

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
1. Directorate to scope for improvement in breast feeding over next six months. 2. Directorate to scope for improvement in deferred cord clamping over next six months. 3. Directorate to scope for improvement in retinopathy screening over next six months. 4. Maternity Badgernet- commencing 2023 5. Perinatal optimisation program adoption over the next six months.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

Appendix Four - Clinical Audit Report

Must be completed and presented at Clinical Standards and Effectiveness Group (CSEG) for ALL National Clinical Audit (NCA)

All audits MUST be registered and updates on AMaT

SECTION A

Title of Audit & Governing body:	Eighth Patient Report of the National Emergency Laparotomy Audit Dec 2020-Nov 2021 Royal College of Anaesthetists		
Audit period	Dec 2020 - Nov 2021	**Case Ascertainment:**	100%

Local data available:	Yes	**Number of cases:**	331 (One of the largest services)
Audit Rational:	8th annual NELA report. It examines care received by NHS patients in England and Wales undergoing emergency laparotomy (emergency bowel surgery) 1.12.20 and 30.11.21. The pandemic continued to have a significant impact on patients, staff, and hospitals during this period, and maintaining adequate staffing levels was a major challenge. Recognition and applause for maintaining high standards of care for patients. The dedication of clinical teams in achieving this is commended.	**Audit Objectives:**	Specific concerns remain around delays in pathways of care for many patients between time of arrival in hospital and definitive surgical intervention. Time to administration of first antibiotics, and overall time to arrival in theatre are unacceptably long and detrimental for many patients with suspected intra-abdominal infection. Surgeons, emergency and general physicians, radiologists, anaesthetists, intensivists and geriatricians, together with their respective hospital management teams, are encouraged to work together near address these delays.
Clinical Lead:	Dr Helen Williams - Anaesthetics Dr Babu Muthuswamy - Intensivist Miss Charlotte Thomas – General Surg Dr Sara Long - Geriatrician	**Division/Specialty**	Anaesthetics, Intensivist, General Surgery, Care of the Elderly

MUST BE COMPLETED BY THE CLINCIAL LEAD

Key 1 (for the action)	2. Action in progress	**Key 2 (for the action priority)**	Medium: requires prompt action

Recommendations:	
1.1	Hospitals should continue to engage further with NELA data collection. In particular, make use of real-time data and resources available from NELA to drive clinical and service quality improvement. These include quarterly hospital, regional and national data reports; excellence and exception case-reporting tools; and process measure and mortality monitoring tools available via the NELA website.

1.2	Funded time within consultant job plans should be available to support invaluable work and contributions by members of clinical teams in collecting data, and coordination and service improvement overseen by NELA surgical, anaesthetic, radiology and emergency medicine local clinical leads. This requires trust/health board recognition of the value of this work.
1.3	Trusts and health boards should support NELA data collection and analysis with funded audit and governance assistance.
2.1	Ensure NELA leads for radiology are appointed in each department, with specific job planned time to facilitate coordination of multidisciplinary review meetings and radiology events and learning meetings (REALM). Conclusions should be shared where applicable with providers of outsourced reporting services.
3.1	Multidisciplinary teams in emergency, surgical, perioperative, acute and critical care should work to produce and implement locally agreed optimised pathways of care, with the aim of streamlining diagnosis with as little delay for patients as possible.
4.1	Clinical teams should be supported by management teams to work together to identify where and why existing standards around antibiotic administration are not being met.
4.2	Clinical teams should establish and introduce locally agreed pathways for administration of antibiotics preoperatively for those with suspected intra-abdominal infection or sepsis, following guidance around timeliness from the Academy of Medical Royal Colleges and the Surviving Sepsis Campaign.
4.3	Clinical/nursing teams should ensure that locally agreed pathways support the administration of antibiotics, without delay, at the time of prescribing.
5.1	Surgeons, anaesthetists and intensivists should ensure a formal assessment of mortality risk has been performed around the time of decision to operate, taking into account the significant impact of frailty.
5.2	Clinical teams should not hesitate to refer a high-risk patient for postoperative monitoring in critical care, even if not currently critically ill.

5.3	Trusts/health boards should ensure critical care capacity is able to meet demand. Any critical care capacity shortfall should be reviewed as part of departmental and hospital-level clinical governance.
6.1	A formal assessment of frailty should be performed for all patients aged 65 or over.
6.2	Surgeons, anaesthetists and intensivists should ensure frailty has been taken into account when assessing the mortality risk of their patients as the NELA risk score does not take frailty into account.
6.3	Trusts/health boards should work towards improving capacity for experts in elderly care to review all elderly, frail and vulnerable patients postoperatively. This liaison work on surgical wards should happen on a systematic and consistent basis rather than in an ad hoc manner. In many hospitals this goal is likely to require specific trust/ health board support and funding.

SECTION B – to be completed by Clinical Lead pre CSEG

Aneurin Bevan University Health Board Summary of results:
• In-hospital mortality rate has not been published in the report; however, the Health Board's numbers for year 8 was 28 deaths and year 9 recorded 32 deaths. All deaths are reviewed with no areas of concern. The deaths are high risk patients with other co-morbidities. • During 2022 set up bi-monthly M&M meetings and the Health Board is fortunate to also have an ED Lead, Dr James where ED have been doing some QI work to improve sepsis screening, also inviting staff from SAU to the M&M meetings to learn from their experiences. • Single site working has improved results, but there is still room for further improvement. • Require better flow plans, with patient transfers for Critical Care Unit (CCU).

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Successes:</u>
• Documented risk factors recorded preoperatively for the Health Board are green at 88.5% year 8 and expected higher at 94.9% for year 9 data.

MUST BE COMPLETED BY THE CLINCIAL LEAD

Aneurin Bevan University Health Board <u>Concerns:</u>

- Preoperative CT with Year 7 data reported by in house consultant 63.2%, Year 8 reduced to 53.8%. Year 9 not expected to shown any better.
- Access the theatre for the Health Board 61.3%, below the National Average (NA) of 71.8%.
- Preoperative input by clinical staff – Cons Surg & Anaes - 74.5%, Surgeon only – 81.2% (expected over 95% for yr 9), Anaes only – 80% (expected over 95% for yr 9) and intensivist 50.9% (expected yr 9 73%).
- 55.6% of ABUHB patients had a decision to operate within 24 hours of admission. This is difficult to interpret as some patients are managed medically initially and then develop to requiring surgical intervention.
- High risk patients who have a risk of death >5% with consultant surgeon (84.2%), consultant Anaesthetist (88.5%) or both (77.6%) in theatre for year 8 (all set to improve for yr9).
- Older patients or those assessed as high risk seen by a geriatrician is 7% for this reporting period, however due to the input of Dr Sara Long, Consultant Geriatrician, this has increased to 64% for year 9 data.
- Admissions to critical care for patients with an estimated mortality of >5%, with the NELA target 80% and the Health Board year 8 result is 70% with year 9 increasing to 74%.
- Length of Stay (LoS) deteriorated within the Health Board however remains better than the NA.

SECTION C - to be completed by Clinical Lead pre CSEG

Outlier on any measures:	No	**Has outlier processes commenced:**	No
Outlier information: (if appliable) Alert/Alarm			

Audit discussed at Directorate level:	Yes/No	**Date: TBC**
Audit discussed at Division level	Yes/No	**Date: TBC**
Action Plans agreed with Division/Directorate?	Yes/No	**Date: TBC**
If Action Plans NOT discussed at Division/Directorate Level, please provide date this will happen:		**Date: TBC**

SECTION C.1

SHOULD BE COMPLETED BY THE CLINCIAL LEAD WITH DIRECTORATE/DIVISION INPUT

ACTION PLANS:
1. Business case being explored for Dr Long's role to continue improving >65 and frail and >80-year Multidisciplinary Team meeting (MDT).

2. ICU lead is to write to the CD for critical care lead and divisional director for scheduled care outlining our concerns.
3. QI work on antibiotic administration in patients with suspected sepsis.

When making your action plan, ensure the objectives are: SMART – Specific, Measurable, Assignable, Realistic, Time-related.

References: n/a

WHSSC Joint Committee
16 May 2023
Agenda Item: 4.5.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**18 April 2023**

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

1.0 MAJOR TRAUMA PRESENTATION – SOUTH WALES TRAUMA NETWORK

Members received an informative presentation from the South Wales Trauma Network Manager, which outlined the background of the South Wales Trauma Network (SWTN) and provided an update following the Peer Review which had been undertaken in March 2022.

The peer review outlined a number of areas of good practice with no immediate risks raised across the South Wales Trauma Network (SWTN) which was extremely positive.

Members noted that, thanks to the commitment of the staff and support networks available to them, the progress on improvement had already started to take shape.

2.0 WELSH KIDNEY NETWORK (WKN)

Members received a report outlining the current Quality Patient Safety (QPS) issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 9 March 2023, and WKN Board meeting on 4 April 2023 and that there were 14 items on the current WKN risk register.

Members were informed that the Annual Renal meeting would be taking place in Newport this year as part of 'Kidney Week'.

3.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points

for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

3.1 Cancer & Blood

Workforce issues within the Neuro Endocrine Tumour Service (NETS) have been addressed with the support of a visiting consultant with NET expertise to oversee the delivery of the service. A full review of the service with stakeholders is planned in the near future with the aim of finding a sustainable solution going forward.

A number of issues have been raised around access to the Extracorporeal Membrane Oxygenation (ECMO) pathway at Guy's and St Thomas. A meeting has taken place with them to discuss the pathway access and prioritisation. Clinical links will be established with services in Wales to review the cases via a Harms Review and data is to be shared with WHSSC regarding numbers accessing the services from Wales.

The findings of this Harm Review will be shared with the committee once completed.

3.2 Neurosciences

There were no changes in risks since the last update and no services were in escalation.

Members noted that the engagement period for the Cochlear Implant and Bone Conduction Hearing Implant Service had now concluded and findings were being presented to Management Group for consideration prior to Joint Committee (JC) in May 2023.

3.3 Cardiac

Within the Cardiac surgery services, there had been significant improvements across all areas in escalation and no new risks had been added to the Risk Register since the last report.

Members noted the improved joint working between CVUHB and SBUHB Cardiac Services. Liverpool Heart and Chest Service had worked with CVUHB and SBUHB to share examples of their initiatives in place around recruitment and retention.

Members noted the Newsletter from the Adult Congenital Heart Disease Team promoting heart health awareness and the work that was ongoing in this area.

3.4 Women & Children

- **Paediatric Surgery**

Members noted the issues in relation to the waiting list and the actions in place to improve the situation following further escalation to Level 3 in February 2023. It was noted that C&VUHB are now engaging and providing weekly update

reports to enable monitoring activity levels in real time and regular Executive led escalation meetings were in place.

Waiting times had decreased to meet the Ministerial waiting time of 104 weeks as at the end of March 2023. However, because this relates to children WHSSC have requested further significant reduction to 52 weeks over the next year and will work with the HB to support them in achieving that.

- **Paediatric Intensive Care Unit (PICU)**

There had been considerable focus on PICU over the last quarter and as a result, weekly SitRep meetings led by Welsh Government (WG) were put in place and have shown that there continued to be increased pressure in PICU services across the UK in relation to recovery from the pandemic. Members were informed that HIW had written to the Cardiff & Vale University Health Board raising a number of concerns. WHSSC had recently received the response which along with the findings from a pressure damage report would be considered to determine the level of escalation attributed to the service.

3.5 Mental Health & Vulnerable Groups

Members noted the following key updates:

- A pre inquest hearing has taken place recently regarding the death of a patient whilst in a Women's Enhanced Medium Secure Unit in West London. The date for the full hearing has not been confirmed to date.
- SBUHB Caswell Medium Secure Adult Mental Health Unit is developing a strategy to reshape the delivery of inpatient care and are currently looking at securing more funding to increase the number of seclusion suites on each ward for patients with a more challenging presentation. Members noted that the repatriation programme was going as hoped and there was an expectation that increased numbers of patients would be admitted to the clinic by the end of May.
- The committee received a detailed summary regarding the Gender Development Service (GIDS) for Children and Young People. Some early discussions have taken place with CVUHB regarding the potential for a regional model linked to the Children's Hospital sometime in the future.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition

Members noted the report highlighting the contractual and inflation risks which had now been mitigated and reduced or closed providing stability to the service going forward.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation

level. Members noted the five services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 3 from 4 in December 2022,
- Paediatric Surgery C&VUHB had been escalated to level 3 in March2023,
- There had been no changes in escalation levels to the other services.

Members provided positive comments on the new template and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report Appendix 1

4.2 Quality Newsletter

Members received a copy of the Quarterly Newsletter which is also available bilingually. A copy is attached to the report ***Appendix 2***

4.3 QPSC Annual Report 2022-2023

Members received the QPSC Draft Annual Report outlining all activities undertaken by the QPSC over the last year. Members approved the draft report noting that any formatting issues would be resolved prior to submission to JC.

4.4 QPSC Terms of Reference

Members received the Draft Terms of Reference (ToR) to consider the changes to the report. Members supported the approach to undertake a minimal review. Members noted that following the Review into National Commissioning they would be updated further to align with the outcome.

4.5 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 and the provider tab that had been added so that individuals who are outside the organisation can see which provider delivers each service.

4.6 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 January to March 2023 was presented to the committee.

4.7 Incident and Concerns report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. The report presented also included an in-depth review of the cardiac incidents reported. This was following queries raised by members at the last meeting requesting further assurance.

Members noted the content of the report and the additional context provided for each of the incidents.

4.8 Service Improvement and Innovation Days

Members received a report providing an update on the Service Improvement and Innovation Days and similar externally organised events relating to specialised services.

Members noted the content of the report, the summary of activities, aims and key points of learning and sharing. The report demonstrated the positive work that had been achieved and undertaken by clinicians

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 16 March 2023
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

- QPSC Annual report 2022-2023
- QPSC Terms of Reference

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	14 June 2023 at 14.00hrs

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

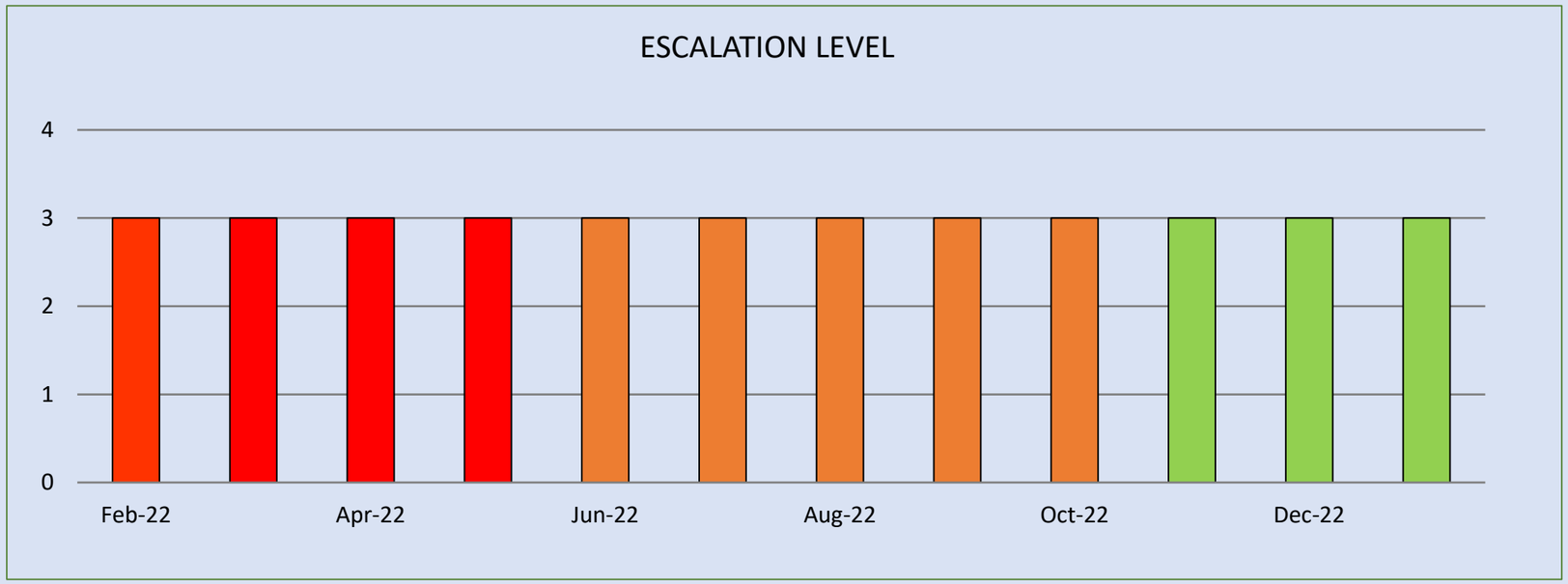
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ March 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 remains on target with the planned timeline.
The next escalation monitoring meeting is arranged for 3rd March 2023.

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.

Next escalation meeting 03/05/23.

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. Meetings held 27/09/22 and 01/12/22.	MD/ Exec Lead WHSSC		Next meeting 03/05/23
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	
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. Capital case remains on target with the planned timeline. The next escalation monitoring meeting is arranged for 3rd May 2023.	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

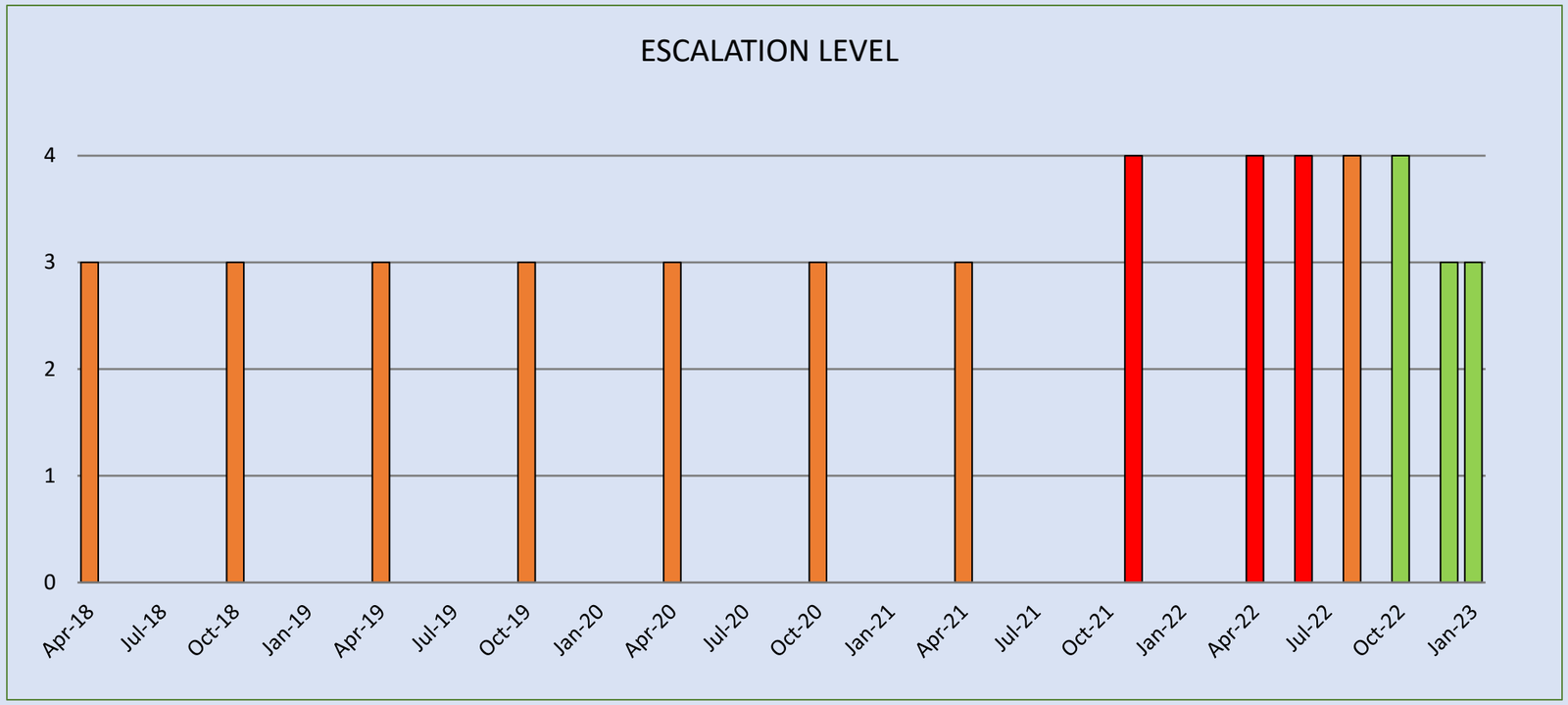
Service in Escalation: Ty Llidiard

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ January 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

Rationale for Escalation Status :
De-escalated to level 3.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.

Actions:

Action	Lead	Action Due Date	Completion Date

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.	Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
	Service specification action plan agreed.	Senior Planner		Completed March 22
	Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
	Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
	Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
	Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
	NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
	Reviewed service specification.	Senior Planning Manager		Completed
	Monitor training status of the staff by QAIS.	Shane Mills		Completed
	Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
	Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
	Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	
	Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Ongoing

Issues/Risks:
This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.

July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments

Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac

Date of Escalation Meetings: 01/06/22, 20/07/22, 21/11/22, 05/04/23, 27/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/23

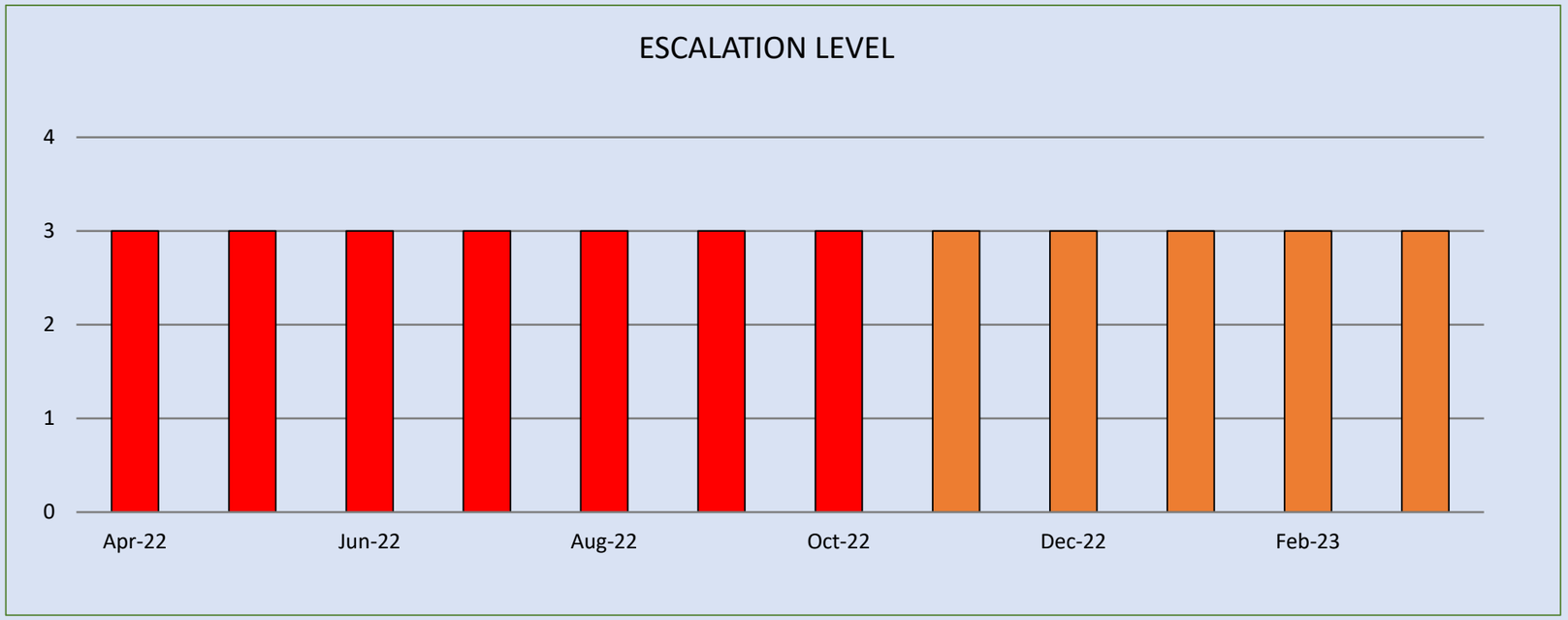
Service in Escalation: Cardiac CVUHB

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ March 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2022– WHSSC escalation	**3**
June 2022– WHSSC escalation	**3**
November 2022– WHSSC escalation	**3**

Rationale for Escalation Status :
Owing to the availability of CVUHB Executive colleagues, there has not been as escalation meeting since November 2022. As such, the Cardiac Surgery service remains in at level 3. Escalation meetings have been scheduled for 5 April and 27 June, at which it is hoped that progress against the GIRFT/HEIW action plan will be evident.

Background Information:

Owing to the failure of Cardiff and Vale University Health Board to…

1. Implement the outcomes of the GIRFT review (June 2021), for which no appropriate SMART action plan has been shared with WHSSC
2. Communicate and address (via a SMART action plan) the additional issues recently identified by HEIW, arising from the concerns with the cardiac surgical service raised by trainees

Actions:

Action	Lead	Action Due Date	Completion Date
Escalate service to Stage 3 of the WHSSC escalation process.	Director of Planning		Completed
Establish regular (every 6 weeks) escalation meetings with CVUHB to oversee escalation process.	Senior Planning Manager		Completed

…there is a risk that people waiting for Cardiac Surgery delivered by Cardiff and Vale University Health Board may receive suboptimal or delayed treatment, and that WHSSC will be unable to effectively monitor.

The following controls have thus been put in place:

- Instituting of regular (every 6 weeks) Stage 3 escalation meetings with Cardiff and Vale University Health Board.
- HEIW report and action plan shared with WHSSC and discussed in escalation meetings.
- Development of SMART action plan to take forward the recommendations of the GIRFT review, shared with WHSSC at escalation meetings to enable the monitoring of progress and identification of any required remedial actions.

WHSSC assurance and confidence level in developments:

Medium – Although progress against the objectives of the action plan is apparent, there has been a noteworthy delay between the last completed and next scheduled escalation meeting, significantly impacting WHSSC's ability to further monitor progress. WHSSC has also experienced a delay in receiving the HEIW report, the provision of which was actioned in the November escalation meeting.

Receive a SMART action plan from the service that addresses the recommendations contained in the GIRFT report.	Senior Planning Manager	In progress - chased 10/06/22	Completed
Receive HEIW report concerning issues with the cardiac surgical service raised by trainees.	Senior Planning Manager		Completed
Monitor implementation of the SMART action plan at escalation meetings.	Senior Planning Manager	In progress	
Development of de-escalation criteria based on recommendations in GIRFT report and action plan.	Associate Medical Director		Completed

Issues/Risks:

June 2022 – Service escalated to Stage 3 of the WHSSC escalation process in April 2022 owing to continuing concerns with engagement; agreed at the 28 June 2022 Cardiac Commissioning Team meeting that the escalation constituted a risk (as opposed to an issue) owing to concern that the failure to implement GIRFT/HEIW recommendations will impact on patients, but that the accompanying narrative should be revised to clarify the precise concerns; escalation meeting held on 01 June 2022, at which an apparently extant action plan was discussed, but not subsequently shared.
July 2022 – Action plan now shared with WHSSC. Second escalation meeting held on 20 July 2022 at which – mindful of the long-term nature of many of the HB's objectives – progress was noted. Agreed that WHSSC would refer to both the GIRFT report and the action plan in order to develop de-escalation criteria in time for the next escalation meeting (September). No change to risk score.
August 2022 – Draft de-escalation criteria shared with Health Board in readiness for discussion at September escalation meeting. No change to risk level.
September 2022 – The de-escalation criteria was discussed with the Health Board in the September escalation meeting. It was agreed in the meeting that the Health Board would provide a formal response in regards to the proposed de-escalation criteria. No change to the risk score.
October 2022 - Health Board had not yet provided formal response to proposed de-escalation criteria. Planned October escalation meeting had been rescheduled to Monday 21 November owing to Health Board availability; Health Board had submitted updated action plan in lieu of meeting. No change to risk score.
November 2022 – Further progress was noted at November escalation meeting; de-escalation criteria discussed – agreed that focus would be on evidencing positive trajectory, assisted by cardiac surgery dashboard; risk score unchanged.
December 2022 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
January 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
February 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
March 2023 – No escalation meetings since the last CRAF review. Risk level remains unchanged; next meeting scheduled for 5 April 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac
Date of Escalation Meetings: 12/07/21, 30/08/21, 21/09/21, 08/11/21, 01/02/22, 13/05/22, 18/07/22, 06/10/22, 16/02/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

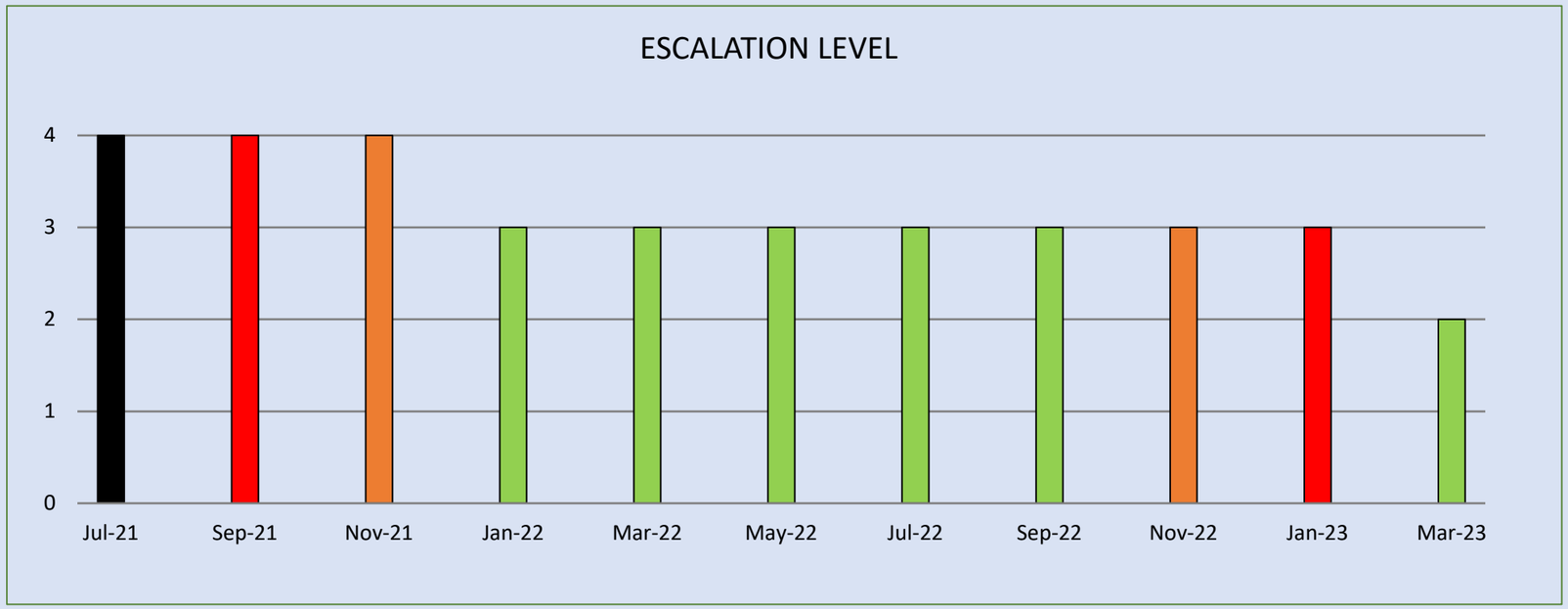
Service in Escalation: Cardiac SBUHB

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2021 – WHSSC escalation	**4**
November 2021 – WHSSC escalation	**4**
February 2022 – WHSSC escalation	**3**
July 2022 – WHSSC escalation	**3**
October 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**
March 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :
Reduced to Level 2 owing to significant progress towards the GIRFT benchmarks and the further assurance provided in response to the recommendations of the Royal College of Surgeons of England (RCS England) Invited Service Review report.

Background Information:

There is a risk patients undergoing cardiac surgery in Swansea are at a greater risk of complications as recent evidence from the Getting It Right First Time Review of cardiac services has highlighted a high rate of poor clinical outcomes. As a consequence patients are at risk of harm from practices during surgery and in the post-operative period resulting in long term morbidity issues.

Actions:

Action	Lead	Action Due Date	Completion Date
Service escalated to Stage 4 of the WHSSC Escalation Process.	Director of Planning		Completed
To receive an improvement plan from the service which addresses the clinical outcomes and the 5 process issues highlighted in the report and set out in the GIRFT recommendations by end of July 2021.	Senior Planning Manager		Completed

- Consultant only operating whilst a review of the clinical outcomes takes place
- Mitral Valve surgery to only be undertaken by the 2 consultants with a sub-specialist interest in mitral valve surgery
- Service has established a gold command structure to steer improvement

WHSSC assurance and confidence level in developments:

High – Evident progress GIRFT benchmarks and further assurance provided by the Medical Director in response to the recommendations of the Royal College of Surgeons of England (RCS England) Invited Service Review report have assured WHSSC of the effectiveness of the actions in progress, leading to de-escalation. Service will be monitored via newly convened Risk, Assurance and Recovery meetings pending further de-escalation.

To establish 6 weekly escalation meetings with SBUHB to review progress against the improvement plan.	Senior Planning Manager		Completed
Arrange meeting with SBUHB and C&VUHB to discuss interim arrangements for Aorto-vascular service.	Senior Planning Manager		Completed
WHSSC to write to SBUHB following agreement of interim pathway.	Senior Planning Manager		Completed
Improvement plan to be monitored through the regular escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Ongoing; timelines extended	

Issues/Risks:
March 2022 – Commissioning Team to agree to lower risk score to 3x4=12 at March team meeting as data shows improvement.
June 2022 – Meeting with SBUHB held on 13 May 2022; service continues to show improvement and consideration will be given to de-escalation on provision of six months of data.
July 2022 – Escalation meeting held on 18 July 2022 and analysis of data illustrated further improvements; significant portion of data points now in line with GIRFT benchmarks. Agreed that de-escalation would be further discussed at September meeting, pending submission of Royal College of Surgeons of England (RCS England) Invited Service Review report.
August 2022 – Still awaiting submission of RCS England Invited Service Review Report. No change to risk level.
September 2022 - An escalation meeting is scheduled with SBUHB for the 6 October 2022. It is anticipated that once the RCS England report has been received that the service can be de-escalated. No change to the risk score.
October 2022 – Escalation meeting had noted further progress, but RCS report had still not been received. De-escalation will only be recommended on receipt of report; no change to the risk score. In the event that the report is not submitted, an additional escalation meeting will be convened.
November 2022 – RCS report has been repeatedly chased, but has still not been received. Convening of additional level 3 escalation meeting with Exec-level attendance now in train.
December 2022 – RCS report received and considered by extraordinary meeting of the Cardiac Commissioning Team, which recommended that the service remain in escalation owing to new and continuing concerns. Endorsed by CDGB; escalation letter sent to SBUHB. Risk level to remain unchanged as escalation status remains unchanged.
January 2023 – Escalation meeting planned for February, at which next steps will be discussed.
February 2023 – Escalation meeting in February followed by submission of revised action plan and accompanying letter, which were subsequently considered by the Cardiac Commissioning Team. WHSSC CDG to consider recommendation status imminently. In the event that escalation level is reduced, risk level may be similarly revised.
March 2023 – WHSSC CDGB agreed that the service be de-escalated from level 3 to level 2 of the WHSSC escalation framework and will be monitored via regular Risk, Assurance and Recovery meetings.

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: 18/04/2023

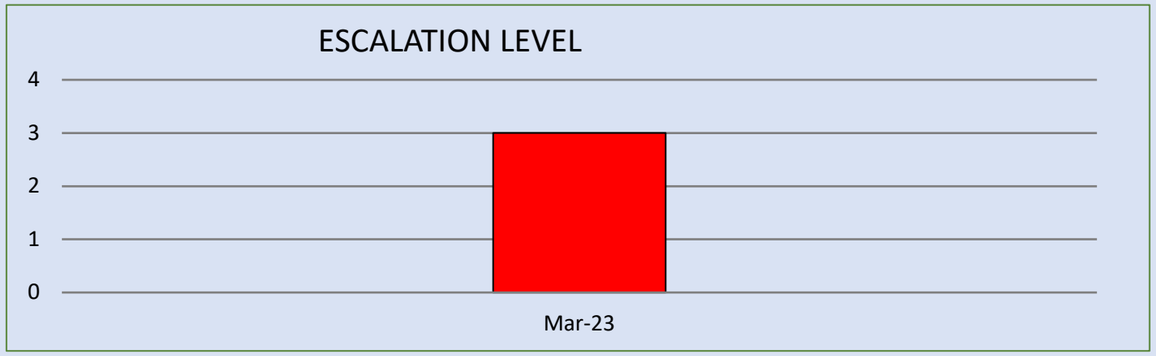
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ March 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
The service has moved from escalation Level 1, 'Enhanced Monitoring', straight to Level 3, 'Escalated Measures'.

Background Information:

• Recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The current plan does not deliver contracted volumes
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

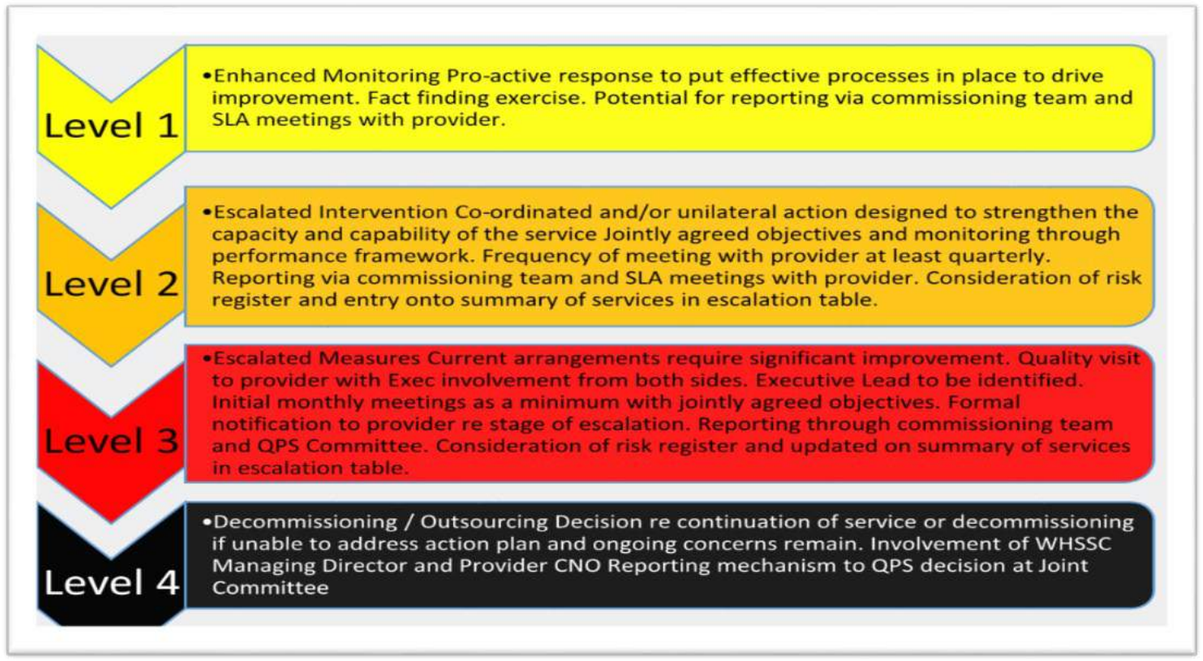
Actions:

Action	Lead	Action Due Date	Completion Date

Issues/Risks:

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

Level of escalation increasing / worsening position

Welsh Health Specialised Services Commissioning

NEWSLETTER

3rd Edition, Winter 2022 - 2023

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

NHS Wales Awards 2022

This is the 3rd edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This Newsletter is available in Welsh on request.
Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from Welsh Health Specialised Services Committee (WHSSC) are provided both in Wales and in England this will only provide a snapshot of our work. Permission has been provided for the content included.

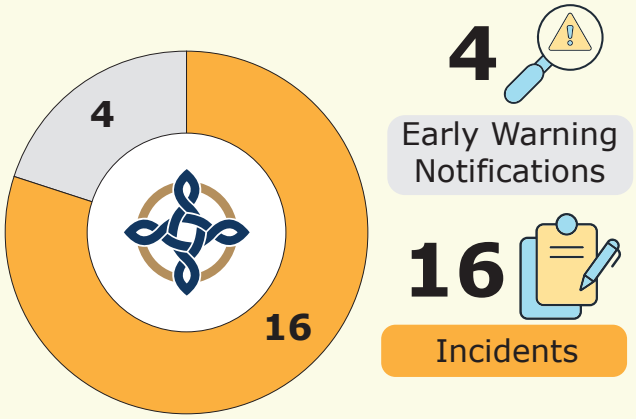
GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Contents

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.

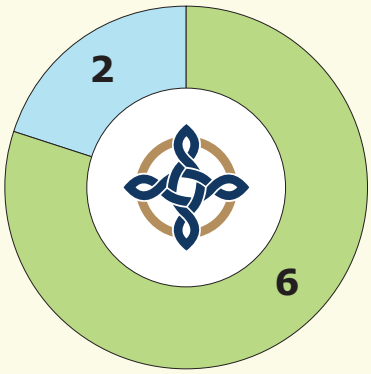
Between the periods of August to December 2022, there were ***16*** Patient Safety Incidents and ***4*** Early Warning Notifications logged.



4 Early Warning Notifications

16 Incidents

Between the periods of August to December 2022, there were ***6*** Patient Safety Incidents and ***2*** Early Warning Notifications closed.



2 Early Warning Notifications

6 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.

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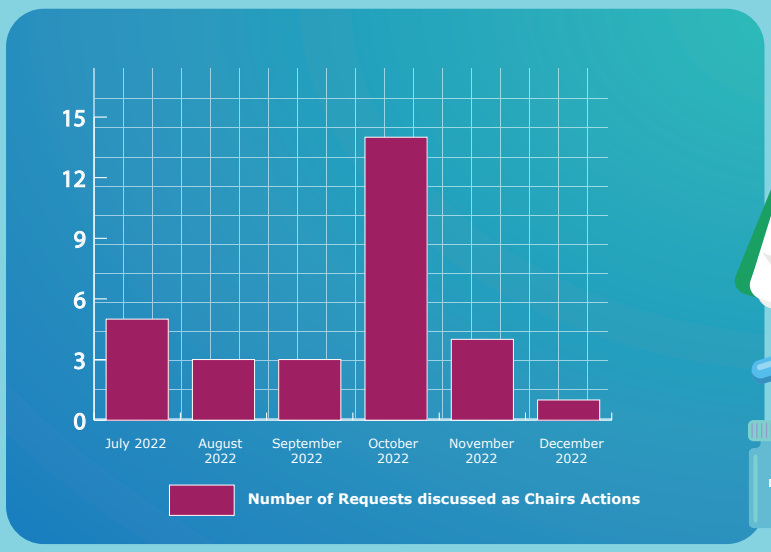
Welsh Health Specialised Services Committee

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

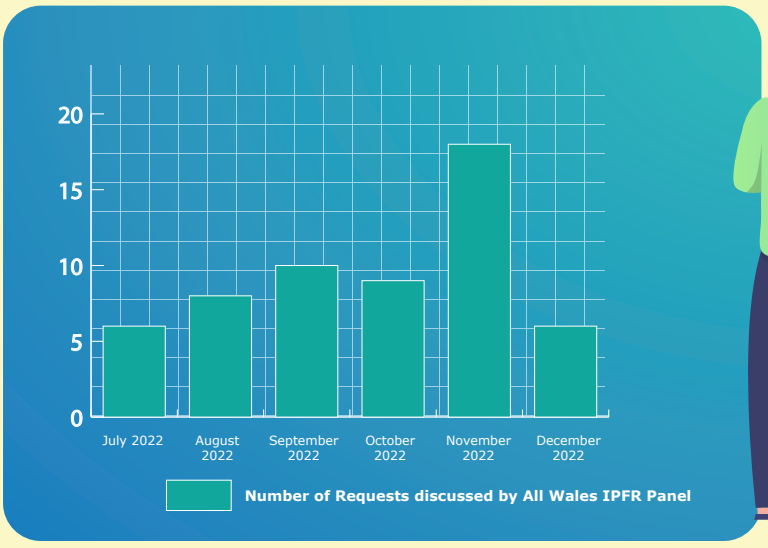
The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarters 2 and 3 2022-23:

Number of Requests discussed as Chairs Actions



Number of Requests discussed by All Wales IPFR Panel



Quality and Patient Safety Development Day

WHSSC held a virtual Quality and Patient Safety Development Day on 26th September 2022. Quality Clinical Colleagues and Independent members from across Welsh Health Boards attended.

The day was a success and featured data systems presentations from NHS England on Specialised Services Quality Programme (SSQD transition project), the data team in WHSSC who presented on MAIR, presentations from the Delivery Unit team on Nationally Reported Incidents and the Delivery Unit's role within these as well as National Quality Metrics Application (NQM App) to support consistent quantitative reporting.

NWSPP presented on the Once for Wales Concerns Management System which also featured updates on CIVICA and the work ongoing producing the platform that will be able to collate and analyse all-Wales data.

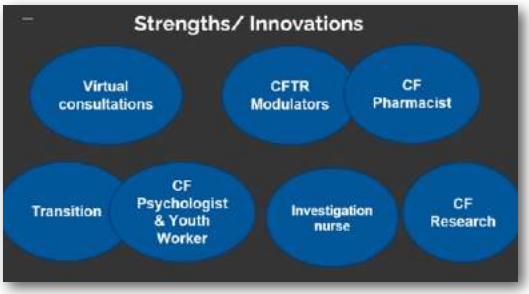
Following evaluation of the day, the following comments were given:

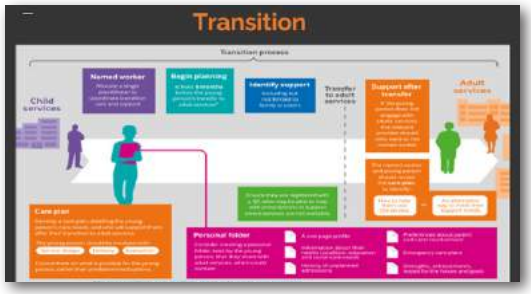
Cystic Fibrosis Service Improvement and Innovation Day

WHSSC held a Cystic Fibrosis Service Improvement and Innovation Day on 11th November 2022 at The Clayton Hotel in Cardiff. The event was attended by 50 people with participants also on Microsoft Teams.

Liverpool Heart and Chest, Alder Hey and Cardiff and Vale Adult and Paediatric teams were in attendance to showcase their excellent presentations and innovative work, with powerful patient stories featured including a patient from Liverpool Heart and Chest who dialled-in via Microsoft Teams to tell his story live!

Slides featured within the Children's Hospital for Wales Presentation:





Slides featured within the All Wales Adult Cystic Fibrosis Centre's Presentation:

Neuro-Endocrine Tumour (NETS) Celebration Event

From left to right: Yolande Mears, Dr Mohid Khan, Angela Hughes, Vicki Dawson-John, Mr Christmas

The NETS celebration took place at the Vale Resort, Cardiff on 13th October 2022. It was well attended by patients, their families, clinicians and stakeholders.

There was a plethora of patient stories that had a huge impact on the audience and it was a wonderful opportunity to network with all who attended in whatever capacity they represented.

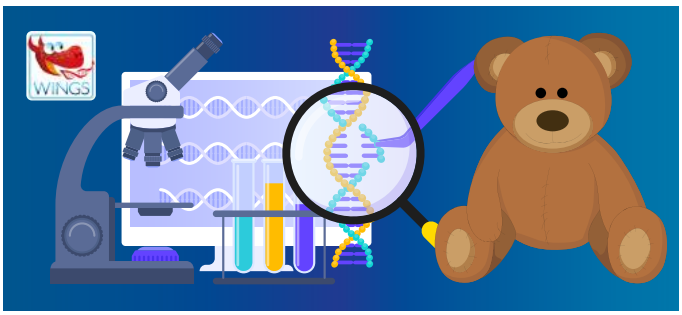
There was a focus on how the service had evolved in order to achieve a Centre of Excellence status. Representatives from this process spoke warmly and with enthusiasm, as to the great efforts made by Dr Mo Khan and his dedicated team to achieve this goal.

Congratulations to all involved!

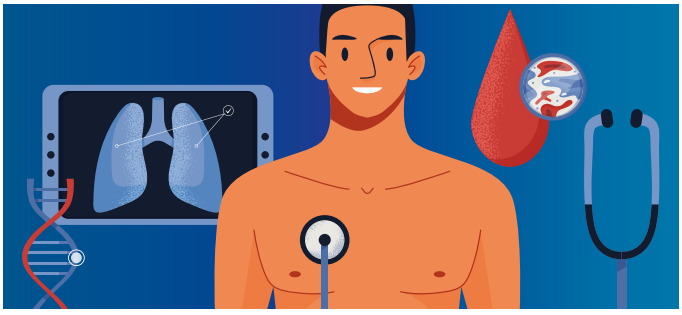
All Wales Medical Genomic Service (AWMGS)

The All Wales Medical Genomic Service (AWMGS) has produced an excellent Quarter 2 Progress Report that highlights excellent work:

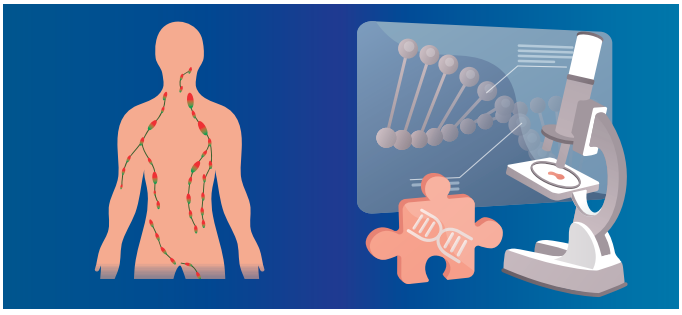
Launch of the PIK3CA Genomic Service for breast cancer in September 2022 which was followed up with an Education Event on 6th October 2022.



An update on the Wales Infants' & Childrens Genome Service (WINGS) that highlights rapid whole genome sequencing testing, diagnosis and patient outcomes.



Secured funding for a pilot to integrate a blood test into the lung cancer diagnostic pathway to accelerate access to personalised cancer treatments.



Development of the Angioimmunoblastic T-cell Lymphoma (AITCL) Service for the DNMT3A, TET2, IDH2 and RHOA genes.

The All Wales Medical Genomic Service (AWMGS) certainly deserve a massive "well-done" on their excellent work and their resulting fantastic news stories!

South Wales Adult Congenital Heart Disease (ACHD) Pilot Wellbeing Group

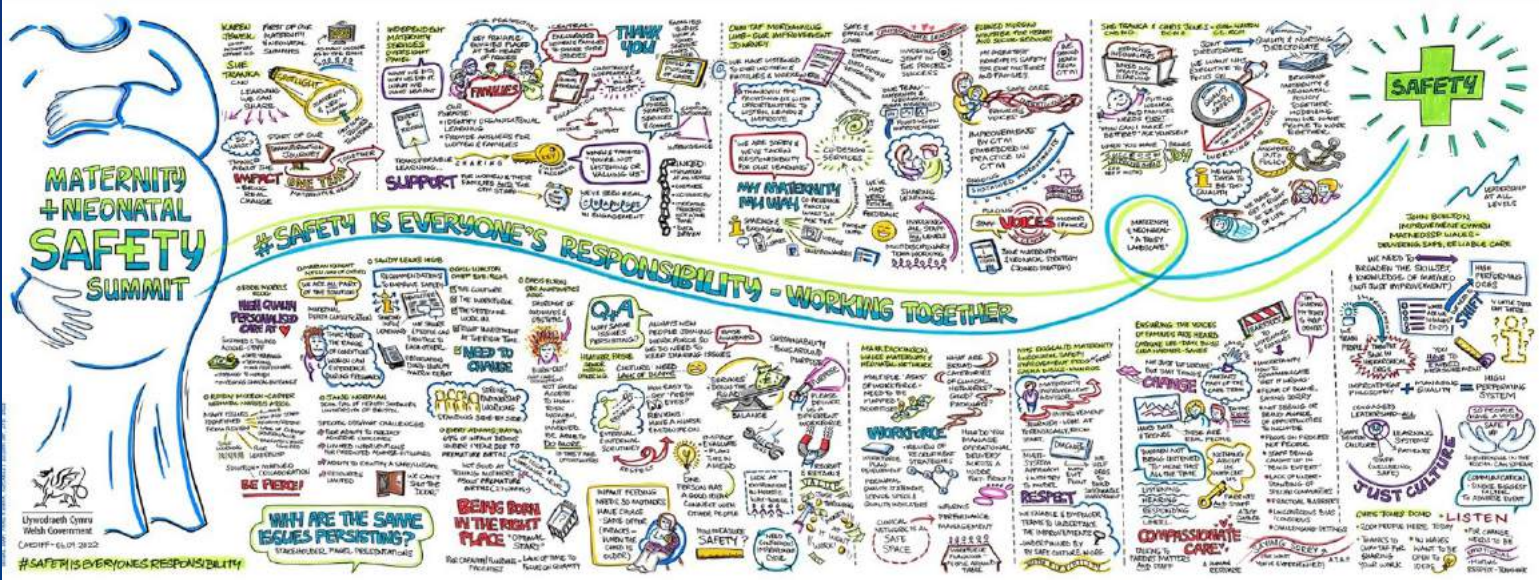
Dr Anna McCulloch and the ACHD Team recently completed a pilot wellbeing project based at the Orchard, Llandough. The project saw 10 patients with ACHD attend with some members also under the supportive care service. Patient feedback was fantastic and saw collaborations with the nursing team and with "Down to Earth" to provide the service. Dr Anna McCulloch and the Team are grateful to the Cardiff and Vale Health Charity for making it possible.

Some of the recommendations for future activity following the pilot were:

- The pilot showed the positive impact a group-based outdoor group can have on the physical and psychological wellbeing of people living with congenital heart disease.
- Patients reported finding peer support to be extremely beneficial.
- The positive outcomes highlighted the need for further group-based activities and for access to peer support.
- The team plan to run a second group, with some original members invited back to participate in a peer mentor training programme.

Maternity and Neonatal Safety Summit

Following on from our last Newsletter piece on the Maternity and Neonatal Safety Summit held on 6th September 2022, the 'Visual Minutes' map has been published that was creatively designed on the day by Scarlet Design.



Click here to be taken to the website which features the interactive 'Visual Minutes' map as well as videos from the day!






Healthcare Financial Management Association (HFMA)

The National Healthcare Finance Awards (HFMA) programme recognises the work of finance teams and individuals from across the UK.

WHSSC colleagues Kendal Smith, Richard Palmer, Dr Kerryn Lutchman-Singh, Karla Williams and some colleagues from outside WHSSC have been looking at access to, and the impact of, WHSSC interventions on our patients.

This cutting edge piece of work was recognised by the Healthcare Financial Management Association (HFMA) and the team were shortlisted for this brand new award and invited to attend the 'Celebrating innovation and excellence in healthcare finance' awards ceremony in London on 8th December 2022.

We are extremely proud to announce that the team won the Addressing Health Inequalities through NHS Finance Action award and we would like to extend our congratulations to all involved; what a fantastic achievement!

WHSSC staff Kendal Smith and Dr Kerryn Lutchman-Singh proudly displaying the award!

NHS Wales Awards 2022

Cardiac Surgical Team: Some of the Cardiac Surgical Team with the NHS Wales Award. Front row (l-r) Cardiac Theatre Scrub staff Chito Fababeir and Victoria Jobson, and Sobaran Sharma, Senior Clinical Fellow, Cardiothoracic Surgery. Back row (l-r) Mark Vernon, Trainee Clinical Perfusionist, Ian Bennett, Senior Clinical Perfusionist, Pankaj Kumar, consultant cardiothoracic surgeon and Deputy Medical Director, Morriston Hospital.

The NHS Wales Awards 2022 saw many excellent innovative projects nominated and Swansea Bay University Health Board were not only shortlisted for the Improving Patient Safety award with their submission 'Impact of implementation of an intra-operative checklist to reduce re-operation for bleeding and blood transfusion' – they went on to successfully win the award!

Quick Round up of Commissioning Teams

Mental Health

5 year Mental health strategy ongoing. Review of current services and further development of these underway.

Women and Chidren's

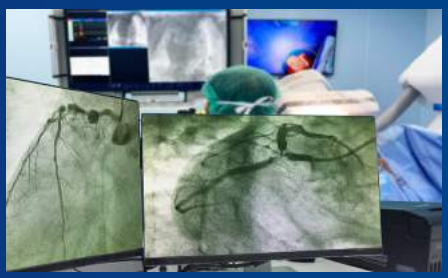
IVF Service Improvement and Innovation Day currently being planned.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic and Inherited Bleeding Disorder Service Improvement and Innovation Days are currenty 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

"I was at Ashworth this week with Alison Cannon from NHSE. We went to every unit in the service, also met with Clinical Director and Director of ops. The general consensus from the visit is that the contact they have from the case management team from Wales is second to none. Whilst they have concerns regarding contact from particular areas in England, they feel that the only area they don't need to worry about is Wales. I also saw a number of Welsh patients whilst there and they were also very complimentary about the service you are providing. Just thought I'd share with you all."

Adrian Clarke, Assistant Director of Nursing and Quality, National Collaborative Commissioning Unit (NCCU)

"As you will know we are currently taking forward an engagement process around the WHSSC 10 year strategy. This is a really complicated piece of communications work and key to this has been inclusion on the WHSSC website and links to the Health Boards. It's been a fantastic piece of work and we couldn't have done it without our very own IT guru Laura Holborn. As ever she's stepped up and done a fabulous job and I wanted you to know how great she has been!"

Dr Sian Lewis, Managing Director, WHSSC

"I'm really proud to tell you about another great achievement by one of our WHSSC teams. We have recently been informed that the Quality Team were assessed by CTMUHB Internal Audit and were rated as providing "Substantial Assurance". This is the highest rating possible and means we are doing our core business really well. I think this is probably the 5th team in WHSSC to get substantial assurance in the last year or so, which is something we should all be very proud of! Fantastic work - well done to Adele and the team."

Dr Sian Lewis, Managing Director, WHSSC

Welsh Gender Service

The Welsh Gender Service published their second Newsletter in Summer 2022, scan the QR code below or click this link to access it!

Useful Links

Other useful links:

Welsh Health Specialised Services Committee

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Welsh Health Services Specialised Commissioning

NEWSLETTER

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

whssc.nhs.wales

Winter 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.

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

COMMUNITY PROMPT WALES
QUALITY ASSURANCE REVIEW

CYMRU / WALES
PROMPT
PRactical Obstetric Multi-Professional Training
Hyfforddiant Aml-broffesiynol Ymarferol mewn Obstetreg

ANEURIN BEVAN
UNIVERSITY HEALTH BOARD

QA VISIT DATE:	**28H FEBRUARY 2023**
DRAFT REPORT ISSUED:	**3RD APRIL 2023**
CONFIRMED ACTION PLAN:	**8TH MAY 2023**
FINAL REPORT ISSUED:	**16TH MAY 2023**

QA REPORT STATUS: FINAL

This report is issued following a draft release to enable the Health Board to review the information, provide feedback and present an action plan to address the findings.

The report and action plan can be used for internal quality assurance processes within the Health Board.

The Welsh Risk Pool will use this report as part of future Quality Assurance Reviews and monitoring processes.

The PROMPT Wales National Team hope that the feedback and recommendations in the report are valuable and provide your organisation with useful guidance for further development of your PROMPT Wales training. The National Team are available as a resource for guidance around the recommendations.

The PROMPT Wales National Team hope that the feedback and recommendations in the report are valuable and provide your organisation with useful guidance for further development of your Community PROMPT Wales training.

REFERENCES

1. Webb J, Davies C. *PROMPT Wales strategy*. 2018. https://nwssp.nhs.wales/a-wp/prompt-wales/prompt-wales-documents/prompt-wales-strategy/
2. Hookes S, Morris S. *Community PROMPT Wales - An evaluation of the pilot programme.* 2018. Internal Report.
3. Siassakos D, Crofts JF, Winter C, Weiner CP. *The active components of effective training in obstetric emergencies*. BJOG. 2009; 1028–1032. https://doi.org/10.1111/j.1471-0528.2009.02178.x

Community PROMPT Wales Quality Assurance Review at Aneurin Bevan University Health Board

Date:

28h February 2023

Location: Ysbyty Ystrad Fawr

The Welsh Risk Pool observing team:

Sarah Morris - PROMPT Wales National Midwife

Jenilee Harrison - PROMPT Wales National Midwife

Aneurin Bevan UHB PROMPT Wales faculty on date of visit:

Donna Crocombe, Practice Development Midwife

Haf Lane, Community Midwife

Helene Taylor, Community Midwife

Laura Williams, Community Midwife

Rebecca Dowden, Lead Midwife for the Midwifery Led Unit in The Grange University Hospital

CONTENTS

00 Community PROMPT Wales

00.1 Community PROMPT Wales (CPW) is an 'all Wales' maternity safety programme developed by the PROMPT Wales National Team, building on the successful implementation of PROMPT Wales. The development of a community midwifery PROMPT Wales programme features in the PROMPT Wales Strategy (2018)[1] – a collaborative strategy between the Welsh Risk Pool, Welsh Government, and the Wales Maternity Network.

00.2 CPW was implemented in September 2021 following a successful 12 month pilot which took place throughout 2020 and participation by all Community Midwives annually has since been mandated.

00.3 CPW aims to meet the needs of community midwifery services in NHS Wales, making childbirth safer and improving outcomes for women and babies through the provision of high-quality training which meets the PROMPT Wales standards (2018)[1].

00.4 PROMPT Wales is centrally coordinated by a multi-professional National Team who provide oversight of this all-Wales programme and offer support and guidance to local faculty teams. Local faculty teams who have undergone an accredited CPW faculty training course are responsible for the planning and organisation of training in their community area.

00.5 Building on the successful roll out of PROMPT Wales in obstetric-led care, training is presented in a way that represents practice in midwife-led settings. Scenarios take place in the birth centres, or a simulated home birth setting and focus on managing emergencies in a small team without early access to obstetric support. Themes and trends arising from local and national incidents are seamlessly incorporated into the scenarios, facilitating the opportunity to learn from events.

00.6 Midwives, Maternity Care Assistants and Paramedics train together, using their own equipment thus providing fidelity to their usual working practice. PROMPT training resources have been adapted to reflect this and the use of CPW algorithms, checklists and proformas have been introduced in NHS Wales.

00.7 As recommended in the Community PROMPT Wales Evaluation Report[2], midwives who may also be expected to provide care in their local obstetric unit should also attend a hospital-based PROMPT Wales training course.

00.8 The standard of CPW training should be equitable to that provided in the obstetric unit, with the same provision of training resources available.

00.9 Commencing in January 2023, the PROMPT Wales National team have coordinated a series of Quality Assurance visits to all training sites to ensure that high standards of Community PROMPT Wales training are being met across Wales. This report will present the findings of the quality assurance review undertaken in the health board and will include examples of good practice and recommendations for action before the next scheduled visit.

00.10 We aim to promote a consistent approach and authenticity to the PROMPT principles throughout NHS Wales and to encourage continuous improvement of CPW training through our objective and balanced feedback. The report will be shared with the Welsh Risk Pool Committee and Welsh Government and contribute to the evaluation of the programme.

01 Venue for Training

01.1 Conducting PROMPT Wales Training in the clinical setting is considered an essential component of effective training[3]. This promotes the principle of 'teams that work together, train together' which underpins PROMPT training and enables the testing of systems and processes - contributing to organisational improvement. In health boards who benefit from a Free Standing Midwife-Led Unit (FMU)/birth centre, it would be expected that CPW training would be held there. In health boards who do not have a FMU, the alongside midwife-led unit (MLU) should be considered as an option, particularly if community midwives are not attending PROMPT Wales training in the obstetric unit as this has the benefit of familiarising them with the unit.

01.2 Community midwives in Aneurin Bevan UHB do not attend PROMPT Wales training in the obstetric unit (OU). Our reviewers were informed that community midwives escalate into the OU on occasions. Recommendation 3 in the evaluation report[2] states,

Community midwives who also work within an obstetric-led unit to attend a PROMPT Wales training session annually in addition to the CPW session. The responsibility for who will attend only CPW, or both CPW and PROMPT Wales training in the OU will sit with the Heads of Midwifery and names will be submitted to the WRP as per PROMPT Wales Standard 1.

Community PROMPT Wales only:

- *Community midwives who are not rostered to provide care on the OU*

Community PROMPT Wales and PROMPT Wales within an Obstetric Unit:

- *Rotational midwives*
- *Community midwives who may be called to the OU in periods of high acuity or escalation*

01.2.1 It is encouraging to note that CPW training at Aneurin Bevan UHB is held on the birth centre at Ysbyty Ystrad Fawr (YYF). Non-clinical elements are held in the Education Centre on site.

02 Organisation of the training

02.1 <u>Structure of the session</u>

02.1.1 The Aneurin Bevan UHB CPW programme is a well-structured, full day programme which consists of six relevant practical sessions of 45 minutes each and one presentation. Fourteen courses are held throughout the year which is sufficient to ensure all community midwives are allocated.

02.1.2 The programme is designed with scenarios set in a simulated home or clinic setting

(using the birth centre rooms), and some set on the birth centre. In the community-based scenarios the midwives are expected to work from their community bags. In the birth centre scenarios, equipment is accessed from its usual location, this familiarising staff with its location and testing the systems.

02.1.3 Delegates receive a detailed pre-course email and are encouraged to borrow a PROMPT Course Manual before attending.

02.1.4 Community PROMPT Wales at Aneurin Bevan UHB is organised by a Practice Development Midwife who is supported by the local community midwives and midwives from the alongside Midwifery-Led Unit in The Grange University Hospital.

02.1.5 The latest Community PROMPT Wales Human Factors presentation is presented in the morning.

02.1.6 An icebreaker is included on the programme; this involved the team working in smaller groups, retrieving equipment from their kits for certain clinical scenarios. This created good discussion on how everyone's bags are different and that in an emergency, the time taken to look in someone else's bag if not familiar, could be detrimental.

02.1.7 The effectiveness of PROMPT training is underpinned by the multi-professional approach. Unfortunately, there was no paramedic facilitator on this course but there were paramedic delegates. It is preferable to have a paramedic facilitator available when paramedics are attending.

02.1.8 The faculty had a 'huddle' before the start of the day to discuss the day ahead and to make any necessary adjustments. They were seen to use the PROMPT Wales Faculty huddle checklist which is excellent practice.

02.1.9 It is useful for all staff to be able to refer to each other by name, particularly if there are new people in the team such as students or Paramedics. Using name labels is helpful.

02.2 Welcome and introduction

02.2.1 Delegates were welcomed, and faculty introduced themselves. Delegates did not introduce themselves this time - this was purposely left until after the ice breaker.

02.3 Presentations

02.3.1 The Community PROMPT Human Factors presentation was given by the PDM and the PROMPT Maternity Foundation's 'What is PROMPT' video was shown.

02.3.2 The Erb's Palsy 'Better Births Cost Less' video was shown, and this was followed by a valuable discussion and a demonstration using the Force Monitor.

02.4 End of Session Feedback

02.4.1 It is useful for delegates to come together at the end of the day as this provides an opportunity for questions and concludes the day nicely. It was great to see the teams regroup and the PDM created an opportunity for questions and final discussion points.

02.5 Faculty Debrief

02.5.1 This provides an opportunity for discussion and reflection, to review the feedback and identify any required changes for future courses. The team came together and were receptive to feedback from the reviewers, demonstrating their willingness to continue to develop their course. There was an openness to improving facilitation skills.

03 Facilitation

Overall, the facilitation was of a good standard. The support to the newer members of faculty was evident. The faculty were supportive and encouraging to their colleagues. It is good to see patient-actors used, this adding to the realism and providing the opportunity for the patient-actor to feedback to the team offering the 'woman's' perspective on the care received.

03.1 Briefing

03.1.1 Briefing is an essential component of the scenario as it prepares the team for what to expect, aiming to put them at ease. Briefing provides the opportunity to orientate the team to the setting/simulated environment, reminds them to use the algorithm/OBS Cymru/MEOWS chart etc., what equipment they should use and to declare the emergency, practise closed loop communication and SBAR handover.

03.1.2 There were some good examples of briefing although the Facilitator's Aide Memoir was not seen to be used in all scenarios. The briefing took place in the room to the whole team and participants were orientated to the environment. The Facilitator's Aide Memoir would ensure that the team are reminded to declare the emergency, use the algorithm; MEOWS; Sepsis Risk Assessment Tool (as appropriate); and SBAR in *every* scenario.

03.1.3 Observers were allocated to complete the human factors and clinical checklists.

03.1.4 Where the Facilitator's Aide Memoir was utilised, the team did well in the scenarios thus showing the importance of a comprehensive briefing.

03.2 Debriefing

03.2.1 The debrief is widely known to be the part where most of the learning takes place and

therefore it is essential this is well executed and follows the PROMPT principles. The debrief is more than the observers feeding back on their observations. Facilitators should lead the team into a discussion by starting with "how do you feel that went?" then moving through the questions on the Facilitator's Aide Memoir, bringing the observers in where appropriate. In scenarios where the Aide Memoir *was* used, there were some very good examples of a structured debrief observed and we suggest this is followed at all times.

03.2.2 Observers and the patient-actor were asked to feedback in all instances. It was good to see the observers read through the checklists in full and provide examples, thus adding to the learning and discussion.

03.2.3 It was good to see the Key Learning Points read through at the end of every session to ensure all learning had been included before concluding.

04 Scenarios

04.1 Postpartum Haemorrhage (PPH) Scenario

04.1.1 This scenario was set in a simulated home environment.

04.1.2 In one of the scenarios observed, the midwife was slow to use the OBS Cymru PPH Management Checklist. Whilst facilitators should avoid interrupting the flow, team members can be gently reminded, otherwise the opportunity to practise is lost. Asking, "Is there anything which would help guide your management?" will act as a gentle prompt. It was also noted that at times, delegates made up their own clinical information, e.g., when palpating the uterus, the delegate reported it was "well contracted." As this is not part of the scenario, this should be corrected by the faculty. By explaining during the briefing that the facilitator will provide details of clinical examinations and observations, it will help to avoid any confusion.

04.1.3 To maintain fidelity to practice as far as possible, and to test the 'systems,' the midwives should access their paperwork from their community bag rather than this being laid out for them.

04.1.4 Following the debrief, it is useful to guide the team through the OBS Cymru checklist as Community Midwives may be less familiar with this than hospital colleagues. Remind them that women in all birth settings should be risk assessed when first attended in labour using stage 0, and as soon as they have measured 500mls blood loss (or have clinical concerns) they should work through stage 1 (and 2 and 3 as appropriate). This will provide a systematic approach to the clinical management.

Identifying the cause of the PPH, measuring blood loss, and noting the woman's weight should be emphasised.

04.1.5 It was observed in one scenario that a Midwife did not give an SBAR handover to the second Midwife or Paramedic. On discussion, the Midwife felt that SBAR would only be used when handing over to hospital staff suggesting that this may not be embedded in community practice. CPW provides the opportunity to reinforce the need for an SBAR when handing over in a variety of different situations.

04.2 Uterine inversion Scenario

04.2.1 This scenario was situated set in the Birth Centre.

04.2.2 One of these scenarios was 12 minutes late starting as the faculty needed to set up. A briefing was not carried out so the opportunity to remind teams to declare the emergency, use closed loop communication, and SBAR was lost. Despite starting late, the scenario and debrief were completed within 23 minutes. Whilst the faculty filled the remaining time with useful discussion, it could have been better used by completing a thorough briefing.

04.2.3 The scenario was paused for a demonstration of manual replacement of the uterus. Whilst a demonstration is very useful, including this in the briefing beforehand would have enabled the scenario to flow without interruption.

04.2.4 Encourage the plotting of observations on the MEOWS chart and discuss the importance of this to aid recognition of the deteriorating woman, or response to treatment.

04.2.5 The paramedic was not utilised in one of the scenarios observed. CPW provides the opportunity to learn from each other and develop working relationships and this should be maximised. Having them take part will increase their engagement and enjoyment.

04.2.6 One observer reported that an Antenatal Clinic Midwife was allocated as the Midwife taking handover, and a Midwife Sonographer was allocated as the second Midwife. Because these midwives do not normally work in an intrapartum setting and because there was no briefing, they reported they felt "bamboozled". Being selective on who is allocated to each role will contribute to the success of the scenario and avoid colleagues feeling out of their depth.

04.3 Care of the Deteriorating Woman in the Community Scenario

04.3.1 This antenatal scenario was set in a simulated home environment.

04.3.2 The Sepsis Risk Assessment Tool and MEOWS chart were laid out. To add to the realism, the team should be asked to retrieve equipment and paperwork from a community bag. A sphygmomanometer was missing from the bag - checking kit beforehand will avoid interrupting the flow of the scenario.

04.3.3 The Sepsis Risk Assessment Tool and MEOWS chart were slow to be used despite being encouraged by the faculty. This will require continued reinforcement.

04.3.4 Handover was given using the SBAR format, however the emergency was not stated as the 'situation' and faculty should continue to encourage this. This was observed on a few occasions.

04.3.5 This scenario should emphasise working through the Sepsis Six checklist as far as possible once sepsis has been identified using the Risk Assessment Tool. The use of these resources in the community is a recent practice and this should continue to be embedded through training.

04.4 Eclampsia Scenario

04.4.1 This scenario was set in the birth centre. The faculty showed the delegates where the emergency equipment was kept during the briefing which was excellent practice.

04.4.2 The scenario began with the patient-actress having a seizure in the pool. This provided a great opportunity for discussion around pool evacuation. Faculty did well to keep any discussions for the debrief.

04.4.3 In one scenario observed, the 'second' midwife did not realise she was allocated to this role which led to some confusion. Using the Facilitator's Aide Memoir to structure the briefing may have prevented this.

04.4.4 The team performed well, declared the emergency and used an SBAR handover, however again, a MEOWS chart was not completed.

04.4.5 Algorithms were laid out on the windowsill in preparation for the delegates. Leaving the algorithms where they are normally kept in the birth centre will test the systems and remind staff where they are located.

04.5 Shoulder Dystocia workstation

04.5.1 The PROMPT Maternity Foundation's Shoulder Dystocia training video was shown at the start. Manoeuvres were then demonstrated using the PROMPT Flex manikin.

04.5.2 The Force Monitor was utilised to reinforce the importance of routine axial traction.

04.5.3 All participants practised manoeuvres (relevant to their role).

04.5.4 It was good to see algorithms and proformas handed out to all of the team.

04.5.5 All the essential learning points were incorporated, and Key Learning Points were read through at the end. This acts as a reminder should any important information have been missed in this busy workstation.

04.6 Breech Workstation

04.6.1 The PROMPT Maternity Foundation's Breech Birth training video was shown. For community teams, this can be stopped before the part showing the application of forceps.

04.6.2 The PROMPT Vaginal Breech module was appropriately followed.

04.6.3 The PROMPT Flex manikin and baby were used.

04.6.4 All participants (relevant to role) had time to practise manoeuvres.

05 Overall Observations

05.1 The overall impression is that Community PROMPT Wales training in this team is well organised. The faculty team have demonstrated a commitment to continually improving their course, being receptive and responsive to previous feedback from the national team. The programme is relevant and interesting. There are some areas where improvement will further enhance the overall quality of the experience, and these will be detailed in the next section.

05.2 Faculty members are clearly keen to provide a high-quality training experience and are open to support and guidance. They are supportive of each other, with experienced faculty members supporting those more recently trained.

05.3 It was excellent to see the delegates shown where the emergency equipment was kept in the birth centre during the briefing in relevant scenarios.

05.4 PROMPT proformas for documentation have been adopted in practice in maternity services in NHS Wales and it was pleasing to see these were promoted during training. Encourage the midwives to document on them when all actions on the algorithm have been carried out and they are waiting for the paramedic to arrive. Proformas are available for eclampsia, cord prolapse, shoulder dystocia and breech.

05.5 Community midwives carry the Community PROMPT Wales algorithms in their bags although they did not always access them straight away or use them effectively to guide the management suggesting this is not yet fully embedded in practice.

05.6 Organisation was good overall but could be improved by setting up in advance or allocating time on the programme. Faculty can disperse to set up for the morning stations during the presentations.

05.7 Algorithms and other resources should be accessed from their usual location or community bag dependant on the setting of the scenario.

05.8 The Shoulder Dystocia and Breech workshops were both delivered to a high standard.

06 Recommendations for further development

06.1 Allocate name stickers to the delegates.

06.2 Consider introducing standardised community kit bags in the Health Board.

06.3 For scenarios set in the birth centre, keep the algorithms and proformas where they are normally kept.

06.4 Continue to reinforce SBAR handovers, in particular, that the 'situation is the emergency.

06.5 Continue to reinforce the use of the Sepsis Risk Assessment Tool and MEOWS charts when assessing an unwell woman. For more immediate effect, this may require reiterating in team meetings.

06.6 Use the Facilitator's Aide Memoir to structure the briefing before every scenario.

06.7 Use the Facilitator's Aide Memoir to structure the debriefing after every scenario.

06.8 Remind the community midwives to use the algorithms early to guide their management and to document timings in the boxes provided.

06.9 The Health Board are asked to consider the recommendation regarding training provision for community midwives as detailed in point 0.12.

06.10 Contact your local PROMPT Wales paramedic facilitator regarding supporting facilitation and booking paramedics as delegates on to your courses. Details are held with PROMPT Wales if required.

07 Health Board Action Plan

Action Ref	Action	Action Description	Timescale
AB/CPW 06.1	Allocate Name Stickers	Ensure Stickers are available for everyone to utilise as name tags. These can be prepared in the huddle on Prompt Days	Actioned Stickers available with effect
AB/CPW 06.2	Introduction of standardised Kit Bags	Working towards all community kit bags having universal equipment. Development of a structured list for equipment requirements for each emergency. Standardised proforma for community kit bag developed and then disseminated to all staff. Evaluate all community Kit bags during the Community Prompt Days by PDM.	3 Months with ongoing audit to be monitored by PDM
AB/CPW 06.3	Keep algorithms where they are usually located in the birth centre	For Algorithms to be located in all the rooms at the birth centre and all community settings, for easy access. Ensuring all midwives have easy access of algorithms in their community Kit Bags by being placed with the equipment required for the situation.	Actioned Algorithms available in community settings and birthing rooms
AB/CPW 06.4	Reinforce SBAR handovers	Continue to encourage the use of SBAR's in the community setting. Encourage all community midwives having these as part of their Diary to utilise when taking their initial telephone call.	Actioned and ongoing reinforcement. Audit as part of transfer meeting
AB/CPW 06.5	Reinforce use of Risk Assessment Tools and Meows Charts when assessing the unwell woman	Continue to encourage the use of Meows and Sepsis risk assessments during the community prompt days. Review and Audit of Meows charts by Governance and supervisors during notes audits.	Ongoing
AB/CPW 06.6	Use of Facilitator Aide Memoir for Briefing	To ensure this is available and used in each scenario to structure the briefing of the scenario	Actioned
AB/CPW 06.7	Use of Facilitator Aide Memoir for Debriefing	To ensure this is available and used in each scenario to structure the debriefing of the scenario	Actioned
AB/CPW 06.8	Remind the Midwives to use the Algorithms early	Encourage midwives to use the algorithms in the briefing of the scenario and to have them contained in their allocated bag/box for that situation rather than in a folder. Allocate algorithms to all rooms in the community settings.	Actioned

AB/CPW 06.9	Consider Community Midwives attending Hospital Prompt as detailed in 0.12	Community midwives are not escalated into the Obstetric Unit, but into the alongside midwife led birth centre. Midwives rotate from the hospital out onto community will have completed the Hospital Prompt Day. The study days are currently under review for the forthcoming year to consider rotational community midwives into the hospital.	Under review
AB/CPW 06.10	Local Prompt Paramedic Facilitator	The local WAST facilitator regularly attends ABUHB Community Prompt days. She is arranging for colleagues to be trained in Facilitation so that she can delegate to others when she cannot participate. The local WAST facilitator was unavailable on the assessment day that took place. The PDM is in regular contact and aware of when she can attend.	Actioned But no presence for the next 2 months due to other commitments

On behalf of the reviewers, the PROMPT Wales National Team would like to extend their thanks to the Health Board, and in particular, the faculty on the day of the review for the warm welcome received.