Patient, Quality, Safety & Outcomes Committee

Tue 12 November 2024, 12:30 - 15:30

Microsoft Teams

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Agenda

1. PRELIMINARY MATTERS

PQSOC Agenda- 12th November 2024 - Final.pdf (2 pages)

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 Monday 2nd September 2024

Attached *Chair*

1.4 PQSOC Minutes 2nd September 2024 reviewed by BC & PBv2.pdf (13 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 Action Log November.pdf (8 pages)

2. ITEMS FOR DISCUSSION

2.1. Committee Risk Report

Attached *Director of Corporate Governance*

2.1 PQSO Committee Risk and Assurance Report.pdf (5 pages)
2.1 Appendix A_PQSOC Strategic Risk Register Database.pdf (1 pages)
2.1 Appendix B PQSOC Dashboard and Strategic Risk Assessments.pdf (7 pages)

2.2. Primary Care Quality Report

Attached *Chief Operating Officer*

2.2 Primary Care Quality Cover Report.pdf (4 pages)
2.2 Appendix 1 Quality Report..pdf (75 pages)
2.2 Appendix 2 4 DoC algorithm FINAL.pdf (1 pages)

2.3. Quality Strategy - Quality Outcome framework

Attached *Director of Nursing*

2.3 Quality Strategy - Quality Outcome framework Cover Report.pdf (5 pages)
2.3 Appendix 1 Quality Strategy Implementation Plan 2024.25 - Final.pdf (22 pages)

2.3 Appendix 2 Quality Outcomes Framework - Potential Indicators - Final Nov 2024.pdf (13 pages)

2.4. Quality Performance and Outcomes Report

Attached *Director of Nursing*

2.4 Quality Performance Report - Q2 2024-25 Cover Report.pdf (5 pages)
2.4 Appendix 1 PQSOC Performance Report - November 2024.pdf (142 pages)

2.5. Falls and Bone Health Management Annual Report

Attached *Director of Allied Health Professions and Health Science*

2.5 Falls and Bone Health Annual Report 2023-24 Cover report.pdf (3 pages)
2.5 Appendix 1 Falls and Bone Health Annual Report_.pdf (18 pages)

2.6. Health and Safety Compliance Annual Report

Attached *Director of Allied Health Professions and Health Science*

2.6 Health Safety Fire Annual Report 2023 - 24. Cover Report.pdf (5 pages)
2.6 Appendix 1 ABUHB Health Safety and Fire Annual Report 2023-24.pdf (40 pages)
2.6 Appendix 2 - Strategic Risk Assessment (SRR 010 A) .pdf (2 pages)

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2024/25

Attached *Director of Corporate Governance*

3.1 Committee Programme of Business 2024-25 Cover Report.pdf (4 pages)
3.1 Appendix 1 PQSOC Forward Work Plan - November meeting.pdf (10 pages)

3.2. NHS Wales Joint Commissioning Committee's Quality Report

Attached *Director of Corporate Governance*

3.2 NHS Wales Joint Commissioning Committee's Quality Report .pdf (5 pages)
3.2 Appendix 1 - Summary of Services Escalation.pdf (10 pages)

3.3. Nurse Staffing Levels (Wales) Act 3-year report

Attached *Director of Nursing*

3.3 NSLWA 3-year Cover Report.pdf (5 pages)
3.3 Appendix 1 Nursing Midwifery SCPHN Workforce Strategy 2023-26 - Priority Action Plans (1).pdf (6 pages)
3.3 Appendix 2 - NWSLA - 3 Year report 1.pdf (17 pages)

3.4. Listening & Learning Forum Minutes

Attached *Director of Nursing*

3.4 Minutes 13.09.24 - Patient Quality Safety Learning Improvement Forum.pdf (8 pages)

3.5. Children and Young Peoples Board Minutes

Attached *Director of Nursing*

3.5 Children and Young Peoples Board Notes of Meeting 30 September 2024 (002).pdf (5 pages)
3.5 Appendix 1 Children and Young Peoples Board TOR.pdf (4 pages)

3.6. Nurse Staffing Levels Spring Recalculations

Attached *Director of Nursing*

3.6 NSLWA SBAR Spring Calculations - September 2024 PQSOC (1).pdf (9 pages)

- 3.6 Apendix 1 slide 1 Spring Recalculation establishments 2024 (003).pdf (2 pages)
- 3.6 Apendix 1 slide 2 Spring Recalculation establishments 2024 (003).pdf (1 pages)
- 3.6 Apendix 1 slide 3 Spring Recalculation establishments 2024 (003).pdf (2 pages)
- 3.6 Appendix 2 ammendments to establishments Spring 2024 Calculations.pdf (1 pages)

4. OTHER MATTERS

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

Oral *Chair*

4.2. Any Other Urgent Business

Oral *Chair*

4.3. Date of the Next Meeting: Monday 20th January 2025

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

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE AGENDA	
Date and Time	**Tuesday 12th November 2024 at 12:30PM-3:30PM**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
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 Monday 2nd September 2024	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR DISCUSSION**		
2.1	Committee Risk Report	Attached	Director of Corporate Governance
2.2	Primary Care Quality Report	Attached	Chief Operating Officer
2.3	Quality Strategy - Quality Outcome framework	Attached	Director of Nursing
2.4	Quality Performance and Outcomes Report	Attached	Director of Nursing
2.5	Falls and Bone Health Management Annual Report	Attached	Director of Allied Health Professions and Health Science
2.6	Health and Safety Compliance Annual Report	Attached	Director of Allied Health Professions and Health Science
3	**FOR INFORMATION**		
3.1	Review of Committee Programme of Business 2024/25	Attached	Director of Corporate Governance
3.2	NHS Wales Joint Commissioning Committee's Quality Report	Attached	Director of Corporate Governance

3.3	Nurse Staffing Levels (Wales) Act 3-year report	Attached	Director of Nursing
3.4	Listening & Learning Forum Minutes	Attached	Director of Nursing
3.5	Children and Young Peoples Board Minutes	Attached	Director of Nursing
3.6	Nurse Staffing Levels Spring Recalculations	Attached	Director of Nursing
4	**OTHER MATTERS**		
4.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
4.2	Any Other Urgent Business	Oral	Chair
4.3	Date of the Next Meeting: • Monday 20th January 2025 at 9:30am		

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Monday 2nd September 2024, 2:00pm-5:00pm
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Helen Sweetland, Independent Member Paul Deneen, Independent Member Penny Jones, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Peter Carr, Director of Therapies & Health Science James Calvert, Medical Director Nicola Prygodzicz, Chief Executive Rani Dash, Director of Corporate Governance Leeanne Lewis, Assistant Director of Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing Moira Bevan, Head of Service Infection Prevention and Control Nurse Tanya Strange, Head of Nursing Person Centred Care Lucy Windsor, Head of Corporate Risk & Assurance Linda Joseph, Llais Cymru Kelly Downes, Deputy Director of Nursing Jeanette Wells, Research and Development Director Ceri Phillips, Consultant Pharmacist Adam Voyle, Critical Care Outreach Practitioner Deb Jackson, Divisional Nurse Fern Cook, Committee Secretariat
APOLOGIES	Michelle Jones, Head of Board Business

PQSOC 0209/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 0209/1.2	**Apologies for Absence** There were no apologies for absence to record.
PQSOC 0209/1.3	**Declarations of Interest** There were no declarations of interest raised to record.

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PQSOC 0209/1.4	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 30th July 2024 were agreed as a true and accurate record of the meeting.
PQSOC 0209/1.5	**Committee Action Log** The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions.
PQSOC 0209/2.1	**Committee Risk Report** *Lucy Windsor joined the meeting* Lucy Windsor (LW), Head of Corporate Risk & Assurance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. LW advised that since the last report to the Committee, the risk environment had remained relatively stable, with no changes in the risk score and advised that the following risks were reported as a risk level of Moderate or High: - • **SRR 005** - There is a risk that the Health Board would be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. (High) • **SRR 008** - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public. (Moderate) • **SRR 010** - There is a risk that the Health Board would fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. (High) There was a request to the Committee to approve the removal of the of the Pharmacy Robot CRR 004 risk from the corporate risk register due to there now being a replacement in process. James Calvert (JC), Medical Director, advised the Committee that there was a team in place to manage the prescribing until the new robot was in place. The Committee noted a slight delay in the robot due to the steel flooring being fitted which would put them in a position of going live in October. Peter Carr (PC), Director of Therapies & Health Science, assured the Committee there was an ongoing improvement action plan in place for Health, Fire and

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	Safety, with regular updates to the Executive Committee which had reduced the risk. The Committee was assured that an annual report would be presented to the Committee in November and there was assurance provided regularly within the quality report. Health, Fire and Safety annual report to be presented to the Committee in November 2024. **Action: Director of Therapies and Health Science** The Committee **NOTED** the delegated strategic risks, the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient, quality, safety and **ENDORSED** the removal of CRR 004 for formal approval by the Executive Committee. *Lucy Windsor left the meeting*
PQSOC 0209/2.2	**Quality Annual Report 2023/24** Jennifer Winslade (JW),Director of Nursing, provided the Committee with an overview of the Quality Annual Report 2023/24 advising that the report covers the quality journey throughout the year, reviews past objectives and sets new priorities for improving patient and staff safety, outcomes, and experiences. The Committee was advised that the Health Board had adopted the reporting structure from NHS England which mapped progress on quality and patient safety against the Pillars of quality, as follows: being the following areas: • 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 JW advised there had been two strategies approved by the Executive Committee, which were now embedded within the Health Board and the focus of 2024/25 would be improving quality. The Committee noted that the learning and improving approach had been approved with a meeting structure to support it. Regular updates from the meeting would be provided to the Committee.

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	Outcomes of the learning and improvement forum to be reported to the Committee on a regular basis. **Action: Director of Nursing** JW and Nicola Prygodzicz (NP), Chief Executive, thanked the team for the work on the Annual Quality Report. The Committee **NOTED** the progress of work over the past 12 months as reflected in the annual quality report and took assurance from the report.
PQSOC 0209/2.3	**Putting Things Right Annual Report 2023/24** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Putting Things Right (PTR) Annual Report which had been prepared in accordance with the PTR Regulations. JW advised during the reporting period, the Health Board had welcomed and fully embraced the introduction of the Health and Social Care Quality and Engagement (Wales) Act and NHS Duty of Candour from 1 April 2023. The Committee noted the PTR team priorities for 2023/24 and what the focus would be for the programme of work for 2024/25: The priorities for 2023/24 • Introduction of the Health and Social Care (Quality & Engagement) (Wale) Act 2020 – (Duty of Candour) • Remodelling of QPS structure across the organisation • Learning Framework/Quality Strategy • Improve Complaint Handling The priorities for the annual work programme for 2024/25: • Putting Things Right Regulations and Health Board Concerns Management and looking how they can adjust to the changes. • Improving Quality Patient Safety experience, Learning and Improving • Partnership Engagement & Collaborative working and look at how they use the relationships with moving forward with improvements Paul Deneen (PD), Independent Member, questioned how many patients were seen on an annual basis to understand what percentage the 1,500 complaints equated to. Tracey Partridge-Wilson (TPW), Deputy Director of Nursing,

	agreed to share this information with members outside of the meeting, and to include in future reports. Percentage of complaints in comparison to total number of patients seen to be shared with members and included in future reports. **Action: Deputy Director of Nursing** Nicola Prygodzicz (NP), Chief Executive, assured the Committee that the Health Board was in the process of having the texting feedback option made available to patients to have a better understanding of the compliments compared to the complaints. JW thanked TPW, Gemma Couch, Head of Quality & Patient Safety and Learning, and Rhiannon Price, Senior Quality, Patient, Safety Manager, for the work undertaken in making a difference in the Putting Things Right department. The Committee **NOTED** the Putting Things Right Annual Report 2023/2024 and the key priorities for the Annual Work Programme in 2024/25.
PQSOC 0209/2.4	**Human Tissue Act Annual Report 2023/24** Peter Carr (PC), Director of Therapies & Health Science, provided the Committee with an overview of the Human Tissue Act Annual Report 2023/24 and confirmed that the standards required to maintain the licences had been achieved. The Committee was advised that the Health Board holds Human Tissue Authority licences for the following 3 sectors and 6 key areas for regulations: 3 sectors • Post-mortem provision at the Grange University Hospital, Royal Gwent Hospital and Nevil Hall Hospital • Human application bone bank at Royal Grange Hospital • Research at Royal Gwent Hospital 6 regulation key areas 1. **Anatomy**: Use of bodies for anatomical examination, teaching, and training. 2. **Post Mortem**: Post-mortem examinations, tissue retention, and disposal. 3. **Public Display**: Display of human bodies and tissue.

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	4. **Organ Donation and Transplantation**: Organ and tissue donation, retrieval, and transplantation. 5. **Research**: Use of human tissue in research. 6. **Human Application**: Use of human tissues and cells for medical treatment. PC advised that Shelley Bosson, Chair of the Human Tissue Act Committee had retired and a replacement was being sought. Rani Dash confirmed that the Chair did not need to be an Independent Member of the Board. The Committee noted the changes made as a result of the Improvement Plan following the high-profile Mortuary case to ensure that this did not happen again. Helen Sweetland (HS), Independent Member, asked about the morale of the Mortuary team due to the pressure of the incident. PC confirmed that tailored support was being provided to the mortuary team, facilitated by organisational development team. PC advised the Committee that the Mortuary team was reviewing the national Mortuary report to ensure that the Health Board was meeting all the recommendations and taking forward any improvements required. It was noted that a Human Tissue Authority inspection was due to take place in the autumn. The Committee **NOTED** the contents of this annual report for assurance.
PQSOC 0209/2.5	**Research and Development Annual Report 2023/24** *Jeanette Wells joined the meeting* James Calvert (JC), Medical Director, provided the Committee with an overview of the Research and Development Annual Report which highlighted the Health Board's key achievements, progress and planned next steps in implementing the Research and Development Strategy. JC advised that the Health Board had exceeded the Welsh Government target of the trials open to recruitment recruiting to time and target with a performance of 95% increased from 89%. The Committee was advised that there was a focus for 2024/25 to establish the Research and Development Committee as part of the priorities.

	Paul Deneen (PD), Independent Member, questioned if there were any private providers from whom additional funding could be sought to support with Research and Development opportunities. JC advised there was £30M allocated to Wales for commercial research trails and a paper was being prepared for consideration by the Executive Committee. Jeanette Wells (JW), Research and Development Director, advised the Committee that there may be funding available to Wales of £20M to support V Pack over a 5-year period and the Health Board was looking at how this could be taken forward at the Grange University Hospital. The Committee **NOTED** the Research and Development Annual report for assurance. *Jeanette Wells left the meeting*
PQSOC 0209/2.6	**Organ Donation Annual Report 2023/24** James Calvert (JC), Medical Director, provided the Committee with an overview of the Organ Donation Annual Report 2023/24 The Committee was advised there had been 8 organ donations over the 12 months period with 13 consented donors which resulted in 19 patients receiving a transplant. JC advised the Committee the Organ Donation team was currently looking at how they could develop training and protocols throughout the Health Board. The Committee was advised that the Organ Donation Committee Chair, Shelley Bosson, had now retired and stepped down as Chair and the Committee was currently seeking a new nomination. Peter Carr (PC), Director of Therapies & Health Science, assured the Committee that Sharron Keightley, Specialist Nurse Organ Donation was continuing to raise awareness and encourage people to become donors. The Committee **NOTED** the Organ Donation Annual report 2023/24 for assurance.
PQSOC 0209/2.7	**Dementia Care Annual Report 2023/24** *Tanya Strange joined the meeting* Tanya Strange (TS), Head of Nursing, Person Centred Care, provided the Committee with an overview of

	Dementia Care Annual Report 2023/24, which reviewed the progress taken on the implementation of the dementia standards. The Committee noted the Welsh Government's commitment to promote the rights, dignity and autonomy of people living with dementia and the people who care for them. An established Regional Dementia Board was in place with a Regional Strategy and Action Plan to drive forward improvement actions against the 6 key aims of the National Plan. The Committee noted that the Gwent Regional Dementia Board and Dementia Friendly Communities programme had delivered against the aims, objectives and priorities aligned to the Dementia Action Plan for Wales. Paul Deneen (PD), Independent Member, asked if a passport for patients presenting in ED to enable the hospital to understand the patient needs had been considered. TS advised that they were looking at creating Dementia cards for patients as an option. Helen Sweetland (HS), Independent Member, requested an update on the outcome of the enhanced care review and pilot. TS advised that the audit had been completed and there was a recommendation to relaunch the enhanced care model. Kelly Downes (KD), Deputy Director of Nursing, confirmed that the new model would be implemented across the Health Board with a programme of training and subsequent evaluation. Jennifer Winslade (JW),Director of Nursing, thanked TS for the work that had been undertaken and ongoing dementa care support to patients. The Committee **NOTED** the progress as set out in the Annual Progress Dementia Care Report. *Tanya Strange left the meeting*
PQSOC 0209/2.8	**Quality Performance and Outcomes Interim Report** Jennifer Winslade (JW), Director of Nursing, led a presentation providng an overview of the Quality Performance and outcomes Interim report for the period. Adam Voyle (AV), Critical Care Outreach Practitioner, gave an overview of the Martha Mills sepsis story and ongoing work within the Health Board to incorporate Martha's rule. The Committee noted the launch of Call 4 Concern in March 2024 in ICU at the Grange University Hospital. This was being rolled out across units and aimed to be in the

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surgical unit by October 2024 and to have champions on each ward to able to provide advice.

The Committee was advised that the Health Board was the first in Wales to role out the Martha's rule programme.

Jennifer Winslade (JW), Director of Nursing, provided an overview of the current postion within the Mental Health and Learning Disabilities division, advising that the Health Board was contuning to work on the escalation status. There had been a reduction in incidents and the team was now working to improve the postion. It was also highlighted Ty Lafant had received an inspection and no recommendations had been made.

JW advised the Committee that the urgent care aim throughout this reporting period was to focus on medical and nursing staffing and ensure flow throughout the hospital.

JW provided an update on the complaints and compliments position advising that the Health Board was not currently meeting the Welsh Governant target to respond to complaints with the 30day period. JW assured the Committee that the team was on quality with the aim to achieve the target by October.

The Committee noted that there were 110 patient safety incidents with 31 early warning notifations reported to Welsh Government.The Committee was assured that future reports would include closure of incident dates and the SBAR would be included within the Perfomance report.

Closure of incident dates and SBAR to be included within the performance report for November.**Action: Director of Nursing**

Moria Bevan (MB), Head of Service Infection Prevention and Control Nurse, provided an update on infection prevention control, advising that the team were working towards completing the action plan, with enhanced cleaning continuing and bespoke training in areas of outbreaks.

The Committee noted that the team had hosted a webinar with 80 attendees and the internet guidance had been reviewed to ensure the correct information was available to patients and staff members.

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	The infection prevention control improvement group was now in place with the first meeting being held on 4th September 2024. Ceri Phillips (CP), Consultant Pharmacist, provided the Committee with an overview on antimicrobial Stewardship, advising that an audit had been undertaken on 36 patients taking piperacillin or co-amoxiclav in the Grange University Hospital and Royal Gwent Hospital with 70% of use in SAU and 40% in MAU. The Committee was advised that 75% of antimicrobial prescribing was being reported in primary care and 25% was being prescribed in secondary care. The Health Board's aim was to reduce the percentage being used due to the organisation reporting the highest in Wales. The Committee requested an antimicrobial report to be brought to the next Committee in November for assurance on of the improvements. Update on antimicrobial reporting for assurance to the next Committee meeting in November. **Action: Medical Director** James Calvert (JC), Medical Director, provided an overview of the position for mortality reporting advising that the Health Board was developing a SOP to undertake deep dives for areas that were not explained. The reporting currently was at a positive position, but the team was continuing to work on making improvements. Peter Carr (PC), Director of Therapies & Health Science, provided an update on the position of Health, Fire and Safety advising that there had been 16 incidents reported to the Health and Safety Executive (HSE) in accordance with reporting Injuries Diseases and Dangerous Occurrences Regulations. Manual handling training compliance was currently 58%. Individual roles had been reviewed in order to tailor the training and this should result in an increase in compliance over the coming months. Kelly Downes (KD), Deputy Director of Nursing, provided an update on safeguarding highlighting 80% compliance in both level 1 & 2 in adult and children safeguarding training and noting that level 3 was being implemented across the Health Board to staff members that required the training.

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	The Committee was advised that the Health Board was experiencing a higher level of reporting in adult and children's incidents from the public this year. Paul Deneen (PD), Independent Member, questioned what the policy was for staff members to wear cameras while they were at work for when incidents occur. KD advised she would bring an update back to the next Committee in November regarding the policy. An update on staff members wearing cameras while working policy to be report to the Committee in November. **Action: Director of Therapies & Health Director of Science** PC advised the Committee that the Health Board was encouraging staff to report any incidents, and this was reported to the People and Culture Committee The Committee **NOTED** the progress of the quality performance report and took the report assurance.
PQSOC 0209/2.9	**Covid-19 Nosocomial Investigation Report** *Deb Jackson joined the meeting* Deb Jackson (DJ), Divisional Nurse, provided the Committee with an overview of the Covid-19 Nosocomial Investigation report advising that the Health Board had successfully concluded its Nosocomial Covid-19 Investigation Programme on 31 March 2024, in line with the objectives set by Welsh Government. The Health Board had been allocated £753,155.00 per annum for 2 years to deliver and develop the structure of the programme, which included the following 3 workstreams to support the Health Board in their investigation: • Establishment • National Learning • Patient Staff and Family Experience. The Committee was advised that the investigation found there was 712 deaths with a total of 2,883 cases of Covid-19 within the Health Board. All family members were contacted with a letter regarding the investigation but not all family members were ready to speak. The Committee was advised that the learning from the investigation had highlighted difficulties in regard to communications with family and friends throughout the pandemic with visiting restrictions having an adverse effect on the patients and family members and only having limited

	opportunity to make contact; however, the investigation found the restriction was necessary to reduce the transmission of the Covid-19. The Committee was assured that the investigation had been completed within the targeted time frame and within the budget allocated by Welsh Government. Peter Carr (PC), Director of Therapies & Health Science, advised when feeding back the findings to the staff members that they were assured the investigation was aimed for the Health Boards learning. DJ advised there had already been communication with the staff members and had been provided assurance. The Committee **NOTED** the assurance of the Health Board's position from the end of Covid-19 Nosocomial Investigation programme report. *Deb Jackson left the meeting*
PQSOC 0209/3.1	**Review of Committee Programme of Business 2024/25** Review of Committee Programme of Business 2024/25 was provided to the Committee for information.
PQSOC 0209/3.2	**NHS Wales Joint Commissioning Committee's Quality Report** NHS Wales Joint Commissioning Committee's Quality Report was provided to the Committee for information.
PQSOC 0209/3.3	**Learning and Improvement Forum** Learning and Improvement Forum was provided to the Committee for information.
PQSOC 0209/4.1	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There was no key risk or issues for reporting or escalation to the Board or other Committees.
PQSOC 0209/4.2	**Any Other Urgent Business** There was no urgent business.
PQSOC 0209/4.3	**Date of the Next Meeting:**

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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
30th July 2024	**PQSOC 3007/07**	**Quality Performance Report** Update to be provided on the timely reporting of child safeguarding incidents to GP Practices.	**Director of Nursing**	November 2024	**Complete** <u>October</u> The first quarter of sharing this information has been completed and received well from GP practices within the Monmouthshire area. Process from a ABUHB Safeguarding Team has been reviewed and changed accordingly to streamline the process for all agencies post first quarter. The next stage will incorporate these changes and be reviewed by the Corporate Safeguarding Team, Monmouthshire County

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					Borough Council and the NCN to evaluate its impact prior to making recommendations regarding how a similar process can be applied in the other four LA areas. A detailed update will be included in the next Quality Performance Report to the Committee in November agenda item 2.4
30th July 2024	**PQSOC 3007/07**	**Quality Performance Report** Information regarding the protocol for patients presenting with Sepsis to be presented to the Committee.	**Director of Nursing**	November 2024	**Complete** November Protocol for patients presenting with Sepsis will be included within the Quality Performance report in November's meeting in agenda item 2.4

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					<u>September</u> Protocol for patients presenting with Sepsis, has been added to the forward work plan and to be included on the agenda for November 2024 meeting.
30th July 2024	**PQSOC 3007/07**	**Quality Performance Report** A report on the timely closure of Patient Safety Incidents to be presented to the Committee.	**Director of Nursing**	November 2024	**Complete** <u>November</u> Time closure of patients safety incidents report will be included within the quality performance report in agenda item 2.4 at Novembers meeting. <u>September</u> Report on time closure of patient safety incidents, has been added to the forward work plan and to

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					be included on the agenda for November 2024 meeting.
30th July 2024	**PQSOC 3007/14**	**Infection Prevention and Control and Cleaning Standards Annual Report 2023/24** An update on optimal prescribing in support of infection prevention and control measures to be provided to the Committee.	**Director of Nursing**	November 2024	**Complete** <u>November</u> Update on optimal prescribing will be included within the quality performance report at November's meeting under agenda item 2.4 <u>September</u> Update on optimal prescribing, has been added to the forward work plan and to be included on the agenda for November 2024 meeting.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
2nd September 2024	**PQSOC 0209/2.1**	**Committee Risk Report** Health, Fire and Safety annual report to be presented to the Committee in November 2024.	**Director of Therapies & Health Science**	November 2024	**Complete** September The Health, Fire and Safety annual report will be presented at Novembers meeting under agenda item 2.6
2nd September 2024	**PQSOC 0209/2.2**	**Quality Annual Report 2023/24** Outcomes of the learning and improvement forum to be reported to the Committee on a regular basis.	**Director of Nursing**	November 2024	**Complete** September Minutes of the Listening and learning forum have been added to the Committee's forward work plan and will be included on the agenda from November under agenda item 3.4
2nd September 2024	**PQSOC 0209/2.3**	**Putting Things Right Annual Report 2023/24** Percentage of complaints in comparison to total number of	**Deputy Director of Nursing**	November 2024	**Complete** November

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		patients seen to be shared with members and included in future reports.			As illustrated the percentage of complaints raised compared to the total number of patient interactions is extremely low. In 2022-23, there was a total of 1,117,572 patient interactions, with 0.27% resulting in a complaint. In 2023-24, the number of patient interactions has increased to 1,419,426, of which only 0.22% led to a complaint, representing an improving position. Percentage will also be included in future reports.
2nd September 2024	**PQSOC 0209/2.8**	**Quality Performance and Outcomes Interim Report** Closure of incident dates and SBAR to be included within the performance report for November.	**Director of Nursing**	November 2024	**Complete** <u>November</u> Closure of incident dates are included within the

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					performance report under item 2.4
2nd September 2024	**PQSOC 0209/2.8**	**Quality Performance and Outcomes Interim Report** Update on antimicrobial reporting for assurance to the next Committee meeting in November.	**Medical Director**	November 2024	**Complete** <u>October</u> Update on optimal prescribing will be included within the quality performance report at November's meeting under agenda item 2.4
2nd September 2024	**PQSOC 0209/2.8**	**Quality Performance and Outcomes Interim Report** An update on staff members wearing cameras while working policy to be report to the Committee in November.	Director of Therapies & Health Science	November 2024	**Complete** <u>September</u> Body-worn cameras have been issued to the Security staff within the Health Board. Clinical staff are not currently utilising body-worn cameras. Some NHS Trusts in England have implemented the use of body-worn cameras for clinical staff to use.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					The use of body-worn cameras by clinical staff across NHS Wales is currently being investigated further. This work is being led by the All Wales NHS Violence & Aggression Case Managers Network.

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:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee (the Committee) for monitoring, on behalf of the Board.

The report also informs the Committee of any significant operational risks identified by the Executive Committee through the Corporate Risk Register that have the potential to impact patient quality and safety.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

At the Committee meeting in September, it concluded that the Committee Risk Register contained **three** high-level risks with **three** sub-risks.

Since September, the risk environment has remained relatively stable, with no changes in the risk score or exposure to the three strategic risks that this Committee monitors.

Asesiad / Assessment

Strategic Risk Register (SRR)

Table 1 shows the current status of the three strategic sub-risks delegated to the Committee as at the end of October 2024. The three sub-risks have been reviewed and updated to ensure that the Committee has the most recent information on the internal control system and sources of assurance for each sub-risk.

The Committee Risk Register is included in **Appendix A** and the individual risk assessments for the **three** sub-risks are included in **Appendix B.**

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer **Theme** Service Delivery **Appetite** Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	**High** **3 x 4** **(12)**	**Y**
SRR 008 Director of Nursing **Theme** Transformation & Partnership Working **Appetite** Open Score 16 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Moderate** **2 x 4** **(8)**	**Y**
SRR 010 Director of Therapies & Health Science **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety	**High** **3 x 4** **(12)**	**N**

		Risk Assessments, and Work-based Risk Assessments.		

It should be noted that, while the risks have been updated to include improved control and assurances, the risk score and level for all **three** sub-risks have not changed. **SRR 005** and **SRR 008** remain within the Health Board's risk appetite for the risk domain, therefore the Committee can be assured that these risks are effectively mitigated.

Work will continue with risk owners to manage the risk and ensure that the controls and assurances in place prevent the potential risk from occurring.

SRR 010's risk score and exposure remain outside of the Health Board's agreed-upon risk appetite for the Compliance and Safety risk domain, as shown in Table 1. However, as the Improvement Plan has not been fully implemented, there is potential for the additional planned action to bring the level of risk down to within appetite.

Monitoring of **SRR 010** will remain a key focus of the Committee, and the findings of the scheduled Internal Audit of Health and Safety, planned for quarter 4 of the 2024/25 Plan, will provide the Board and Committee with the evidence needed to determine whether the Improvement Plan has delivered the necessary improvements.

The closing position as at the end of October 2024, if accepted by the Committee, is that the Committee Risk Register includes **three** high-level risks and **three** sub risks.

Corporate Risk Register (CRR)

At its September meeting, the Committee endorsed the removal of CRR 004, concerning the potential failure of the Royal Gwent Hospital (RGH) Pharmacy Robot, from the CRR. This removal, subsequently approved by the Executive Committee, reflects the decommissioning of the robot, thus eliminating the associated risk.

As of the end of October, only one risk remains on the CRR under the Committee's oversight: CRR 006 - The Health Board's potential breach of its safeguarding duties to children and adults at risk of harm. This risk was deescalated from the SRR earlier in the year following Board approval and continues to be actively managed within the appropriate division, ensuring thorough oversight and mitigation. An updated risk assessment will be presented as part of the newly established CRR which is currently under development.

Due to recent operational and capacity challenges, the Executive Team did not review the draft corporate risk portfolio at its September Executive Time Out

Session. However, the Corporate Risk Register will be addressed in an upcoming Executive Team weekly business meeting.

A comprehensive report on strategic and corporate risks will be submitted to the Board in January, after which all risks within the Committee's remit will be included in subsequent reports.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the delegated strategic risks;
- **NOTE** the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

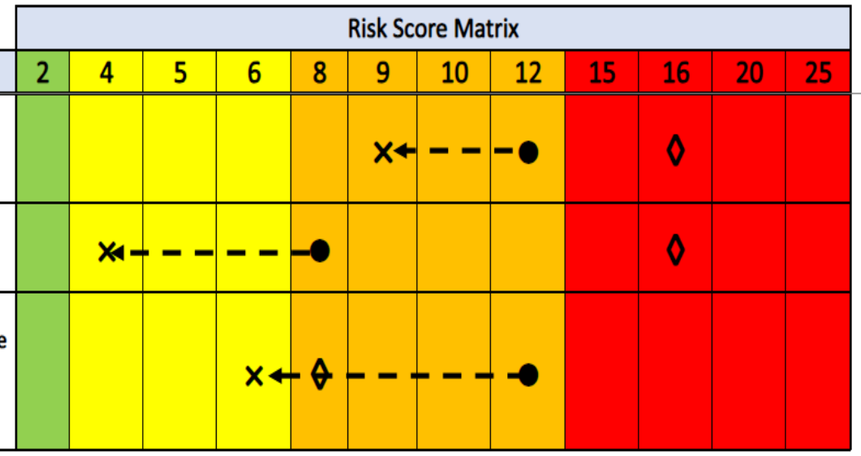
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A

Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

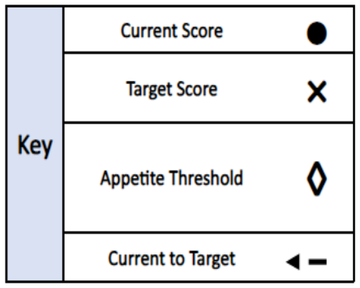
Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

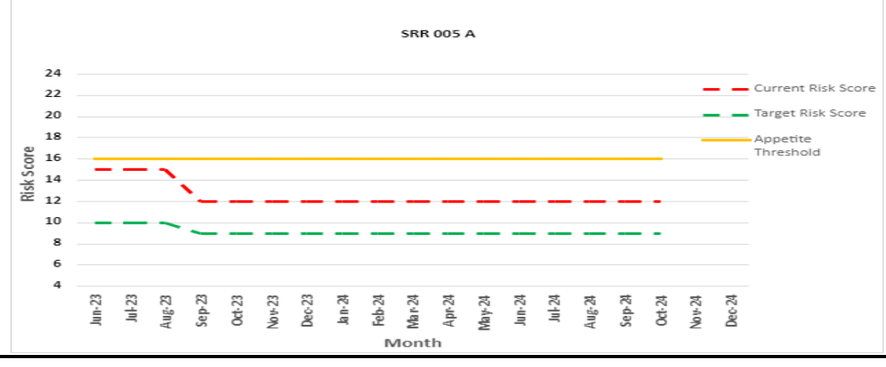
Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/07/2024	01/10/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/07/2024	01/01/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Safety of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/08/2024	01/11/2024

Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	



Assessment of adequacy of assurances	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.



RISK THEME	SERVICE DELIVERY					
SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**				**Publication Status**	**Public**
Strategic Threat	**A.** Due to inadequate arrangements to support system-wide patient flow				**Risk Appetite Level - Open** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	• Avoidable deaths or significant harm • Delays in releasing ambulances from hospital sites back into the community • Delayed discharges from acute and non-acute settings resulting in deteriorating patients; • Litigation & Financial Penalties • Reputational damage and loss of public confidence				**Risk Appetite Threshold – Open SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**3** *(Possible)* X	**3** *(Possible)* X		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Catastrophic)*	**3** *(Minor)*		
Last Reviewed	01 July 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*		
Next Review (Quarterly based on risk score)	01 October 2024					

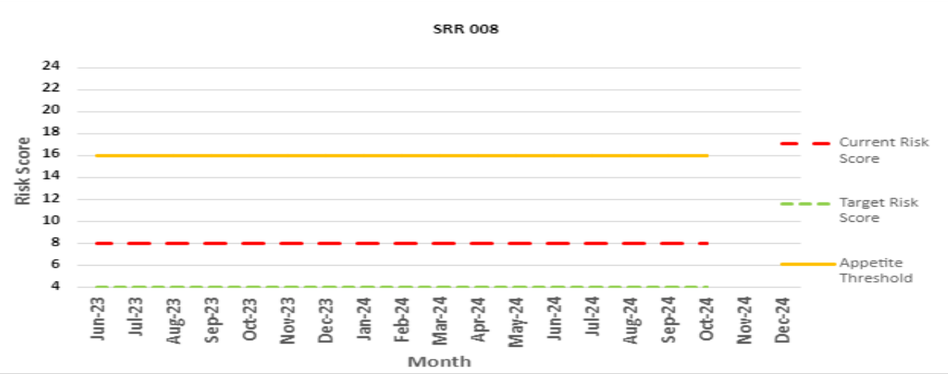
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Operational framework – Being revamped through operational framework ahead of next winter. • Improve regional acceptance of flow processes with neighbouring Health Boards. • Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan.	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.

	• The impact of the Performance and Accountability framework in improving patient flow	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits.		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable** - adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**			**Publication Status**	**Public**
Strategic Threat	A. Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	• Unmet patient need resulting in harm • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence			**Risk Appetite Threshold – Open SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.	
				Expected Date Target Score will be Achieved –	
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**2** (Unlikely) x	**2** *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**2** *(Minor)*	
Last Reviewed	01 July 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Low)*	
Next Review (Six monthly based on risk score)	01 January 2025				



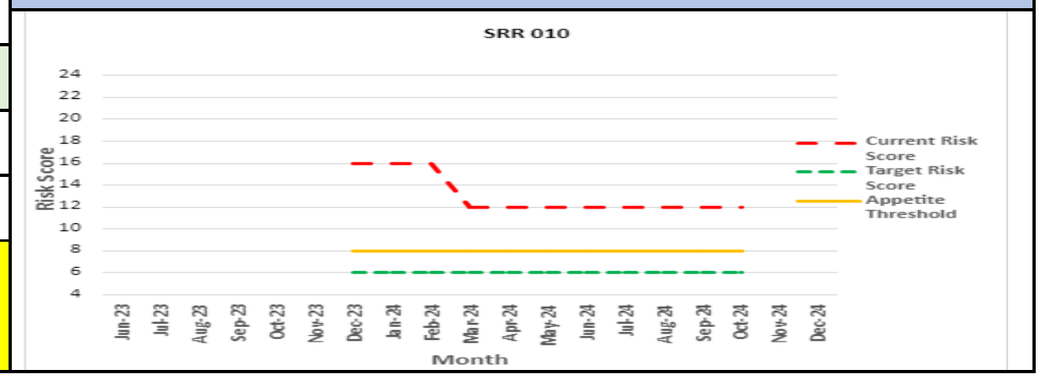
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. - Discussions with VBHC to pilot SMS in ED through DrDoctor • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns	• No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	• Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. • Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template

		patient experience report and CIVICA surveys will be built into ward accreditation.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• LLais Reports • HIW inspections • Advocacy reports		

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	COMPLIENCE AND SAFETY					
SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**				**Publication Status**	**Public**
Strategic Threat	B. Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				**Risk Appetite Level - MINIMAL.** Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.	
Impact	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage				**Risk Appetite Threshold -** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**	
					SUMMARY The current risk level is **OUTSIDE** of target level and **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**	**Expected Date Target Score will be Achieved –**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**3** (*Possible*) x	**2** (*Unlikely*) x		
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*		
Last Reviewed	01 August 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*		
Next Review (Quarterly based on risk score)	01 November 2024					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Health and Safety compliance data extracted from ESR and Datix and reported	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • H&S processes • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.		

Assurance Rating (*Overall Assessment of controls and assurances)*			
Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety & Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Primary Care Quality Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge, PCC Divisional Director Rachel Prangley, Head of Primary Care

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The 2023/24 Annual Quality Report for Aneurin Bevan University Health Board details the commissioning arrangements and quality assurance activities across General Dental Services, General Ophthalmic Services, General Medical Services, and Community Pharmacy. It highlights contract reforms, training programs, performance metrics, and governance mechanisms.

Cefndir / Background

The 2023/24 Annual Quality Report updates on the following:

- **General Dental Services:** The Health Board commissioned 80 General Dental Contracts in 2023/24, with 41 practices opting into Contract Reform focusing on prevention and needs-based care, while the rest continued under traditional Units of Dental Activity (UDA) metrics.
- **Urgent Access and Wait Times:** Urgent dental access was prioritised with 370 Emergency Dental Service appointments commissioned weekly. The report also noted significant growth in patient demand and referral rates since the pandemic, leading to longer wait times.

- **Orthodontic Services:** Orthodontic services were provided by eight practices, with waiting times for assessment and treatment extending up to 3-4 years due to increased demand and prioritisation changes.

- **General Ophthalmic Services:** In 2023/24, 55 optometry practices provided various eye care services, including urgent and essential appointments. The new Welsh General Ophthalmic Services (WGOS) regulations were implemented for enhanced clinical care.

- **General Medical Services:** The Health Board managed 68 General Practices, with five previously managed practices successfully returned to independent contractor status. Access and sustainability were key focus areas.

- **Enhanced and Supplementary Services:** Various enhanced services, including childhood immunisations and minor surgeries, were commissioned to meet local population needs. Financial support was provided to practices under the Sustainability Assessment Framework.

- **Community Pharmacy Services:** 125 community pharmacies and 12 dispensing doctors provided pharmaceutical services, including dispensing and clinical services like emergency contraception and common ailments.

Asesiad / Assessment

The 2023/24 Annual Quality Report outlines robust mechanisms for monitoring contract delivery, including regular reviews, post payment verification, and engagement with Health Inspectorate Wales. The report also provides assurances regarding compliance with the Duty of Candour across all contractor areas, emphasising transparency and patient safety.

The report provides information on the Primary and Community Care Academy which supports training and development within Primary Care, offering programs for healthcare support workers, nurses, pharmacists, and pharmacy technicians to meet the objectives of the Primary Care Model for Wales.

Argymhelliad / Recommendation

The PQSOC is requested to **NOTE** the 2023/24 Annual Quality Report, with a commitment to provide further updates as needed.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 3. Effective Care 5. Timely Care Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable
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 prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability services Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• **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/	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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

ANNUAL QUALITY REPORT 2023/24

Primary Care & Community Services Division

Primary Care Contracting, Community Pharmacy, QPS and Primary Care and Community Academy

2023/24 Annual Quality Report

Introduction

This report provides the detail in respect of commissioning arrangements between Aneurin Bevan University Health Board and its Independent Contractors across General Dental Services, Welsh General Optometry Services, General Medical Services and Community Pharmacy.

The report shows how, during a time of significant contract reform the Health Board continues to provide patient centred, timely, quality health care through local commissioning with robust governance arrangements in place.

The report also provides assurances in respect of Duty of Candour compliance across all contractor areas.

In addition, the Primary and Community Care Academy section details how the Health Board is supporting and driving forward training and development within Primary Care, to meet the objectives of the Primary Care Model for Wales.

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1. General/Personal Dental Services

The Health Board commissions General Dental Services (GDS) throughout Aneurin Bevan University Health Board from independent contractors, through The National Health Service (NHS) GDS Contracts (Wales) Regulations 2006.

In 2023/24 there were 80 General Dental Contracts that were responsible for providing general dental care to patients. Since the inception of the NHS General Dental Services contract in 2006, patients are not registered with dental practices. It is the patient's responsibility to ensure regular attendance at a dental practice to receive ongoing dental care.

Since the pandemic, NHS dental practices have had the option to deliver NHS dental services either by traditional Units of Dental Activity (UDA) or via the Contract Reform metrics determined by Welsh Government, with a focus on prevention and needs based care. In 2023/24 41 NHS GDS practices opted-in to deliver dental services via Contract Reform.

Practices that opted into Contract Reform in 2023/24, were required to deliver the following:

- Complete and report **ACORN** (Assessment of Clinical Oral Risk and Needs assessment) findings,
- Accept at least 104 **New patients** and 156 **New Urgent patients** per £177,650 of Annual Contract Value (ACV) (per year)
- See a minimum of 1,280 **Historical patients** per £177,650 ACV. A historical patient is defined as someone who a dentist has submitted a claim for in the previous four financial years,
- Apply Fluoride Varnish (FV) to at least 80% of all adult patients with risk of (amber), or active decay (red) and at least 80% of all child patients aged 3 and over as well as for child patients aged under 3 with a risk of caries (red or amber) and
- Deliver 25% of their contracted UDAs.

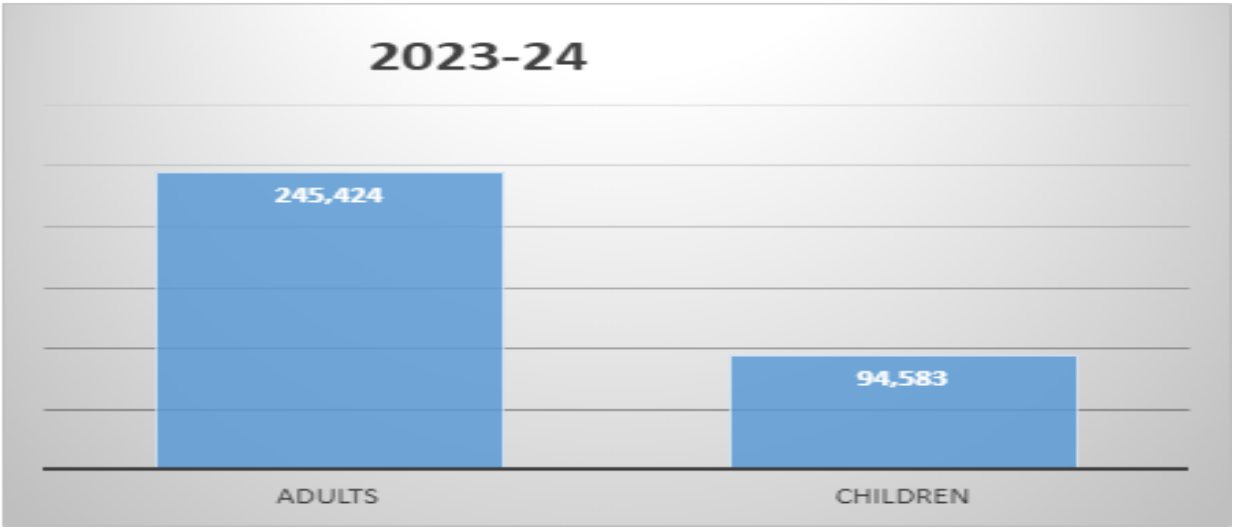
For those practices that remained with UDAs, they continued to provide dental services in accordance with The NHS (GDS Contracts) (Wales) Regulations 2006.

Below is a summary of the number of practices within each borough that opted into Contract Reform or delivered activity against UDAs in 2023/24:

Borough	2023/24	
	Contract Reform (CR)	**UDA**
Blaenau Gwent	7	3
Caerphilly	13	16
Monmouth	5	8
Newport	9	6
Torfaen	7	6
Totals	**41**	**39**

The following table details the total number of patients seen during 2023/24:

CR	New Patients	25,941
	New Urgent Patients	20,512
	Historic Patients	134,372
CR + UDA	*Adults*	245,424
	Children	94,583
CR + UDA	Total Patients Received Dental Care* **Some patients may have been seen more than once*	340,007



1.1 Urgent Access

Urgent Access remains a key priority for the Health Board. From 1st April 2023, the Health Board commissioned 130 core Emergency Dental Service (EDS) appointments per week with an additional 240 EDS appointments

commissioned per week as a result of the Contract Reform requirements for 2023/24, across 48 practices.

Below is a summary of the number of EDS appointments provided per week:

Borough	Contract Reform EDS appts per week	Core EDS appts per week
Blaenau Gwent	43	21
Caerphilly	58	12
Monmouth	10	27
Newport	73	61
Torfaen	56	9
Totals	**240**	**130**

The Health Board has maximised the use of these appointments by introducing a pathway between Gwent Urgent Primary Care (OOH) and in hours EDS appointments via the Dental Helpline. A number of appointments have been ring fenced to enable patients that contact Urgent Primary Care the opportunity of an EDS appointment.

The following table details the number of patients seen for EDS care during 2023/24:

Number of pts seen 2023-24	
April	1104
May	1126
June	1141
July	1200
August	1225
September	1118
October	1097
November	988
December	870
January	777
February	638
March	599
Total	**11883**

The Primary Care Contracting Team monitor EDS demand and capacity throughout the year. From November 2023 onwards the Health Board saw a reduction in patients seeking urgent dental care with reduced contact made to the ABUHB dental helpline resulting in lower demand for urgent dental appointments. On closer analysis of the data available the reduction in urgent dental demand is in direct correlation with an increase in general access to dental practices with more New Patients accessing dental practices within this timeframe.

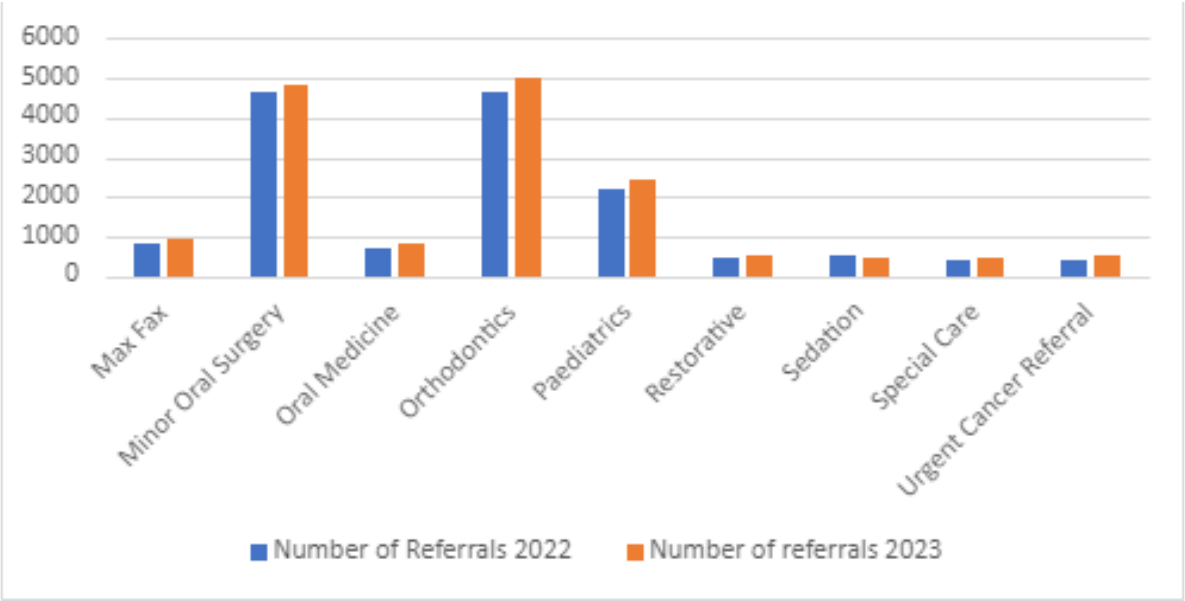
Information has also been issued to all GP Practices and Pharmacies to ensure patients that are experiencing dental pain are directed to this service. Public communication has also been shared via social media.

1.2 Backlog/Waiting Times

Since the pandemic, General Dental Services and Specialist Dental Services have seen a significant growth in patient demand and/or referral rates, resulting in an increase in patient wait times.

The table below details the referral growth during 2023 compared to 2022:

Speciality	Number of Referrals 2022	Number of referrals 2023
Max Fax	800	916
Minor Oral Surgery	4658	4837
Oral Medicine	683	837
Orthodontics	4659	4989
Paediatrics	2184	2452
Restorative	466	537
Sedation	542	457
Special Care	407	439
Urgent Cancer Referral	380	501



1.3 Orthodontics

The Health Board commissions Orthodontic services from 8 providers across the region.

Historically, Orthodontic services have always managed a waiting list from referral to assessment and then from assessment to treatment. However, with the prioritisation of treatment changing in 2020, waiting times have increased.

The criteria for orthodontic referral remain unchanged, patients that score a 3.6 as part of the Index of Treatment Need (IOTN) assessment can be referred for NHS orthodontic treatment but following the pandemic, Welsh Government advised that patients with an IOTN of 4 or 5 should be prioritised for treatment.

The Health Board regularly collates wait times and waiting list numbers from Orthodontic practices and as at March 2024, Orthodontic practices reported approximately 6,000 patients waiting for either an assessment or treatment appointment within Primary Care.

Prior to the pandemic, the longest wait time from referral to assessment was 30 months, with the shortest wait being 1 month. For assessment to treatment the longest wait time was 2 years and the shortest wait time was 6 weeks. At the end of 2023/24, patients were typically waiting up to 3

years for an assessment appointment with the shortest wait time being 18 months. The wait time for assessment to treatment was up to 3-4 years, with 6 weeks being the shortest.

There is no guidance for Orthodontic practices to follow with regards to the management of waiting lists. Some practices will have a longer wait time for an assessment appointment and shorter wait time for a treatment appointment and vice versa.

Orthodontic provision across ABUHB is detailed below by borough.

Borough	**Number of Orthodontic Practices**
Blaenau Gwent	1*
Caerphilly	2
Monmouth	1
Newport	3*
Torfaen	1*
Totals	**8**

*1 orthodontic practice in BG, Newport and Torfaen closed their list in 2023/24 as a result of ever-growing waiting lists/times.

The Primary Care Contracting Team monitor each orthodontic contract via its activity delivery and also via an annual independent Peer Assessment Review (PAR) outcome audit. For 2023/24, orthodontic performers were asked to PAR score 20 completed patient treatments. Where a performer has less than 20 completed patient treatments, they are asked to PAR all. Of the 212 patient treatments reviewed in 23/24, 15% of cases had improved and 85% of cases had greatly improved.

The Primary Care Contracting Team also manages patient transfer requests, typically for patients who are receiving active orthodontic care outside of the Health Board area and are relocating within ABUHB. In 2023/24, the team managed 5 transfer requests, supporting 3.

The Health Board received no patient concerns in 2023/24 relating to Orthodontic services.

The Health Board acknowledges that since the pandemic wait times have increased and this is partly due to the backlog of referrals being made since 2021/22 when services began to resume in full, along with recruitment and retention difficulties faced by practices. Historically, the Health Board has

invested additional non-recurrent funding into Orthodontic services and this is something the Health Board will consider again in 2024/25. However, it is important to recognise that this is reliant on the capacity and appetite of existing providers to be able to increase their provision.

1.4 Oral Surgery (Sedation)

1.4.1 Oral Surgery

The Health Board commissions a referral based Primary Care Oral Surgery Service via 2 practices:

- Blackwood Dental Centre – Caerphilly; and
- Kensington Court – Newport.

In March 2024, the wait time across both sites, from referral to assessment was between 2-16 weeks with approximately 521 patients waiting for an assessment and the wait time from assessment to treatment was between 13-16 weeks with approximately 1081 patients awaiting treatment.

Every 6 months the Health Board's Dental Practice Advisor(s) reviews a sample of patient referrals to ensure clinical appropriateness.

1.4.2 Oral Surgery with Sedation

The Health Board has historically commissioned an Oral Surgery with Sedation service, however, from 1st April 2023 the service was suspended due to the existing provider terminating their agreement. During 2023/24 the Primary Care Contracting Team successfully procured the service in order for it to be resumed from 01/06/24.

This service will enable those patients referred, prior to the termination of the previous agreement, to receive treatment. This service is not currently accepting new referrals.

1.5 Sedation

Gateway Dental Surgery, Monmouthshire, is commissioned to provide an inhalation sedation service to adults, via an NHS Personal Dental Service (PDS) contract and as at March 2024 the practice reported a wait time of approximately 8 months. The contract delivered 98% as at 2023/24 end of year.

In the previous year, 2022/23, the wait time for an appointment was approximately 4 months, with 221 patients waiting. The contract delivered 79%. A 20% carry forward was agreed with the remaining underperformance being financially recovered. This is in keeping with the contract management process followed for all NHS dental contracts.

Bettws Dental Surgery, Newport, is commissioned to provide an IV sedation service to adults via the practices existing NHS GDS contract. The practice does not receive additional funding for this element, but should an NHS patient attend the practice that requires IV sedation, they have the ability to offer this service as part of their routine GDS contract Therefore, there is no specific target that the sedation element of the contract needs to deliver against, and as such the contract is monitored against usual GDS metrics. In 2022/23 the full contract underperformed slightly and faced a small financially recovery but in 2023/24 the contract delivered in full.

1.6 Domiciliary Services

A Health Board wide domiciliary service is commissioned via Blackwood Dental Centre.

The purpose of the domiciliary dental care service is to deliver safe and effective oral health care to people whose circumstances make it impossible, unreasonable or otherwise impractical for them to receive care in a dental surgery.

The range of dental care that can be provided safely at a person's home/residence is limited.

The following services are usually provided to patients. However, this list is not definitive and clinicians will assess and provide the best and most appropriate dental care possible under the circumstances presented to them:

- Oral health risk assessment (ACORN) and clinical examination
- Oral health prevention, oral hygiene instruction and dietary advice
- Prescription of higher strength fluoride varnish, toothpaste and mouthwashes
- Denture repair and construction
- Temporary dental fillings (restorations) or smoothing of sharp teeth
- Sealing of root remnants, where appropriate
- Sub and supra gingival debridement (Scaling)
- Simple extractions that do not require radiographic examination

The Primary Care service was previously supported by an Oral Health Improvement Practitioner (OHIP), who the domically dentist refers to after they have seen a domiciliary patient. The OHIP, employed by CDS, provides support to patients, including those in residential homes, as well as providing preventative care to patients. In 2023/24 this post was vacant and this element of the service has not resumed in 2024/25.

In addition to this practice, there were 2 practices within the Monmouthshire borough who have historical contracting arrangements in place to provide domiciliary care to their own practice patients in 2023/24.

Requests for domiciliary visits are managed via the Dental Helpline with the Community Dental Service triaging those referrals to ensure the patient is seen in the most appropriate setting, i.e. CDS or Primary Care.

In 2023/24, 704 referrals were received in total and 37% of these were directed to Primary Care; 36% to Blackwood Dental Practice, who underperformed by 2.5% against their UDA target. This 2.5% was carried forward into 2024/25, in line with usual contract management processes. The remaining 63% of referrals was retained by the Community Dental Service and this is likely to be due to the patients' medical needs being too complex for Primary Care to manage.

In 2023/24, the Primary Care Contracting Team met with both CDS colleagues and Blackwood Dental Practice to discuss the referral pathway, referral criteria and clinical triage process.

1.7 Governance and Reporting

The Primary Care Contracting Team have robust mechanisms in place to monitor all contract delivery on a monthly basis, meeting with the wider Primary Care Team on a quarterly basis to undertake a more in-depth analysis of contract activity. Members of the quarterly meeting include, Primary Care Contracting Managers, Dental Practice Advisor(s) and NHS Business Service Authority (BSA) colleagues.

Whilst monitoring of the contract activity occurs monthly, the NHS Business Service Authority (BSA) also undertake independent reviews of contract activity in the form of, Immediate Assurance reports, Peer Assessment Report (PAR), and Provider Assurance Dental (PAD) ACORN support.

Immediate Assurance reports are high level contract reports provided monthly to the Health Boards. The contract data is presented in a way which is benchmarked against the Health Board and Welsh averages to help identify outliers in service provision. If outliers are identified the Health Board can request NHSBSA to undertake a Peer Assessment Report (PAR) audit. This provides the Health Board with an in-depth review of practices claiming data. The process is a supportive mechanism for practices, ensuring inconsistencies are highlighted at the earliest opportunity for practices to make amendments to their claiming processes.
In addition, NHS BSA offer support to Dental Contractors with the completion of an ACORN, via PAD Acorn assessment review. The primary focus of these reviews is around education regarding Oral Health Assessments.

In 2023/24:

- 10 PAR reports were prepared and shared with practices. All of which we will receive a further review in 12 months.
- 1 data report was compiled but it was agreed with the provider that a further review would be carried out in 2024/25.
- 3 contracts were identified as 'at risk' as they flagged as outliers within the Clinical Data Set review. It was therefore agreed that these contracts also receive a PAR review.

Primary Care Contracting Team ensures that risk is managed appropriately and through prompt identification and assessment, reported into Divisional QPS. This ensures that where possible, the Health Board is informed of the risks that are present and how they are managed or minimised.

The GDS risk register is reviewed regularly and describes risks in sufficient detail so that they can be clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

In addition, the Primary Care Contracting Team monitor mid-year and end of year contract activity as per the NHS General/Personal Dental Services Contract (Wales) 2006.

1.7.1 Mid-Year

The NHS G/PDS contract stipulates a threshold of 30% achievement at mid-year. Of the 39 UDA contracts, 7 contracts achieved less than 30% as at 30th September 2023.

Of the 41 Contract Reform contracts, 5 contracts achieved less than 30% as at September 2023 against the New Patient (NP), New Urgent Patient (NUP), Historic Patient (HP) metric or any of the combination.

To understand the reasons for under achievement, the Primary Care Contracting Team met with practices to discuss the issues affecting contract delivery. All practices identified similar challenges which were attributed to their low performance as detailed below:

- NUP difficult to achieve due to low demand;
- Due to practices being able to offset NUP with NP to aggregate the total, practices have identified that NP's have a higher level of dental care required;
- High level of DNA's and late cancellations;
- Software claiming issues; and
- Workforce, recruitment and retention issues of dental associates and therapists.

Whilst the above were noted as challenges impacting contract delivery, all providers were able to provide the Health Board with assurances that they had instigated processes to remedy the low performance, with the aim for full year contract delivery at year-end. The Primary Care Contracting Team agreed with all providers to continue to monitor delivery and maintain dialogue through the second part of the year.

As part of the Mid-Year process any practice can request a meeting with the Health Board to discuss their performance. The Health Board received requests from 2 providers who had achieved over the required 30% threshold. The Primary Care Contracting Team met with both providers who are providing services against the Contract Reform metrics, with both practices having specific queries in relation to their contracts which were mainly around recent reporting undertaken by the NHSA BSA Clinical Advisor, as part of assurance exercises. Queries were discussed and resolved with both providers.

1.7.2 End of Year

Practices delivering against the contract reform metrics are managed in accordance with the Welsh Government End of Year Performance management guidance issued 21 December 2022 Eich cyf (nhs.wales).

Whilst UDA practices are managed in accordance with the NHS GDS/PDS Regulations 2006 [The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 (legislation.gov.uk).]

In addition to the above, Welsh Government issued Pay Award guidance to Health Boards and practices on 13 December 2023, detailing that those practices who completed 2 Quality Improvement Projects/Audits during the financial year, would receive a 0.5% reduction in their metrics for each project completed. There were predetermined audits listed and practices were required to complete a self-declaration to confirm completion.

Of the 80 GDS contracts 52 practices confirmed via self-declaration that they had completed the necessary audits, 30 of those being Contract Reform practices and 22 UDA practices. Therefore, each of those practices had a reduction of their associated metrics by 1%.

GDS practices are paid 1/12 of their Annual Contract Value each month. Where a practice was projecting under-performance in March 2024, the Primary Care Contracting Team made contact with those practices to encourage commencement of recoveries early, with the Health Board reconciling at final year-end (June).

Practices were given the option for financial clawback to be recovered via COMPASS in instalments or in a lump sum. In addition, practices had the option to pay via a one-off Bacs payment. Where a practice had under-performed recoveries are required to be paid in full by 30th September.

To confirm the position of all contract types at end of year:

Contract Reform

Breakdown	**Practices Affected**
Financial Recovery	10
Carry Forward of underperformance activity 95%-100%	0 – No practice opted for a Carry Forward
Carry Forward of 5% underperformance activity where a practice achieved < 95%	0 – No practice opted for a Carry Forward
Overperformance	13 – (35 NP, 70NUP & 1037 HP)

UDA

Breakdown	Practices Affected
Financial Recovery	23
Carry Forward of underperformance activity 95%-100%	2
Carry Forward of 5% underperformance activity where a practice achieved < 95%	6 (1 UDA practice & 5 CR practices)
Financial Recovery excl carry forward	21
Overperformance	16 (15 UDA practices. 1 CR practice as converted for 2024/25

Orthodontics

Breakdown	Practices Affected
Financial Recovery	2
Carry Forward of underperformance activity 95%-100%	1
Carry Forward of 5% underperformance activity where a practice achieved < 95%	0 – Practice opted for no carry forward
Financial Recovery excl carry forward	1
Overperformance	6

Specialist

Breakdown	Practices Affected
Financial Recovery	2
Carry Forward of underperformance activity 95%-100%	1
Carry Forward of full underperformance activity where a practice achieved < 95%	1
Financial Recovery excel carry forward	0
Overperformance	2

In addition to the above, the Primary Care Contracting Team issued contract breach notices to those practices who under-performed greater than 5%, in accordance with the relevant sections as detailed in the respective contracts under the UDA, Orthodontic and Specialist contracts.

Below is a breakdown of numbers of contracts that received a contract breach notice.

Speciality	**Number of Breach Notices Issued**
UDA	15
Orthodontics	1
Specialist	0
Totals	**21**

1.7.3 Quality Assurance System

The Dental Public Health team hosts the all-Wales dental practice Quality Assurance System toolkit and co-ordinates the annual self-assessment process on behalf of Health Boards and dental practices in Wales.

The QAS is an annual self-assessment toolkit that supports GDS/PDS providers to identify areas for Quality and Safety improvement in their practice.

The Quality Assurance System (QAS) was first introduced in 2007 as a manual system and then in 2008/2009 as an "on line" computerised system. When the information is entered electronically on to the system for the first time, it only requires information to be amended in subsequent years for any changes to be made or for any new questions to be answered.

In December 2023, Caforb was released as the new QAS platform, hosted by Digital Health and Care Wales (DHCW). This is an updated, web-based platform which satisfies the strengthened requirements for data security.

One of the benefits of Caforb is that it will remain live and accessible throughout the year, other than a brief period when Dental Practice Advisors will take a snapshot of the data the practice has entered to analyse and prepare a report for Welsh Government. After this, practices can log in again as many times as they wish to amend any information, so the record will always be up to date which will mean the process will not be arduous year on year. Over time the platform will evolve to introduce new features such as reminders being sent to practices to inform them if audit expiry dates are approaching and anything else which might be useful.

All completed QAS returns are reviewed by the Health Boards Dental Practice Advisor(s) who prepare a report and provide advice to the Primary Care Contracting Team in respect of any Quality and Safety concerns arising from the practices' self-assessments.

The Dental Public Health team produces an annual QAS report based on the summary reports provided by the DPAs across the seven health boards.

The practice returns were 'RAG' rated and the Primary Care Contracting Team liaised with practices to request additional information to satisfy the requirements of the QAS.

The following table highlights the 'red' categorisation of submissions;

Health Board	**Issues that resulted in practices categorised as 'Red'**
ABUHB	• Verification of QAS submission not carried out by a Provider • Staff Immunisation status/records • H&S training • Level 2 Child Protection training • Annual CPR training • Legionella Testing by a qualified body • DBS checks • Autoclave & Compressor inspection/certification dates • IRMER personnel • Safe storage of prescription pads • Duty of Candour policy • Information Commissioner's Office (ICO) registration • Fire extinguisher inspection date • Employers' liability insurance/certificate • Laboratory work not carried out at MHRA registered facilities • VDU policy and appropriate staff eye tests • Use of Wrong Tooth Extraction checklist • Radiography equipment inspection overdue

Other common issues highlighted included:

Health Board	**Other common issues identified from the QAS submission**
ABUHB	• No written communication available in Welsh • No HIW certificate on display

	• No contract for collection of business non-clinical non-hazardous waste • Out of date information within complaints policy • Competency of person carrying out PAT procedure

The Primary Care Contracting Team provide regular report updates to the Senior Management Team (SMT), Divisional Senior Leadership Team (SLT), Access Group, Enhanced Services Operational Group (ESOG), Divisional Quality and Patient Safety Group (DQPS) and wider external groups either on an All-Wales basis or regional basis via the Managed Clinical Network (MCNs), All Wales QPS meeting, Welsh Government.

1.7.4 Health Inspectorate Wales (HIW)

HIW inspect all NHS dental practices for clinical and managerial/administrative compliance, providing a report of each inspection to the practice and the Health Board identifying any areas for improvement. During 2023/24, 9 HIW inspections were undertaken, 4 of which received improvement plans.

In summary, practices were reminded to ensure:

- Regular audits are carried out and the findings shared and discussed, also identifying any lessons learnt
- Staff training is kept up to date
- Practice policies are kept up to date and easily accessed for staff members
- Public facing information to be translated to Welsh
- Equipment is stored securely with cleaning and testing labels attached
- Decontamination and WHTM01-05 (Welsh Health Technical Memorandum) Compliance

In 2022/23, 11 practices inspections were undertaken and, for 2024/25, to date 4 practice inspections have been carried out with 2 further inspections planned in the coming months. Overall, the same findings have been reported by HIW Teams. The Primary Care Contracting Team continue to share learning with dental practices.

Practices engage directly with HIW but the Health Board offers support and guidance to a practice before and after inspections have occurred, via the Health Board Dental Practice Advisors.

1.8 Contract Variations and Terminations

There are many challenges facing NHS dentistry across Wales and Aneurin Bevan have received numerous contract variations and terminations

The Health Board is not obliged to source alternative dental practice provision for patients affected by contract variations/terminations, however, without the support from the Health Board, overall access will reduce and wait times will inevitably increase. The Health Board is committed to maintaining access to NHS GDS and as such has developed a Variation and Termination Policy, reflective of the NHS GDS Regulations 2006, which is implemented upon receipt of such a notification with the aim being to secure alternative NHS dental care for those patients affected by the change.

The Health Board received the following contract variations and terminations during 2023/24:

23/24	Apr-23	Contract Reduction	Sparkle Dentist, Torfaen (and convert to UDA)
	Feb-24	Contract Termination	Bupa, Gaer Road Newport
24/25	Apr-24	Contract Termination	Bridges Dental, Caldicot
	Apr-24	Contract Termination	Oakdale Dental Centre, Caerphilly
	Apr-24	Contract Termination	Trefynwy Dental, Monmouth

Approximately, 15,000 NHS patients were affected by the contract variations/terminations. The Primary Care Contracting Team procured for new service provision via alternative NHS dental practices and all patients affected were assigned to a new NHS dental practice within the Health Board area.

To provide an overview:

- Sparkle Dental – 2,346 patients affected and directed to

Sarratt House - Caerphilly	1,998 patients
Blackwood Dental Centre, Caerphilly	28 patients
Cox & Hitchcock, Newport	320 patients

- Bupa Gaer – 5,137 patients affected and directed to Cox and Hitchcock, Newport

- Bridges Dental, Caldicot – 1,574 patients affected and directed to Severn Dental, Chepstow

- Oakdale Dental Centre – 710 patients affected and directed to Smart Smiles, Caerphilly

- Trefynwy Dental – 5,504 patients affected and directed to Severn Dental, Chepstow

1.9 Prison Services

The Health Board commissions Time for Teeth Ltd to provide General Dental Practitioner/Therapist sessions to the population of HMP Usk and HMP Prescoed to ensure equitable access to NHS Dental Care. The delivery of the service is regularly reviewed by the Primary Care Contracting Team and quarterly meetings take place with the service provider.

Regular updates are provided to the Prison Delivery Group and Prison Partnership Board.

1.10 Occupational Health

Occupational Health services are commissioned by the Health Board for dental teams working within the Aneurin Bevan area. Services include:

- Pre-placement health assessment and further re-assessment as required
- Long term health/sickness absence consultation
- Blood tests and screening *(e.g. screening for hepatitis B / HIV / hepatitis C/ T.B.)*
- Vaccination for work related preventable disease (e.g. hepatitis B, MMR, T.B, chickenpox etc.)
- Flu vaccination (details will be circulated annually, some staff may qualify to receive flu vaccination from their GPs)
- Advice on sharps / body fluid incidents including post-exposure prophylaxis if required
- Advice on possible contact with or symptoms of communicable diseases

1.11 Concerns/FOI

In respect of GDS, during 2023/24 the Primary Care Contracting Team managed and responded to:

- 2 – PTR Concerns
- 17 – MS/MP Requests
- 14 – FOIs

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward.

1.12 Looking Ahead

The Primary Care Contracting Team continue to work closely with all key stakeholders to ensure access to NHS dental services is maintained and enhanced.

Where possible, any contract variations/terminations will be considered for reinvestment along with awarding additional monies to enhance current service provision.

There is ongoing investment into NHS Dental services in Aneurin Bevan developments with a new dental practice, Ty Dant, within the new Bevan Health and Well Being centre opening from 1st April 2024 and the Newport East Development, 19 Hills, due to open winter 24/25.

The Health Board is aware that from April 2026 a new NHS General Dental Services Contract is expected to be introduced.

In addition, a national Dental Access Portal will be launched across Wales and will go live in Aneurin Bevan on the 20th November 2024.

The Dental Access Portal (DAP), designed and built by Digital Health and Care Wales (DHCW), is a centralised, digital service that will allow patients in Wales to access NHS dental services on a more equitable basis. The DAP will enable all Welsh Health Boards to manage the allocation of places for routine dental treatment at NHS dental practices within their area. The system will be hosted on the DHCW website and linked to from third-party websites such as Health Board and dental practice sites.

The Primary Care Contracting Team is working closely with all relevant stakeholders in preparation for the 20th November, including Llais. Clear messaging has been developed for the profession, wider primary care and the public to raise awareness of the DAP whilst managing expectations.

The Health Board does not currently hold a centralised waiting list; therefore, no patient information will be uploaded to the portal prior to 20th November 2024 and it will be the patient's responsibility to add their details to the DAP, once it goes live, should they wish to access routine NHS dental care and have not done so in the previous 4 years. It is important to recognise that this will not facilitate earlier access to routine NHS dental

care but will allow for it to be managed on a more equitable basis and also allow for demand and capacity reporting and analysis.

Once embedded, the DAP will require considerable additional resource to manage the administrational processes at Health Board level.

2. General Ophthalmic Services

In 2023/24 there were 55 Optometry practices providing WGOS 1 and 2 services, all of which were open for urgent and essential appointments and could also provide routine sight tests to patients. Practices continue to prioritise and schedule patient appointments based on clinical need and presenting symptoms relative to the risk of sight loss and harm.

Of the 55 practices across the Health Board in 2023/24, 14 practices provide mobile services, 35 practices provide WGOS 3 services and 15 practitioners/14 practices were eligible to provide the WGOS 5 service.

The Health Board also had 5 Ophthalmic Diagnostic Treatment Centre's (ODTCs) which provided care for patients with Glaucoma that were suitable to be treated within Primary Care. Referrals are made and reviewed by Secondary Care. One of the ODTCs in Newport also provides a Wet AMD service.

In order to address the demand and capacity issues in Optometry and to switch the focus of Primary Care Optometry services to a more clinical model of care, Welsh Government announced plans for a Contract Reform and Health Boards were invited to attend the Welsh Government Optometry Contract Reform Group meeting where papers were considered and agreed, including the Contract Clinical Framework.

As part of the Contract Reform Clinical Framework, services have been categorised as follows:

- WGOS 1 (Core Clinical service) – Eye examination with Holistic Health element;
- WGOS 2 (Core Clinical Service) – Previously Eye Health Examinations Wales (EHEW), includes examinations for urgent eye problems;
- WGOS 3 – Low Vision Services Wales (LVSW) and Certificate of Visual Impairment Wales (CVIW) and SPECS;
- WGOS 4 – Referral Refinement/Monitoring (including, Glaucoma, Medical Retina and Hydroxychloroquine); and
- WGOS 5 – Independent Prescribing (IPOS).

Financial allocations were shared with each Health Board for 2022/23 and 2023/24 and Health Boards received confirmation that a Contract for each

provider would not be required and services would be commissioned through a Primary Care Contracted Services (PCCS) framework. Some services will be non-cash limited and, as a minimum, providers must ensure they are accredited to provide WGOS Levels 1 and 2 as core service provision. All WGOS services are available to all providers that meet the requirements, and Health Boards are expected to commission on that basis.

The new NHS (Ophthalmic Services) (Wales) 2023 Regulations, which govern WGOS 1 and WGOS 2, were laid before the Senedd on 29th September 2023 and came into force on 20th October 2023. The new regulations and legislative directions replace all previous GOS instructions for Optometry service provision, for example, sight tests, optical vouchers, maintaining ophthalmic lists and removal from lists following disciplinary processes; and all WECS instructions for example, EHEW and LVSW.

2.1 Current Position

2.1.1 WGOS 1 and 2 - Fully Implemented

WGOS 1	A sight test as defined by the Opticians Act as well as the inclusion of prevention and wellbeing provision as part of a Patient Management Plan
WGOS 2- Band 1	Examinations for Urgent Eye Problems This examination is for patients who have eye problems of an acute nature. It can also be used to accept referrals from another healthcare provider
WGOS 2- Band 2	Further investigation/examinations These examinations enable patients to have additional investigations following a WGOS 1 or Private sight test only. They can only be used to further inform or prevent onward referral to the hospital eye service
WGOS 2- Band 3	Follow-up examinations This examination enables a patient to be followed-up after they have had an initial appointment for a WGOS 2, Band 1 or for a post-operative cataract check

From 20th October 2023, WGOS 1 and 2 became mandatory services for all Ophthalmic practices on the Ophthalmic list and all Optometrists on the Ophthalmic and Supplementary list. All practitioners performing a WGOS service must have completed mandatory compliance training, which consists of four training modules:

- WGOS;
- Make Every Contact Count (MECC);
- Infection Prevention Control and Sharps Safety; and

- Improving Quality Together-Improvement Foundations Training.

All contractors were required to submit a 'Contractor Declaration for the Introduction of WGOS' confirming all team members performing WGOS services had completed the relevant training modules, if training was not completed and a declaration not received by the 17th November 2023, the practitioner(s) have been removed from Aneurin Bevan University Health Board's Ophthalmic/Supplementary list unless exceptional circumstances were demonstrated.

The Primary Care Contracting Team received communication from 6 practitioners who had not completed the necessary requirements within the timeframe stipulated. Extenuating circumstances were granted for 3 of those practitioners due to training being planned but not yet completed, where clear extenuating circumstances were evidenced.

In addition, should Practitioners wish to provide a WGOS 1 and 2 mobile service, they are required to submit a Mobile Service Agreement. Mobile services are for patients who are unable to leave their home unaccompanied.

2.1.2 WGOS 3 – Fully Implemented

Low Vision Service Wales (LVSW)	A low vision assessment is for patients who reach the criteria for the service. This assessment helps a patient make the best use of their remaining sight. When a patient first enters the service, they will receive an initial examination and they are entitled to a follow up examination every year.
Certificate of Vision Impairment Wales (CVIW)	Certification is the pre-requisite to being registered with a vision impairment. Practitioners accredited to provide the Low Vision Assessments are now able to certify eligible people with sight loss.

WGOS 3 is an opt in service. Practitioners must undergo additional training to provide LVSW and have a LV qualification. In order to undertake the training practitioners must practice in Wales, be WGOS compliant and be an Optometrist or Ophthalmic Medical Practitioner registered with the General Optical Council (GOC) or Dispensing Optician registered with the GOC.

Practitioners with the qualifications continue to provide services under WGOS 3 from 20th October 2023 providing they have submitted a practice declaration and completed all the training modules detailed above.

In respect of the CVI element of WGOS 3, the WHC (Certification of vision impairment in primary and community care (WHC/2024/029) [HTML] | GOV.WALES) was issued (2023 – 010) on 3rd July which allows Optometrists to be able to sign a Certification of Visual Impairment (CVI).

The All-Wales patient pathway was introduced to support Optometrists who are also low vision accredited to certify eligible patients with sight loss in the community, which historically, could only be signed by Consultant Ophthalmologists.

The Health Board awaits the final manual in respect of School Pupil Eye Care Service (SPECS).

2.1.3 WGOS 5 – Partially Implemented

IPOS – Urgent	Practitioners with an independent prescribing qualification can manage certain acute conditions in primary care for their own patients or following a referral from another WGOS practitioner.
IPOS - Discharge **	Practitioners with an independent prescribing qualification will monitor conditions initially seen in hospital eye casualty

To date, this part of WGOS 5 IPOS has not been implemented

The WGOS 5 IPOS Urgent Service was implemented on the 27th November 2023 in Aneurin Bevan and is an opt in service for those practitioners with an Independent Prescribing qualification. The service is provided on a rota basis and all IP's working within Aneurin Bevan, with a WP10, are expected to provide the service. The Primary Care Contracting Team manage the IP rota and circulate to all practices on a fortnightly basis, also publishing on Optometry Wales's secure professional webpage. Non-IP practitioners can refer patients to an IP practitioner but retain responsibility for the patient until they have been accepted by the IP practitioner. Please refer to section 2.2.5 for an activity breakdown.

This service is subject to Post Payment Verification (PPV) and claims will be audited from November 2024, once a years' worth of activity has been claimed. In addition, prescribing data will be reviewed and monitored by the Health Boards Optometric Advisor and Medicines Management team on a quarterly basis to identify trends and any outliers.

2.1.4 WGOS 4 - Implementation

The WGOS 4 service will see patients who would previously have been referred to/managed in the Hospital Eye Service (HES) for Glaucoma,

Medical Retina and Hydroxychloroquine, instead remain in Primary Care for further enhanced assessment as part of an agreed referral filtering or monitoring pathway.

Health Boards were required to submit implementation plans to Welsh Government for each service, which have been shared. Aneurin Bevan University Health Board's plan outlines how Primary and Secondary Care, through integration and collaboration, will transition the existing ODTC services (Glaucoma and Wet AMD) to the WGOS 4 pathway and will consider the number of eligible patients currently waiting in secondary care.

Work to implement WGOS 4 has been on-going since 2023,

The Health Board undertook an expression of interest exercise to determine those practices who would be interested in providing WGOS 4 services, and practices were required to confirm if they have the relevant equipment and qualifications, as per the clinical manual, in order to be considered.

The Health Board met with Welsh Government in April 24 where plans and timelines for implementation were discussed and subsequently agreed.

The Health Board is now in a position to progress with its implementation during 2024/25.

From 1st November 2024,

- 3 practices will be commissioned to provide the WGOS 4 Glaucoma service,
- 21 practices will be commissioned to provide the WGOS 4 Medical Retina service and
- 7 practices will be commissioned to provide the Hydroxychloroquine service

Practices can 'opt in' at any point, we therefore anticipate a growth in the number of practices providing each service during 2024/25 and beyond.

Whilst we cannot predict the referral rate from non WGOS 4 provider to a WGOS 4 provider, Secondary Care have reported the number of referrals by sub-specialty that require review in readiness for onward referral to a WGOS 4 provider:

- 2373 Glaucoma (referral filtering)
- 4741 Glaucoma (monitoring)
- 190 Medical Retina (referral filtering)
- 1197 Medical Retina (monitoring)

- 500 Hydroxychloroquine (monitoring)

2.2 Reporting

It should be noted that for 2023/24 claims were processed under a combination of both the old and new optometry regulations.

2.2.1 GOS / WGOS 1

Prior to October 2023, the fee for a GOS sight test was £21.71 but is now £43.00.

In 2022/23 154,314 GOS sight tests were claimed. The table below details the number of GOS sight tests claimed since April 2023:

	Total NHS Sight Test
Apr-23	12,757
May-23	12,237
Jun-23	14,123
Jul-23	14,389
Aug-23	12,476
Sep-23	13,440
Oct-23	14,781
Nov-23	13,409
Dec-23	14,483
Jan-24	11,351
Feb-24	14,724
Mar-24	14,497
	162,667 (+5.4% compared to 22/23)

Mobile Sight Tests

The table below details the number of mobile sight tests claimed since April 2023;

	Total Mobile NHS Sight Test
Apr-23	509
May-23	246
Jun-23	598
Jul-23	434
Aug-23	408

Sep-23	553
Oct-23	626
Nov-23	548
Dec-23	469
Jan-24	485
Feb-24	290
Mar-24	599
	5,765 (+35.6% compared to 22/23)

2.2.2 EHEW / WGOS 2

Prior to October 2023, the fee for:

- EHEW B1 was £63.68, now £70.00
- EHEW B2 was £42.46, now £53.00
- EHEW B3 was £21.22, now £26.00

In 2022/23 41,667 EHEW claims were processed broken down as follows:

- EHEW B1 – 25,991
- EHEW B2 – 9,288
- EHEW B3 – 6,388

The table below details the number of EHEW/WGOS 2 examinations claimed since April 2023:

	Total number of EHEW Claims	**Band 1 Claims**	**Band 2 Claims**	**Band 3 Claims**
	Per Patient	Per Patient	Per Patient	Per Patient
Apr-23	3,944	2,491	835	618
May-23	3,767	2,451	693	623
Jun-23	4,277	2,771	852	654
Jul-23	4,102	2,580	908	614
Aug-23	3,875	2,415	816	644
Sep-23	4,085	2,587	898	600
Oct-23	3,999	2,452	917	630
Nov-23	4,050	2,459	958	633
Dec-23	4,487	2,584	1,169	734
Jan-24	3,482	1,968	930	584
Feb-24	4,898	2,832	1,238	828
Mar-24	4,388	2,501	1,276	611

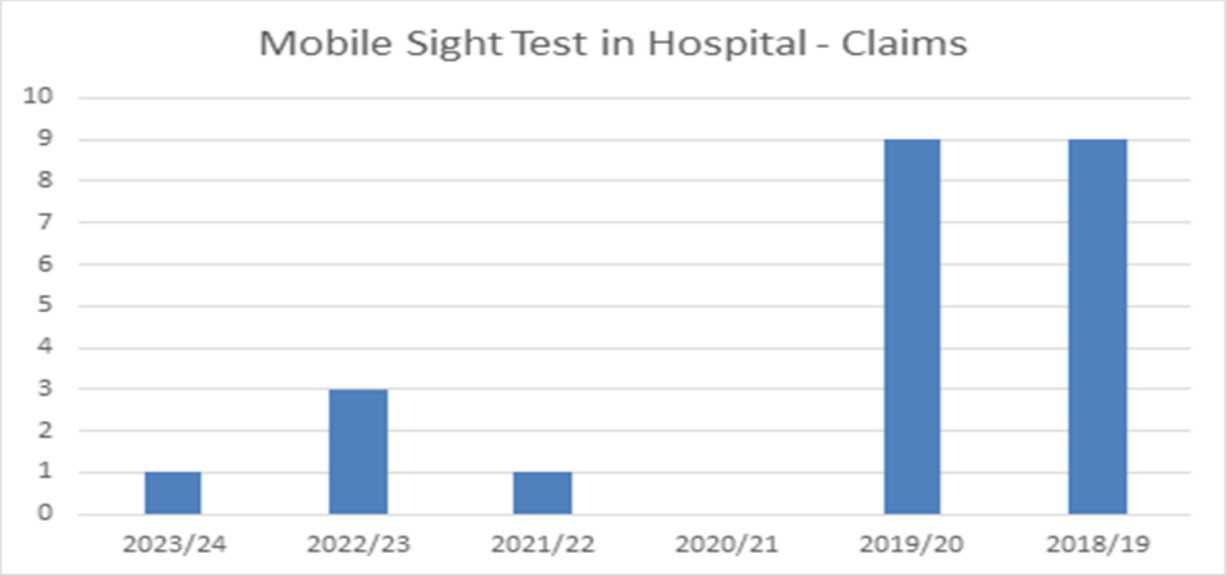
	49,354	**30,091**	**11,490**	**7,773**
Compared to 22/23	+18.4%	+15.8%	+23.7%	+21.7%

Mobile Sight Tests in Hospital

The following practices are accredited to provide mobile sight tests in hospital:

Practice Name	Practice Address	Borough	Post Code
Ebbw Vale Optical Centre	23 Market Street, Ebbw Vale	Blaenau Gwent	NP23 6HL
Rhymney Optical Centre	The Lawn Estate, Rhymney	Caerphilly	NP22 5PW
Monnow Eyecare Ltd	11 Cinderhill Street	Monmouthshire	NP25 5EY

The graph and table below demonstrates the number of claims processed since 2018:



One claim was submitted in November 2023.

Mobile WGOS 2

The following practices are approved for the provision of WGOS 2 mobile services;

Practice Name	Practice Address	Borough	Post Code
CATVOG Domiciliary Specsavers Ltd	Mailbox 1, The Stables, Castleland Street	Barry	CF63 4LL
Gwyns Opticians Group Ltd	90 Queen Victoria Street, Tredegar	Blaenau Gwent	NP22 3PX
Williams and Parry Ltd	50 Church Street, Abertilley	Blaenau Gwent	NP13 1DB
Ebbw Vale Optical Centre	23 Market Street, Ebbw Vale	Blaenau Gwent	NP23 6HL
Bristol 1 Domiciliary Specsavers Ltd	Specsavers Homevisits, S01, Pure Offices Ltd, Kestrel Court, Waterwells Drive, Quedgeley	Bristol	GL2 2AT
Gwent Domiciliary Specsavers Ltd	Britannia House, Caerphilly Business Park	Caerphilly	CF83 3GG
Rhymney Optical Centre	The Lawn Estate, Rhymney	Caerphilly	NP22 5PW
RJD Jenkins Opticians	13 New Street, Pontnewydd	Caerphilly	NP44 1EF
Gwyns Opticians Group Ltd	39 Hanbury Road, Bargoed	Caerphilly	CF81 8QU
Adipose Ltd, Darlington Opticians	2a The Cross	Caldicot	NP26 4HY
Optical Healthcare Ltd	Temple Court, Cathedral Road	Cardiff	CF11 9HA
Monnow Eyecare Ltd	11 Cinderhill Street	Monmouthshire	NP25 5EY
RW Cole	58-59 Commercial Street, Pill	Newport	NP20 2PF
Outside Clinic	Stirling House, 10 Viscount Way	Swindon	SN3 4TN

2.2.3 Low Vision Service Wales and CVI

Prior to October 2023, the fee for:

- LVSW Initial Assessment was £80.00, now £90.00
- LVSW Follow Up was £0, now £53.00

During 2020/21 the LVSW was suspended in quarter 1 and resumed on 17th August 2020. The table below provides a claim breakdown for 2023/24 (claims are one month in arrears):

	LV Claims Per Assessment
Apr-23	128
May-23	111
Jun-23	131
Jul-23	120
Aug-23	142
Sep-23	148
Oct-23	128
Nov-23	128
Dec-23	79
Jan-24	60
Feb-24	95
Mar-24	58
	1,328 (-9% compared to 22/23)

With the implementation of the WGOS Regulations in October 2023, there was a requirement for Optometrists to reapply to the All-Wales Ophthalmic list and for Contractors to have a Mobile Service Agreement in place with the Health Board, aligned to the location where the service is to be delivered with a predetermined list of equipment required at every domiciliary appointment. Optometrists were given a grace period until mid-November

2023 to ensure they were compliant with the new Regulations and a further extension into 2024/25 to ensure they had their own equipment. From November 2023, there were 14 Optometrists with a mobile service agreement in place. For 2024/25 this has reduced to 11 Optometrists with a mobile service agreement, a reduction of approximately 35% compared to previous years. 7 of the 11 are accredited to provide LV services.

The Health Board has not received any patient concerns regarding this service.

One claim has been submitted for a CVI examination and Certificate in March 2024

2.2.4 ODTC; Glaucoma and Wet AMD

Glaucoma

The Glaucoma ODTC service commenced on 1st April 2016 and is designed to allow patients to receive both New and Follow Up Glaucoma reviews within the community. This service has been extended, as part of WGOS transition arrangements, until 31st March 2025 where a fee of £69.15 can be claimed per patient episode.

As part of contract reform, this service will transition to WGOS 4 where a fee of £125.00 will be claimable when a practitioner with a higher qualification in glaucoma treats a patient with glaucoma. In addition, the Hospital Eye Service (HES) will be able to refer patients out to Primary Care to continue their treatment and therefore the accredited practitioner will be able to claim £94.00 per patient treated. In the event that a patient requires a 'follow-up' visit, the accredited practitioner will be able to claim £62.00.

A 'core' referral rate for each ODTC was agreed for 2022-23. Practices were able to request additional referrals, above their core, should they have the capacity to see more patients however referrals have been capped at practices agreed core from the 1st April 2024 as part of implementation planning for WGOS 4.

The following 2 tables demonstrate the referral rates for each practice and the number of patients treated as either new of follow up since 2021:

Practice	Borough	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Specsavers Newport	Newport	75	90	48	0	0	67	68	68	66	67	69	69

Julian Davies	Newport	87	81	88	96	86	87	58	81	77	92	83	81
Phillips Newbridge	Caerphilly	109	109	103	132	126	125	168	203	159	175	183	177
Ebbw Vale	Blaenau Gwent	85	73	60	69	51	65	65	73	66	62	70	62
Monnow Eyecare	Monmouth	79	83	78	103	84	84	83	83	80	80	80	80

	Follow Up				New		
	2021/22	**2022/23**	**2023/24**		**2021/22**	**2022/23**	**2023/24**
Patients Invited	3872	3475	3421		1017	918	1830
Patients Assessed	2872	3477	2408		716	633	1153
DNA Rate	84	83	66		23	25	57
CNA Rate	483	450	373		131	109	194
No response	433	465	402		147	151	321
Patients Requiring Assessment	0	0	172		0	0	105

In 2022/23, 3,023 glaucoma claims were processed.

The table below provides a claim breakdown for 2023/24:

	Glaucoma ODTC Claims
	Per Episode
Apr-23	332
May-23	308
Jun-23	287
Jul-23	283
Aug-23	323
Sep-23	254

Oct-23	307
Nov-23	273
Dec-23	354
Jan-24	289
Feb-24	347
Mar-24	339
Total	**3,696** (+22.2% compared to 22/23)

Wet AMD

The Wet AMD ODTC service commenced on 1st April 2016 and is hosted by Specsavers Austin Friars, Newport and is a referral refinement service for patients with suspected Wet AMD. This service has been extended until 31st March 2025, under WGOS 4 transition arrangements, where a fee of £60 can be claimed per patient episode.

As with the current glaucoma ODTC services, the Wet AMD service will also transition to WGOS 4 under the same financial framework.

The table below, provides a breakdown of the number of referrals seen in Primary Care (to undertake initial assessment) and the number of patients then seen by Secondary Care colleagues

2023	April	May	June	July	August	Septembe	October	Novembe	Decembe
Wet AMD RF (Specsavers)	104	135	140	115	125	111	120	123	89
Secondary Care	100	125	114	92	122	88	115	122	70

2.2.5 IPOS Urgent

Aneurin Bevan University Health Board established the IPOS Urgent service on 27th November 2023 with 15 Independent Prescribers providing the services across 14 practices with good coverage across all boroughs with the exception of Torfaen.

Borough	Practice name	Practice Address	Post Code
Blaenau Gwent	Williams & Parry	Williams & Parry Ltd, 50 Church st, Abertillery.	NP13 1DB
Blaenau Gwent	Williams & Parry	Williams & Parry Ltd, 17 Beaufort St, Brynmawr	NP23 4AG
Blaenau Gwent	EV Optical Centre	23 Market St, Ebbw Vale, NP23 6HL	NP23 6HL
Blaenau Gwent	Darlingtons	37 Commercial Street, Tredegar	NP22 3DJ
Caerphilly	Asda Blackwood	Asda Opticians, High Street, Blackwood	NP12 0NT
Caerphilly	Specsavers	59-61 Cardiff Rd Caerphilly CF83 1FP	Cf83 1FP
Monmouthshire	Monmow Eyecare	Monnow Eyecare, 11 Cinderhill Street, Monmouth	NP25 5EY
Monmouthshire	Monnow Eyecare	Monnow Eyecare, 11 Cinderhill Street, Monmouth	NP25 5EY
Monmouthshire	The Optical People	The Optical People, 6 St Mary St, Chepstow	NP16 5EU
Newport	Liverton Opticians	Liverton Opticians, 26, Charles St, Newport.	NP20 1JT
Newport	FL Wangler	FL Wangler Opticians, 282 Chepstow Rd, Newport	NP19 8NN
Newport	Specsavers	Specsavers, Spytty Rd, Unit 1, Tesco Extra Newport	NP19 4TX
Newport	Julian Davies	29 Commercial Road, Newport	NP20 2PB
Newport	R. W. Cole	58- 59 Commercial Road, Newport	NP20 2PF

This service has been established within Primary Care to allow non-accredited IP practitioners to refer directly to IPs for patients requiring urgent eyecare. However, this service does not replace HES, and therefore patients can still be referred to HES.

Since the establishment of the service **546** patients have received an IPOS Urgent initial assessment and **462** have received 'follow up' care in 23/24.

£125 can be claimed for a patient's initial assessment and £62 for a follow up visit.

Over the coming months, this service will expand as HES will be able to discharge patients out to Primary Care for ongoing care/monitoring. The IP Practitioner will be able to claim £94.00 for patients who are referred from HES.

The service is operating well and has been well received. The table below shows the number of claims in 2024/25 to date;

	WGOS 5 - IPOS Urgent			
	IPOS Urgent Initial	**IPOS Urgent Follow Up**	**IPOS Urgent DOM**	***Total WGOS 5 Claims***
April	196	222	0	*418*
May	194	204	1	*399*
June	225	235	2	*462*
July	257	263	2	*522*
	872	924	5	*1,801*

2.3 Backlog/Wait Times

Since the pandemic, Optometry services have seen a significant growth in patient demand and/or referral rates, resulting in an increase in patient wait times.

The table below details the wait times as at the end of 2023/24:

Position as at 15/02/2023			
	URGENTS - WAIT TIME UP TO 8 WEEKS	ROUTINE	
SPECIALTY	TOTAL NUMBER OF PATIENTS WAITING	TOTAL NUMBER OF PATIENTS WAITING	WAIT TIME (WEEKS)
AMD			
CATARACT	36	6606	92
CORNEA	0	463	88
Diabetic virtual - out patients waiting for Diabetic nurse appointments	4	165	28
GENERAL	20	812	53
GLAUCOMA HOSPITAL	20	365	53
GLAUCOMA ODTC - patients being seen via ODTC opticians for glaucoma check	18	873	45
LASER	8	82	30
MINOR OPS	3	120	53
ADULT OCULAR MOTILITY	4	180	72
ORTHOPTIST	18	199	38
OCCULOPLASTIC	64	552	87
PAEDIATRIC	3	548	47
RETINA	75	402	60
Grand Total	**273**	**11367**	

It is envisaged that the full implementation of all WGOS services, and particularly WGOS 4 and 5 through the development of integrated pathways will go some way to address the backlog with appropriate cases being managed in a Primary Care setting by suitably qualified practitioners and thus releasing some capacity in HES for Secondary Care to manage those cases that only they can manage.

The impact will be monitored closely and reported through the Health Boards Eye Care Collaborative Board.

2.4 Governance and Monitoring

The Primary Care Contracting Team has developed a robust monitoring process whereby data available to the Health Board (claiming and prescribing data) will be reviewed on a monthly and quarterly basis to identify trends and understand claiming and prescribing patterns. As the services evolve, so will the monitoring and support processes which will also include engaging with the profession. This will of course, support with financial reporting and planning.

WGOS services are also subject to Post Payment Verification (PPV) which is undertaken by NWSSP on behalf of the Health Board. Once the PPV team has undertaken their visit and the report has been finalised, this report is shared with the Health Board. The Health Board reviews each report received and for an error rate of 10% or more OR a recovery value of £1000 or more a practice visit is scheduled, for an error rate of 5%- 9% an initial

letter is issued to practices. Anything less than 5% results in no further action.

In addition to the Primary Care Contracting Team's monitoring process, the team continues to engage with the PPV team, the Eye Care Collaborative, Welsh Government and the National Eyecare Wales Committee.

Regular updates are provided to the profession by way of local communication.

Primary Care Contracting ensures that risk is managed appropriately and through prompt identification and assessment, reported into Divisional QPS. This ensures that where possible, the Health Board is informed of the risks that are present and how they are managed or minimised.

The GOS risk register is reviewed regularly and describes risks in sufficient detail so that they can be clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

2.5 Training

During 2023/24, the Health Board scoped practitioners with a higher qualification and the willingness to undertake first time/additional qualifications which was mapped at NCN level. The Health Board continues to work with HEIW in respect of training:

- 13 with therapeutics qualifications, 3 undertaking currently and 5 keen to undertake;
- 22 with certificate in glaucoma, and 2 keen to undertake;
- 14 with a certificate in med retina and 11 keen to undertake; and
- Paediatrics: 2 with higher qualifications and 4 keen to undertake.

2.6 Honorary Contracts

During 2023/24 the Primary Care Contracting Team facilitated the process to award 8 Honorary Contracts for Ophthalmology placements in the Royal Gwent Hospital:

- 4 Higher Qualification, Post Graduate Placements;
- 3 IP Placements; and
- 1 Optometrist.

2.7 Practice Closures/Relocation

To reflect the WGOS regulatory changes, a robust process is currently being developed across Wales regarding the notification and management of practice changes.

In March 24, Armstrong and North Opticians merged branches in Magor and Caerleon Road, and relocated to a new premise in Friars Walk in Newport. Patients were notified by email and telephone with the practice patient records transferred electronically to the new premise at Friars Walk in April 2024.

2.8 Accelerated Cluster Development (ACD)

Optometry Contract Reform also incorporates the Accelerated Cluster Development plan for Optometrists and Dispensing Opticians.

Welsh Government requested a Primary Care Collaborative Lead (PCCL) from each Optometry practice to be identified, who will engage and support the Collaborative Optometric Lead for each of the cluster/NCN areas across the Health Board. The PCCL will receive £1000 per annum and the COL will receive £2000 per annum. The National Health Service (Ophthalmic Services) (Wales) Regulations 2023 state that a contractor must attend at least 4 meetings per financial year.

The ACD was developed within Aneurin Bevan University Health Board in quarter 4 of 2023/24.

The Primary Care Contracting Team are currently developing a process, which will align with South East Wales (SEW) Health Boards to ensure compliance in line with the regulations.

Participation at cluster level will support the identification of Quality and Safety improvements within the borough footprint. There is also an expectation that pathways will be developed and tested, that optometry priorities will be aligned to the Health Boards overarching NCN plans, provide support and leadership for the profession and contribute to the Health Board's Neighbourhood Care Network IMTP plan.

There is currently no PCCL in Newport or Torfaen South, the NCN team continue to link with practices and SEW Regional Optometric Committee to ensure a lead is identified in order to take forward the NCN plans in this area.

2.9 Prison Services

Prior to 2023/24, Welsh Government developed narrative for inclusion within Health Boards Prison SLAs to ensure the new services that will be provided in community Optometry are factored into prison services ensuring equitable services for all and consistency across Wales. Following a robust procurement exercise in 2022/23, the prison Optometry contract was re-awarded to 'The Prison Opticians Ltd' from April 2023.

The Primary Care Contracting Team undertake regular monitoring of the service, in line with the wider processes.

2.10 Occupational Health Service

As part of the Optometry contract negotiations, the provision of an Occupational Health Service was agreed during 2023/24 for the following cohort of professionals providing WGOS services:

- Optometrists
- Dispensing Opticians
- Contact Lens Opticians

The service does include those in pre-registration training (student optometrists) and trainee opticians. *It is noted that the inclusion of student optometrists will be reviewed in 2024/25 in line with the changes to the undergraduate programme to an integrated MSc.*

The Health Board has commissioned the following via Occupational Health from April 2024:

- Needlestick/sharps injury service, including access to any relevant BBV screening including any related blood tests and any onward monitoring related to risk of infection
- Annual influenza vaccines
- Pre-placement health check using a standardised questionnaire for new starters, plus the provision of any necessary and essential vaccines and/or immunisations
- Baseline assessment of the vaccination status of current staff, with the offer of any necessary and essential vaccines and/or immunisations to be undertaken within the first year of the service being established
- Sickness absence assessment on request to assist with the management of sickness absence (both short and long term); including plans for supporting a return to work following long term absences

2.11 Eye Health Needs Assessment

As part of the NHS Legislative Directives each Health Board must prepare and publish an Eye Health Needs Assessment for its area. The first publication is required by March 2025 and every 3 years thereafter.

The Health Board has commissioned PCC to commence this requirement through 24/25.

2.12 Concerns/FOI

In respect of Optometry services, during 2023/24 the Primary Care Contracting Team received:

- 1 – PTR Concerns;
- 0 – MS/MP Requests; and
- 0 – FOIs.

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward.

2.13 Looking Ahead

Through collaboration and integration, the Primary Care Contracting Team will be developing and implementing the following services during 2024/25:

- WGOS 4
  - referral filtering
  - monitoring
- WGOS 5
  - discharge

The team will continue to engage with the profession, Secondary Care Ophthalmology colleagues and SEWROC to ensure services are patient focused and fit for purpose, taking ideas/plans forward via the Eye Care Collaborative Working Group and Board.

In addition to enhancing service provision, the Primary Care Contracting Team will also play a key role in shaping the Eye Health Needs Assessment.

3. General Medical Services

The Health Board is responsible for providing General Medical Services (GMS) to residents throughout Aneurin Bevan University Health Board and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.

Approximately 90% of all NHS patient interventions take place in the Primary Care setting.

During 23/24 there were 68 (*71 at the start of the 23/24*) General Practices that are responsible for providing care to patients between 08:00 and 18:30 Monday to Friday. Outside of these "core hours", access to medical care is provided by the Health Board's Out of Hours Service, which operates between 18:30 and 08:00 each weekday evening and throughout weekends and Bank Holidays.

Outside of the period the Urgent Primary Care Service provides clinical assessment including face to face consultation in urgent care centres in Newport, Abergavenny and Ystrad Mynach and also home visits where patient is medically unfit to attend one of the centres. Patients are initially assessed by the 111 service which is provided by the Welsh Ambulance Service Trust. More recently we have established an in-hours urgent care service in Newport and Abergavenny for those who have been diverted by the 111 service, the Emergency Department in the Grange University hospital or the Minor Injury Units in Abergavenny, Newport, Ebbw Vale and Ystrad Mynach.

During 23/24 the Health Board had five managed practices, Aberbeeg Medical Practice, Brynmawr Medical Practice, Blaenavon Medical Practice, Tredegar Health Centre and Bryntirion Surgery (plus Markham branch surgery), which were all successfully returned to Independent Contractor status by the 1st April 2024, through a robust recruitment process in line with the Health Boards Vacant Practice Process.

Practices continue to provide a blended approach to patient consultations, offering both face to face and remote consultations, as appropriate.

3.1 Access

The Health Board has a mature Access Group in place to review, sustain and develop Primary Care access within General Medical Services to ensure it is sufficient to meet the needs of the patient population and remains sustainable for the future.

The objectives are:

- Develop good quality access across Primary Care to ensure sustainability for future generations
- Consider and update on applications received from practices in relation to:
    - Branch Surgery Closures/reduction in service provision
    - Boundary Changes: monitor, review and consider applications
    - Plan and prepare for contract terminations/variations
    - List closure requests o Premise relocation
- Review GMS Access Achievement, mechanism for quality assurance for access
- Consider and develop schemes to help improve access via Task and Finish Groups where required

During 23/24 Access Group considered:

3.1.1 Branch Surgery Closure/Reduction

The Health Boards Access Group considered two applications to permanently close a branch surgery, one in Caerphilly North and one in Caerphilly South. All steps detailed in the Health Boards Branch Surgery Closure Process were followed and both applications supported with no reduction in overall service provision as both practices consolidated their resources onto their main sites.

One practice in Newport West submitted applications to reduce opening hours at both of its branch sites, one was supported and the other was declined due to a number of factors including proposed structural work required at the main site in the future.

3.1.2 Boundary Changes

Six practices submitted requests to redefine their practice boundaries in 23/24, one in each of the following areas; Torfaen South, Torfaen North, Monmouth South, Caerphilly South, Blaenau Gwent East and Newport West.

None of the practices were seeking to reassign patients that resided outside of their re-defined practice boundary and all requests were considered in line with the criteria set in the Health Boards process and supported by the Access Group.

3.1.3 Contract Resignations

General practice continues to face significant challenges including recruitment and retention of workforce, financial pressures and managing patient expectations and demand. In line with the Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice, the Health Board has a robust process in place to consider all GMS contract resignations, and upon receipt of a contract resignation the Vacant Practice Policy is implemented.

Each Vacant Practice is considered on its individual merit, in line with the Health Boards strategic plan and the local population health needs. When a Practice becomes vacant, the Health Board seeks to determine the most appropriate, sustainable option for the delivery of services to the registered population.

Following acknowledgement and early engagement, in confidence, with interested parties including neighbouring practices and local elected members, a Vacant Practice Panel is convened with representatives from Health Board officials, Llais Cymru and the Local Medical Committee (LMC).

At the Vacant Practice Panel meeting, the options for the future of the practice where a vacancy is declared are discussed and a recommendation reached. The options are listed below (options 1-6 do not have to be considered in sequential order, and/or each one implemented before considering the next option. Option 1,2 and 3 may be considered together):

Option 1: *Aim to fill vacancy through local interest under a GMS Contract, (the practice could be passed completely over to another practice in the borough under GMS Contract arrangements (through inviting local expressions of interest))*

Option 2: *Aim to fill vacancy through national interest under a GMS Contract, (the whole practice would be advertised nationally as a vacancy under current GMS Contract arrangements)*

Option 3: *Managed list dispersal with existing neighbouring practices (through inviting local expressions of interest). Practices to consider taking on a proportion of the list*

Option 4: *If vacancy not filled, the LHB take on the management and delivery of GMS services, in accordance with GMS Regulations*

Option 5: *Dispersal of practice list (the LHB decide to disperse the practice list)*

Option 6: *Fill the vacancy through interest from existing/remaining partners (where clauses 525-529 of the GMS contract do not apply (existing partners agree to the transfer of the existing contract to one or more of the existing partners following dissolution)) aim to fill the vacancy through interest from existing partners*

The Health Board will be required to undertake a procurement exercise in relation to options 1-3. Practices may be required to attend for interview at a later stage.

*** Options 1, 2, 4 and 6 maybe subject to Policy for the Reassignment of Patients whose Address is outside the Catchment Area of their Registered GP & Application Process.*

The panel recommendation is presented to the Health Boards Executive Team for consideration and ratification.

During 23/24, the Primary Care Contracting Team managed the Vacant Practice Process for four Independent Contractors and also followed the same process to return the directly managed practices to Independent Contractor status.

- Meddygfa Gelligaer, Caerphilly North, 8,194 registered patients -GMS contract successfully awarded to new GP partnership; Dr Allinson and Dr Ahmed.
- The Mount Surgery, Torfaen North, 11,348 registered patients – GMS contract successfully awarded to new GP partnership; Dr Allinson and Dr Ahmed.
- Churchwood Surgery, Torfaen North, 7,037 registered patients – GMS contract successfully awarded to new GP partnership; Dr Allinson and Dr Ahmed. Churchwood Surgery occupied the same premise as The Mount Surgery and both contracts subsequently merged to form Pontypool Medical Centre.
- The Lawn Medical Practice, Caerphilly North, 5,661 registered patients. GMS contract successfully awarded to Dr James and Partners of Meddygfa Cwm Rhymni. Both practices occupied the same premise and the Health Board supported the subsequent merger of these practices under the name of Meddygfa Cwm Rhymni.
- The GMS contracts for the directly managed practices were awarded to the partnership of Dr Allinson and Dr Ahmed;
    - Brynmawr Medical Practice, Blaenau Gwent East, 10,769 registered patients
    - Aberbeeg Medical Practice, Blaenau Gwent East, 4,696 registered patients
    - Tredegar Health Centre, Blaenau Gwent West, 6,666 registered patients
    - Bryntirion Surgery, Caerphilly, 11,107 registered patients
    - Blaenavon Medical Practice, Torfaen North, 6,586 registered patients

3.1.4 Practice Mergers

General Practice has changed considerably in recent times and is evolving from your small local GP to larger Health and Well Being centres with average list sizes in excess of 10,000 patients. It is on this scale that a wider skill mix can be explored, and prudent health care embraced. With a larger critical mass of patient's economies of scale can be achieved. There are many advantages to practice – economies of scale, knowledge and skills pooling, and improved quality of care for patients.

The Health Board first rolled out a discretionary payment scheme in 2015 to support practices that are considering merging and it was re-launched in 2023/24.

The scheme is backed by significant financial incentive payments. Any practice in Aneurin Bevan Health Board area can apply, regardless of its current sustainability situation, however prior consideration may be given

to those considered more vulnerable depending on their sustainability risk matrix scoring. This scheme applies only to practices in Aneurin Bevan Health Board area. A typical merger between two practices may attract payments of approximately £30,000.

There were no direct applications under the scheme for 23/24 however, the Health Board was able to provide support to three practice mergers under elements of the scheme. In addition to Pontypool Medical Centre and Meddygfa Cwm Rhymni already discussed, St David's Clinic and St Brides Medical Centre in Newport West, whose GMS contracts were held by the same partnership formally merged with St Brides Medical Centre becoming a branch site.

The table below shows the contractual changes for 2023/24:

23/24	Apr-23	Contract Resignation	Meddygfa Gelligaer, Caerphilly
	Apr-23	Merger	St Brides Medical Centre became branch of St David's Clinic
	Apr-23	Branch Closure/Boundary Change	Bedwas – branch of Aber Medical Centre, Caerphilly
	Apr-23	Boundary Change	New Chapel Street Surgery, Torfaen
	Jul-23	Boundary Change	Trosnant Lodge, Torfaen
	Jul-23	Contract Resignation	The Mount Surgery, Torfaen
	Aug-23	Contract Resignation	The Lawn Medical Practice, Caerphilly
	Sep-23	Merger	Meddygfa Cwm Rhymni & the Lawn Medical Practice
	Sep-23	Contract Resignation	Churchwood Surgery, Torfaen
	Oct-23	Branch Closure	Deri, branch of Meddygfa Cwm Rhymni, Caerphilly
	Oct-23	Boundary Change	Castle Gate Surgery
	Oct-23	Boundary change	The Village Surgery
	Oct-23	Merger	The Mount Surgery & Churchwood Medical Centre, Now Pontypool Medical Centre
	Dec-23	Boundary change	Blaina Medical Practice
	Jan-24	Boundary change	Westfield Medical Centre
	Jan-24	Contract Awarded	Tredegar Health Centre, Blaenau Gwent (Managed Practice)
	Apr-24	Managed Practice Contract awarded	Aberbeeg Medical Practice, Brynmawr Medical Practice, Bryntirion Surgery & Blaenavon Medical Practice

3.2 Sustainability Assessment Framework

There is a national framework in place that provides a consistent approach to the assessment of the sustainability of practices and enables practices to request support. In lieu of physical resource, Aneurin Bevan University Health Board has a mechanism in place to determine a level of financial support available to practices, under this framework.

The 'financial calculator' applies a consistent formula to enable partial reimbursement for locum sessions for those practices that have a shortfall in their core clinical sessions against the local benchmark of 1 clinical session per 200 registered patients. This ensures the sustainable delivery of services whilst the practice seeks to recruit permanent staff, whilst mitigating some of the financial risk.

During 2023/24 6 practices received a financial support package under the framework; Blaenau Gwent East x2; Blaenau Gwent West x1; Caerphilly North x1; Caerphilly South x1 and Torfaen South x1.

With all sustainability applications, financial support is subject to regular review and ongoing monitoring, and the Health Board reserves the right to adjust for any significant changes in circumstances. Practices are required to demonstrate that they are undergoing active recruitment campaigns.

3.3 General Practice Escalation

GMS practices are required to accurately report their escalation level monthly and/or when it changes. The contracting team and respective borough teams continue to support the practices in escalation in line with the agreed process, with additional on the day support from Urgent Primary Care if required, for practices reporting level 3 and above. Gwent Local Medical Committee (LMC) continue to promote accurate escalation, and the contracting team has prepared a presentation for Practice Manager forums to support with the escalation process.

ABUHB Practice Reported Escalation Status 2023/24				
Escalation Level	**1**	**2**	**3**	**4**
Qtr 1	59	10	1	0
Qtr 2	52	15	1	1
Qtr 3	37	21	9	1
Qtr 4	35	20	11	2

Demand on General Medical Services (GMS) remained high throughout 2023/24 particularly during Winter months as highlighted in the table above.

In September 2023, the Welsh Government, NHS Wales and General Practitioners Committee were engaged in negotiations for the GMS Contract 2023/24. In December 2023, negotiations reached an impasse whereby a negotiated contract agreement was not mutually agreed upon. In response, the LMC wrote to GP practices highlighting how escalation levels are reported to the Senedd, public and wider level and encouraged practices to accurately record and maintain escalation levels. Therefore, practices reported an increase in escalation levels in quarter 3 and quarter 4 2023/24.

Escalation reported by practices via the Primary Care Information Portal (PCIP) in quarter 1 2024/25 shows a reduction in level 3 and 4 escalation levels as outlined in the table below.

ABUHB Practice Reported Escalation Status 2024/25				
Escalation Level	**1**	**2**	**3**	**4**
Qtr 1	36	25	6	1

3.4 Enhanced/Supplementary Services

The Enhanced Services Operational Group is established to develop and monitor primary care enhanced/supplementary services, ensuring a consistent approach is applied to the delivery and management of the services.

Enhanced/ Supplementary Services are, in essence, an element of core provision delivered to a higher specification, outside of the normal scope of primary medical services which are designed around the needs of the local population and provide the Health Board with the opportunity to develop more local and integrated services across primary and secondary care. Enhanced/Supplementary Services are optional for practices to deliver and are commissioned by the Health Board from those practices who can meet the requirements within the service specification.

In order to deliver effective and efficient Supplementary Services in primary care it is crucial that there are:

- Appropriate facilities in local communities as referred to above. Contractors must ensure they meet required health and safety standards for primary care premises.
- Staff with appropriate skills, knowledge and attitude to meet the needs of the local population.
- Practices with systems to ensure effective communication in place, between all primary care professionals and patients, to support the delivery of high-quality primary care.

During 2023/24 the following services were commissioned Quality Improvement Framework (QIF) and GP Contract (sharepoint.com);

Directed - all LHBs must commission or provide

Service	**% Practices Commissioned 23/24**
Pneumococcal	100%
Childhood Imms	100%

Asylum Seeker	41%
Learning Disability	91%
Violent Patients (Alternative Treatment Scheme)	1 practice commissioned via SLA
Minor surgery - Fee A & B	78%
Minor surgery - Fee B Only	88%
Diabetes Gateway DES	90%
Care Home	72%
Anti-coagulation Level A & B	85%
Anti-coagulation Level B Only	10%
Homeless	13%
Gender Identity for Registered Patients or on behalf of the NCN	37% registered and 9% for NCN

National - all LHBs should commission or provide but not mandatory

Service	**% Practices Commissioned 23/24**
GLP1 Monitoring	44%
Flu Immunisation	100%
Unscheduled Immunisations	100%
Non-Routine Imms	88%
Substance Misuse	18%
Shingles	100%
Rota virus	98%
Meningitis	100%

Catch Up Programme Vaccination of Children Who Have Outstanding Immunisations	34%
People Fleeing War and Persecution in Ukraine	35%

Local - optional commissioning of services based on local need

Service	% Practices Commissioned 23/24
Minor Surgery Non-Registered patients	10%
DOAC Initiation & Monitoring	84%
DOAC Monitoring Only	16%
Depo-Provera	96%
Depo/Sayana Press	25%
Contraceptive Implants (Nexplanon) for Registered and Non-Registered Patients	56% registered/ 3% non-registered
Depression/Lithium	50%
IUCD Registered and Non-Registered Patients	54% registered/ 29% non-registered
Near Patient Testing	97%
Denusomab	94%
Pertussis	100%
Gonadorelin/Zoladex	100%
Extended Minor Skin Surgery	12%
Additional Clinical Sessions (suspended January 2024)	40%

A Schedule 7 is prepared annually and shared with each contractor which details each Supplementary Service the contractor is commissioned to provide.

3.4.1 Alternative Treatment Scheme

Welsh Government issued WHC 2002 (082) "Stopping Violence against Staff Working in the NHS: Tackling Violence Against those in Primary Care". This guidance stated that professionals and staff working in the health service would no longer tolerate aggression, violence and threatening behaviour by the public. The report recommends that Health Boards adopt a "zero tolerance" approach to patients, relatives and members of the public who use violence and aggression towards NHS staff.

The ATS was introduced as a Directed Enhanced Service in 2004 with the aim of providing a secure environment in which patients who have been violent or aggressive in their GP practice can receive General Medical Services.

The right of individuals to receive mainstream primary care services remains a fundamental principle of the NHS and patients who have been subject to immediate removal from a practice list will not be excluded from receiving primary care services.

The ATS is designed to provide General Medical Services to patients who meet the criteria for inclusion into the Scheme.

This Scheme allows Health Boards to balance the rights of patients to receive services from GPs whilst ensuring that GPs, practice staff and bystanders are able to deliver a service without threats or occurrences of unacceptable behavior.

The incident leading to the immediate removal of the patient from the practice list and into the Scheme, whether it is as a result of unacceptable actions, threats or inappropriate behavior must be in accordance with the GMS Contract Regulations 2023.

During 2023/24 13 referrals were received for the scheme of which 7 were accepted and 6 rejected.

St Julians Medical Centre in Newport, is commissioned via SLA to provide this service across the Health Board area.

3.4.2 Welsh Government Additional Capacity Funding

First available in 2021/22, this scheme is to fund additional staff resources (GPs, practice nurses, administration staff etc.) above what is already in place within GMS.

For 2023-2024, the Health Board was allocated £763,630 to enable the reimbursement of up to 50% of the total cost (salary / sessional fee & on-costs) of either additional posts upon appointment (including those in post from December 2021 under the 2021-22 scheme) or additional hours worked by existing post holders. Practice allocation is based on patient list size.

Four practices confirmed that they would not be utilising their allocation and this was distributed between the remaining practices. Reimbursement is made on the submission of verified claims and the total amount of funding utilised in 23/24 totalled £724,197.57

Welsh Government Additional Capacity Utilisation in Hours

Role	2023/24**	2022/23**	2021/22
GP	5,522.20	9,054.47	801.3
Nurse	11,213.91	4,842.84	808.5
Other Healthcare	7,744.69	4,312.08	149
Admin	49,016.17	27,041.96	4,832.90
Total	**73,496.97**	**45,251.35**	**6,591.70**

**** number of hours is the 100% figure stated on the claim form but funded for 50%**

The additional capacity is aimed to support the backlog in Primary Care as a result of the pandemic.

This funding is time limited and will be available up to 31st March 2024. However, if those posts/hours continue after April 2024 they may be eligible for 50% match funding under the new 2024-25 scheme.

3.4.3 Child Health

The Healthy Child Wales Programme (HCWP) sets out what planned contacts children and their families can expect from their Health Boards; from maternity service handover to the first years of schooling. These universal contacts cover three areas of intervention: screening, immunisation and monitoring and supporting child development.

The 6–8-week examination is delivered by Health Boards and undertaken by General Practitioners as part of the GMS contract. An internal process has been implemented for the monitoring of the uptake of the 6 – 8 week baby checks in General Practice. This provides assurance that GP practices are undertaking 6 – 8 week baby checks in line with the Unified Services element of the GMS Contract

and the Healthy Child Wales Programme. The process has been developed in collaboration with Child Health Department.

The childhood immunisation programme is delivered by Health Boards and undertaken by General Practitioners as a direct enhanced service. An internal process has been implemented to monitor practice immunisation queues in General Practice. This provides assurance that GP practices are undertaking childhood immunisations in line with the DES and the Healthy Child Wales Programme. The process has been developed collaboratively with the immunisation team within ABUHB.

3.5 Access Standards

In October 2022, Welsh Government announced that the current Access Pre-qualifiers (Phase 1) would move into the Unified Contract from 1st April 2023. Additionally, Phase 2 Access Standards would run for a further year to 31st March 2024 to allow for evaluation. Practices are required to report against the access standards each quarter, with achievement measured as at 31st March each year.

Standard	Standard Requirement
1	All existing patient facing staff who did not undertake the national care navigation training package provided by HEIW in the financial year 2022/23 are required to undertake this training, as well as all new patient facing staff completing this training within 3 months beginning with their start date. Practices will supply names of new starters and date of training undertaken.
2	All patients telephoning the practice are to have their calls received by a standard recorded message, and subsequently calls are answered with appointments made available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without 4 the need for the patients to contact the practice again. Where clinically appropriate, patients may be signposted to another appropriate service.
3	To maintain a planned and forward-looking approach to consultations, practices to undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable. A more planned and forward-looking approach should be taken to the scheduling of appointments throughout the day, or for future dates, meaning it is no longer acceptable for all appointments for that day to be released at 8.00am.
Standard	**Standard Requirement**

4	Practices must confirm each quarter that they regularly maintain an automated and standardised public facing dashboard and make this available via a range of communication methods to meet the needs of their patients. (an Infographic is available via the PCIP for practices to use)
5	Practices are required to undertake the national patient experience survey which should include 25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods.
Standard	**Standard Requirement**
6	Practices are required to undertake care navigation on digital requests in a similar and equitable fashion to telephone requests

Practices are also required to produce a reflective report to include; Equality Impact Assessment, Patient Engagement, National Patient Experience Survey, Patient Survey Action plan, Digital Request and Telephone System Intelligence. The Primary Care Contracting Team reviewed all evidence submitted by practices, and provided support to those facing challenges in uploading the relevant documentation. 100% of practices reported 100% achievement in 2023/24.

3.6 Quality Improvement Framework

As set out in The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, GP practices are required to fully evidence completion of all three Quality Improvement (QI) projects to be in receipt of aspiration, interim and full achievement payments. The time period applied to the QI projects was 1st October 2022 to 31st March 2024.

The three mandatory projects were: -

a) GP activity data QI project (35 points)

b) Green Inhaler – Phase 2 QI project (35 points), and

c) Unhealthy Behaviours (100 points)

At the 31 March 2024, contractors were required to submit evidence to the Local Health Board against each of the three QI projects for verification and were provided with national templates to support submissions.

The Primary Care Contracting Team reviewed submissions for all GMS practices to ensure sufficient evidence of achievement had been provided.

On initial review, 46 practices were rejected on the portal due to insufficient evidence provided as at the 31st March 2024.

Common themes for rejection of evidence included; insufficient evidence against requirements set out in Welsh Government guidance. The late release of QI 1 poster template to practices meant that a number of practices reused the poster for 2022-23 titled 'Access and GP Data Activity'. This led to misinterpretation of what information was required by practices for inclusion in the poster.

Practices were given the opportunity to resubmit evidence via PCIP up until the 21st May 2024 to allow time for review prior to the portal closing again on 31st May 2024.

67 out of 68 practices within ABUHB met all requirements set out in Welsh Government guidance against all three mandatory projects.

During both Access and QIF cycles, there had been a small number of practices whereby there has been a change in partnership or merge. Therefore, a manual calculation has been made using the Statement of Financial Entitlement (SFE) to ensure both outgoing and incoming partnerships received appropriate payment, pro rata, for their contributions to the work involved.

3.7 Prison

Primary Care General Medical Services (GMS) services are being provided at both HMP Usk and HMP Prescoed via a Service Specification in accordance with the requirements of the General Medical Services contract and in accordance with the NHS (GMS) Contracts Regulations 2023. This includes but is not limited to the provision of Unified Services described in the GMS contract and Supplementary Services as agreed between provider and commissioner.

Prescoed is a category D prison and Usk is category C open resettlement prison. Current population of 276 at Usk and 340 at Prescoed.

Malpas Brook Health Centre provide general medical services on a sessional basis at both HMP Usk and HMP Prescoed and are commissioned to provide 5 sessions per week across both sites.

3.8 Governance

The Primary Care Contracting Team have robust mechanisms in place to monitor all contract delivery on a monthly basis, and specifically for reviewing claiming data in respect of locum reimbursement payments and

Enhanced/Supplementary services to ensure timeliness of submissions. The Enhanced/Supplementary services monitoring also enables the team to identify any gaps or anomalies in claims which may highlight staffing or training issues at practice level. Appropriate support is provided to practices to ensure practice cash flow is maintained and training issues are addressed. It also allows for the contracting team to identify where practices may be commissioned but not delivering a service and allow for appropriate steps to be taken.

Primary Care Contracting ensures that risk is managed appropriately and through prompt identification and assessment, reported into Divisional QPS. This ensures that where possible, the Health Board is informed of the risks that are present and how they are managed or minimised.

The GMS risk register is reviewed regularly and describes risks in sufficient detail so that they can be clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

The Post-payment Verification (PPV) service is delivered by NWSSP on behalf of Health Boards providing assurance to Health Boards that claims made by GP Practices are appropriate and in line with the regulations set and guidance documents issued.

The PPV programme runs on a three-year cycle, monitoring a third of the contractors each year. A random sample of claims are reviewed and verified against the patient's clinical record.

Once the PPV team has undertaken their visit and the report has been finalised, this report is shared with the Health Board.

The Health Board reviews each report received and for an error rate of 10% or more OR a recovery value of £1000 or more then a practice visit is scheduled, for an error rate of 5%- 9% an initial letter is issued to practices. Anything less than 5% results in no further action.

During 2023/24 the Health Board received 36 reports for GP practices, 22 of which required primary care action including 3 meeting the criteria for a practice visit. Of these, 2 practices had received a PPV final visit due to the GMS Contract ending. In total £60,700.38 was recovered due to claims errors.

HIW inspect all GMS practices for clinical and managerial/administrative compliance, providing a report of each inspection to the practice and the Health Board identifying any areas for improvement. A total of four HIW

inspections were carried out in 2023/24 compared to two HIW inspections undertaken in 2022/23.

Of the GP practices inspected in 2023/24, three practices received an improvement plan and one practice an immediate improvement plan. Practices engage directly with Health Inspectorate Wales and the Health Board offers support and guidance to a practice before and after inspections have occurred.

3.8.1 Annual Contract Review

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, requires general practice contractors to comply with all relevant legislation and submit an annual return relating to the contract to the relevant Health Board. The same categories of information will be requested from all persons who hold GMS contracts with the Health Board. Failure to comply could result in the Health Board activating remedial notice procedures.

General Practices are required to work collaboratively with the Health Board by completing an Annual Contract Return (ACR) self-declaration to evidence their compliance with contractual and statutory requirements. The annual review process has varied over recent years in order to adopt the most suitable approach and to avoid undue bureaucracy. The process provides assurance that General Practice contractors are meeting their contractual and statutory obligations.

All practices were required to complete the GMS Contract Annual Return for the period April 2023 to March 2024 via Microsoft Forms. Annual Contract Review visits are an opportunity to review any challenges over the previous 12 months and any particular contractual concerns as well as sharing best practice. Visits are led by the Primary Care Contracting team, alongside a Primary Care Clinical Director. Practices are prioritised for a practice visit, based on their submissions, with all practices offered an opportunity to meet each year should they wish.

The way in which this process in managed is changing for 24/25, in line with the 2023 Regulations.

3.9 Concerns/FOI

In relation to GMS, in 2023/24, the team investigated and responded to a total of:

- 19 FOI requests;
- 16 PTR concerns; and

- 51 MS MP concerns.

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward. Common themes include access to GP appointments, difficulties in contacting practices and access to vaccines and immunisation.

3.10 Looking Ahead

The following information is based on local knowledge and at this stage there is no indication that any of these practices present a change to their current service.

Blaenau Gwent
Currently no single-handed contractors or managed practices.

Caerphilly
Single Handed Contractors:

Practice	Location	List Size
Sunnybank Health Centre	Caerphilly East	5,592
South Street Surgery	Caerphilly North	3,275

No current concerns.

Monmouthshire
Single Handed Contractors:

Practice	Location	List Size
Wye Dean Practice (Tintern)	Monmouth South	1,934

No current concerns.

Newport:
Single Handed Contractors:

Practice	Location	List Size
St Paul's Clinic	Newport West	6,582

Torfaen:
There are no single-handed contractors or managed practices.

3.10.1 Contract Variations

In March 2024 68 practices in ABUHB were given notice under clause 516 of the Contract that the terms of the Contract are varied with effect from

1st April 2024. These variations are made in order to ensure that the Contract complies with the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 (as amended).

4. Pharmaceutical Services (Community Pharmacy)

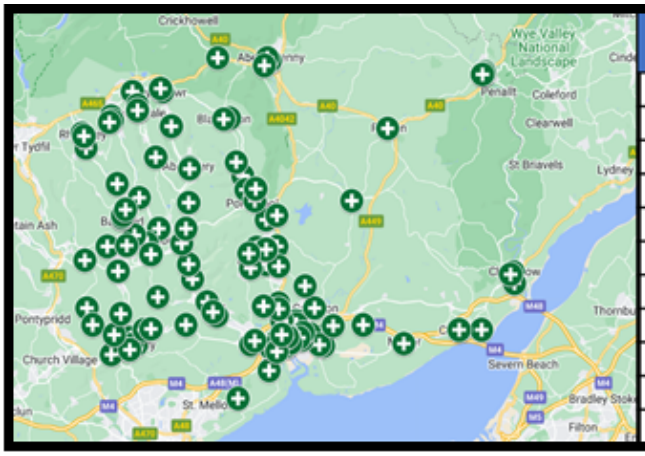
The Health Board has an obligation to make arrangements for the provision of proper and sufficient drugs, medicines and listed appliances ordered for its population. It does this by commissioning provision from 125 pharmacies and 12 dispensing doctors in accordance with the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020.

Alongside dispensing services, the Health Board also commissions a range of additional clinical services from community pharmacies utilising the provisions in the Pharmaceutical Services (Clinical Services) (Wales) Directions 2022.

This report focusses on the pharmaceutical services provided by Community Pharmacies.

4.1 Distribution of services

The 125 community pharmacies are distributed across the Health Board area in line with population need identified by historical arrangements for control of entry. The pharmacies provide NHS services as set out in the 2020 regulations and this is managed by inclusion in a pharmaceutical list maintained by the Health Board.



Neighbourhood Care Network	Number of Pharmacies
Blaenau Gwent East	7
Blaenau Gwent West	9
Caerphilly East	13
Caerphilly North	14
Caerphilly South	14
Monmouthshire North	10
Monmouthshire South	7
Newport East	13
Newport West	17
Torfaen North	10
Torfaen South	10

4.2 Pharmaceutical Needs Assessment

The NHS Wales Act 2006 requires health boards to produce a statement of their needs for pharmaceutical services, this statement is termed the Pharmaceutical Needs Assessment (PNA) and must be published every five years. The Health Board's first PNA was published on 1st October 2021 and

is used when considering whether or not to grant applications to join its pharmaceutical list or dispensing doctor list under the 2020 regulations.

The PNA does not identify any existing additional pharmaceutical needs for Aneurin Bevan University Health Board. A geographical inequality was identified regarding the provision of the Seasonal Influenza Vaccination Service and the Smoking Cessation Service and was addressed by utilising existing pharmacies to meet the need.

Market changes and contractor restructuring has resulted in six pharmacies withdrawing from the pharmaceutical list since the PNA was published. The five pharmacies in the table below all ceased to operate during 2023/24.

Pharmacy	Address	NCN
Boots	Caerleon Rd	Newport East
Boots	Chepstow Rd	Newport East
Boots	Pontypool	Torfaen North
Knights Pharmacy	Newbridge	Caerphilly East
Avicenna Pharmacy	Ystrad Mynach	Caerphilly North

Following each closure, local engagement processes and submissions from remaining contractors were used to inform the Primary and Community Care division's Senior Leadership Team. No gaps in provision were identified as a result of the closures and no replacement services were sought.

Planned housebuilding and the creation of new communities has identified a future need for pharmaceutical services in Newport East and Torfaen North. The needs are contingent upon defined house completion levels within each of the identified areas and this is monitored by periodic contact with the site developers. Current building rates suggest that the need is not likely to be realised during the lifetime of the 2021 PNA.

4.3 Opening Hours

Community pharmacies included on a Health Board's Pharmaceutical List must open for 40 "core" hours during which they provide NHS pharmaceutical services. Pharmacies may also open for additional hours and these are termed "supplementary" hours. Initial pharmacy submissions of core and supplementary hours must be accepted by the Health Board without variance. However once submitted, core hours can only be varied with the consent of the Health Board. Supplementary hours may be changed without consent. All changes to hours are subject to a 90-day notice period.

Pharmacy opening hours across Gwent range from 8am to 8pm Monday to Saturday with some pharmacies open between 10am and 4pm on Sundays. The majority of opening hours are between 9am and 6pm Monday to Friday. Sixty-five (52%) pharmacies are open on Saturdays although only a third of these are open all day with the remainder closing by early afternoon. Eight pharmacies open on Sundays.

The Health Board has seen a significant rise in applications to reduce core hours, notably to close on Saturdays, and a corresponding rise in notifications to reduce supplementary hours. Since 2018-19, thirty pharmacies have ceased trading on Saturdays. The majority of applications and notifications citing lack of footfall, recruitment and retention challenges, and operating costs threatening pharmacy viability as reasons for the change. Sunday opening has remained consistent with only one pharmacy closing since 2018-19.

In response to the increase in applications to change core hours, the Health Board has convened a change of core hours review panel and formalised a policy for the amendment of community pharmacy opening hours and withdrawal from the pharmaceutical list.

All applications to change core hours are subject a four-week patient consultation period and are scrutinised by the pharmacy team before being presented alongside an options paper to the Panel. Panel decisions are ratified by the Primary Care and Community division's Senior Leadership Team. Decisions made take into account the existing Pharmaceutical Needs Assessment. To date, the panel has not identified a need for a new pharmacy or a new service provision.

To ensure citizens have access to medicines during the out of hours period, a pharmacy rota service is commissioned as an additional service outside of the core and supplementary hours requirements.

4.4 Contract Monitoring.

To ensure pharmacies provide their NHS services in line with their NHS terms of service, two health board officers visit each of the one hundred and twenty-five pharmacies at least once every three years. The visits are conducted according to the formal community pharmacy contract monitoring process.

In 2023/24 forty-one pharmacies received contract monitoring visits. Twenty-nine were fully compliant with their terms of service at the point of monitoring or at the end of a one-month local resolution period. Utilising

the arrangements laid out within the terms of service for performance related sanctions, twelve non-compliant pharmacies were issued with Remedial Notices. Nine of these pharmacies made the necessary adjustment to practice to comply with their terms of service and the Remedial Notices were withdrawn. One remedial notice is still in place and we are working with the contractor to attain compliance.

Two pharmacies did not respond to the Remedial Notice within the allocated timeframe and have been issued with Breach Notices. None of the breaches relate to terms of service that have an impact on patient safety and the Health Board continues to work with the contractors concerned to attain compliance.

4.5 Dispensing Activity

The community pharmacies included on the Health Board's Pharmaceutical List are operated by different contractors ranging from single handed independent pharmacies, through small chains to large national chains with multiple pharmacies. During 2023-24 the pharmacies dispensed a total of 16,384,273 prescription items. An average of 315,000 items each week.

Depending on the geographical location and the communities the pharmacies serve, the dispensing activity ranges from 800 to 6000 prescriptions a week.

4.6 Additional Service Activity

4.6.1 Clinical Community Pharmacy Service

Alongside dispensing activity, all community pharmacies in Aneurin Bevan University Health Board offer the NHS Clinical Community Pharmacy Service (CCPS). A nationally directed service within the community pharmacy contractual framework.

The CCPS comprises the following five components:

- The provision of emergency contraception
- The provision of Bridging and QuickStart contraception
- The supply of prescribed medicines in an emergency
- The provision of the national common ailments service
- The provision of seasonal influenza vaccinations

During 2023-24 community pharmacies provided over 90,773 patient consultations through the service.

Service name	Activity
Emergency Contraception	4,228 consultations
Bridging and Quickstart Contraception	163 consultations
Emergency Supply	18,668 consultations (31,661 medicines)
Common Ailments	53,619 consultations
Seasonal Influenza	14,095 vaccinations

The other nationally directed community pharmacy services available within the Health Board are the Discharge Medication Service and the Pharmacy Independent Prescriber service.

4.6.2 The Discharge Medication Review Service

The service offers an additional safety assurance by reconciling a patient's medicines after being discharged from hospital. Because if the transfer of care, there may be differences in the medicines compared with those the patient used before admission.

All pharmacies in the Health Board are commissioned to provide the directed service but not all actively provide it on a regular basis. During 2023-24 one hundred and one pharmacies (81%) provided 2,403 Discharge Medication Reviews (DMRs) between them.

The clinical record system used in the Gwent hospitals is incompatible with the national system developed for the DMR service and our patients are at a disadvantage compared to those discharged from other hospitals. Our information transfer is reliant on paper records and self-referral compared with automated electronic notification in other areas. Our Health Board has the second lowest uptake of DMRs per unit of pharmacy activity of all seven Health Boards in Wales. The IT compatibility issue has been raised directed with Digital health and Care Wales and the Executive team in ABUHB, a new system to replace Clinical Work Station (CWS) is currently being explored with "open" architecture which would support the electronic transfer of this information to the Community Pharmacy System (Choose Pharmacy).

4.6.3 The Pharmacist Independent Prescriber Service

Pharmacy: Delivering a Healthier Wales, the pharmacy profession's vision for the development of pharmacy to meet the Welsh Government's long-term vision for health and social care, identified a goal to have a Pharmacist Independent Prescriber in every community pharmacy in Wales by 2030.

The Health Board has been involved in this journey since its inception, developing local pilot services and collaborating on a national approach. From tentative first steps with seven community pharmacists qualifying in 2019, the Health Board now has thirty-nine community pharmacies (31%) commissioned to provide the service in line with the national service specification.

During 2023-24, ABUHB pharmacies provided 11,677 consultations via the service. Growth is again expected in future years with approximately thirty pharmacists entering training each year.

The current rate limiting step for growth is the lack of prescribers willing to act as Designated Prescribing Practitioners to supervise candidates entering training. With more employment options for qualified pharmacist prescribers, retaining them in community pharmacy once qualified is also challenging.

4.6.4 Local Additional Services

Alongside the directed services detailed above, the Health Board commissions additional clinical services locally. The services include:

Service name	Number of pharmacy providers
Care Home Support	4
Covid vaccination service	5
Directly Observed Therapy	commissioned on demand
Inhaler use review	43
Medicines Administration Record Supply	106
Needle Exchange	27
Out of hours rota	64
Palliative Care Out of Hours	7
Prison supply service	1
Smoking cessation level 2	123
Smoking Cessation level 3	93
Sunday rota	25
Supervised Consumption	115
Tuberculosis Compliance Support	2
Urgent Medicines Supply	24

Waste Reduction Intervention	107

The Health Board commissions these services via 764 individual service level agreements stipulating provision in line with agreed national or local service specifications. The commissioning arrangements are dependent upon local and overall need and geographical location. For example, the seven pharmacies commissioned for the out of hours palliative care service work with the ABUHB OOH and provide for the entire Gwent region. Smoking cessation is commissioned much more widely to ensure good local access. Given the range and nature of services available, activity information can be provided separately on request.

4.7 Governance

Governance regarding the NHS Terms of Service for community pharmacy is managed through the Contract Monitoring Process identified earlier in this document. Annual reporting of clinical and information governance feed into the monitoring process and issues of suspected non-compliance are managed through the performance related sanctions described in the 2020 regulations.

The community pharmacy team also provide local scrutiny of additional clinical service provision. For the Pharmacy Independent Prescriber service, prescribing trends are regularly monitored to identify potential variance from the service specification. Services where supplies are enabled by Patient Group Directions (PGD) undergo the same scrutiny with a focus on service specifications and PGD requirements.

Potential discrepancies are firstly discussed with pharmacy superintendents for local resolution with continued monitoring evaluating compliance. Sanctions are limited to suspending or removing a service, but as these impact upon patients' access to NHS care, support and guidance is the usual route to resolution.

Claims for service activity are monitored against commissioning information and account schedules paid by NHS Wales Shared Services Partnership. Monitoring of dispensing is managed as part of medicines management overseen by the wider pharmacy team.

Information Governance

With community pharmacists and technicians having access to the NHS Wales "Choose Pharmacy" platform, related information governance around access is also managed by the community pharmacy team. A formal

process is in place utilising the National Intelligent Integrated Audit Solution (NIIAS) to monitor access. In common with the service scrutiny above, reports are sent to superintendent pharmacists for local resolution. The ultimate sanction is removal of access rights. During 2023-24 forty-four potential breached were identified, documented and communicated to superintendent pharmacists for investigation and appropriate action.

DATIX Reporting

Community pharmacies in Wales are obligated to submit reports of patient safety incidents via the Once for Wales Primary Care Wales National Incident Reporting tool, DATIX Cymru. Each submission comes to the Health Board to be closed. Whilst it's important to note that it's the pharmacy that is responsible for investigating and managing incidents, acknowledging receipt and closing the reports is an additional function of the community pharmacy lead with support from a medicines management technician. During 2023-23 three hundred and eighty-four incidents were receipted and closed. For context, over sixteen million prescription items and one hundred thousand patient consultations were completed during the same period.

4.8 Performance Related Sanctions

The 2020 Pharmaceutical Services Regulations introduced the ability for Health Boards to manage non-compliance with the community pharmacy Terms of Service with a series of remedial and breach notices, the opportunity to withhold monies associated with non-compliance and provided the ultimate sanction of removal from the pharmaceutical list.

To ensure consistent application of the sanctions the Health Board utilises the formal "Procedure for Managing Breaches of the NHS Terms of Service for Community Pharmacy Contractors". Initially the process was used to manage potential breaches of the terms of service relating to pharmacy opening hours. With contract monitoring becoming fully operational post covid in 2022-23 the process is also used to manage any non-compliance identified during the visits.

Broadly speaking the process has several stages, progressing from local resolution through remedial notices and finally breach notices. The process is managed via a sub group that gathers evidence and presents a recommendation, and a main contractual breach group that formally decides the action to be taken. The community pharmacy development manager compiles, issues and manages the remedial and breach notices.

During 2023-24, eighty-eight potential breaches were investigated. Three breach notices were issued.

4.9 Consistency of Action

To ensure that the Health Boards' interests are fully represented when national services and policies are being developed that for community pharmacy the community pharmacy team have roles in a variety of relevant national boards and working groups. They also work closely with equivalents in other Health Boards and liaise with Llais, Welsh Government and Community Pharmacy Wales to ensure monitoring and development arrangements are equitable and proportional for all Health Boards and pharmacy contractors in Wales.

5. Duty of Candour/Duty of Quality

The Duty of Candour on health care providers has been active since 1st April 2023 with the aim of being open and honest with patients receiving care and treatment.

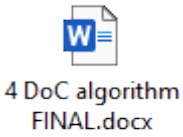
Divisional representation at the national Welsh Risk Pool DoC and learning network with specific responsibility for promoting raising of awareness for independent contractors, sharing tools, templates algorithms and direct support when DoC is triggered.

The Primary Care and Community QPS team continue to review all incidents reported by the Division to establish and support with any cases that could potentially trigger the Duty. The more information included within the initial Datix report and management review sections, the easier it is to establish whether the duty has been triggered. The number of incidents triggering DoC have reduced, as processes for review and validation have been embedded.

Once the duty has been triggered, initial contact (in person notification) is made with the patient/NOK by clinically responsible person. This is followed up with a written notification sent to patient or next of kin by day 5 (template provided by QPS to ensure all required information for the written notification is captured). The investigation can then commence and its outcome can be shared with the patient/relative if agreed.

Rapid review of incidents by managers is important and the QPS Team currently review all divisional incidents to establish potential cases whilst processes are being embedded.

Divisional Process and toolkit developed and shared with all boroughs and directorates. (See attachment algorithm)



5.1 Monitoring and assurance

Robust mechanisms in place for screening of all incidents and concerns and timely escalation within the division and to corporate team where indicated.

Weekly focussed review of all DATIX reports and liaison with clinical teams

Continued engagement with GP's via LMC to further explore implementation of the All-Wales strategic review, awareness raising, promotion of Primary Care drop-in clinics and additional training and support for practice staff.

The Health Board is engaging the with national Welsh Risk Pool DoC and learning network to develop a State of the Nation self-assessment to demonstrate to Welsh Government its maturity and progress made for implementation. The division has contributed case studies to inform the All-Wales DoC casebook to share and promulgate learning identified.

A scoping exercise undertaken for all independent contractors undertaken which requested confirmation of all incidents which triggered Duty of Candour up until 30 September 2024.

266 responses in total out of 346 which is a **77%** response rate.

58/69 for General Practice 84% response rate

40/68 for Optometrists; 58% response rate

62/83 for Dentists; 75% response rate

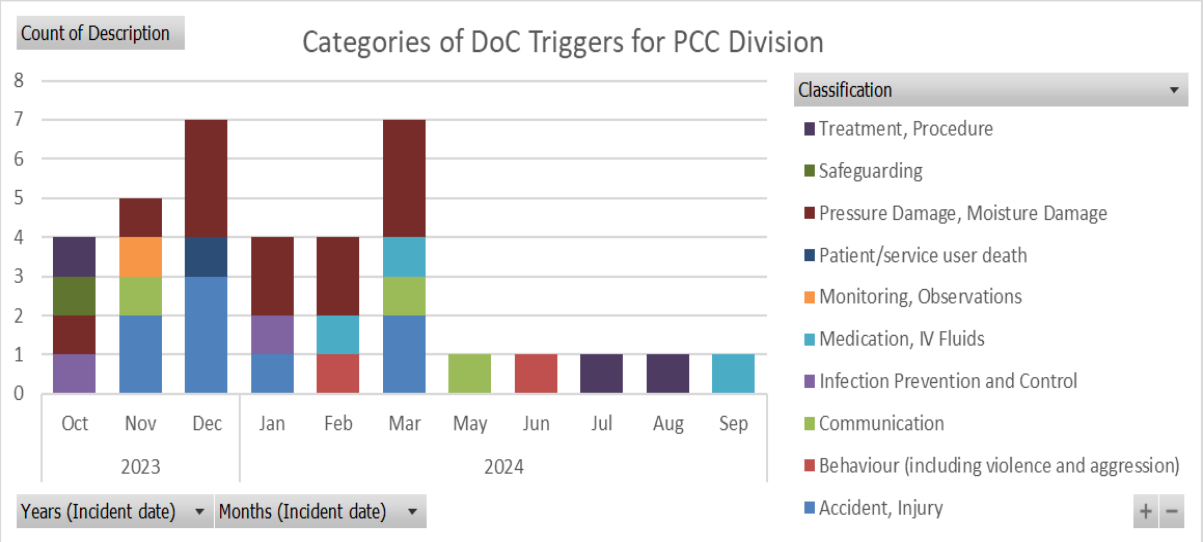
106/126 for Pharmacy; 84% response rate

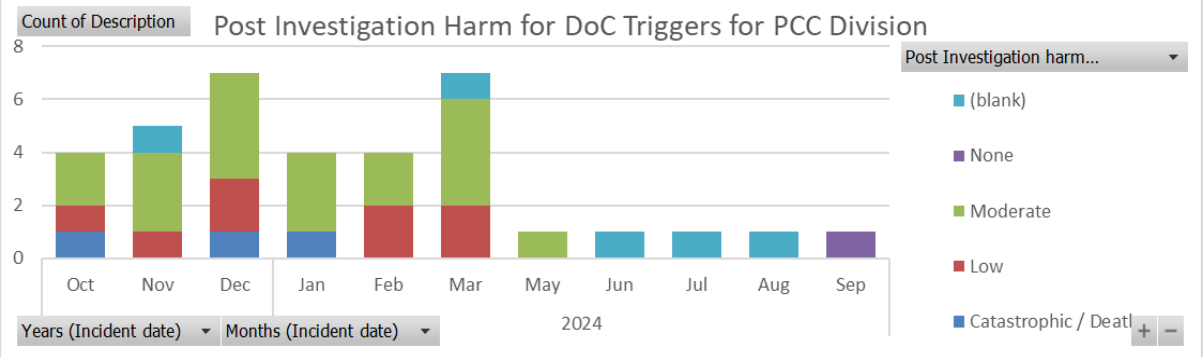
58 General Practice Duty of Candour responses, ***41 have submitted a form and 17 use Datix for reporting*** and out of the 58 responses ***58 Duty of Candour were triggered during the reporting period***.

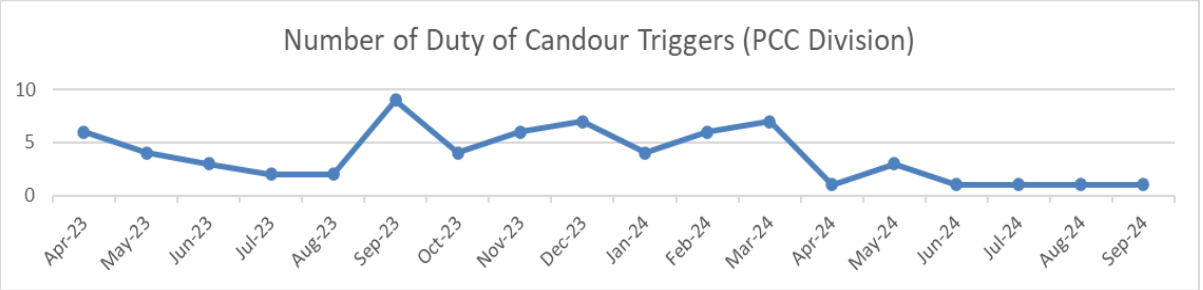
40 Optometrist Duty of Candour responses, ***37 have submitted a form and 3 use Datix for reporting*** and out of the 40 responses ***3 Duty of Candour were triggered during the reporting period.***

62 Dentist Duty of Candour responses, ***60 have submitted a form and 2 use Datix for reporting*** and out of the 62 responses ***11 Duty of Candour were triggered during the reporting period***.

106 Pharmacy Duty of Candour responses, 5***5 have submitted a form and 51 use Datix for reporting*** and out of the 106 responses ***13 Duty of Candour were triggered during the reporting period***.





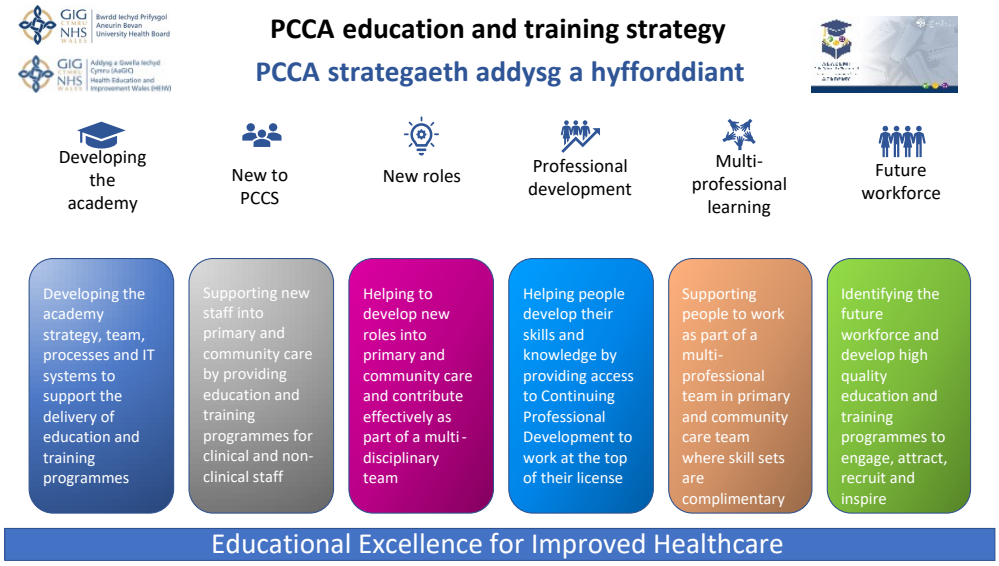


6. Primary and Community Care Academy

Development of the multi-professional workforce is an essential component of delivering the Primary Care Model for Wales (PCMW). The PCMW sets out a vision for the development of primary care where coordinated teams

including a range of professions such as General Practitioners, Pharmacists, Allied Health Professionals, Nurses, Community Health staff, Mental Health workers, Physicians' Associates, Non- Registrants, Local Authority and Third Sector staff who work collaboratively to manage the everyday needs of the Aneurin Bevan University Health Board population working in a seamless way to deliver health and social care.

The Aneurin Bevan Primary and Community Care Academy (PCCA) has been established through HEIW and Health Board funding to develop and deliver training and education for a broad range of professionals working in Primary and Community care to ensure the multi-professional workforce has access to the necessary training and education and associated support to deliver a wider range of services and interventions within these settings. The PCCA also aims to support the development of the multi-professional team in primary care including embedding new roles to promote effective collaborative working and development of multi-professional through accessible learning. The PCCA is part of a wider HEIW/all Wales Academy network, working collaboratively to develop education and training resources for the workforce.



The PCCA aims to provide positive educational experiences for trainees to allow them to develop skills and confidence to work at the top of their licence and provide excellent healthcare. Courses and events are being planned and delivered to a range of professional to help achieve this. These include:

6.1 Healthcare Support Worker Programme

HCSW Programme to support Primary and Community Care HCSWs though effective induction and training to allow them to deliver safe, effective healthcare. In 2024, 36 Primary and Community HCSW's have complete the programme with further courses planned for later in the year.

6.2 Nursing Foundation Programmes

The General Practice Nurse (GPN) Programme supports qualified nurses who are new to Primary Care. This comprehensive programme of training events, delivered in collaboration with Swansea University over 9 Months. Learners receive a Post Graduate Certificate in Primary Care Practice at the end of the programme. Two cohorts of GPN trainees have completed the programme, 13 trainees in total, with another cohort of 10 trainees starting the programme in October 2024.

The Journey of Excellence programme supports newly qualified nurses to develop tools they need to start their Journey of Excellence (JOE©) with Aneurin Bevan University Health Board, to enable a smooth transition from a newly registered nurse into a confident practitioner.

The programme will ensure that the nurses will learn and perfect the fundamental clinical skills required to practice confidently and efficiently in their wards/departments and provide guidance on how to continue with their professional development. 16 nurses have completed the programme this year with a further 16 starting in Sept 2024

Advanced Practice Programme is being developed with Swansea University to allow existing HCPs to complete a Masters Degree in Advanced Practice. Development of Advanced Practitioners is critical to provide HCPs the ability to deal with more complex medical issues, to fill potential skills gaps and contribute towards stability and sustainability of services. The Academy is offering Advanced Practice modules in Primary Care to develop existing Advanced Practitioners and a part-time Master Programme to HCs wishing to develop into Advanced Practitioners. The programme will start in 2025.

6.3 Pharmacists

In January 2021, the GPhC published the revised Standards for the Initial Education and Training of Pharmacists (IETP). These new learning outcomes provide newly qualified pharmacists with the necessary consultation skills and confidence to provide the clinical services expected by patients and the NHS, working across health systems - and will enable pharmacists to be independent prescribers at the point of registration.

By 2026, the aim is for all newly registered pharmacists to be able to independently prescribe medicines.

With the introduction of the new IEPT standards, the pathway for early careers pharmacists has moved away from the traditional diploma model and HEIW have introduced a temporary bridging post-registration pharmacist programme in collaboration with Cardiff University and RPS. This programme is aimed at pharmacists who have qualified within the last 2 years. The programme has been developed in order to suit single or multisector pharmacists and will provide the pharmacist with the same skills as the undergraduate pharmacists being trained behind them, the programme is closely aligned to the RPS 4 pillars of practice and meets the RPS post-registration foundation curriculum, reflecting the core changes in the pharmacist career pathway. HEIW provide a protected development time funding grant equivalent to 1 day of a band 6 per week and 1 day of an 8a per month in order to protect learning and development time for the trainee and a practice supervisor.

There are two intakes per year, September and January with the deadline for applications to Cardiff University to be enrolled on the September intake being the middle of August 2024. The PCCA secured 2 places for the September cohort and 1 place for the January cohort.

At the end of the programme the pharmacists will achieve 80 level 7 credits, the independent prescribing qualification and the RPS post-registration foundation credential award – this provides assurance that they are working at the required level and enables progression into advanced practice. Pharmacists who complete the programme are prioritised for HEIW advanced practice funding in order to complete modules equating to 40 credits in order to make-up their qualification to a traditional diploma and the modules undertaken can be selected flexibly.

The Pharmacist Academy programme has been remodelled in order to address sustainability needs across Community and Primary care. The updated model will encompass a multisector approach to include community pharmacy, where the Health Board employ the pharmacist on a 2-year fixed term contract and place them in GP practices and community pharmacies with a memorandum of understanding/SLA, and during the last rotation allow time to experience other areas of primary care outside GP practice in order to fully understand the primary care sector. They will be placed with a full-time mentor and complete a competency handbook alongside the post-registration foundation programme, providing assurance that they are highly skilled competent pharmacists who can go on to work in either primary care or community pharmacy sectors. An

advert is currently live to employ a Post-Registration Foundation Pharmacist for the upcoming January 2025 cohort.

All pharmacists currently working within primary care GP practices with independent prescriber status are eligible to apply to complete advanced practice modules through the academy in order to expand their scope of practice and skill set, allowing them to deal with more complex patients contributing towards stability and sustainability of services.

6.4 Pharmacy Technicians

It is proposed that the PCCA will introduce a Pharmacy Technician programme early in 2025. The programme will support qualified pharmacy technicians new to primary care. There has been no transition pathway available for pharmacy technicians new to primary care in Wales to ensure their competence in undertaking the activities required within primary care. Many G.P practices are unaware of the roles and responsibilities that a pharmacy technician can undertake and therefore Pharmacists are still routinely completing some of these roles and therefore this is not a prudent use of their time.

The aim of introducing a Pharmacy Technician programme through the academy is to showcase the work that Pharmacy technicians can complete within primary care and consequently evidence the more effective use of Pharmacist time on more complex/clinical tasks. The overall aim would be to increase the amount of confident and competent pharmacy technicians employed directly by practices at the end of the programme in order to expand the multi-professional team and improve sustainability of services within primary care.

The Pharmacy technicians will be employed by ABUHB on a fixed term contract and will be placed in GP practices with a mentor and complete a 14-month competency-based education pathway - General Practice Pharmacy Technician Medicines Optimisation Training Programme (GPPTMOT) which is delivered by delivered by Pharmacy Workforce Development South. This course has been developed to meet the standards required in the APTUK national competency framework for primary care pharmacy technicians which links to GPhC professional standards and was developed to support the ambitions of delivering a healthier Wales and the NHS long term plan.

Completing a structured programme provides us with the assurance that technicians transitioning to primary care are working to a level in line with

the national competency framework. HEIW have agreed that they will provide ABUHB with a training funding grant for places on the course.

When this programme has been implemented, we will then look to implement a multi-sector pre-registration technician training programme.

6.5 Clinical Skills Programme

The Clinical Skills Programme offers a range of courses to healthcare professional across primary, community and care home settings to allow them to develop or refresh their clinical skills. This includes ANTT, BLS, Bowel Management, Catheterisation, Wound Care HICC&PICC lines, Recognising the Deteriorating Patient, NEWS and Sepsis.

6.6 Continuing Professional Development (CPD) sessions

A range of CPD sessions including lunchtime learning events covering a range of subject for HCPs have been delivered. These are either pre-planned or in response to requests to address specific training needs. These have included GLPT1 shortages, dementia, dermatology, gender services and menopause.

6.7 Other courses

A number of other education and training courses / events been delivered through the PACC on a range of subjects. These include Customer Service, Art of Brilliance wellbeing webinar, NB Medical Hot Topics, PrescQuipp Prescription Clerk Training and Professional Nurse Advocate training.

6.8 Placements

The PPCA has been working with HEIW to increase the number of undergraduate nursing placements in Primary Care practices. Nurses have traditionally had little exposure to Primary Care during their training and have not always been aware of it as a careers option. Working with the HEIW PEF, 18 practices in the ABUHB area have been identified which are willing to take nurse placements. A number are conversations with other practices are being held to further increase nurse placement opportunities in primary care practices

6.9 Schools and Colleges

Engagement with schools and colleges is essential to promote careers in Primary and Community Care to students who are our potential future workforce. The PCCA has attended a number of engagement events at schools and colleges through the Gwent Schools Programme. These events

have been very well received and given PCCA staff an opportunity to explain the range of career opportunities and career pathways in Primary and Community Care.

7.0 Conclusion

This Primary Care Annual Quality Report for 2023/24 from the Primary Care and Community Services Division has outlined the robust mechanisms for monitoring contract delivery, including contractual review, post-payment verification processes, and engagement with Health Inspectorate Wales. Assurances regarding compliance with the Duty of Candour across all independent contractor areas has also been provided, emphasising both transparency in care provision and patient safety.

Patient Safety Incident (graded moderate or above) **occurs**

Patient Safety Incident report completed in RL Datix by reporter

Datix incident report is reviewed by QPS team (Asst QPS Managers initial review) to ensure appropriate level of harm – (inform Senior QPS team of any queries or incidents that trigger) and confirm whether duty is triggered.

Datix review process begins as per current investigative process by the allocated investigating manager, who identifies if the duty is triggered (final harm rating to be confirmed in management review on datix record, however management harm should not be updated if DoC has been triggered and initial contact made)

Within 2 days of DoC triggering

Initial contact (in person notification) is made with the patient/NOK by responsible person (i.e. ward manager, team leader, doctor, practice manager, senior nurse) **within 2 days of the duty of candour triggering**

In-person notification may be via telephone, face to face or video call.

Within 5 days of In Person notification

Datix report is updated by responsible person to ensure the details of in person and written notifications are recorded (use template provided by QPS to ensure all required information for the written notification is captured)

QPS team to run weekly incident reports and follow up with clinical areas to encourage initial contact and ensure they update the datix

Written notification sent to patient/NOK by day 5 (and uploaded to Datix) following in-person notification (by responsible person who completed in-person notification). The written notification is to be completed and sent to QPS team to co-ordinate quality assurance and divisional signoff of report and written notification

Within 30 days of Duty triggering

Divisional QPS request update on investigation on day 15. Once investigation complete, IO to contact patient/relative to establish how they wish to receive outcome.

IO to inform Divisional QPS team if patient/relative is happy with verbal communication of outcome. Update datix with investigation outcome and close

If no harm is confirmed:
IO to provide a standard Regulation 24 CEO Draft response letter. Divisional Triumvirate review/sign off then send to PTR. Ensure all information is uploaded to datix.

If harm is confirmed:
IO to provide CEO QPS Draft response which clearly identifies harm, Breach of Duty and LFER. Divisional Triumvirate review/sign off then send to PTR. Ensure all information is uploaded to datix. Refer to generic Legal Services inbox for consideration of redress.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN MEETING	
DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 November 2024
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Implementation of the Quality Strategy Year Two and Quality Operating Framework Year Two
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson – Deputy Director of Nursing

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

ADRODDIAD SCAA SBAR REPORT
Sefyllfa / Situation In April 2023, the Health Board launched its first Quality Strategy and Patient Experience & Involvement Strategy. As part of ensuring successful implementation of the Strategies, a Quality Outcomes Framework (QOF) and implementation plan was developed. This has been updated for Year Two, demonstrating our commitment to deliver the highest quality healthcare to our local communities and how we are putting Quality, Safety and Learning at the heart of everything we do.
Cefndir / Background

Quality Outcomes Framework

The Quality Outcomes Framework aims to drive continuous improvement in healthcare services by focusing on measurable outcomes. Key objectives include:

- Identifying Improvements and Risks**:** Spotting areas for improvement and potential risks to patient safety.
- Quality Indicators and Benchmarks**:** Establishing metrics to measure and compare performance.
- Evidence-Based Practices**:** Promoting standardised care processes based on evidence.
- Patient Satisfaction**:** Enhancing patient satisfaction and experience.
- Regulatory Compliance**:** Ensuring adherence to regulatory standards and accreditation requirements.
- Data-Driven Decisions**:** Facilitating informed decision-making and resource allocation.
- Culture of Accountability**:** Fostering a culture of accountability, transparency, and learning.

Quality Strategy - Year Two Implementation Plan

The implementation plan for the second year of the quality strategy outlines the deliverables and timelines for the next financial year. Key workstreams and enablers for 2024/25 have been mapped to ensure continued progress and improvement in healthcare quality.

Asesiad / Assessment

The Health Board's Quality Strategy, aligned with "A Healthier Wales," focuses on quality and safety through our 'pillars of quality' program. These pillars guide performance reviews and reporting to the Board and PQSOC, ensuring high standards in:

- Patient and staff experience
- Incident reporting (falls, pressure ulcers, medicines management, mortality)
- Complaints, concerns, and compliments
- Health, safety, and security
- Infection control and prevention
- Safeguarding

Reporting and Monitoring

- Report Updates: Primary indicators mapped to the pillars will be updated monthly for 'always on' indicators and reported quarterly to PQSOC.
- Dashboard Development**:** Collaborating with Digital, Data, and Technology (DDaT) team to create a dashboard for efficient reporting and trend analysis.
- Exception Reporting: Other indicators will be available but reported by exception. Deep dives will be conducted as needed based on data trends.

Quality Indicators

These have been aligned with the Duty of Quality and the six domains of quality (person-centred, safe, timely, effective, efficient, and equitable), these indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency. The quality enablers will also be considered for the report.

Year Two Plan for QOF

The plan for the year two QOF aims to refine and consolidate indicators into one report, ensuring all data is housed in one place for integrated reporting. This will enhance understanding of pathway performance and inform quality improvement.

A feedback loop will be established to monitor the impact of improvement initiatives and quality indicators, allowing for regular evaluation and necessary adjustments. This will support the delivery of the 2nd Annual Quality Report to Welsh Government and future reports to NHS Executive.

Year Two Implementation Plan – Quality Strategy

Workstreams for Year Two:

- Refinement of Quality Reporting Structures
- Sepsis
- Infection Prevention and Control
- Human Factors Programme

Each workstream has a SMART action plan with named objectives and milestones, and will be reviewed for effectiveness and learning.

Key Enablers

Following the Annual Quality Report, key enablers include a learning organisation, culture, quality management system, and quality improvement. A workplan has been developed to hold the Health Board accountable for delivering the three-year ambitions of the quality strategy.

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Not applicable currently

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback 2.6 Medicines Management
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper?
Asesiad Effaith Cydraddoldeb	**No does not meet requirements**

Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

LEADERSHIP

WORKFORCE

CULTURE

INFORMATION

LEARNING, IMPROVEMENT & RESEARCH

WHOLE SYSTEMS APPROACH

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Quality Strategy Implementation Plan Year Two 2024/25

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Introduction

This implementation plan for the Quality Strategy was launched in April 2023. An implementation plan was written for Year One and has been updated for Year Two. This plan provides the workstreams and priorities for 2024/25 and holds timelines for how it will be delivered throughout Aneurin Bevan University Health Board in 2024.

Quality is embedded in our culture, and we are committed to continually improving. Delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do. We have fantastic teams delivering safe, timely, effective, efficient, and person-centred care. Every day we hear positive stories about how they go above and beyond.

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

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

Our Quality Strategy Commitment

- Aneurin Bevan University Health Board will be a learning organisation where staff members work towards delivering high quality clinical care every day.
- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.
- We will ensure that quality is embedded throughout the organisation creating a culture of openness and transparency where people are supported to raise concerns.
- Our patients, relatives, carers, staff and communities will partner with us to achieve this vision.

Quality Priorities

Our quality ambitions for the first three years have focused on prioritising quality and safety, acknowledging that challenges evolve. Over the past year, our key commitments were:

- **Learning Organisation**: We strive to be a learning organisation where staff deliver high-quality clinical care daily.
- **System Understanding and Capability Building**: We aim to understand our care systems, build capability through an all-teach/all-learn philosophy, encourage innovation, and engage patients, relatives, carers, staff, and communities in improvement efforts while learning from mistakes.
- **Embedded Quality and Supportive Culture**: Quality is embedded throughout the Health Board, fostering a culture of openness and transparency where concerns can be raised.
- **Collaborating and Partnership**: Patients, relatives, carers, staff, and communities will partner with us to achieve our vision.

Our strategies have been shaped by the experiences of patients, relatives, carers, staff, and communities, focusing on improvement, planning, and assurance in alignment with the Duty of Quality and Duty of Candour.

Quality Strategy

Provides:

- **Blueprint for Patient Safety and Quality**: Outlines patient safety and quality for the next three years.
- **Focus on Quality and Safety**: Prioritises quality and safety while addressing emerging challenges.
- **Improvement Objectives**: Sets improvement goals and a supporting framework for the next three years.
- **Commitment to Continuous Improvement**: Embeds a culture valuing quality and continuous improvement.

Patient Experience & Involvement Strategy

Provides:

- **Feedback-Driven Culture**: Created & based on feedback from staff, patients, families, and carers, focusing on what matters to them.
- **Passion for Improvement**: Acknowledges staff's dedication to improving service experiences.
- **Learning from Experience**: Places learning from experiences at the Health Board's core.

These strategies ensure that quality, safety, and continuous improvement are central to all our activities, fostering a culture of excellence and collaboration.

Pillars of Quality Programme

The Health Board initiated a comprehensive program to prepare for implementation of the Health and Engagement Act.

The Health Board's Quality Strategy is underpinned by "A Healthier Wales," focusing on quality and safety through our 'pillars of quality' program. These pillars help review performance and reporting to the Board and Patient Quality and Safety Outcomes Committee, ensuring high standards of care in:

- Patient and staff experience
- Incident reporting (falls, pressure ulcers, medicines management, mortality)
- Complaints, concerns, and compliments
- Health, safety, and security
- Infection control and prevention
- Safeguarding

Health and Care Quality Standards

As part of the Quality Strategy an Implementation Plan was produced for the Health Board to enhance the quality of healthcare throughout 2023.

In order to deliver the Health and Care Quality Standards, the plan has been mapped with quarterly objectives aligned to the six key quality domains.

Ongoing work will ensure the Health and Care Quality Standards are met throughout 2024/25.

Deliverables – the goals of the implementation plan include:

1. Enabling staff to improve quality

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

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

2. Implement the Duty of Quality

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

3. Meet the requirements of the Duty of Candour

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

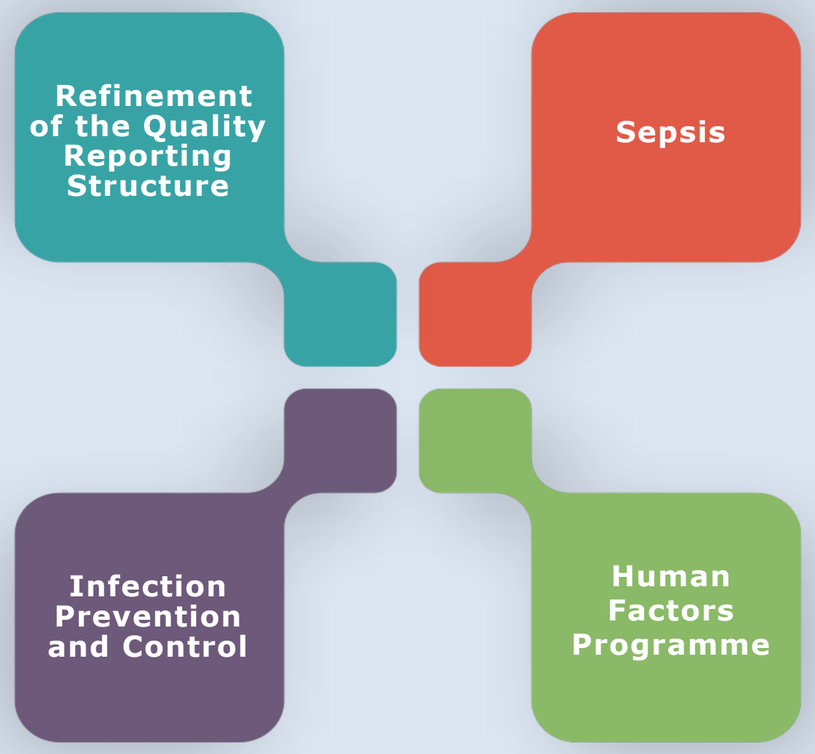
A culture of openness, transparency and candour is widely associated with good quality care. This must encourage learning and be achieved without apportion of blame.

Key Workstreams for 2024/25

Commitment to Quality, Safety, and Patient Experience:

The Health Board remains steadfast in its commitment to quality, safety, and patient experience. By enhancing systems of care, promoting continuous learning, fostering innovation, and maintaining a culture of openness and transparency, we aim to create a healthcare environment that consistently delivers high-quality care and positive patient outcomes. Through the strategic initiatives outlined above, we are building a robust foundation for continuous improvement and excellence in healthcare delivery.

Key workstreams for 2024/25 include:



A workstream has been produced for each of these for 2024/25 with SMART action plans. A brief description is provided:

Infection Prevention and Control

With the routine reporting of infection rates, the Infection Prevention and Control pillar of our quality strategy will include a workstream to focus on improving antibiotic prescribing. Work going into 2024/25 already includes:

- **Enhanced Cleaning Programme:**
  - Need for a robust cleaning programme to reduce healthcare-associated infections.
  - Balancing the safety of patients with bed availability and ward reconfiguration.
  - Proposal submitted to Executives for a more focused approach.

- **Patient Flow and Infection Prevention:**
  - Daily challenge of protecting patients from infection while managing bed availability.
  - Attendance at Patient Flow Meetings to support patient placement.

- **Reporting and Root Cause Analysis:**
  - Use of Datix for reporting and analysing healthcare-associated infections.
  - Reinstated virtual root cause analysis meetings to identify themes and learning.

- **Supporting Divisions:**
  - Ongoing promotion of best practices in infection prevention.
  - Financial support from Regional Integration Funds (RIF), with potential risk to service provision if not funded in 2025.

- **Antimicrobial prescribing, stewardship and resistance:**
  - Work closely with Divisions to reinforce start smart and focus guidelines.

Infection Prevention and Control

Objective	Q1	Q2	Q3	Q4	Delivering (so what)	Indicators
Enhanced cleaning programme	• Develop enhanced cleaning strategy for approval • Monitor compliance with Synbiotic and cleaning schedules	• Monitor progress against the programme • Monitor periods of increased incidence • Monitor compliance with Synbiotic and cleaning schedules	• Monitor progress against the programme • Monitor periods of increased incidence • Monitor compliance with Synbiotic and cleaning schedules	• Monitor period of increased incidence • Monitor compliance with Synbiotic and cleaning schedules	• Number of outbreaks or periods of increased incidence • Health Board rate of infection • Lessons learned from root cause analysis and outbreak reviews • Genosequencing report • Clean, safe environments	• Welsh Government reduction expectation goals • Completion/slippage for completing the cleaning strategy • Reflect outcome in annual report • Lessons learned to reflect into the annual programme of work 25/26 • Reduce the number of concerns raised in relation to hospital cleanliness
Patient flow & infection prevention	• Monitor the number of bed days lost due to infection • Support Cross site meetings • Review SOPs linked to patient placement	• Monitor the number of bed days lost due to infection • Support Cross site meetings • Develop a Comms strategy for public and staff awareness	• Monitor the number of bed days lost due to infection • Support Cross site meetings • Promote the winter vaccine programme • Arrange a winter planning webinar • Promote mask fit testing sessions • Review intranet messages	• Monitor the number of bed days lost due to infection • Support Cross site meetings • Review respiratory SOPs linked to patient placement	• Number bed days lost to infection • Number of outbreak/periods of increased incidence • Lessons learned from outbreak reviews • Uptake of vaccine • Uptake of mask fit testing	• Decrease the number of lost beds/closed bays & wards • Decrease the number of outbreaks/periods of increased incidence • Improve compliance with uptake of vaccine and mask fit testing • Reflect outcome in annual report • Lessons learned to reflect into the annual programme of work 25/26
Reporting & root cause analysis	• Continue to report healthcare associated infections linked to Welsh Government reduction expectation • Develop a divisional surveillance dashboard • Explore re-establishing Qlik • Develop individual ward graphs • Develop a learning platform for themes from blood stream infection RCAs • Improve the use of Progress Notes and Learning within Datix	• Monthly performance reports shared with divisions including learning from RCAs • Monitor the number of staff trained for infection prevention e-learning and ANTT	• Monthly performance reports shared with divisions including learning from RCAs • Monitor the number of staff trained for infection prevention e-learning and ANTT	• Monthly performance reports shared with divisions including learning from RCAs • Monitor the number of staff trained for infection prevention e-learning and ANTT	• Timely feedback and response to concerns/themes • Early indication of outbreaks/periods of increased incidents • Compliance rate with training numbers	• Themes from RCA identified for learning & improvement • Reduce common themes • Reflect outcome in annual report • Lessons learned to reflect into the annual programme of work 25/26 • Improve the number of staff trained
Antimicrobial prescribing, stewardship and resistance		• Develop secondary care antimicrobial usage data dashboard & migrate Start Smart Then Focus audits onto AMAT	• Incorporate AMAT audit data into antimicrobial dashboard & automate reporting	• Demonstrate antimicrobial dashboard reports to divisions & directorates and communicate reporting expectations	• Health Board rate of infection	• Number of SSTF audits completed, and dashboard outputs discussed at divisional and directorate level

Refinement of the Reporting Structure

Ensure clear, evidence-based reporting across all committee and group levels to assure Health and Care Standards delivery. A workstream will include the following workplan:

- **Health Board Corporate Clinical Audit Plan:** Complete and refine the Clinical Audit Plan to ensure systematic evaluation and improvement of clinical practices.
- **Annual Health and Care Standards Reports:** Develop and regularly update these reports to track compliance with health and care standards, identifying areas for improvement.
- **Implementation of Standardisation Efforts:** Standardise processes and procedures across the Health Board to ensure consistency in care delivery.
- **Establishment of Corporate Support Roles:** Create roles dedicated to providing corporate support and integrating decision frameworks to streamline operations and improve decision-making.
- **Enhancement of Assurance Mechanisms:** Improve mechanisms for assurance to ensure that quality and safety standards are consistently met across all areas of care.
- **Utilise Existing Resources:** Leverage the Health Board's existing resources and support systems to effectively implement key initiatives. This includes using available tools, staff expertise, and technological solutions to drive improvements.
- **Alignment with Health Board Commitments:** Ensure all initiatives and actions are aligned with the Health Board’s overarching commitment to quality, safety, and patient experience. This alignment ensures that every effort contributes to the broader goals of enhancing patient care and operational excellence.

Refinement of Reporting Structure

Ensure clear, evidence-based reporting across all committee and group levels to assure Health and Care Standards delivery. Develop **Corporate Clinical Audit Plan**, addressing assurance gaps through systematic audits.			
Period	**Action**	**Measurable Target**	**Monitoring**
Quarter 1 2024/25	Review current reporting structures and identify areas for improvement.	Ensuring clear evidence-based reporting across all committee and group levels to assure Health and Care Standards delivery.	Regular progress reports for NHS Exec, quarterly QOF report and performance reports for PQSOC.
Quarter 2 2024/25	Develop Annual Report in line with Pillars of Quality and for each Health and Care Standards, scheduled for consideration by Patient Quality Safety and Outcomes Committee	Develop and implement new reporting templates and guidelines. Identify key areas requiring audits and develop an audit schedule.	Regular progress reports for NHS Exec, quarterly QOF report and performance reports for PQSOC.
Quarter 3 2024/25	Strengthened Assurance Mechanisms: Enhancing oversight for commissioned services.	Develop and implement new reporting templates and guidelines.	Regular progress reports for NHS Exec, quarterly QOF report and performance reports for PQSOC.
Quarter 4 2024/25	Standardisation Efforts: Implementing consistent resources, role profiles, appraisal systems, and evidence-based agendas.	Defining corporate support roles related to quality, safety, and patient experience, and setting clear expectations.	Monitor and evaluate the effectiveness of the refined reporting structure.

Sepsis

The Health Board will focus on implementing the updated **National Institute for Health and Care Excellence (NICE)** sepsis guideline **(NG51)**. The updated guidance aligns with the Academy of Medical Royal Colleges (AoMRC) statement on the initial antimicrobial treatment of sepsis. This will build on improving patient safety by addressing systemic issues related to deteriorating patients. A workstream will be dedicated to sepsis recognition and early assessment from primary care to acute care. A full improvement plan will be developed and ensure the Health Board is delivering the Sepsis 6, focusing on the following:

- Initial treatment
- Including prescribing/admin of antibiotics
- Finding the source of infection
- Early monitoring
- Escalating care (Call for Concern / Martha's law)
- Information and support, - sepsis awareness and safety netting, patient information
- Training and education
- Audit strategy – develop an implementation plan for the Health Board on audit and assurance for sepsis organisation

We will look to work with the UK Sepsis Trust to embed best practice and to mirror any work undertaken nationally and UK wide to enable early recognition of sepsis and improve sepsis awareness.

Sepsis – Annual Work Plan 2024/25

Quarter One	Quarter Two	Quarter Three	Quarter Four
Deteriorating patient group meeting taking place	Scoping Exercise – work with divisions and directorates, understanding the specific issues in recognising and responding to sepsis.	Develop Audit Strategy – review current measures. Scope opportunities to capture missed patients, e.g. Careflow, DATIX, ED & Outreach team. Undertake Thematic review of common incidents.	Standardise education and deliver ahead of change to monitoring tool to ensure success implementation and reduce risk. Continue delivering education around the new Sepsis monitoring tools.
MDT 'task and finish group' established to update The Health Board Deteriorating Patient Policy	Assessing Education - establish what is currently in place, identify gaps in deteriorating patient/Sepsis training	Produce Driver Diagram for Sepsis.	Implementation plan for NICE guidance
Deteriorating Patient Policy approved by Clinical Standards and Policy Group.	Public Awareness Campaign for Sepsis	Hold workshop to develop sepsis strategy, by identifying key areas for improvement and ensuring new monitoring tools are suitable for the Health Board.	Introduce NEWS2, PEWS, MEWS and NEWTT2 across ABUHB. Ensure good communication with directorates and provide support around the new early warning scores.
Roll out of Deteriorating Patient Policy across Health Board	Standardise Sepsis education – incorporating the new Sepsis Screening tool, NEWS2, MEWS, NEWT2 and PEWS	Introduce Pilot – to test and measure new Sepsis screening tool and NEWS2. Working closely with wards during the pilot in order to capture issues and provide support.	Continue communication strategy to ensure all staff are aware of new Early warning tools and Sepsis screening tool and NICE guidance.
Meeting with UK Sepsis Trust	Scope and review current Antimicrobial stewardship. Establish what steps are needed to comply with NICE guidance.	Staff awareness campaign – to reinforce the signs and symptoms of Sepsis, the importance of early recognition, Sepsis Screening and Escalation. Additional focus around new Sepsis guidance and antimicrobial guidance.	Implement Audit Strategy – Implement new audit to capture compliance with Sepsis treatment and ensure recognition, response and treatment is captured.
Sepsis Working group established and initial meeting held	Continue to work with UK Sepsis Trust and meet with health boards to share good practices.	Communication campaign to inform staff of upcoming change to NEWS, PEWS, NEWTT2 and MEWS. To include further awareness around new Sepsis Screening tool.	Implement monthly meetings with wards/directorates and feedback data around Sepsis to ensure continuous monitoring and support areas in need of improvement.

Human Factors Programme

A programme of Human Factors training has been initiated from within the Department of Medical Education, initially as an innovation to address concerns within Theatres in relation to never events. Developed with a multidisciplinary approach, the programme promotes patient safety, team working and staff wellbeing through simulation in a protected and psychologically safe environment. This approach enables staff to identify and discuss factors impacting on clinical situations and develop sustainable solutions and has already been expanded to include Cardiology and Obstetrics & Gynaecology. The work is being evaluated both by looking at its impact on patient safety (for example, never events) and on team process (for example psychological safety).

Additionally, regular training sessions open to all staff and covering an introduction to Human Factors followed by an advanced session developing integration methodologies are led by the Health Board's Human Factors Lead and supported by the Department of Medical Education.

For Human Factors to be successful, the principles have to be adopted at departmental level across the Health board. While Human Factors training is required to introduce staff to the principles and overall concept, it isn't enough to simply attend a training session. Human Factors methodology has to be integrated into everyday activities, ensuring that all areas are safe listening spaces and that all staff are able and willing to speak up safely. As this represents a significant cultural change for the organisation, it is crucial that this workstream is identified as a separate workstream and fully supported at all levels, in order to take this work forward.

Human Factors Programme

Objective	Q1	Q2	Q3	Q4	Delivering (so what)	Indicators
Implement Human Factors across the Health Board	• Implement introductory sessions planned for the full year. Sessions will be half a day in length and offered twice per month. Sessions are open to all ABUHB staff across all teams. • Develop programme of advanced sessions for the full year.	• Implement Advanced Human Factors sessions to offer practical skills to help teams **embed principles into practice**. These half day sessions will be run once a month. • Continue to offer " introduction to Human factors" workshops as per Q1 • Utilise feedback from sessions to enhance future sessions.	• Connect with teams who have attended the Human Factors sessions and explore their progress with implementation of Human Factors in their areas. • Explore any barriers they may face with this process and to support them to overcome them. • Develop repository of action to enable impact assessment in 2025.	• Evaluate the impact of Human factors programme with the respective teams. This will include measure of safety culture, patient and staff experience and team working. • Report the impact of the programme at the divisional level to ensure ongoing support for sustainability of the programme.	• Delivering sustainable training sessions to introduce staff to HF concepts. • By Q3, identifying required actions in order to integrate HF into every day activities.	• Feedback from Sessions • Feedback from follow-up sessions • Implementation of actions • Resolution of barriers

Key Enablers for 2024/25

1

A Learning Organisation

Foster a culture of continuous learning and improvement throughout the organisation.

2

Culture

Establish a supportive and proactive culture focused on quality improvement and patient safety.

3

Quality Management System

Integrate quality management systems to ensure continuous improvement and compliance with health standards.

4

Quality Improvement

Use data-driven approaches to inform quality improvement initiatives and enhance patient safety.

These will be mapped by quarterly goals as part of the year two objectives for the quality strategy. Improvement Plan for 2024/25: Aneurin Bevan University Health Board

A Learning Organisation

Goal: Foster a culture of continuous learning and improvement throughout the organisation.			
Period	**Action**	**Measurable Target**	**Monitoring**
Quarter 1 2024/25	**Embed our quality patient safety and quality teams within our Nursing Division**	Complete embedding process by end of Q1.	Bi-weekly team integration meetings, progress reports.
Quarter 2 2024/25	**Develop a learning repository for all our staff which will allow us to review how learning will be identified, stored, triangulated, shared, disseminated, and implemented.**	Launch repository by end of Q2.	Monthly usage analytics, feedback from staff.
	Develop a learning bulletin to share learning across the organisation	Publish monthly bulletins starting Q2.	Bulletin readership metrics, feedback surveys.
	Review mortality data and implement a Learning from Death Framework and report	Complete framework and initial report by end of Q3.	Monthly mortality review meetings, action plan tracking.
Quarter 3 2024/25	**Scope our Deteriorating Patients Collaborative**	Develop collaborative framework by end of Q3.	Collaborative progress meetings, stakeholder feedback.
	Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives.	Implement evidence-based initiatives in 3 high-impact areas.	Quarterly performance reviews, audit feedback loops.
Quarter 4 2024/25	**Review quality and safety structures and reporting structures ensuring learning at every level**	Strengthen the link between learning from direct and indirect feedback, investigations, and improvement work. Revise structures by end of Q4.	Monthly review sessions, implementation progress checks.

Culture

Goal: Establish a supportive and proactive culture focused on quality improvement and patient safety.			
Period	**Action**	**Measurable Target**	**Monitoring**
Quarter 1 2024/25	**Develop our methodology to learn from incidents and establish a listening and learning framework, enabling us to deliver a learning forum.**	Establish framework by end of Q1.	Monthly learning forum sessions, incident review outcomes.
Quarter 2 2024/25	**Establish bespoke Patient Experience Collaboratives and use feedback for learning and improvement.**	Launch 3 collaboratives by end of Q3.	Collaborative progress reports, patient feedback integration.
Quarter 3 2024/25	**Formalise an approach to supporting staff involved in patient safety incidents.**	Develop and implement support program by end of Q3.	Staff feedback surveys, program effectiveness reviews.
Quarter 4 2024/25	**Support a data informed experience (Civica), quality and patient safety agenda Health Board wide.**	Implement Civica platform by end of Q4.	Monthly data reviews, user feedback sessions.

Quality Management System

Goal: Integrate quality management systems to ensure continuous improvement and compliance with health standards.			
Period	**Action**	**Measurable Target**	**Monitoring**
Quarter 1 2024/25	**Reconciliation of the performance report and the quality outcomes framework, working with Digital, Data and Technology to develop automated reports.**	Achieve reduction in number of metrics to 4-5 per domain of quality Q1. Mapped to the Duty of Quality of Quality and Quality Pillars by Q2. Achieve automation by Q3.	Regular progress reports for NHS Exec, quarterly QOF report and performance reports for PQSOC.
Quarter 2 2024/25	**Utilise and triangulate patient experience data listening and learning from lived experience to provide qualitative data.**	Implement patient experience surveys in all wards; achieve 85% satisfaction response rate. Aim for 25 surveys per month for meaningful data.	Quarterly analysis of survey results, feedback sessions with patients and staff.
Quarter 3 2024/25	**Support the ward accreditation programme with quality and patient safety measures.**	Achieve 80% implementation across all wards & nursing teams within the HB by the end of Q3, with 100% implementation by the end of Q4.	Regular progress reports, monthly ward performance reviews.
Quarter 4 2024/25	**Identify specific areas within national clinical audits that require improvement.**	Completed SMART action plans for National Clinical Audits and development of improvement plans.	Quarterly audit committee reviews, tracking action plan implementation.

Quality Improvement

GOAL: Use data-driven approaches to inform quality improvement initiatives and enhance patient safety.			
Period	**Action**	**Measurable Target**	**Monitoring**
Quarter 1 2024/25	**Review of QI Knowledge and Skills Framework**	Framework of QI Knowledge and Skills development training opportunities in place	Numbers attending training, particularly PocEd QI, PocEd Measurement and Quality Improvement Coach/QI Alumni list
		Complete testing of Quality Improvement Coach Programme and set up Cohort 1	Number of coaches completing programme, coaching minutes provided
Quarter 2 2024/25	**Produce a quality improvement strategy**	Board development session in October, strategy published by end of Q3	QOF data, Monthly milestones check-ins, stakeholder review sessions.
Quarter 3 2024/25	**QI Faculty supporting initial Quality Planning in response to national Safe Care Partnership work**	Agreed direction of travel around three national priorities: Acute Deterioration, Deconditioning, Leadership	Monthly reporting, feedback to Patient Safety Learning and Improvement Forum
Quarter 4 2024/25	**Scoping use of QI Platform e.g. Life QI / HIVE for use from 2025 onwards**	Review of platform specification and decision	Number of projects on QI Platform
	Ongoing work with Digital, Data and Technology Team in support of SPC charts in Qlik/Google Cloud	Automatic phasing on Qlik SPC charts	as part of QI strategy check-ins

Learning and Improvement

Organisational Learning for Continuous Healthcare Improvement

In 2023/24, the Health Board placed a significant emphasis on organisational learning to drive continuous improvement in healthcare. By engaging staff and key stakeholders, we began to develop a comprehensive **Listening and Learning Framework**, demonstrating our commitment to embedding lessons learned to enhance patient care, safety, quality, and experience. This framework is set to be approved in April 2024.

Initiatives and Developments for 2024/25:

- **Bi-Monthly Learning and Improvement Forum:** Establishing a regular forum dedicated to learning and improvement, allowing staff to share knowledge, discuss insights, and drive change.
- **Learning Repository:** Creating a central repository to store and share knowledge, ensuring that valuable lessons and best practices are easily accessible.
- **Transformation of the Quality and Patient Safety Operational Group:** Evolving this group into a learning and improvement forum to reinforce a culture of continuous improvement.
- **Quality Improvement Strategy:** Developing a strategy over the next 6-9 months to provide a structured approach to quality improvement across the Health Board.

Commitment to Continuous Improvement:

The Health Board is committed to fostering a culture of continuous improvement, learning from every opportunity to enhance patient care, safety, quality, and experience. By embedding a Just culture and triangulated approach, we aim to create an environment where learning is a fundamental part of our operations, driving excellence in practice and improving outcomes for our patients.

Next Steps

- Refine the Quality Outcomes Framework for Year Two reporting. Establish limitations with reporting of the data and quality limitations.

- As part of the newly refined QOF, reporting of the indicators will involve working with Digital, Data and Technology Directorate. This will allow automation of reporting and enable reports to be standardised. The use of iconography will provide detail on trends.

- Increase validity of the data.

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

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

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

LEADERSHIP

WORKFORCE

CULTURE

INFORMATION

LEARNING, IMPROVEMENT & RESEARCH

WHOLE SYSTEMS APPROACH

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Quality Outcomes Framework Design Principles Year Two

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Pillars of Quality and Quality Outcomes Framework

The Health Board's Quality Strategy is underpinned by "A Healthier Wales," focusing on quality and safety through our 'pillars of quality' program. These pillars help review performance and reporting to the Board and PQSOC, ensuring high standards of care in:

- Patient and staff experience
- Incident reporting (falls, pressure ulcers, medicines management, mortality)
- Complaints, concerns, and compliments
- Health, safety, and security
- Infection control and prevention
- Safeguarding

The Quality Outcomes Framework is being mapped from the Health and Care Quality Standards to the pillars of quality.

Reflecting 'always on' reporting the primary indictors mapped to the pillars will be updated monthly and reported quarterly to PQSOC.

Working with Digital, Data and Technology a dashboard will be produced that will enable more efficient reporting and trends to be seen.

The other indicators will be available but reported by exception. Once data is available and trends are visible then a deep dive process can be established to determine if there needs to be a highlight report on certain areas.

Quality Outcomes Framework

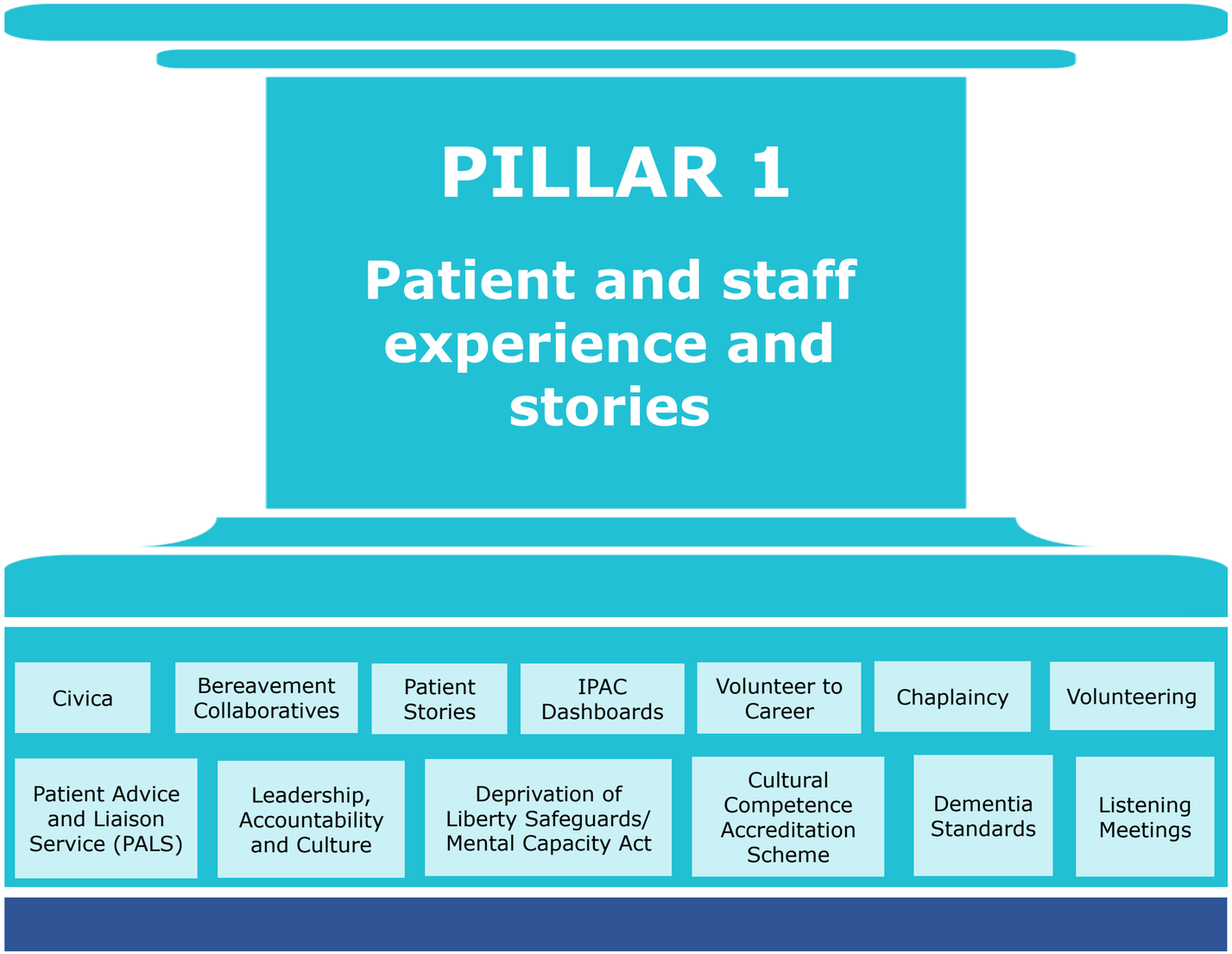
The Health Board developed a Quality Outcomes Framework (QOF) as part of its Quality Management System is being refined for 2024/25. This framework tracks outcomes to systematically measure, monitor, and enhance healthcare quality.

The QOF aimed to enable continuous improvement with key goals to:

- Identify improvement areas and patient safety risks
- Establish benchmarks and quality indicators
- Promote evidence-based practices
- Enhance patient satisfaction and experience
- Ensure compliance with standards and regulations
- Enable data-driven decisions and resource allocation
- Foster a culture of accountability, transparency, and learning

The QOF has enhanced **reporting requirements** to the Board and Executive Committee, and providing assurance to PQSOC. Benefits of the QOF have included:

- Improved patient outcomes and safety
- Enhanced patient experience and satisfaction
- Increased adherence to evidence-based practices
- Efficient resource utilisation
- Regulatory compliance
- Improved staff engagement and professional development
- Accountability and transparency in care delivery



Proposed Metrics: -

- CIVICA data
  - Total new responses
  - Patient satisfaction % positive emotion trend, negative emotion trend
- Staff culture – WF&OD
- Narrative – AI for themes and use of stories

PILLAR 2

Incident Reporting
Falls
Pressure Ulcers
Medicines Management
Mortality

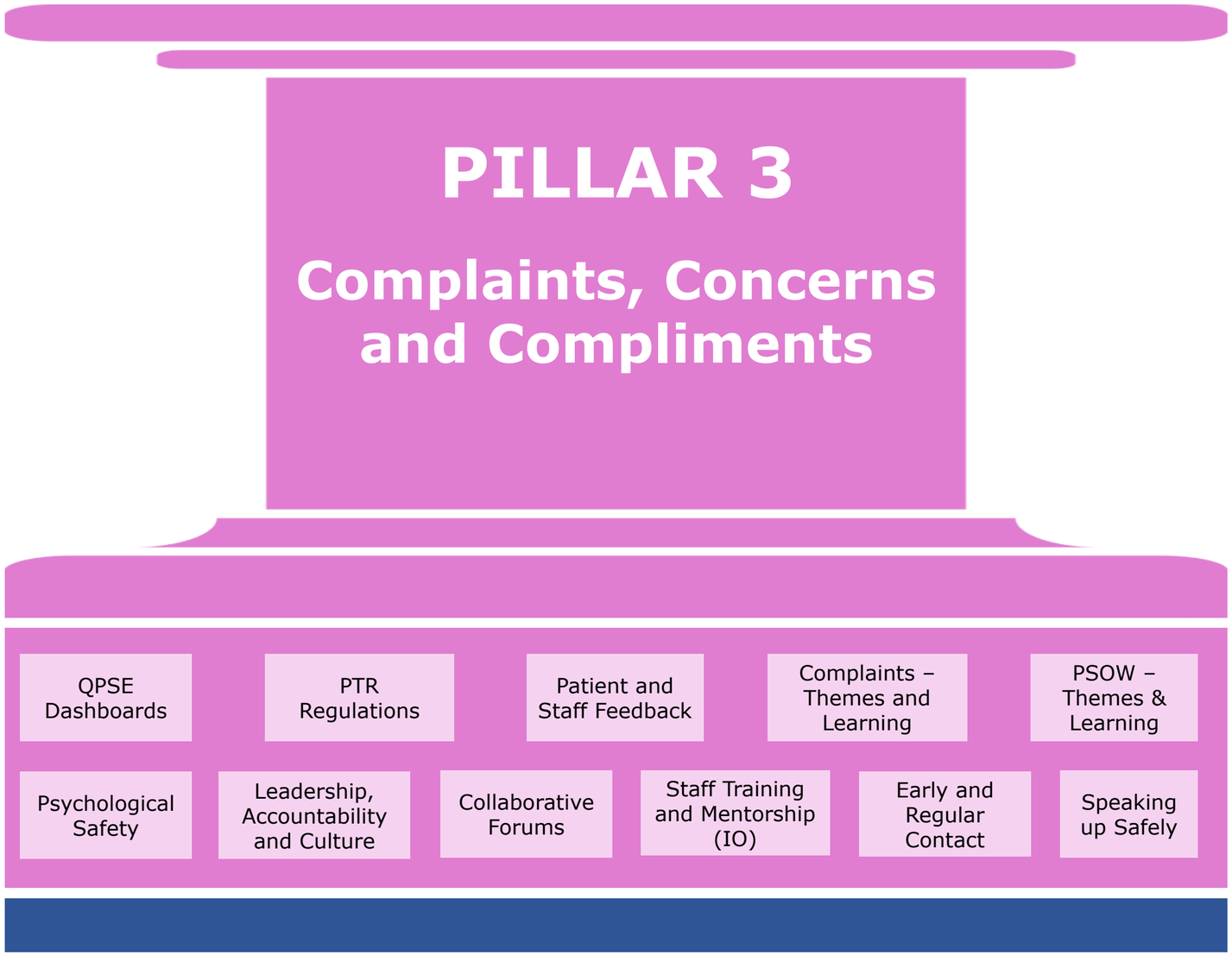
Leadership, Accountability and Culture	Never Events	Deteriorating Patient	Patient Safety Incident process	QPSE Dashboards
Pressure Ulcers / Medicines Management	Staff Training	Datix (validation)	Falls Panel	Duty of Candour
Learning, Monitoring & Assurance	Just Culture/ Psychological Safety	Mortality	Risk Registers	Human Factors

Proposed Metrics: -

- Mortality
- Incidents presented as – level of harm and closure date of incident
  - Global category of incident to ensure themes care captured – PUs, falls, HATs, medicines, H&S, RIDDOR
  - Ensure rate is accurate, e.g. DVTS per patient episode, falls – severity of harm against OBD, co-ordinated metric 1,000 bed days
  - Trends in severe medicines incidents
- Nationally reportable incidents & compliance with closure timeframes
- Duty of candour – Datix numbers and themes, indications (WRP report)
- Thematic analysis of Regulation 28 reports
- Thematic analysis of Patient Safety Incidents graded severe

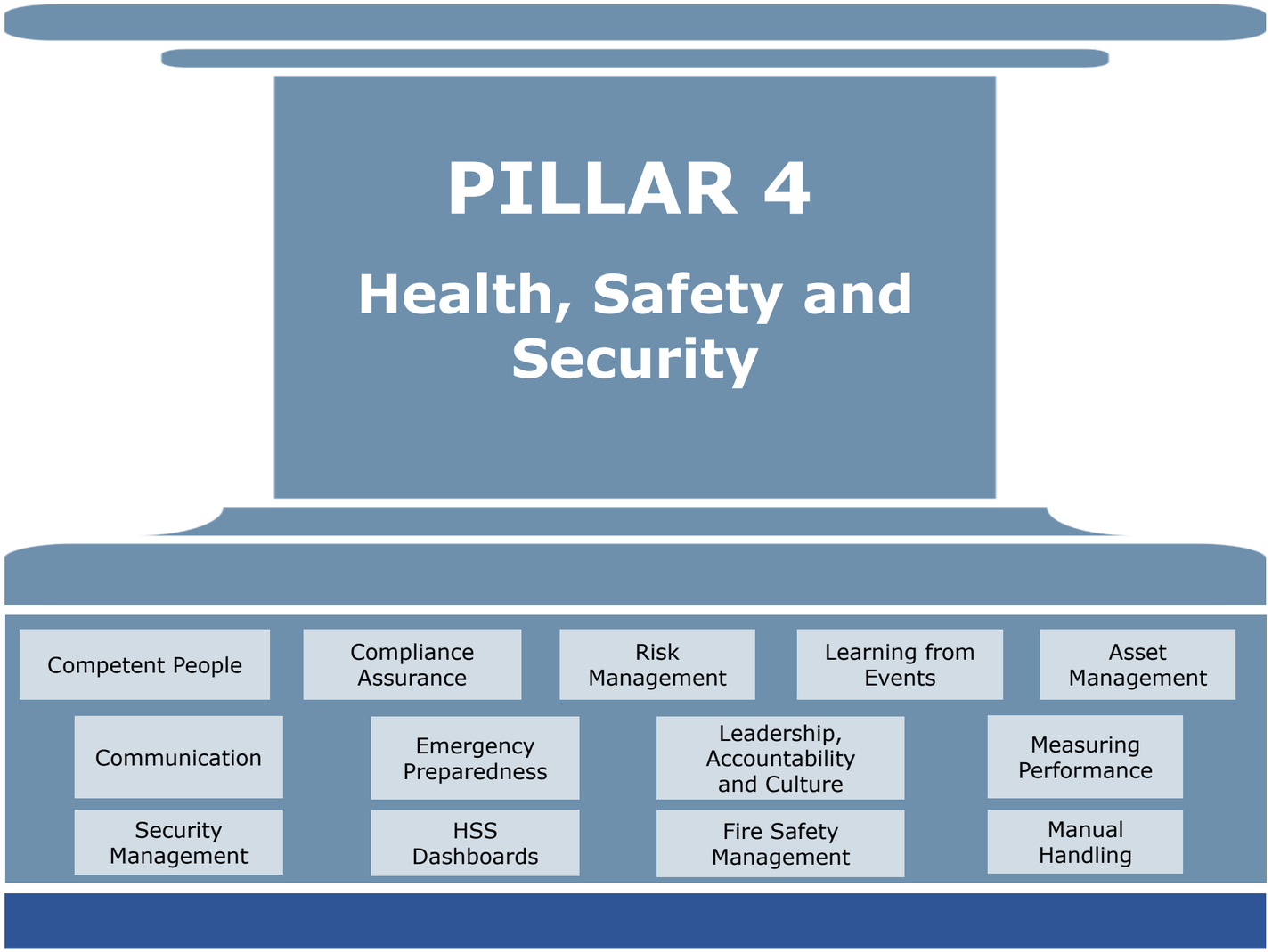
Suggestions for long term: -

- Number of inquests that take place face to face (compared to the number completed on paper), ensuring meeting family needs
- Investigate the possibility of capturing incidents related to urgent care delays / flow in DATIX.



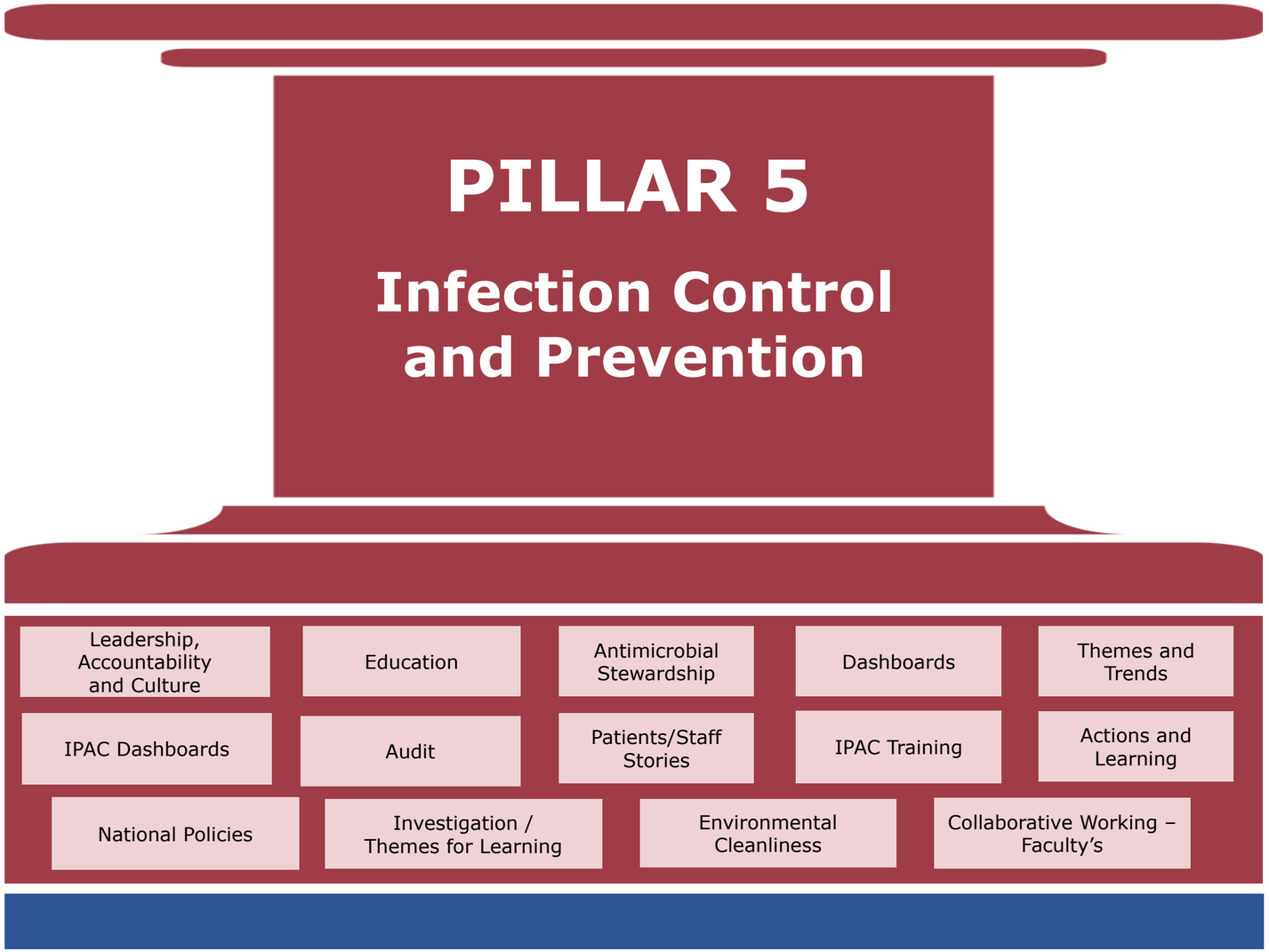
Proposed Metrics: -

- 30 day performance
- Complaints
  - Review layers to look at compliance and closure
- Compliments
- PALs (especially early resolution)



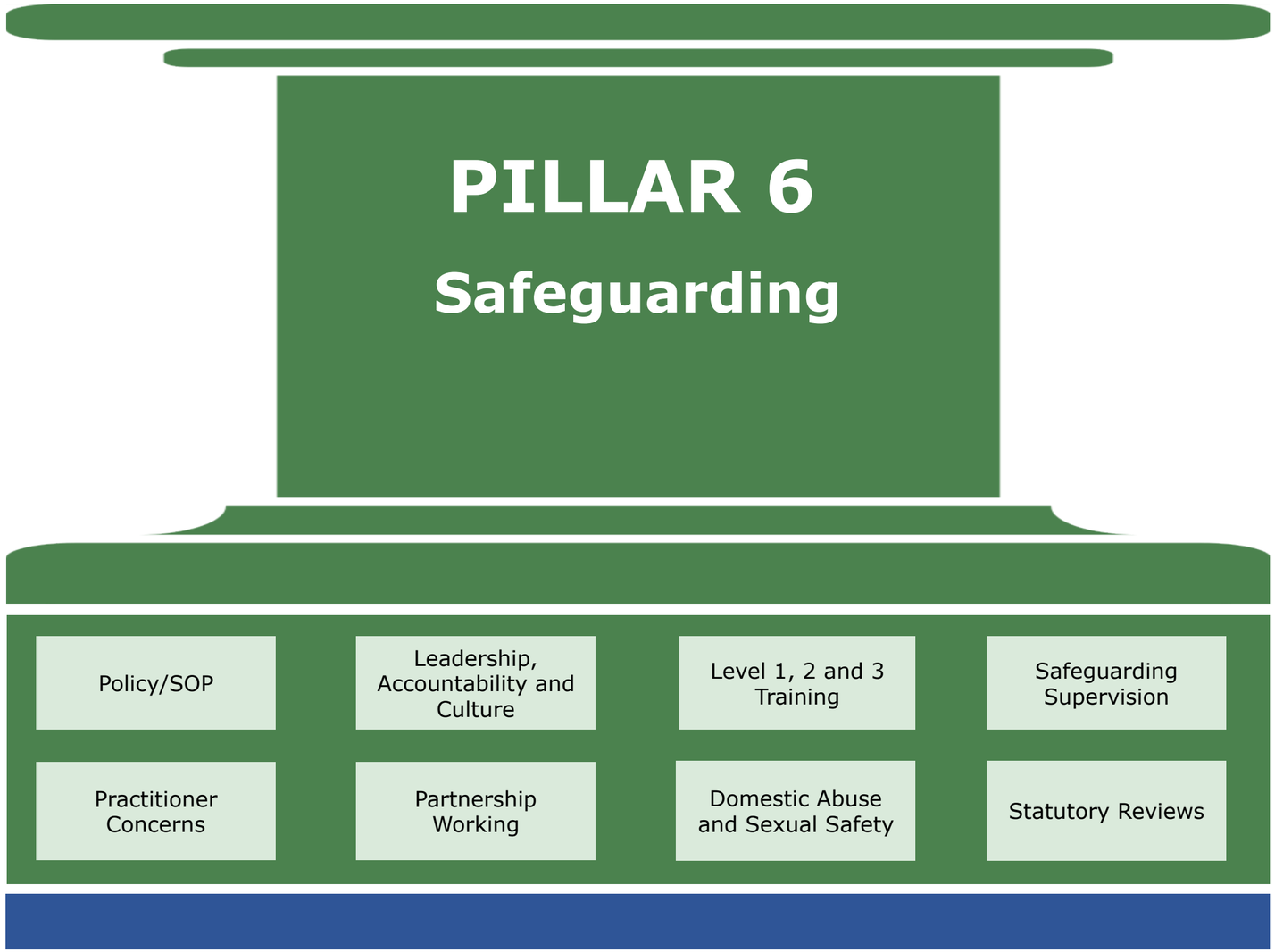
Proposed Metrics: -

- RIDDOR reporting compliance (in line with HSE criteria) – target 100%
- Health & Safety statutory and mandatory training compliance – target 85% all modules
- Compliance with the Health Board Health, Safety & Fire risk assessment programme – target 100%



Proposed Metrics: -

- Infection Control measures including DECI & Hand Hygiene
- Welsh Government Reduction Goals
- C-Section Surgical Site Infections
- AMR prescribing trends
- Audit & Education: Respiratory Infections



Proposed Metrics: -

- Adult Duty to Report / Child Duty to Report
- Training compliance
- Themes from domestic homicide reviews and serious case reviews

Additional Indicators STEEP

These indicators will form layer two of the QOF expectation of regular reporting will be defined

Safe

- Number of readmissions within 7 days and 28 days
- Suicide rate
- Number of Cardiac Arrests

Timely

- Elective waiting list themes – capturing patient experience and reviewing complaints, PREMS for elective services

Professional Standards

- WF&OD - Staff registered and fit to practice – registered workforce. Longer term look at how this can be captured in the QOF and how it is to be reported.

Additional Measures

Effective Metrics:

- Audit – proportion of audit recommendations reported as completed within 12 months
- Audits – review risk, look at proportion with limited assurance and review clinical audit risk
- Ward accreditation - % of wards achieving bronze, silver, gold, platinum
- Number of quality improvement coaches / people trained in QI - work with Rachel Trask to review QI measures
- Low birth weight babies

Equitable Metrics:

- Consult with public health to identify appropriate metrics for screening in high-risk populations and immunisation rates, including uptake of influenza by staff and high-risk groups in the community
- Link with public health population team to look at measures for obesity and smoking
- H&S measure to look at violence and aggression -going to people plan
- What measures do we have for dementia?
- Discuss with Tanya the possibility of including metrics for neurodiversity and learning disabilities in the quality outcomes framework.
- Mortality gap for LD
- BME Group stillbirth rate

Additional Indicators

- GP core access standards
- Patients cancelled on day of surgery – Lloyd Bishop
- Delayed transfers of care (ITU transfers onto wards)
- % occupancy of long stay- steps downs
- Inappropriate conveyance into hospital (patients brought into hospital that didn't need to be). Surrogate measure or readmission. Proportion of ambulance and WAST conveyance rate.
  - Inappropriate attendance
  - Delayed handover
- Preferred place of death (DNACPR/ TEPs)
- SPS cancer chart compliance with 62 days
- Time limited interventions in stroke pathway – within 4 hours, review thrombolysis and thrombectomy data
- Fracture neck of femur pathway – time-based outcomes in relation to fracture and bone health
- Waiting lists, number of patients on waiting lists for longer than 36 weeks, metric to include OPs and waiting lists for surgery
- WG target – time for 1a assessment in CAS/ ED, similar adult metric for adults in time to assess

It was noted not all of these measures may be available, so they would be explored to define what could be reported end of life measure –immediately, and what would be longer term goals for reporting in the QOF.

Next Steps

- Refine measures for 2024/25 and test.
- Work with Digital, Data and Technology to automate reporting
- Align quarterly QOF dates with dates for PQSOC to establish reporting deadlines.
- National QOF is being established and Health Board will need to establish reporting on these indicators. Ensure timelines are established not to duplicate work.
- Develop deep dive process to look at when additional reports are needed for PQSOC.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Performance Report Quarter Two (July – September 2024)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health and Care Quality Standards provide a clear framework to help the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board. The Quality Report is mapped to the six domains of quality and the six quality enablers and structured under the Health Board's Six Pillars of Quality.

The outcomes and indicators reported are a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover aspects of care, clinical outcomes, patient safety and patient experience.

This report provides measures and narrative on the data for the Pillars of Quality. The quality outcomes framework (QOF) is being refined and potential indicators for year two have been suggested for development and automation. This provides the Board/ 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, to comply with the Duty of Quality.

Cefndir / Background

The Quality Report provides current data on quality and patient safety as mapped against the Pillars of quality:

- 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

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

Asesiad / Assessment

Areas of Achievement/ Improvement in Quarter Two

- PALS Service: Fully established, focusing on early intervention and support for patients and families with concerns. Continues to support the PTR process.
- Improvement in the timeliness of closure of Nationally Reportable Incidents from 29% in July 2023 to 51% in September 2024 having achieved 71% in July 2024. Further improvement is expected in Quarter 3
- Civica Satisfaction: Maintained at 92%, above the 85% benchmark. SMS rollout to ED and MIU is underway, expected to increase feedback.
- RAMI: Improved Risk Adjusted Mortality Indicator, currently 1st among six Health Boards in Wales, with a focus on Learning from Deaths reporting.
- Complaint Early Resolution: Maintained at 72%, with Surgery, Medicine, Urgent Care, and CSS divisions consistently above 80%.
- Compliments Recording: Increased month on month, with a notable rise in September.
- Safeguarding Training: Improved uptake of Level 1 and Level 2 training, with increased referrals indicating greater awareness.
- Quality Assurance: Developing with standardised agendas and data sets based on Quality Pillars and STEEEP principles, promoting Ward to Board assurance.
- Ward Accreditation: Rolling out across several divisions, with the first wards formally accredited.
- Quality Outcomes Framework: Workshops focused on refining measurements, with proposals shared at this month's PQSOC.
- Theatres Safety Programme: No Never Events reported since November 2023 in Theatres, with one event in Quarter Two within a non-theatre environment this is under review for early learning.
- Bereavement Focus: Increased focus on bereavement following a collaborative event.

These improvements highlight our commitment to enhancing patient care and safety across the Health Board.

Areas of Focus in Quarter Two

There are several issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Committee consideration the areas are summarised below.

- Learning Report: Following the death of a 9-year-old boy, key learnings and recommendations for improvement have been identified.
- Quality and Safety Focus: Continued emphasis on care quality and safety improvement within Mental Health & Learning Disability Services.
- Infection Rates: Enhanced monitoring and an improvement plan are in place, including work on antimicrobial prescribing and a sepsis update.
- PTR Concerns: Steady improvement in aged complaints over 12 months, with a plan to achieve 75% closure of PTR concerns within 30 days.
- Urgent Care Quality: Ongoing work on metrics for example Ambulance Handover times, 12 and 24-hour waits in ED, and improving patient experience.
- Falls: Focus and scrutiny on falls, with a new enquiry from HSE related to a fatal fall reported under RIDDOR. An ongoing HSE case from 2019 is also being addressed.
- Safeguarding Review: Engagement with Monmouthshire NCN to review General Practice and the Child Protection Register.
- Training Challenges: Level 3 Children's and Adults training remains a challenge, requiring further work to ensure proper staff training and compliance data analysis.
- Consent Improvement Plan: Implementation of the consent improvement plan, with public consent videos developed and soon to be launched.

These areas of focus demonstrate our commitment to enhancing patient care and safety across the Health Board.

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

Quality Improvement

The Health Board is embedding Quality Improvement into everything we do and producing a Quality Improvement (QI) Capability Strategy 2025-2028. A QI Strategy for next three years is being drafted and a successful Board Development Session was held in October 2024. A number of QI projects have been shared which demonstrate financial and performance improvements, increased staff well-being and enhanced patient safety.

The Safe Care Partnership (SCP) is now in its next phase and involves working with Improvement Cymru, Executive Clinical Peer groups, Welsh Government and NHS Wales Executive colleagues. The priorities identified for the next phase include:

- Acute Deterioration – recognition and response
- Deconditioning – prevention and identification
- Leadership – Quality Management System

A co-design event between Health Boards, Trusts, Improvement Cymru was held in October to develop the national approach. Key priorities for the next six months include automation and revision to the Quality Outcomes Framework, development of Integrated reporting with Finance, Workforce and Planning, strengthening of Quality Patient Safety structures within Divisions, refreshing the Quality Improvement Plan and strengthening assurance and reporting.
Argymhelliad / Recommendation The Committee is requested to note the progress of the quality performance report and to take assurance from this report.

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 prioritise 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.

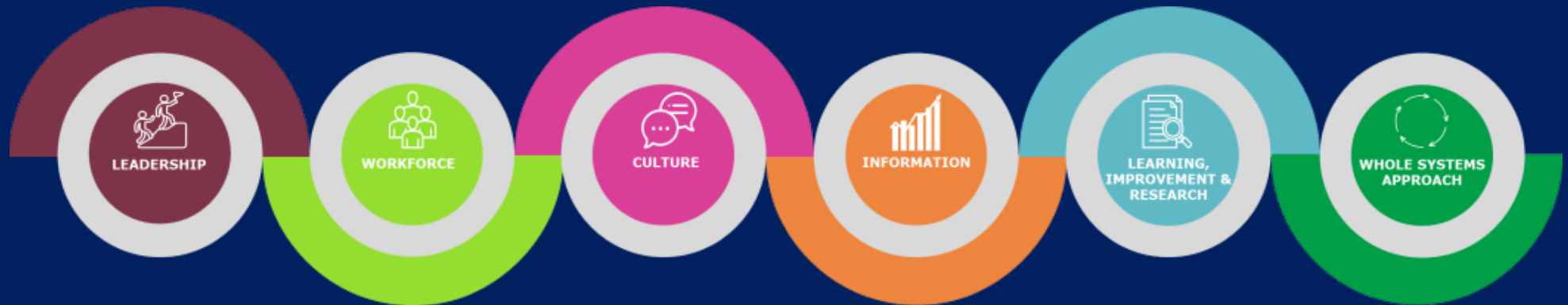
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Patient Quality, Safety and Outcomes Committee

Performance Report

Quarter 2: July – September 2024



Overview

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

Quality and Safety Pillars

- Patient Experience and Staff Feedback
  - Civica and PALS update
- Incident reporting
  - Patient Safety Incidents
  - National Reportable Incidents
  - Near Misses
  - Duty of Candour
- Complaints and concerns
  - Continue to focus on closure of historical complaints over 6-12 months
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

Escalated Risk Concerns

Clinical Effectiveness

Information

Urgent Care

QPS Update

- Annual Quality Report 2023/24 produced, reviewing past objectives and setting priorities for improving patient and staff safety, outcomes, and experiences. The report provided a narrative on our quality journey throughout the year. The report demonstrated the work involved to implement the Health and Social Care (Quality and Engagement) (Wales) Act (2020), which emphasised quality, transparency, and engagement through the Duty of Quality, Duty of Candour, and the creation of the Citizen's Voice through Llais.
- The patient engagement and involvement strategy continue to progress the delivery of person-centred care, which included patient participation panels, PALS and bereavement services.
- Quality Outcomes Framework (QOF) being refined for 2024/25. To include a smaller number of metrics which demonstrate assurance and compliance. Reconciliation to be carried out with current QOF. Working with Digital, Data and Technology to automate reporting. Ensure triangulation of data.
- Strengthened Divisional learning/reporting through Governance structures and standardised agendas. Supporting a culture of shared learning and a triangulated approach to quality, patient safety and experience. Development of a listening and learning framework, a learning and improvement forum and learning repository.
- Commissioning Assurance Framework developed – August 2024.
- Developing Quality Improvement Strategy
- Review alignment of Datix Management System
- Progression of workplan for quality strategy for next 12 months with SMART objectives.

QPS Update: Progress against 2023/24 Objectives

• Delivery of an approved strategy for Quality, Framework and Delivery Plan with a clear understanding of priorities.	**Quality Strategy Implementation Plan d**eveloped and approved, supporting our reporting structure through a quality outcome framework.
• Through the launch of the new system for patient experience and the Health and Well-being survey, put in place mechanisms to learn from the insight gained.	**Civica Platform Launch**: Enhanced real-time patient experience feedback, enabling ongoing partnerships with patients, families, carers, staff, and communities.
• Establish a framework for learning and skills at all levels and the capacity and capability to grow and develop our skills and learning networks.	**Listening and Learning Framework**: Held meetings to engage and inform this nearly completed framework. **Developing Best Practices**: Through listening and learning, supporting staff to deliver excellent person-centred care.
• Deliver the Safe Care Partnership, Faculty workstreams and the outcomes as set by each team.	**Quality Improvement Capability**: Expanded through the Safe Care Partnership, building capacity, conditions, and connections for staff to use QI methodology to solve complex problems consistently. **Just Culture**: Continuously working to correct mistakes, encouraging experience sharing, and restoring confidence.
• Agree and implement the measures and reporting structures.	**Reporting Structures**: Huge progress on developing our reporting structure, reporting via a quality outcomes framework has enabled clear indicators reported aligned to the Health and Care Quality Standards. We have made this a priority to refine reporting for 2024/25.
• Review the capability of our data capture systems for resilience and suitability.	**Quality Management System**: working collaboratively with the Divisions of planning and digital, data and technology has enabled data capture to be developed through existing systems.
• Implement new systems to provide insight and support for delivery.	**Quality Management System**: developing the quality outcomes framework provided quantitative data that can be reported. We have enriched this data with narrative and included patient stories and staff feedback.
• Review our quality and safety structures and teams along with the reporting structures to ensure learning at every level and appropriate assurance and governance.	**Reviewed Structures**: Aligned resources within Quality and Patient Safety. A review of the reporting and assurance via current governance structures and Groups and Committees will continue through 2024/25.

Patient Quality and Safety Learning and Improvement Forum Highlights

Date: 18th September 2024 (please see notes for more detailed information)

Key Updates:

Terms of reference: Signed off by Executive team and comments being sought from members of the forum.

Good News:

- New consent videos are now available in both English and Welsh and will be launched soon.
- The recent work of the bereavement collaborative raised the need to support staff dealing with the loss of colleagues and loved ones, this is being looked into.
- A roundtable approach for serious incidents (SIs) has led to more efficient action plans. This methodology is being considered for other incidents where appropriate.
- Quality improvement - successful launch of the quality coach training program and its positive reception. Progress towards the one million minutes of QI coaching.
- Ward accreditation efforts have been positively received .
- A positive patient story was shared related to a patient with ongoing rehabilitation needs and the impact of the support from therapists in prevent deconditioning.

Enhanced Care Framework: A training programme is being delivered to Heads of Nursing on the enhanced care framework. The framework will be piloted in older adult mental health wards. There will need to be a focus regarding fall risks when patients are stepped down to local general hospitals. More details can be found on the intranet page.

Audit Management and Tracking (AMaT):There is a need to promote the wider use of AMaT for clinical audits and inspections. Training sessions will need to be provided.

Learning from Incidents: A number of incidents were discussed to consider how learning could be disseminated widely. This included one that related to falls post-transfer from enhanced care, anticoagulation safety post discharge, and deteriorating patient management were highlighted. A learning event and shared learning initiatives are planned to address these concerns across the organisation.

Complaints and Patient Feedback: A pilot project is underway on a trauma and orthopaedic ward to collect feedback post-discharge, aimed at improving early complaint resolution.

Annual Quality Report: The report has been approved by the Executive Committee and Patient Quality and Safety Oversight Committee (PQSOC). It outlines achievements, challenges, and plans for the next year, aligning with the Health and Care Quality Standards.

Putting Things Right Annual Report: The report was discussed with the Group, highlighting key statistics and improvements in complaints management and early resolution.

World Patient Safety Day: Members were encouraged to share projects focusing on diagnosis improvements for the learning repository.

Safe Care Collaborative: The 2024/25 focus will be on acute deterioration and deconditioning. Updates will be shared.

Next Meeting: Wednesday 13 November 2024, 13:00–16:00hrs via MS Teams.

Good Practice

Section 1

Diverse Cymru Cultural Competency Accreditation

Accreditation

- Diverse Cymru's Cultural Competence Certification Scheme is an award winning workplace development tool to help organisations implement good workplace practice, ensuring services are fair and equitable for Black, Asian and Minority Ethnic people in Wales.

- "We believe that an organisation that understands and appreciates cultural difference will promote diversity, inclusion and belonging so that individuals of all backgrounds feel respected and valued. Practicing cultural competence will enable an organisation to attract the best talent as employees and to provide fair and equitable services for everyone."

Achievement

Addressing health inequalities with a focus on the MBRRACE report, access to services, PREMS and PROMS, leadership and cultural change

Completed service improvement initiatives, changes in practice and innovation to include over 300 items (e.g., maternity volunteer service, multifaith celebrations, black and brown torsos and dolls for training, modest uniforms for staff, improved translation services, mandatory training in E,D,I including unconscious bias training, bespoke antenatal services like Bengali women's antenatal class, 'Welcome' support for Afghan women, Hungarian mothers coffee and chat, and more).

Completed self assessment and evidence document.

Ward

- First (and only)maternity service in Wales to achieve the **Silver distinction** accreditation (embedding excellence in cultural competent practice)
- First maternity services in Wales to achieve accreditation (alongside Powys maternity and RCM Wales)
- Awarded by the First Minister for Wales
- ABUHB have supported maternity services in Wales, and Guernsey, to work towards accreditation
- We are supporting a midwife from ABUHB as lead midwife for equality, diversity and inclusion in a secondment to Welsh Government
- Aiming for Gold accreditation next year

Diverse Cymru Cultural Competency Accreditation

- Following a self assessment and verification by Diverse Cymru, the Patient Experience and Involvement Team have been awarded a **SILVER AWARD DISTINCTION**.

- This Award is a symbol of recognition for the organisations that have embraced and implemented **culturally competent practises** and are committing to the process of continual improvement in this area.

- Evidence of progress was submitted to reflect culturally competent practice in areas of the Patient Experience work programme including:

  - Staff recruitment and training
  - Volunteering (including recruitment, reasonable adjustments and marketing)
  - Listening and Learning
  - Dementia
  - Chaplaincy Services
  - Bereavement
  - Engagement
  - Patient Experience Activities

Celebrating Success

Volunteering Awards

- Winners of GAVO Blaenau Gwent Awards for Ffrind I Mi
- Winners Stroke volunteers won the Caerphilly GAVO awards
- Finalists at TVA awards
- Finalist for Stroke Volunteering at Newport GAVO Awards

Patient Experience and Involvement Awards (October 2024)

- Chief Nursing Officer for Wales Excellence Award (Lead Nurse, Dementia)
- Margetts Scholarship Award (Clinical Skills Trainer)

Escalation

Section 2

Mental Quality, Mental Health & Learning Disabilities: Quality, Safety & Governance Update

- Additional governance and oversight were implemented to address concerns about the assurance of safety and quality of services within the Mental Health and Learning Disability Division.
- A structured 30, 60, and 90-day improvement plan was developed to manage serious incidents and improve safeguarding, quality, safety, and governance practices.
- The plan targeted initial areas of concern and launched wider initiatives aimed at workforce modelling, leadership enhancement, performance, risk management, and transformative service changes.
- Notable achievements include the appointment of a new Divisional Director, staff engagement workshops, enhanced governance, better processes for learning from deaths, and progress in delivering sustainable improvements.
- Ongoing challenges include integrating governance and assurance processes, improving patient security, staff welfare, cultural initiatives, and addressing persistent problems with the patient information system.
- Continuous reporting on quality, safety, and governance will continue through various committees, and the Executive will conduct bi-weekly Divisional Assurance Meetings to maintain a consistent emphasis on improvement.

Urgent and Emergency Care: Focus on Patient Safety and Experiences

- New Operational Framework developed to support the management of departmental / Unit, site and system risks.
- Weekly Safety Flow (Enhanced Monitoring) cross-Divisional meetings focus on dynamically reviewing and evolving practice and processes to improve outcomes, efficiencies and patients' experiences.
- Emergency Department Triggers revised to reflect system demand, acuity, flow and capacity, focussing on patient safety to expedite transit aligned to patients' needs.
- Improved system escalation processes enacted dynamically via the Operations Directorate, ensuring that senior support is mobilised, actions taken and accountability to manage evolving system risks.
- Safe-to-Start processes and principles being reviewed with the aim of empowering specialties to take greater accountability for their demand, risk and flow profiles to support first floor services / risks, to enhance the quality of care provided and to improve patients' safety.
- New Transfer Lounge with increased capacity being operationalised at the GUH (Q4, 2024//25) to improve the timeliness of flow and to generate an earlier bed capacity profile.

External Assessments – Q2 2024/25

Health Inspectorate Wales – Inspections and National Reviews

None during Q2

Llais Gwent Region Visiting/Survey Reports

Hip and Knee Survey Report – July 2024
3 recommendations highlighted
Health Board improvement plan submitted – 04/09/24

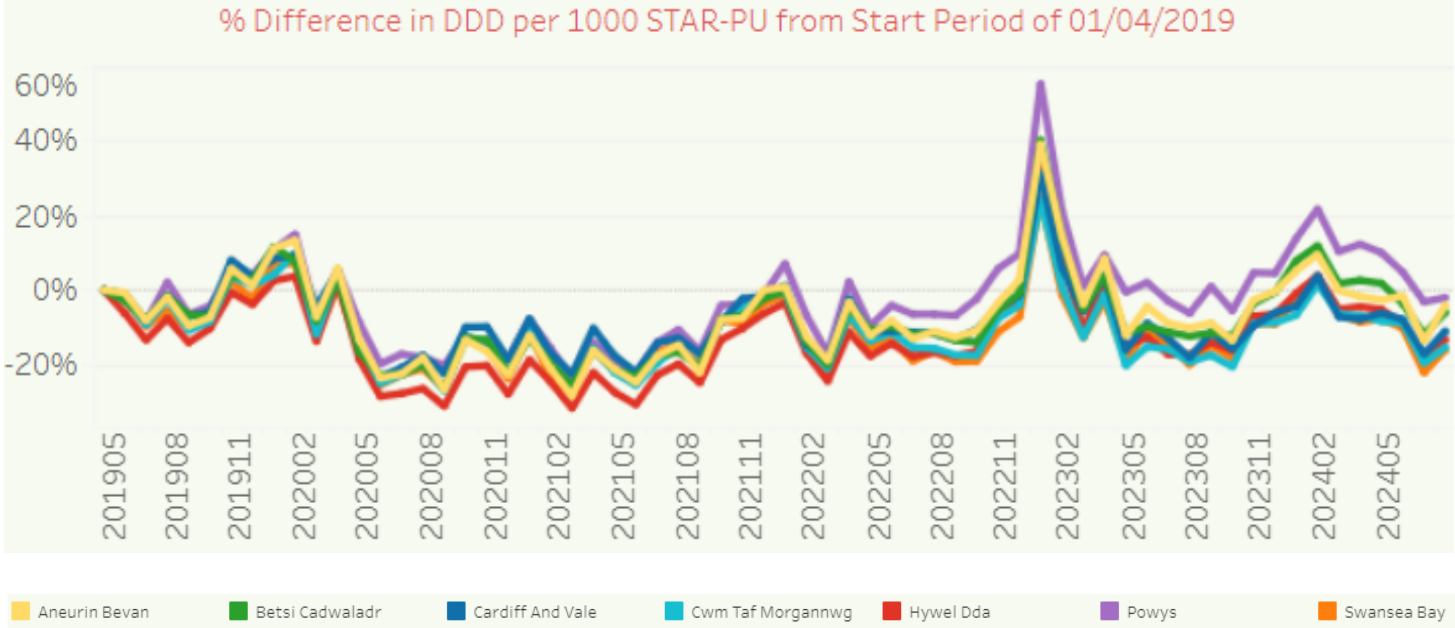
Health Inspectorate Wales – Immediate Assurance Letters

Month	No. of Immediate Assurance Letters	Ward/Area of concern
July	1	Hafen Deg Ward, County Hospital
August	4	D5 West, Royal Gwent Hospital
		Wyecliff Dental Surgery, Pontypool
		Kaleidoscope Project Clinical Provision in Wales
		Beechwood Ward, St Cadoc's Hospital (follow-up to a previous concern)
September	3	Kaleidoscope Project Clinical Provision in Wales (follow-up to previous concern)
		Cedar Ward, Ysbyty Tri Chwm
		Consultant cover – Application of the Mental Health Act

Update on Actions from September 2024

Antimicrobial Prescribing

WG Targets – Antimicrobial Prescribing: Primary Care



A change in strategy to address these new targets is under discussion, with a move away from audit and feedback cycles with individual practices towards wider thematic work.

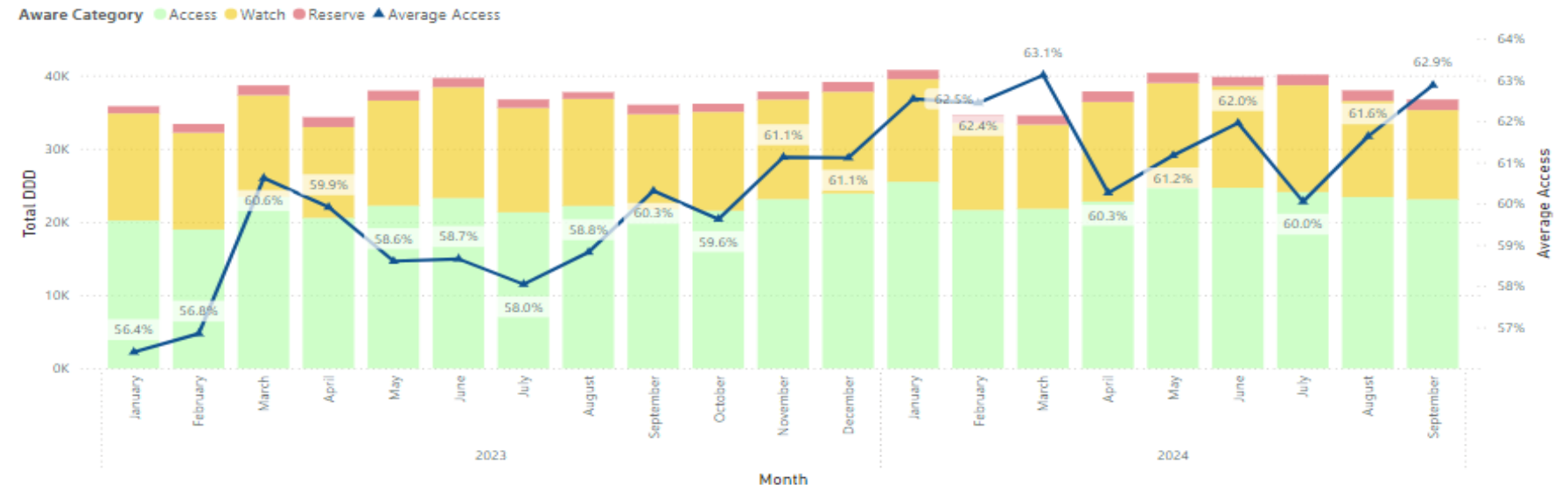
WHC 2024/038 27/09/24 sets out two new targets for antimicrobial use in primary care:

- Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline. This will now be measured in defined daily doses (DDDs) of antibiotics, equivalent to the number of days of therapy supplied.
  - A formal baseline is awaited from Public Health Wales but preliminary data below suggest AB is currently around the baseline.
  - Ongoing work on reducing course durations from 7 days to 5 days will help with this metric

- WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30. This will be measured in defined daily doses (DDDs).
  - A formal baseline is awaited from Public Health Wales.
  - Ongoing work to minimise use of higher risk '4C' antibiotics will help achieve this target. There have been reductions in 4C use in both Q4 23/34 and Q1 24/25 demonstrating improvement in practice.

Antimicrobial Prescribing

WG Targets – Antimicrobial Prescribing: Secondary Care



WHC 2024/038 27/09/24 sets out two new targets for antimicrobial use in secondary care:

- Reduction in total antimicrobial use in secondary care by at least 5% by 2029/30 against 2019/20 baseline.
- Minimum of 70% of total antibiotic use from the adapted WHO 'Access' category by 2029/30.
- Both targets measured in defined daily doses (DDDs) of antibiotics, equivalent to the number of days of therapy supplied.
- Formal baselines are awaited from Public Health Wales, however local data (below) suggest antimicrobial volume is static (bar charts), while the Access proportion is on an upward trend.
- Working with e-prescribing team to embed best practice from go-live, as this will mandate behaviours that cannot currently be enforced on paper, however roll out approx. 2 years away.
- Joint antimicrobial ward rounds with Medical Microbiologists are key in managing the most complex patients and minimising unnecessary use, however staffing issues are currently impacting on the availability of the Medical Microbiologists, resulting in cancellation of rounds.
- Penicillin allergy delabelling will assist with 'Access' category target by allowing people with a false 'allergy' label to safely receive penicillins. Planned roll out Nov-Dec 24.

Sepsis Progress Report – Update

Conducting a scoping exercise to understand current practice of sepsis management and to improve sepsis awareness, treatment, and outcomes across our Health Board. Work to date includes:

- **Awareness Campaigns**: Posters such as "THINK Sepsis" and "Spotting the unwell child" are displayed in the Emergency Department (ED) and Children's Emergency Assessment Unit (CEAU) to raise awareness among patients and staff.
- **Sepsis Group**: A dedicated Sepsis Group meets bi-weekly in ED to monitor and review sepsis treatment and compliance. Feedback is given to staff, highlighting areas for improvement and recognising excellent work. Sepsis stars are awarded when good work is identified. Use of database monitor to progress and to recognise trends.
- **Education**: ED Practice Educators provide informal teaching and deliver training on managing deteriorating patients to new staff during induction.
- **Sepsis Board**: A sepsis board in the ED helps keep staff informed in the department and raises awareness.
- **Safety Netting**: CEAU staff provide safety netting information to patients and next of kin upon discharge, emphasising the signs and symptoms of sepsis.
- **Triage Tool**: The "Could this be Sepsis?" triage tool has been in use in the CEAU since July 2024.
- **Case Reviews**: The Health Board reviews all sepsis cases from the previous three months to share best practices and areas for improvement with staff.
- **Monitoring Tools**: A pro forma is used in CEAU to monitor open access calls and GP clerking. Weekly reviews ensure appropriate actions are taken.
- **Escalation Protocols**: Paediatric patients showing red flag signs of sepsis are escalated for urgent senior review.

These efforts aim to improve sepsis awareness, treatment, and outcomes across our health board.

Sepsis Progress Report – Future Work

- Welsh Government released a circular recommending adoption of the Early Warning Score systems throughout Wales, includes:
  - National Early Warning Score 2 (NEWS2), National Paediatric Early Warning Scores (PEWS), New-born Early Warning Track and Trigger 2 (NEWTT2), Maternity Early Warning Score (to be confirmed)
- This initiative aims to ensure high-quality, safe, and effective care and will need to be implemented through a collaborative approach.
- To achieve compliance with this, a scoping exercise is underway to assess the health board's current sepsis management, focusing on workforce, education, resources, and current guidance, while identifying good practices and areas for improvement.
- Current and Upcoming Initiatives to support this work
  - **Sepsis Screening Tool:** Development of a new tool for Adults, Paediatrics, Neonatal, and Maternity to complement NEWS2, PEWS, NEWTT2, and MEWS.
  - **Workshop 29th November:** A forum for staff to contribute to a two-year Sepsis strategy, setting out aims and objectives for the next two years.
  - **Safer Care Partnership:** Acute deterioration workstream is being run by NHS Exec and will run parallel to this work. This focuses on implementation of NEW2 and Call 4 Concern (Martha's rule).
- Key Actions and Groups to deliver this work
  - **Deteriorating Patient Working Group**: Long standing group within the Health Board to address patient deterioration. Recently updated the Acute Deteriorating Patient Policy.
  - **Sepsis Working Group**: Group formed to focus on improving sepsis practices.
- Both Groups consists of a patient facing multidisciplinary team (MDT) from Medical, Nursing, Physiotherapy, Pharmacy, Microbiology, and Quality and Patient Safety.

These efforts are part of a broader strategy to enhance sepsis care and patient outcomes across the Health Board. Sepsis is a workstream for year two of the quality strategy and a workplan is being developed.

Action	What is needed?	How will this be achieved?	Who	When
Understanding Our Health Board's Position on Sepsis	A scoping exercise is currently underway to assess the health board's current stance on sepsis. The main objectives are: • Reviewing Existing Education: Evaluating the current sepsis education provided to staff to ensure it aligns with best practices. • Clinical Practices: Examining current clinical practices, including a review of the latest antimicrobial guidance. • Cultural Assessment: Understanding the existing culture around sepsis management within the health board. This exercise will help us prepare for the implementation of the latest NICE guidelines and the new Early Warning monitoring tools. These steps are crucial for enhancing our sepsis management and ensuring high-quality, safe, and effective care for our patients.	Appointment of a new Assistant Quality and Patient Safety Assurance Lead under the Medical Director's team, who will primarily focus on sepsis within our Health Board. Key Responsibilities and Actions: Scoping Exercise: The new lead has begun meeting with key stakeholders and divisional leaders to understand our current position on sepsis, ongoing improvement efforts, and areas needing enhancement. Support and Collaboration: This role will provide additional resources to support ongoing improvement work and collaborate on implementing upcoming changes. This initiative aims to strengthen our sepsis management practices and ensure we deliver high-quality, safe, and effective care to our patients.	Assistant Quality & Patient Safety Assurance Lead	Post started Sept 2024 To be completed by Dec 2024
Standardise Sepsis education	To ensure the Health Board is delivering the highest standard care around Sepsis and complying with NICE guidelines, ensuring each member is provided with the same level of education is paramount. By reviewing and implementing a collaboratively agreed standardised Sepsis education monitoring and reviewing the impact will subsequently be more robust, which will enable opportunities for deliverable improvement.	Following the scoping exercise and utilising the Sepsis Working group forum, Task and Finish groups to be created with the aim of reviewing what is currently in practice and standardising across the divisions.	Assistant Quality & Patient Safety Assurance Lead	To be completed by April 2025
Assessment of Sepsis Education within the Health Board	Effective education is critical to ensuring successful implementation of the Sepsis strategy, NICE guidelines and new Sepsis Early Warning monitoring tools.	Through discussions with education leads, clinical directors and practitioners a data base is being formulated to gauge current Sepsis education delivered, resources for each department and improvement work all ready being undertaken.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Dec 2024

Action	What is needed?	How will this be achieved?	Who	When
Public Awareness Campaign for Sepsis	As winter is approaching, providing a robust Sepsis awareness campaign will aid the public in recognising symptoms of Sepsis and provide recommendations on when to seek medical advice.	Communication with UK Sepsis Trust has commenced and agreement to utilise readily available resources. Additionally, the Health Board Comms team and QPS are working collaboratively to deliver a Health Board Sepsis communication plan.	QPS and Comms	Nov 2024
Working in Collaboration	Ensuring a collaborative approach is maintained throughout Sepsis delivery is fundamental to ensure best practice is upheld and risk is mitigated. The Sepsis Working group has been created to provide a forum for members of the MDT to discuss ongoing issues, areas for improvement and gives further opportunity to deliver Health Board and national updates.	This will be achieved through maintaining the Sepsis working group to enable a MDT approach to discussing and implementing actions/ solutions. The Assistant Quality and Patient Safety assurance lead will work closely with Directorates and provide a link between services, sharing good practice and supporting quality and improvement initiatives. By working directly with each area/speciality this will enable an additional opportunity to gain a true understanding of what is needed to improve how we recognise, diagnose and treat Sepsis.	Divisions and QPS	Ongoing
Continue working with UK Sepsis Trust and other health boards/trust	UK Sepsis Trust was founded in 2012 and has become a invaluable resource for both NHS England and NHS Wales. Working collaboratively will shared practice from Health Boards and Trusts across Wales and England. The Charity provide a wealth of evidenced based resources currently being utilised, including Sepsis UK screening tools, Educational resources and Signs and Symptoms awareness posters/leaflets.	Representatives from UK Sepsis Trust have supported the Health Board previously with the initial NEWS implementation and have remained a valuable contact. By ensuring regular communication is upheld between ABUHB and UK Sepsis, it enables a further opportunity to share evidence based resources to support our clinical practice.	Divisions and QPS	Ongoing
Develop Audit Strategy for Sepsis and ensure learning from incidents	Ensuring a robust method is in place to capture data around Sepsis is crucial. Currently, Sepsis monitoring is captured in different ways across the Health Board, which prevents creditable data to support improvement.	Working closely with the divisions to understand what universal data is required and agree standardised method for capturing identified patients with Sepsis. Use of AMaT to develop a proforma and ensure the audit is efficient and the workforce have the capacity to input. There is a need to developing a system for learning from incidents where Sepsis was missed. Undertake thematic review from Datix incidents.	Sepsis Working Group	March 2025

Sepsis Annual Workplan 2024/25

Quarter One	Quarter Two	Quarter Three	Quarter Four
Deteriorating patient group meeting taking place	Scoping Exercise – work with divisions and directorates, understanding the specific issues in recognising and responding to sepsis.	Develop Audit Strategy – review current measures Scope opportunities to capture missed patients, e.g. Careflow, DATIX, ED & Outreach team. Undertake Thematic review of common incidents.	Standardise education and deliver ahead of change to monitoring tool to ensure success implementation and reduce risk. Continue delivering education around the new Sepsis monitoring tools.
MDT 'task and finish group' established to update The Health Board Deteriorating Patient Policy	Assessing Education - establish what is currently in place, identify gaps in deteriorating patient/Sepsis training	Produce Driver Diagram for Sepsis.	Implementation plan for NICE guidance
Deteriorating Patient Policy approved by Clinical Standards and Policy Group.	Public Awareness Campaign for Sepsis	Hold workshop to develop sepsis strategy, by identifying key areas for improvement and ensuring new monitoring tools are suitable for the Health Board.	Introduce NEWS2, PEWS, MEWS and NEWTT2 across ABUHB. Ensure good communication with directorates and provide support around the new early warning scores.
Roll out of Deteriorating Patient Policy across Health Board	Standardise Sepsis education – incorporating the new Sepsis Screening tool, NEWS2, MEWS, NEWT2 and PEWS	Introduce Pilot – to test and measure new Sepsis screening tool and NEWS2. Working closely with wards during the pilot in order to capture issues and provide support.	Continue communication strategy to ensure all staff are aware of new Early warning tools and Sepsis screening tool and NICE guidance.
Meeting with UK Sepsis Trust	Scope and review current Antimicrobial stewardship. Establish what steps are needed to comply with NICE guidance.	Staff awareness campaign – to reinforce the signs and symptoms of Sepsis, the importance of early recognition, Sepsis Screening and Escalation. Additional focus around new Sepsis guidance and antimicrobial guidance.	Implement Audit Strategy – Implement new audit to capture compliance with Sepsis treatment and ensure recognition, response and treatment is captured.
Sepsis Working group established and initial meeting held	Continue to work with UK Sepsis Trust and meet with health boards to share good practices.	Communication campaign to inform staff of upcoming change to NEWS, PEWS, NEWTT2 and MEWS. To include further awareness around new Sepsis Screening tool.	Implement monthly meetings with wards/directorates and feedback data around Sepsis to ensure continuous monitoring and support areas in need of improvement.

General Practice and Child Protection Register

Introduction

- It was highlighted by the Monmouthshire NCNs that their member practices were not always being made aware when Children went on to or off of the Child Protection Register.
- The ABUHB Safeguarding Team agreed to engage with Monmouthshire County Borough Council to:
  - Receive the list of children on the Child Protection Register
  - Check NHS systems to confirm which GP the child is registered with
  - Provide lists of which children are on the Child Protection register to each individual General Practice
  - Provide Monmouthshire County Borough Council with a list of which General Practice the child is registered with

Review of First Quarter

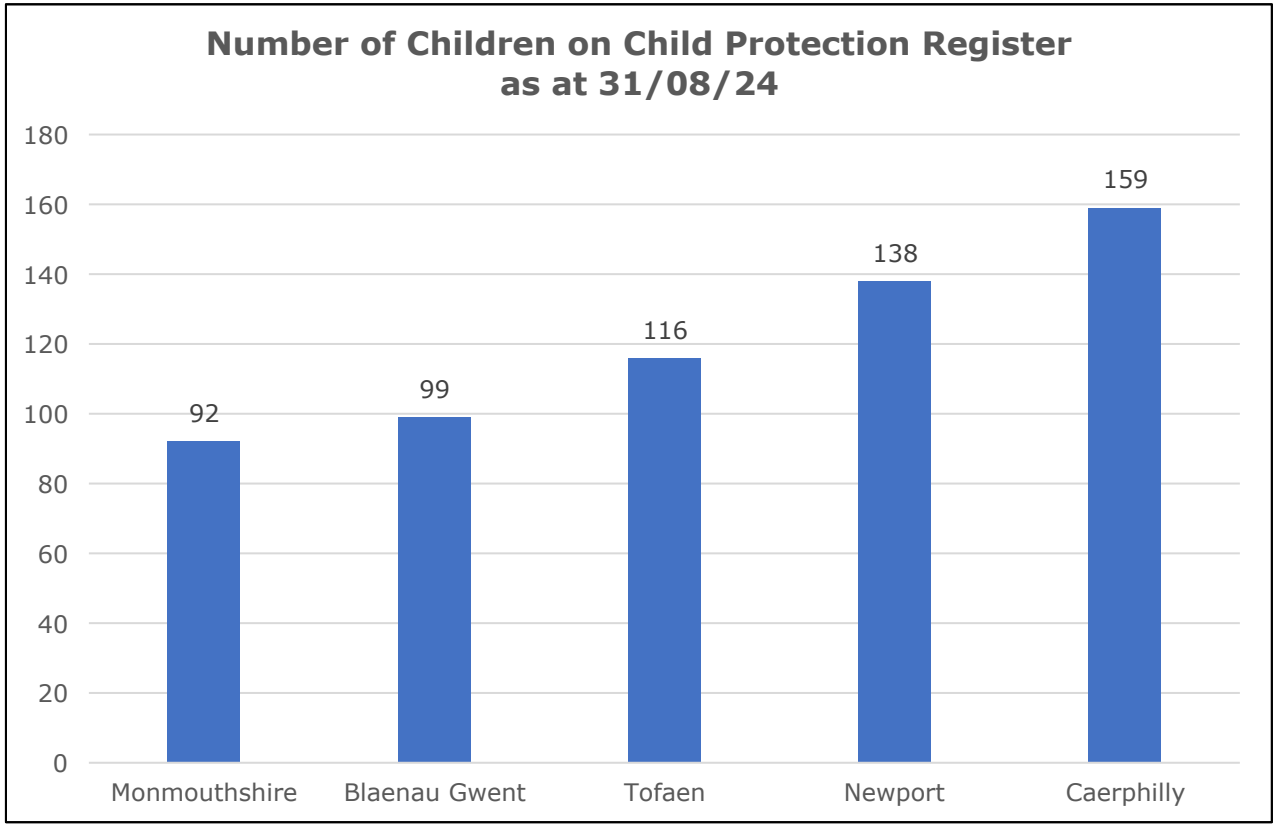
- Following the first quarter of this process it has been noted:
  - The LA are finding updated contact details enables them to ensure that the correct General Practice teams are invited to Child Protection Conferences.
  - Practices have fed back that knowing the child is on the Child Protection Register has enabled them to contact the Local Authority to request detail and context.
  - Practices have been able to identify concerns and ensure that they are fed back in a timely and appropriate way to interested agencies.
  - In a small amount of cases, NHS systems do not reflect the current GP.

Data

Data provided by the five Gwent Local Authorities demonstrated the volume of children on the Child Protection Register at any given point, with children going on to and off the register with regularity.

On 31/08/2024 there were:

- 92 Children in Monmouthshire
- 99 Children in Blaenau Gwent
- 116 Children in Torfaen
- 138 Children in Newport
- 159 Children in Caerphilly



Next Steps

- A further quarter of trailing the process in Monmouthshire, to resolve challenges in format and availability of data.
- Discussion with the NCNs in the remaining four boroughs to determine if there is a necessity or appetite for the same process.
- Negotiations with the Local Authorities in the remaining four boroughs, to ensure they will engage with process.
- Planned to extend approach Gwent wide from 01/04/25, following discussions with the NCNs and Local Authorities.

For Discussion

Section 3

PSI Learning Report: Incident Summary

A 9-year-old boy referred to the Children's Emergency Assessment Unit (CEAU) at GUH with suspected appendicitis was diagnosed with Influenza A and discharged without a senior medical review. Four days later, he returned critically ill with septic shock from a bowel infection. Despite treatment and transfer to UHW, he sadly passed away.

PSI Learning Report: Key Learning and Insights

Ensuring Senior Medical Oversight:

- **Issue:** The child did not receive a senior medical review during his initial visit, resulting in a missed opportunity for accurate diagnosis and timely intervention.
- **Insight:** Senior clinical oversight, particularly in cases presenting with ambiguous symptoms, is essential to ensure comprehensive assessment and appropriate decision-making.

Strengthening Communication and Triage Processes:

- **Issue:** Gaps in communication, including the lack of a structured triage process, contributed to the mismanagement of the case.
- **Insight:** A well-defined and consistent triage system, supported by clear communication protocols, is critical for ensuring that all incoming referrals are appropriately assessed and managed.

Capacity Management and Adaptation:

- **Issue:** Increased patient volume at the CEAU impacted the ability to provide timely care, contributing to delays in appropriate diagnosis and treatment.
- **Insight:** Adequate capacity planning and process adaptation are necessary to manage patient surges effectively and maintain high-quality care standards.

PSI Learning Report: Key Learning and Insights

Developing a System for Re-Presentation and Safety Netting:

- **Issue:** Lack of a structured approach for managing patients who re-present to CEAU contributed to delays in recognising the seriousness of the child's condition.
- **Insight:** Implementing a clear system for re-presentation, including defined pathways and guidelines, can ensure timely reassessment and prevent adverse outcomes.

Importance of Family Engagement in Care and Feedback:

- **Issue:** Communication with the family could have been improved, and their feedback was not sufficiently integrated into the investigation process at the start.
- **Insight:** Engaging families as active partners in care and using their feedback during reviews can lead to more thorough investigations and help identify areas for improvement.

Enhancing Resuscitation, Transfer, and Communication Training:

- **Issue:** Identified gaps in staff training, particularly around resuscitation, patient transfer, and communication protocols with external services like WATCh, hindered the effective management of critical cases.
- **Insight:** Regular, comprehensive training programs are vital to equip staff with the skills needed to manage emergencies effectively and coordinate with external services.

PSI Learning Report: Recommendations for Improvement

- **Implement Safety Netting Protocols:**
  Distribute new safety leaflets incorporating elements from the UK Sepsis Trust to inform families about serious illness signs and when to seek further medical advice.

- **Revise Senior Review and Discharge Procedures:**
  Enhance the process to ensure senior doctors are involved in cases, with clear criteria for when a senior review is mandatory before discharge.

- **Ensure GP Referrals are Prioritised:**
  Develop a new admission form that explicitly highlights the source and reason for referral, ensuring that all GP referrals are read and considered during initial assessments.

- **Strengthen Staff Training on Critical Protocols:**
  Update training for paediatric staff to include resuscitation, patient transfer, and communication with external services, ensuring better preparedness in managing critical cases.

- **Establish Clear Guidelines for Re-Presentations:**
  Display guidelines within CEAU on how children can re-present (via GP, 111, or direct access), and ensure staff are well-versed in these pathways.

- **Optimise Capacity Management:**
  Implement measures to manage increased demand, ensuring timely and effective care without compromising safety.

PSI Learning Report: Recommendations for Improvement

- **Integrate CCTV Review in Safety Investigations:**
  Add CCTV review to the agenda for patient safety investigations, where relevant, to provide additional insights into case management.

- **Engage Families in Incident Investigations:**
  Include patient and family input in the Terms of Reference (TOR) for incident reviews, promoting a more comprehensive analysis.

- **Share Learnings Through Case Presentations:**
  Present this case at Clinical Governance Day 6 September 2023 and PQSOC in November 2024 to ensure lessons are shared and integrated across teams.

- **Conduct a Governance Review for Safety Monitoring:**
  Review security and monitoring arrangements in restricted areas to improve patient safety.

- **Ensure Accurate Data Entry for Patient Tests:**
  Reinforce the need to enter NHS patient numbers in testing systems to facilitate seamless data integration with ICNET.

- **Develop a Sepsis Awareness Improvement Programme:**
  Launch a Health Board-wide program to enhance early recognition and response to sepsis, ensuring prompt and effective intervention.

PSI Learning Report: Conclusion

This report and action plan highlights the need for robust processes, effective communication, and continuous learning to prevent future incidents. The Health Board remains committed to implementing these recommendations to improve patient safety and quality of care.

Ward / Team Accreditation

Ward / Team Accreditation creates a structured system to continuously raise standards of care through effective goal setting, measurement, feedback and staff engagement which brings benefit to patients, staff and the organisation.

Phase 1: Adult Wards GUH, MH & LD Wards, and Paediatric wards (complete)

Phase 2: ED, MIU, MAU, SAU, Theatres, OPD Critical Care

Phase 3: HV, DN, Maternity services, Specialised Teams

Working Towards: -
- 55 adult wards
- 2 paediatric wards
- All inpatient MH & LD wards

Whole System Approach: -
- Monthly audits
- Triangulate Quality Metrix
- Patient and staff feedback
- Improvement project
- Workforce measures

Independent Reviews: -
- 10 Independent Reviews across four sites, of those reviewed 7 wards met the criteria for Bronze Level status

A2 Cardiology - first ward to achieve Bronze - success shared on the Intranet.

NEXT STEPS

- Progress with phase 2
- Coordinate timely cross divisional Independent Reviews when applicable
- Develop Ward Accreditation Padlet for the Intranet
- Liaise with ABCi department to determine how they can support Wards / Teams with improvement projects
- Share and upscale effective Improvement Projects throughout the organisation
- With the assistance of data analyst identify organisational themes for learning

Ward/Team Accreditation – Learning and Improvement

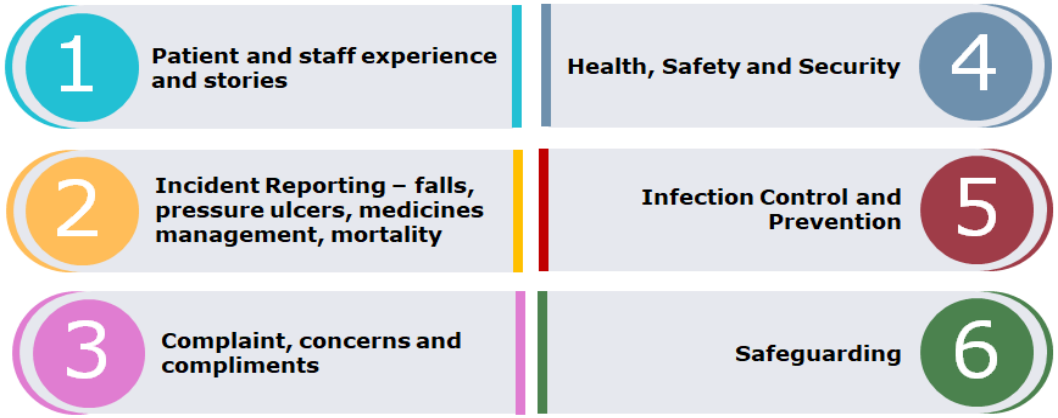
Issue	Action	Learning and Improvement	Who	When
The independent Reviews have raised questions regarding timescales for completion of risk assessments-current target has been set at 6 hours for all risk assessments.	Implementation team to benchmark with other health boards and clarify All-Wales guidelines on timescales for completion if risk assessment	The 6-hour target for all risk assessments may have prevented some wards from qualifying for Bronze award following independent review. Early indications suggest certain risk assessments need to be completed within 24 hours of admission / transfer rather than 6 hours. Following clarification, the audits will be adjusted accordingly in AMaT.	Senior Nurses Professional Practice	October 2024
Delay in progressing some areas in phase 2 of the programme due to availability of staff	Ongoing meetings with ED and Theatre staff to determine what and how to audit, develop and adjust existing audits. Full time 8a senior nurse has been appointed to progress programme.	The availability of the implementation team and the senior nurses for each department has delayed progress – it takes time to determine what to audit and how to adapt the audits to specialised areas.	Senior Nurses Professional Practice ED Senior Nurse and Band 7s Theatre Senior Nurses / Practice Educators	October/November 2024
Analysing the data and identify themes	Data analyst to assist the programme has been agreed-currently developing JD to advertise band 7 post.	AMaT is an excellent platform to undertake the audits and see the results at a glance. It is excellent for wards/Teams to analyse their individual data. However, it is not easy to create organisational reports from the data or to pull organisational themes.	Senior Nurses Professional Practice Data Analyst	November 2024

Questions

6 Pillars of Quality
1
Patient and staff experience and stories
2
Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
3
Complaints, Concerns and Compliments
4
Health, Safety and Security
5
Infection Control and Prevention
6
Safeguarding

Section 4

Pillars of Quality



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.

We must put the quality and safety of our health services above everything else. This strategy signals our intention to progress these six pillars of quality to establish our level of performance. The pillars will be our Quality Markers in our Quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services.

These measures of quality will allow standardised agendas for Divisions to report on quality measures.

PATIENT AND STAFF EXPERIENCE AND STORIES

Through the introduction of CIVICA – an electronic Citizen Feedback platform that will help people who are using our services to tell us what they think about their care. Providing feedback on our services will help us learn, make changes where we need to and celebrate what we do well. Staff will also be able to feedback on a regular basis, helping them to make improvements in their areas.

Analysis of patient experience data including complaints and compliments will provide a comprehensive picture of areas of positive performance and areas for improvement.

COMPLAINTS, CONCERNS AND COMPLIMENTS

Our commitment to patients is, wherever possible, to respond to their complaints timely and provide the information requested in an open and transparent way. Where it is not possible to provide immediate resolution, we commit to agree an appropriate investigation and to carry out that investigation to a high standard and on time. To ensure that all complainants have access to an investigating officer and are contact regularly.

INFECTION PREVENTION AND CONTROL

The Health Board is committed to zero tolerance of preventable Healthcare Associated Infections (HCAIs). Welsh Government sets reduction expectations for healthcare acquired infections which are achieved via collaboration from experts across healthcare. The Health Board are committed to providing clear programmes of work and evidence-based Policies which sets the expectation on the organisation. Our workforce will be skilled and trained to deliver against national, local and organisational objectives. We will monitor outcomes and reporting compliance/ learning through the Reducing Nosocomial Transmission Group (RNTG), Patient Safety Operational Group and Committee.

INCIDENT REPORTING

Through our 'Pillars of Quality' Programme, we will continue to focus on incident reporting as a key enabler of organisational learning and improvement. We will co-ordinate a comprehensive rolling Programme of quality improvement initiatives which strive to reduce avoidable harm with a focus on falls, pressure ulcers, deteriorating patients, mortality, end of life care, medicines management, discharge and safe transfers of care.

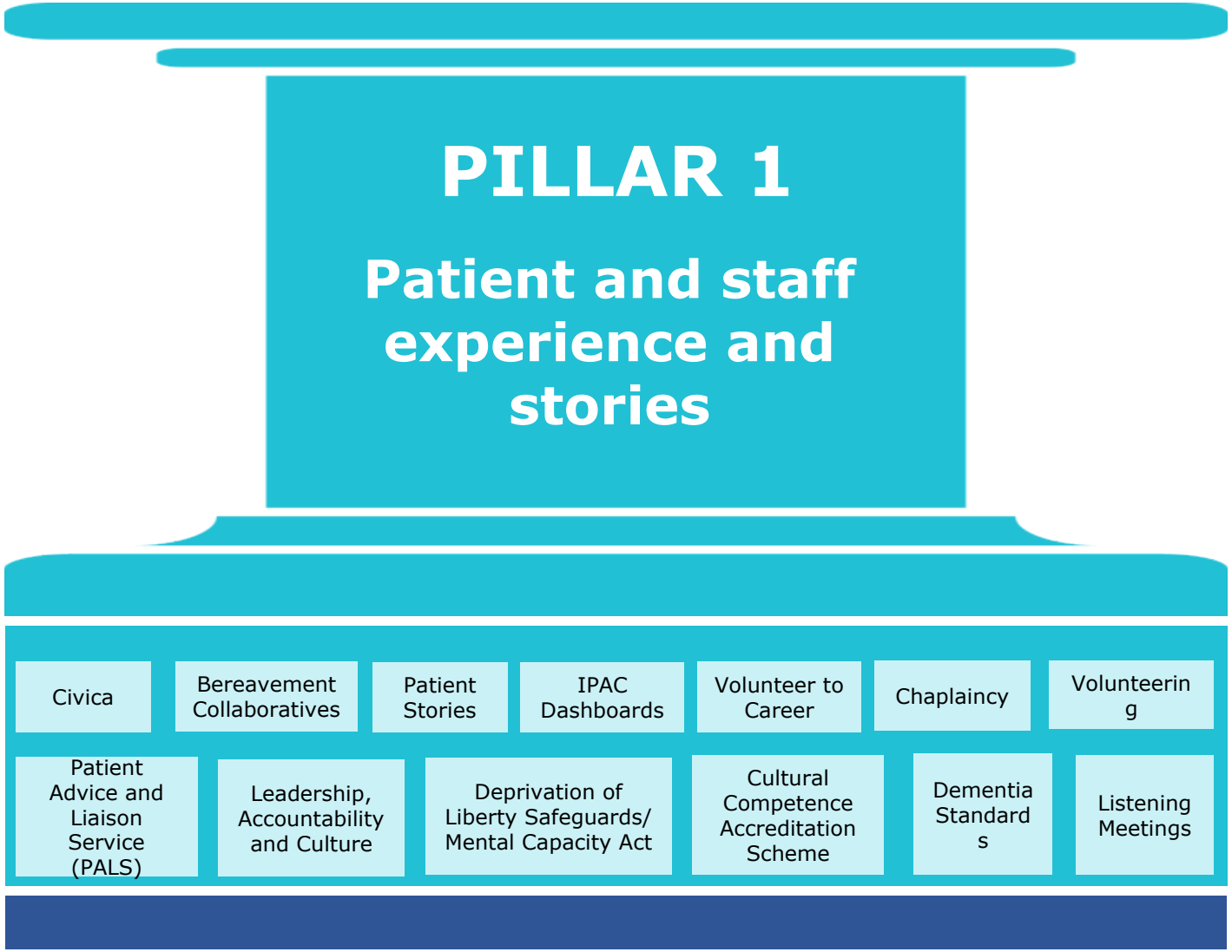
Our commitment to staff is to have a **just** culture, where staff feel safe to report concerns, incidents and near misses, knowing this will result in a timely, fair, comprehensive investigation. Our incident reporting system 'Datix' is a key component in providing insights to data gathering and learning actions.

HEALTH, SAFETY AND SECURITY

We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies and practices through our Health, Safety and Security Practitioners. We will conduct reviews of all sites and an annual snapshot of health and safety. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips and falls.

SAFEGUARDING

Safeguarding is everybody's responsibility. We will demonstrate reasonable steps to ensure the safety of children and adults at risk. The Health Board's Strategy and Policy sets the expectation of accessing services. The workforce will be skilled and trained to deliver national, local and organisational objectives. The Health Board will support and enable operationalisation through provision of tools and direct support from the corporate safeguarding team, as the workforce undertakes its duties in relation to safeguarding. We will monitor outcomes and report effectiveness through effective audit and clear governance processes.


PILLAR 1
Patient and staff experience and stories
Civica
Bereavement Collaboratives
Patient Stories
IPAC Dashboards
Volunteer to Career
Chaplaincy
Volunteering
Patient Advice and Liaison Service (PALS)
Leadership, Accountability and Culture
Deprivation of Liberty Safeguards/ Mental Capacity Act
Cultural Competence Accreditation Scheme
Dementia Standards
Listening Meetings

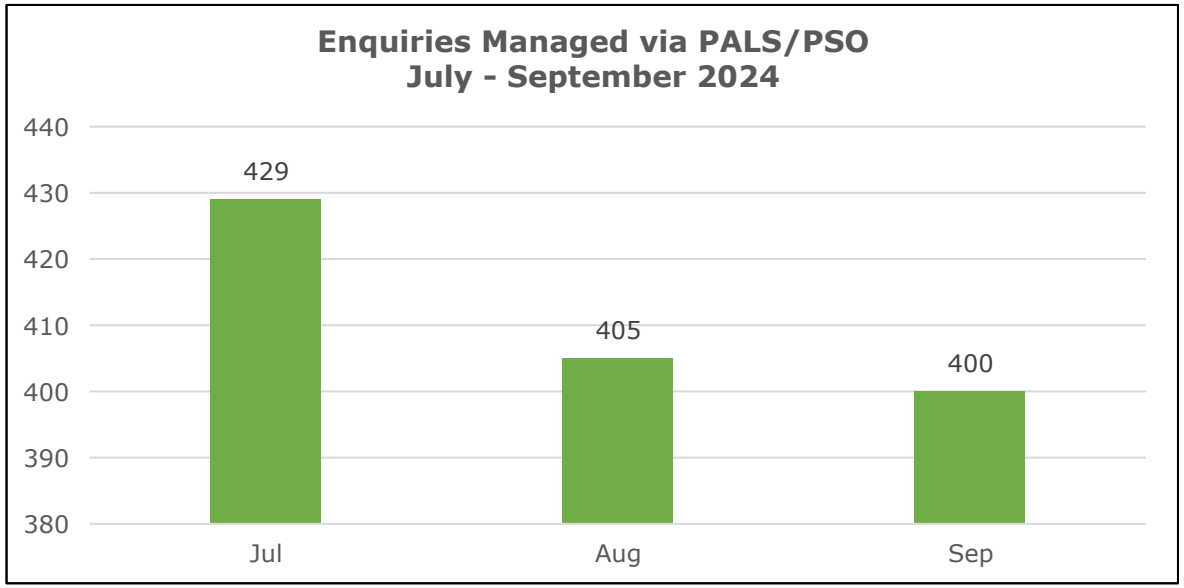
Adborth Cleifion: Gwrando a Dysgu

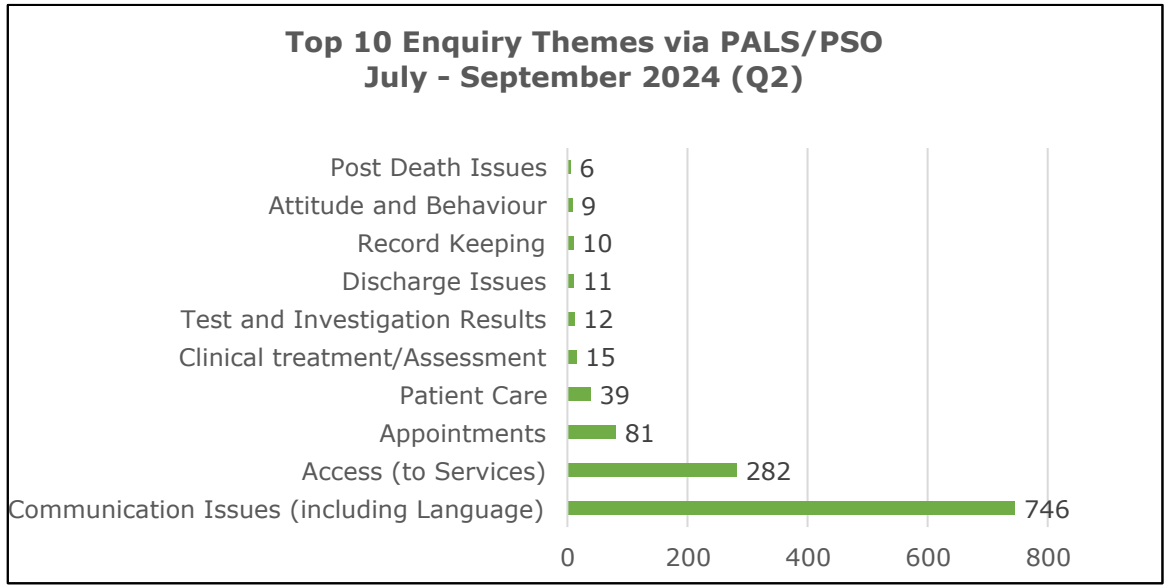
Patient Feedback: Listening and Learning

CIVICA & PALS

July – September (Q2) Update

Patient Advice & Liaison Service – Quarter 2 2024/25

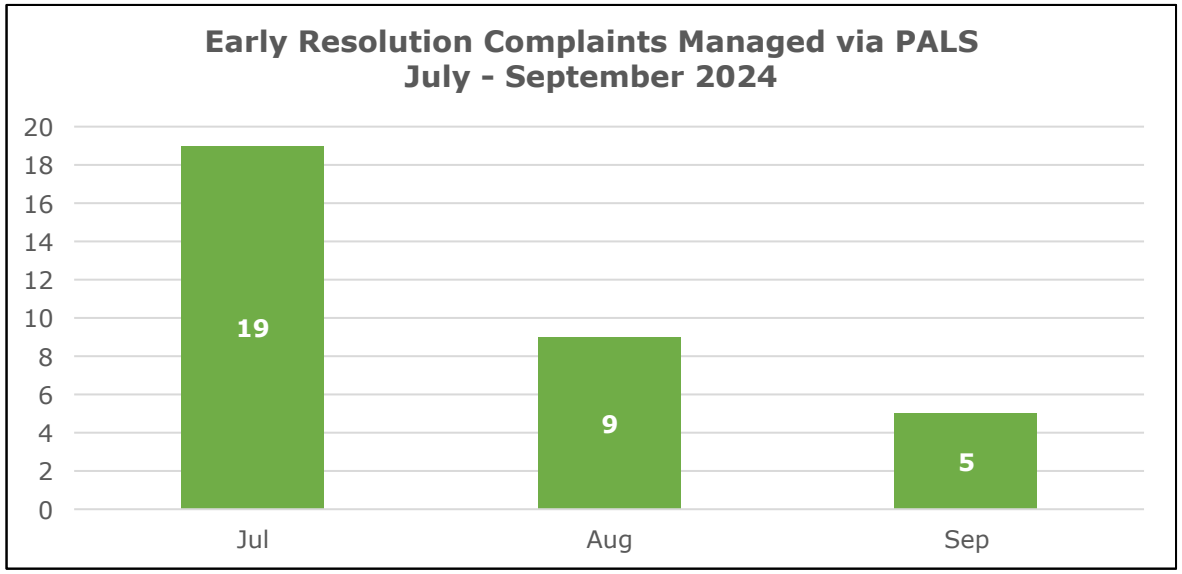


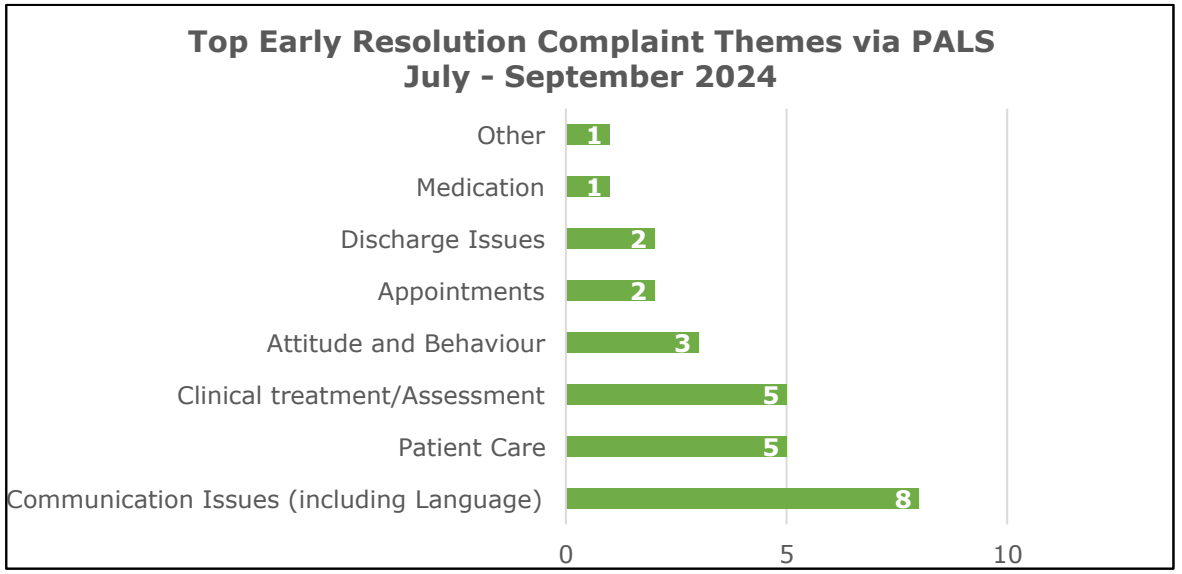


Enquires Overview: -

- **Average number of Enquiries -** 411 per month. This is a significant number, albeit a drop from previous quarter. The drop is likely due to an absence of a PSO; when a PSO is not in, the PSO phone goes to voicemail and therefore we are not connecting with the service users who do not leave a message.
- **Top Theme** - Communication Issues make up for 60.4% of the total Enquires for July – September 2024.
- **Enquiry Majority** - relate to lack of updates regarding Emergency Admissions. This is something the PALS, and especially PSO's, deal with on an hourly basis.

Patient Advice & Liaison Service – Quarter 2 2024/25





Early Resolution Complaints Managed via PALS
Complaints are often managed via Enquires unless specifically requested "Logged as Complaint" by the complainant.

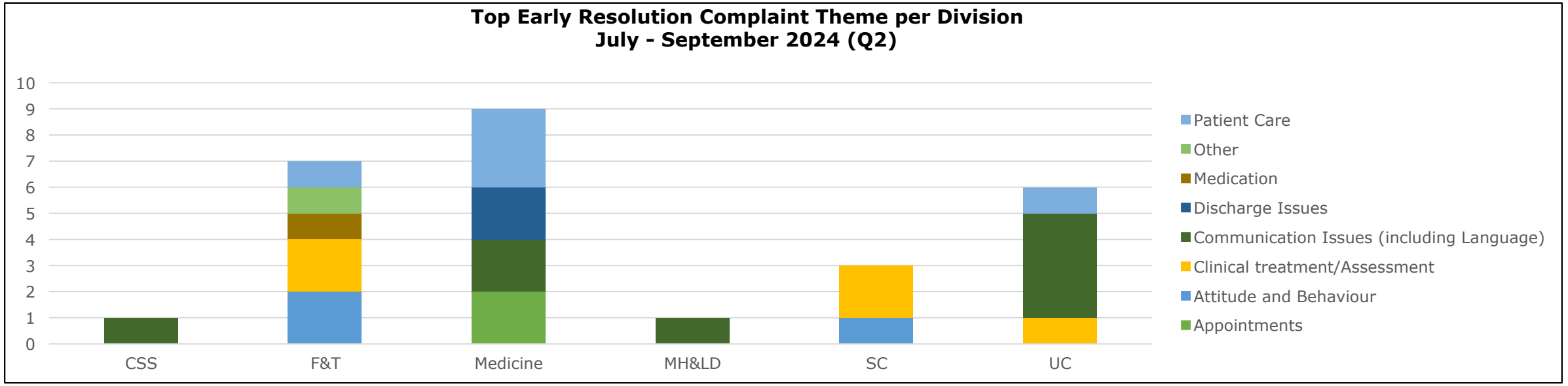
The other reason why they're logged as Enquires is that PALS do not fall under remit of The Putting Things Right policy. Therefore, PALS do not need to adhere to the strict regulations relating to Acknowledgement Letters, Holding Letters, and Final Response.

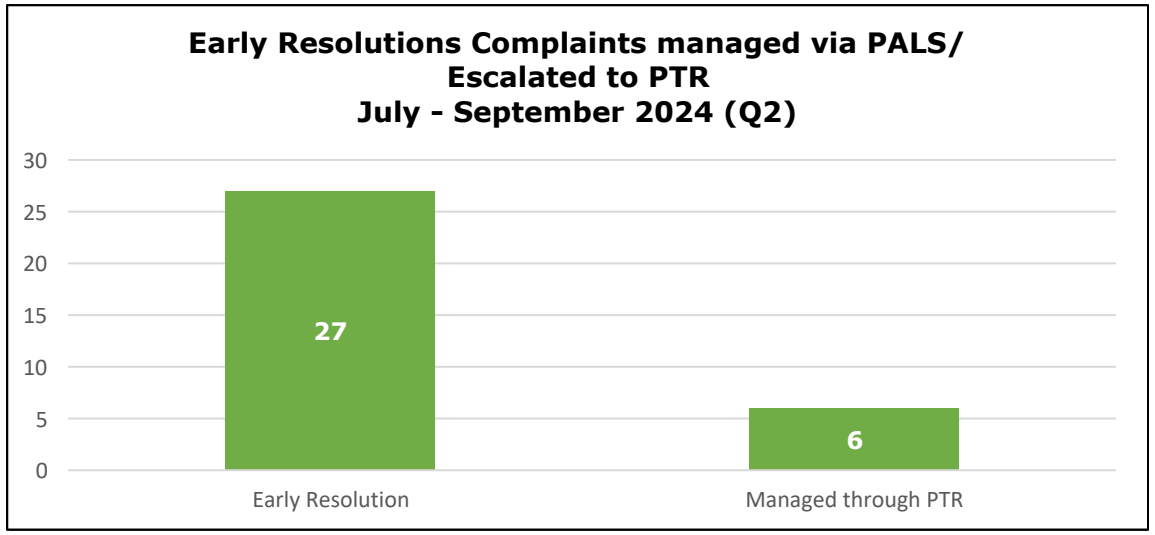
This guidance was provided after discussions with Quality and Patient Safety Leads. Therefore, we are likely to see a decrease in Early Resolution Complaints.

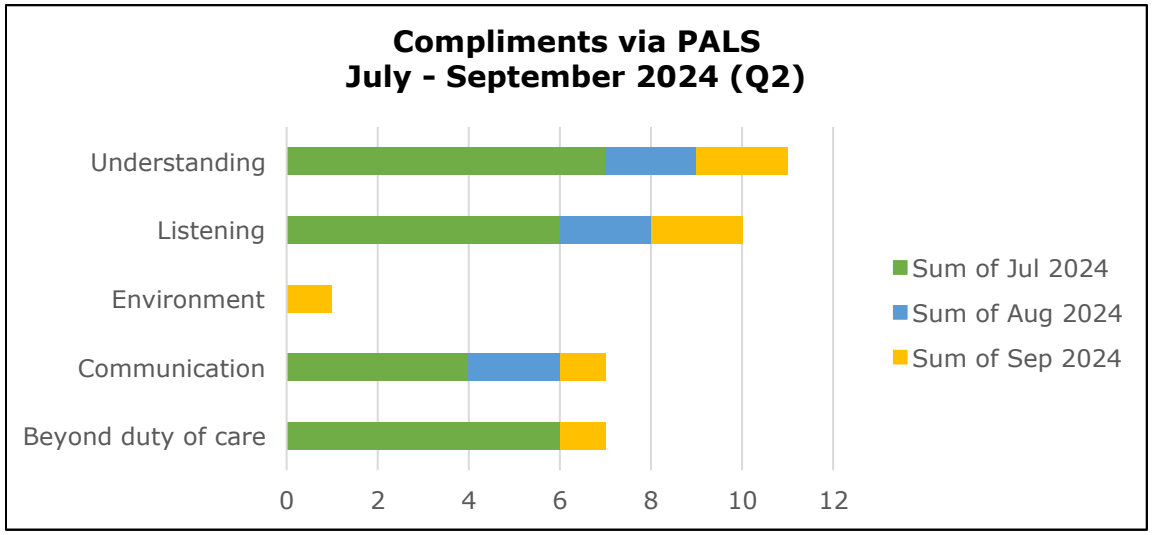
Average number of ER complaints - 11 a month over July – September.

Top Theme - Communication 29.6% of Early Resolution Complaints.

Patient Advice & Liaison Service – Quarter 2 2024/25







Qualitative Data:

It is difficult to convey the complexity and the value of the support the team have offered with the quantitative data. Below are some case studies from Quarter 2.

Case Study 1:

Patient A's sister contacted PALS as she was worried about him. PALS said that they could reach out to Patient A or he could contact us.

Patient A's sister followed up and said her brother would like a conversation with the health board. PALS contacted him and he told a PALS Officer that he had been diagnosed with terminal cancer, and the Officer was the first person he told. We agreed, that although he had no issues with the health board, a PALS officer would call him each week to check in with him. This check in was primarily to check on his wellbeing, and secondly it was to be active regarding any issues he may be experiencing. This is ongoing.

Case Study 2:

Patient B has been an open case with PALS for several months. PALS were originally contacted by the family of the patient. They were concerned for her wellbeing – the family live far away – and were fearful that Patient B would have no support as an inpatient.

Patient B had her arm amputated in an emergency situation and has had to process losing her arm at a late stage in her life. PALS have advocated for Patient B on each ward she has been on. PALS have facilitated video calls with Patient B 's family, as well as working to improve her wellbeing. PALS have visited as often as we can, provided company and assisted with activities (wordsearches) to improve Patient B 's hand-eye co-ordination. This is ongoing.

Case Study 3:

PALS were approached by a lady whose husband passed away earlier this year. The wife, did not want to raise a formal complaint as she is fiercely private about her husband's healthcare - she wanted only a PALS officer to know the details.

The PALS officer met with the wife and built trust and arranged a meeting with the Senior Nurse for Patient Experience to accompany. The PALS officer obtained all medical documentation relating to the husband's final week in hospital. The PALS officer and Senior Nurse met with the wife and went day by day through the notes and answered all questions that had raised.

This meeting was incredibly beneficial for the caller. The PALS team were able to give clarity and provide closure. There are some outstanding questions – relating to other issues – and the PALS team are currently still supporting until we have covered all grounds.

Case Study 4:

A young patient, was admitted into hospital. Her mother contacted us as she was concerned about her daughter. Her daughter has ASD and has difficulty communicating. The mother was attending 12 hours day but this was taking its toll on her and her other young children.

PALS, alongside the PSOs, visited the patient when her mother could not. The PSO and PALS officer developed a relationship with the patient where we encouraged activities, and conversations. This developed relationship meant the patient was comfortable in raising concerns to us and in turn we could broach with the nursing teams. This support lasted two months until the young lady was discharged.

Case Study 5

Patient C had been in touch with the Corporate team as she is unhappy with the pain medication she is being given and the care that she is receiving. This led to the corporate team contacting PALS.

PALS contacted patient C over the phone but was unable to talk on the phone. PALS visited Patient C to discuss her concerns, continuing to visit over the course of a few weeks.

PALS listened and supported patient C with her concerns, liaised with the medical and pain management team, helping patient to understand her options for her care and pain management. PALS continued to support patient C and although patient C isn't engaging with the staff or agreeing to care plans, patient C has capacity to make these decisions, the PALS team will remain available when needed for ongoing support.

Case Study 6

Patient D's daughter contacted PALS as she wasn't happy with the discharge plan that was being agreed. Patient D's daughter was struggling to liaise with the staff, with tension rising with concerns that communication was breaking down. PALS spoke with patient D for consent, checking that his daughters concerns were also his own concerns. PALS were able to alleviate stress by talking to patient D's daughter and the medical team involved in patient's care. PALS supported in arranging a family meeting to discuss discharge planning in more detail and to support patient D's daughter in expressing her concerns in the correct forum. Positive results from this meeting meant that patient D was safely discharged and the communication breakdown between patient D's daughter and the ward was resolved.

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback Q2 2024/2025

All Surveys

Number of Responses
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , Emergency Department Survey, Health Visiting Feedback Questionnaire, National Nosocomial COVID-19

1942
Responses
Export Options

Satisfaction Score
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , Emergency Department Survey, National Nosocomial COVID-19 Programme Investigation Survey, Palliative Care

91%
Satisfaction
Export Options

Emergency Department Survey

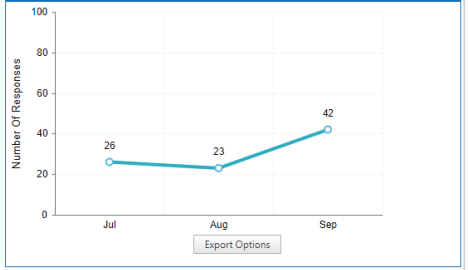
Number of Responses ED
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Emergency Department Survey - Standard)

91
Responses
Export Options

Satisfaction Score ED
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Emergency Department Survey - Standard)

76%
Satisfaction
Export Options

Responses Trend Graph ED
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Emergency Department Survey - Standard)



Response Trend

Person Centred Care (PCC) Survey

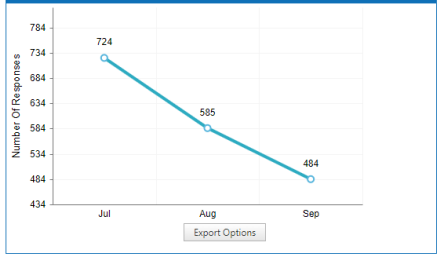
Number of Responses PCC
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Person Centred Care - Standard)

1793
Responses
Export Options

Satisfaction Score PCC
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Person Centred Care - Standard)

92%
Satisfaction
Export Options

Responses Trend Graph ED
Health Board Wide - 01/07/2024 to 30/09/2024
All Questions (Person Centred Care - Standard)



Response Trend

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback Q2 2024/2025
Emergency Department Survey

Location/Department	Responses	1 - Did you feel that you were listened to?	2 - Were you able to speak in Welsh to staff if you needed to?	3 - From the time you realised you needed to use this service, was the time you waited:	4 - Did you feel well cared for?	5 - If you asked for assistance, did you get it when you needed it?	6 - Did you feel you understood what was happening in your care?	7 - Were things explained to you in a way that you could understand?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall exp	Overall
		Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	
Emergency Department	91	82	50	53	81	82	77	78	78	80	76
	Overall	82	50	53	81	82	77	78	78	80	76
	Benchmarks	85	85	85	85	85	85	85	85	85	85

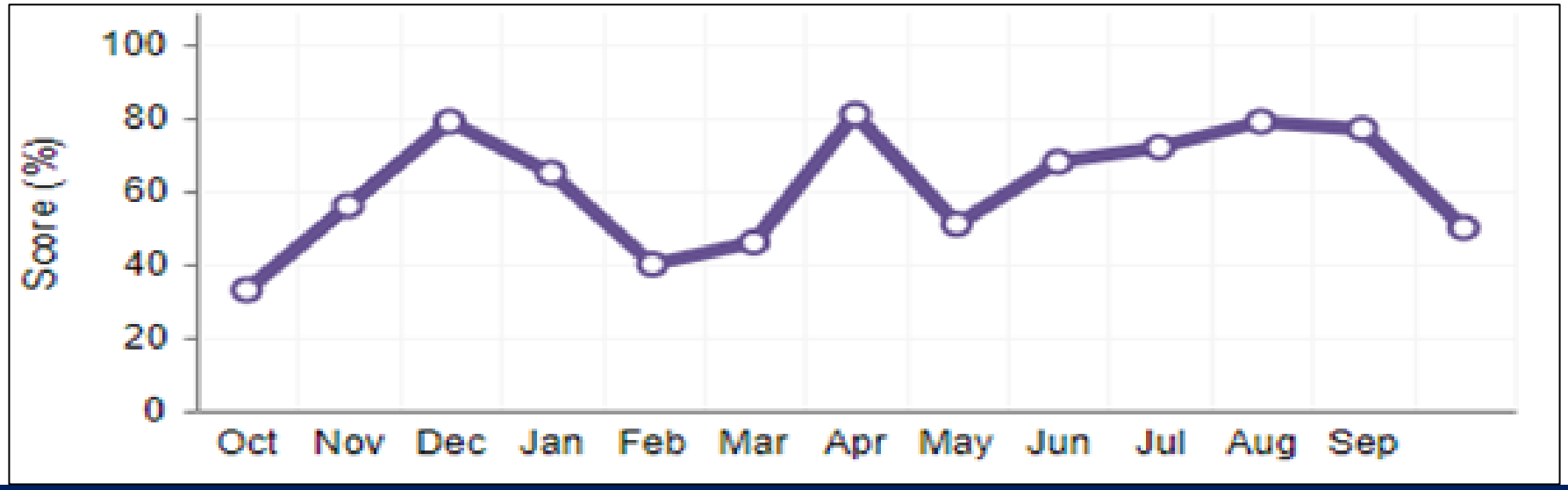
Overall feedback for the Emergency Department has increased from 68% in Q1 to 76% in Q2

Was there anything particularly good about your experience that you would like to tell us about?	Was there anything that we could change to improve your experience?
Top themes	**Top themes**
15 comments around **Compassion**	**12** comments around **Waiting**
10 comments around **Emotional & Physical support**	**2** comments around **Pain, Professional and Competent and Food & Beverages**
9 comments around **Helpfulness**	

Patient Experience Feedback Q2 2024/2025: Emergency Department Survey

- Completion of surveys still limited to QR code access, or support of PALS team to support patients with inputting responses via a tablet .
- Roll-out of SMS to ED and MIU underway – working with Urgent care, digital data team and information services and CIVICA with the view of launching within the next couple of months – this should then increase feedback for these areas.
- Improvement this quarter in overall Satisfaction Score and scoring against questions against Q1
- Push reports are sent monthly to the wider Urgent Care team showing feedback.

Emergency Department Survey Trend
October 2023 – September 2024

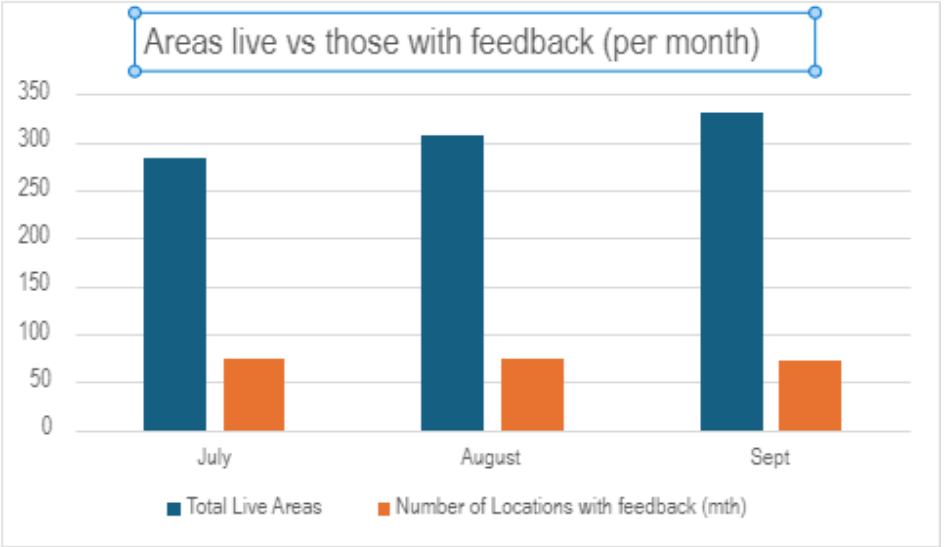


Patient Experience Feedback Q2 2024/2025

- There has been an increase in survey feedback for Q2 (1942) compared to Q1 (1733), with July being the highest month to date (759). However a number of locations still have no feedback even though they have been live for some time.
- Completion of surveys still limited to QR code or paper. Work to implement SMS is underway (initially for ED and MIU).
- A monthly report covering all Divisions concerning facilities are now being sent direct to the Facilities Team to highlight patient comments relating to these areas.
- Looking at how our volunteers can support with helping to collect Civica Survey feedback, initially will start helping within YYF.
- We can see from the data, that the number of positive comments are higher than the negative comments (see slide 52).

Top 10 locations for Q2

Site	Location/Department	Q2 Total
Ysbyty Ystrad Fawr	Ward 2.3 Rhymney	182
Grange University Hospital	Emergency Department	128
St Woolos Hospital	Orthopaedic Surgical Unit	92
Royal Gwent Hospital	Respiratory Ambulatory Care Unit	90
Royal Gwent Hospital	Ward C4 East	69
Nevill Hall Hospital	Ward 3/3	63
Royal Gwent Hospital	Ward D3 East	60
Ysbyty Ystrad Fawr	Ward 3.1 Risca	54
Royal Gwent Hospital	Rapid Diagnostic Clinic	53
Ysbyty Ystrad Fawr	Ward 2.2 Bargoed	52



Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback Q2 2024/2025

Division	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Primary Care & Community	230	96	92	96	94	99	96	96	90	95
Complex & Long Term Care	19	92	88	97	92	94	89	97	86	92
Mental Health and Learning Disabilities	51	91	74	91	87	90	87	88	83	87
Family and Therapies	40	96	93	96	86	95	92	95	94	93
Clinical Support Services	131	98	96	100	98	99	96	100	96	98
Surgery	531	97	94	97	98	99	95	97	94	96
Medicine	711	88	81	91	91	95	88	88	80	88
Urgent Care	64	86	79	92	92	94	85	87	75	86
	Overall	**92**	**88**	**94**	**94**	**97**	**92**	**93**	**87**	**92**
	Benchmarks	85	85	85	85	85	85	85	85	85

Person Centred Care (PCC) Survey – Questions 1-8

Top 3 Themes from PCC Survey

What did we do well? Q9	What could we have done better? Q10
Top 3 themes	**Top 3 themes**
• **335** comments around **Compassion** • **314** comments around **Emotional & Physical support** • **267** comments around **Friendliness**	• **71** comments around **Waiting** • **37** comments around **Food & Beverages** • **28** comments around **Comfort**

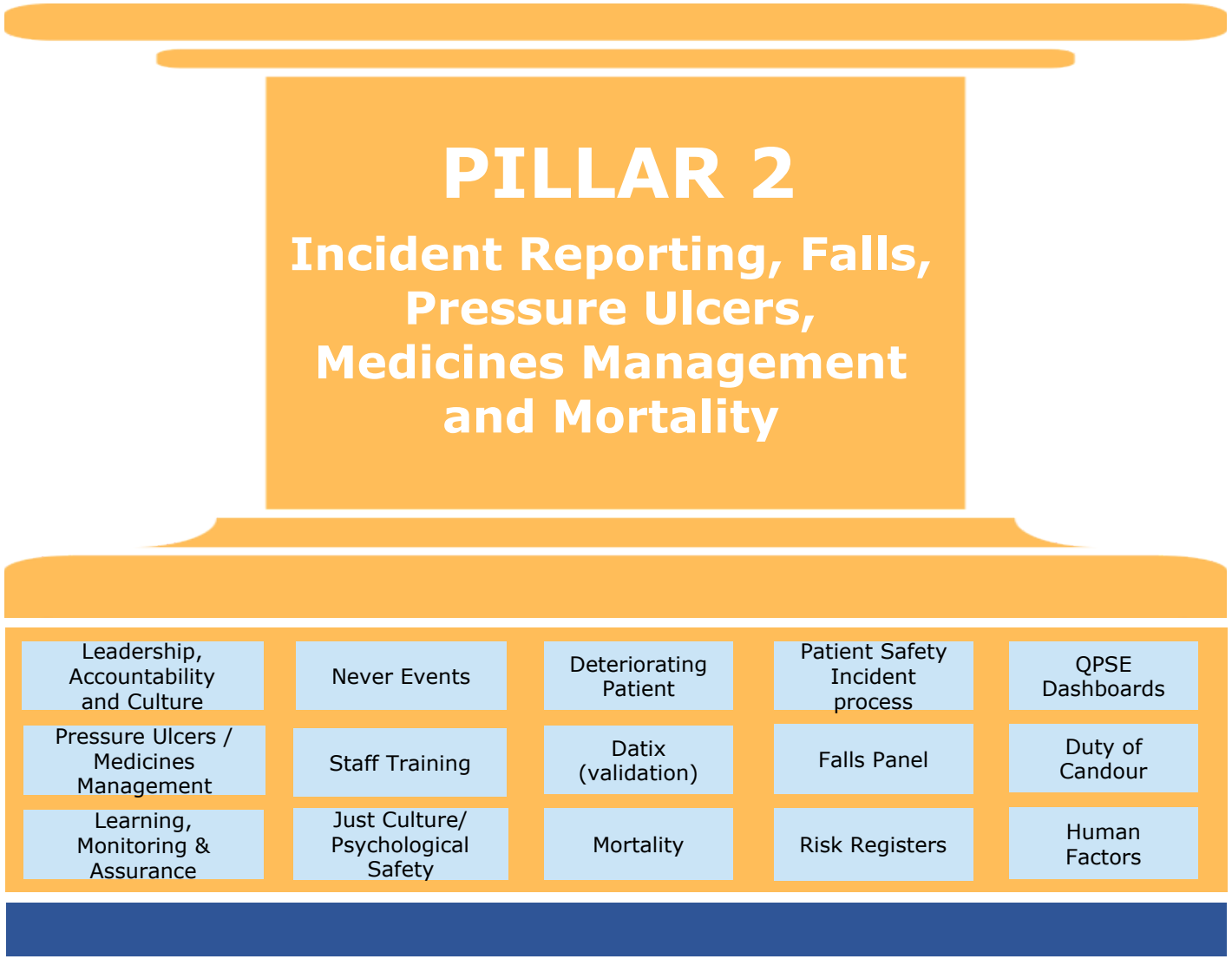
Top 3 Themes from PCC Survey

Positive Themes	Negative Themes
Compassion (335)	**Waiting (71)**
Emotional and Physical Support (314)	**Food & Beverages (37)**
Friendliness (267)	**Comfort (28)**

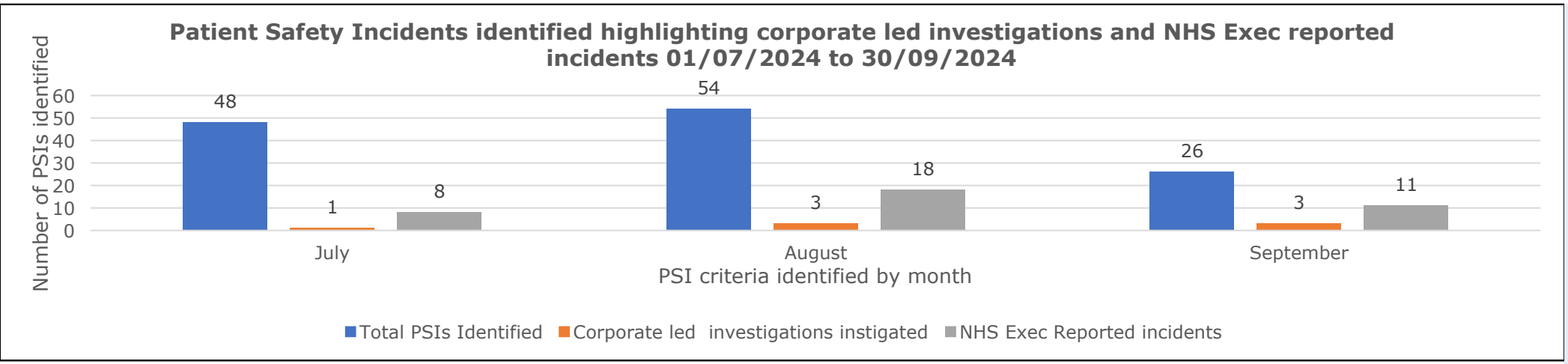
Adborth Cleifion: Gwrando a Dysgu

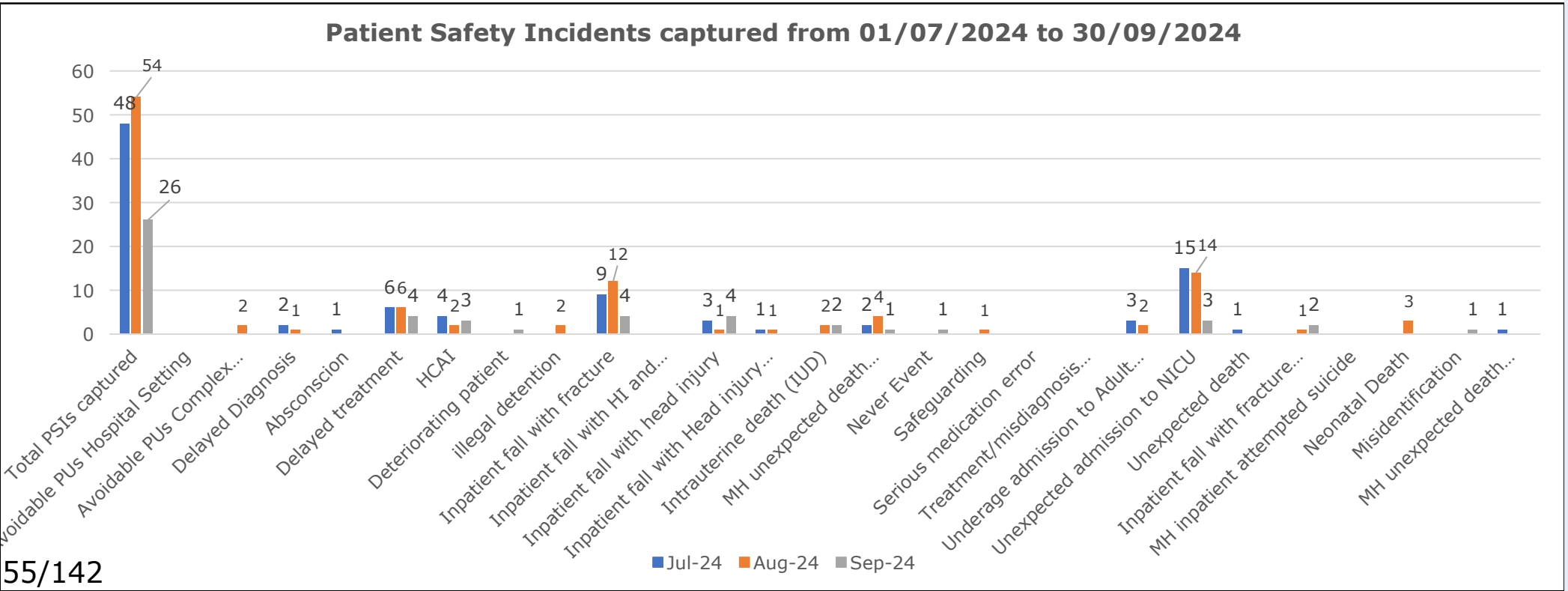
Patient Feedback: Listening and Learning

Patient Comments from PCC Survey


PILLAR 2
Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
Leadership, Accountability and Culture
Never Events
Deteriorating Patient
Patient Safety Incident process
QPSE Dashboards
Pressure Ulcers / Medicines Management
Staff Training
Datix (validation)
Falls Panel
Duty of Candour
Learning, Monitoring & Assurance
Just Culture/ Psychological Safety
Mortality
Risk Registers
Human Factors

Patient Safety Incidents Q2 2024/25





A total of **128** Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified between July and September 2024. This is in comparison to **148** in Q2 of 2023/24.

Although not shown in the graph, there were **17** PSIs which met the criteria for Divisional led Investigation in July, **15** in August and **3** in September (total **35**).

Not all PSIs under investigation were reported as National Reportable Incidents (NRIs). Some incidents are not reported immediately to NHS Executive, as it does not become apparent until during, or following the conclusion of the investigation that the criteria for reporting has been reached. In addition, the Health Board investigates some incidents that do not meet the reporting threshold for its own learning and development.

Patient Safety Incidents

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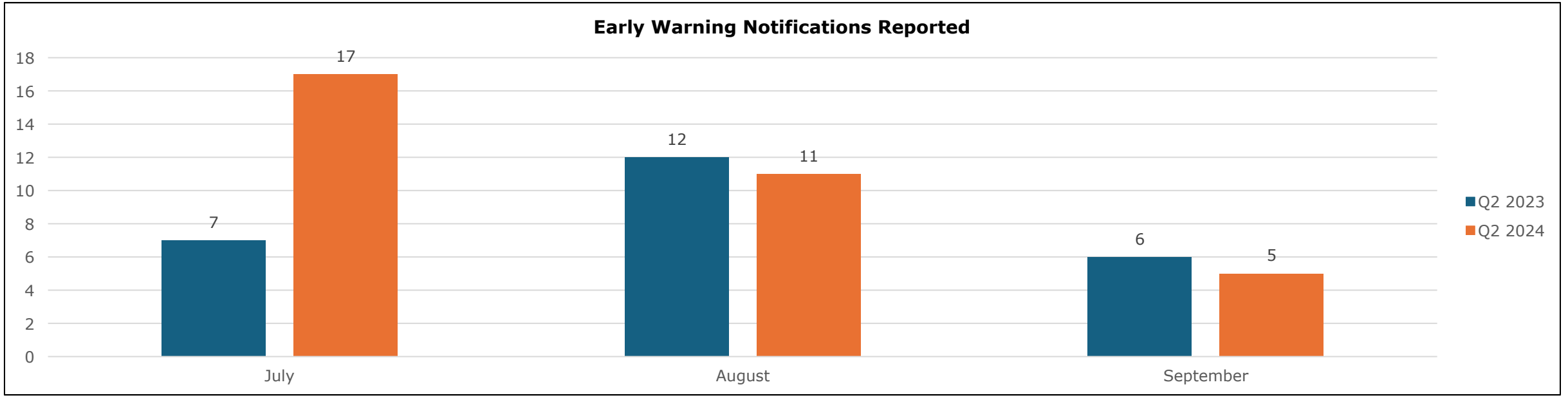
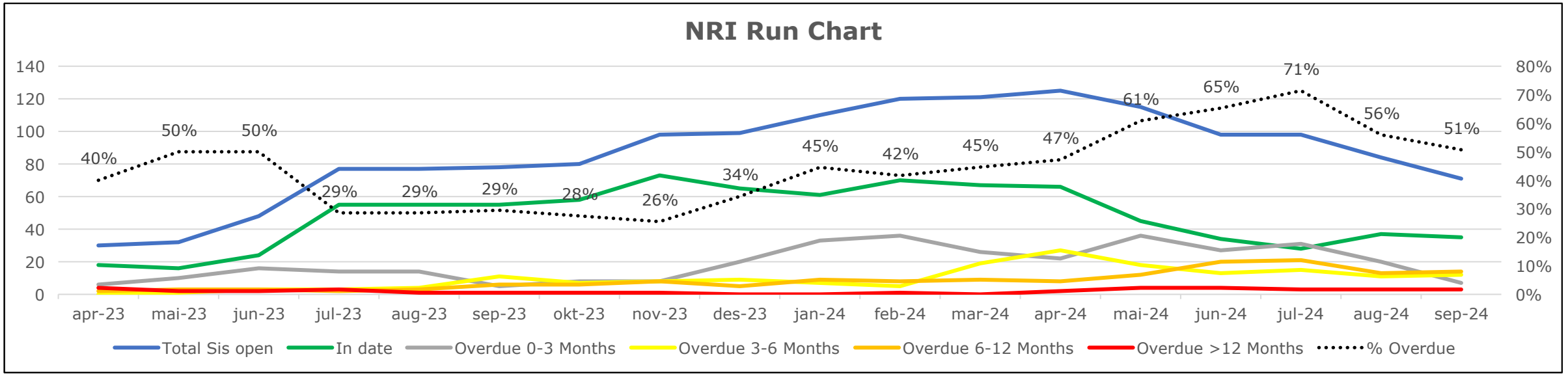
There were **33** Early Warning Notifications (EWNs) reported to Welsh Government (WG) during this period; **17** in July, **11** in August and **5** in September. Themes included safeguarding concerns and patient absconsions. This is in comparison to **7** in July, **12** in August and **6** in September in Q2 of 2023/24.



NRI Data



As of June 2024, the Health Board reported a concerning compliance rate of 35%, with 98 open NRIs, of which 64 were overdue. The increase in NRIs was partly due to new reporting policies, including Healthcare Associated Infections (HCAIs) mandated as NRIs in July 2023 and additional criteria added in November 2023.

The National Patient Safety Policy initiated in May 2021 redefined the management of Patient Safety Incidents (PSIs) and made NRIs the responsibility of local Health Boards. Measures have been implemented to improve compliance, including revising the incident policy, defining roles, and establishing oversight systems. Although overdue NRIs decreased from 71% (July 2024) to 51% (September 2024), challenges such as IO appointment delays, limited availability, and coordination of meetings with key stakeholders has been challenging.

Recommendations for improving compliance include regular monitoring, monthly reporting to divisional teams, enhanced communication, increased training for Investigating Officers, standardised follow-up processes, and fostering a culture of learning among Clinical Investigating Officers. These actions aim to meet NHS targets, bolster patient safety, and ensure quality care.

Never Events

During this reporting period one PSI met the Never Event criteria and is being investigated as a round table exercise. Early learning will be identified and implemented following the investigation.

Notably, the Health Board had not registered a Never Event since November 2023, until this occurrence (Q2 2024/25).

Improvement Work related to historical never events – theatre safety improvement project

A programme of '**Back to Basics' sessions** is being delivered across Theatres to ensure theatre safety of procedures is reinforced as a core priority. This includes the action of 'pause for the gauze', and 'quiet for the count' the processes undertaken for swab, instrument and needle counts and how swabs are monitored and recorded on the Theatre white board. The 'Back-to-Basics' sessions also includes training to promote active listening and assertiveness among all members of the Theatre team.

An **agreed number of swab counts** will be introduced within Theatres.

When there is a change to the team responsible for the swab count, **there should be a swab count completed at this point** to ensure situational awareness of the theatre team is maintained.

A quality improvement (QI) strategy underpinned by National Safety Standards for Invasive Procedures 2 (NatSSIPS 2) is ongoing, supported by the Theatre Safety Advisor post.

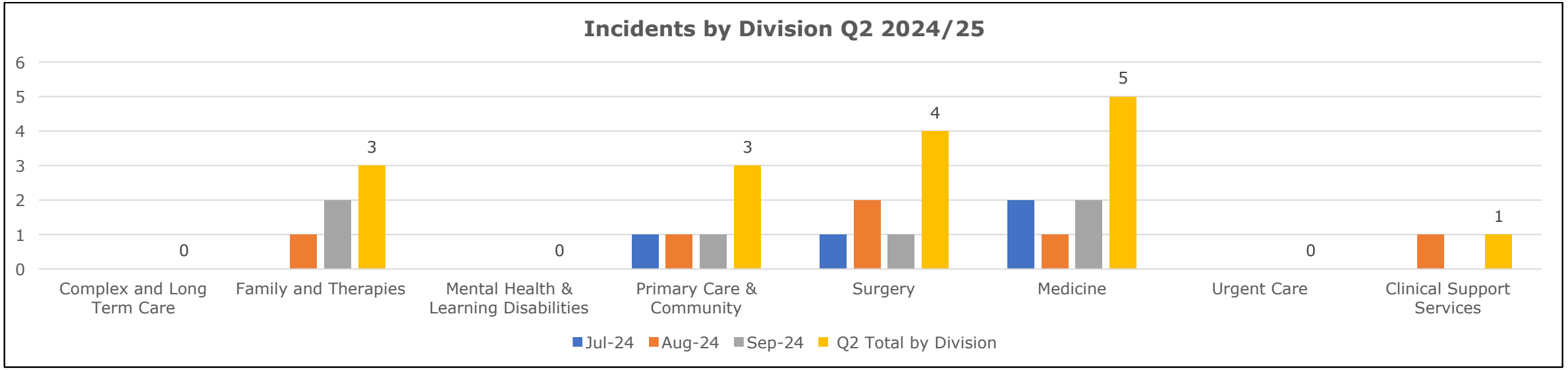
Duty of Candour

In Quarter 2 2024/25 there were **6356** incidents affecting patients reported on the Datix Cymru system. This is in comparison to 6516 incidents in Q2 of 23/24.

There have been **16** incidents that have triggered Duty of Candour. *This figure is based on the question -* ***Was Healthcare provided a factor?***

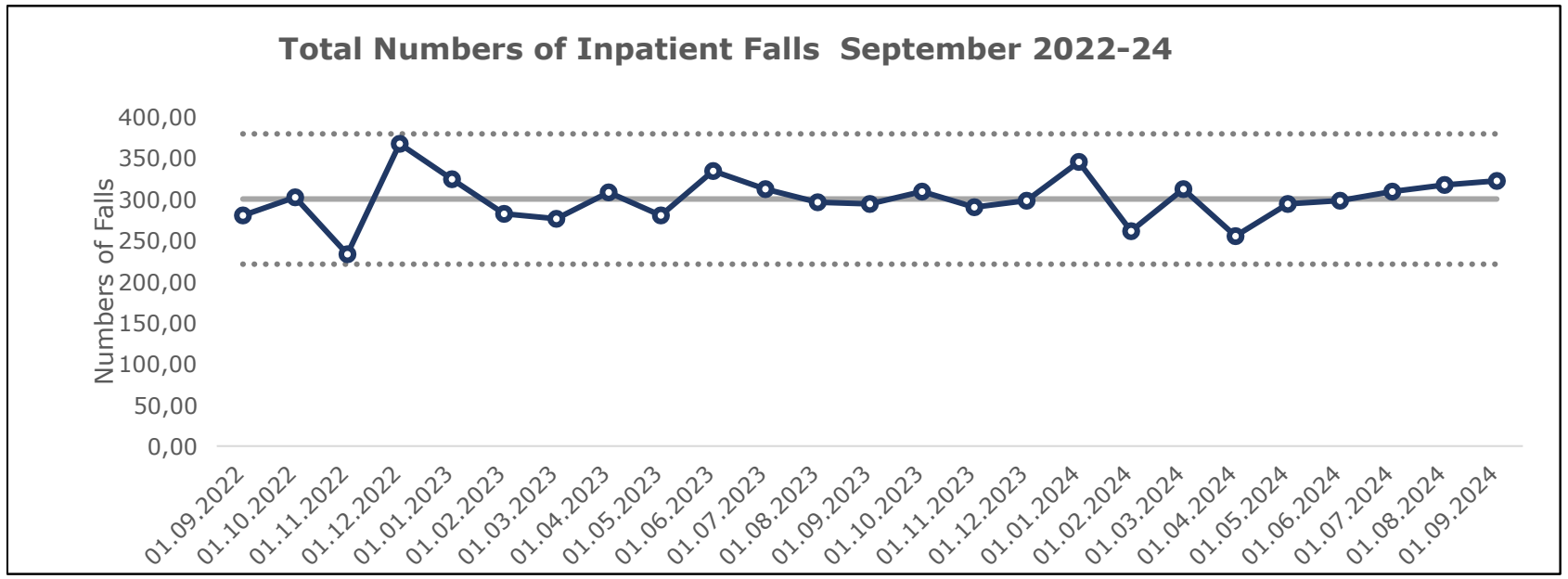
These incidents covered inadequate supervision resulting in a fall, Post-operative complications, Communication around discharges and prescribing, and maternity occurrences. All these incidents have undergone the formal DoC process.

The table below shows these incidents broken down by Division.



The way in which Duty of Candour is captured on RL Datix, has been refined for the 2024/25 reporting. In the 2023/24 period DoC was triggered when the management review had, been undertaken, and harm assessed at that time as moderate and above. Therefore, **46** incidents triggered in Q2 of 2023-24. The introduction of the question of 'was a healthcare a factor' focuses the investigator on the essence of DoC harm, in that it is the delivery or lack of delivery of healthcare that has led to the harm caused to the patient/service user.

Total Numbers of Inpatient Falls



October2024 - Context

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

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period September 2022-24. This period length for this data is selected to ensure the analysis is statistically valuable.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the given period of analysis, the mean average of fall incidents is 317 which represents an increase since the last report in July 2024. • Since April 2024, a gradual upward trend has been experienced and although the values remain within control limits September has seen the highest numbers of reported falls incidents since January 2024.	

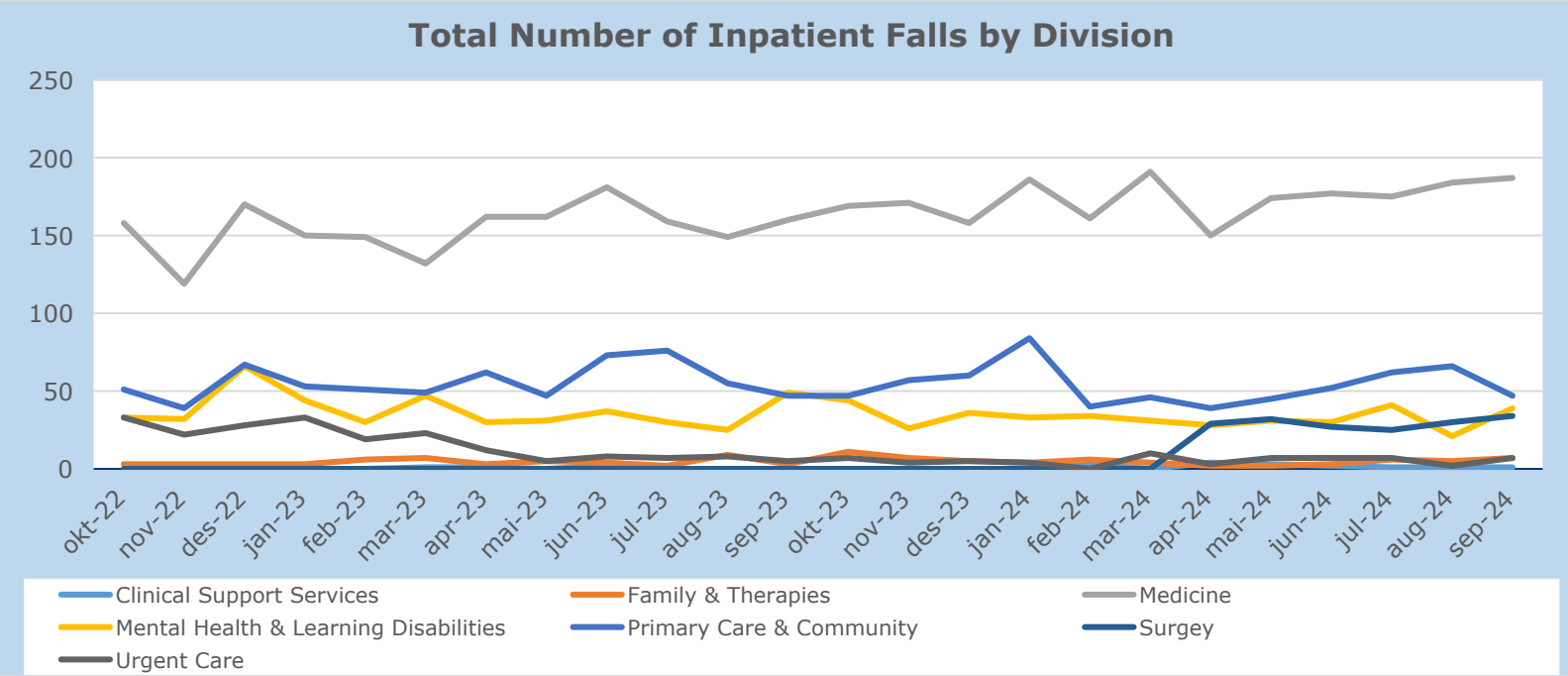
Inpatient Falls Data by Division

Data Sharing

All data is available to ward level for review and discussion.

Any areas of concern are flagged to QPS Improvement and Development Managers for investigation.

Falls with fractures are presented at the weekly Executive Huddle. These discussions are informed by a weekly data review.



October 2024 - Context

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

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period September 2022-24. This period length for this data is selected to ensure the analysis is statistically valuable.

What the chart tells us Key Variations By Division

Primary Care and Community
- July and August 2024 has seen the highest numbers of reported falls incidents since January (62 & 66 falls incidents respectively) this has been followed by a decrease to 47 for September. This has resulted in a marginal rise in the mean average value from 50 (January to May) to 54 (July- September).

Medicine
- September 2024 represents the second highest value for reported falls incidents since March 2024 with a gradual upwards trend being demonstrated from May 2024. This has resulted in an increase in the mean average value from 172 (January to May) 176 (July to September).

Urgent Care
- Falls incidents in this environment are representative of a mean average value of 6 for the period January to September 2024.

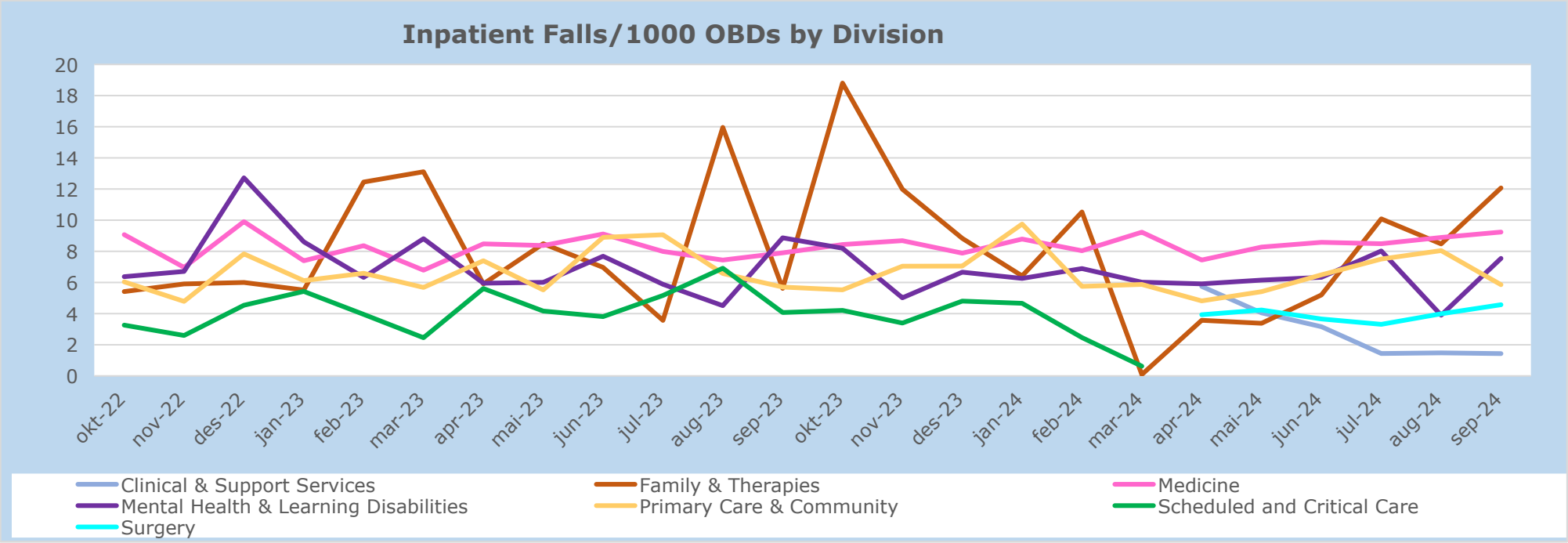
Clinical Support Services
- Falls associated with patients attending for diagnostics are small in number with a mean average value of 2 for the period January to September 2024.

Mental Health & Learning Disabilities
- Following the peak value in the latter months of 2023 August 2024 has seen the lowest value for reported falls incidents for the year to date.(21) Mean average value of reported incidents at 32 for the period January to September 2024.

Surgery
- As of April 2024, Surgery has been represented as a data set. To date September represents the highest value of reported incidents at 34.
  Mean Average Value 29

Family and Therapies
- Falls incidents are more often a reflection of patients being lowered to the floor whilst undertaking therapy. Mean average value of 4 for the period January to September 2024

Inpatient Falls Data by Division



July 2024 - Context

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

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

For note As of April 2024, a change in Divisions is represented to include Surgery and the Clinical Support Services.

What the chart tells us

The information provided represents Inpatients Falls per 1000 Occupied Bed Days (OBD's) per Division for the period October 2022 to September 2024.

The significant downward trend represented for family and Therapies for March 2024 represents a statistical anomaly.

Since April 2024, the collective data has demonstrated an upward trend for the Health Board in relation to Falls incidents per 1000 OBD's. The Mean average value is 7.1 which is above the National average. This value has been impacted upon by information represented in the key variations

Key Variations

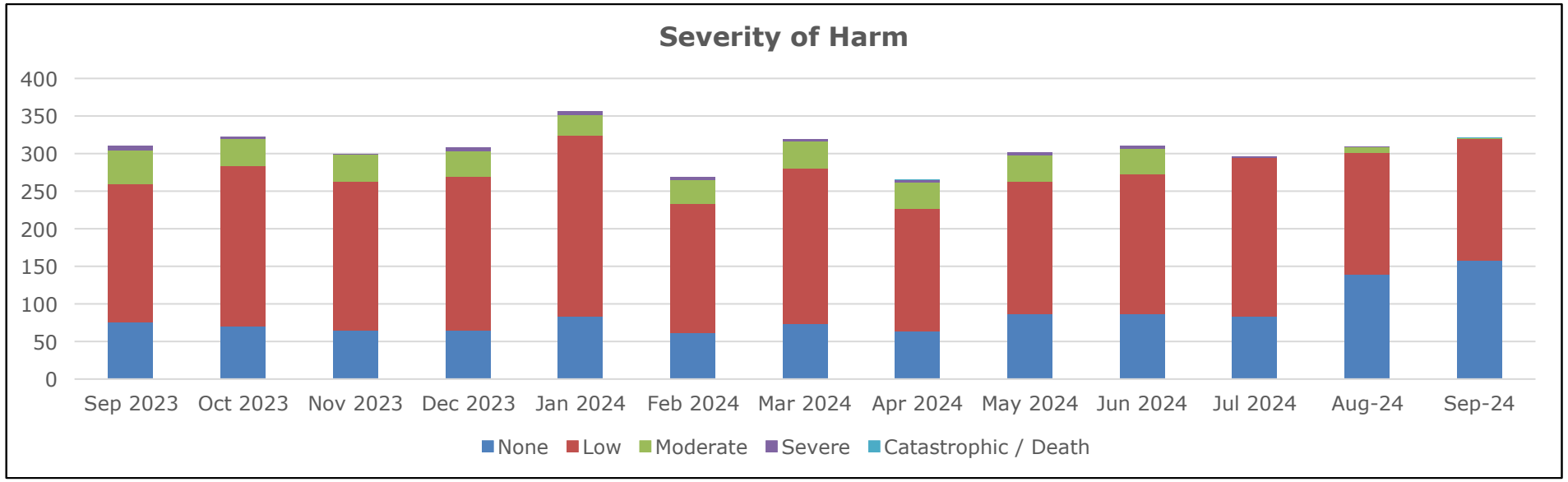
The significant downward trend represented for family and Therapies for March 2024 represents a statistical anomaly.

For the Medicines Division September 2024 has seen the highest value for number of falls per 1000 OBD's since February (9.2) with another significant peak occurring in July.

For Mental Health and Learning Disabilities September saw its second highest value (7.5) since April however August also saw the Divisions lowest value at 3.9.

Family and Therapies Division saw a significant peak in September at 12.1.

Inpatient Falls – Severity of Harm

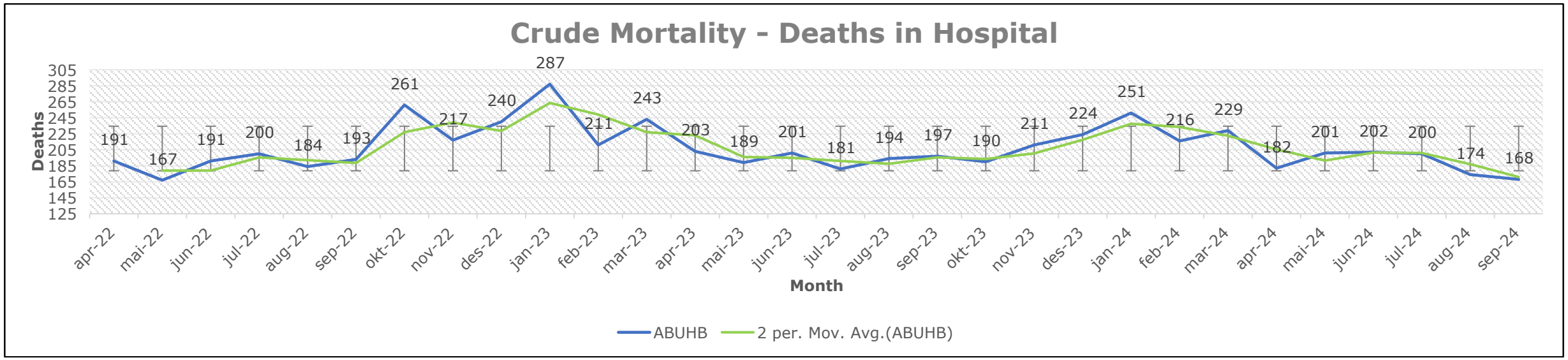


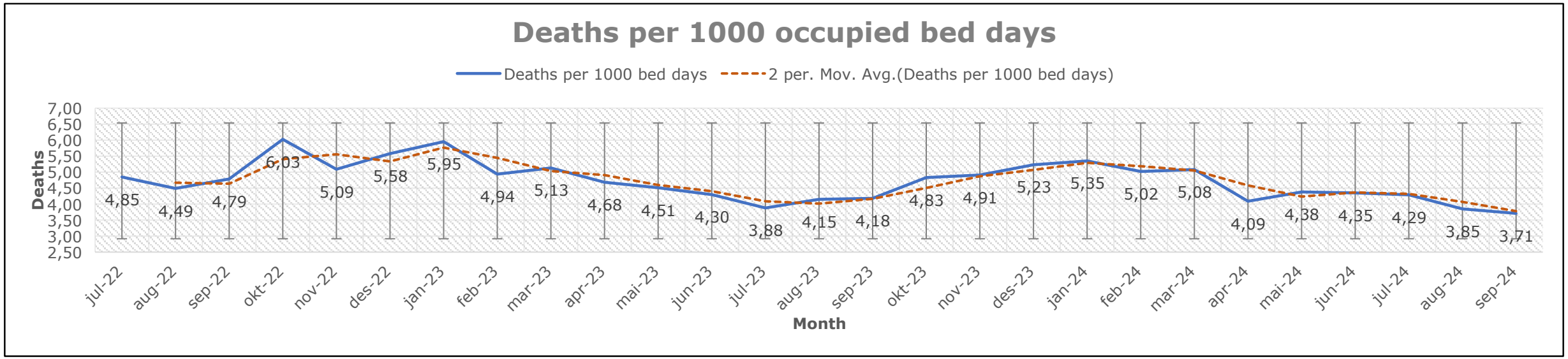
October 2024 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period September 2022- 2024.

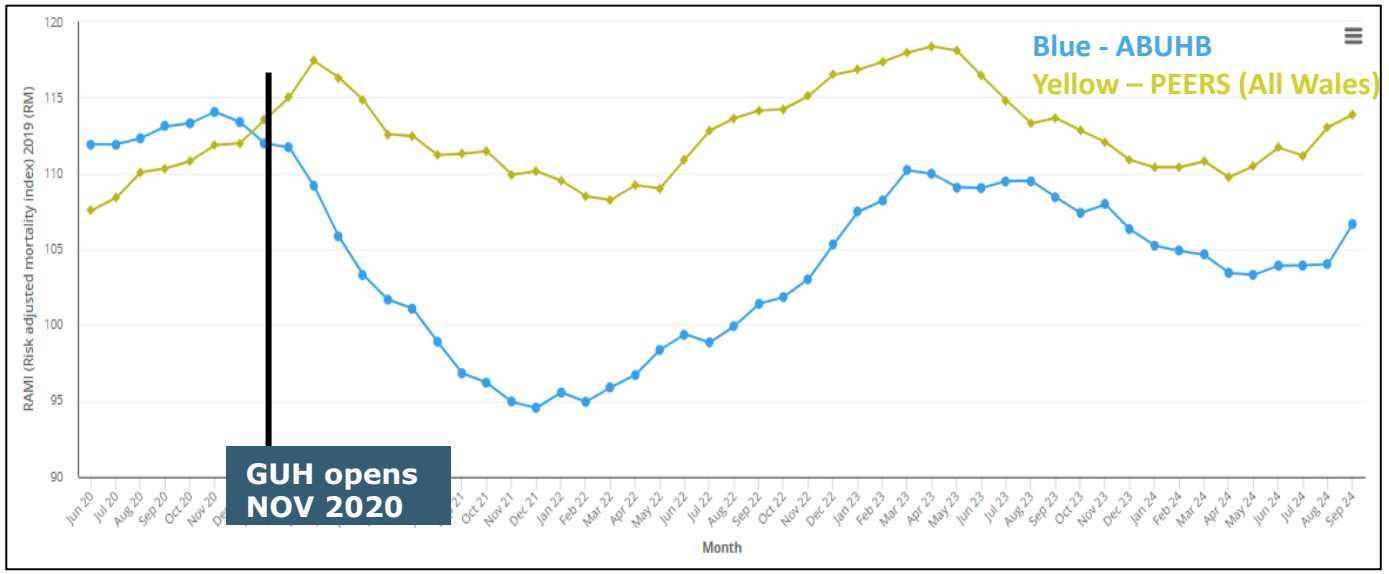
Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the the severity of harm is categorised for the given period is 3990. Of this figure the following is identified. • 97% No or low harm. • 2.5% - Moderate harm • 0.4% Severe harm • 0.1% Catastrophic	The severity data is now reflective of the identified level of harm recorded post investigation. As compared to previous reports the % no or low harm is significantly higher than previously represented with a % reduction in the other associated categories of harm.

Crude Mortality in Hospital





RAMI (Risk Adjusted Mortality Index)

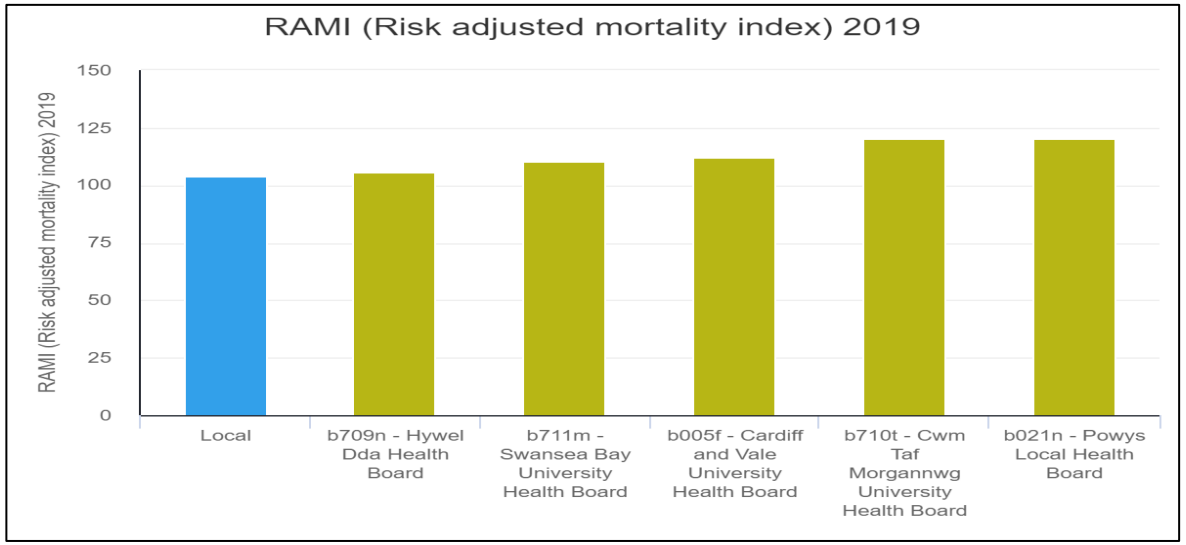


RAMI has been trending in line with peers and remains lower. RAMI is inconsistent from month to month.

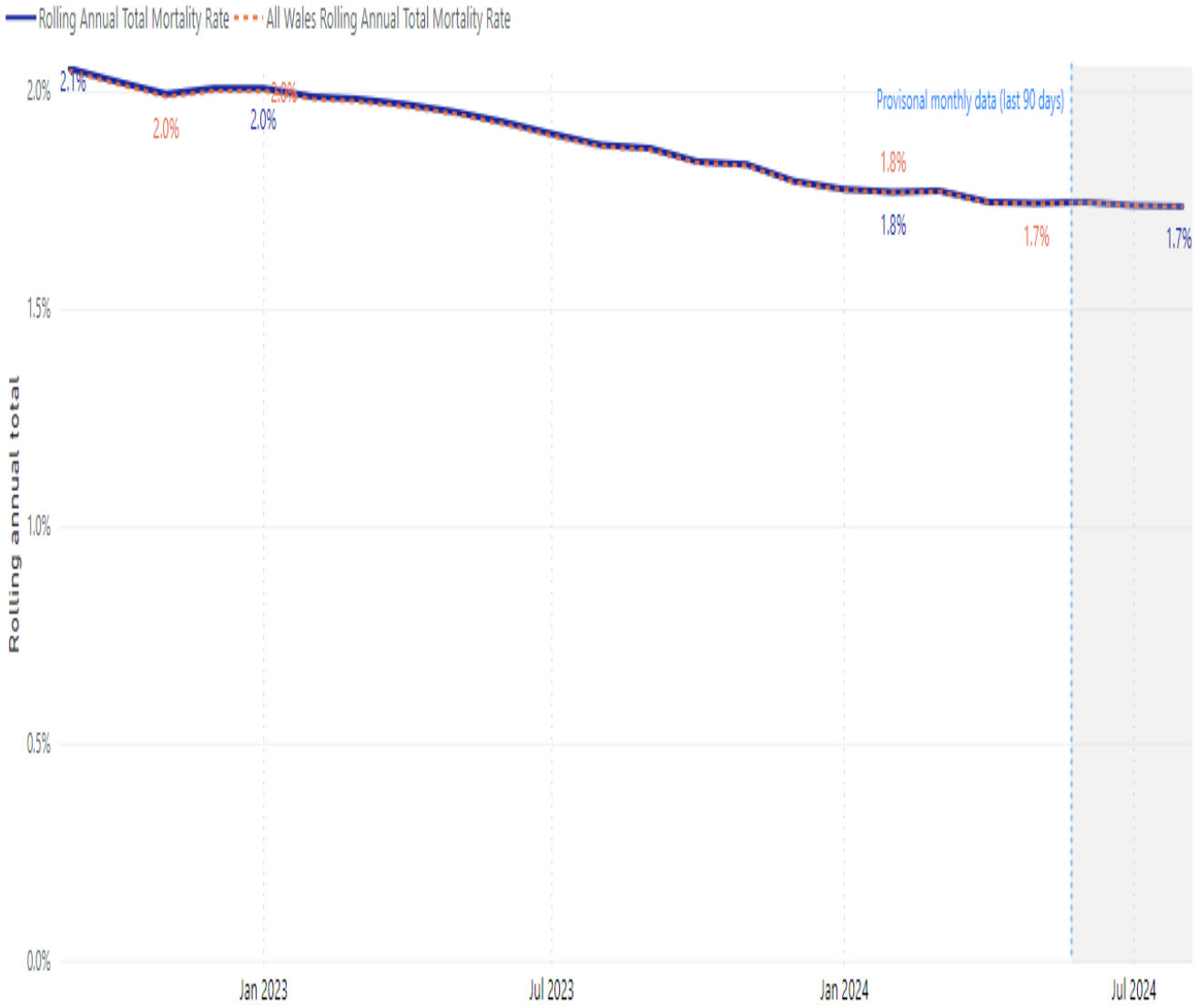
Currently performing 1st of 6 within All Wales peer group

The Health Board's Risk adjusted Mortality Index (RAMI) is 101 for Q2. The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations.

The accuracy of RAMI is dependent on the completion and accuracy of clinical coding.



Mortality Rate

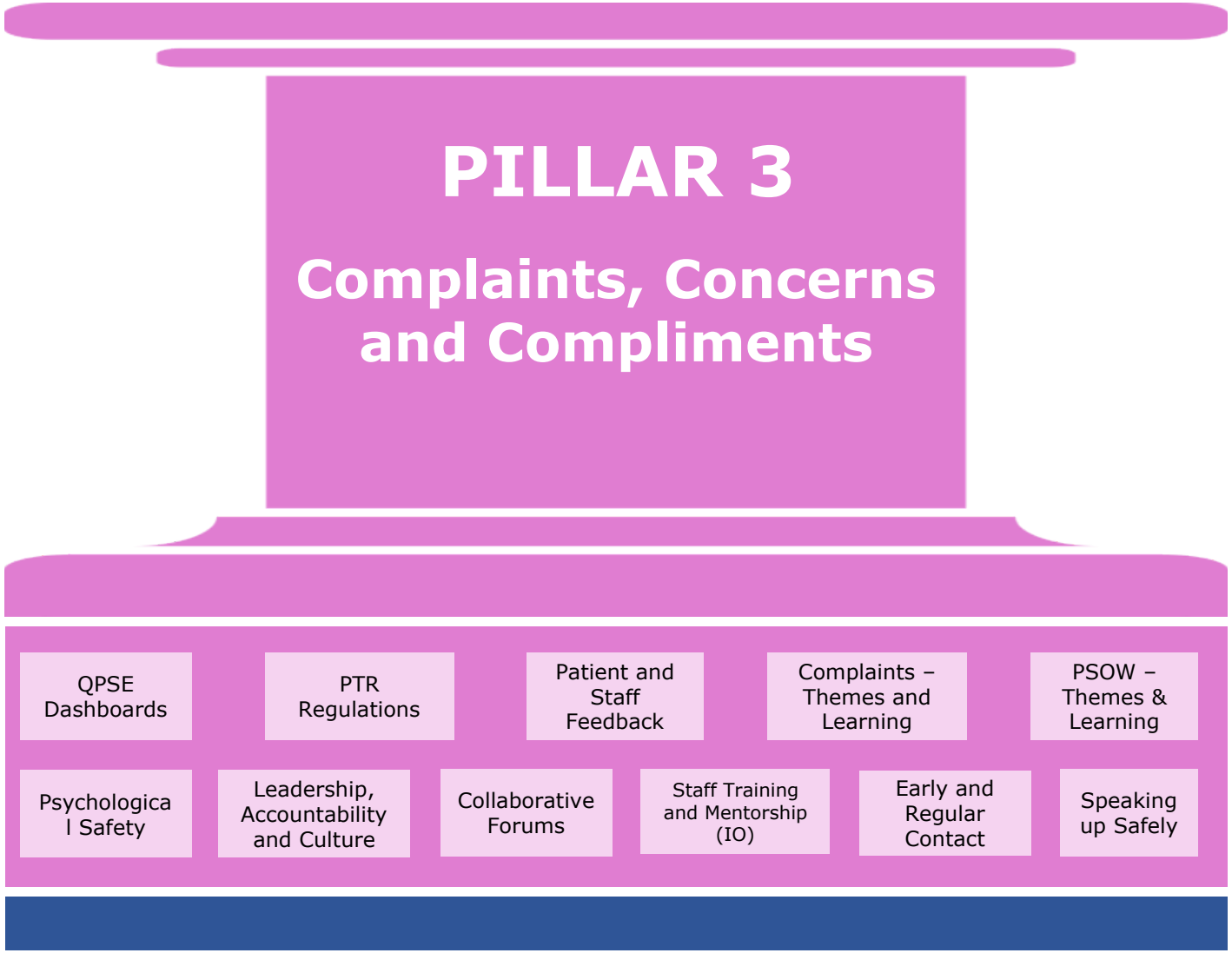


Our mortality rate remains stable and flat. Actual deaths in hospital have decreased over Q2 2024.

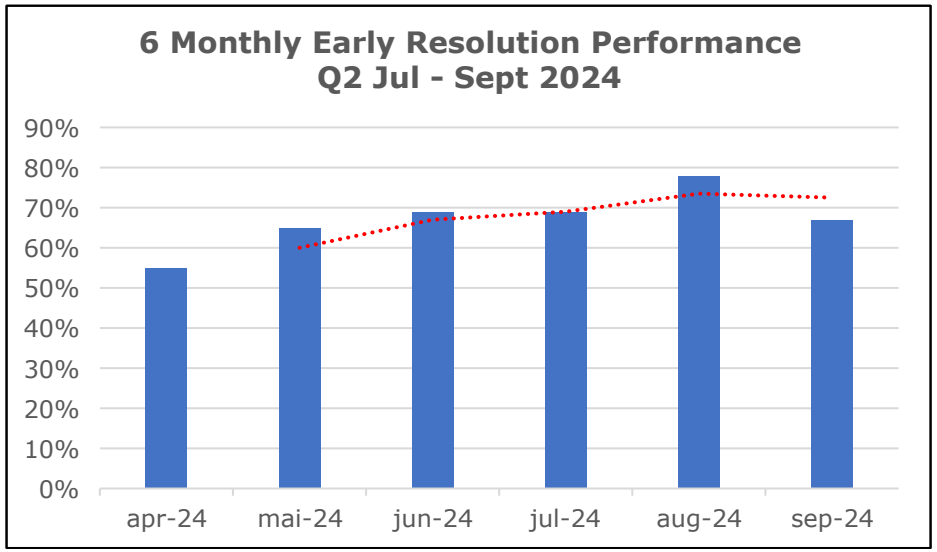
In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers numerous sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit.
Addition of the Health Board's learning from death report advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI). This is observed in the additional mortality indicators for reporting.

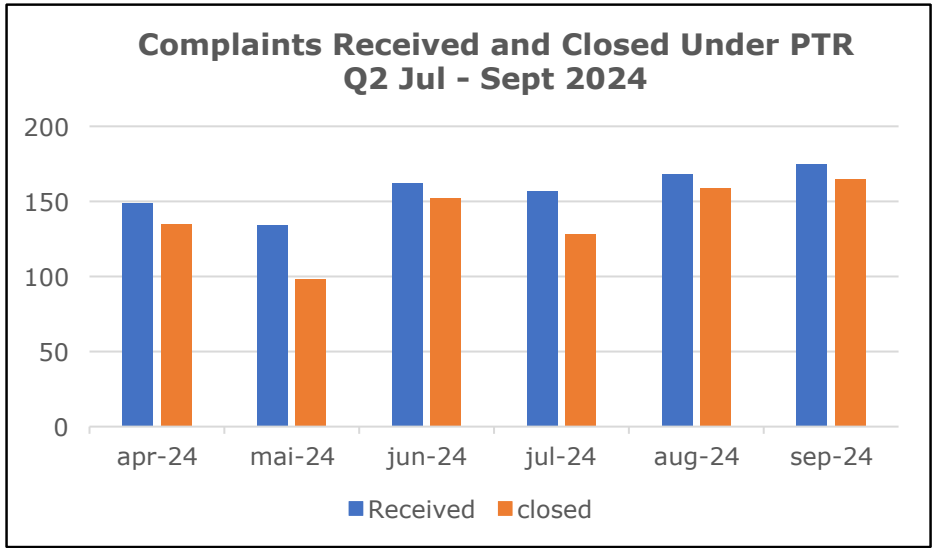
Mortality Actions

Issue	Cause	Learning and Improvement	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. NHS England produce a Learning from Death framework which enables a standardised mortality report.	The Health Board presented a Learning from Death report at April PQSOC. This will be reported every 6 months. Includes the development of Learning from Death Framework, triangulated with learning from the Medical Examiner service and the mortality review screening panel. Reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality framework developed for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity.	Working with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	On-going
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide.		
	Mortality indicators not available to all	Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data.		


PILLAR 3
Complaints, Concerns and Compliments
QPSE Dashboards
PTR Regulations
Patient and Staff Feedback
Complaints – Themes and Learning
PSOW – Themes & Learning
Psychological Safety
Leadership, Accountability and Culture
Collaborative Forums
Staff Training and Mentorship (IO)
Early and Regular Contact
Speaking up Safely

Concerns & Compliments Q2 2024/25





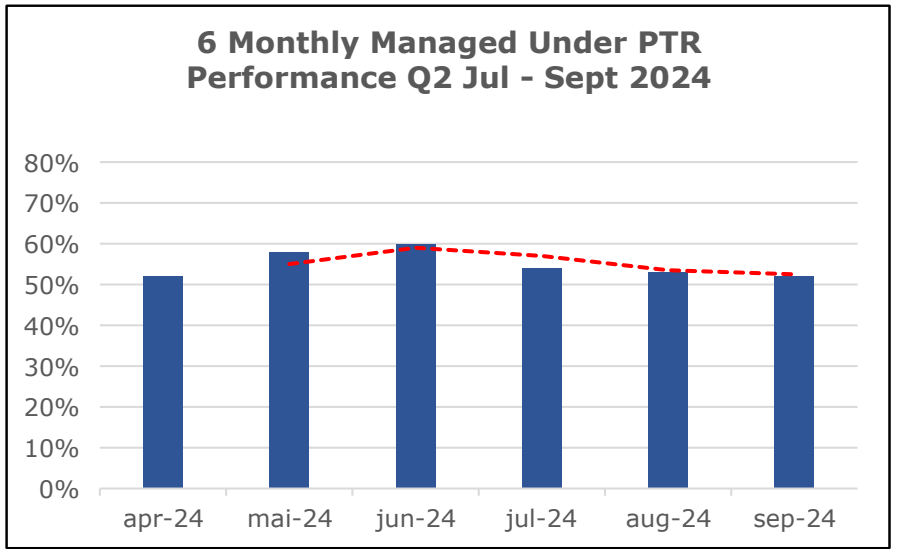
Early Resolution has been maintained on average at 72% The Division of Surgery, Medicine, Urgent Care and CSS have been consistently above 80% across the period.

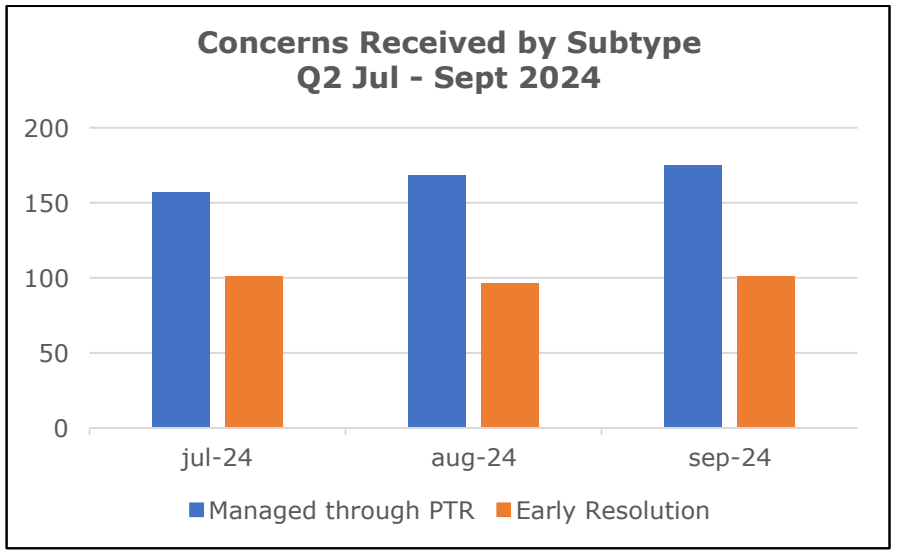
Managed Under PTR concerns received and completed within compliance has averaged 52% across the period.

This sustained high volume of complaints has been acknowledged by external stakeholders, including Llais and the Public Services Ombudsman for Wales (PSOW), who have noted the pressures the teams are facing. The unanticipated strain on resources has required additional coordination to ensure timely responses and maintain operational standards.

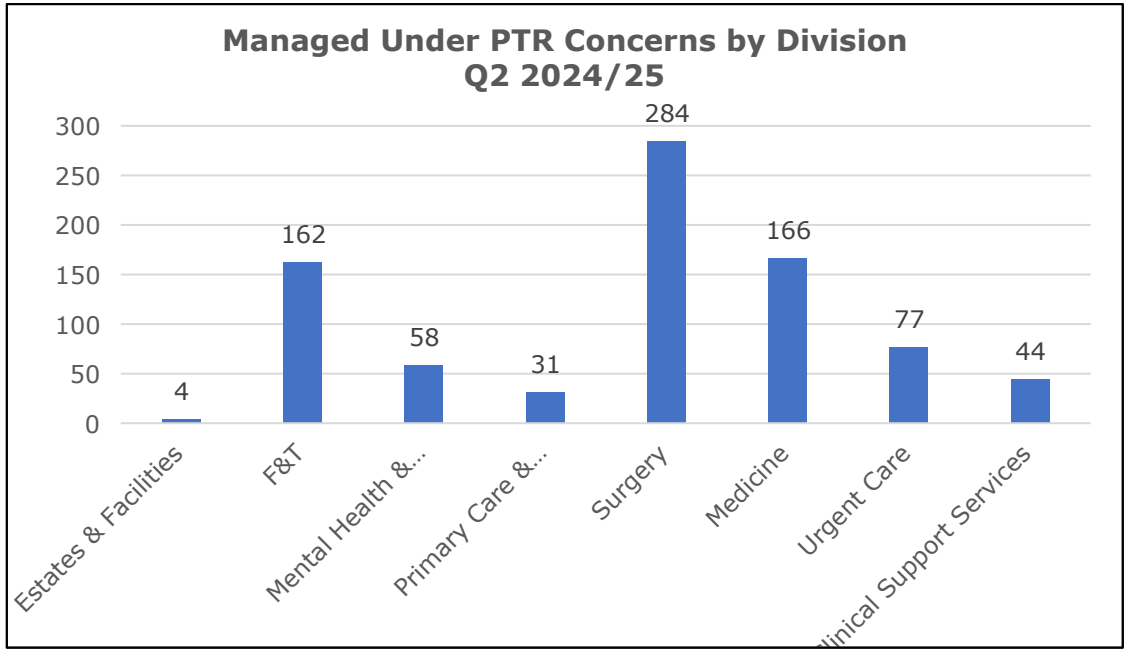
Looking ahead, we will continue to closely monitor this trend and explore strategies to alleviate these pressures, ensuring the quality of patient care and services remains unaffected.

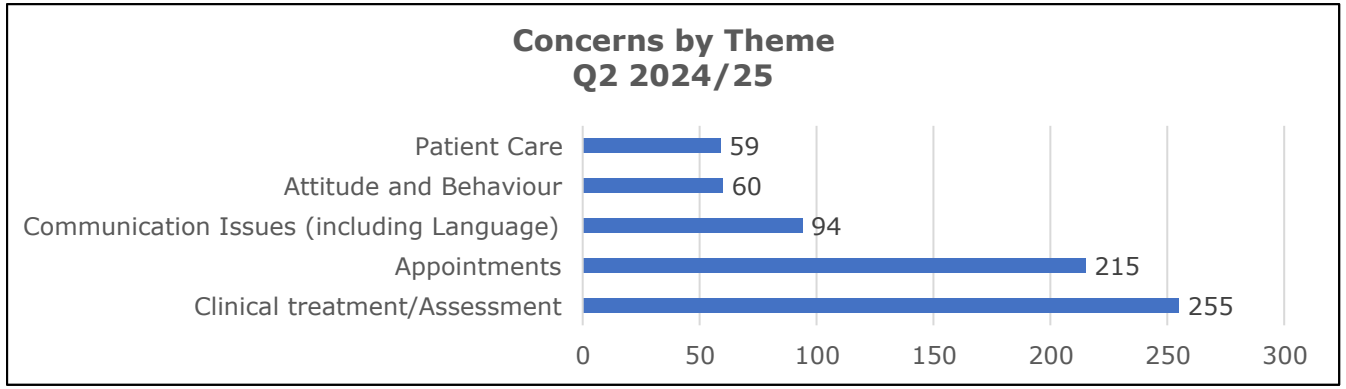
Weekly meetings have been established with the complaints teams, along with daily huddles, to enhance communication, provide direction and support, and identify challenges within the system that are escalated after each meeting.

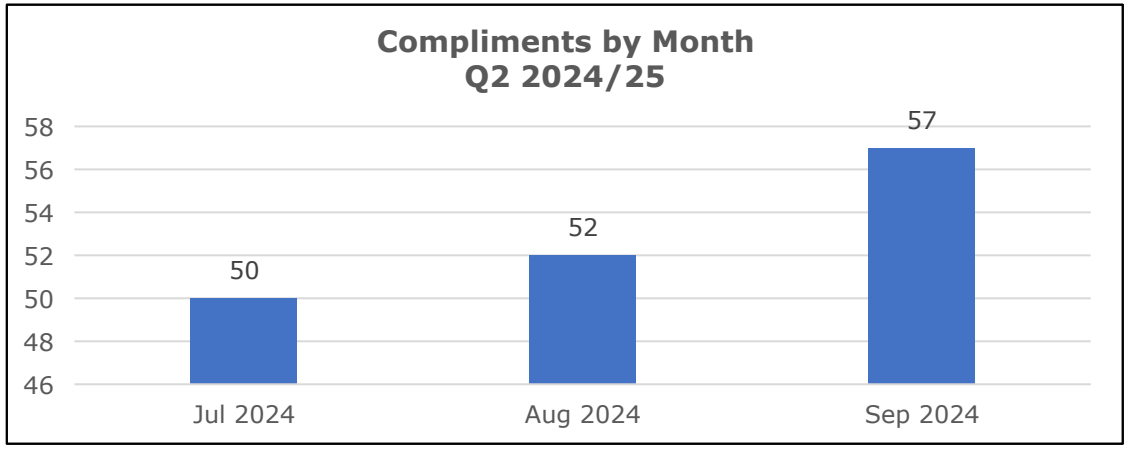




Concerns & Compliments Q2 2024/25







The recording of Compliments has continued to increase month on month, with all concerns teams being alert to identifying and recording positive comments identified within concerns received. In September there was a significant rise in the number of recorded compliments.

Clinical Support Services: Despite an increase in the number of concerns received. CSS have seen a positive upward trajectory in the management of their formal concerns exceeding the WG compliance target in September 2024. Furthermore, they have maintained 100% compliance with Early Resolution matters across the entire quarter.

Mental Health & Learning Disabilities: Although the Division's compliance with formal concerns is lower than expected, they are consistently reducing the number of open concerns each month. Early resolution compliance has remained steady across the reporting period.

Surgery: Continues to hold the second highest number of formal concerns by Division. However, compliance has averaged around 56.65%. September, Surgery accounted for nearly half of the formal concerns received across the entire organisation. Early Resolution performance has consistently remained above 95% throughout the reporting period.

Medicine: Compliance has continued to improve throughout Q2, averaging 53.52% against the Welsh Government (WG) target. Early Resolution has also shown a positive trend, consistently staying above 80% during the period.

Urgent Care: Successfully halved the number of open formal complaints between July and September. The division has maintained excellent Early Resolution compliance during this period, achieving 100% in the last two months of the quarter.

Primary Care & Community: has performed exceptionally well, reducing the number of formal concerns by 50% from July to September.

Family & Therapies: The quarter began very well, with a slight decline in August, but an increase in compliance by September. Early Resolution showed a positive improvement in August, though it tapered off towards the end of the quarter.

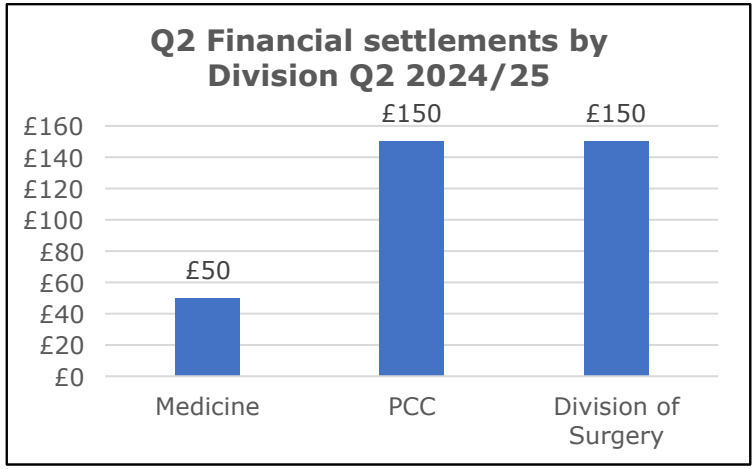
Estates & Facilities: As always, the Division have been 100% compliant with closing their concerns.

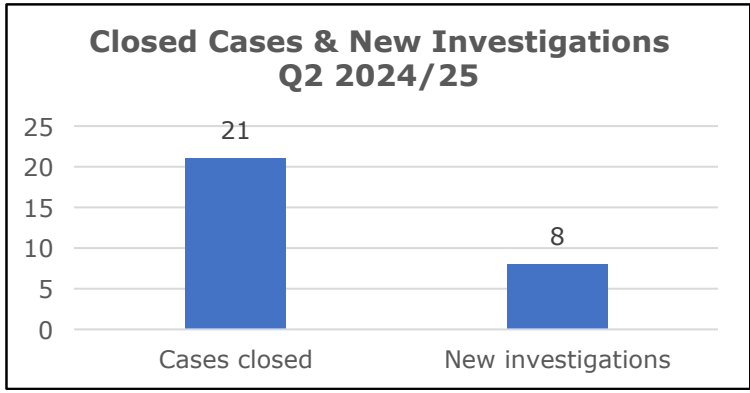
PSOW Q2 2024/25

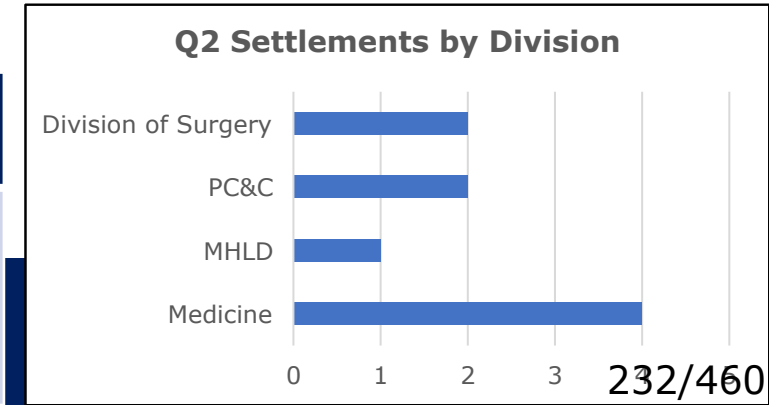
Issue	Learning & Improvement
1 PSOW Report was upheld F&T The PSOW considered that the Health Board had failed to offer advice regarding hydration and leg exercises:	1. Quality and Patient Safety Managers have devised an Educating and Recommendations After Significant Events (ERASE) poster, which has been shared throughout their respective teams, highlighting the Ombudsman's findings and ensuring learning from the case is shared. 1. The Service Manager for Obstetrics and Gynaecology, along with the Bladder & Bowel Nurse Service and Sexual and Reproductive Health, has consulted with the Lead Consultant in Obstetrics and Gynaecology. They have implemented a discharge information sheet on Ward A3 that includes the following guidance: - Advice on worsening symptoms - Contact details - Recommendations for fluid intake to prevent dehydration - Post-discharge advice that covers: a) Leg exercises and the use of Thrombo Embolus Stockings (TEDS) b) Guidance on using fragmin c) Recommendations for antibiotic prescribing d) Hygiene practices for wound management."

Of all settlements across this period, a third resulted in financial payments. Positively this is more than 50% less than the previous reporting period.

The main themes across the reporting period related to delay in clinical assessment and provision of pain relief. Subsequent learning identified was regarding the importance of giving clear and explicit worsening recall advice whilst patients are awaiting OOH assessment. As a result, the Dr has been asked to discuss this case and his reflections at his annual performance appraisal. Reflective discussion to be facilitated with the wider UPC clinical team at the next Clinical Continuous Professional Development (CPD) meeting to ensure meaningful learning at service level.







Issue	Action	Learning and Improvement	Who	When
PSOW interventions	Future PSOW recommendations will be captured on the Health Board's Datix system.	The aim is to improve timely compliance with recommendations put forward by PSOW and ensure that these can be regularly monitored and reported upon	PTR Team	November 2024

PTR – Achievements Q2 2024/25

Achievements	Update
PTR Policy updated and shared at Board	The PTR policy has been updated to reflect the latest legislation and PTR regulations and is now available via the PTR intranet page.
PTR Annual Report completed and shared	The PTR Annual Report has been compiled and shared with the Board. The report outlines the challenges faced in the previous year and establishes the goals and priorities for the upcoming year
Training/Divisional Relationships	Bespoke training continues to be delivered by the Senior QPS Manager to complaints teams to ensure data recording and validation is accurate from the outset of the concerns file.
Collaborative PTR meeting with key internal stakeholders	A collaborative meeting was held in early September with key stakeholders of the PTR teams including Complaint Coordinators and managers, MS/MP and PALS teams to map and define the stages of the PTR process. This offered an opportunity to consider the changes to internal complaint handling processes that were undertaken following centralisation. The aim was to refresh the key focus for the PTR team as a whole moving forward and to reinforce complaint management priorities and strengthen team cohesion.

Claims and Redress – 2024/25 Q2 Activity

Clinical Negligence:

- 38 new clinical negligence matters received during quarter 2.
- 401 total number of open clinical negligence matters as at the end of September 2024.

This represented an increase in clinical negligence matters received during this quarter.

Personal Injury:

- 13 new personal injury matters received during quarter 2.
- 78 total number of open personal injury matters as at the end of September 2024.

Personal injury claims remained steady, and at a historic low, during this quarter.

Redress:

- 9 cases were taken through the Health Board's Redress Panel during this quarter.
- 6 Redress cases were settled during this quarter.

On average, each case settled through the Redress process will save the Health Board an estimated £30,000 in costs arising had those cases become clinical negligence claims.

Inquests – 2024/25 Q2 Activity

Inquests:

- 55 new inquests received.
- This represented a slow down in the number of inquests received compared with the quarter 1.
- 59 inquests were listed by the Coroner to be concluded within quarter 2.
- Of the 59 inquests listed, 11 inquests were held in person by the Coroner and where Health Board witnesses attended in person to give their evidence. Legal Services attended all 11 inquests in support of staff attending.

Of the 59 inquests listed in this quarter, 48 inquests were concluded in writing by the Coroner. This meant Health Board staff had prepared statements which were submitted to the Coroner but those members of staff did not need to attend the inquest in person to give oral evidence.

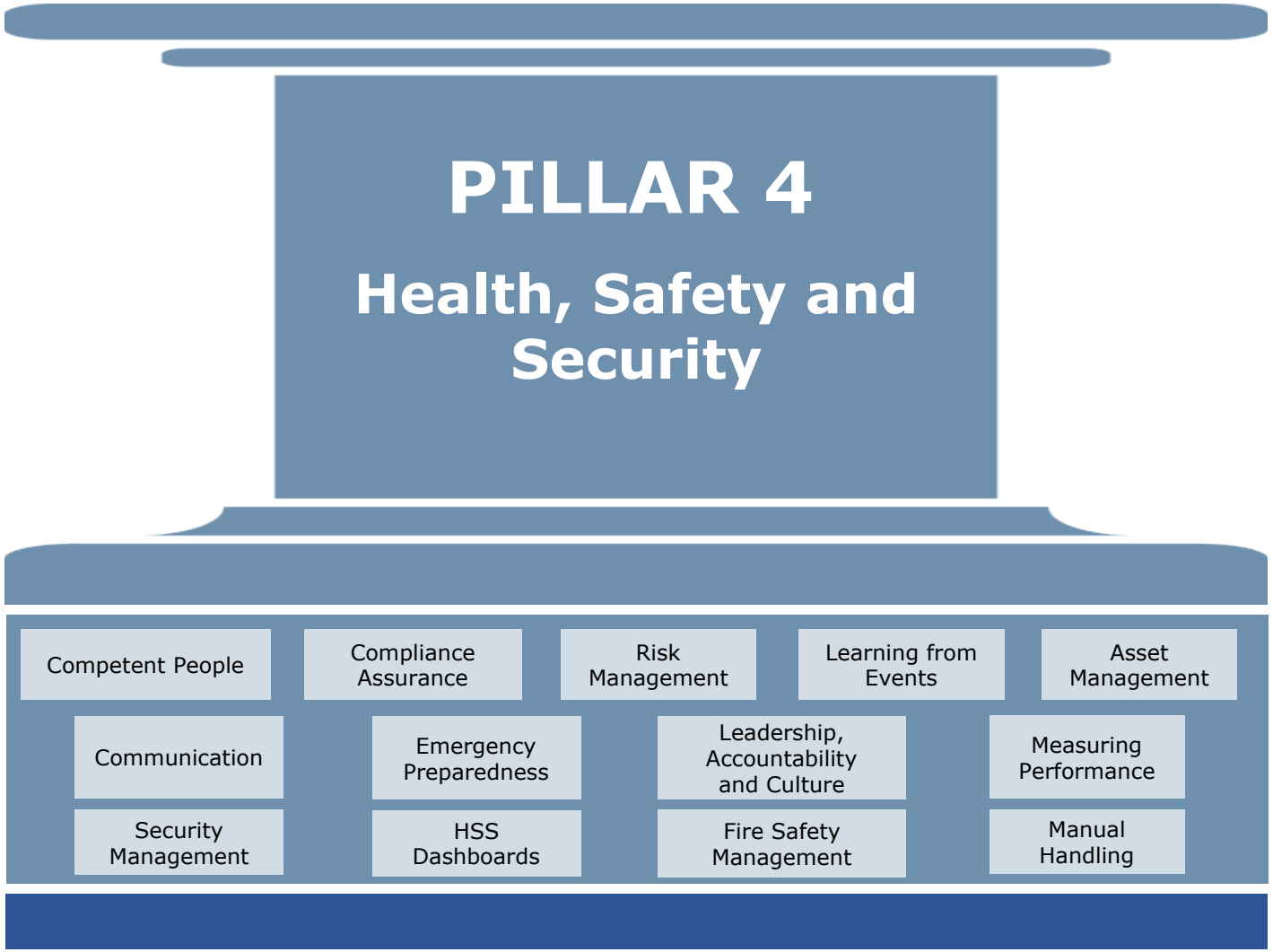
Reg 28: Prevention of Future Deaths Reports:

- Only 1 Regulation 28 report issued this quarter.
- The Coroner was concerned with NEWS scoring in the Emergency Department.

The Health Board provided the Coroner with a response within the required timescale, including details of actions taken to introduce an electronic NEWS scoring system within the Department.

Coroner Update

- At the end of August 2024, the Coroner's court moved from Newport Civic Centre to Langstone Court.


PILLAR 4
Health, Safety and Security
Competent People
Compliance Assurance
Risk Management
Learning from Events
Asset Management
Communication
Emergency Preparedness
Leadership, Accountability and Culture
Measuring Performance
Security Management
HSS Dashboards
Fire Safety Management
Manual Handling

Health, Safety and Security

Health and Safety Executive Engagement

There was one new enquiry from Health and Safety Executive (HSE) during quarter 2 of 2024/25. This related to a fatal patient fall reported under RIDDOR.

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

South Wales Fire & Rescue Service Activity

The Health Board are progressing the recommendations of the two enforcement notices relating to fire safety at Residences at Nevill Hall Hospital (Gerylyn and Bron Haul). Extensions to both notices have been approved by the Fire & Rescue Service.

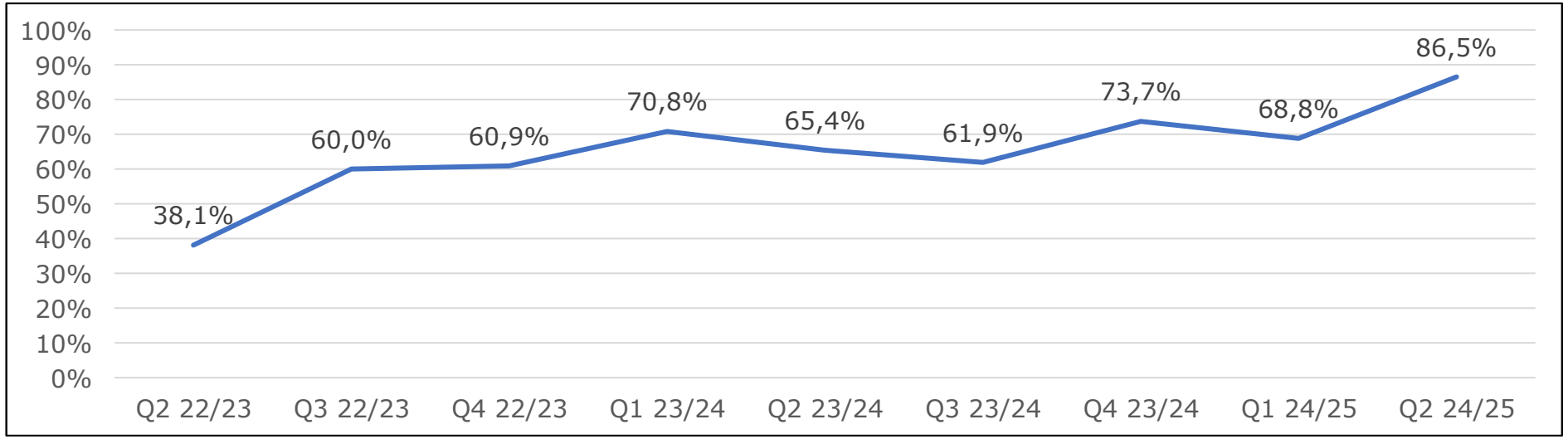
Compliance with the requirements of the notices will be achieved by end of November 2024.

Health, Safety and Security

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During Q2 (July to September 2024) the Health Board have reported **22 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

86.36% of these cases were reported within the legal timeframes within the legislation.



Health, Safety and Security

Health and Safety Statutory and Mandatory Training

At end of September 2024 training compliance for the Health Board was reported as:

There has been a slight decrease in compliance with health & safety and fire safety compared with the previous report, however, compliance with Manual Handling has increased significantly.

Health & Safety	**86%**
Fire Safety	**83%**
Violence & Aggression	**86%**
Manual Handling	**68%**

Health and Safety Training for Senior Leaders

IOSH Safety for Executives and Directors being planned for Q3 2024/25.

Health, Safety and Security

Anti Social Behaviour (ASB) Review
Bettws Health Centre

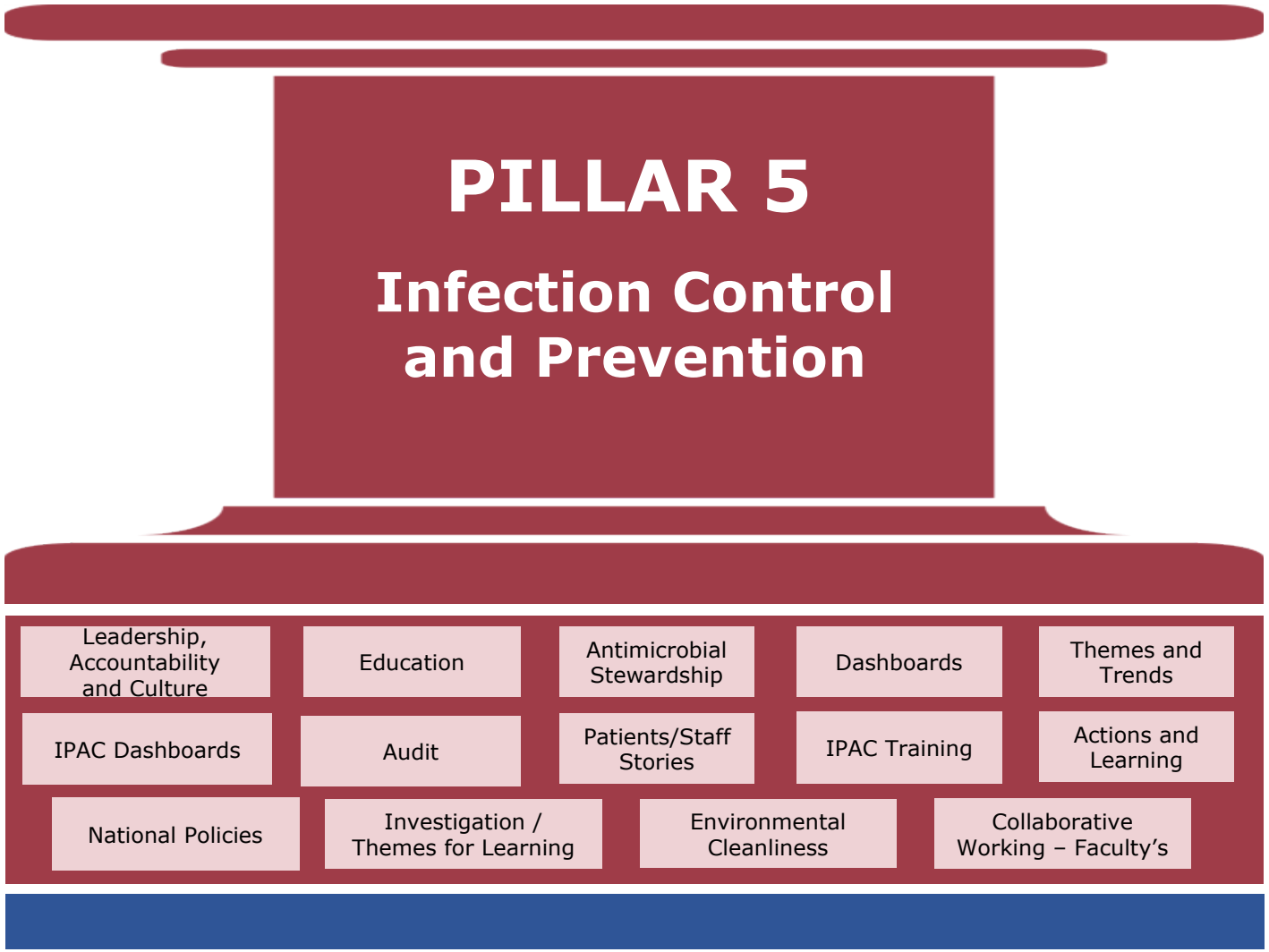
An application has been submitted to Newport City Council to activate an ASB Case review under Section 104, Anti-Social Behaviour, Crime and Policing Act 2014.

A multiagency panel will be brought together to review the case in November 2024.

Recruitment of Violence Prevention & Reduction Lead

The Health Board have been successful in recruiting a Violence Prevention & Reduction Lead.

The successful applicant will be onboarded in November 2024 and will commence work on a gap analysis against the Violence Prevention & Reduction Standards.


PILLAR 5
Infection Control and Prevention
Leadership, Accountability and Culture
Education
Antimicrobial Stewardship
Dashboards
Themes and Trends
IPAC Dashboards
Audit
Patients/Staff Stories
IPAC Training
Actions and Learning
National Policies
Investigation / Themes for Learning
Environmental Cleanliness
Collaborative Working – Faculty's

Infection Prevention

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

All Wales – Current FY count of specimens

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	152	8	94	184	66	21
Betsi Cadwaladr UHB	193	7	79	281	64	11
Cardiff and Vale UHB	111	3	90	147	66	18
Cwm Taf Morgannwg UHB	81	3	66	179	49	9
Hywel Dda UHB	109	5	67	189	54	13
Powys THB	15	0	1	0	0	0
Swansea Bay UHB	132	3	56	117	60	7
Velindre NHST	2	0	1	5	6	0
Wales	795	29	454	1102	365	79

All Wales – Current FY rate per 100,000 population

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	51.26	2.7	31.7	62.06	22.26	7.08
Betsi Cadwaladr UHB	55.94	2.03	22.9	81.44	18.55	3.19
Cardiff and Vale UHB	43.79	1.18	35.51	57.99	26.04	7.1
Cwm Taf Morgannwg UHB	36.38	1.35	29.65	80.4	22.01	4.04
Hywel Dda UHB	56.45	2.59	34.7	97.89	27.97	6.73
Powys THB	22.35	0	1.49	0	0	0
Swansea Bay UHB	68.66	1.56	29.13	60.86	31.21	3.64
Velindre NHST						
Wales	50.63	1.85	28.92	70.19	23.25	5.03

C. difficile antibiotic root cause analysis themes

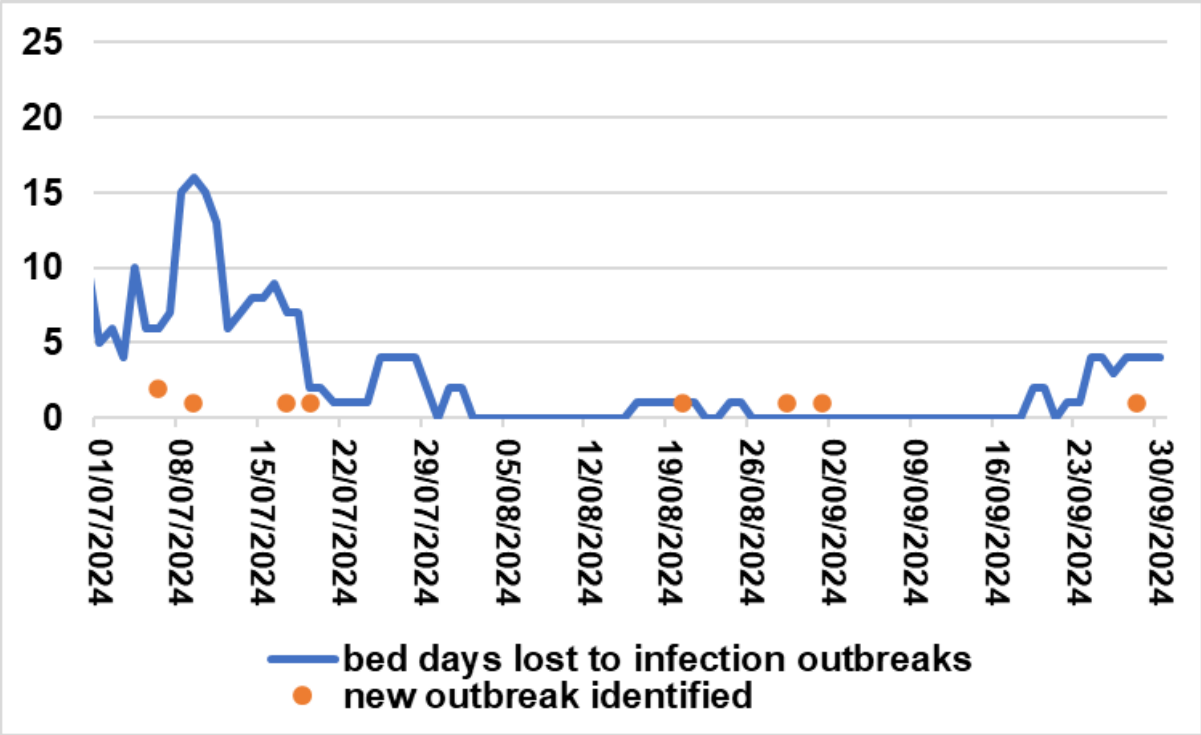
September 2024

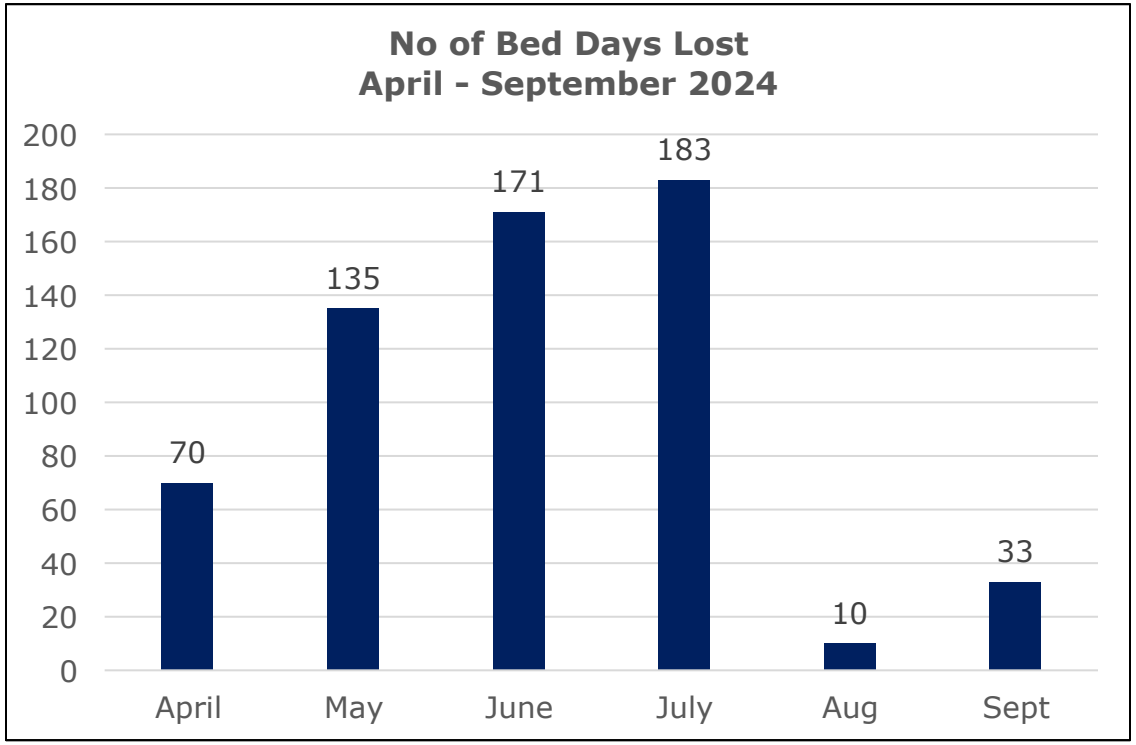
Antibiotic findings	HCAI	CAI	Relapse	Grand Total
No antibiotics received		1		1
No suboptimal antibiotics	6			6
possible suboptimal use - no increased risk	2	1		3
Possible suboptimal use - increased risk of C.diff	6			6
Awaiting GP response		4	1	5
RCA pending	2	3	5	10
Grand Total	**16**	**9**	**6**	**31**

- 6 suboptimal antibiotics (19%), all HCAIs, but with no specific themes
- 2/6 patients on acid-suppressing medicine did not have it held whilst on antibiotics
- Trend: Suboptimal antimicrobials, increasing the risk of *C. diff:*
  - 23/24 FY: **23%** (53/229)
  - 24/25 Q1: **21%** (14/66)
  - 24/25 Q2: **15%** (12/82)

Issue	Action	Learning and Improvement	Who	When
C difficile infection Jul - Sept = 79 cases 44 x healthcare associated 32 x community acquired 3 x relapse	Ongoing proactive enhanced cleaning Bespoke education	Fundamental Infection Prevention Antibiotic stewardship Slippage of proactive HPV clean Boarding and capacity	ALL	Ongoing
Wards closed due to C difficile July = Ebbw ward Aug = nhh4/3, rghC6E, rghD4W Sept = nhh3/1, rghD2E, rghD4W	Outbreak control meeting convened Samples sent for genomic sequencing, D2E linked Decant HPV clean	Inappropriate sample collection High dust Antibiotics not within guidelines Not withholding PPI while on antibiotics	MDT team	Ongoing
Staph Aureus Jul - Sept = 54 cases 19 x healthcare associated 35 x community acquired 0 x relapse	Webinar for line care implemented ANNT incorporated into ward accreditation	Overview of HB guidance for the management of lines Compliance increasing several areas now able to achieve bronze accreditation	ALL ALL	Sept
E coli blood stream infections Jul - Sept = 96 cases 28 x healthcare associated 66 x community acquired 2 re-isolate	Main source of infection is UTI Webinar implemented August promoting 9 key standards	No catheter November arranged for primary care	ALL	All
Klebsiella blood stream infections Jul - Sept = 34 cases 11 x healthcare associated 21 x community acquired	Sepsis, Antimicrobial Stewardship and Infection prevention training to new Doctors	Prescribing within policy	Clinical prescribers	Aug/Sept
Pseudomonas blood stream infections Jul - Sept = 10 cases 4 x healthcare associated 6 x community acquired	Reviewed training resources for water flushing Incorporated flushing onto the ward accreditation environmental audit	Increase staff awareness	ALL	Ongoing
Wards closed due Covid-19 Jul = C5W Gwanwyn, Anwylfan Aug = 0 Sep = 0	Promoted covid safety measures Enhanced cleaning of touch point areas Patients cohorted on a like for like	Shared facilities Ventilation Symptomatic staff/visitors to wear face covering	ALL	Ongoing
Jul - C6E closed due to norovirus	Enhanced cleaning Isolation of infection patients	Shared facilities Linked to visitor	Ward Staff	July

Infection Prevention – Bed Days Lost

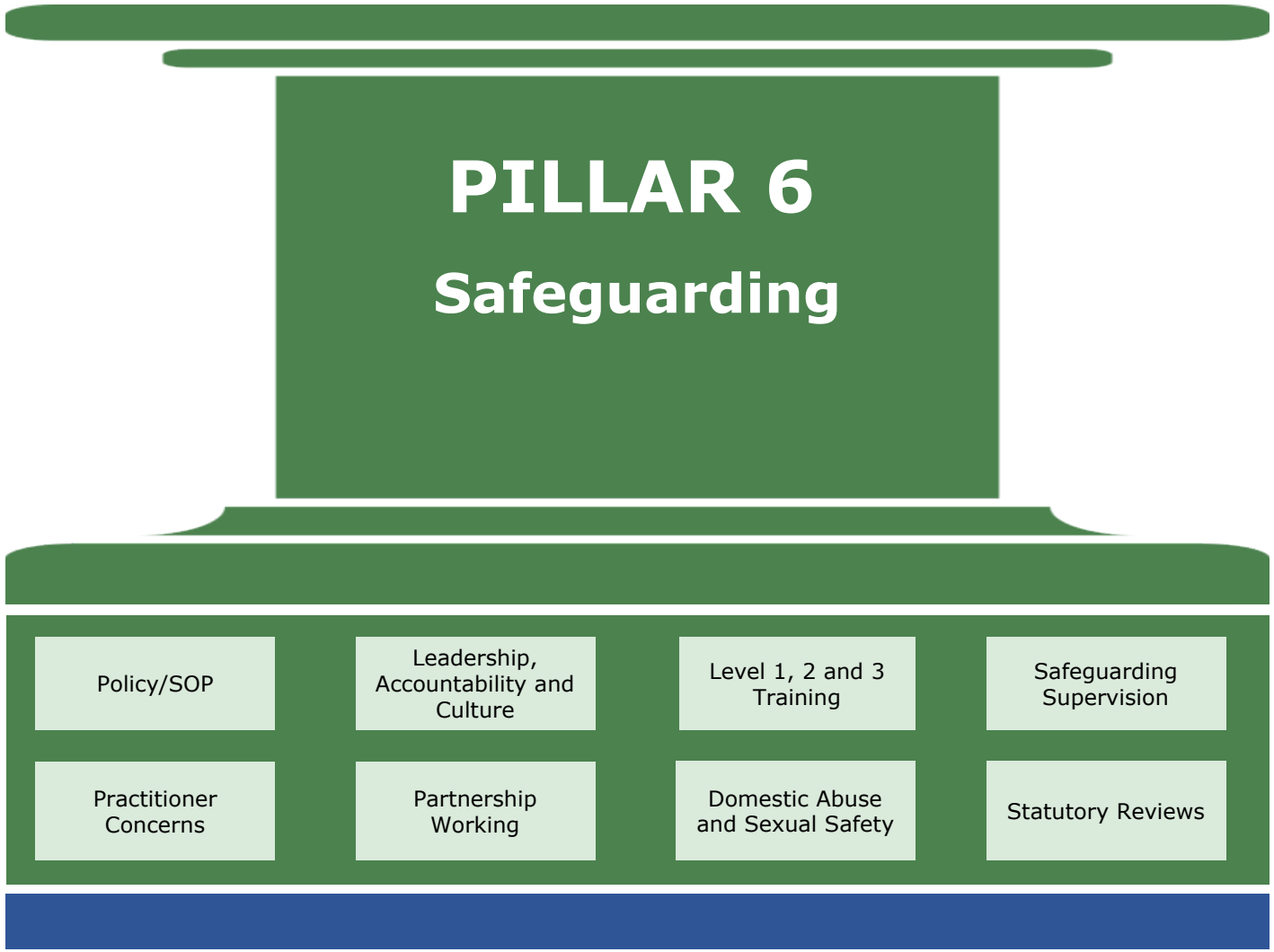




Bed days lost due to respiratory illness rising during September.

Infection Prevention – Decontamination

Issue	Cause	Remedial Action	Who	When
Community Dental Service (CDS) washers have been tested but not serviced, indicating non compliance with required standard.	Lack of works and estates trained staff to undertake the role and their focus on other decontamination testing, eg HSDU.	All Wales Authorised Engineer (Decon) AE(D) aware. Waiting CDS agreement on release of monies for band 5 Works personnel.	Authorised Person (D). Works & Estates lead. CDS Directorate.	October 2024 October 2024
Delay in centralised endoscopy unit project build at the Royal Gwent Hospital (RGH). Still increased demand on the interim unit with breakdowns occurring.	Non agreement of revenue costs initially created delay however this has since been approved by ABUHB Board and still awaits decision for funding by Welsh Government.	The interim decon unit continues to decontaminate scopes however has failings on recent Bowel Screening Wales (BSW) audit. Action plan produced to address issues.	Still awaiting Welsh Government funding review HSDU lead	End October 2024
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D) for JAG accreditation.	Identified significant progress with works & estates input. Electronic track & trace (T&T) indicated requirement for green rating..	Ward staff have been trained in weekly testing for decontamination and has been accepted by AE(D) Wales. Awaiting report to decide JAG accreditation.	Directorate manager & Senior Nurse	November 2024
AP(D) role not fully functioning from a governance aspect.	Lack of AP(D)s and decontamination works trained staff. Remains under review.	Decontamination manager continues to support AP(D)with joint report review.	General Manager Facilities / Works & Estates	December 2024
Risk of losing automated decon process for US probes in Radiology Units. Compatibility issue with Trophon preclean.	Trophon 1s HPV probe disinfectors are obsolete. Disinfection assurance only on Incidin Oxywipe at this moment	Replacement programme within Ultrasound directorate & agreed on 8 new machines. All Wales meeting with possible independent testing proposed.	Ultrasound Lead Decontamination manager & Ultrasound Lead	November 2024 November 2024


PILLAR 6
Safeguarding
Policy/SOP
Leadership, Accountability and Culture
Level 1, 2 and 3 Training
Safeguarding Supervision
Practitioner Concerns
Partnership Working
Domestic Abuse and Sexual Safety
Statutory Reviews

Safeguarding – Training Compliance

Training Module	Compliance %
Adult Safeguarding Level 1	87%
Children Safeguarding Level 1	86%
Adult Safeguarding Level 2	90%
Adult Safeguarding Level 2	88%

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

All training for Safeguarding level 1 and 2 is now above the required 85% compliance.

Level 3 Children's and Adults training continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR and that compliance data can then be analysed.

Wales Safeguarding Procedures - Section 5 - Safeguarding Allegations/Concerns about Practitioners and those in Positions of Trust

The Wales Safeguarding Procedures Section 5 have an overarching aim to ensure that children at risk and adults at risk are safeguarded from individuals who may pose a risk in the setting within which they work or volunteer.

There has been a steady increase in the number of cases managed under Section 5 by the five Gwent Local Authorities and serious allegations can take a long time to be processed by Police, sometimes resulting in staff being unable to work for prolonged periods. Therefore, delays in cases reaching their conclusion has impacted on:

- Staff wellbeing
- Completion of internal investigative processes
- Duty of Candour being fulfilled in a timely manner
- Closure for patients and/or their representatives
- Staffing and recruitment

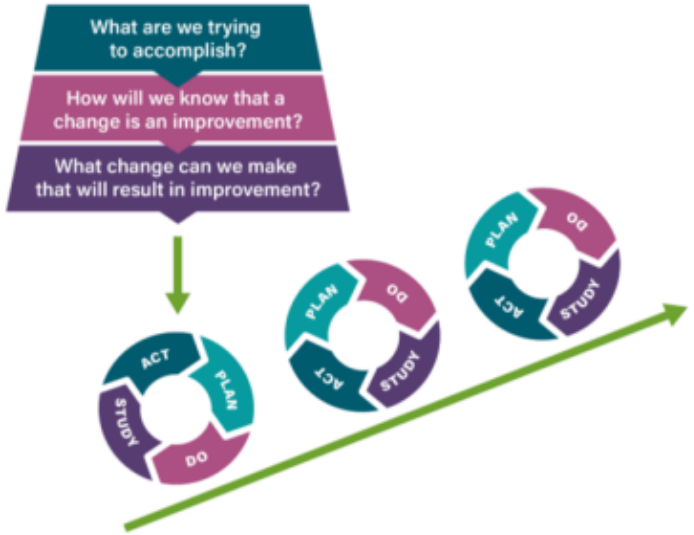
At this current time the Corporate Safeguarding Team are working with Divisional and Directorate Leadership teams to ensure:

- Early and meaningful engagement with patients and their representatives to explain safeguarding processes, manage any anxieties and establish their wishes
- Timely completion and review of risk assessments to ensure protective measures are put in place for all parties whilst investigations are ongoing
- Regular meetings take place with external agencies to ensure that cases are not overlooked and that we are providing support to the investigation in a timely way
- Appropriate escalation to Executive Leadership and completion of EWN as appropriate
- Provision of regular feedback and wellbeing support for the staff member involved

Safeguarding Actions

Issue	Action	Learning and Improvement	Who	When
Safeguarding Level 3 Training Non Compliance ▪ Delays in being mandated via ESR	Extensive work has been completed by Corporate Safeguarding and the ESR Team which should result in mandate showing on staff records from the beginning of 2025.	Upon completion of this action it will be simple for managers at all levels of organisation to monitor compliance and identify areas for improvement.	ESR Team	Q4
Decommissioning of Specialist Domestic Abuse Service in General Practice ▪ Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme	A number of presentations are being delivered to the NCNs to outline what services are available to support survivors of Domestic Abuse and an interim pathway for management of a disclosure has been provided to practices.	System leaders in primary care will have received bespoke training and support to enable them to embed pathways within their practices	Corporate Safeguarding	Q3
Significant increase in safeguarding referrals and strategy meetings for vulnerable children and adults ▪ It is unclear if there is any singular cause for this increase in activity, though improved staff awareness will be a contributory factor.	An SBAR is being drafted, highlighting the risks associated with this increase in activity and outlining the operational challenges in meeting demand.	Increases in safeguarding activity are difficult to predict, so developing more robust methods of monitoring increased activity will facilitate early escalation	Corporate Safeguarding	Q3

Quality Improvement



Quality Improvement – Q2 2024/25

QI is the AB way: Embedding Quality Improvement into Everything we do

Our QI Capability strategy is to build:

Capacity for QI

- QI Knowledge and Skills Development Framework
- QI Tools and Resources

Conditions for QI

- Quality Management System
- Leadership for QI Capability
- **QI Coaches embedded**
- **Human Factors & Psych Safety**
- Systems to share learning
- Protected Time for QI
- Patient Involvement in QI
- Access to Data Systems for QI
- Aligning QI to Health Board priorities

Connections for QI

- Health Board QI Networks
- External QI Networks & Strategic Partners

Progress: –

Embedding Quality Improvement into everything we do: Quality Improvement Capability Strategy 2025-2028

- QI Strategy for next three years being drafted
- QI Strategy development session with Maxine Power
- Board Development Session 24th October 2024

1 Million minutes of QI Coaching in next 4 years
QI Coach development programme (click for more info)

- Test cohort of Quality Coach Programme completed in June
- Cohort 1 of Quality Coach Programme initiated in September. Fully booked with key staff from QPS, Primary Care, QI Project teams. Participants from Cwm Taff and Improvement Cymru
- 16/300 QI Coaches trained in ABUHB
- 8500/1,000,000 minutes of QI Coaching up to September

Human Factors and Safety Culture

- ABCi Improvement Advisor supporting work to reduce Never Events in Theatres – presented to PQSOC
- 306 days since last Never Event in theatres (data to September) equating to 4 events avoided

Quality Improvement Successes

	Deteriorating Patients – Safer Care Collaborative	Paediatric Outpatients - Impact	Head and Next – Impact of Current State	Impact of Quality Improvement in Theatres
Safety	▪ **13 Cardiac Arrests Avoided**	▪ **Children receiving appointments and treatments in a more timely manner**	▪ **7 Patient deaths avoided to date**	▪ **Avoided 4 Patient Never Events**
Staff	▪ MDT approach and wider administrative staff in QI process.	▪ Involving resident doctors, consultants and wider administrative staff in QI process.	▪ Increased Staff Wellbeing.	▪ Inspiring a culture of Safety and Improvement. Improving staff well-being, encouraging development.
Financial	▪ Potential Savings in hospital care - £226,772	▪ Efficiencies achieved through QI rather than additional resources.	▪ Health Foundation Investment Grant £97,500.	▪ Savings of approx. £268,000 in costs of Never Event
Performance	▪ 308 days between avoidable cardiac arrests on C0 Ward GUH.	▪ Reduction in waiting times from 26 weeks to 15 weeks.	▪ 62 Day SCP % Compliance Increased ▪ Head and Neck NOT in Special measures.	▪ 32629 operations since last never event in Theatres. (337 days).

Safe Care Partnership – Next Phase

The Safe Care Partnership (SCP) is an ongoing collaboration between NHS Wales Health Boards, Trusts, Improvement Cymru and the Institute for Healthcare Improvement (IHI). The aim of the SCP was to provide nationally coordinated, locally delivered support for safe, reliable and effective care supporting national collaboration and cross boundary learning.

Previous work of the SCP included the Safe Care Collaborative which came to an end in May 2024. Workstreams focussed on Patient Deterioration across the system in Acute, Community, Ambulatory Care and Leadership.

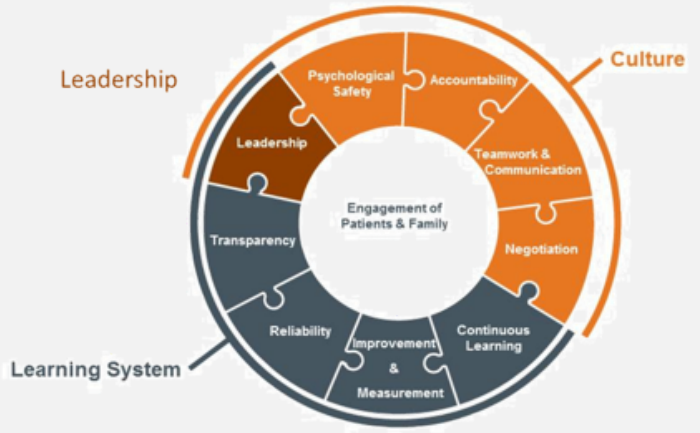
Leadership was a key area of the work aiming to build a system to support Safe, Reliable and Effective Care as seen in the figure.

The Safe Care Partnership (SCP) – Next Steps

The next phase of the Safe Care Partnership no longer includes support from the IHI. Improvement Cymru have worked with Executive Clinical Peer groups, Welsh Government and NHS Wales Executive colleagues to identify priorities for the next phase of the SCP. Priorities include:

- Acute Deterioration – recognition and response
- Deconditioning – prevention and identification
- Leadership – Quality Management System

A co-design event between Health Boards, Trusts, Improvement Cymru is being held in October to develop the national approach.



Quality, Patient Safety and Experience

Additional Information

Section 5

Listening & Learning – Focus on Bereavement

Bereavement Collaborative - Key Highlights: October 2024

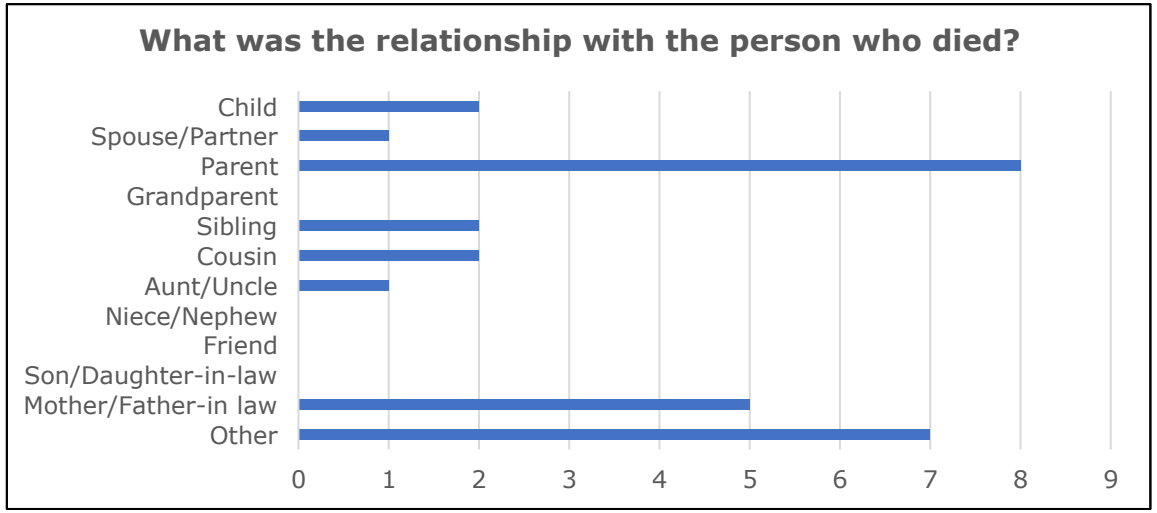
- **94 people** - staff and bereaved members of the public.
- **42** attended in person Collaborative 04/09/24.
- **Bereavement Survey** tested and amended (snapshot of responses included). Will help prioritise actions. This has now been built on Civica and includes National Core Question.
- **Reasonable Adjustments** - Survey will be available in audio and BSL.
- **Collaborative Priorities** - Pregnancy Loss, Child Loss, Loss from Traumatic Experiences.
- **12** bereavement subgroups identified- some will be led by bereaved people.
- **Staff** Bereavement Collaborative arranged for 3 December 2024 to coincide with National Grief Awareness Week. Includes psychology, workforce and staff.
- Focused plan in development for engaging bereaved people with **protected characteristics** (face to face and webinars).
- **EOLC Senior Nurse and Patient and Family Support Officer** - commenced 28/10/24

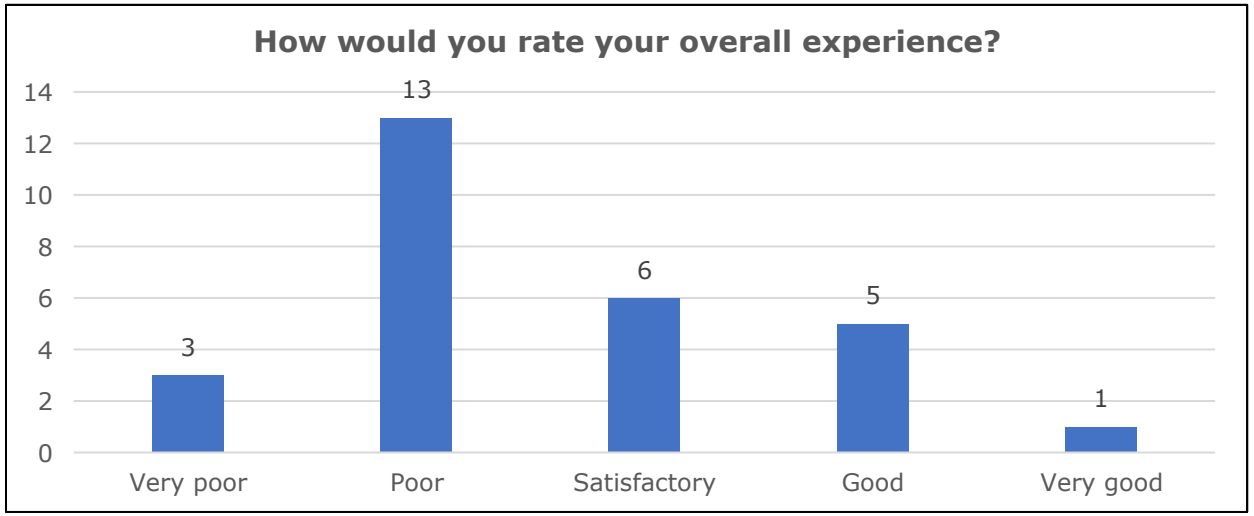
Bereavement Webinars and Face-to-Face

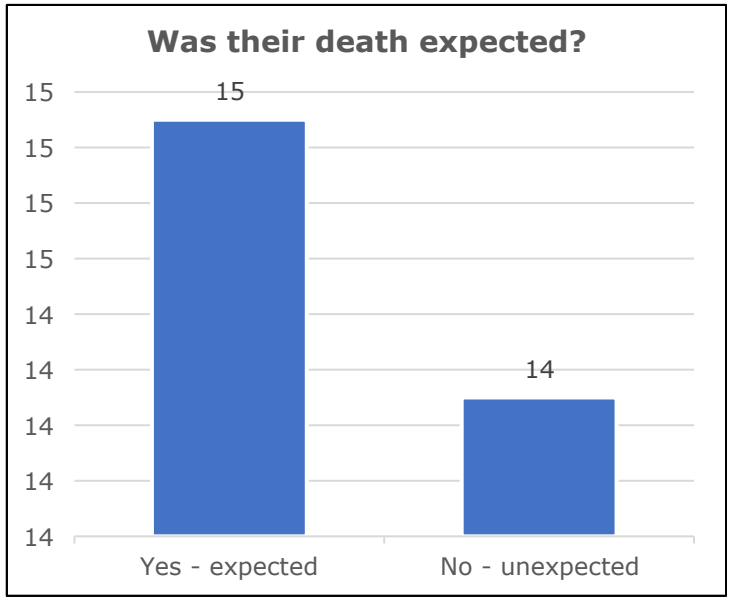
Engagement Events Agreed:

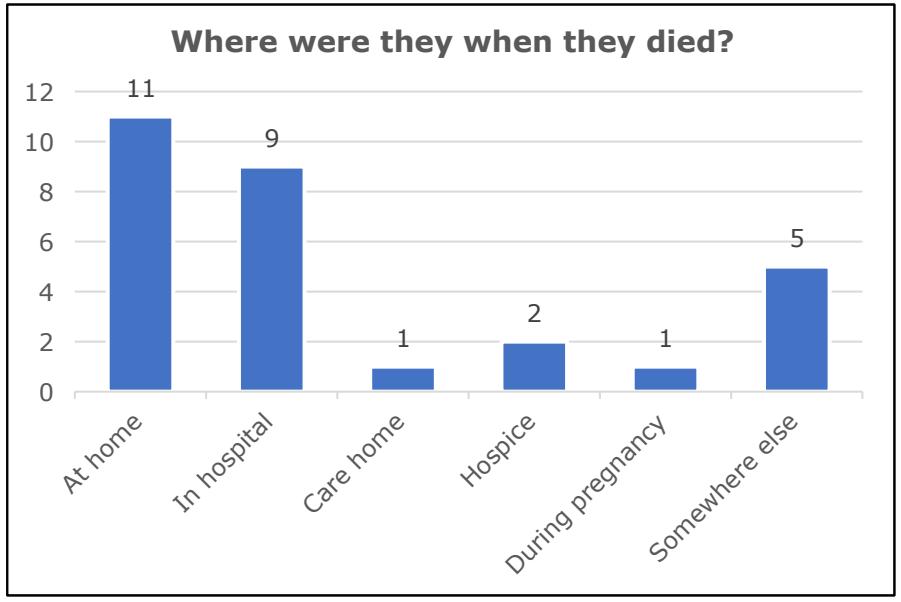
- Staff (Webinar)
- People living with Dementia (Webinar)
- People with Sensory Loss (face to face)
- People whose first language is not English (Webinar)
- Baby Loss (Webinar)

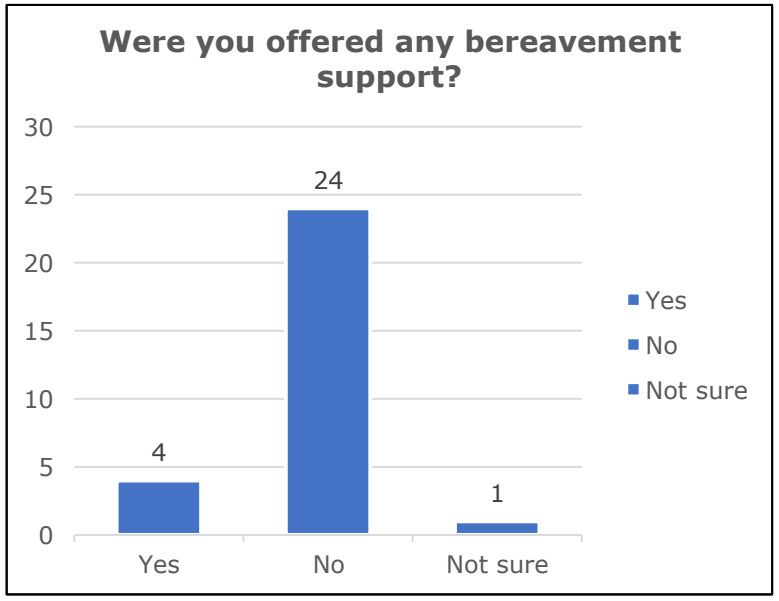
Bereavement Survey - Snapshot of Responses





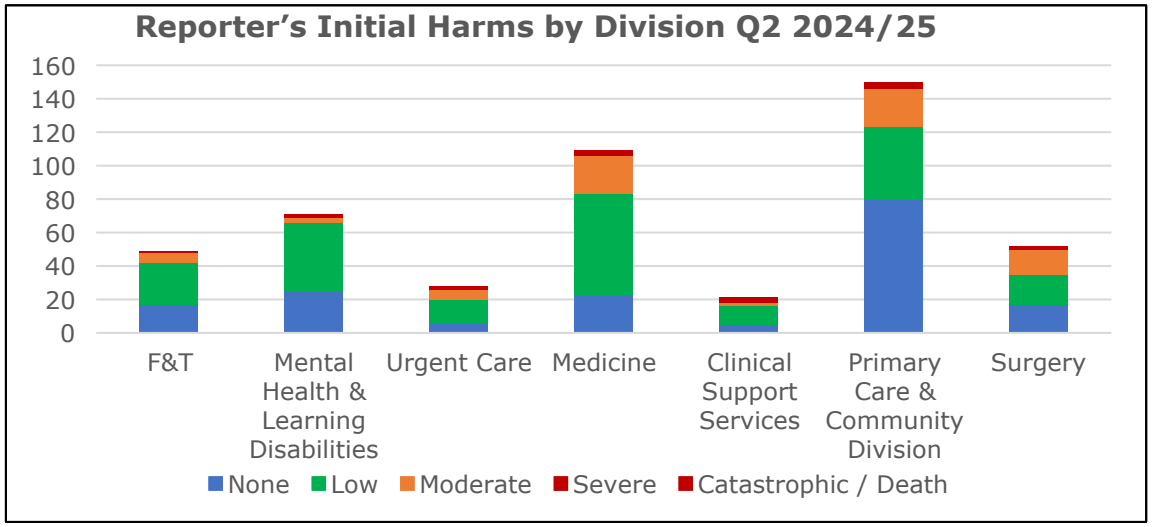


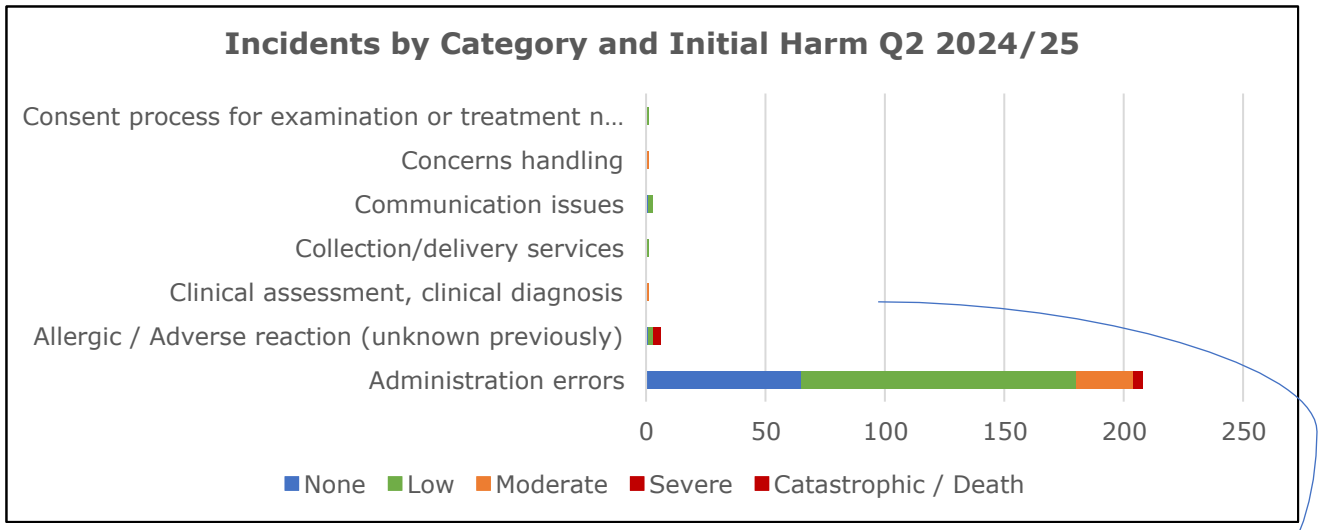




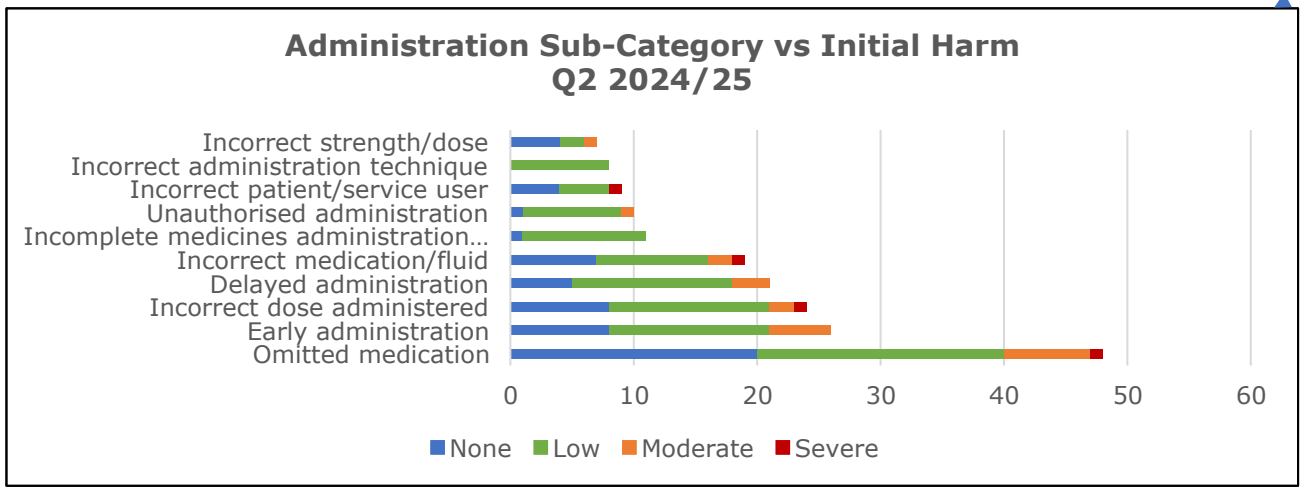
Medication Safety Group (MSG) Q2 2024/25

Medication Incident Report for Q2 2024/25





Post Investigation Harm Assessment				
	Q3	**Q4**	**Q1**	**Q2**
None	226	208	245	187
Low	95	98	169	118
Moderate	32	35	3	7
Severe	7	5	0	0
Catastrophic	0	0	0	0
Total	**360**	**346**	**417**	**312**



Medication Safety Group – Actions Q2

- **All Wales Penicillin Allergy Delabelling Protocol**
  Protocol endorsed by MSG. Roll out agreed in ABUHB in line with AWTTC. Microbiology have agreed to provide specialist support, with immunology support available through C&V.

- **Medication Safety Incidents – examples discussed**
  - Administration errors
  - Medication supply
  - Prescribing

- **Oxygen BOC**

Coroners Regulation 28 Repost shared by BCUHB for learning, regarding a death involving use of an oxygen cylinder that was not turned on during an emergency.

  - Training package being developed for use on ABUHB ESR.
  - Safety alert developed to highlight the issue with link to video showing how to check oxygen valve is open and gas flowing.

- **Themes – anticoagulation**

Thematic review completed. A task and finish group set up to develop action plans. This is an ongoing piece of work which will be highlighted during Medication Safety Week (Nov 4th-10th).

- **Bung Coring**

Following an increase in reports of bung coring, an organisational change in practice has been initiated to use a blunt filter needle to reconstitute and a blunt needle for any further dilutions. Education has been provided as a poster and shared with practice educators, QPS leads and divisional nurses for onward cascade.

- **Heavy Bupivacaine**

Following an All Wales QC review and risk scoring, the sterile wrapped high strength bupivacaine is no longer an All Wales contract item. This poses a new risk due to the similarity with tranexamic acid vials. Risk assessment and mitigation plans are being implemented.

Medication Safety Group – Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Anticoagulation incidents	Task and Finish group set up and a thematic review completed and discussed. This action plan will be progressed by MSG as part of the work plan.	All divisions to look at local issues and MSG to agree what organisational/ divisional actions need to happen to prevent future harm. Consider a QI for this work.	MSG (QPS collaborative)	On workplan for next 6 months.
Bung coring	Poster developed and disseminated to QPS/ Divisional leads and practice educators.	Change of practice initiated to reduce risk of bung coring. Monitor roll out and any new issues e.g., availability of needles.	MSG (KH lead)	Complete
Oxygen BOC	Develop an alert to highlight the risk and sign-post staff to videos demonstrating best practice. Actions tracked as part of Patient Safety Notice Policy and reported back to NHS Exec.	An All Wales training available on ESR – very long and complex. ABUHB to develop a shorter session to cover key points considering the coroners regulation.	MAG (KH lead)	November 2024

Patient Safety Notice

Following the death of a patient in NHS Wales, a regulation 28 prevention of future deaths coroner's report was issued after the incorrect use of Oxygen CD cylinders manufactured by BOC. Guidance reflects the actions required in PSN041- Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders harm (2018).

This has been reviewed in collaboration with the Health Board's Medical Gases Group and the Medicines Safety Group and will be linked with the workplan aligned to training for medical devices.

Actions taken:

- Education in the form of information sharing (posters and training video) across the Health Board including;
  - ✓ Pictural instruction and video on the safe use and initiation of oxygen therapy from a cylinder
  - ✓ To remind staff of the importance of completing a Datix for any incident or near miss which relates to the use of an oxygen cylinder (with reference to the criteria for an MHRA Yellow Card)

- A module on ESR module is under construction. This includes the safe use and management of oxygen cylinders and is relevant for all clinical staff who use oxygen cylinders. A different training process is being followed for non-clinical staff. Compliance will be complete with the roll-out of this module with the current posters and video as an interim measure.

- A full review of oxygen cylinders throughout sites is taking place as part of an audit in clinical areas.

Training video for
BOC O2 cylinders

All Wales Patient Safety Solutions: Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	This project is being lead by the Chief Nursing Information Office. Work is still on-going.	In-progress
PSA018- Risk of oxytocin overdose during labour and childbirth	31 March 2025	This has recently been issued. A task and finish group is being developed within the Families and Therapies Division to map actions.	In-progress

Nurse Staffing Levels Wales Act 2016

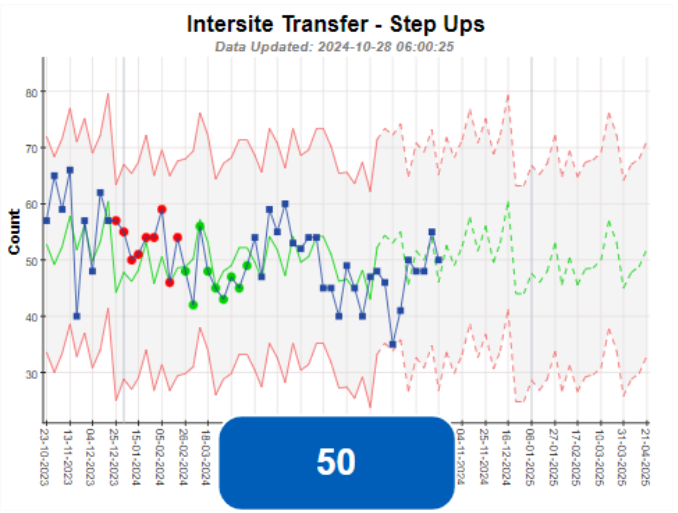
Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical/ surgical and paediatric inpatients wards					
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints – **1st July -30th September 2024**	Number of closed incidents/complaints – **1st Julyl-3oth September 2024**	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
Avoidable Hospital acquired pressure damage (grade 3, 4 and unstageable)	**16**	**9 (only 2 found avoidable)**	**7**	**1**	0
Falls resulting in Moderate harm or death (i.e. level 3, 4 and 5 incidents)	13 **Reported as moderate/ above**	**3 moderate (? Should be low)** **1 catastrophic – harm not attributed to HB**	**4**	**1**	**0**
Medication errors, level 3,4,5 & never events	**85**	75 **all closed as low**	**10**	**0**	**0**
Any complaints about nursing care	**37 not just nursing**	13 **nursing**	**Difficult to determine until investigation complete**	**0**	**0**
Infiltration/ extravasation injuries	**0**	**0**	**0**	**0**	**0**

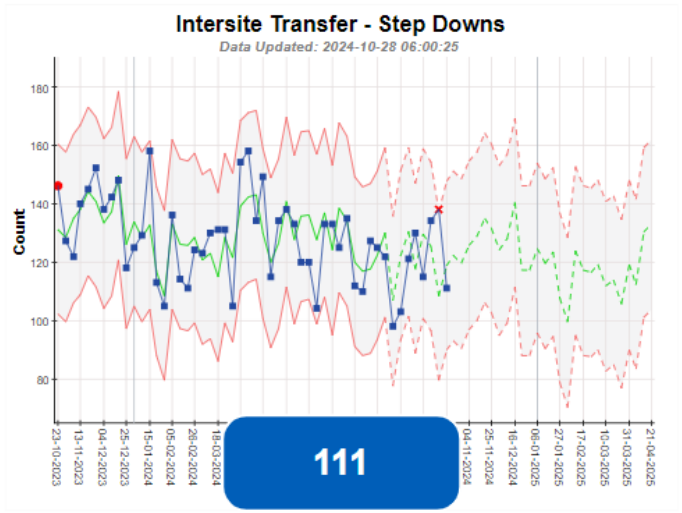
Nurse Staffing Levels Wales Act 2016 – Learning and Improvement

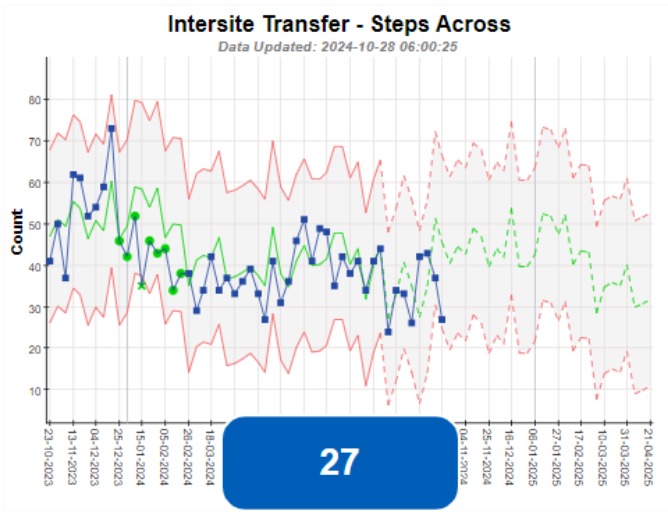
Issue	Action	Learning and Improvement	Who	When
Delay in undertaking RCA and focussed reviews of Hospital acquired pressure ulcers	Divisions to speak to senior nurses to understand barriers to timely investigations	Agenda HAPUs on monthly QPS meetings and one to one meetings with senior nurses and ward managers- discuss barriers to completion of timely focussed reviews.- determine what support is need from divisional leads	Divisional leads Senior nurse Ward managers	Monthly QPS meetings and one to one discussions
Delay of closure of some DATIX relating to injurious falls	waiting for presentation to Falls Panel	Ward managers to be reminded to close DATIX timely following presentation to Falls Panel	Divisional Nurses Senior Nurses	Monthly Divisional QPS meetings
Accurate completion of staffing Act Questions regarding planned roster and appropriateness of levels in complaints.	Divisional leads to meet with QPS teams to ensure there are processes in place to obtain the correct information regarding the Staffing Act questions prior to closure of complaints	NSA lead has met with complaints lead and divisional hubs to inform them of correct process of obtaining staffing level information - but the process does not appear to be followed- resulting in mis-information regarding staffing levels when complaints in Datix are closed.	Divisional leads Senior Nurses Complaints Hubs	Monthly QPS meetings

Urgent and Emergency Care: Flow Centre

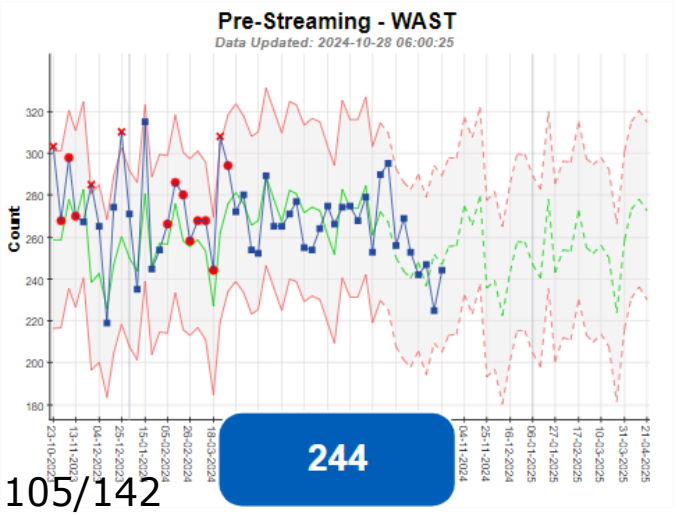
Goal 2: Signposting people with urgent care needs to the right place, first time

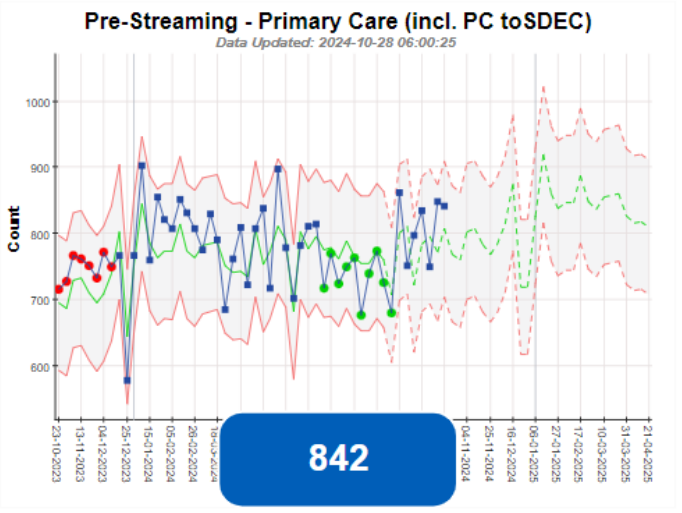


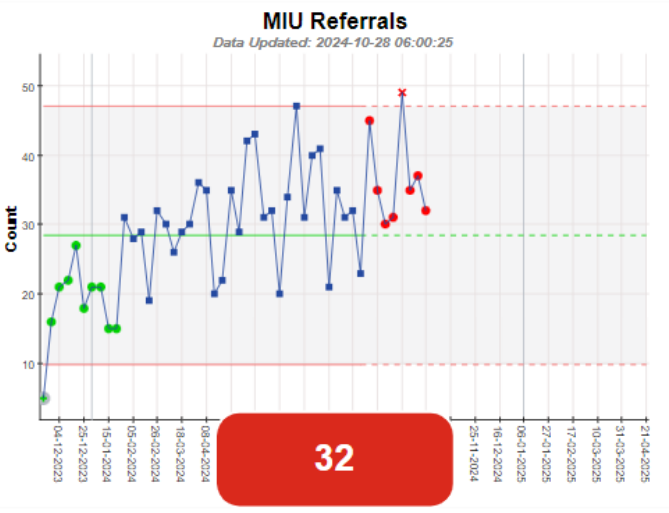




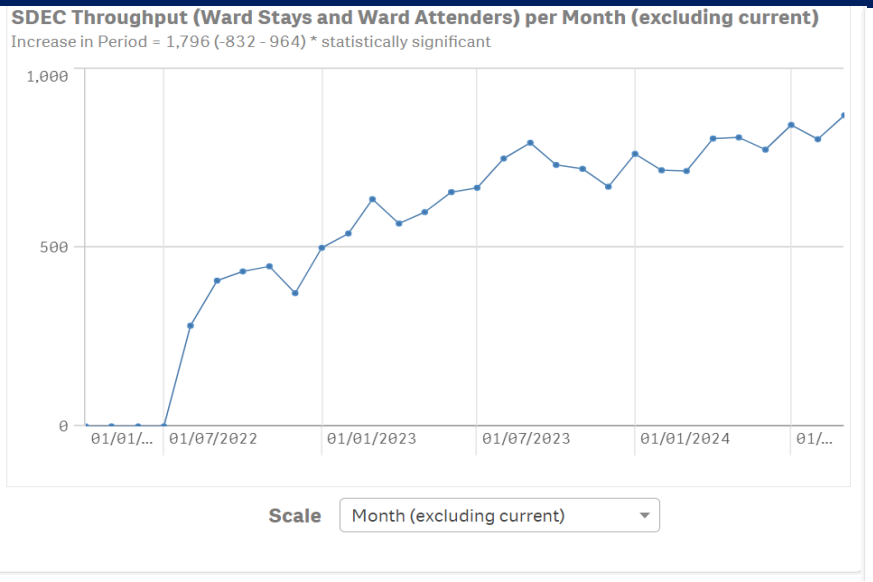
- **Referrals via MIU** are now measured via Flow Centre activity – numbers have been increasing to a recent range of 30-50/week

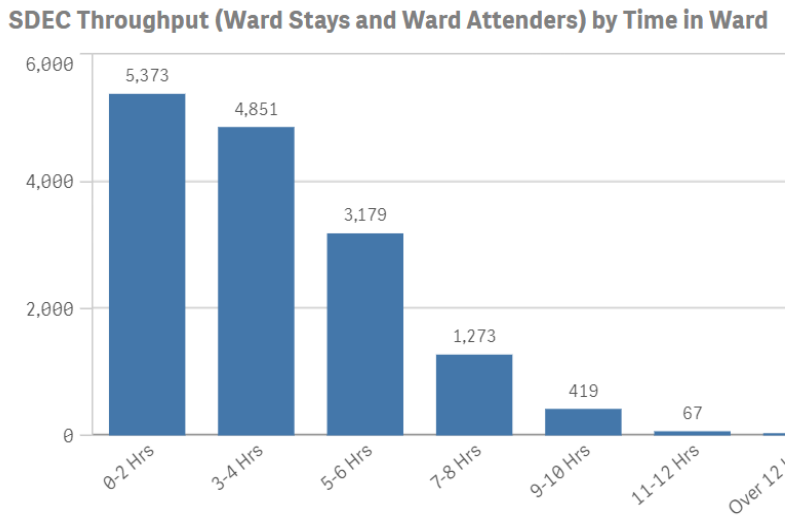


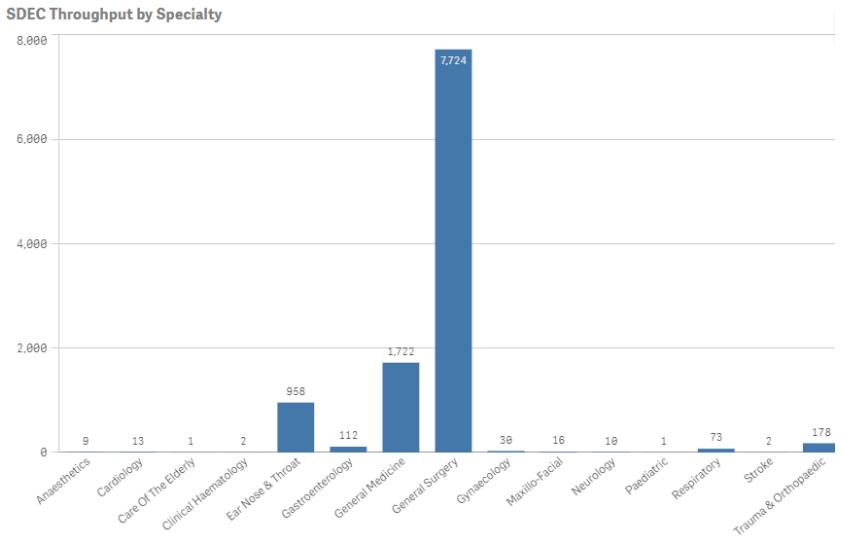




Urgent and Emergency Care: SDEC GUH at a Glance 08/08/22 – 25/10/24







17620 Patients seen

Average 38 Patients per day

14448 patients Discharged Same Day (82%)

Median time 3:48 hours

3171 Admissions

Progress Summary:

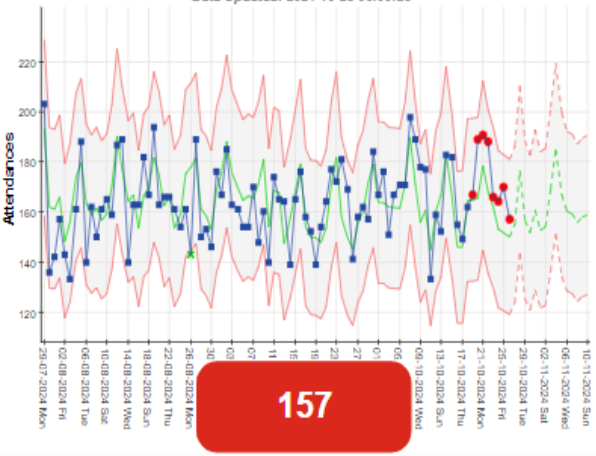
- Sept 2024 saw busiest month since opening with 871 patients
- Average daily patient throughput up to 33 some days reaching 50
- Surgical model working very well, great feedback from Primary Care
- Pathway opportunity review for T&O, Neuro, Haematology
- Medical Model GP referral process now in place
- Medical referrals have stabilized to around 30 per week,
- Reviewing pathways for direct referral from ED/MAU to SDEC
- Reviewing process for next returning patients from ED
- Reviewing links with frailty Ambulatory care strategy

Urgent and Emergency Care – GUH ED Activity

Goal 4: Rapid response in physical or mental health crisis

Ambulances	37
Admitted	11

Majors Attendances
Data Updated: 2024-10-28 06:00:25



Walk-ins to ED
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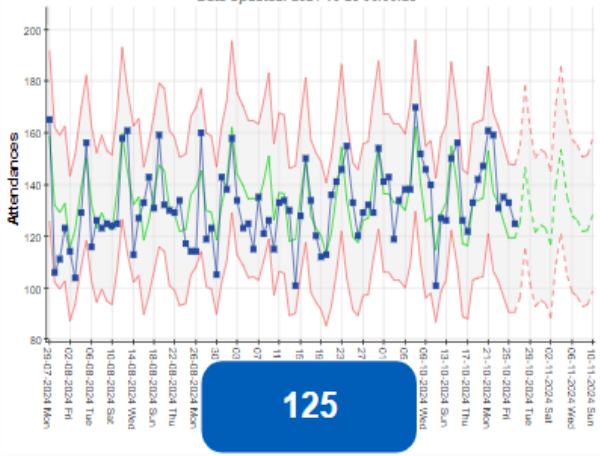

ED Ambulance Admit Rate - ED departures (%)
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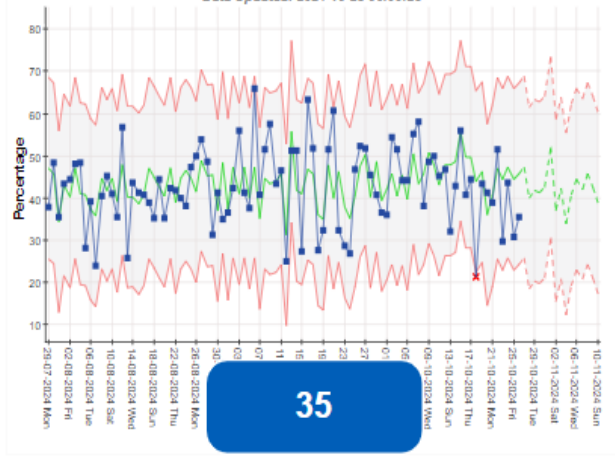

Number of Ambulances
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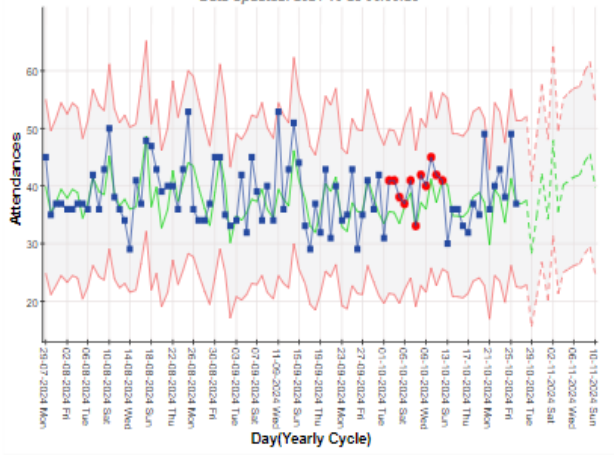

Redirections from ED
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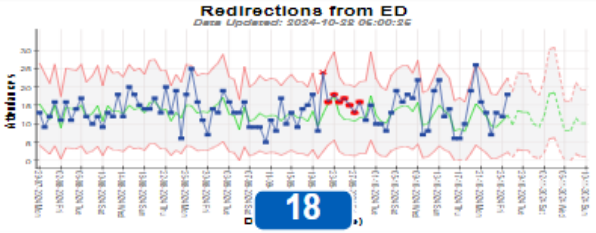

% of Attendances Redirected
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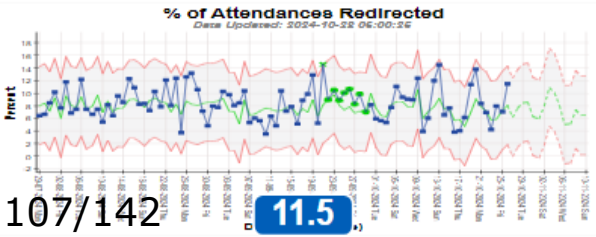

Admitted
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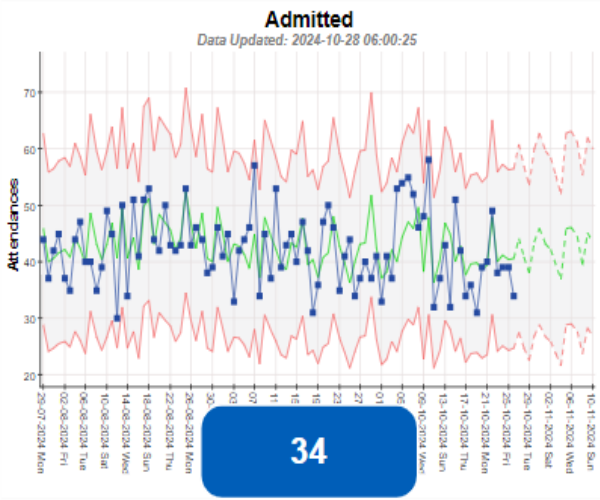

Referred and Discharged
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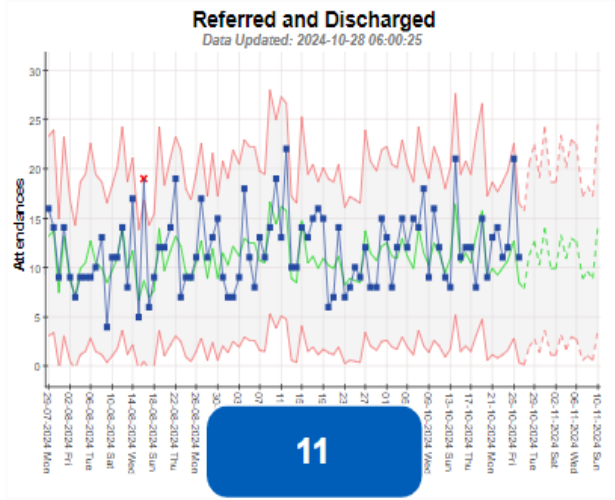

Discharged
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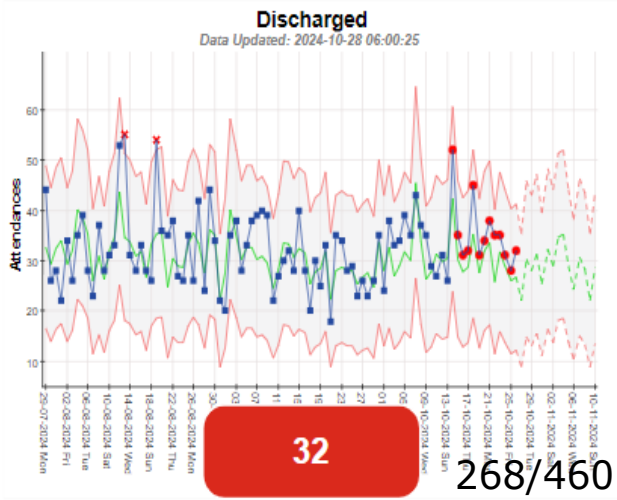
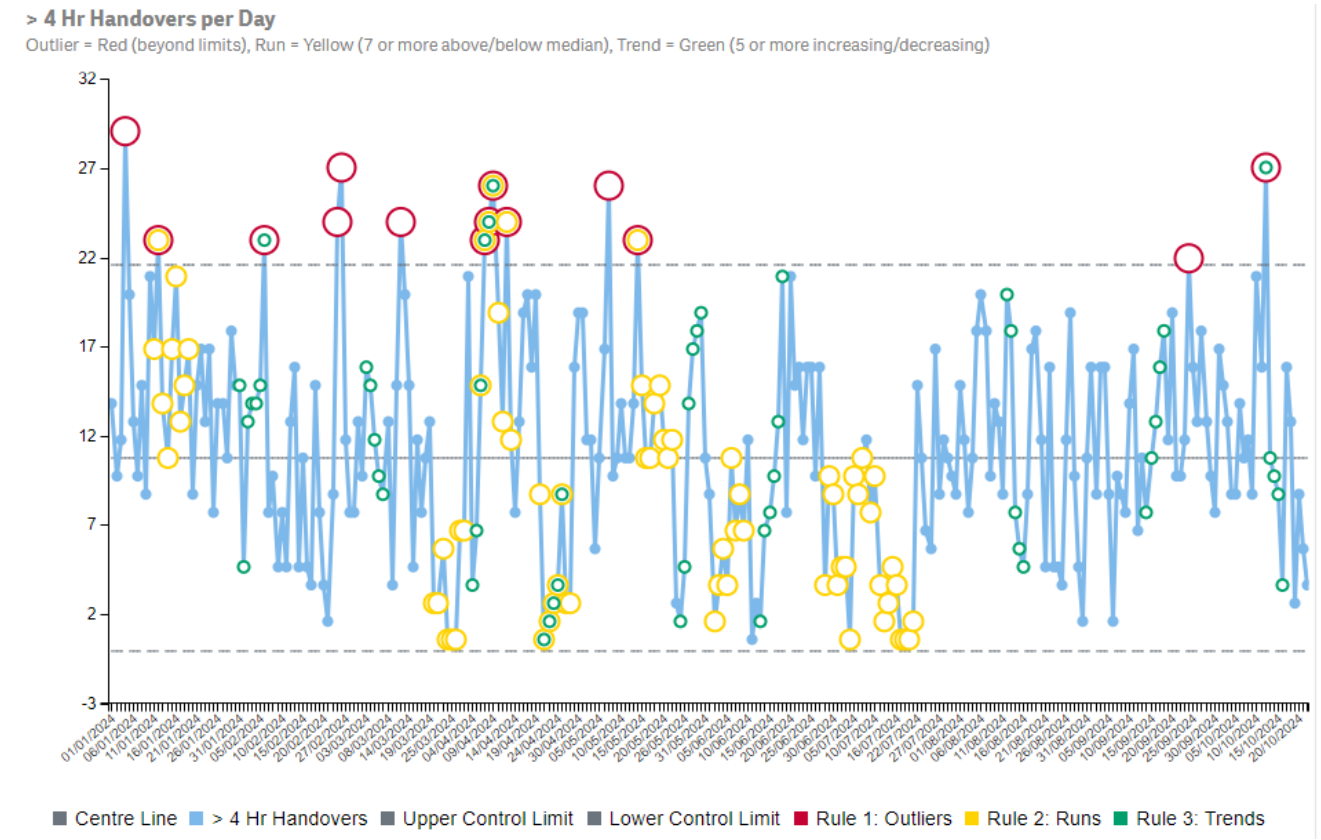
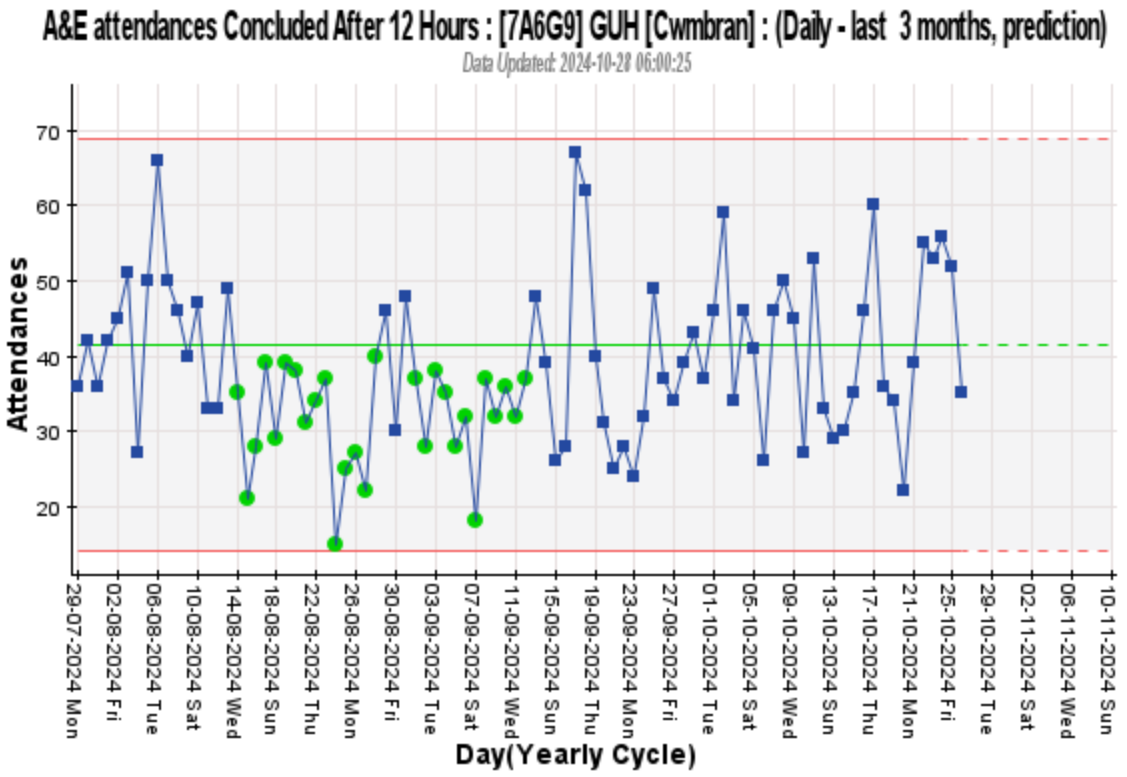


Urgent and Emergency Care

Goal 4: Rapid response in physical or mental health crisis





Data Updates & Forecasting:

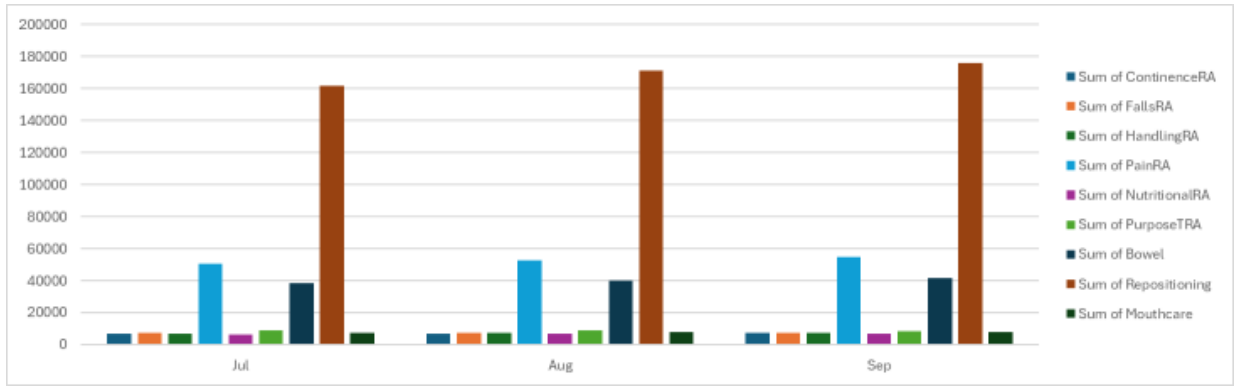
- **Around 11 patients a day** waiting over 4 hours for ambulance handovers at GUH
- **Around 42 patients a day** spending over 12 hours in ED, this was slightly improved in August and September

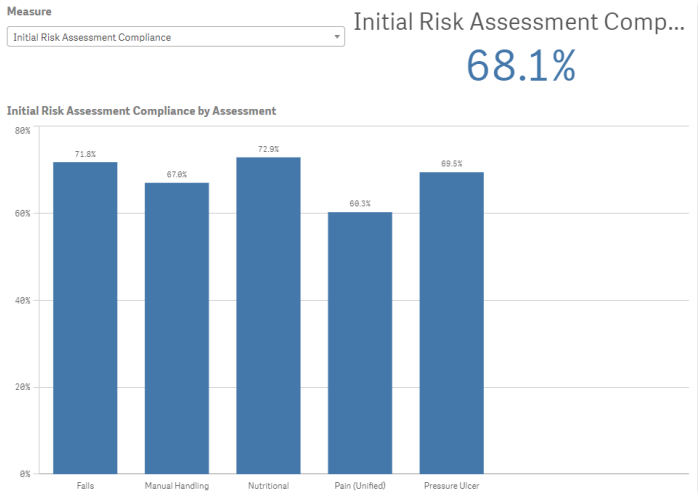
Urgent and Emergency Care

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 • Demand & Capacity modelling completed	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. ABUHB Board agreed funding for 6 x 1.0 wte ED Consultants in September 2024 to support departmental safety, demand and acuity		
	• Implementation of different models of care	• Exploring alternative roles e.g. ACPs and ANPs – ACP Paper going to Urgent Care DMT in November 2024		
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	• Recruitment drives for Registered Nurses and HCSWs continues with recent (Q2) increased conversion to substantive supporting departmental safety and efficiencies • 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 • Progress alternative roles	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	• Operational / Escalation Plan in place to support movement of patients • Full Capacity Protocol (FCP) in place • Expansion of ED Main Wait in progress with anticipated completion date of June 2025. • SDEC in GUH open. Medicine utilisation of SDEC increasing and additional pathways such as ED direct referrals, Haematology and potential Neurology service / hot clinic options being reviewed • Flow Centre /SPA maximising alternative pathways to ED • Acute Frailty Response and CAATT teams within ED to facilitate early discharge or to expedite appropriate transfers to other care settings	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

Welsh Nursing Care Record

WNCR is now live across all adult in-patient wards (57 wards)
Over 2600 staff have been trained
Now a steady state of assessments completed





On time risk assessment on admission running at 68%

Re-assessment timeliness at 65% (however this data is influenced by a number of assessments being open when the patient has been Discharged *n=859)*

Welsh Nursing Care Record: Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Not currently providing quantitative data to wards to support service improvement due to lack of resources within information team	Raised as risk High level data on UAT platform but not up to date	Escalated to Assistant Director of Nursing and Director of Digital	DoD	TBC
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	Disparate ways of recording information across both digital applications and paper based systems with variation across wards.	Digitisation Nursing Documents Steering Group	Q4
Lack of WPAS skills means that WNCR patient lists are not always correct and digital records cannot be started. WPAS is updated by RPA and there are exceptions which require manual intervention	WPAS planned care academy to develop training materials Review ward clerk skills	WPAS awareness limited across organisation due to CWS being the main application to admit, transfer and discharge patients Improvement to be led through academy	Planned Care Academy	Q3
Delay in release of further nursing documents means an extension to the period where paper documents will continue to be used and the health board will not have the benefits of the system	Escalation to WNCR Service Management Board	Inability to support improvement activity due to the lack of digital data	DHCW	Q4
Lack of use of Nadex accounts and the ability to create temporary accounts means traceability access / investigation is fragmented	Improvement activity now WNCR in business as usual	Develop method of feedback to wards, identifying staff who regularly get temp access, maintaining bank contact to ensure new starters get Nadex	Service Manager	Q4

Consent to Examination & Treatment

Review of Current Consent Practices in Aneurin Bevan University Health Board undertaken in September 2023 by Welsh Risk Pool

Understanding the risks and benefits of medical treatments is crucial for patients. This review assessed how well our Health Board obtained patient consent for examinations and treatments, ensuring patients are fully informed and involved in decision-making.

The Welsh Government's 2017 Guide to Consent and the 2018 updated Model Policy for Consent to Examination or Treatment set the legal framework for informed consent. Despite improvements, issues in the consent process still led to clinical negligence claims. The WRP review aimed to assess compliance with the All-Wales Consent Policy, evaluate the quality of consent documentation and gather feedback from patients and healthcare professionals. The review involved inspecting consent forms and medical records.

Findings included: Five consent forms were reviewed. Most patients signed their forms on the day of treatment, with some forms completed weeks in advance. However, there were issues with illegible signatures and missing clinician details.

The WRP Team reviewed the processes for obtaining patient consent and their recommendations were:

- Content of ABUHB Consent to Examination & Treatment Policy be reviewed to reflect All-Wales guidance.
- Consent Forms are compliant with the All-Wales Forms.
- Update the Health Board Intranet page to include the new e-learning on consent in Wales accessed via ESR.
- Adopted the All - Wales Model Policy for consent to examination or treatment for Adults , Children & Young People.
- Implement a governance process for the development of locally produced patient information leaflets.
- Introduce an organisational audit programme for the monitoring of the consent process.

Consent to Examination & Treatment

- The **WRP** report stated the Health Board can take limited assurance in respect of the processes relating to Consent to Examination and Treatment and recommended the organisation review its process.
- This review highlighted the importance of clear, informed consent processes to ensure patient safety and satisfaction. As a Health Board we are committed to making necessary improvements to enhance the quality of care provided to our patients. Here is an update on the vast amount of work and improvement on processes around consent.
- In response to the report recommendations and in liaison with the Quality and Patient Safety Department, an Action Plan was produced. This was presented to PQSOC in February 2023.

The Health Board has made considerable progress in implementing the actions proposed and to date the following improvements have been implemented:

- The Health Board Policy has been reviewed and updated in line with All Wales Model Policy.
- Noncompliant consent forms have been withdrawn
- Health Board Intranet page has been updated
- An organisational audit programme for monitoring of consent process has been outlined
- Staff consent training compliance has increased
- Staff awareness sessions to raise the importance of obtaining informed consent are continuing.

Consent to Examination & Treatment

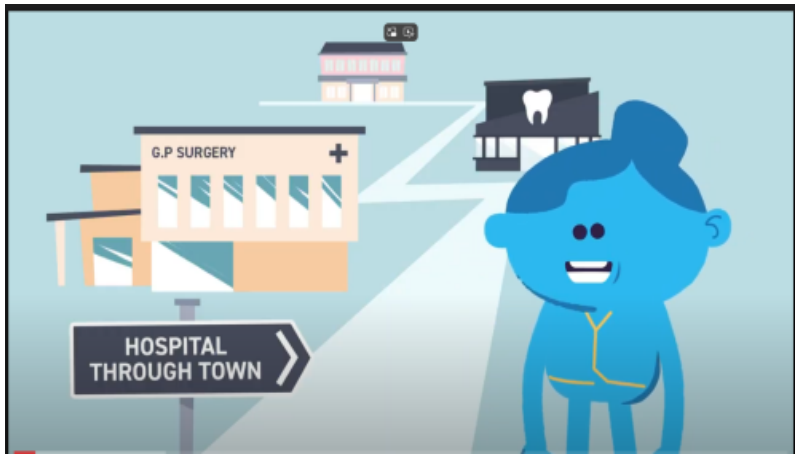
Issue	Action	Learning and Improvement	Who	When
THEME – Health Board's Intranet page Update the Consent Intranet page to provide information on how to access the new e-learning training on consent in Wales.	Corporate Quality and Patient Safety Team updated the Health Board's Consent Page. The updated consent page included a link to the new e-learning training on Consent in Wales. Work was undertaken with the communication team to ensure that EIDO is an easy to find/prominent feature on our Intranet Website under Patient Information Leaflets.	The Health Board's Intranet page has been updated to raise staff awareness and include links to on-line learning, Consent Forms and EIDO patient Information leaflets. A Newsletter has been produced by Corporate Quality & Patient Safety Team and is available on the Health Board Intranet	Corporate Quality & patient Safety Team Health Board Comms Team Corporate Quality & patient Safety Team	Completed 2024
THEME - Patient & Public Information	The Health Board review the standard of information available to aid public knowledge and understanding of the importance of giving consent.	In liaison with patient representatives, medical, clinical staff, legal and governance teams develop easily accessible animated Consent information video.	Mental Health & Learning Disabilities, Head of Nursing Person Centred Care, Representatives, Nursing & Midwifery, Legal Services, Comms & Animation Team	September 2024 Launch early December 2024

Consent Videos for the Public

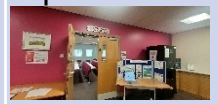
These videos are due to be launched by the Clinical Executives.

They have been specifically created for our patients to explain the crucial process of obtaining informed consent for medical procedures. This video was developed by a team of highly qualified professionals, including healthcare providers and risk management experts, with the goal of helping you, our patients, fully understand your rights and responsibilities when asked to give your consent to an examination or proposed plan of treatment. Two videos have been produced one appropriate for adults in primary and Secondary Care and the second specifically for Obstetric and Maternity Services. Both are available in English and Welsh.

Informed Consent



Our patients are at the heart of everything we do. We are committed to ensuring that you feel informed, empowered, and secure in the knowledge that your health is in the hands of a team dedicated to providing the best care while managing all potential risks.

Issue	Action	Learning and Improvement	Who	When
THEME – Staff Education & Training Implement a requirement for all clinicians who take consent from patients to evidence completion of a recognised training programme. It is recommended that the frequency of this training should be at least once per revalidation cycle for the relevant professional group (e.g., every 5 years for doctors), it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session. The Health Board must have a system in place for identifying and tracking compliance.	Raising awareness of e-learning module To improve the process of obtaining and documenting patient consent, several initiatives have been implemented.	**e-Learning Training Model**: An online Consent to Examination & Treatment training module has been assigned to all employees in designated staff categories, including Clinical, Dental, Nursing & Midwifery, and Allied Professional. **Nominated Leads**: Each designated category has a named person responsible for leading on consent, supporting, and monitoring staff education and training needs. Contact details for these leads are maintained by the Quality and Patient Safety (QPS) Team. **Awareness Sessions**: The QPS Team attends medical and clinical lunchtime learning sessions to emphasise the importance of obtaining and documenting patient consent. **Visual Aids**: Posters and visual aids have been displayed across all ABUHB sites to raise awareness about the importance of obtaining consent. **Informational Handouts**: Handouts detailing professional standards and providing QR Code access to ABUHB Policies and EIDO leaflets are distributed to all attendees. **Junior Doctors Training**: A one-hour consent training session provided by the Medical Defence Union is included in the Junior Doctors induction programme, held every six months. These measures aim to ensure that all staff are well-informed and compliant with consent procedures, ultimately enhancing patient safety and care quality.	Clinical and Managerial Divisional Leads QPS Team have attend 10 Grand Rounds Total >145 attendees 2 F1 & F2 Induction days. Total attendees 120 Medical Defence Union	April 2024  June – August 2024 February & August annual

Issue	Action	Learning and Improvement	Who	When
THEME – Staff Education & Training Training could be either via the national e-learning consent training package or an approved in-house face to face training session. The Health Board must have a system in place for identifying and tracking compliance.	The online training module on ESR (NHS Wales – Informed Consent to Examination or Treatment Course be made available to all Health Board employees.	Online Consent to Examination & Treatment e-Learning training model has been assigned to all employees within the designated staff categories (Clinical, Dental, Nursing & Midwifery, Allied Professional.	Organisational Workforce & Development Corporate QPS team	Completed June 2024
	All employees who are involved in consent are required to complete the online training.	A named nominated person has been identified in all designated categories to Lead on consent, support and monitor staff education and training needs. Nominated persons contact details are held with QPS Team	Clinical and Managerial Divisional Leads	Completed April 2024
	Compliance to be monitored via Divisions.	QPS Team attend medical & clinical lunchtime learning sessions to raise staff awareness of the importance of obtaining and documenting patient consent prior to examination and treatment.	Corporate QPS Team Division Leads	June - August 2024
THEME – Staff Education & Training	Completion of e-learning module to form part of appraisal and revalidation.	Clinical and Divisional Leads are encouraged to evidence staff compliance in maintaining the required Health Board consent training recommendations.	Clinical & Divisional Leads, Senior Managers	On-going
		Corporate QPS Team to monitor staff e-learning compliance bi-annual on ESR.	QPS Team Workforce & Organisational Development	April October

Issue	Action	Learning and Improvement	Who	When
THEME – Peer Review Undertake a peer review of the organisation's consent process using the peer review tool developed by an All-Wales basis. In addition to monitoring the organisation's consent process, it will enable the organisation to comply with requirement number 6 of the WRP RMA 2020-01 Consent to Treatment – monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets. Provides feedback on the audit results to both individuals and more generically in order to initiate improvements.	The Health Board to undertake an organisational review using the All-Wales Peer Review audit tool every two years to assess compliance with the All-Wales Consent Standards.	An in-depth review using the All-Wales peer review tool was undertaken to assess standard of practice in obtaining patient consent to examination & treatment in seven specialist services has been completed.	Corporate QPS Team	September 2023
		The review findings were presented to the Clinical Governance and Effectiveness Group and the above actions identified to improve compliance with national consent standards.	Assistant Director for Quality and Patient Safety	February 2024
		Copies of the review findings were distributed to Clinical & Divisional Leads.	Corporate QPS Team	March 2024
THEME – Continuous Monitoring ABUHB introduce processes to access implementation of National and Local standards for the obtaining of patient consent prior to examination and treatment.	Implement a Snapshot analysis to assess compliance with All Wales Consent standards within Divisions.	QPS Team will review 30 medical records to assess standard of compliance in obtaining patient consent every six months.	Corporate QPS Team	October & March annual
		Corporate QPS Team in collaboration with Clinical and Divisional staff assess compliance with All Wales Consent standards every two years using the All-Wales Peer review audit tool. QPS Team liaise with nominated specialty leads requesting volunteers to participate in peer review.	QPS Team & Nominated Medical & Clinical staff	April 2025

Issue	Action	Learning and Improvement	Who	When
THEME – peer review Undertake a peer review of the organisation's consent process using the peer review tool developed on an All-Wales basis. In addition to monitoring the organisation's consent process it will enable the organisation to comply with requirement number 6 of the WRP RMA 2020-01 Consent to Treatment - monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets.		Undertake peer review.	QPS Team Medical & Clinical staff	June - July 2025
		Collate and analyse audit data and produce report.	Corporate QPS Team	August - September 2025
		Findings of the Peer Review to be presented to Clinical Governance & Effectiveness Group, and appropriate actions plan agreed to address any issues of concern.	Corporate QPS Team	Autumn 2025
		Divisional reports to be completed and shared with the Clinical Leads	Corporate QPS Team	Late Autumn 2025

For Information
Clinical Effectiveness

Section 6

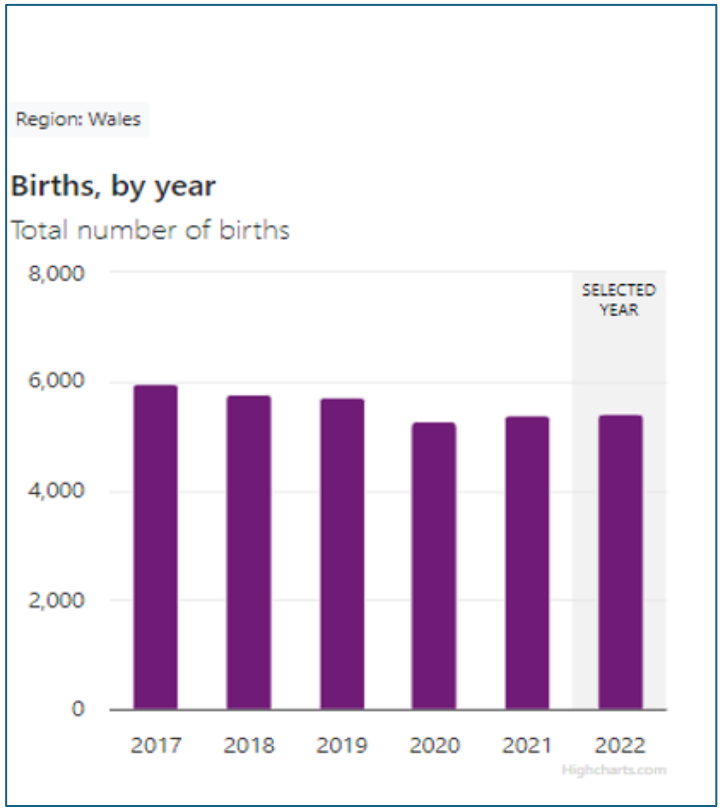
Audit Title: MBRRACE-UK Perinatal mortality surveillance 2024 State of the nation report UK perinatal deaths of babies born in 2022	Clinical Lead: Jayne Beasley - Head of Midwifery & Gynaecology (& on behalf of Dr Maity – Consultant Neonatologist)
Rationale:	The report is divided into five sections: perinatal mortality rates in the UK; mortality rates for Trusts and Health Boards; mortality rates by gestational age; mortality rates by ethnicity and socioeconomic deprivation; and a description of the causes of perinatal death
Objectives:	This report focuses on births from 24 completed weeks' gestational age, with the exception of the section on mortality rates by gestational age, which also includes information on births at 22 to 23 completed weeks' gestational age. This avoids the influence of the wide disparity in the classification of babies born before 24 completed weeks' gestational age as a neonatal death or a late fetal loss.
Presented at Clinical Standards and Effectiveness Group – 26th September 2024	

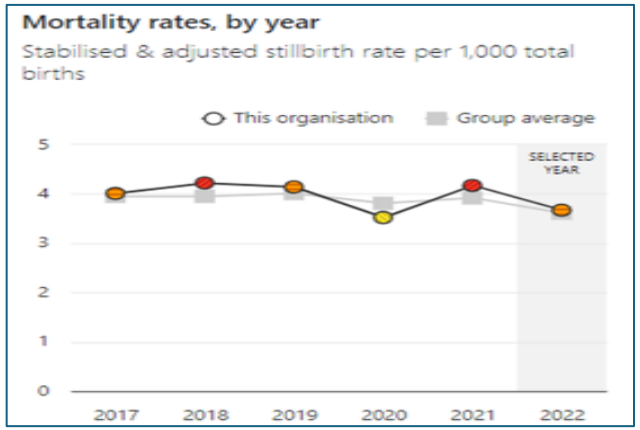
Key messages

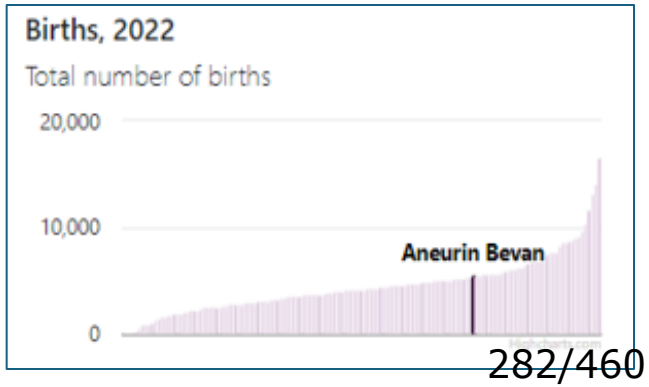
- Extended perinatal mortality rates decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020.
- Compared with rates in 2021, stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
- There were increases in the neonatal mortality rate per 1,000 live births in England and Wales compared with 2021: 1.69 (UK);1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).

Aneurin Bevan University Health Board

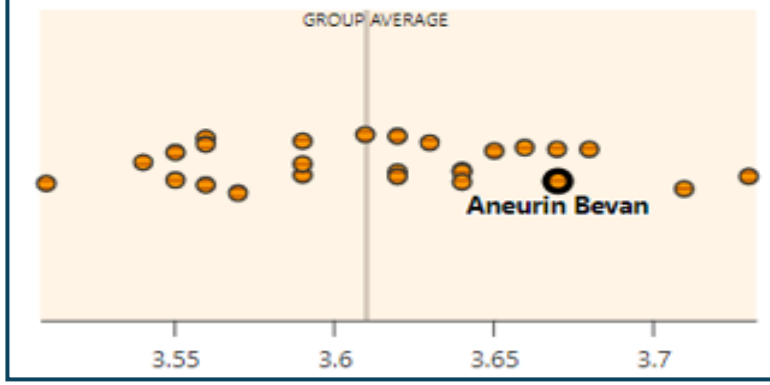
Year	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate (95% CI)
2017	5,975	4.02	4.01	(3.32 to 4.74)	0.50	1.50	(0.90 to 2.36)	4.52	5.50	(4.76 to 6.97)
2018	5,778	5.02	4.22	(3.39 to 5.32)	2.26	2.26	(1.47 to 3.51)	7.27	6.47	(5.40 to 8.38)
2019	5,710	4.90	4.14	(3.47 to 5.28)	0.88	1.48	(0.93 to 2.48)	5.78	5.59	(4.81 to 7.25)
2020	5,292	2.46	3.52	(2.69 to 4.57)	1.14	1.58	(1.05 to 2.40)	3.59	5.09	(4.20 to 6.51)
2021	5,398	4.45	4.17	(3.23 to 5.36)	0.93	1.66	(1.05 to 2.51)	5.37	5.81	(4.80 to 7.62)



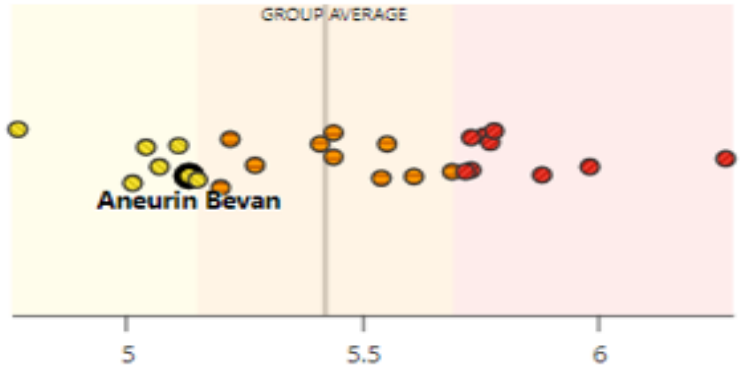




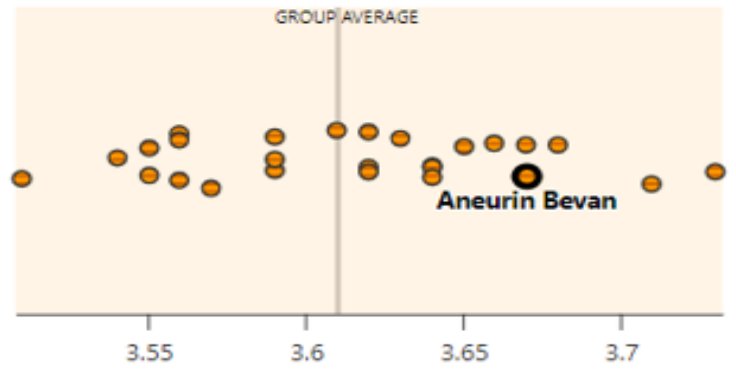
Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted stillbirth rate per 1,000 total births



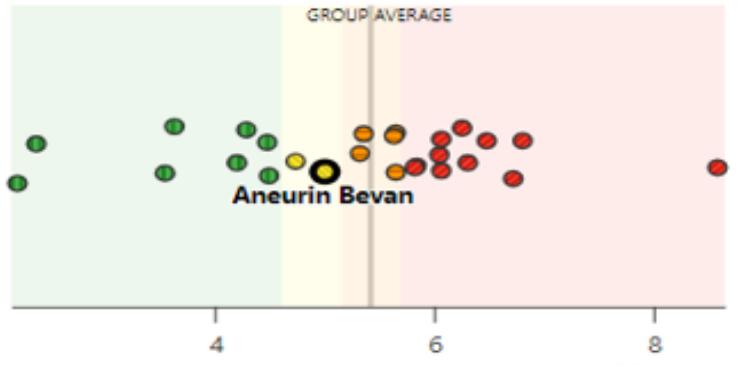
Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted extended perinatal mortality rate per 1,000 total births



Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted neonatal mortality rate per 1,000 live births



Mortality rates, Level 3 NICU, 2022
Crude extended perinatal mortality rate per 1,000 total births



Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Minor	Overall treatment or service suboptimal- minor implications for safety if unresolved

Report Successes:	
1	Raising awareness regarding stillbirths and neonatal deaths to the public and professionals – Nil intrapartum stillbirths, NND green
2	Increased support re public health messaging – MECC and smoking cessation
3	Increased support and funding re sonography services – detection of Small babies
4	Implementation of local and national audit and case reviews & Perinatal optimisation 97% compliance with audited data for MBRRACE 100% offer of PM
5	Development of maternity improvement plan – re PH messaging

Report Concerns:			
1	Variation in Still Birth rate in comparison to level 3 units, increase in 2021, reduction in 2020 and 2022 – prematurity greatest risk factor for NND	3	Higher % babies born post mature (5.6% as opposed to 1.5%)
2	Mothers giving birth more likely to live in deprived areas (31%)	4	93% stillbirths reported within 7 days 13% NND reported within 7 days – target 100%

Report Recommendations: *Audience: Commissioners*		**S.M.A.R.T Actions:**	**Responsible:**	**Due Date:**	**Progress:**
New Recommendation:					
1	Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks' gestational age receiving survival-focused care.	Review of cot capacity	S Papworth Clinical Director & C Satherley Service Group Manager	Ongoing	NICU GUH follow BAPM recommendations as per: The Perinatal optimisation pathway, Welsh Neonatal Network Peri prem pathway and National Cot configuration
Previous recommendations supported by most recent data – Audience: *UK Governments, Royal Colleges, Commissioners*					
2	Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation.	Monthly review of cases as per PMRT Monthly review of cases All Wales	PMRT Team & maternity and neonatal network	Ongoing	All cases undergo local review and form wider All Wales mat/neo network monthly review Local and national earning disseminated
3	Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes.	BAPM perinatal optimisation pathway adopted	A Pinto/ S Papworth maternity and neonatal network	Ongoing	In place with monthly audit of all standards across Wales
4	Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.	Development of maternity services improvement plan	HoM – senior management team	Ongoing	Improvement plan in place, Forms part of IMTP, Working with P Health- smoking cessation, Audit cases, Digital data system

Local Recommendations:	**S.M.A.R.T Actions:**	**Progress:**
Monitoring of all stillbirth and Neonatal Deaths	Ongoing yearly Audit, MDT - PMRT review, Feedback and learning to wider local and national teams	Ongoing
There should be targeted Public Health messaging	MECC training, Maternity improvement plan, Smoking cessation carbon monoxide monitoring, Review of AN services and community continuity, Reintroduction of Healthy weight pathway, Digitalisation and information sharing – language	Ongoing
IOL to be offered at <42 weeks	Change in IOL for term plus women (T+12)	Complete
MBRRACE to receive 100% of cases by 7 days	Bereavement lead midwife in place, NICU have designated nurses supporting	Complete
Continued implementation of periprem pathway	Review of monthly audit of periprem standards, Wider feedback and learning	Ongoing

Audit Title:	Twist and Shout – Testicular Torsion	Clinical Lead:	Mr John Pollitt Consultant Surgeon
Rationale:	To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.		
Objectives:	The Study Advisory Group (SAG) identified the following areas to address: • Patient and parent/carer knowledge of torsion prior to the clinical episode and the availability of information for patients and parents/carers • Pre-hospital care • The admission process, including assessment and decision-making • The use of accurate diagnostic tools • Protocols for the management of testicular torsion and scrotal pain suggestive of torsion • Staffing availability, training, and use of networks of care • The timeliness of surgery including emergency surgery access • The appropriateness of transfer arrangements • The consent process • Surgical practice in respect of fixing testicles at the time of orchidectomy/exploration • Post-operative complications and follow-up of the patient • Audit of services		
Presented to Clinical Standards and Effectiveness Group: 26th September 2024			

Testicular torsion was not recognised by 157/239 (65.7%) patients or 83/239 (34.7%) parents/carers.

Only 294/403 (73.0%) patients had contacted a healthcare professional within six hours of developing symptoms.

60/475 (12.6%) patients were referred by a GP, 34/475 (7.2%) from an urgent treatment centre and 25/475 (5.3%) NHS 111.

91/143 (63.6%) hospitals reported that patients were transferred out of the hospital for treatment on occasions.

Patients not on a pathway were more likely to have their testicle removed (154/389; 39.6%) compared with those who were (16/67; 23.9%).

136/435 (31.3%) patients had their first assessment on arrival at hospital performed by a junior specialist trainee.

113/422 (26.8%) patients had not had their first ST3+ surgical review within two hours of arrival and 40/422 (9.5%) patients waited more than four hours.

There was a delay in making a diagnosis in 116/635 (18.3%) patients which impacted their care in 69/116 (59.5%) cases.

Information on prosthetic replacements could only be found in the case notes of 139/534 (26.0%) patients who had a testicle removed, with an explanation recorded for 83/139 (59.7%) patients.

Adequate written information given to the patient and family at discharge could only be found in the case notes of 123/233 (52.8%) patients.

Testicular torsion occurs when the spermatic cord twists and cuts off the blood supply to the testicle. Testicular torsion is a surgical emergency requiring prompt diagnosis and surgical intervention to preserve the testicle. Delay in recognising testicular torsion and delay in presenting to hospital is known to lead to poorer outcomes. There needs to be greater public awareness about testicular torsion. Hospitals need to be equipped to deal with testicular torsion as an emergency operation, with senior clinicians able to decide whether surgery is needed and to be able to perform the surgery/anaesthetise the patient. If these services are not available, then there should be robust transfer arrangements in place to get the patient to theatre. Patients will need good information at discharge, and the option to return for further follow-up should they need psychological support or wish to discuss the use of a prosthesis.

NCEPOD Studies do not provide local data breakdown other than the participation numbers

IN THIS STUDY:

- The Patients aged 2 to 24 years, inclusive, admitted to hospital who had a diagnosis of testicular torsion (ICD10 code N44), and who underwent a non-elective operation for testicular torsion (OPCS codes N03.4; N05; N06; N08; N09; N13.2; N13.3 and N13.5) between 1st April 2021 and 31st March 2022.
- Patients admitted with scrotal pain (ICD10 codes N45 and N508) were also identified for context but were not sampled for inclusion in the clinical peer review process.
- The audit consists of 3 elements:
  - Organisational Questionnaire
  - Clinical Questionnaire
  - Case Note review

	Number of participating hospitals	Number of organisational questionnaires received	Number of cases selected	Number of clinician questionnaires returned	Number of sets of case notes returned
Aneurin Bevan UHB	1	1	4	4	4
Betsi Cadwaladr UHB	3	0	19	0	0
Cardiff & Vale UHB	1	1	6	6	6
Cwm Taf Morgannwg UHB	3	0	10	5	10
Hywel Dda UHB	3	1	7	5	7
Swansea Bay UHB	1	1	5	5	5

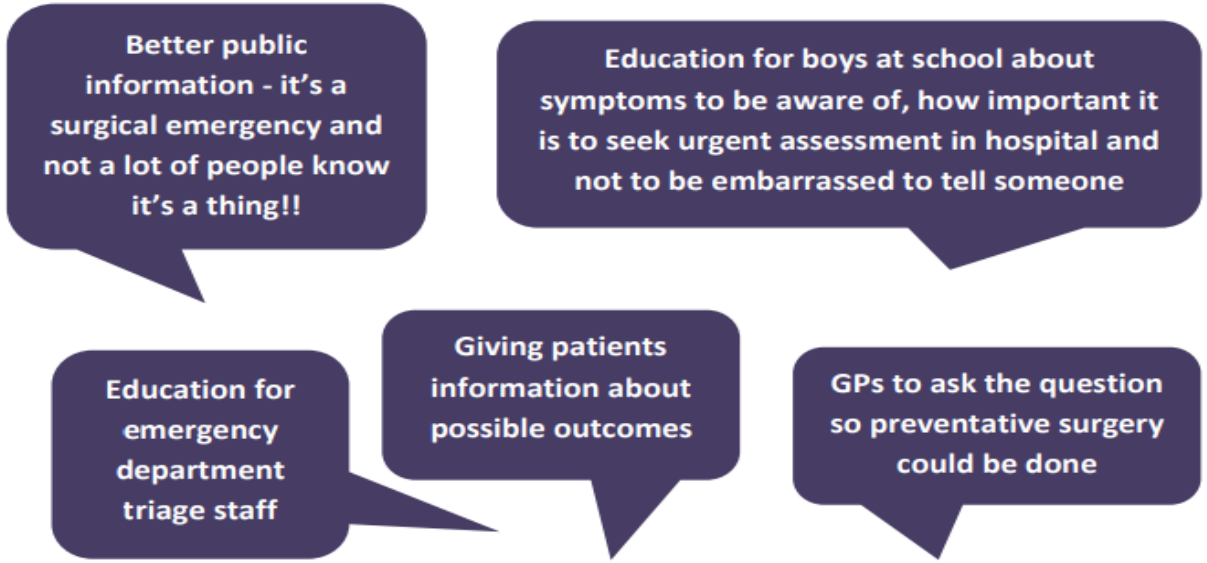
WHAT PATIENTS AND PARENTS/CARERS SAID

Young people and parents/carers were asked about their experience of care following admission to hospital and an operation for testicular torsion. The age of children and young people at the time of their operation ranged between 3-24 years with a median age of 14 years.

WHAT IS THE ONE THING YOU THINK COULD CHANGE TO IMPROVE CARE FOR FUTURE PATIENTS WHO HAVE TESTICULAR TORSION?

Only 3/17 young people were taught about testicular torsion at school or college.

12/17 young people felt that their symptoms were an emergency… HOWEVER, four of them delayed telling anyone about their symptoms and two of them said they experienced a delay before going to hospital.

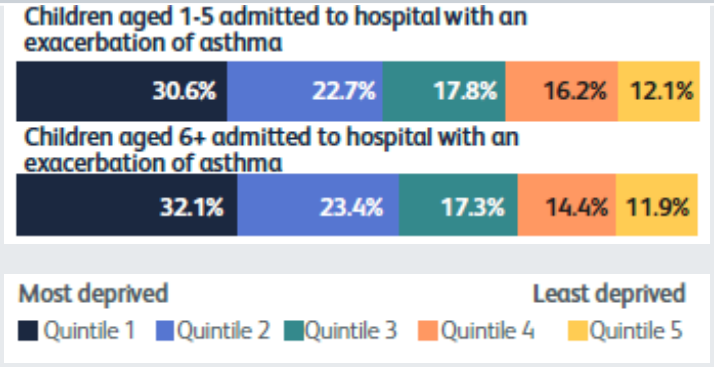


Report Recommendations: RECOGNITION OF TESTICULAR TORSION IN PRIMARY CARE AND THE EMERGENCY DEPARTMENT		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
2	Update training modules for primary care, and emergency department staff, to emphasise the importance of early recognition of testicular torsion, including atypical or warning presentations, urgent referral pathways and timely surgery	Training for 1st assessing clinicians (GP/A&E /NHS111)	RCGP/RCEM		
3	Reduce delays for patients with testicular pain/suspected testicular torsion by: • Minimising transfers to another hospital by referring patients to a hospital where scrotal exploration can be performed safely on-site – ideally including a pre-alert to the receiving hospital. • Ensuring that any essential transfer is as urgent as possible*, including when patients self-present but need to be at another hospital. • Having a clear, documented clinical pathway of care for patients with testicular pain/suspected testicular torsion in hospitals where surgery for testicular torsion is undertaken, which is communicated to all healthcare professionals involved in the care of this group of patients. • Auditing the testicular torsion pathway, at least annually, to identify areas for improvement.	Education of GPs A&E triage staff WAST			
4	Patients with suspected testicular torsion should have an urgent* referral and clinical review by a senior surgical decision-maker (minimum ST3 or equivalent) specialising in urology, paediatric surgery, or general surgery.	Pathway for testicular torsion in place at ABUHB Senior/EPIC A&E to delegate to surgical specialty. Annual audit	Senior A&E on site Surgical consultant on call Urology consultant on call MJKP (CL)		

Report Recommendations: PATHWAY IN HOSPITAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
5	A consensus is needed on the role of Doppler ultrasound in the care pathway for suspected testicular torsion to aid surgical decision-making whilst not adding delay to surgery.	Consensus to be drawn- Current practice is not to USS suspected torsion in this HB	BAUS/RCS/BAPS		
6	Perform surgery for testicular torsion as an immediate or urgent procedure (NCEPOD 1 or 2)*, once the decision to operate has been made.	Booked cat 1			

Report Recommendations: DISCHARGE AND FOLLOW-UP		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
7	Discharge information for patients, and parent/carers should include: a) Any follow-up arrangements. b) Delayed side effects that might occur following orchidectomy, or the risk of late testicular atrophy in patients who had an operation that led to no orchidectomy, but fixation (orchidopexy), including risks to fertility. c) Details of patient-initiated follow-up (PIFU) follow-up e.g. to discuss prosthetic implants for patients who underwent an orchidectomy. d) How to access psychological support.	All proven torsions are followed up at GPS clinic Or Urology if>16	Surgical team on d/c		
8	Review the care of all patients who underwent an orchidectomy in a multidisciplinary morbidity and mortality meeting. This should include primary care and, ideally a regional approach to shared Learning and quality improvement.	Audit of orchidectomies 2dry to torsion.	CL- GS & Urology	Feb 2025	In progress

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Optimise testicular pain pathway at ABUHB		MJKP/A&E		Ongoing discussion with A&E/Urol/GS directorates
2	Education of at risk group at school level to minimise delayed presentation				

Audit Title:	Breathing well An assessment of respiratory care in England and Wales	Clinical Lead:	Dr Pierrepoint - Paediatrician
Rationale:	NRAP works with patient panels run the Royal College of Paediatrics and Child Health (children and young people) to ensure our audit programme focuses on improvements in the areas most important to people living with respiratory conditions. The Asthma &Me Ambassadors are aged 13–21 and have joined together from across the country with a shared mission to improve asthma care and services for children and young people. Some of them have personal experiences of asthma, others have an interest through family or friends, all have a passion to make a difference. They have collected voices from children, young people and families, and hope to represent their voices in NRAP, with the support the support of decision makers to act and implement the changes they say are needed.		
Objectives:		There is a national focus on health inequalities in respiratory care, as outlined in the NHS Long Term Plan and the Core20PLUS5 approaches for all age groups. Among people admitted to hospital with a COPD or asthma exacerbation, the highest proportion of people live in the most deprived. Importantly, in current analyses, it has not been observed that key outcomes related to the quality of care as inpatients vary based on the level of deprivation of a person's postcode. This suggests that the interaction between socio-economic inequalities and important clinical outcomes, including hospitalisation and mortality, are complex and driven by deep-rooted structural and societal factors associated with respiratory ill-health. Even though we need to see an improvement in the wider drivers of respiratory outcomes, it is crucial that we do everything we can to ensure that the standard of care given to all patients, regardless of their background, is as high as it can be.
Presented at Clinical Standards and Effectiveness Group – 26th September 2024			

Spotlight on healthcare improvement

Providing optimal care remains a key healthcare improvement area for NRAP. We suggest the following areas of improvement for services:

- All services should participate in NRAP and achieve a minimum of 50% case ascertainment.
- Hospitals in England should ensure resources generated from achievement of asthma and COPD best practice tariff (BPT) are available to frontline clinical and administrative teams to support NRAP participation and quality improvement.
- Locally collected NRAP data should be reviewed at least annually by both providers and commissioners to monitor delivery of optimal care and drive improvement.
- Specifically, this should generate locally agreed actions plans to improve performance against national guidance on the first hour of care and specialist respiratory review within 24 hrs.

Patients who received systemic steroids within 1-hour of arrival at hospital:

CYP aged 6–18

35.0%

2021/22: 31.0%

The percentage of smokers offered a referral to smoking cessation services as part of a discharge bundle.

Children and young people (CYP) with asthma (aged 11+)	parent or carer
72.7%	**36.0%**
2021/22: 54%	2021/22: 37%

The percentage of all patients who had smoking status, or second-hand smoking exposure, recorded.

Children and young people (CYP) with asthma (aged 11+)	second-hand smoke exposure recorded
44.7%	**58.8%**
2021/22: 42.1%	2021/22: 37%

The percentage of patients with documentation of a current self-management plan following an admission to hospital due to an exacerbation:

Children and young people (CYP) with asthma (aged 1–5)	with asthma (aged 6+)
45.8%	**47.0%**
2021/22: 35.0%	2021/22: 41.3%

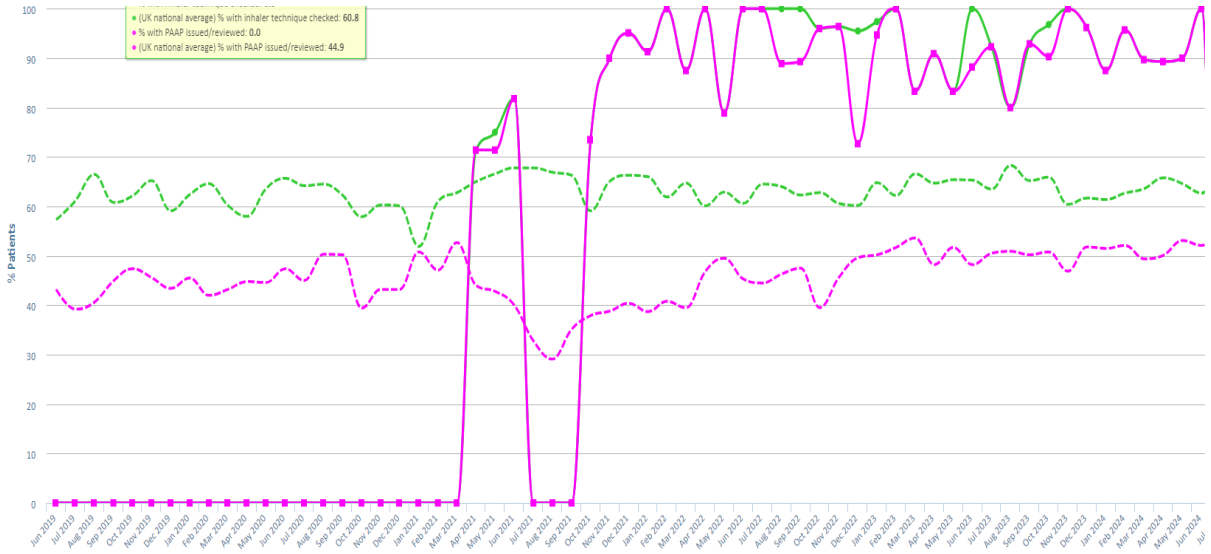
Children and young people (CYP) aged 1–18

85.2% Percentage of children and young people with asthma who are reviewed by a member of the MDT trained in asthma care.

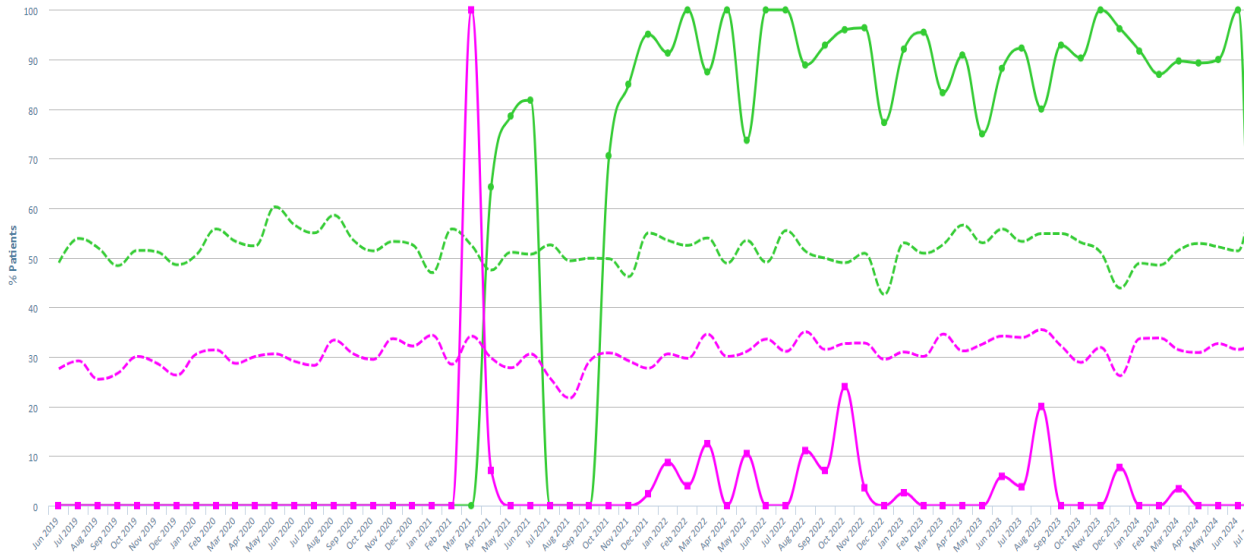
Hospital / Unit	Cases	KPI 1: Steroids administered within 1 hour of arrival (aged 6 - 18 years)%	KPI 2: Current smokers (patients 11+) with tobacco dependency addressed %	KPI 3: Current smokers (Parent/carer) with tobacco dependency addressed %	KPI 4: Inhaler technique checked as part of discharge planning %	KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %
The Grange University Hospital	47	27.8	0.0	27.3	91.5	91.5
All audit data	**3,307**	**41.8**	**26.7**	**44.9**	**65.1**	**51.9**

NHS Regional totals	Cases	KPI 1: Steroids administered within 1 hour of arrival (aged 6 - 18 years)%	KPI 2: Current smokers (patients 11+) with tobacco dependency addressed %	KPI 3: Current smokers (Parent/carer) with tobacco dependency addressed %	KPI 4: Inhaler technique checked as part of discharge planning %	KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %
Wales	148	26.1	0.0	44.1	77.8	65.3
All audit data	**3,307**	**41.8**	**26.7**	**44.9**	**65.1**	**51.9**

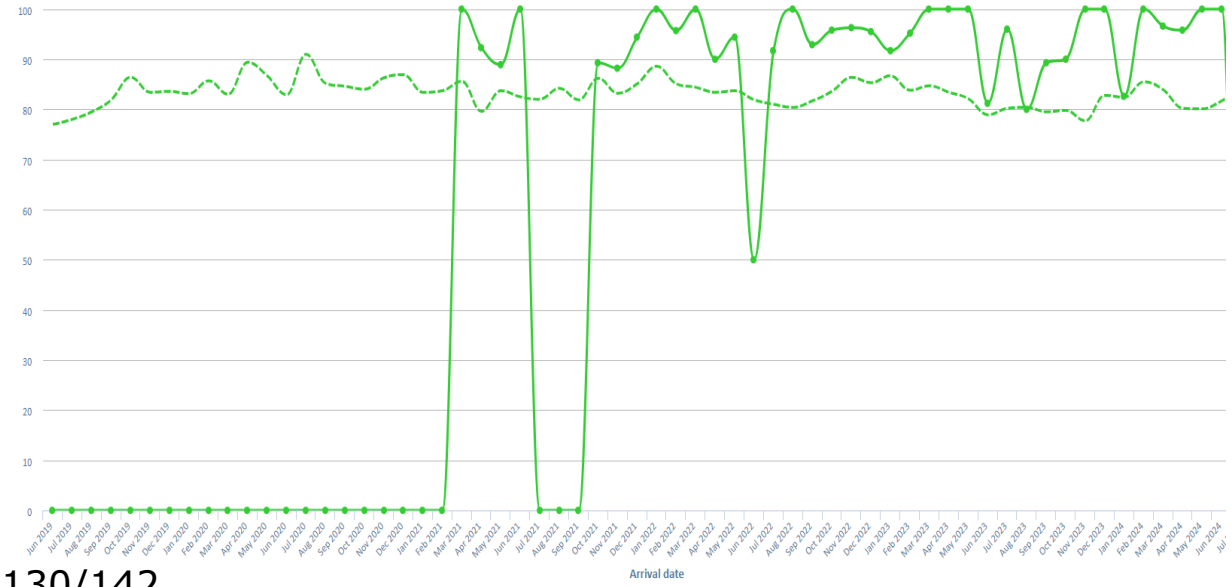
GUH – Green -% with inhaler technique checked
Pink - % with PAAP issued
Dotted line National data – solid lines relate to ABUHB



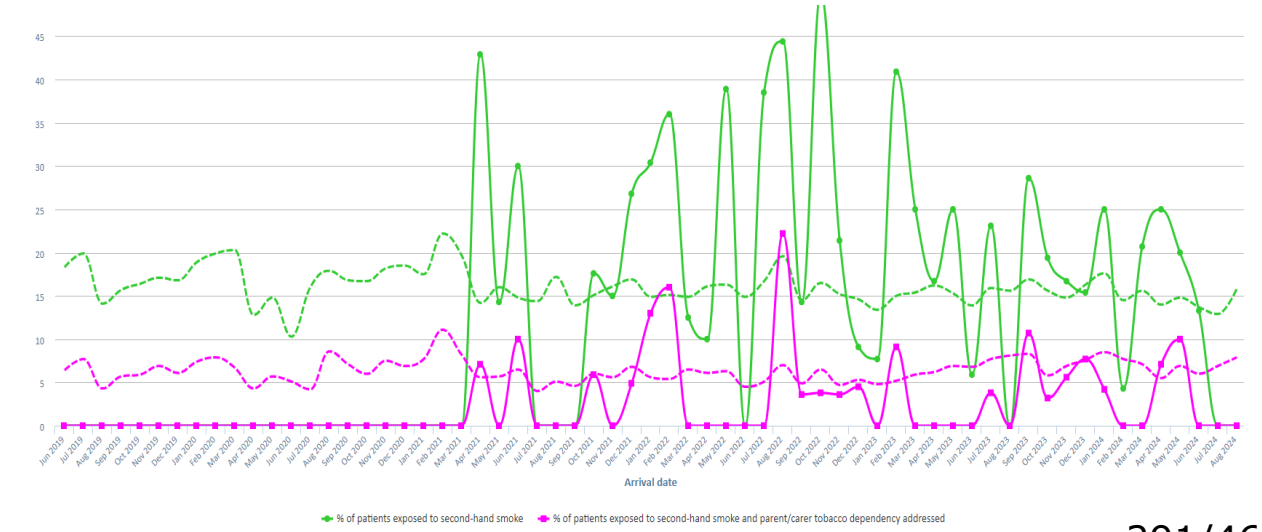
GUH – Green - % in receipt of a discharge bundle
Pink - % referred to clinic within 4 weeks
Dotted line – National Data, solid line – ABUHB data



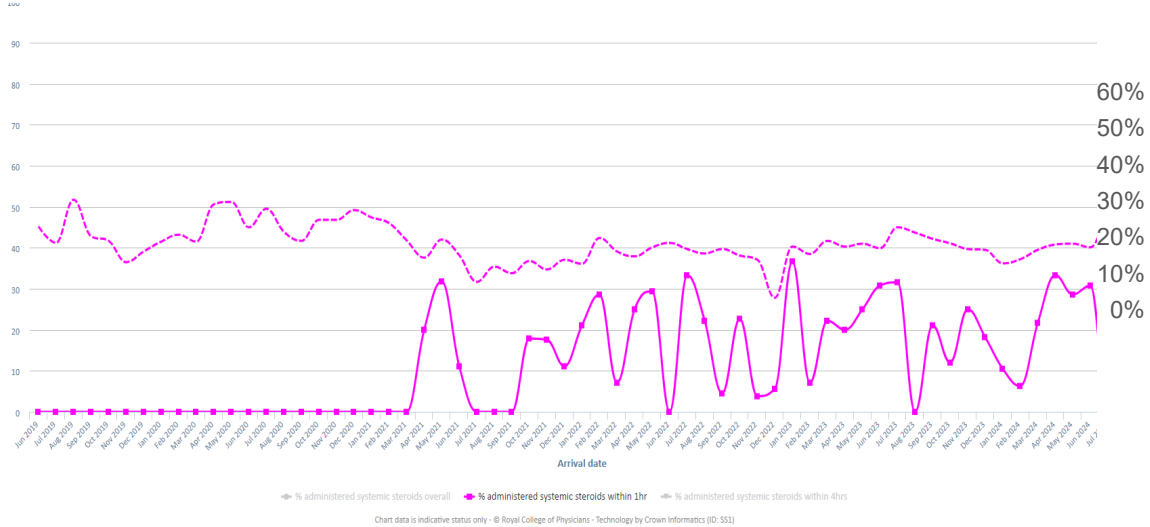
GUH - % Discharge Steroids
Dotted line National data – solid line relate to ABUHB



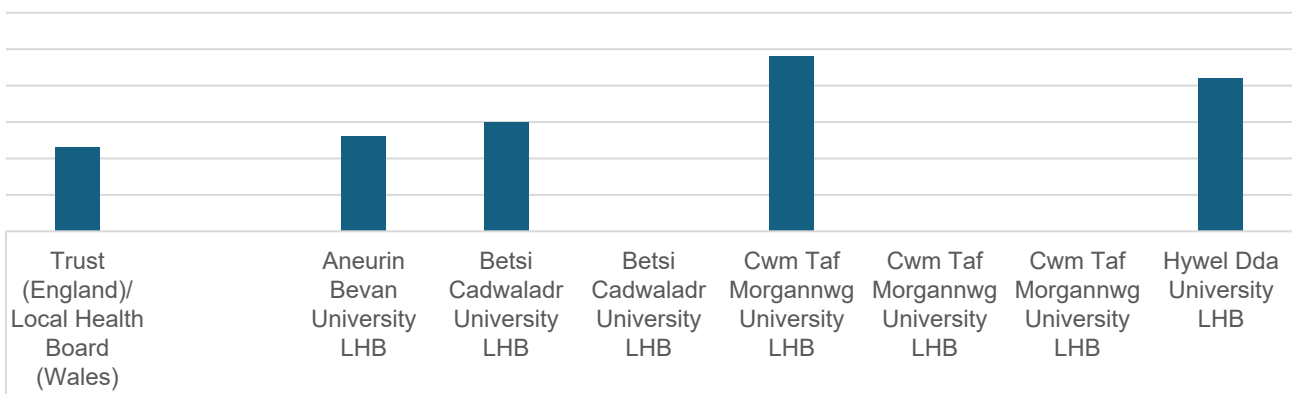
GUH – Green - % children exposed to second hand smoke
Pink - % children exposed to second hand smoke & parent/carer tobacco dependency addressed
Dotted line National data – solid line relate to ABUHB

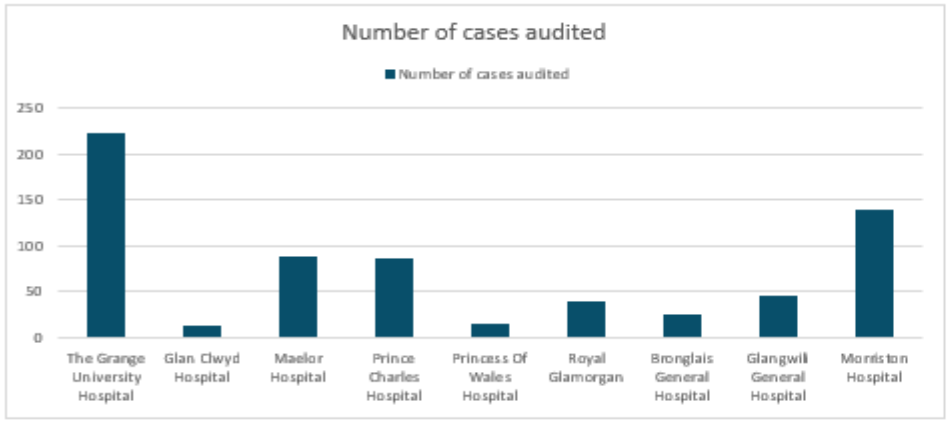


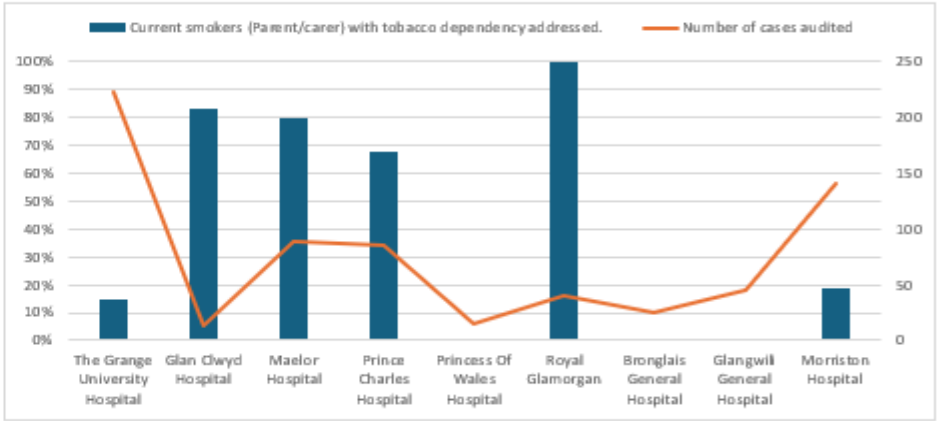
GUH - % Steroids in 1st hour
Dotted line National data – solid line relate to ABUHB

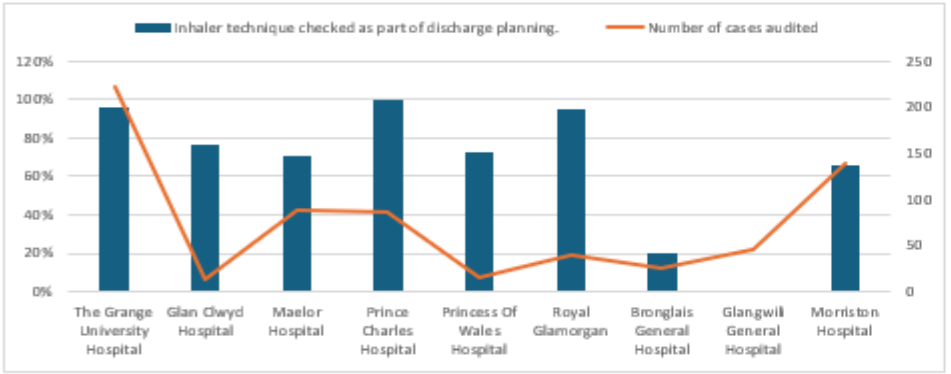


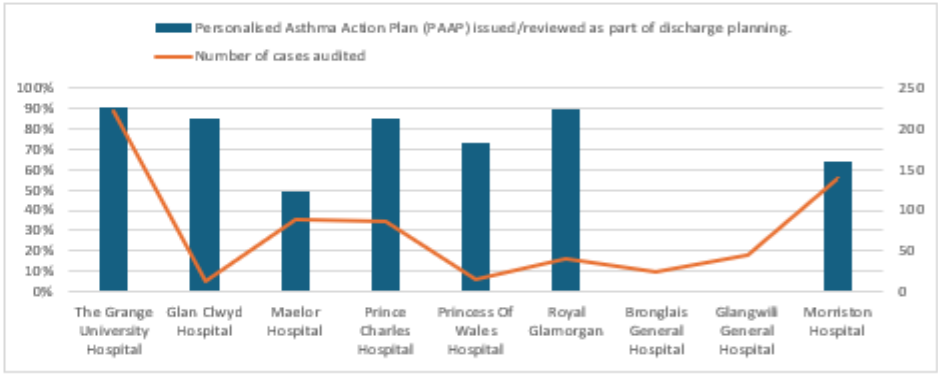
Steroids administered within one hour of arrival at hospital for children and young people of 6 - 18 years old.

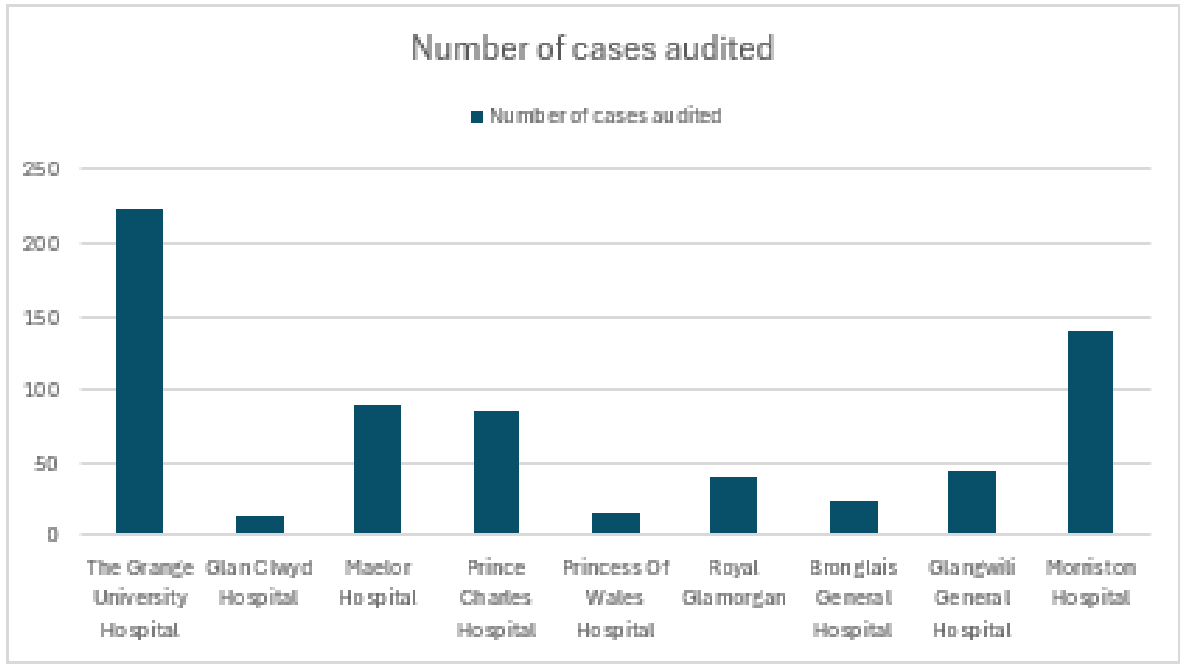


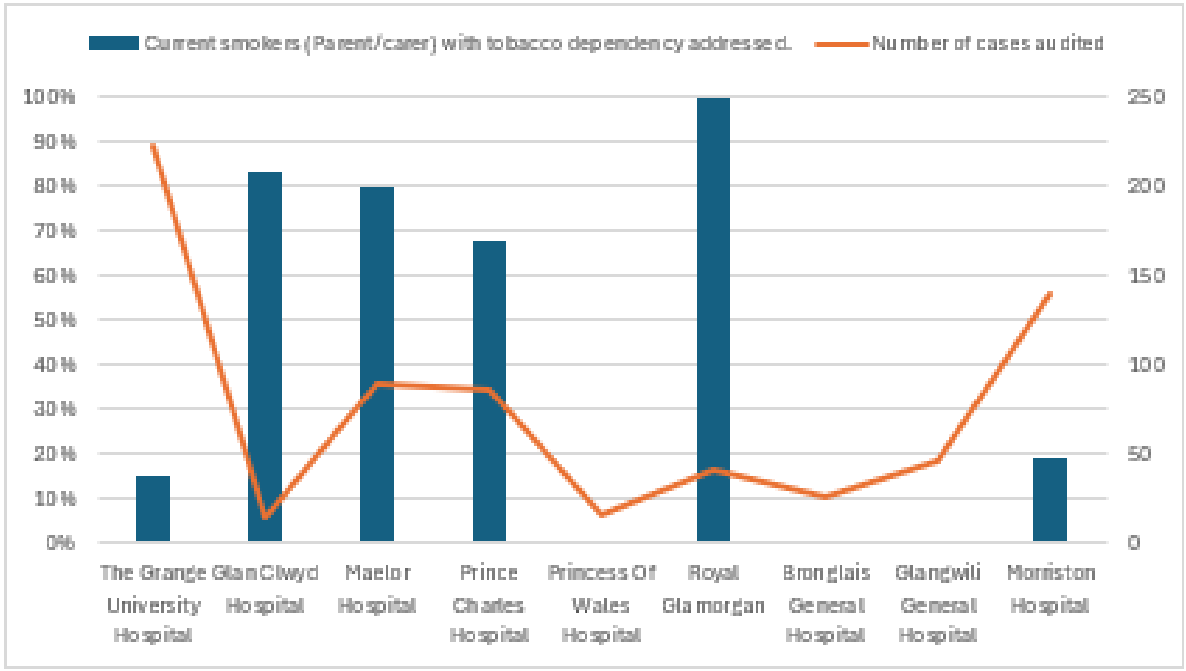









Number of cases audited
Number of cases audited
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital


Current smokers (Parent/carer) with tobacco dependency addressed.
Number of cases audited
100%
90%
80%
70%
60%
50%
40%
30%
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The Grange University Hospital
Glan Clwyd Hospital
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Prince Charles Hospital
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Royal Glamorgan
Bronglais General Hospital
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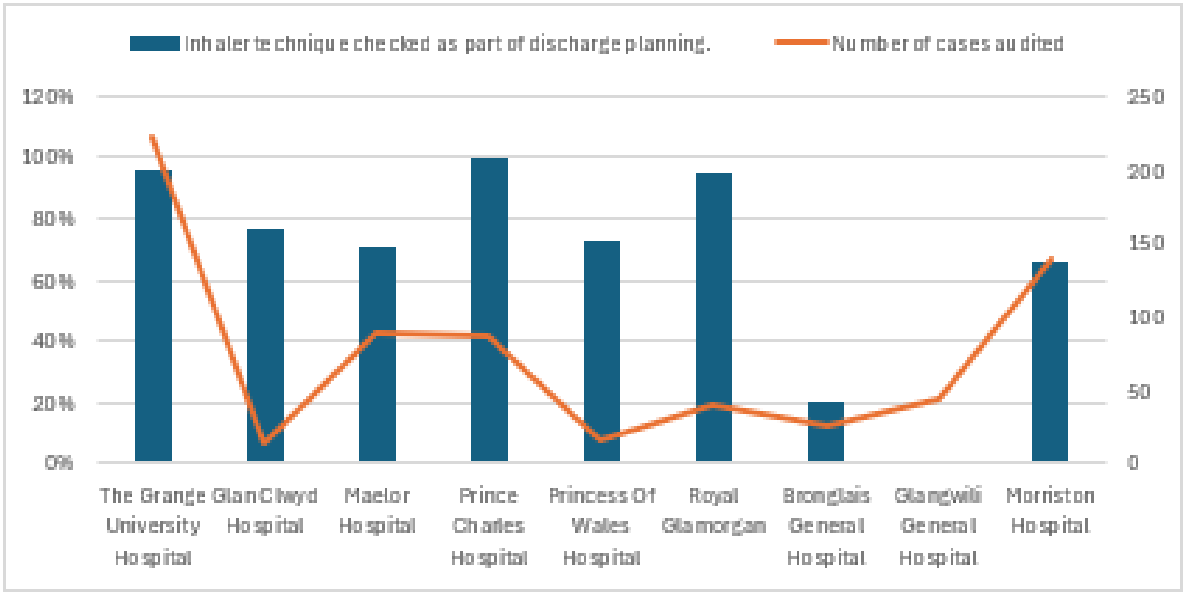
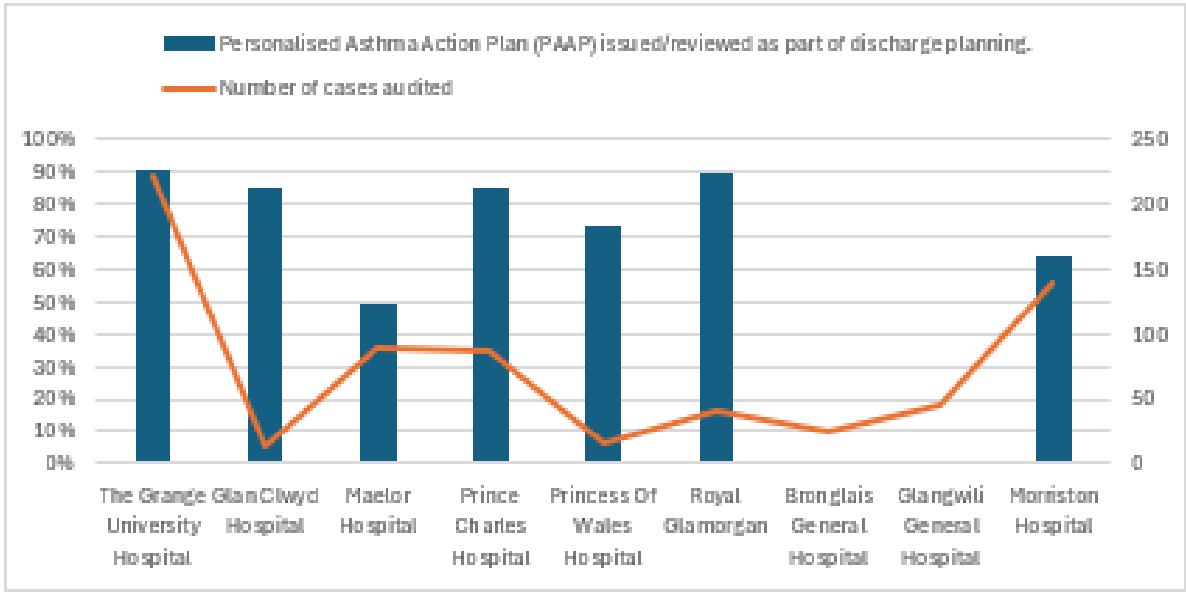
Morriston Hospital


Inhaler technique checked as part of discharge planning.
Number of cases audited
120%
100%
80%
60%
40%
20%
0%
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital


Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning.
Number of cases audited
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
250
200
150
100
50
0
The Grange University Hospital
Glan Clwyd Hospital
Maelor Hospital
Prince Charles Hospital
Princess Of Wales Hospital
Royal Glamorgan
Bronglais General Hospital
Glangwili General Hospital
Morriston Hospital

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	
Significant	The project has mostly achieved the standards or criteria being audited against	**yes**
Limited	The project did not achieve the standards or criteria being audited against	
Very limited	The project failed to achieve the standards or criteria being audited against	

Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	**yes**
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	
Major	Non-compliance with national standards with significant risk to patients if unresolved – Major risk to patient safety	
Catastrophic	Totally unacceptable level or quality of treatment/service - Gross failure to meet national standards – Gross failure to meet standards	

Has this audit been placed on a Risk Register (N/A if above risk is None)	**YES/N**
If not on a risk register, why not:	

Report Successes:	
1	Data Capture is the best in Wales and in comparison, to the rest of the UK
2	Structure education pathways are good (exc. Smoking)
3	Personalised Asthma Action Plans (PAAP) at discharge one of the best in Wales

Report Concerns:	
1	Patient Flow issues at front end impact the 1 hr Steroid administration
2	Actions from previous report have not all been actioned re pathways and updating proforma

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Integrated care boards and local health boards should ensure that they achieve 100% service participation and that services achieve a minimum 50% case ascertainment in NRAP audits by May 2026. This will require all hospitals having named NRAP clinical leadership and dedicated audit support.				**Achieved**
2	All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	To ensure the smoking status data is recorded on the proforma	Dr Marcus Pierrepoint	31/12/2024	3/12
3	All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management.				**Achieved**

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	A meeting planned with Primary Care to discuss pathways	Cancelled on 2 occasions	Asthma team in Primary and Secondary Care	31/12/2024	Ongoing
2	A joint meeting with Adult services to discuss internal pathways		Asthma Paediatric & Adults Services	31/12/2024	Ongoing

Endometriosis: A Long and Painful Road **A review of the quality of care provided to adult patients diagnosed with endometriosis**	**Clinical Lead:** **Dr Anita Nargund – Consultant Obstetrics and Gynaecology**
Rationale:	Endometriosis is often treated as multiple episodes of acute care, instead of on a continuum like other chronic conditions, such as diabetes or inflammatory bowel disease. This approach needs to change to enable appropriate pathways of care, holistic and medical management, discharge planning and follow-up.
Objectives:	To review remediable factors in the quality of care provided to patients aged 18 and over with a surgical diagnosis of endometriosis To explore the clinical and organisational structures in place for the provision of care for patients with endometriosis, reviewing the entire pathway of care with a focus on: • Triage • Endometriosis specialist centres • Policies/protocols/care pathways in place – including delays • Communication between providers • Information and support for patients • Staffing • Surgical services • Imaging services • Holistic care and multidisciplinary team (MDT) provision • Discharge and follow-up
Presented at Clinical Standards and Effectiveness Group – 26th September 2024	

Please note there is no local data for Aneurin Bevan University Health Board

OVERARCHING MESSAGE

Endometriosis is often treated as multiple episodes of acute care, instead of on a continuum such as chronic conditions like diabetes, to enable appropriate pathways of care, holistic and medical management, discharge planning and follow-up.

1. Endometriosis is a chronic condition

Unlike other chronic conditions, such as diabetes, there is no pathway for endometriosis.

36/136 **(26.5%)** patients had a **delay in initial referral to gynaecology** and in 25/36 patients this impacted on the quality of the care they received.

124/238 **(52.1%)** patients experienced **recurrence or persistence of endometriosis symptoms** following laparoscopy. 32/124 **(25.8%)** patients had a **delay in being reseen**.

2. Endometriosis has symptoms and signs that need earlier recognition for appropriate timely management

Signs and symptoms of endometriosis need to be recognised and not just seen as troublesome periods.

Presenting symptoms were most often **painful/irregular/heavy periods** or painful intercourse in 220/234 **(94.0%)** patients. But **also bowel** in 34/234 **(14.5%)** and **urinary/bladder** symptoms in 14/234 **(6.0%)** patients, or an **inability to conceive** in 12/234 **(5.1%)**

546/941 **(58.0%)** patients surveyed **had multiple visits to the GP** before any investigations were undertaken or treatment initiated

3. Endometriosis affects quality of life. All patients should be asked about the effect of disease on their life

Access to supportive services would enable patients with endometriosis to manage their condition.

Failure to refer to supportive services resulted in **less than best practice** for 70/309 **(22.7%)** patients.

420/941 **(44.6%)** of survey respondents stated that they were **not asked at any point about the impact of symptoms on their quality of life**.

4. Endometriosis requires holistic, joined-up, multidisciplinary care

Multidisciplinary care is essential to ensure patients with endometriosis have all their care needs met.

Only 73/167 **(43.7%)** of **hospitals reported MDT meetings** were held for patients with endometriosis.

Reviewers found that only 27/242 **(11.2%)** patients were **formally discussed in an MDT meeting** and 28/215 **(13.0%)** patients who were not discussed **should have been**.

NCEPOD Studies do not provide local data breakdown other than the participation numbers

Demographics

The study population mainly comprised women of reproductive age with a mean age of 34 years (Figure 2.1).

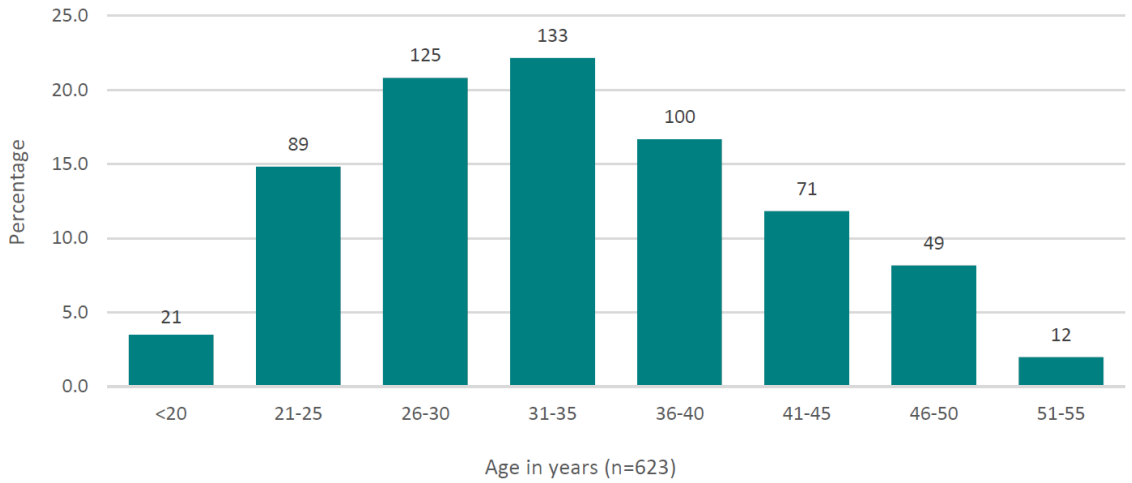


Figure 3.5 demonstrates the timeline of events in the treatment pathway for endometriosis for the patients in this study. It illustrates that once symptoms are recognised and reported, referral to appropriate services takes place and the time delay reduces. This suggests that education of both patients and GPs is essential in helping people to recognise symptoms of endometriosis to reduce the delay in initiating appropriate

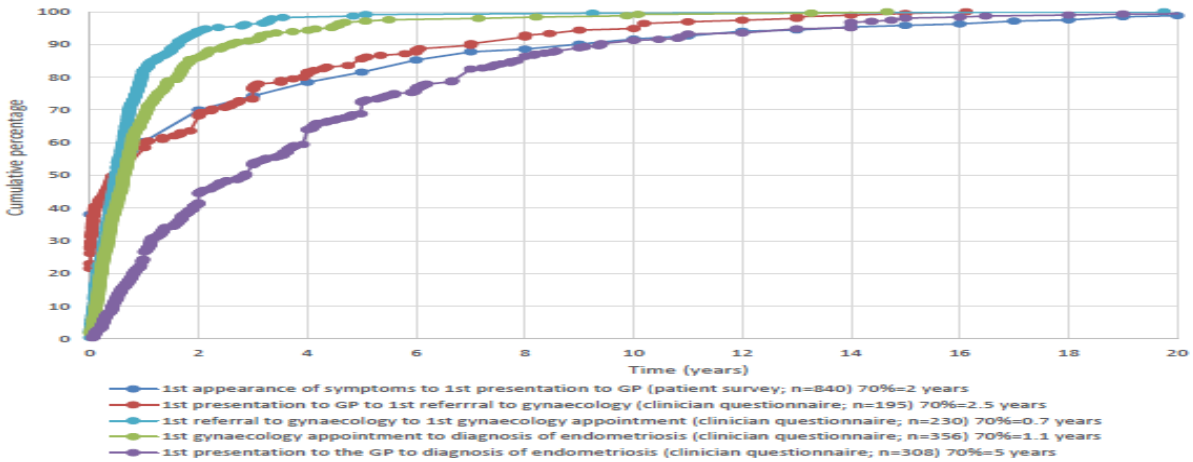


Figure 3.5 Timeline of events in the treatment pathway for endometriosis

Table 4.1 shows which specialties were involved in the MDTs. However, these were not always whole-time equivalent roles. Within the MDTs, 111/167 (66.4%) hospitals had one whole-time gynaecologist, 34/167 (20.3%) had two, and 36/167 (21.5%) had three or more. Only 8/167 (4.8%) hospitals had more than one whole-time endometriosis clinical nurse specialist. In terms of pain specialists, 25/167 (14.9%) hospitals had one whole-time pain specialist within the endometriosis team, while 6/167 (3.5%) did not have any pain specialist available.

Thirty-one hospitals had one or more dedicated colorectal surgeons as part of the service, 26/167 (15.5%) hospitals had one or more whole-time fertility specialist employed in the team and three hospitals had a dedicated physiotherapist. Forty-seven hospitals had at least one or more radiologist specialising in endometriosis.

Table 4.1 All the healthcare professionals who comprised the multidisciplinary team

	Number of hospitals	%
Gynaecologist	160	95.8
Radiologist	96	57.5
Colorectal surgeon	93	55.7
Urologist	85	50.9
Pain specialist	73	43.7
Endometriosis clinical nurse specialist	64	38.3
Reproductive medicine specialist	58	34.7
Physiotherapist	40	24.0
Histopathologist	35	21.0
General surgeon	35	21.0
Pharmacist	33	19.8
General nurse	29	17.4
Gynaecology specialist nurse	19	11.4
Psychologist	17	10.2
Dietitian	10	6.0
Occupational therapist	4	2.4
Other	10	6.0

Answers may be multiple; n=167, organisational data

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Has this audit been placed on a Risk Register (N/A if above risk is None)	No

If not on a risk register, why not: Improvements to the service and work towards completing recommendations remains an ongoing process and the audit is mostly achieving the standards with areas of good practice not part of recommendations.

	Report Successes:
1	ABUHB has been accredited by BSGE as an endometriosis centre.
2	Raising awareness of endometriosis with the public and patients. Raising awareness with healthcare professionals regarding endometriosis being a chronic condition
3	CNS support in secondary care
4	Simulation training for laparoscopic procedures
5	Trainees in clinic with consultant for development of skills
6	The use of PROM'S and PREM'S to attain quality-of-life and perception of disease

	Report Concerns:
1	No dedicated theatre list for joint surgery with colorectal surgeon/gynaecologist
2	Cardiff declining referrals
3	If accreditation is not maintained there will be no clear pathway for women with stage 3 and 4 endometriosis involving the bowel which requires colorectal support
4	Withdrawal of pelvic pain MDT clinic
5	Lack of CNS in primary care
6	Lack of mental health support and psychologist. Need for more procedures to be undertaken as see and treat rather than diagnostic laparoscopy.

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
1	Raise awareness about endometriosis symptoms with the public and patients, highlighting that it is a chronic condition and how they can seek help.	• Open access to endometriosis CNS for teaching sessions at schools, universities, fundraising events this has already been taking place at a number of venues including Cardiff University. • Using the Health Boards (HB) social media platforms for Q&A events, short videos to talk about endometriosis. • Using the intranet/HB webpage to promote education around endometriosis. ABUHB has a dedicated page to endometriosis as well as signposting to support sites such as Endometriosis Cymru and Endometriosis UK.	**Ms Nargund/ Jo Kitt CNS** **In Progress** - OAK Talks – Patients can self-refer from the community to a zoom call regarding endometriosis and its treatment. There is an endometriosis roadshow planned for 2025 across all HB in Wales.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
2	Raise awareness with all healthcare professionals that endometriosis is a chronic condition and should be treated as such.	• Endometriosis/Pelvic pain study days. Offering teaching to GP's, medical students. This is already incorporated into the teaching programme. Education for consultants working in other specialities. Highlighting endometriosis on the intranet during March which is endometriosis awareness month.	**In progress** - Development of an online learning tool on ESR for healthcare clinicians to complete.
3	Improve training on the recognition of symptoms of endometriosis, such as pelvic pain and heavy menstrual bleeding. a. In primary care - to support healthcare professionals in the initial assessment, and any ongoing care of patients b. In secondary care - enhanced training on endometriosis should be made available for all health care professionals who might care for patients with endometriosis.	• Training in medical management and excision of endometriosis already incorporated into the ABUHB teaching programme and this has been developed by the endometriosis lead. • Simulation training on a regular basis to teach laparoscopic procedures. • Trainees attending dedicated endometriosis clinics and theatre sessions with endometriosis lead consultant to develop skills.	**Completed** - ABUHB has achieved accreditation status from the BSGE as we do have the specialist skills/resources available as bowel surgeons are supporting in their own time on an adhoc basis. ***Outstanding -*** *There are concerns regarding the long term multidisciplinary surgical management of endometriosis as currently there is NO dedicated theatre list for a colorectal surgeon to do a joint case with the gynaecologist. Funding for bowel surgeons is not available and Cardiff are declining referrals due to their own vast caseload.*
	If accreditation is not maintained there will be no clear pathway for women with stage 3 and 4 endometriosis involving the bowel which requires colorectal support. This will unfortunately affect patients access to services they should be offered for this complex disease which affects their quality of life significantly. ***Another concern is the access to a dedicated pelvic pain anaesthetic consultant. ABUHB did have a dedicated multi-disciplinary pelvic pain clinic which involved, anaesthetist, gynaecologist, physiotherapist and psychologist. This was withdrawn during covid, and the funding was withdrawn so we can no longer provide this service to patients.***		***Outstanding*** *- Dedicated theatre list for complex endometriosis cases on regular basis involving colorectal surgeon.* ***Outstanding*** *- To further develop sonographers' skills to recognise deep infiltrating endometriosis signs.*

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
4	Ask patients with endometriosis about the effects it has over and above physical symptoms, including its impact on their daily life and refer them as needed to support services (e.g. psychology/pain services), at all stages of the pathway.	The endometriosis CNS is a key contact for initial support. Both the nurse led, and consultant endometriosis clinic has a proforma that asks about patients' quality of life and the impact the disease has on it. This is also recorded on our PREM/PROM data in a quality-of-life score.	***Outstanding*** *- Access to mental health support for patients with endometriosis and living with a chronic illness. A dedicated pelvic pain psychologist would have a huge impact on patients' quality of life and perception of the disease.* ***Outstanding*** *- To approach occupational health to be part of our wider MDT to support patients further.*
5	Ensure multidisciplinary teams/clinical networks are set up and utilised across all healthcare settings to help agree treatment plans and support women with confirmed endometriosis. Input from specialties should be proportionate to the patient's needs.	This service already exists within ABUHB with consultant and endometriosis nurse led MDT's taking place weekly. Monthly MDTs already exists with bladder, bowel, pelvic physio, sexual health, fertility, menopause, pain CNS as and when required for complex patients. The endometriosis nurse is also able to make contact to the above specialities on an ad hoc basis as required. For any joint cases we hold an MDT pre-operatively with the other specialities to plan the surgical management and ensure patient is fully aware of risks/benefits of procedure. We would benefit from psychology support but at present a business case would be needed for this.	***Outstanding*** *- Development and involvement of a primary care lead for endometriosis not just women's health. Occupational health involvement as endometriosis does affect impact on the ability to work.* ***Outstanding*** *- In the future we are looking to develop a nurse led nutritional advice-based clinic*.
6	Manage pain effectively for patients who have endometriosis: a. Set a low threshold for the prescription of analgesia b. Set a low threshold for hormonal treatment which may improve pain as well as other symptoms –while always considering fertility intentions c. Refer to pain management services as needed d. In parallel, refer patients for non-medical pain management e.g. physiotherapy	This is largely managed in both the consultant led and nurse led endometriosis clinics. Education to patients around taking analgesia, using TENs, living well with pain etc. Advice can also be given to GPs as needed via email queries sent. Making care plans for patients to take to their G.P to explain the need for analgesia to help manage endometriosis. Utilising the ability to refer to pelvic physio.	***In progress*** *- We cannot refer direct to pain team if patients are awaiting surgery or any other investigations. There was a pre-existing multi-disciplinary pelvic pain clinic which unfortunately was stopped during covid. This needs to be re-instated with support from anaesthetic team.*

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
7	Use interactions between patients with endometriosis and prescribing healthcare professionals to undertake a medication review.		Completed
8	Provide patients with clear, written information as part of the process that allows the patient to give informed consent for the laparoscopic diagnosis/treatment of endometriosis. This should form the basis of a documented discussion with the surgeon before the day of surgery. Include: a. What the procedure involves b. The purpose of the procedure e.g. to diagnose, stage, treat the symptoms of endometriosis, or a combination of these c. What the patient's expectations are d. The possible effects on endometriosis symptoms e. Risks, benefits and limitations f. The need for further laparoscopic/open surgery for recurrent endometriosis or if complications arise This is consistent with NICE guideline NG73	Dedicated consent clinic.	**In progress** - We provide patients with clear, written information as part of the process that allows the patient to give informed consent for the laparoscopic diagnosis/treatment of endometriosis. This process is performed in the endometriosis clinic or in any general gynaecology clinic if listing for diagnostic laparoscopy prior to surgery. Information leaflets should be given regarding proposed surgery, diagnostic laparoscopy or excision of deeply infiltrating endometriosis leaflet.
9	Provide patients with clear, written information at discharge following laparoscopic diagnosis/treatment of endometriosis, including who to contact and how to initiate direct access back into the endometriosis care pathway. a. Who to contact if they have any concerns, e.g. GP, endometriosis clinical nurse specialists, consultant b. The follow-up plan and ongoing management of the endometriosis c. The option of patient-initiated follow-up d. Types and dosages of medication they are on at discharge, including analgesia and hormone therapy e. The consideration of bone health for people with endometriosis on long-term hormonal medication, including nutrition, weight-bearing exercise and alcohol intake	Patients are all offered a follow up appointment or be left on a PIFU pathway and be able to access endometriosis CNS who can then offer an appointment or refer back to the consultant if needed. This ensures long term management of the condition to allow for medication and Implications – the case load is becoming too large for one endometriosis nurse hence ideally an endometriosis CNS is needed in primary care. Numbers into the service are recorded and data collected regarding the value of a PIFU pathway. symptom review as needed.	**Completed** **Outstanding**

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
10	Formalise a care pathway for patients with or suspected to have endometriosis. This pathway should include implementation of NICE guideline NG73, the European Society of Human Reproduction and Embryology (ESHRE) endometriosis guidelines, as well as the recommendations from this report.	Endometriosis referral pathway.pptx (sharepoint.com) Guidelines Ref Forms - OneDrive (sharepoint.com) Guidelines Ref Forms - OneDrive (sharepoint.com)	**Completed**
11	a. Collect surgical outcome data, including patient-reported outcomes, for benchmarking. b. Review local practice against NICE guideline NG73, the recommendations in this report. c. Undertake clinical trials to ascertain the efficacy of surgery for endometriosis-associated symptoms, especially for minimal or mild endometriosis. d. Assess the use of pain medication, and the medical treatment of endometriosis. e. Explore the use of imaging modalities in the diagnosis of endometriosis.	• Collect surgical outcome data, including patient-reported outcomes, for benchmarking. • Undertake clinical trials to ascertain the efficacy of surgery for endometriosis-associated symptoms, especially for minimal or mild endometriosis. (R&D are involved to see if we can be selected for trials) • Using PREM's and PROM's to assess the use of pain medication, and the medical treatment of endometriosis. We are already collecting this data in regard to Dienogest.	**Completed**

Completed	Not Due	In Progress	Outstanding

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Falls and Bone Health Annual Report 2023-24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr – Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Hatch – Assistant Director of Allied Health Professions and Health Science.

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

Er Sicrwydd/For Assurance

The Falls and Bone Health Annual report (2023-24) looks to provide an overview of data analysis, key activities, challenges and next steps in support of reducing falls incidents alongside improving bone health as an ongoing commitment in further enhancing the quality of patient care.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper outlines the current work that has been and is being undertaken across the organisation and the collaborative approaches being adopted in support of falls management whilst respecting the intrinsic link to bone health requirements. Falls management remains a significant challenge for the Health Board and the report looks to demonstrate the range of quality improvements initiatives which are being undertaken whilst recognising the spread and scale opportunities that this represents.

The work in relation to falls continues to evolve with alignment to the changing demands, environmental pressures and both local and national guidance. A focus on the learning aims to provide sustainable change opportunities to manage falls at all levels in the organisation.

It is important to recognise that the content of the annual report is falls associated and is not exhaustive but looks to provide an overview of the key aspects of work being undertaken.

Cefndir / Background

Detail is outlined in the main body of the report, highlighting the implications of falls on the population and the national and local drivers/ guidance to promote improvements.

Asesiad / Assessment

A comprehensive overview of management of falls and bone activities is embedded in the main body of the report. The key assurances are represented in terms of the proactive management and analysis of Inpatient falls data to monitor shifts and trends which contributes to the continued learning opportunities. Such opportunities translate into actions in terms of continually evolving quality improvement initiatives.

ABUHB are fully engaged as represented in the many national forums and have been at the forefront of developing key pieces of work that have contributed to national discussions and adoption across other Health Boards in Wales. As a Health Board we are key contributors to data collection for national programmes such as the National Hip Fracture Database (NHFD) and the National Audit for Inpatient Falls (NAIF), Fracture Liaison Service (FLS).

Argymhelliad / Recommendation

The Committee is requested to note the contents of this annual report as an assurance of the ongoing work in support of the management of both falls and bone health.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable – Falls represented as an issue as opposed to a risk.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.3 Falls Prevention 3.1 Safe and Clinically Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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:	As detailed in the SBAR and associated report.
Rhestr Termau: Glossary of Terms:	Acronyms/ Glossary of terms as defined within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The report was presented at the Falls and Bone Health Committee on the 24th September 2024.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• **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/	Not Applicable Choose an item.

Aneurin Bevan University Health Board
Falls and Bone Health
Annual Report
2023-24

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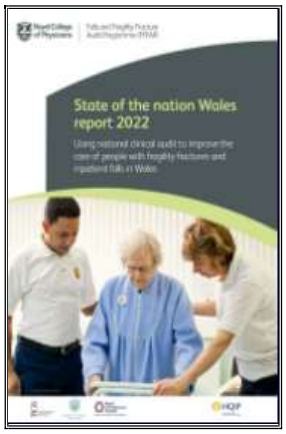
1. Introduction

Falls prevention and management remains a key issue in the improvement of the health and wellbeing amongst our older people, as falls represent 'a major cause of injury disability, morbidity and mortality' (World Health Organisation: 2018). Globally, falls represent a major public health concern and remain the second most common cause of unintentional injury death. Approximately 28-35% of people aged over 65 years and over fall each year increasing to 32-42% for those over 70 years of age. Each year it is estimated that 684,000 individually die globally from falls.

In the United Kingdom (UK) around 1 in 3 adults over 65years and half of the population over 80 years will have at least 1 fall per year. This means that each year in the UK at least 5 million people will experience at least one fall.

The Strategy for Older People in Wales, 2013-23' (Welsh Government: 2013) identified the prevention of falls as an emerging area for policy development and initiatives. Within the context of the document, 'Ageing Well in Wales's identified the importance of reducing the impact and number of falls as a national issue, as well as the contribution to an individual's social isolation.

The State of the Nation Wales Report 2022' (Royal College of Physicians: 2022) was published as part of the Falls and Fragility Fracture Audit Programme (FFFAP) and looked to use clinical audit to improve the care of people with fragility fractures and inpatient falls in Wales. This summary report examined how the care of inpatient falls and fragility fracture has changed since 2020, showing what the audit reveals about the quality of patient care, and the impact of the COVID-19 pandemic



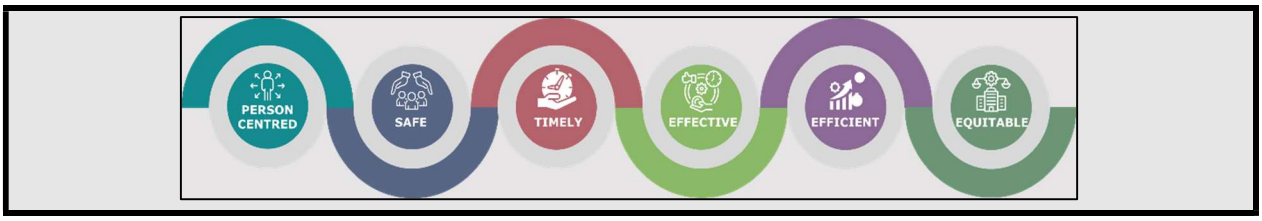
In April 2016, the Welsh Government issued the Principles, Framework and National Indicators: Adult Inpatient Falls, Welsh Health Circular (WHC 022 :2016). The circular provided clear recommendations to Health Boards in Wales about the actions required to prevent inpatient falls with a framework for delivery and remains applicable today.

All patients, of all ages, have a heightened risk of falling when admitted to hospital, either due to their past medical history, their current condition or by the very fact that they are within an unfamiliar environment.

It is therefore important to ensure that all patients admitted to hospital are systematically assessed for 'falls risk', and effective preventative measures are put in place to reduce the risk of an initial or further fall, whilst promoting enablement.

Prevention, reduction and management of falls within the hospital setting is complex and changes according to individual circumstances, clinical specialties and clinical environments.

With the implementation of the 'Duty of Quality' (Health and Care Engagement Act, Welsh Government: 2022) which came into force on the 1st April 2023, the management of falls remains a key component under the newly defined quality standards. This is reflected likewise in the recently published Health Boards Quality Strategy (ABUHB:2023). This serves to further promote and build upon what has already been accomplished with quality, safety and learning at the heart of everything we do.



2. Executive Summary

The Executive Director of Allied Health Professions & Health Science represents the Clinical Executive with responsibility for falls within the Health Board (HB). As chair of the 'Falls and Bone Health Committee' they retain strategic oversight through the defined governance structure.

The purpose of the report is to provide the Aneurin Bevan Health Board (ABUHB) with a summary of the principal activities and outcomes in relation to falls prevention and management for 2023-24 to date. It will look to summarise by means of data analysis, detailing key activities undertaken focused on quality improvement interventions and provide an overview of proposed future initiatives.

Prevention of falls and effective management of patients following a fall, remains an important patient safety challenge for the HB and should be recognised as a key priority. Falls, whether they take place in the community or in the hospital, have both human and financial costs. For the individual patient, their relatives and carers, the consequences range from distress and loss of confidence to injuries that cause pain and suffering, loss of independence and, occasionally, death (National Patient Safety Agency: 2007).

It remains important that falls prevention and management are not considered in isolation of concerns associated with maintaining bone health.

However, to optimise the improvement of falls management across the HB, an increased focus is being attributed to reducing the severity of impact of falls by promoting bone health through early identification and treatment of osteoporosis.

Osteoporosis is also considered as a serious public health problem due to a very high prevalence and it is estimated that over 200 million people worldwide have suffered osteoporotic hip fractures.

About 30% of postmenopausal women in the United States and Europe suffer from this condition and the overall prevalence based on low bone mass is 43.9%.

The incidence of an osteoporotic fracture increases exponentially with age; particularly over 50 years of age, the lifetime probability of sustaining an osteoporotic fracture is one in every two women and one in five men. In the UK, every two minutes, a person above the age of 50, sustains a fragility fracture, resulting in more than 300,000 osteoporotic fractures per year that cost over £1.7 billion to treat.

The risk of future fragility fractures increases with the number of previous fractures of the hip, spine or wrist, independent of age. Prevalence of osteoporotic fractures are predictive of risk for subsequent fractures, even in individuals with normal Bone Mineral Density (BMD), and increased mortality particularly for those with osteopenia and osteoporosis.

Osteoporosis has previously represented a hidden condition, often undertreated and leads to hip fractures which result in a high cost and impact on humanity. It is known that one-third of the population have a fragility fracture including vertebral or wrist and have not been treated in alignment with the guidance. These patients are also at a high risk of sustaining hip fractures; therefore, treatment of osteoporosis is evidence-based and has been endorsed by revised National Institute for Health and Care Excellence (NICE) guidance, 'Osteoporosis-Prevention of Fragility Fractures Summary' (NICE: 2023). Hip fractures have an immeasurable impact on patients and family but hip fracture prevention is not only about avoiding hospital admission, reduction in associated workload or saving money, but it is about preventing irremediable changes in people's lives.

3. Key Achievements and Challenges

This section will take account of both quantitative and qualitative work associated with falls prevention and management together with considerations associated with bone health.

3.1 Inpatient Falls – Quantitative Data Analysis

Chart A. Total Numbers of Inpatient Falls April 2023- March 2024

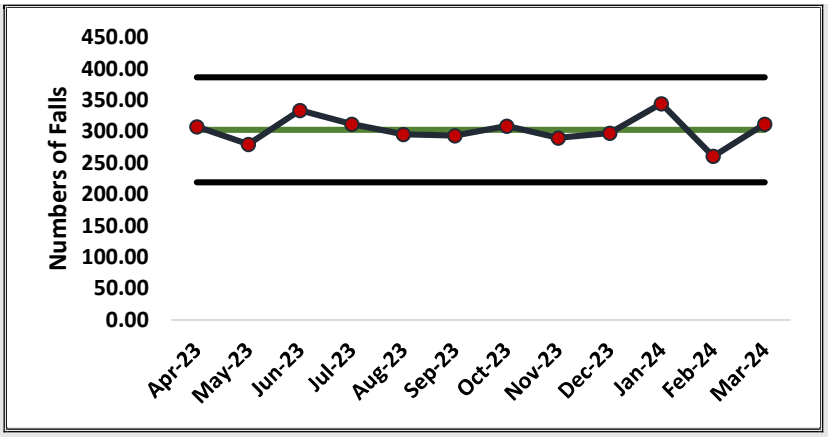


Chart A provides data for the period April 2023- March 2024 with a mean average value of total number of falls at 303. For the given timeframe there were no instances in which the numbers of falls incidents were in close proximity to the established control limits.

The most significant peak occurred in June 2023 and January 2024. Following the increased numbers of falls reported in June 2023 the HB saw a sustained period in which incidents were aligned to or below the mean average value.

The rise in incidents in January 2024 was followed by a siginificant downwards trend to the lowest value (261) for the reporting period. No noteworthy shifts were evident for the given data set.

Chart B. Average Number of IP Falls per 1000 Occupied Bed Days (OBD) April 2023- March 2024

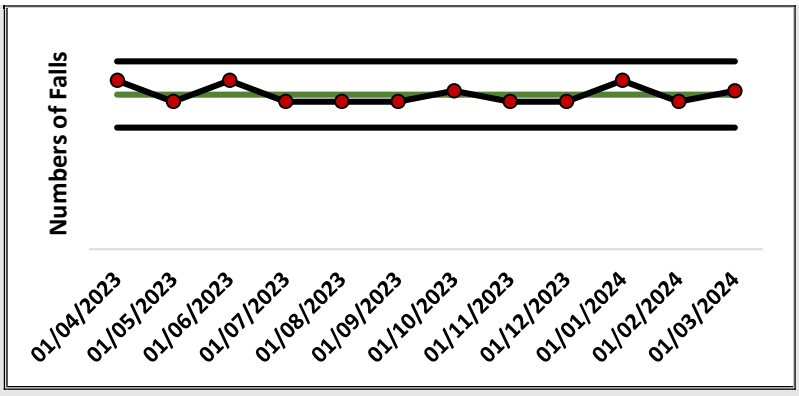


Chart B provides data for the period April 2023 to March 2024 with a mean average value of 7.3 against the National average of 6.6. This value was influenced by peaks which occurred in June 2023 and January 2024. Both correlate with an increased number of reported falls incidents within Medicine and the Primary and Community Care Inpatient settings.

Overall the falls per 1000 OBD's have remained within the established control limits and are consistent with values represented by other HB's in Wales.

Severity of Harm

Aligned to the reporting of numbers of falls, it is important to assess the level of harm at the time of the incident. The reporting period is April 2023 to March 2024.

Chart C. Categorisation of harm following initial assessment. For the period April 2023-March 2024 a total of 3776 falls incidents were reported.

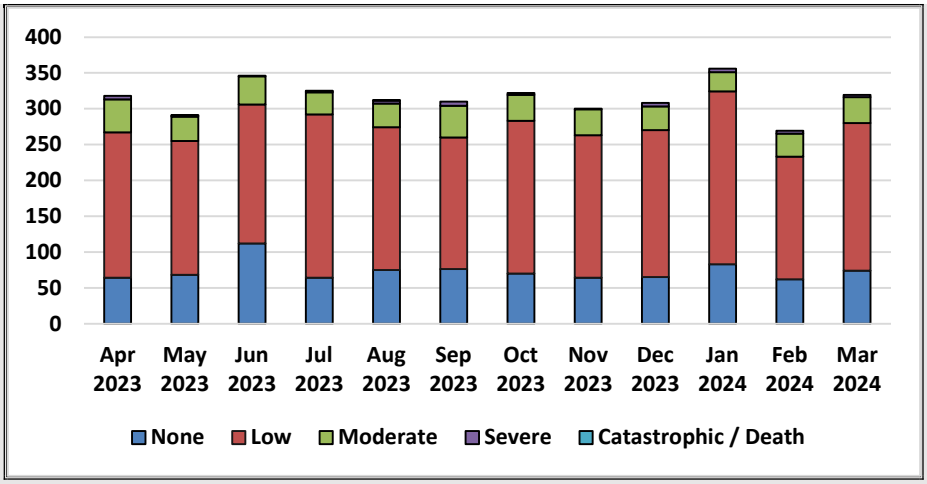


Table 1. Severity of Harm

At the time of reporting incidents 88.17% were categorised as low or no harm.

Reported Category of Harm	Percentage of total number of Falls Incidents April 2023-March 2024
No Harm	23.22%
Low Harm	64.95%
Moderate Harm	10.43%
Severe Harm	1.03%
Catastrophic	0.07%

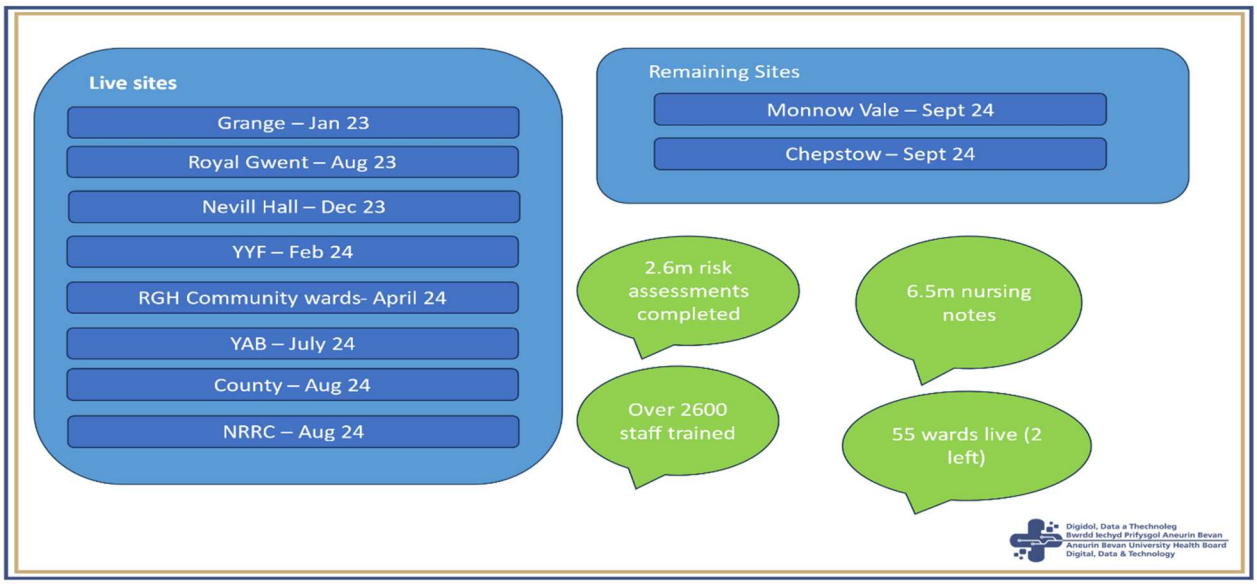
3.2 Falls Improvement Programmes

3.2.1 Key Achievements:

- **National Contributions**: Contributed to the development of the 'Falls National Head Injuries Pathway' and the National Inpatient Falls Network's work on sensor use, setting a national standard. Further contribution relates to work associated with the availability of flat lifting equipment required to safely lift a patient who has fallen from the floor. A National 'Task and Finish' group was established in May 2024 to look at a coordinated approach across Wales.

- **Data Improvement**: Enhanced availability and analysis of falls data across the HB have informed key quality improvement initiatives, leading to better monitoring and reduction of falls. The HB has well established processess to monitor data metrics.

- **Digital Integration**: Successful rollout of the Welsh Nursing Care Record (WNCR) Multi-Factorial Risk Assessment (MFRA) to adult wards, with completion in September 2024. Additionally, a modified MFRA has been developed for use in Emergency Departments (ED).



ABUHB has been instrumental in securing two additions to the Falls and Bones Assessment in WNCR; the addition of an environmental assessment and prompts to include medication reviews. In the next release lying and standing blood pressure will also be included.

The HB has led on the development of an 'Immediate Post Falls Risk Assessment' record for WNCR, which will be released in 2025.

- **Training**: Continued delivery of falls prevention and management training, adapted for the digital format of the WNCR, MFRA.

Quality Improvement (QI) Initiatives

- **SWARM Methodology Implementation**:

  Swarms represents a quality improvement methodology that promotes the delivery of quick insights and reflections generating prompt learning. It is based upon the concept of 'swarm intelligence' in social insects such as bees, where the collective intelligence is greater than that of individuals. Using the ethos the aim is for the Multi-Disciplinary Team (MDT) to swarm to the site of the incident to investigate the cause and the means to prevent it reoccurring. Roll out commenced in April 2023 within the Medicine Division, this MDT approach is being expanded across the wards. All YYF wards reponsibile to this Division have now implemented this methodology. As of August 2024, this has commenced on B4 Grange University Hospital (GUH).

- **Emergency Department (ED) Yellow Arm Band Project:** Commenced in May 2024 as an initiative to heightening visual recognition and identification of patients at high risk of falls whilst in the ED setting. This work has been undertaken alongside the implementation of the modified MFRA.

- **Ward Accreditation**: Falls prevention and management have been incorporated into the ward accreditation initiative, further embedding the falls management practices into daily routines.

- **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Compliance**: Established a Standard Operating Procedure (SOP) and development of a compliance dashboard within RL Datix in support of improved reporting and monitoring. RIDDOR Awareness Training has been developed and aligned to the SOP.

- **Falls Awareness**: A highly successful Falls Awareness Week in September 2023 saw significant patient and staff engagement across the HB with a wide reaching raising awareness campaign.

- **Publication** - ' Stumble Crumble' a Falls related book developed with the children of New Inn Primary School. A children's book aimed at reigniting conversations across generations.

- **Fracture Liason Services (FLS):** FLS are a fundamental component in ensuring that patients aged 50 and over who have a sustained a fracture following a fall have their bone health and falls risk checked and managed to lower their risk of subsequent fractures.

- FLS have been shown to bring clear benefits to the patient in the long term and are a clinically and cost-effective early intervention method to keep people out of hospital.

  Key stakeholders in the National FLS Quality and Assurance Group. ABUHB are actively participate in informing the development of a National standardised approach to delivering equitable services to the population of Wales.

  ABUHB FLS Journey: 2021-22 ABUHB work has been undertaken adopting a quality improvement methodology of Plan-Do-Study-Act (PDSA) cycles to implement change initiatives whilst strengthening the evidence base. This work has been supplemented with a process mapping exercise.

  This saw the establishment of ownership by the Division of Medicine with cross Divisional engagement with key stakeholders through Clinical Leads for Rheumatology, Care of the Elderly (COTE), and Radiology. Process mapping has seen the establishment of the two FLS-DB pathways: Rheumatology team to provide care for patients under 75 with the current Clinical Nurse Specialist (CNS) and COTE team to assess all patients above 75 years. In support of this collaboration with Radiology has seen the establishment of a system in which weekly fracture data lists are generated to aid proactive identification of patients at risk.

  ABUHB FLS has continued to evolve 2022-23 as consiered an exemplar model across Wales.

The service continues to be engaged in the submission of patient data to inform the FLS data base (FLS-DB). ABUHB FLS (2022) has demonstrated an 88% increase in case identification as compared to the year 2021 with further improvements demonstared for 2023-24.

Table 2. Represent compliance rates with Key Performance Indicators (KPI)

	2021	2022	2023	2024 *
Total identified (n)	875	1649	2178	1710 *
16 weeks reviews for treatment (%)	8.3%	18.1%	46.8%	49.9%*
52 weeks reviews for treatment (%)	18.4%	13.8%	22.6%	

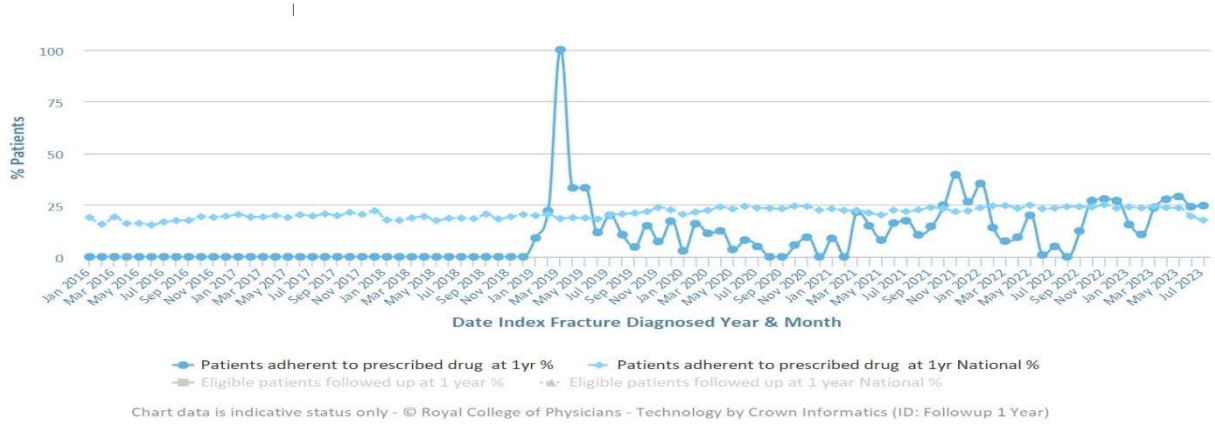
* Data up to June 2024

Table 3. Represent compliance rates with Key Performance Indicators (KPI) Significant improvement have been observed in relation the KPI as follows:

	2021	2022	2023	National Benchmark 2023
Total identified KPI 2 (%)	875	1649	2178 (61.3%)	40.4%
16 weeks follow-up KPI 9 (%)	13.7%	21.4%	57.7%	28.1%
16 weeks reviews for treatment (%)	8.3%	18.1%	46.8%	30.6%*
52 weeks reviews for treatment (%)	18.4%	13.8%	22.6%	22.4%

Chart D. First Follow Up

Chart E. Follow Up (1 Year) – Adherance to precscribed medication



ABUHB is currently working with the HB's Value Based Healthcare (VBHC) team and have initiated a pilot for the completion of Patient Related Outcome Measures (PROM's). The HB represents the lead on this work in Wales with agreement nationally that the aproach would be adopted/ adapted by other HB's.

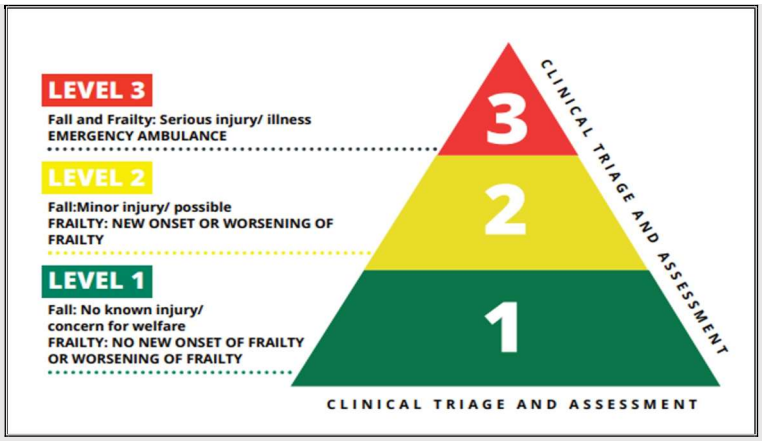
Partnership working with the Royal Osteoporosis Society (ROS) has also facilitated the FLS economic benefit calculations. The provision of Welsh Government funding has provided the opportunity to secure additional staff resources and enhance service sustainability.

Service developments have been supplemented by a continuous review and evaluation of the way in which the clinics are run. The outcomes of a critical analysis resulted in the modification of clinics with efficency gains in service delivery by Clinical Nurse Specialists (CNS) allowing patients to have a more structured approach to their FLS journey.

- **Collaborative Partnerships.**

  Welsh Ambulance Service Trust (WAST) Quantative Data Analysis (For the purposes of this report the data period is April 2023- July 2024. The period has been chosen to provide a valid representative data sample.

  Falls and Frailty Response Model:

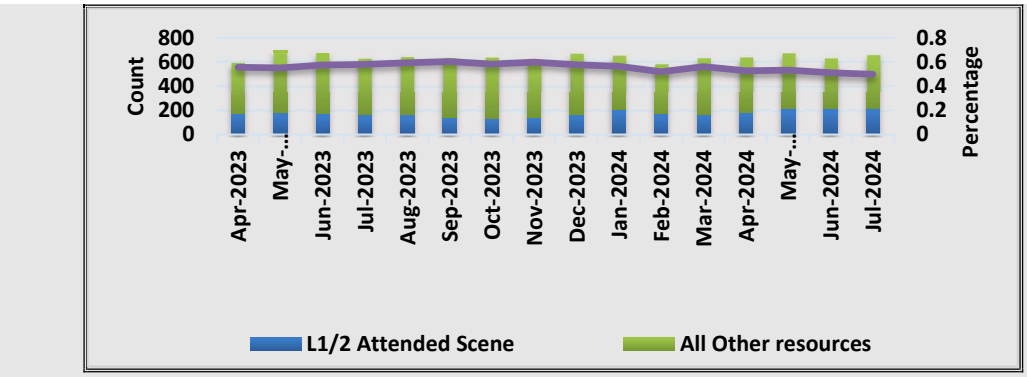


Summary Overview ABUHB for the period April 2023 – July 2024

- Approximately 73,000 calls to WAST in ABUHB were attended.
- 14% of all attended calls were falls related as categorised by 'Nature of Incident'. This represented approximately 10,200 responses to falls.
- ABUHB. Specialist Falls response service 28% of 1st Response attendance to falls incidents was provided by Specialist falls response resources. Up 15% as compared to 2021/2022.

- Level 1 response was provided by 6 different resources. Of those 18% was provided by the Gwent System Resilience (GSR) funded additional Level 1 night time resource which came online in December 2023 ,
- For Q1 -24/25 the GSR resource provided 35% of Level 1 response.
- Falls Calls to WAST from Care Homes = 1,911 with a conveyance rate of 39%

Chart E: Falls 1st Response L1/L2 versus all Other Resources and Overall Conveyance: ABUHB April 2023 -July 2024



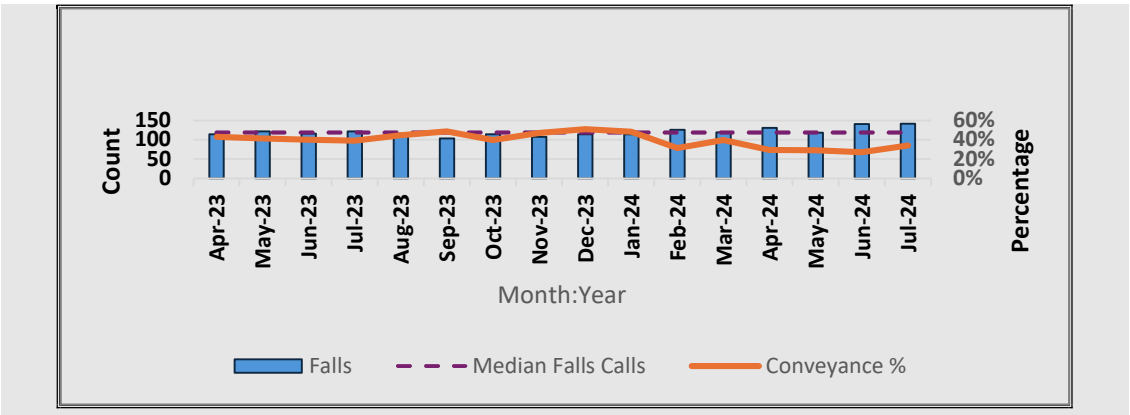
For the given period the Level 1, Falls Assistants (FA) contributed to 24% of the overall demand on average for the period, this includes support from other HB Level 1 FA's. When level 1 and level 2 are combined a 28% contribution is seen in response to falls demand.

In 2022 Level 1 FA's responded to approximately. 1,600 falls in ABUHB as 1st response, this already been matched at the end of July 2024.
For the given period the Level 2 resource responded to 700 calls of which 71% were falls by nature of the incident.

Level 2 has faced significant resource challenges with recruitment of Therapies with approx. 50% of hours covered based on 7/7 08:00 -20:00 model)

All resource falls conveyance in ABUHB over this period was 57% - July 2024 at lowest Conveyance (50%) , for comparison this was 58% July 2023.

Chart F: WAST Care Home Falls Calls and Conveyance %: ABUHB April 2023 - July 2024



Median Call out 118.5 per month with conveyance average of 39%
Reasonably static call out volume with decreasing need for conveyance.

- **Community Programmes:**

  Monmouthshire QI Project: A project initiated to look at establishing a more sustainable, expansive falls service for the borough. This has looked to secure a permanent location to support patients attending for face-to-face interventions as appropriate.

  Torfaen: Connecting with our population through talks to community groups to promoting falls prevention awareness.
  Increasing Falls class client numbers, back to pre- COVID levels whilst selecting new patient education sessions. Incorporating Bone health exercises into the class.

  Utilising the Mini ACE tool to more rapidly identify patients with possible cognitive impairment. Utilising trained Physiotherapists and Nurses with opportunities for onward referrals following discussion to Mental Health Nurse Practitioners.

  Establishment of a permanent full-time Physiotherapist in Falls, appointed on 15th July to support with training and development.

  Direct involvement of Pharmacy across the falls services.

  Improved triage within the team to deem more urgent patients for walking aid assessments.

  Reduced waiting list for Bone Health treatments and Frop2. Reduced waiting time for Frop I / Triage.

- Falls Nurses completing Care Programme Approach (CPA) modules to improve decision making for treatment/ bringing patients to clinic.

3.2.2 Key Challenges:

- **Consistency in Practice**: Ensuring consistent application of the swarm methodology and completion of the MFRA across all wards and specialties remains a challenge.
- **Data Utilisation**: While data availability has improved, fully leveraging this data to drive sustained reductions in fall rates and severity of harm requires ongoing effort.
- **Staff Engagement**: Maintaining high levels of staff engagement in falls prevention initiatives, especially in the face of evolving clinical environments and pressures, is a continuing challenge.
- **Technological Integration**: The successful digital integration of falls management tools like the WNCR, MFRA needs continuous support to ensure all staff are proficient and the tools are used effectively. The need to transition from paper to the electronic format of the 'immediate post falls assessment and falls care plan remains a key component to inform improvements.
- **Resource Allocation**: Ensuring that adequate resources, including appropriate flat lifting equipment and trained personnel, are available across all units to effectively manage falls.
- **RIDDOR Reporting**: Despite progress, achieving full compliance with RIDDOR reporting protocols across the Health Board requires ongoing monitoring and training efforts.
- **Training**: Lack of sustainabilty due to the reallocation of available staff resource.
- **FLS:** Limited resources to deliver DEXA (Bone Densitometry scan) imaging and reporting resulting in subsequent delays. This is subject to National discussions.
- **Communities:** Continuing upward trends in referrals as we improve utilisation of the Community Resource Team (CRT) services which influences waiting times. Expansion of services with no change in staff resource levels**.**

Torfean specific:

- Reablement Practioner staff being affected by the new services that came into effect on 1st April this year, based at Ty Glas Y Dorlan. This has had a direct effect on the Falls Team staffing levels.
- **Falls and Frailty Model:** From a care home perspective adherance to lifting policies whilst optimsing the use of available decision making tools continues to influence call out rates.

3.2.3. Next Steps:

- **Falls Policy for Hopsital Adult Inpatients**: Review and update in accordance with Local, National and United Kingdom guidance.

  Reflect and incorporate updates on NICE Clinical Guidelines 161: Falls in older people: assessing risk and prevention (2013) and NICE Quality Standard 86 "Falls in Older People" (2015) due March 2025.

  Provide revised guidance in relation to WNCR digital MFRA.

  Incorporate 'All Wales's Head Injuries Pathway post ratification.

  Provide updated links to other, current ABUHB Policies and guidelines to include ABUHB revision of enhanced care.

  To utilise the policy update to support a further awareness raising campaign and the establishment of a target reduction in inpatient falls of 10% from an agreed baseline position.

- **Review of Injurious Falls with Fractures**:Reestablish the purpose and functionality of the 'Falls Review Panel' as one of strategic oversight with process changes to align to Divisional responsibilities and Quality Patient Safety (QPS) structures.

  Underpin change process with the establishment of an Standard Operating Prpcedure (SOP) and falls specific concise review. For implementation in January 2025 post ratiification. Pilot of concise review undertaken in August – November 2024 to ensure this fulfils the needs of the Falls Strategic Oversight Panel going forward.

  Projects Specifics: To spead and scale swarms and the yellow arm band initiatives to ensure a cross Divisional approach in order to maximise falls prevention opportunities.

  Commence a pilot project which has been designed to facilitate visual assessments at the bedside to support informing the requirements of the MFRA and to improve falls prevention opportunities.

  Ulilise the Safe Care Collaborative methodology to develop a falls reduction and prevention change package.

- **Equipment:** To contribute to and particiapte in the development of a National strategy in support of an 'All Wales's consensus on suitable levels of available flat lifting equipment, numbers as defined by stratification of inpatient poulation at risk of falls, financial implications and funding streams. Timeline as defined National level.

- **Training:** Development of a future training strategy with the adoption of a MDT approach to delivery. For completion by March 2025.

- **Benchmarking:** To complete this exercise, gap analysis and risk review of current dedicated resources attributed to the management and prevention of falls. Work being undertaken aligned to the provision of four Nations information and ABUHB rightsizing resource appoach.

- **FLS:** Look at further opportunities to identify patients who would benefit from referrals to the FLS service and subsequent bone health medication.Target 3730 identified, to treat 50% and to monitor 80%.

  To support community teams as learning regarding bone health medication.

- **WAST Falls and Frailty Model:**

  Sustainability of level 1 to ensure 24/7 response (Goal4)
  Further development Urgent Care Community Response (Goal 3)
  Develop Level 2 role to support Level 1 resources, respond and/or access key pathways to support Urgent Care (Goal 3)
  Ensure Non-injurious referrals received and actioned, (Goal 1).

  Commencment of the National work aligned to the publication of the 'National Community-Based Falls Response Framework' (NHS Executive, Six for Urgent and Emergency Care:2024)

- **Publication:** Work is underway to support the introduction of Stumble Crumble into libraries in Gwent commencing in Newport and Blaenau Gwent. This is to be supplemented with a lauch event during the October half term.

These achievements and challenges reflect the Health Board's commitment to reducing falls and improving patient safety across its facilities. The next steps focus on building upon these successes through enhanced training, data utilization, and multi-disciplinary collaboration.

References:

1. The Strategy for Older People in Wales, 2013-23' (Welsh Government: 2013).
2. Health and Care Standards (Welsh Government:2015)
3. The Principles, Framework and National Indicators: Adult Inpatient Falls (Welsh Government: 2016).
4. The National Hip Fracture Database annual report (Royal College of Physicians: 2017).
5. Falling Standards, broken promises (Royal College of Physicians: 2010)
6. The Care of patients with fragility fracture (British Orthopaedic Association: 2007).

7. National Institute for Clinical Excellence Guidance CG124, 2011; QS16, (2012 and 1241, 2017).
8. National Institute for Clinical Excellence Guidance CG161: Falls in older people: assessing risk and prevention (2013).
9. National Institute for Clinical Excellence Guidance Quality Standard 86 "Falls in Older People" (2015).
10. The Health and Social Care (Quality and Engagement) (Wales) Act 2020
11. Duty of Quality Guidance (Welsh Government:2023).
12. Quality Strategy (ABUHB:2023).
13. National Community-Based Falls Response Framework (NHS Executive, Six for Urgent and Emergency Care:2024)

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health, Safety & Fire Annual Report 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of AHPs & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Scott Taylor, Head of Health, Safety & Fire

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Committee the Health, Safety & Fire Annual Report for 2023/24.

The report identifies both the opportunities and challenges for the Health Board in ensuring and sustaining compliance with Health and Safety legislation, including specific compliance improvement action delivered in this period.

The Committee is asked to take assurance from the annual report and note the actions being taken to achieve compliance.

Cefndir / Background

The purpose of the annual report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2023/24. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2024/25.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities

undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of AHPs & Health Science.

Asesiad / Assessment

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 49.4% (2022/23) to 67.7% (2023/24)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2023/24 compared with 2022/23. This includes Health & Safety and Violence & Aggression surpassing the Welsh Government standard of 85%
- **Reduction in the following incident types:** Contact with needle of medical sharps; manual handling; slips, trips or falls
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for the Inpatient areas across Acute Hospitals. These assessments yielded an average Health Board compliance score of 88.2%.
- **Health and Safety Risk Assessments:** an additional 295 employees trained in Health & Safety Risk Assessment
- **Fire Risk Assessments:** 96% completed/reviewed against of the planned areas in 2023/24. This is an increase of 30% compared with 2022/23.
- **Fire Alarm Systems:** work programmes have commenced on replacing the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** condition of fire barriers analysed across Hospital sites, identifying improvements required at Nevill Hall Hospital and Royal Gwent Hospital.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2024/25.

Health and safety leadership
The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance
The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures
Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training
The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training
Compliance with requirements of fire safety training guidance (HTM 05-03 part A: Operational provisions – Training) presents a risk to the Health Board. The organisation is currently dependant of staff completing their training and gaining competence by attending eLearning training.

Violence in the Workplace
The level of violence Health Board staff are exposed to is a significant risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring
The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments
The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

Adequacy of fire alarm systems
The adequacy of fire alarm systems in some of the hospitals within the Health Board present a risk. This is primarily a result of the systems being well beyond life-cycle.

Fire barriers (compartmentation)
Breaches in the fire barriers at Nevill Hall Hospital and the unknown condition of the fire barriers at the Royal Gwent Hospital presents a risk to the fire strategy and evacuation plan.

Recognising the Health Board challenges in compliance, a health and safety strategic risk (SRR 010) was developed in 2023/24 – see Appendix 2. The risk is monitored monthly and reported via the Audit, Risk and Assurance Committee. The risk level

has been reduced following the implementation of plans to improve controls, however, the risk level remains outside of target level and outside appetite threshold (minimal risk appetite level which should be managed to a Score of 8 or below). The risk areas of focus, listed above and set out in the annual report, will be the basis of the ongoing compliance improvement plan for Health & Safety, with routine progress reported to the Executive Committee.

Argymhelliad / Recommendation

The Committee is asked to receive the annual report for assurance and note improvement in compliance during the reporting period, and the actions being taken to achieve ongoing compliance improvement.

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 Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Draft Health, Safety & Fire Annual Report 2023/24
Rhestr Termau: Glossary of Terms:	

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Health Board Health and Safety Committee Health Board Executive Committee

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**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
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.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Health, Safety and Fire Annual Report 2023/24

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Our Values and Behaviours

- People First
- Personal Responsibility
- Passion for Improvement
- Pride in What We Do

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1 EXECUTIVE SUMMARY

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The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of AHPs & Health Science.

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

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In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2024/25.

1.1 Risk Areas for Focus in 2024/25

Health and safety leadership
The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

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2 INTRODUCTION

This report provides analysis of the level of health and safety performance throughout the Health Board for 2023/24.

The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular, the Act requires an organisation to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities;

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

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Health, Safety and Security is an identified quality pillar within the Health Board Quality Strategy. The 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

The Health Board operates a Health and Safety Management System, utilising the Health and Safety Executive (HSE) '*Managing for health and safety*' (HSG65) model.

Diagram 1: PDCA Health and Safety Management Model

The model is structured into the Plan, Do, Check, Act approach (see diagram 1).

Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

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3 HEALTH, SAFETY AND FIRE GOVERNANCE STRUCTURE

3.1 Accountability

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of AHPs & Health Science.

3.2 Health and Safety Leadership

Effective health and safety performance is led by the senior responsible officers of the Health Board. Members of the Board have both collective and individual responsibility for health and safety. Directors and boards need to examine their own behaviours, both individually and collectively, against the guidance given and, where they see that they fall short of the standards it sets them, to change what they do to become more effective leaders in health and safety.

Why directors and board members need to act:

- Protecting the health and safety of employees or members of the public who may be affected by your activities is an essential part of risk management and must be led by the board.
- Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.
- Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

Business leaders have responsibility for determining and implementing effective health and safety management and monitoring its success, so it's essential that they understand how to implement a risk management strategy.

To support Board Members and Executive Directors to deploy their health and safety responsibilities, training for will be arranged in 2024/25. A Board Development session is planned for April 2024.

Regulation 7 of The Management of Health and Safety at Work Regulations 1999 states that *"Every employer shall, subject to paragraphs (6) and (7), appoint one or more Competent Persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions"*.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge and 'other qualities'.

The Corporate Health and Safety Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards.

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The department structure (as at end of March 2024) is illustrated in diagram 2.

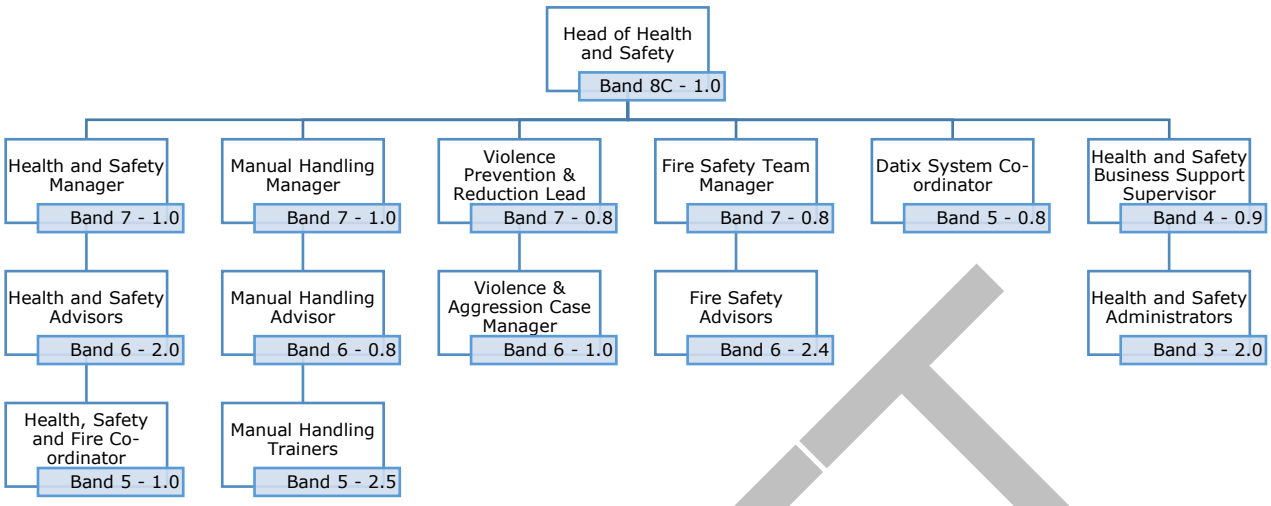

Diagram 2: Corporate Health and Safety Department Structure

The department is currently carrying vacancies in posts; Violence Prevention & Reduction Lead (Band 7) and Manual Handling Trainer (Band 5). Plans are in place to recruit to these posts in 2024/25.

The Corporate Health and Safety Department is structured within specific functions i.e. health & safety, fire safety, manual handling and violence & aggression.

The individuals within the functions are allocated areas of responsibility across the Health Board to support the development of effective relationships with key stakeholders. (See diagram 3)

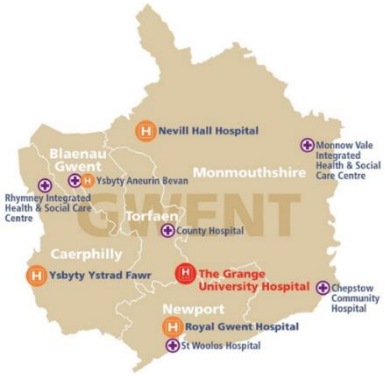

Diagram 3: Map of Gwent Hospitals

During 2023/24 the Corporate Health and Safety Department has effectively integrated into the Health Board leadership structures and regularly engage via specific Health Board meetings, including Quality and Patient Safety, Hospital Management Groups etc.

To ensure the Health Board can effectively meet its legal duties under Health and Safety legislation there is a need to consider the current resource available to the Corporate Health & Safety Department.

A review of the Corporate Health and Safety Department was completed in 2023/24. The review identified additional positions as key to enhancing the current establishment.

3.3 Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

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The Executive Director of AHPs & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within Aneurin Bevan University Health Board. The Health and Safety Committee is accountable to the Quality and Patient Safety Operational Group, which is in turn, responsible to the Patient Quality and Safety Outcomes Committee.

The Health and Safety Committee receives reports from the subgroups and ratifies policies. The reporting arrangements are illustrated in diagram 4.

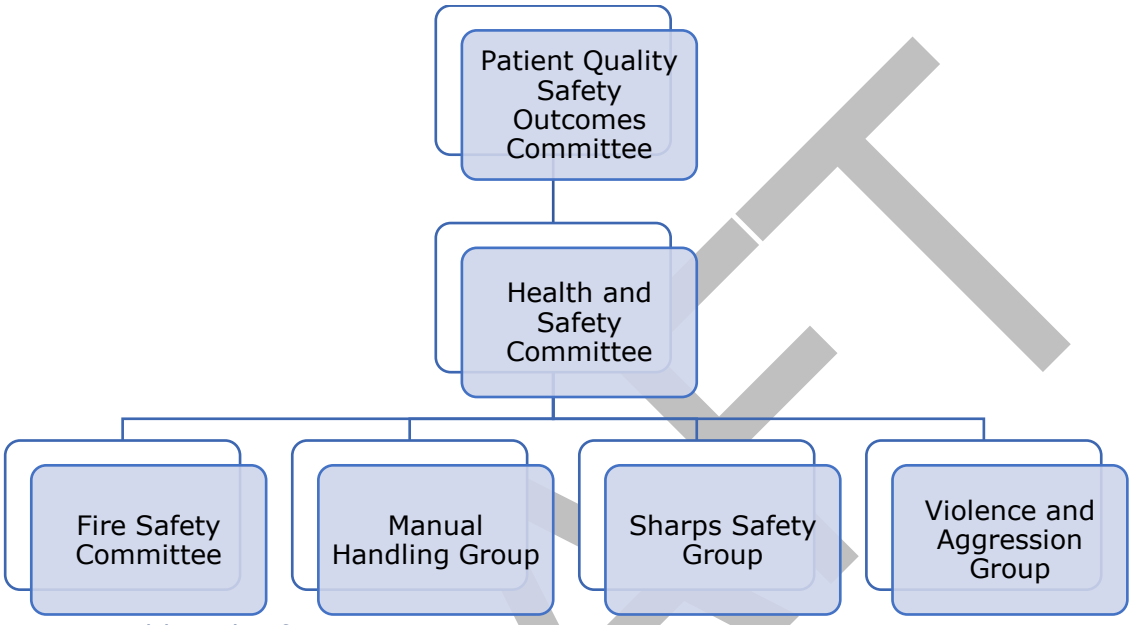

Diagram 4: Health and safety reporting arrangements

The Health and Safety Committee met three times in 2023/24. In May, July and November 2023.

The Committee Terms of Reference was reviewed early in 2024 with agreed membership comprising of Executive Team members.

3.4 Health and Safety Committee Subgroups

The review of the Health and Safety Committee terms of reference included an assessment of the current subgroups.

The revised subgroups reporting to the Health and Safety Committee are documented below.

Group	Chair	Frequency of Meetings
Fire Safety Management Group	Head of Health, Safety & Fire	Quarterly
Health and Safety Operational Group	Head of Health, Safety & Fire	Quarterly
Violence Prevention & Reduction Group	Head of Health, Safety & Fire	Quarterly

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Each subgroup is responsible for the production and updating of their own policies and terms of reference. These documents are submitted to the Health and Safety Committee for ratification.

During 2023/24 only the Fire Safety Management Group (previously known a Fire Safety Committee) has routinely met. A plan of meeting dates for the subgroups will be implemented in 2024/25.

In addition to the corporate reporting arrangements, health and safety is a regular agenda item at the Divisional Quality and Patient Safety forums providing an opportunity to monitor health and safety performance.

3.5 Health and Safety Policies & Procedures

Health and safety policies and procedures have been developed within the Health Board to outline the organisations plans to achieve compliance with the relevant health and safety legislation and/or standards.

The table below illustrates the current health and safety policies and procedures within the Health Board and their status. An objective for 2024/25 is to ensure all policies are reviewed and updated as appropriate.

Policy Title	Issue Date	Review Date	Status
Handling Violence and/or Aggression (Internal Sanctions) Policy and Procedure	Oct 2014	Oct 2017	Overdue Review
Use of Restrictive Physical Intervention Policy	Sep 2016	Jun 2019	Overdue Review
Lone Working Policy	Apr 2017	Apr 2020	Overdue Review
Control of Substances Hazardous to Health (COSHH) Policy	Oct 2017	Oct 2020	Overdue Review
Safer Manual Handling Policy	Jan 2019	Jan 2022	Overdue Review
Occupational Health & Safety Policy	Mar 2019	Mar 2022	Overdue Review
Incident Reporting Policy	Dec 2019	Dec 2022	Overdue Review
Procurement and Use of Portable Items of Non-Clinical Electrical Equipment Policy	Jan 2020	Jan 2023	Overdue Review
Fire Safety Policy	Jan 2020	Jan 2023	Overdue Review
Management of Violence and Aggression by members of the Public Policy	Jul 2021	Jul 2024	Current
The Use of Bedrails and Bedrail Covers Policy	Feb 2022	Feb 2025	Current
Policy for Workstation Display Screen Equipment (DSE)	Mar 2022	Mar 2025	Current
First Aid at Work Policy	Nov 2022	Nov 2025	Current
New & Expectant Mothers Health and Safety Obligations at Work Policy	Feb 2024	Feb 2027	Current

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The Health Boards policy for New & Expectant Mothers Health and Safety Obligations at Work was reviewed and updated in 2023/24.

All of the policies highlighted as 'Overdue Review' have been partly reviewed in 2023/24 by the Corporate Health and Safety Department, however, these need to be progressed further for approval.

Enforcement action taken by the Fire & Rescue Service against NHS Wales organisations relating to the control and management of ignition sources in healthcare has highlighted the requirement to develop a 'Search Policy'. This development is currently being led by the Corporate Health and Safety Department with engagement from key individuals across the Health Board.

3.6 Audit and Assurance

There has been no Internal Audits conducted during 2023/24 which relate to health and safety.

Recommendations from previous Internal Audits conducted in 2019/20, which elicited a 'limited assurance' response, are still being monitored. The recommendations relate to health and safety workplace inspections and quality of risk assessments.

The plan to revitalise the health and safety monitoring process was severely impacted by the demands placed on the Corporate Health and Safety Department by the Covid-19 Pandemic. A programme of health and safety monitoring in the form of health, safety and environment workplace inspections was completed in 2023/24. (See Health and Safety Monitoring under section 10.1 of this report for further information).

There has been engagement with the Divisions to actively review and update risks recorded on the risk module on the DatixWeb system. This will support the programme to improve the quality and management of risk assessments. The Corporate Health and Safety Department are leading the education programme for risk assessment within the Health Board. (See Risk Management and Risk Reporting under section 5 of this report for further information).

An audit conducted in 2022/23 to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates, specifically the Health and Safety Executive (HSE) identified matters requiring management attention. These include:

- A standard operating procedure should be developed to set out how HSE actions are monitored, tracked, escalated and overall assurance provided.
- An inconsistent approach and a lack of evidence to the tracking of HSE actions by the respective committees

A draft standard operating procedure 'Management of Health and Safety Executive (HSE) Inspections and Reviews' has been developed and is currently awaiting approval.

The Health and Safety Legislative Assurance Framework identifies the compliance with health and safety statutory instruments. The document is subject to an assessment by the Corporate Health and Safety Department in 2024/25.

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4 HEALTH, SAFETY AND FIRE ENFORCEMENT ACTIVITY

During 2023/24, no prosecutions or enforcement actions have been issued by the Health and Safety Executive (HSE), however, South Wales Fire & Rescue Service (SWFRS) issued the Health Board with an enforcement notice in February 2023. The notice related to concerns with the fire safety arrangements for the Gerylyn accommodation building at Nevill Hall Hospital.

The following matters highlight the non-compliance with the provisions of the Regulatory Reform (Fire Safety) Order 2005 for the building.

- Fire doors are being held open inappropriately
- Intumescent strip seals missing, damaged or defective
- The fire safety measures evaluated in the fire risk assessment have not been implemented
- The fire detection system is inadequate for the type and use of the premises
- The existing provision of manual firefighting equipment is inadequate
- Emergency routes and exits could not be used as quickly and as safely as possible
- The standard of fire separation is not adequate
- Fire resisting doors are not adequately maintained

The timescale for compliance with the notice is August 2024.

During 2023/24 there have been HSE intervention costs of approximately £17,000. These costs relate specifically to HSE investigations into a patient fall incident. (The Health and Safety (Fees) Regulations 2012 places a duty on HSE to recover its costs for carrying out its regulatory functions, from those found to be in material breach of health and safety law.)

In 2023/24, the Health Board received a workplace concern from the Health and Safety Executive (HSE) about Diesel Engine Exhaust Emissions (DEEE) exposure at the Grange University Hospital's Emergency Department, primarily from idling ambulances on the forecourt. DEEE exposure, while generally low, can pose health risks, particularly with prolonged exposure.

In response, the Health Board, in collaboration with WAST, conducted a comprehensive risk assessment and workplace air monitoring, which found DEEE levels to be significantly below legal limits. However, recognising the presence of emissions, the Health Board implemented additional control measures, including installation of industrial fans, provision of designated welfare areas for WAST employees, implementation of safe working practices, and increased staff communication in relation to DEEE exposure.

Plans are underway to install a High Low Extraction Ventilation System as part of the Emergency Department expansion to further mitigate DEEE risks. Ongoing job observations and safety talks have been conducted to improve compliance with safe working practices, and further air monitoring will be done post-installation to ensure the effectiveness of these measures.

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5 RISK MANAGEMENT AND RISK REPORTING

A health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored monthly and reported via the Audit, Risk and Assurance Committee.

The risk level has been reduced following the implementation of plans to improve controls, however, the risk level is outside of target level and outside appetite threshold.

The completion of risks assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the risk assessment programme, the Corporate Health and Safety Department deliver risk assessment training, promoting best practice in the completion of a risk assessment and the principals of effective Risk Management within departments and in the wider organisation.

The Health and Safety Professionals within the Corporate Health and Safety Department continue to provide advice and guidance on the implementation of statutory risk assessments through the various subgroups. Specialist risk assessments being completed by the Health and Safety Professional upon request.

Most of the health and safety risks are reported via the risk module on the DatixWeb system. The Health Board also subscribe to CoSHH management software for the risk assessments relating to substances hazardous to health. All fire safety risk assessments are recorded via the NWSSP fire auditing and reporting system. New software for recording and monitoring fire risk assessments will be introduced in 2024/25.

To aid Divisions in Risk Management practices, a Risk Assessment Self-Assessment tool was developed and communicated to the Divisional Triumvirates with the request of the self-assessment tool being disseminated within their areas of responsibility. The self-assessment tool was developed in order support Divisions in evaluating their risk assessment practices against industry best practices as well as collecting necessary data to aid wider improvement in relation to risk assessment activities.

A total of 106 responses were received. The table below identifies the number of responses received by Division or Service.

Division / Service	Number of Responses
Primary Care & Community	42
Digital Data & Technology	24
Scheduled Care	23
Clinical Support Services	6
Urgent Care	6
Families & Therapies	5
Medicine	0

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On the back of the Risk Assessment Self-Assessment results, a new guidance document on Health & Safety Risk has been developed and communicated to all persons who have undertaken Health & Safety Risk Assessment Training, formally Competent Person Training. The guidance documents aim to:

- **Provide comprehensive Risk Assessment Procedures:** Step-by-step instructions to identify, evaluate, and control risks.
- **Identify Best Practices:** Proven strategies and examples to ensure a safe working environment.
- **Improve Legal Compliance:** Guidelines to meet regulatory requirements and industry standards.
- **Provide Tools and Templates:** Ready-to-use resources to streamline the risk assessment process.

The Health and Safety Committee receives reports on health and safety risks from the Divisions for consideration, action and assurance.

As part of the monitoring arrangements, the Corporate Health and Safety Department continually engage with Risk Leads to review the risks recorded as Extreme High and High with the view to provide further advice and support and ensure that appropriate mitigation is applied as a means to manage the risks at a level that is so far is reasonably practicable.

6 HEALTH, SAFETY AND FIRE TRAINING

Suitable and sufficient training is a requirement of The Health and Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

The Management of Health and Safety at Work Regulations state "every employer shall ensure that his employees are provided with adequate health and safety training".

The health and safety statutory and mandatory training compliance as of 31 March 2024 was as follows:

Training Course	2023/24 Compliance %	2022/23 Compliance %
Health and Safety Awareness	87%	82%
Fire Safety	83%	79%
Manual Handling	55%	52%
Violence & Aggression	85%	81%

During 2023/24 there has been an increase in compliance against all of the health and safety statutory and mandatory training compared with 2022/23.

Except for manual handling training, the delivery of the health and safety statutory and mandatory training programme in 2023/24 continues to be delivered by eLearning with access via the electronic staff record (ESR) self-service portal for ease to individuals. Line managers can view their team's compliance and are also notified when staff are nearing non-compliance.

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Compliance levels for manual handling training are well below the required standard. The manual handling training strategy is to be reviewed in 2023/24 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

During 2023/24, the Manual Handling Team have continued to deliver manual handling training to Health Board staff. The table below provides details of the manual handling training delivered and the attendance.

Manual Handling Course Title	No. of Sessions	No. of Attendees	No. of DNA's
People Handlers Foundation Training	43	444	164
People Handlers Update Training	10	62	39
Object Handlers Foundation Training	8	73	14
Object Handlers Update Training	8	48	5
People Handlers Trainers Foundation Training	2	19	0
People Handlers Trainers Update Training	7	46	5
Object Handlers Trainers Foundation Training	5	29	5
Object Handlers Trainers Update Training	4	29	4

Staff attendance on manual handling training and specifically those who do not attend remains a challenge.

Violence and aggression training is aligned to the All-Wales NHS Violence & Aggression Passport Scheme. The passport scheme is broken down into four areas:

Module A – Induction and Awareness Training: Introduction to the basic concepts of violence and aggression prevention, including organisational policies and employee responsibilities.

Module B – Theory of Personal Safety and De-escalation: In-depth theoretical training on personal safety techniques and strategies for de-escalating potentially violent situations.

Module C – Breakaway Techniques: Practical training on breakaway techniques to safely disengage from physical confrontations.

Module D – Restrictive Physical Intervention: Training on the appropriate and safe use of restrictive physical interventions when necessary.

All Health Board staff are mandated to complete modules A & B, whist module C & D is based on risk assessment. Members of the Corporate Health and Safety Department have attended accredited training to enable them to teach module C.

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During 2023/24, the Violence & Aggression Team undertook a targeted initiative to address specific risks associated with the violence and aggression from elderly patients within our Care of the Elderly Wards. Training sessions have been delivered across Acute and Community Hospital settings, with a total of 254 Health Board employees receiving this training.

Recognising the unique challenges faced by staff in these settings, a series of bespoke training sessions were developed and delivered, aimed at enhancing staff capability in managing violence and aggression, particularly where these risks intersect with conditions such as dementia, other mental health issues and environmental constraints.

Feedback from staff who attended the training has been positive. Colleagues have reported that the training provided them with a deeper understanding of the complexities associated with managing violence and aggression from these patients. They have particularly valued the practical techniques taught during the sessions, which they have found immediately applicable in their daily work. Staff have noted an increase in their confidence when dealing with challenging behaviours, as well as a reduction in the number of incidents requiring physical intervention.

6.1 Health and Safety Training for Managers

A Health and Safety for Managers Training package is currently being developed nationally. This work is being led by Cwm Taf Morgannwg University Health Board and will be agreed at the All-Wales Health and Safety Management Group.

Once the course is approved it will be implemented within the Health Board to provide Managers with an awareness of their role in health and safety management and implementation. The course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

6.2 Ward Talk Safety Talks

Ward Talk Safety Talks have been implemented as a method to provide further information, instruction & training to Health Board employees in relation to health and safety matters.

The Ward Talk Safety Talks are short training presentations that are conducted within the working environment and provide safety reminders, brief refreshers and quick lessons on safety topics. The Ward Talk Safety Talks are developed by the Corporate Health and Safety Department and can either be delivered by a member of the Corporate Health and Safety Department or local Ward / Department Manager.

The use of Ward Talk Safety Talks has provided greater opportunity to discuss recent incidents, near misses and everyday tasks. The following Ward Talk Safety Talks have been developed during 2023/24:

- Diesel engine exhaust emissions (DEEE)
- Management & prevention of slips, trips and falls
- Safe use of ladders
- Selecting the right ladder
- Workplace exposure to Entonox in maternity

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6.3 Manual Handling Cascade Trainers Training

To support the delivery of the manual handling training strategy, cascade trainers are nominated in areas across the Health Board. The cascade trainers i.e. Transfer Specialists, Safer Handling Coaches etc. attend foundation training and are required to attend an update every two years to maintain their competency.

The COVID-19 pandemic contributed to a backlog of trainers becoming out of date with their two-yearly refresher. The register of cascade manual handling trainers was cleansed and a programme of updates was delivered in 2023/24. This included 10 update courses for Transfer Specialists with a total attendance of 62 learners.

6.4 Risk Assessment Training

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the Health Board to maintain its legislative requirement and ensuring the provision of competent risk assessors, the Risk Assessor Training course has been revitalised for 2023/2024, 37 courses have been delivered and 295 Health Board Employees trained in Health & Safety Risk Assessment.

The aim of the course is to ensure all participants have an understanding on the concept of risk assessment, when a risk assessment is required within the workplace and how to conduct a suitable and sufficient risk assessment. A training programme has been developed and communicated through the Health Boards structure, further to the delivery of Risk Assessment Training in 2023/2024. There has been positive feedback in relation to the updated course and participants who have attended the training have scored their confidence and ability to conduct a risk assessment highly.

6.6 Fire Safety Training

The compliance data for fire safety training appears acceptable, however, these results are derived from compliance with eLearning modules alone. Staff with the responsibility to evacuate immobile patients require additional, in-depth evacuation training, delivered face-to-face by a Fire Safety Advisor. This requirement is highlighted in the fire safety guidance contained in Welsh Health Technical Memorandum (WHTM) 05:01.

This additional level of training is delivered to all Theatres, Critical Care and similar departments caring for high dependency patients. Unfortunately, concerted efforts by the Fire Safety Team to expand face to face training to all inpatient wards in 2023/24 have been unsuccessful.

There is an aspiration to introduce a programme of face-to-face fire evacuation training for staff on inpatient wards in 2024/25. However, this will require a review of Health Board resources to deliver this effectively.

6.7 Fire Warden Training

Fire wardens at Health Board premises perform a vital function in maintaining safe environments. Their role during fire emergencies is as a *critical friend* to department and ward managers who are responsible for initiating and managing evacuations.

Key functions of fire wardens include the continual monitoring and completion of monthly safety checks of their areas to identify fire safety problems. They provide the valuable service of liaison with the Fire Safety Advisors to provide early warning and resolution of potential safety issues.

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The Fire Safety Team continue to promote the role via the fire risk assessment process with the goal that every work area in the Health Board has at least one fire warden assigned.

An additional 73 fire wardens were identified and attended training in 2023/24.

6.8 Fire Response Team Training

Following liaison with the operations directorate and site management teams, training has been provided (in line with the training needs analysis) for fire response teams at County Hospital, Grange University Hospital, Nevill Hall Hospital, Royal Gwent Hospital and Ysbyty Ystrad Fawr Hospital.

The training included awareness of how the buildings are constructed to limit fire spread, site specific evacuation procedures and facilities on site to allow movement of patients between floors i.e. escape stairs, evacuation lifts and sprinkler isolation, where appropriate.

6.9 Fire Drills & Exercises

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust.

In 2023/24, The Fire Safety Team carried out 12 fire exercises across the Health Board. The majority of the exercises were conducted on Acute Hospital sites and the areas were both clinical and non-clinical, including Inpatient areas and Theatres.

An evacuation exercise was conducted at Ysbyty Ystrad Fawr in 2023/24 which included engagement from South Wales Fire & Rescue Service.

7 RIDDOR REPORTING

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded. Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the Health and Safety Executive (HSE).

The reporting process to the HSE is undertaken by the Corporate Health and Safety Department.

During the period of April 2022 to March 2023 the Health Board reported a total of 79 incidents to the Health & Safety Executive which met the criteria of being reportable under RIDDOR. 49% of these incidents were reported outside of the legal reporting timeframes.

This highlighted the significant need for improvement in ensuring that all areas are fully aware and compliant with their RIDDOR duties. Non-compliance with RIDDOR duties can have severe consequences, both in terms of Health & Safety and legal ramifications for the Health Board.

To address this, the Health Board has undertaken a comprehensive review and enhancement of its processes.

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The Standard Operating Procedure (SOP) for RIDDOR has been updated to reflect the latest requirements and best practices.

A new RIDDOR Awareness Training Session has been developed. This training is designed to provide all managers with a clear understanding of their duties under RIDDOR, ensuring that they can fulfil their responsibilities effectively.

A RIDDOR Compliance Dashboard have been established within the Datix Cymru system to enable Divisions to proactively monitor their RIDDOR compliance and identify areas of good practice, but also areas of further improvement. Compliance with RIDDOR is a health and safety performance indicator and will be included in the Divisional Assurance Reviews in the future.

The total number of RIDDOR reportable incidents reported to the HSE in 2023/24 was 90 incidents. This is a 13.9% increase on the number reported in 2022/23. (*See figure 1*)

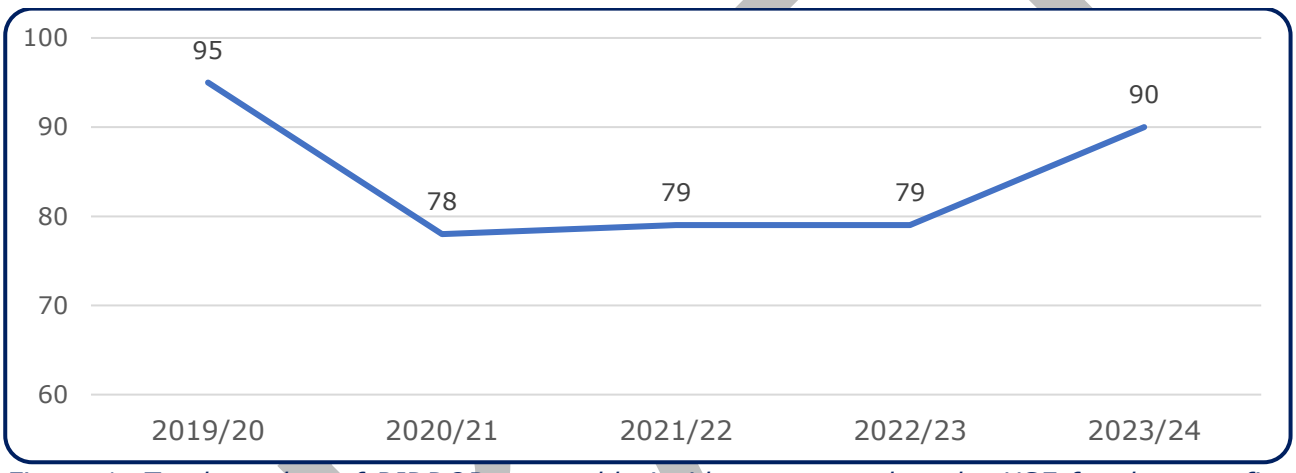

Figure 1: Total number of RIDDOR reportable incidents reported to the HSE for the past five financial years

In 2023/24 there has been one fatal incident reported, a patient fall. The same number of fatal incidents reported in 2022/23. Over-seven-day incapacitation of a worker are the highest reported classification in 2023/24 with 57 incidents reported, an increase of 4 incidents compared with 2022/23. The number of specified injuries has risen from 18 incidents reported in 2022/23 to 26 in 2023/24. *(See figure 2)*

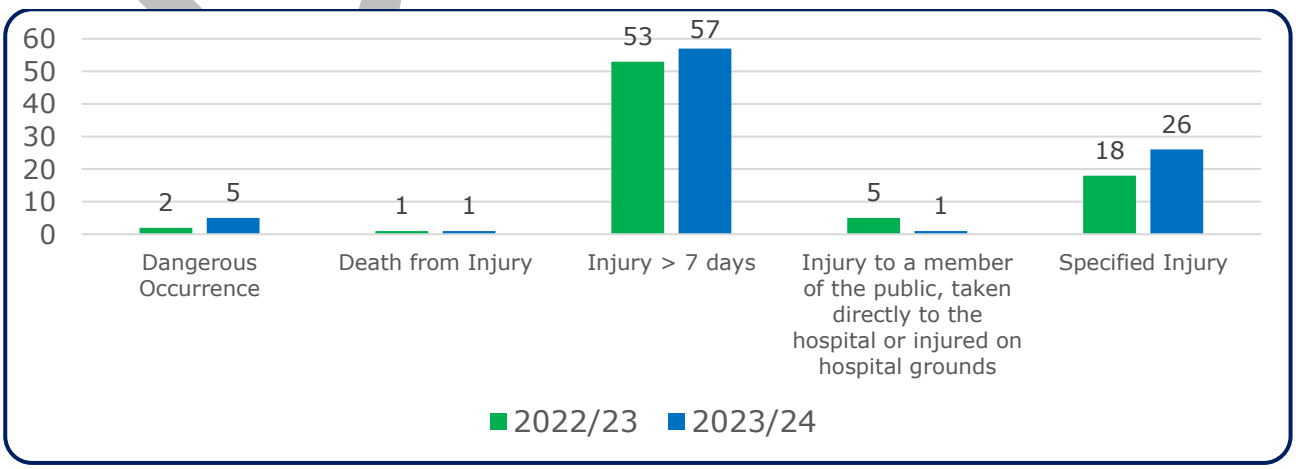

Figure 2: RIDDOR reportable incidents by classification reported to the HSE for 2023/24

Slips, trips and falls to staff continue to be the highest type of RIDDOR reportable incident reported to the HSE. The 38 slips, trips and falls reported in 2023/24 was a slight increase from the 35 reported in the previous financial year.

There was a 109% increase in the number of abuse to staff RIDDOR reportable incidents reported to the HSE in 2023/24 (23) compared with 2022/23 (11).

Manual handling RIDDOR reportable incidents have decreased by 67% from 20 in 2022/23 to 12 in 2023/24. *(See figure 3)*

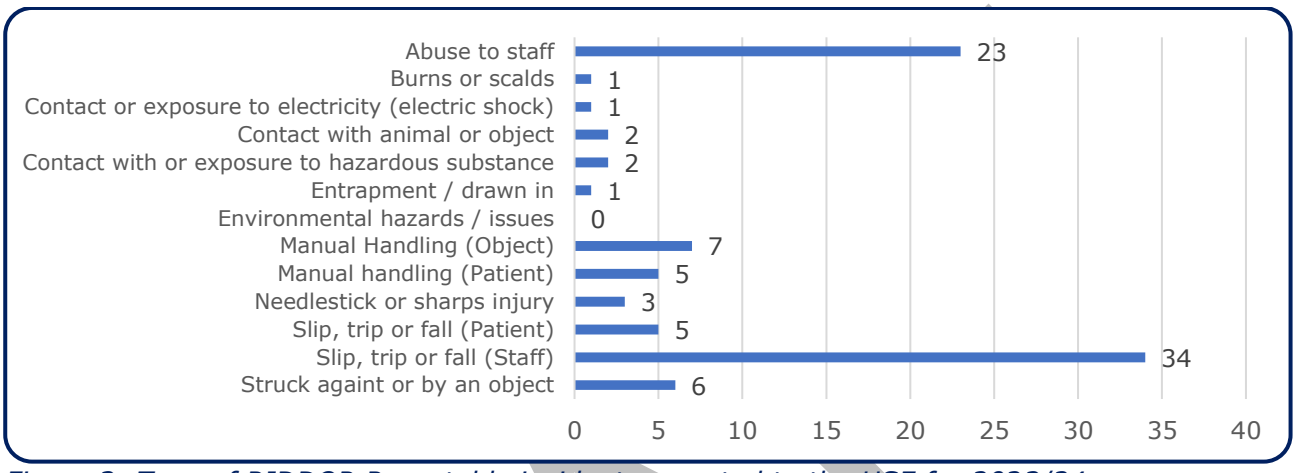

Figure 3: Type of RIDDOR Reportable incidents reported to the HSE for 2023/24

RIDDOR reporting compliance for 2023/24 was 67.7% an 18% improvement on the compliance reported in 2022/23 (49.4%).

8 LEARNING FROM EVENTS

The Corporate Health and Safety Department has implemented various communication methods to support learning from incidents across the Health Board.

As part of these methods, information is cascaded through Health and Safety performance reports, post investigation meeting de-briefs, amendment to relevant health and safety training packages and organisational alerts.

During 2023/24 there have been twelve information sheets issued which relate to the following:

- HSI-2023-001 – Fire Safety Arrangements – Royal Gwent Hospital
- HSI-2023-002 – Management of hoist batteries
- HSI-2023-003 – Hazard Identification – Mental Health Garden Inspections
- HSI-2023-004 – Labelling of High-Risk Samples
- HSI-2023-005 – Management of Banner Stand Displays
- HSI-2023-006 – Risk posed by items in the vehicle footwell
- HSI-2023-007 – Management of Hazardous Substances
- HSI-2023-009 – Hazard Identification (Slips, Trips and Falls)
- HSI-2023-010 – Safe Movement & Transportation of Beds
- HSI-2024-001 – Management of Bed and Air Pump Power Cords
- HSI-2024-002 – Survival Bracelets in Mental Health Units
- HSI-2024-003 – Unauthorised Access Tailgating

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The Corporate Health & Safety Department has provided support to Legal Services in relation to Personal Injuries Claims by assisting in the investigation process, supplying necessary documentation, and facilitating the identification and communication of key learnings from events to prevent future occurrences.

An example of this collaboration occurred after an incident in which a Health Board employee sustained an injury due to a fall within a Mental Health Unit Garden. The employee was assisting a service user in the garden area and tripped over a protruding tree stump which caused obstruction on the garden pathway. In response, the Corporate Health & Safety Department conducted an investigation into the incident, which led to the development of a Mental Health Unit Garden Inspection Checklist. This checklist serves as a proactive tool to identify and mitigate potential hazards within mental health garden environments. This includes specific examples of common risks, such as uneven pathways, poor maintained greenery, inadequate lighting, security deficiencies, along with recommended corrective actions. The checklist is now an integral part of the safety measures implemented, ensuring that similar incidents are less likely to occur in the future by promoting regular inspections and prompt hazard management.

10 HEALTH AND SAFETY

10.1 Health and Safety Monitoring

The Corporate Health & Safety Department initiated a programme of workplace health, safety, and environment inspections spanning from December 2023 to March 2024.

These inspections align with the Workplace (Health, Safety and Welfare) Regulations 1992, which encompass fundamental health, safety, and welfare concerns applicable to the Health Board.

The inspection criteria have been developed based on the stipulations outlined in the Regulations, as well as consideration of other pertinent workplace hazards. The inspection criteria included:

- Lighting
- Noise
- Prevention of Slips, Trips, & Falls (including falls from height and falling objects)
- Temperature & Ventilation
- Workstations, Seating, Furniture, and Fittings
- Welfare Facilities
- Cleanliness, Waste Management, & Sharp Safety
- Access and Egress
- Electrical Equipment
- Handling of Chemicals & Hazardous Substances
- Prevention of Violence & Aggression
- Alert Systems & Communications
- Provision of First Aid

A goal was established to complete health, safety, and environment inspections for all inpatient areas across Acute Hospital sites by the end of March 2024. This objective has been successfully met, with a total of 51 inspections carried out.

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These assessments yielded an average Health Board compliance score of 88.2%. The table below offers a detailed breakdown of the number of inspections completed per site and the corresponding site compliance score (average).

Site	Total Number of Inspections Completed	Site Compliance (Average)
Grange University Hospital	16	90.1%
Nevill Hall Hospital	8	89.6%
Royal Gwent Hospital	18	84.8%
Ysbyty Ystrad Fawr	9	91.2%

The inspections revealed both areas of compliance and areas requiring attention to ensure a safe working environment. While an average Health Board compliance score of 88.2% indicates overall adherence to regulations, specific areas of concern were identified of which further attention is required.

The main findings of the health, safety and environment workplace inspections are as follows:

Control of Substances Hazardous to Health (COSHH)

- Most areas lacked COSHH Inventories and Assessments.
- Employees lacked clarity on accessing COSHH Assessments and understanding precautionary measures for substance use.
- Cleaning substances, such as Actichlor solution, were frequently left unattended without proper storage and security measures.

Electrical Equipment Checks

- While user checks on electrical equipment were noted, there was insufficient evidence to confirm regular checks.

Tripping and Entrapment Hazards

- Cables supplying air mattresses and electric profiling beds were often positioned in ways that posed tripping and entrapment risks.

Unauthorised Access

- Various areas within ward environments were frequently left open, allowing unauthorised access.

Signage for Anti-Violence Measures

- Absence of signage regarding NHS Wales Anti-Violence Posters was noted.

Seating for DSE Use

- In some clinical areas, ergonomic office chairs were utilised but often had castors unsuitable for the flooring type.

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General Condition of Premises

- Flooring was generally in good condition with no significant defects or obstructions affecting safety.
- Lighting levels were found to be adequate for activities within the areas.
- Window restrictors limiting window opening were robust and tamper-proof.
- No workplace noise issues were identified, and employees did not raise concerns.
- No defects such as exposed wiring or damaged casing were identified.
- Workplace temperature was considered reasonable, and concerns regarding thermal comfort were limited.

Provision and Access to Welfare Facilities

- Welfare facilities such as break rooms and W/Cs were routinely available.
- Facilities for heating food/drinks and storing personal items were provided.

Employee Awareness and Reporting

- Employees demonstrated substantial awareness of how to raise health and safety concerns and report accidents, incidents, and near misses.

Where actions in relation to non-compliance have been identified, these areas must be addressed in order to reduce the likelihood of accident and ill health and to close any gaps in compliance. The responsible person must ensure that sufficient progress notes are recorded within the assigned action point detailing the action(s) taken to address and remedy the identified non-compliance.

As part of the 2024/25 Corporate Health & Safety Department monitoring programme, further workplace health, safety and environment inspections have been scheduled. These will be conducted for all inpatient areas across Community Hospitals and Mental Health & Learning Disabilities sites. The programme will also include a review of outpatient settings across both Acute and Community Hospitals.

10.2 Health and Safety National Meetings

The All-Wales Health and Safety Management Steering Group represents Health & Safety professionals working in NHS Wales in all areas of health and safety management, providing a forum to network, share best practice and work collaboratively to develop improvements in health and safety.

The group represent all NHS organisations, recognising the importance of providing informative and stimulating meetings, workshops, and seminars for the continued professional development of all members.

The purpose of the All-Wales Health and Safety Management Steering Group is to:

- Discuss all areas of health and safety management to ensure compliance with the legislative and regulatory frameworks in place for managing health and safety effectively.
- Share lessons learned and best practice identified for effective health and safety management.
- Encourage strong leadership in health and safety and championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.
- Where appropriate, advise the Health Boards and Trusts on where and how, its health and safety management may be strengthened and developed further.

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The aims of the group are to:

- Support members to develop the health and safety management arrangements within healthcare organisations.
- Provide a forum in which health and safety risk and issues can be debated, to ensure effective communication of ideas, sharing of experiences and areas of best practice.

Subgroups and workstreams have been established to review current health and safety practice is specific areas and develop minimum standards for implementation across NHS Wales.

During 2023/24 an All-Wales Health & Safety Workstream has been developed in relation to Health & Safety Incident Codes recorded within Datix Cymru. The purpose of this workstream is to standardise the Health & Safety Incident Codes for all NHS organisations in Wales in order to reduce barriers to incident reporting and to improve the quality of incident data which will further support in identifying learning from incident themes and trends.

10.3 Reinforced Autoclaved Aerated Concrete (RAAC)

The Corporate Health & Safety Department has conducted comprehensive Risk Assessments in areas of Nevill Hall Hospital (NHH) where Reinforced Autoclaved Aerated Concrete (RAAC) has been identified during structural surveys.

To ensure safety, Acrow props have been installed in these areas. The Risk Assessments focus specifically on evaluating the hazards and potential risks associated with the introduction of Acrow props into the working environment.

The assessment aims to mitigate any risks posed by the structural supports, ensuring that the hospital environment remains safe for both staff and patients. The Risk Assessments have been recorded within the Datix Risk Module and local Department risk leads have been assigned to enable ongoing management of the risk.

As part of the governance arrangements in relation to the management of RAAC, the Corporate Health & Safety Department attend the RAAC Fortnightly Governance Group of which the group focus is on the actions that have been taken and the ongoing management of the challenges enabling wider discussions of service implications and also remediation plans.

10.4 Falls Awareness Campaign

During Falls Awareness Week in September 2023, the Corporate Health & Safety Department actively supported the campaign by introducing a Slips, Trips, and Falls Hazard Spotting Checklist. This checklist was specifically designed to help departments and areas identify common hazards and assess potential risks related to slips, trips, and falls in the workplace. The checklist provides examples of hazards that can be found in and around workplaces, and suggests actions that can be taken to resolve them.

Additionally, a comprehensive presentation on the Management and Prevention of Slips, Trips, and Falls was delivered throughout the week. This presentation aimed to educate employees on best practices for minimising these risks and to reinforce the importance of maintaining a safe working environment.

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10.3 Health and Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2023/24. *This excludes violence and aggression and fire incidents as these are reported on in the relevant sections of this report.*

Figure 4 indicates an increase of 21.1% in the number of reported incidents affecting staff, contractors or visitors compared with last five financial year.

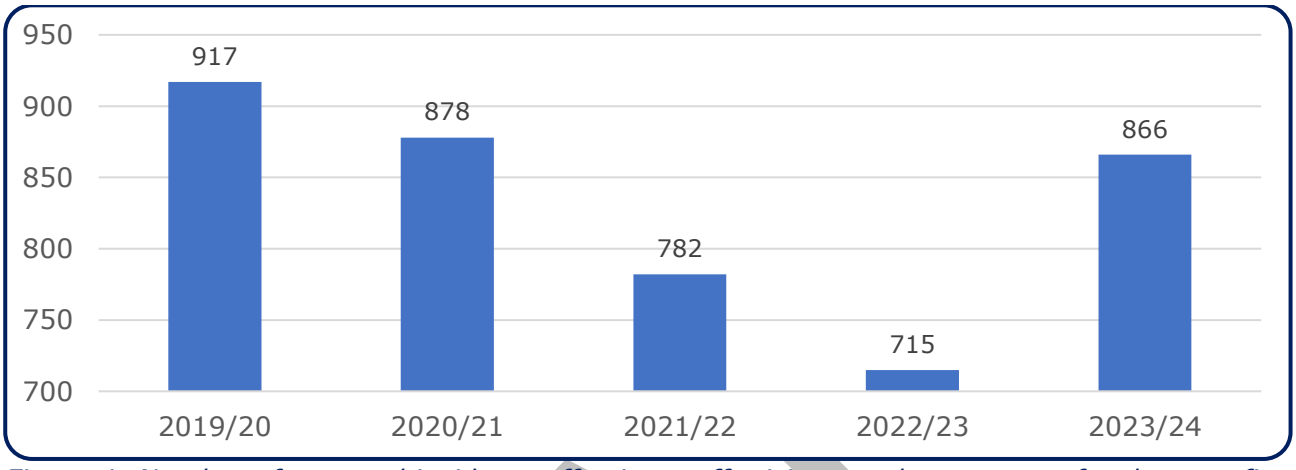

Figure 4: Number of reported incidents affecting staff, visitors and contractors for the past five financial years

Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (189 incidents), however, this is a slight reduction on the number of incidents reported during 2022/23. *(See figure 5)*

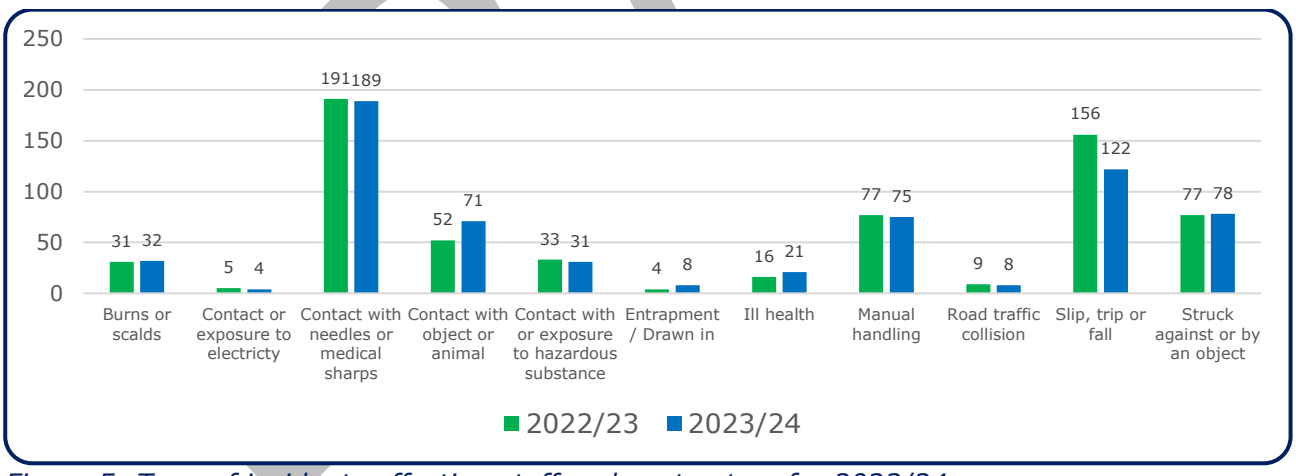

Figure 5: Type of incidents affecting staff and contractors for 2023/24

The number of sharps incidents reported in 2023/24 has reduced by 1% from the previous financial year (191 reports). The incidents from contaminated / used sharps devices have also reduced in 2023/34. *(See figure 6)*

It is difficult to obtain data on the number of tasks or procedures carried out across the Health Board using needles or medical sharps. However, based on the incidents reported and the significant number of tasks and procedures the incident rate would be very low.

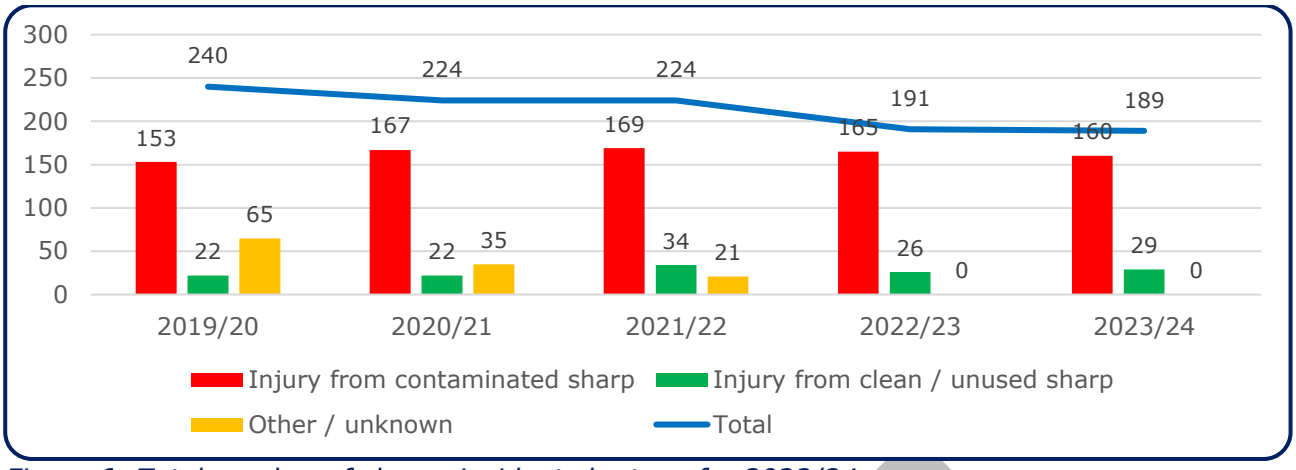

Figure 6: Total number of sharps incidents by type for 2023/24

To identify learning outcomes from sharps incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix system.

The revitalisation of the health and safety monitoring programme included an assessment of clinical area's adherence to best practices for the safe use of sharps. This assessment was designed to ensure that areas comply with the standards set out within the Health Boards Sharps Policy, and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

As part of the inspection process, wards were specifically monitored for their procedures regarding sharps use and disposal of sharps. This includes the availability of safety engineered devices, the availability and correct use of sharps trays and sharps containers and adherence to protocols designed to reduce the likelihood of needlestick injuries and other sharps related incidents.

Throughout the inspections, instances of good practice were routinely identified. These practices provide assurances of compliance with best practice guidelines and legislative requirements. The findings of these inspections have also supported the development of training information such as Ward Talk Safety Talk on the Safe Use of Sharps in order to further reinforce best practices.

The outcomes of the monitoring are reported to the Health and Safety Committee.

Slip, trip or falls is the second highest reported health and safety incident category affecting staff or contractors (122 incidents). *(See figure 6)*

The number of slips, trips and falls incidents to staff, contractors or visitors reported in 2023/24 has decreased by 20.1% from the previous financial year (139 reports). *(See figure 7)* These types of incidents continue to be the highest reported to the HSE in accordance with RIDDOR and personal injury claims.

Most of the reports in 2023/24 were categorised as 'Fall on a slippery or wet surface' (32), 'Trip or fall over an object or obstacle' (16) or 'Fall on uneven ground' (9) which is a significant reduction from the previous year's reporting.

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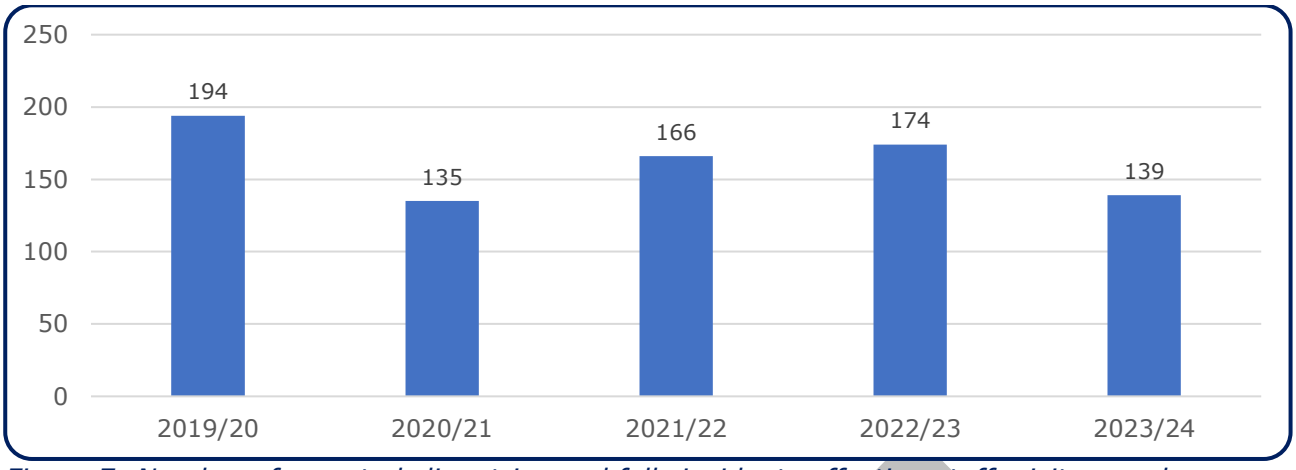

Figure 7: Number of reported slips, trips and falls incidents affecting staff, visitors and contractors for the past five financial years

10.3 Face Fit Testing

The Covid-19 Pandemic has brought an increased requirement for the use of Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE) within healthcare settings. Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Face Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

The delivery of Face Fit Testing continues to remain a key tasking for the Corporate Health and Safety Department with weekly Face Fit Testing sessions being offered across the Health Board. Since March 2020 the Corporate Health & Safety Department have conducted over 15,000 individual Face Fit Tests.

To enable the Health Board to maintain compliance with Face Fit Testing requirements a comprehensive review of the Health Boards Face Fit Testing Strategy and Face Fit Testing resource allocation has been undertaken. The review was endorsed by the Infection Prevention & Antimicrobial Stewardship Group and requires escalation to the Executive Committee for consideration.

11 FIRE SAFETY

Fire safety is an umbrella term covering fire prevention and fire precautions. The principal requirements of fire safety legislation are:

- To reduce the probability and severity of a fire occurring within a building.
- To ensure that persons are kept safe or can safely evacuate a premises in the event that a fire occurs.

Fire has the potential to cause widescale damage and disruption of NHS services that could have a serious consequence for service users. Therefore, in addition to life safety, property protection and business continuity are key aims of the Health Board fire safety policy.

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The principal legislation governing fire safety in the UK is The Regulatory Reform (Fire Safety) Order 'RRO', that came into force on 1st October 2006. The RRO places liability on responsible persons within an organisation to take general fire precautions for the protection of the relevant persons.

The legislation applies a system of vicarious liability to organisational leaders. The responsible persons in the Health Board are principally directorate and departmental leaders.

The Executive Director of AHPs & Health Science is the Executive Director with delegated responsibility to ensure compliance with Fire guidance, current fire safety legislation and responsibility for ensuring that fire safety issues are highlighted at Board level. In particular they will ensure, by delegation to The Fire Safety Manager that fire safety policy is promulgated, and that Fire Risk Assessments are completed to record the general fire precautions required for all areas.

Individual Board Level Directors and The Board as a collective are responsible for ensuring compliance with the Health Board Fire Safety Policy and that the general fire precautions are applied within the scope of their areas of control.

The following summary profile gives brief details of this Health Boards development towards compliance with the minimum mandatory requirements for the NHS in Wales.

11.1 Provision of Officers with Specific Fire Safety Responsibilities

Health Boards are required to provide a structure of Fire Safety Management within their organisations aligned with WHTM 05:01.

The structure is based on delegated responsibility of fire safety functions to functional roles within the organisation. The nominated offers are accountable for fire safety functions assigned to them.

Fire Safety Protocol 031 Roles and Responsibilities for Implementation details the roles and delegated responsibilities for fire safety within the Health Board. An update to this protocol is required. The current protocol contains some ambiguity where responsibilities overlap and are assigned to multiple roles. In addition, a more robust method of communicating responsibilities to the duty holders is required.

In addition to the designated roles mentioned above, it should be understood that leaders are accountable for adherence to fire policy in any areas that are under their control or influence.

11.2 Fire Safety Risk Management

The Health Board are legally required to carry out and record fire risk assessments at all sites. The legislation requires that assessments are to be *suitable and sufficient* and reviewed on a regular risk-based approach.

Fire risk assessments must be carried out when staff first occupy an area, and reviewed:

- When staff change venue
- When structural changes are made to a work area
- If new hazards are reported or become apparent
- Periodically to ensure accuracy is maintained as set out in the table below

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Type of Area to be Assessed	Frequency of Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation	12 months
Other than above but areas provided for public access such as outpatient facilities	24 months
Other than above. Areas not provided for public access such as offices, plantrooms etc.	36 months

During the period April 2023 to March 2024 the Fire Safety Team completed 258 programmed fire safety risk assessment reviews. This represents 96% of the programmed assessments. The figures for major sites are displayed in the table below:

Hospital	Annual Assessments	Bi-annual Assessments	Tri-Annual Assessments
County Hospital	5	8	2
Grange University Hospital	26	2	1
Nevill Hall Hospital	20	12	7
Royal Gwent Hospital	28	19	10
St Cadocs Hospital	7	1	8
St Woolos Hospital	8	0	7
Ysbyty Aneurin Bevan	5	0	2
Ysbyty Ystrad Fawr	11	13	0

In addition to the above the Fire Safety Team completed fire risk assessments to:

- Support various moves of departments at the Royal Gwent, St Woolos and Nevill Hall Hospitals.
- Assess and record hazards associated with RAAC at Nevill Hall Hospital.
- Support the opening of The Bevan Heath and Welling Centre and the new Breast Care Unit at Ysbyty Ystrad Fawr.

A register of the risks identified during the assessment process is handled by the Fire Safety Team and recorded on the DatixWeb system. The table below highlights the current fire safety risks by category.

Fire Safety Category	Number of risks
Fire Alarm Systems	26
Fire Door Replacement/Upgrade	37
Compartmentation	23
Hazard Room Protection	10
Fire Door Fastenings	12
Other	29

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The decision taken by the Health Board to provide sprinkler protection at new hospitals has produced massive benefits for the management of fire safety at the relevant premises. The hospitals are relatively risk free with no significant fire safety issues.

The major fire safety risks held on the system are legacy fire risks at older building stock including Royal Gwent and Nevill Hall Hospitals. These premises remain a priority for resolution and are likely to dominate the Fire Safety Discretionary Capital spend for the foreseeable future.

11.3 Planning and Implementing Fire Safety Improvement Works

The duties of the Fire Safety Manager include planning and implementing a programme of improvement works to remove or mitigate fire risks carried by the organisation.

During 2023/24 improvements have been made in the following areas to ensure the Health Board meets minimum safety standards and fulfils its legal requirements.

Site	Area	Improvement
Nevill Hall Hospital	First Floor	Replacement fire alarm system
Royal Gwent Hospital	Whole Site	Installation of a fibre optic cable network and new *Gent* fire alarm panels
Royal Gwent Hospital	Various Departments	Installation of new fire detectors connected to the new *Gent* panel system and controlled by a graphical interface monitor

In addition to the above there has been a continued incremental improvement across all building stock.

11.4 Key Fire Risks

The key residual fire risks carried by the Health Board are related to management of the aging infrastructure and degradation of fire protection at older acute hospitals, namely the Royal Gwent and Nevill Hall Hospitals.

The safety of large numbers of inpatients at these hospitals relies on the capability of the alarm systems to give early warning of fire and the capability of fire walls and fire doors to stop the spread of fire through the buildings.

Fire Alarm Systems: The fire alarm systems at both hospitals have safety issues. At Nevill Hall Hospital the detectors in the inpatient areas and the staff residencies are 4 years older than their recommended life. In other 'backroom' areas 28-year-old detectors that have a 14-year recommended lifespan are still in use.

At the Royal Gwent Hospital, the situation is more severe. The control panels that monitor the detectors on the system are obsolete and spare parts are no longer being manufactured. On two occasions in 2023/24 fire alarm panels have failed resulting in the loss of detection to whole departments. On these occasions spare parts were obtained and repairs were made but there are no guarantees that this will continue to be the case.

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A network of replacement panels is in place alongside the obsolete panels and some mitigation can be provided by systematically installing new detection in areas, transitioning to the new system and harvesting the replaced older panels for spare parts. This process has commenced but is facing significant obstacles including a lack of a clear funding strategy.

Fire Walls and Fire Doors: The safety of inpatients at the Royal Gwent and Nevill Hall Hospitals relies on the ability of the structure of the buildings to withstand fire and stop fire spread between wards.

Management of fire barriers fitted across hospital sites is problematic. The Fire Safety Team are working collaboratively with Facilities to introduce measures to ensure that fire barriers are effectively managed and protected.

A survey conducted at Nevill Hall Hospital has identified extensive works that is required to fix damage to the fire walls.

Applications for funding in 2023/24 to carry out remedial works at Nevill Hall Hospital and commission a compartmentation survey at The Royal Gwent Hospital were unsuccessful.

11.5 Emerging Risks

Capital investment is required to mitigate fire safety risks in the following areas.

- Expand the new fire alarm system at Royal Gwent Hospital and reduce the number of areas covered by the old system
- Replacement of end-of-life fire detectors on Levels 3 & 4 at Nevill Hall Hospital
- Replacement of end-of-life fire detectors at County Hospital
- Replacement of end-of-life fire detectors at Ysbyty Aneurin Bevan
- Replacement of the fire alarm system in the old hospital buildings at St Woolos Hospital (the system is not acceptable to modern standards, however clarity on the future use of the buildings is required before a commitment to spend circa £300k on a replacement system can be made)
- Establishment of a system to manage compartmentation to avoid a damage and repair cycle.
- Risks associated with aging electrical infrastructure on older sites.
- Risks associated with aging ventilation infrastructure (Fire Dampers) for inpatient areas on older sites.

11.6 Planned Improvements

The following improvement schemes are planned to be completed in 2024/25.

- Partial replacement of the fire alarm system at Royal Gwent Hospital Site including fitting new detection and transition of levels 6 & 7 C & D Block to the new fire alarm network.
- Full replacement of the fire alarm system at St Cadocs Hospital.
- Repairs to fire partitions on Ward 4/1 at Nevill Hall Hospital.
- Replacement of 30-minute fire doors with 60-minute fire doors on ward 4/1 at Nevill Hall Hospital.
- Replacement of out-of-date detectors on level 4, including wards 4/1, 4/2, 4/3 and 4/4 at Nevill Hall Hospital

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11.7 Future Challenges and Priorities for the Fire Safety Team

The strategic goals for the Fire Safety Team are to improve fire strategies at older hospitals while replacing older, complex and costly alarm systems with modern systems incorporating graphics information displays that are easier to manage and more economical to maintain.

A lack of available information on safety systems at these buildings continue to pose challenges in the move away from generic fire safety strategies to the provision of detailed, site specific fire safety building strategies. Continued improvement will rely on acquisition of reliable documents such as:

- Fire Zone Plans
- Fire Alarm Cause and Effect Matrices
- As Fitted Fire Alarm System Device Drawings
- Fire Damper Plans
- Detailed Fire Evacuation Plans
- Detailed Fire Evacuation Notices for Staff and Visitors
- Detailed Fire Response procedures

11.8 Fire Safety Advice and Support for Internal and External Partners

The Fire Safety Team provides advice and support to both internal and external partners across a variety of issues affecting fire safety.

Internal queries include advice and assessment of risk posed by shutting off areas to allow building work and application of building regulations for the repurposing of individual areas within a hospital.

External queries range from assessment of the suitability of fire safety building materials, design of cause and effect for fire alarm systems to active consultation with project managers on fire safety building regulations and fire strategies during the planning phase of new builds.

On completion of projects the Fire Safety Team provide training, risk assessment and updated fire safety strategies for new or repurposed areas and buildings.

The Fire Safety Team has been involved in the following projects currently being progressed or completed within the last financial year:

- Adoption of Chepstow Community Hospital from PFI
- Extension to Emergency Department (ED) at the Grange University Hospital
- Satellite Radiology Unit at Nevill Hall Hospital
- Newport East Wellbeing Centre and Temporary Accommodation
- Upgrade to Pharmacy at Royal Gwent Hospital
- Decontamination Suite at Royal Gwent Hospital
- Crisis Hub at St Cadocs Hospital
- Replacement Roof Glen Usk Suite at St Cadocs Hospital
- The Bevan Health and Wellbeing Centre

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11.9 Fire Safety National Groups

In addition to their duties for the Health Board the Fire Safety Team are actively engaged as members of The National Association of Healthcare Fire Officers (NAHFO). Fire advisors attend regular meetings of the Wales Branch of NAHFO where they receive updates on fire safety building regulations and legislation and discuss common issues and best practice with colleagues from the other health boards in Wales and Shared Services fire advisors.

The Fire Safety Team are also involved in the All-Wales Fire Safety Managers Group. The group is engaged in the development of a number of All Wales Fire Safety protocols, the Health Board currently chair the working group on Control of Ignition Sources and contribute to groups working on Fire Safety Training and Fire Safety Considerations for Bariatric Patients on Healthcare Premises.

11.10 Fire Safety Incident Reporting

There has been a reduction in the number of fires in 2023/24 compared with 2022/23.

The number of unwanted fire signals (UwFS) reported in 2023/24 has seen a 22.6% increase compared with 2022/23 (See figure 8).

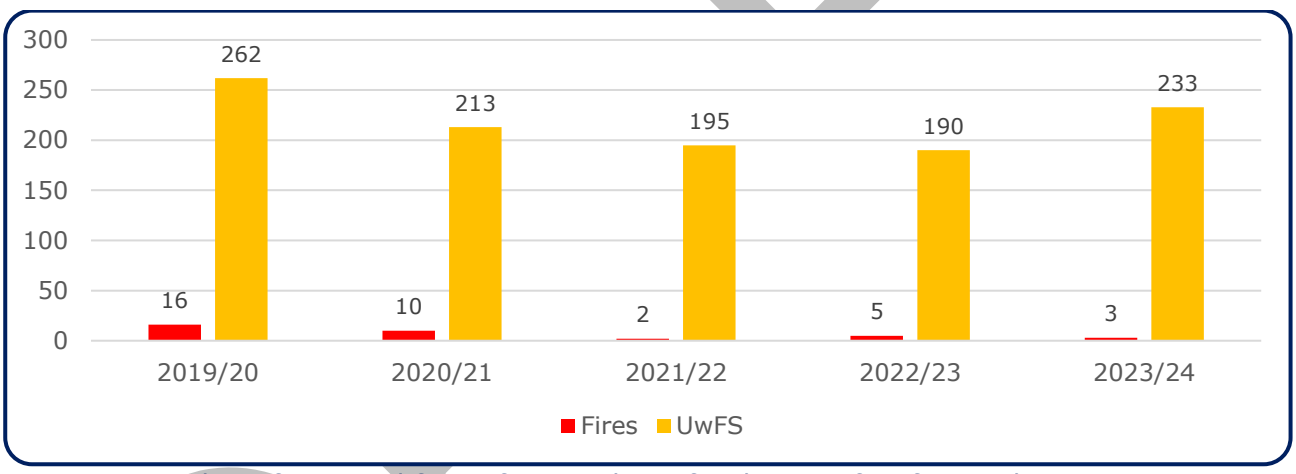

Figure 8: Number of reported fire safety incidents for the past five financial years

The increase in unwanted fire signals is largely due to the rise in fire activations at County Hospital (56.5%) & Royal Gwent Hospital (33.9%). Figure 9 provides a comparison on the number of unwanted fire signals by hospital.

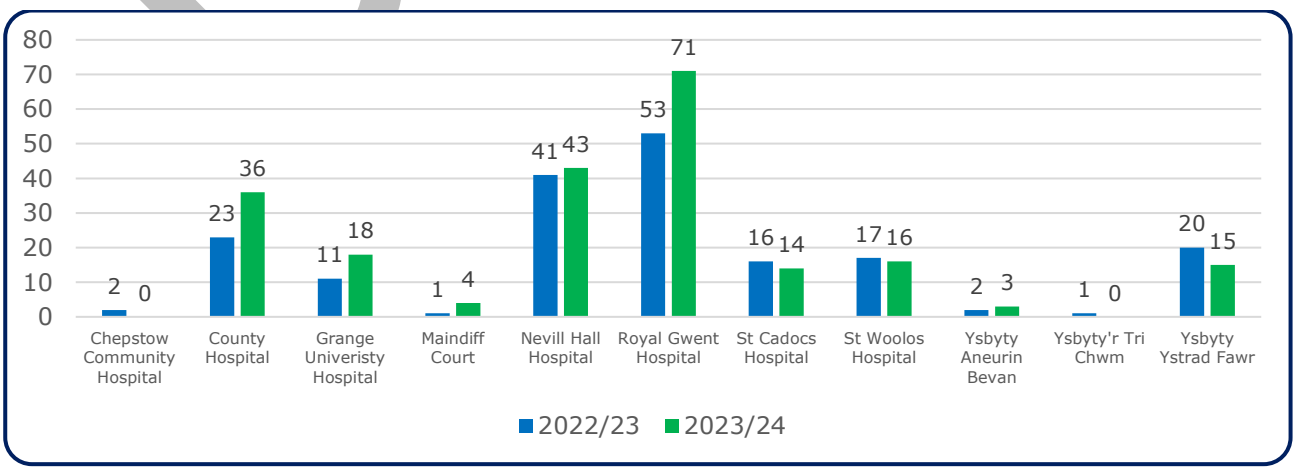

Figure 9: Number of reported unwanted fire signals by Hospital

Although the largest percentage increase in unwanted fire signals during 2023/24 has been reported against the Grange University Hospital the performance is regarded as acceptable (See figure 10).

Hospital	False alarms including UwFS	Actuation devices	Grade
Chepstow Community Hospital	0	504	no incidents
County Hospital	36	1018	C - 40% reduction in UwFS
Grange University Hospital	18	2978	A - performance should be maintained
Llanfrechfa Grange	6	400	B - 10% reduction in UwFS
Maindiff Court Hospital	4	388	B - 10% reduction in UwFS
Monnow Vale Health & Social Care Facility	0	169	no incidents
Nevill Hall Hospital	43	2850	B - 10% reduction in UwFS
Royal Gwent Hospital	72	4560	B - 10% reduction in UwFS
St Cadoc's Hospital	14	1225	B - 10% reduction in UwFS
St Woolos Hospital	16	953	B - 10% reduction in UwFS
Ysbyty Aneurin Bevan	3	1150	A - performance should be maintained
Ysbyty Tri Chwm	0	130	no incidents
Ysbyty Ystrad Fawr	15	2267	A - performance should be maintained

Figure 10: Unwanted fire signals performance indicators by Hospital for 2023/24

The performance calculations are based on the size of the systems as well as the number of unwanted signals. On this basis, Grange University Hospital generated 0.60 false alarms per 100 devices for 2023/24 compared with 3.54 at County Hospital and 1.56 at the Royal Gwent Hospital (See figure 11).

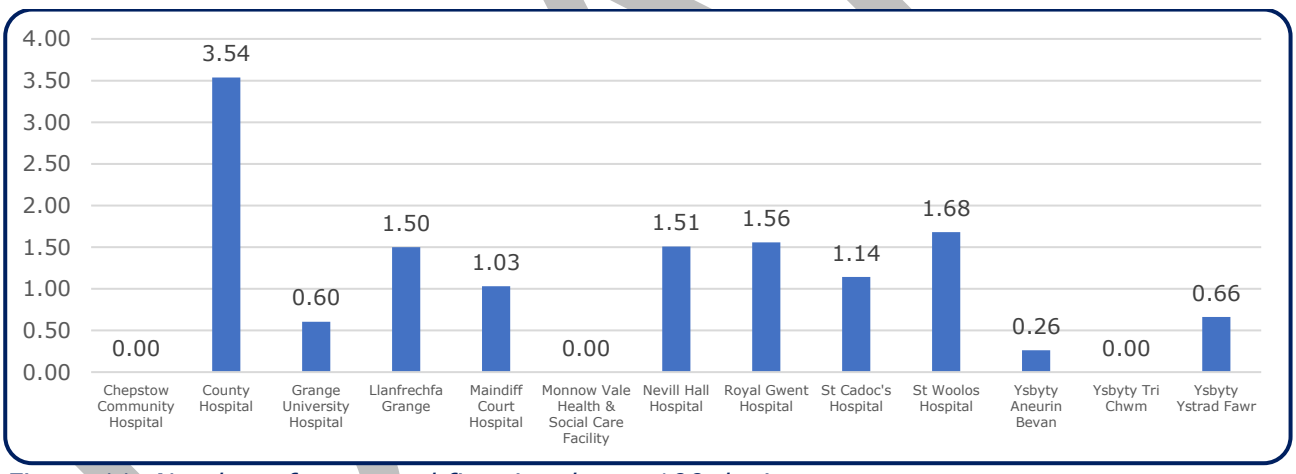

Figure 11: Number of unwanted fire signals per 100 devices

The Fire Safety Team investigate all fires, unwanted fire signals and incidents that are related to fire or any report or incident that may affect fire response.

The purpose of the investigations is to provide data to facilitate a reduction in false alarms and a reduction in the number and severity of fire incidents.

A significant proportion of the unwanted fire signals generated at County and Royal Gwent Hospitals in the period 2023/24 are directly related to the age and condition of the fire alarm systems.

At County Hospital 26 of the 36 unwanted signals were generated by old detectors that are due for replacement. Of the 72 false alarms at Royal Gwent Hospital 12 activations were directly attributed to faults on panels and another 15 to unspecified system faults.

Conversely, the number of unwanted fire signals caused by patients activating call points at County Hospital have reduced from 11 in 2021/22 to 1 in 2023/24 following a project to fit covers to the call points.

During 2023/24 the Health Board experienced two fires of note and two very minor incidents caused by discarded cigarettes in external areas on hospital grounds.

The first notable incident occurred at the Grange University Hospital in a sprinkler pump room in December 2023. One of two heating fans fitted to the room to ensure that the system does not freeze overheated and caught fire. The fire was quickly extinguished using an extinguisher and damage limited to the fan itself. The cause was attributed to a fault in the equipment. A survey was carried out of all heaters used for this purpose and all fans of this type were replaced with alternative models.

The second incident involved a domestic toaster that was in use in a staff kitchen at an office premises. The toaster developed a fault while in use that caused the plastic body to melt and ignite. The item was quickly extinguished using an extinguisher with no damage to the surrounding area. In response a safety notice was circulated to reinforce the policy that domestic toasters are not to be used on Health Board premises and that toasters procured via Procurement must have metal bodies and side panels.

12 MANUAL HANDLING & ERGONOMICS

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment.

Based on current demands the Team's activity is primarily focused on training and improvements in compliance.

12.1 Manual Handling National Meetings

Manual Handling subject matter experts across NHS Wales meet on a quarterly basis to identify and support each NHS organisation with manual handling learning, best practice and action plan going forward.

12.2 Manual Handling Incident Reporting

The number of manual handling incidents reported in 2023/24 has reduced compared with previous years reporting (See figure 12). However, there has been a shift in the number of patient handling incidents and inanimate load handling incidents. Patient handling incidents reported this financial year has reduced by 35.1% from 2022/23.

There has been a 56.5% increase in inanimate load handling incidents in 2023/24 compared with the previous year.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix system.

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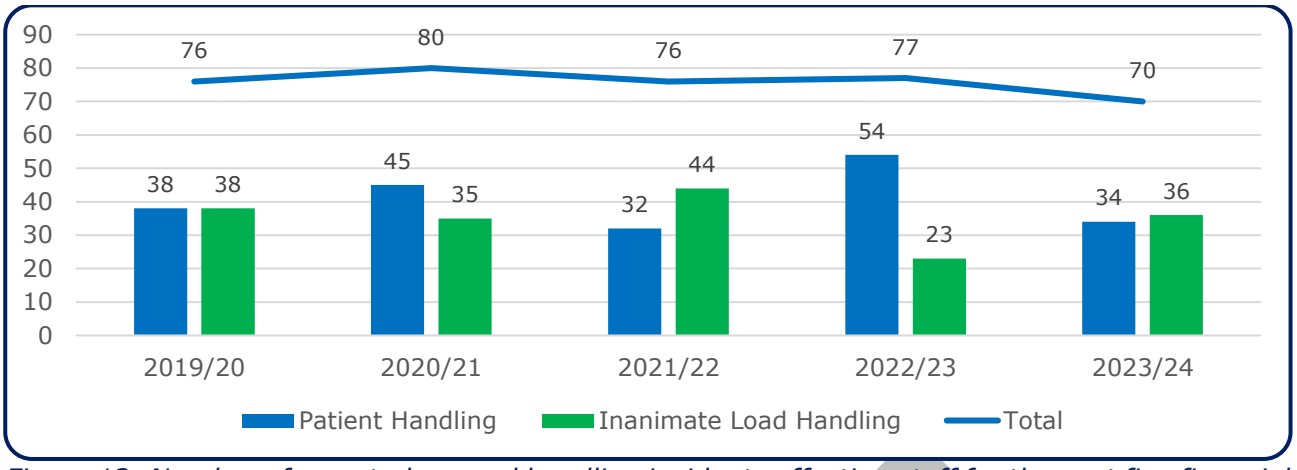

Figure 12: Number of reported manual handling incidents affecting staff for the past five financial years

12.3 Manual Handling Equipment

The Manual Handling Team lead on providing the necessary advice and support to the Health Board in the selection of manual handling equipment to aid in the delivery of care to patients.

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

'Insight' assessments are planned for 2024/25 across all Acute and Community Hospitals. The assessments assess the mobility levels of patients, the type, age and condition of patient handling equipment available and service and routine maintenance information.

The findings will provide the Health Board with the following information:

- Patient handling equipment assessments.
- Identification of aged/obsolete equipment with limited/no service support.
- The need for new equipment to meet patient functional levels and care processes.

12.4 Manual Handling Patient Handling Risk Assessments

The Manual Handling Team have contributed to the implementation of the patient handling Welsh Nursing Care Record (WNCR).

12.6 Display Screen Equipment (DSE)

Since the outbreak of Covid-19 more Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

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To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department in collaboration with the Occupational Health Department have conducted DSE risk assessments for the more complex cases.

13 VIOLENCE & AGGRESSION

It is recognised that NHS staff (Hospital, Ambulance, Community and Primary Care) are among those most likely to face violence and abuse during the course of their employment and there is a strong public interest in prosecuting those who verbally and physically assault NHS staff deliberately.

Following a short hiatus, the Anti-Violence Collaborative (AVC) has been established. Following the group's reinstatement, there was a commitment to refresh the 'Obligatory responses to violence in healthcare document'. The document sets out the responsibilities of healthcare organisations when dealing with incidents relating to violence or aggression in the NHS.

Its focus is on those incidents that need to be addressed by the criminal justice system that includes:

- Improving the reporting of violent incidents.
- Strengthen the investigation and prosecution process by improving the quality and timeliness of shared information.
- Improve victim and witness care and confidence.
- Raise the issues of violence and aggression against NHS staff as well as the action that will be taken by all parties.

The Health Board is committed to the delivery of a safe and secure environment for staff and patients, so that the highest possible standard of care can be delivered. The Health Board plans to launch a new awareness campaign in 2024/25.

13.1 Violence & Aggression National Meetings

The Violence and Aggression Case Managers Group has been established as a Sub-group of the NHS Wales Health and Safety Management Steering Group. The group plays a crucial role in ensuring the safety of both staff and patients by developing and implementing strategies to prevent and respond to violence and aggression.

The purpose of the group is to:

- To provide a collaborative support to NHS V&A Case Managers.
- Ensuring that National Frameworks and Guidance associated with Violence and Aggression Management is successfully embedded and implemented across organisations. E.g. Obligatory Response to Violence and Aggression in Healthcare (ORV) and associated Welsh Health Circular.
- Establish Task and Finish Groups that will be responsible for the development of National Violence and Aggression Standard Operating Procedures/Guidance that can be adopted by NHS Wales E.g. Violence and Aggression Risk Management/

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Assessment.

- The Group is also a forum for partner agencies from the CPS and the four Police Services in Wales, Health and Safety Executive to attend and participate, in order to foster good relationships and to ensure compliance with the aims of the ORV.
- Develop and agree Datix Violence and Aggression related codes. Review coding and changes to the Datix reporting system when necessary.
- Support and contribute to the review of the Violence and Aggression Training Passport and Information Scheme. Particularly in relation to risk assessment module.
- In support of the V&A Case Managers professional development, this Group will facilitate information and training opportunities for its members to participate, either as part of normal agenda or occasional separate events.
- To develop a minimum standard Job Description and Specification for a Violence and Aggression Case Manager.
- To inform the Anti-Violence Collaborative (AVC) of any relevant developments and concerns relating to the management of violence and aggression within NHS Wales organisations and seek support from the collaborative in influencing partner agencies in meeting the principles of the ORV.

13.2 Violence & Aggression Incident Reporting

Reported incidents of violence and aggression have increased in 2023/24 from the previous year by 2.7%. (See figure 13).

Approximately 53% of violence and aggression incidents in 2023/24 were reported from the Mental Health and Learning Disabilities Division. This is the same as the previous year (2022/23).

The increase in physical assaults reported in 2023/24 compared with 2022/23 is comparable with those reported between 2019/20 to 2021/22.

There has been a significant increase (283%) in the number of sexual assaults / sexual inappropriate behaviour incidents reported in 2023/24 compared with 2022/23. The data prior to 2022/23 has not been reviewed. A thematic review of sexual safety incidents is planned for 2024/25.

To ensure quality data is available the Corporate Health and Safety Department will validate all reported incidents of violence and aggression.

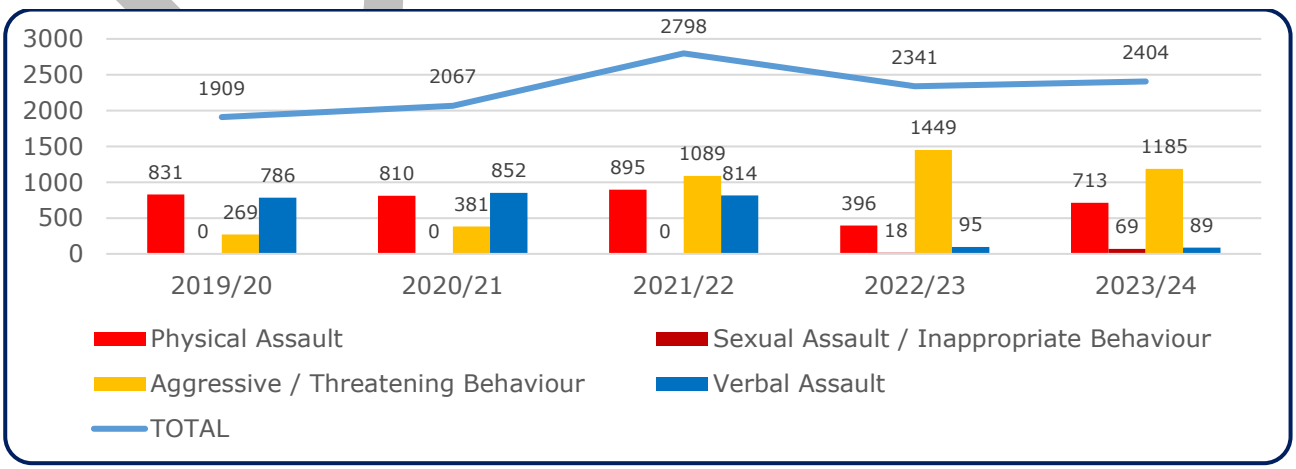

Figure 13: Number of reported violence and aggression incidents for the past five financial years

13.3 Support for NHS Staff Members

The Violence & Aggression Case Management Team continue to support staff who have been subjected to incidence of workplace violence & aggression and where matters relating to personal safety are identified.

Where incidents are reported via Datix Cymru, a Violence & Aggression Case Manager is assigned to the incident and will provide advice in relation to the investigation of the incident, signposting to relevant support services. A new collaborative approach to supporting victims of crime has been implemented and includes Wellbeing Services, Occupational Health and Connect Gwent to offer specialist and bespoke support to Health Board employees.

Between April 2023 and March 2024, the Violence & Aggression Case Management Team has been actively involved in 1,146 incidents, demonstrating their critical role in supporting Health Board Employees who have been subjected to incidents of workplace violence and aggression.

Figure 14 illustrates the Violence & Aggression Incidents with V&A Case Manager Involvement during 2023/24.

Figure 14: Number of violence and aggression incidents with V&A Case Manager involvement

13.4 Engagement with Gwent Police

During 2023/24 the Health Board has further improved its working relationship with Gwent Police, which has resulted in increased collaboration and wider partnership engagement.

As part of these improved relationships the Health Board has also been able to implement a new ABUHB and Gwent Police Violence and Aggression Incident Review group which brings together key Health Board Employees and Gwent Police colleagues where the aim of the group is to implement a multi-agency approach to incidents of violence and aggression to reduce risks and attempt to achieve the safest outcome for the person, emergency services workers and members of the public.

13.5 Police Outcomes

Following a review of reported incidents, the Health Board is engaging with the NWSSP Once for Wales Programme Team to progress enhancements to Datix Cymru to enable accurate recording of outcomes e.g. civil, criminal sanctions in relation to violence and aggression incidents.

The alignment of the terminology used by the Police and Crown Prosecution Service (CPS) with the language used by the Health Board when recording outcomes of crimes will support more accurate and consistent reporting and enable more effective partnership working.

13.6 All Wales Violence Prevention and Reduction Standard

During the period 2023/24, significant progress was made on an All-Wales basis to enhance the management and prevention of violence and aggression within NHS Wales.

A key focus has been on the comprehensive review of the NHS England Violence Prevention and Reduction Standard, with the aim of updating and adopting it as a new Welsh standard.

This collaborative effort has involved stakeholders from across NHS Wales, including health boards, and other key partners such as the Anti-Violence Collaborative. The review process has entailed a detailed assessment of the existing standard, with particular attention to its relevance and applicability within the Welsh healthcare context. This has included evaluating current best practices, identifying potential areas for improvement, and ensuring that the standard aligns with the unique operational, cultural, and regulatory environment of NHS Wales.

The adoption of this updated standard is anticipated to bring several significant benefits to the Health Board, including:

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents of violence and aggression, leading to better data collection, analysis, and accountability. This will enable NHS Wales to monitor trends, identify high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The standard emphasises the importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will not only improve staff confidence and competence but also reduce the likelihood of incidents escalating to physical violence.

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14 CONCLUSION

This report highlights the level of health, safety and fire focussed activity that has been undertaken during 2023/24 to improve the management of health, safety and fire in the Health Board.

The Health and Safety Committee continues to promote the health and safety programme.

The Corporate Health and Safety Department works to actively support the delivery of safe and compliant systems within the context of a health and safety culture. Failure to embed an interdependent and mature health and safety culture presents a risk to the Health Board.

The internal health and safety monitoring programmes are continuously improving as is the ongoing health and safety training programme.

There are challenges in relation to the current level of resource available within the Corporate Health and Safety Department to support the delivery of the legal requirements of health, safety and fire.

The implementation of the health, safety and fire improvement plan in 2023/24 provided a focus for the Health Board on key risk areas. This had a positive reduction on the risk level associated with each area.

An improvement plan will be developed for 2024/25 to address the risk areas for focus. Implementation of the actions, outlined in the improvement plan will support the Health Board to demonstrate continuous improvement and compliance with its legal responsibilities.

An Internal Audit is planned for quarter 4 of 2024/25 to asses the health and safety arrangements within the Health Board.

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RISK THEME	COMPLIENCE AND SAFETY					
SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**				**Publication Status**	**Public**
Strategic Threat	A. Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				**Risk Appetite Level - MINIMAL.** Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.	
Impact	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage				**Risk Appetite Threshold -** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**	
					SUMMARY The current risk level is **OUTSIDE** of target level and **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**	**18 Months**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**3** (*Possible*) x	**2** (*Unlikely*) x		
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*		
Last Reviewed	01 November 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*		
Next Review (Quarterly based on risk score)	01 January 2025					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Health and Safety compliance data extracted from ESR and Datix and reported	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		

• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • H&S processes • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.		

Assurance Rating (*Overall Assessment of controls and assurances)*

Negative – Insufficient evidence that the controls in place are working effectively.	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Negative Assurance**

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer Head of Corporate Governance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report as Appendix 1.

The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

The Forward Work Programme Plan is designed to assist the Committee in the review of its programme of business. It captures the timing of report submissions, identifies items that have been deferred, and captures new requests for reports. The plan also allows the Committee to monitor and review its business at each meeting.

During the period of September to November the following requests and changes to the Forward Work Plan have been included:

Items deferred on the Forward Work Programme:

- Development of Committee Annual Programme of Business 2025/26 deferred to January's meeting;
- Annual Review of Committee Terms of Reference 2024/25 deferred to January's meeting;
- Annual Review of Committee Effectiveness 2024/25 deferred to January's meeting;
- Commissioning Outcomes Report deferred to January's meeting;
- Learning from Death Report deferred to January's meeting;
- Medical Devices Annual Report deferred to January's meeting;
- Radiation Protection Committee Report deferred to January's meeting;
- Nutrition and Hydration Committee Update Report deferred to January's meeting;
- Clinical Advisory Committee Minutes deferred to January's meeting.

Amendments to the Forward Work Programme:

- Clinical Effectiveness and Standards Committee report, included with the Quality Performance report and will be reported on in January's meeting;
- Stroke Delivery Group Annual Report will be removed due to an annual report no longer being required;
- Radiation Protection Group Report name changed to Radiation Protection Committee Report;
- Overview of Audit Internal & External Recommendation Tracking removed from the programme.

Additions to the Forward Work Programme:

- Closure of Incident Dates SBAR, included to be reported in November's meeting as part of the Quality Performance report;
- Serious Incident Learning Report to be reported in November's meeting;
- Pharmacy and Medicines Management Annual Report to be reported in January's meeting;
- Ward Accreditation Report to be reported in November's meeting;
- Nurse Staffing Levels Act 3 Year Report to be reported in November's meeting for information;
- Update on Staff Members Wearing Cameras While Working Policy to be reported on in November's meeting.

Argymhelliad / Recommendation The Committee is requested to **NOTE** the updated Patient Quality, Safety and Outcomes Committee Forward Work Plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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.

Annual Programme of Business for 2024-25

Patient, Quality, Safety and Outcomes Committee

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

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	QTR 1		QTR 2	QTR 3		QTR 4
			30th April	4th June	30th July	2nd Sept	12th Nov	20th Jan
Attendance and Apologies	Chair	SI	√	√	√	√	√	√
Declarations of Interest	All members	SI	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN					**√D**	√
Review of Committee Programme of Business 2024/25	Chair	SI	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN					**√D**	√
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN					**√D**	√
Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN						√
Committee Annual Report 2023/24	Chair & DOCG	AN	√					

Committee Annual Report 2024/25	Chair & DOCG	AN						√
Committee Risk Report	DOCG	SI	√	√	√	√	√	√
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	√	√	√	√	√	√
Pharmacy Robot Risk Assessment	DOCG	Action			√ (incl. in risk report)			
Quality Strategy - Quality Outcome framework	DoN	Quarterly			√		√	
Quality Annual Report 2023/24	DoN	AN				√		
Quality Assurance Framework Annual Review and Evaluation of Progress	Clinical Executives	AN						√
Primary Care Quality Report	COO	Bi-AN				**√D**	√	
Performance Report on the Pillars of Quality, to include:- • Patient experience and stories • Incident reporting - falls/ pressure ulcers medicines management and mortality • Healthcare Inspectorate Wales Operational Plan • Complaint, concerns and compliments • Health Safety and Security • Infection Prevention and Control • Safeguarding	DoN /MD & DOTHS	Quarterly		√	√		√	√

• Clinical Negligence Claims and Coroners Inquests Report
• Quality & Engagement (Wales) Act, Preparedness and Implementation
• Tracking of Improvement Actions Arising from Inspections and Reviews
• Cleaning Standards Annual Report
• Infection Prevention and Control
• MCA & DOLs
• Child and Adolescent Mental Health Quality Outcomes Report, including self-harm and suicide
• Clinical Audit
• Mental health and learning disabilities assurance
• Listening and Learning Framework Outcomes
• Never Event Incidents
• Clinical Effectiveness and Standards Committee Report (January Meeting)
• Closure of incident dates Sbar
• Operational Quality updates on:
  ○ Cancer
  ○ U&EC
  ○ Planned Care								

Pillars of Quality Interim Report	DoN	Bi-Annual	√			√		
Healthcare Inspectorate Wales Annual Report	DoN	AN	√					
Commissioning Assurance Framework, Development, and Implementation	Clinical Executives	AN		**√D**	√			
Commissioning Outcomes Report	Clinical Executives	Bi-An				**√D**	**√D**	√
Putting Things Right Annual Report 2023/24	DoN	AN				√		
Maternity Services: Organisational Improvement and Action Plan	DoN	Bi-An			√			√
Learning from Death Report	MD	Bi-AN	√				**√D**	√
Listening and Learning Framework	DoN	AN	√					
Listening & Learning Forum Minutes	DoN	SI	√	√	√	√	√	√
IPC and Cleaning Standards	DoN	AN		**√D**	√			
Annual Volunteering Report	DoN	AN		√				
Mortuary Incident Action Plan	DoT&HS	AN		**√D**	√			
Covid-19 Nosocomial Investigations Report	DoN	AN		**√D**	**√ D**	√		

Challenges in securing improvements within the Mental Health & Learning Disabilities	DoN	Action				√		
Clinical Advisory Committee Minutes	DoN	SI	√	√	√	√	**√D**	√
Protocol for patients presenting with Sepsis **PQSOC 3007/07**	DoN	Action					√	
Report on time closure of patient safety incidents **PQSOC 3007/07**	DoN	Action					√	
Serious Incident Learning Report	DoN	AN					√	
Medical Devices Annual Report	DoT&HS	AN					**√D**	√
Radiation Protection Committee Report	DoT&HS	AN					**√D**	√
Falls and Bone Health Management Annual Report • Deep Dive on Falls **PQSOC 3007/07**	DoT&HS	AN		**√D**	**√D**	**√D**	√	
Health and Safety Compliance Annual Report	DoT&HS	AN			**√D**	**√D**	√	
Human Tissue Act Group Annual Report	DoT&HS	AN				√		
Pharmacy and Medicines Management Annual Report	MD	AN			√			√
Safeguarding Annual Report	DoN	AN			√			

GP Engagement and Child Protection Report **PQSOC30/07 3.4**	DoN Action	AN				√		
Update Optimal Antimicrobial Prescribing **PQSOC 3007/14 & PQSOC 0209/2.8**	MD Action	AN					√	
Ward Accreditation Report	DoN	AN					√	
Nurse Staffing Levels (Wales) Act 3-year report	DoN	AN					√	
Nurse Staffing Levels Wales Act Recalculations	DoN	AN				√ **D**	√	
Update on Staff Members wearing cameras while working policy. **PQSOC 0209/2.8**	DoT&HS	Action					√	
Research and Development Annual Report	MD	AN				√		
Hospital Transfusion Committee Annual Report	MD	AN			√			
Organ Donation Annual Report	MD	AN				√		
Annual Report on Clinical Audit Activity 2023 – 2024	MD	AN		√				
Nutrition and Hydration Committee Update Report	DoT&HS	AN					√**D**	√
Review of neurodevelopmental service for U18s	DoN	AN			√			
Children's Rights & Participation Forum	DoN	Bi-AN			√			√

Dementia Care Annual Report	DoN	AN				√		
Children and Young Peoples Board Minutes	DoN	SI				**√D**	√	√

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Reporting Committee	**Quality and Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**2nd September, 2024**

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

1. PATIENT STORY

Members received an ITV media clip which involved a young woman (HL) who formerly was an in-patient in Ty Llidiard the Children and Adolescent mental Health Unit on the Princess of Wales site with a diagnosis of Anorexia Nervosa. The video interviewed Helen and explained the progress that had been made by the unit whilst in special measures. The importance of patient engagement was seen as a critical element in the success working with young people to improve services. Members acknowledged how difficult it can be to tell your story and applauded the patient who has gone on to undertake her medical training. The story also highlighted the collaborative working between the former WHSSC and NCCU in supporting the Health Board in improving the service.

2. FEEDBACK CORONOR'S INQUEST

Members received a presentation containing an update following the Conclusion of the inquest concerning the death of a young woman (aged 29), who was a patient from HDUHB who sadly took her own life whilst an inpatient at a Women's Enhanced Medium Secure (WEMMS) Unit in London. Members noted that the coroner's inquest hearing was held in the West London Coroner's Court and concluded on 23 July 2024. The inquest was held in public with a jury of 8.The recommendations arising from the hearing were shared and it was noted that NHS England have decommissioned the services following a review. The implications of this will be considered as part of the Mental Health Strategy.

The Director of Mental Health and Vulnerable Groups explained that he was currently working with Welsh Government around continuing healthcare, which is a complex area. In response, an independent member stated that little had changed as how continuing health care was managed, it was costly and demand was increasing. It was agreed that these concerns would be escalated to the Joint Commissioning Committee.

3. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales and a summary of the highest scoring risks was provided.

4. COMMISSIONING TEAM AND NETWORK UPDATES

Reports from individual Commissioning Teams were received and taken by exception. Members noted the information presented and a summary of the services in escalation as attached. 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.

4.1 Cancer & Blood

Quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

South Wales Plastic Surgery

It was reported that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. In July 2024, however, the NWJCC agreed to fund some of this additional capacity focusing on higher priority clinical groups who will receive their surgery before the end of December 2024. This was discussed at the July 2024 JCC and MG meetings. Further consideration will be given in August/September 2024 to the remaining funding required to meet the target in full, taking into account the context of the wider JCC financial position.

Neuroendocrine Tumours

It was noted that following a patient concern a review of the service provided by CVUHB was to be undertaken. The commissioning team will support the review and consideration given to the findings. The timescales and terms of reference are yet to be agreed.

4.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio.

Obesity Surgery Waiting Times

It was noted that there has been no improvement in the waiting list positon for Salford and little or no activity undertaken over the last twelve months. NWJCC are working closely with providers to open up the pathway to South Wales Service as an alternative, and Llais will be updated in relation to this pathway when it becomes available.

4.3 Neurosciences

Members received an update of the quality issues for services relating to the Neurosciences Team Portfolio.

Deep Brain Stimulation

The service provided by North Bristol NHS Trust (NBNHST) remains temporarily suspended for new referrals. Work is ongoing to secure a temporary alternate pathway into University College Hospitals London (UCL) in partnership with Cardiff and Vale University Health Board (CVUHB) which was agreed by the Senior Leadership Team (SLT) on 19th August 2024. NWJCC are in discussion with NBNHST to gain assurance on the issues raised with a view to reopening the pathway subject to those assurances. NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

4.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio.

Children's Hospital For Wales

A reset meeting is due to take place on the 18th September to consider the services in escalation and undertake a collaborative approach to agreeing the way forward. It was noted that the Director of Nursing CVUHB had written providing assurance on the review which had been undertaken relating to pressure damage issues on the Paediatric Intensive Care Unit and the actions that had been taken to address the issues.

Princess of Wales Hospital (POW)

Members were informed of the planned closure of the Maternity and Neonatal Unit within Princess of Wales Hospital Bridgend, (POW) and CTMUHB from the 2nd September, 2024 for 12 weeks. This was due to essential maintenance work to be undertaken in both the Neonatal and Maternity Unit. Assurance was given that plans were in place to redirect patient flow.

Wales Fertility Institute

Members were informed that a positive HFEA report had been received by the service. No critical or major concerns within the service were highlighted. Four staff members have passed the exam to be the person responsible (PR).The team agreed that the service has met the required standard to be de-escalated from level 4 to level 3. NWJCC continue to work with the provider on service improvements.

4.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Eating Disorders (ED)
The new unit in Tŷ Glyn Ebwy Hospital, Hillside and Ebbw Vale was reported at the last meeting to be a 2Q service with an action plan in place with the JCC, via the Framework agreement processes, to improve areas relating to training and supervision arrangements. The service has evidenced improvement in various areas since the last review but quality issues remain, therefore, it is now a 3Q service.

Mother and Baby Unit / North
It was noted that provisional works have begun on the new Mother and Baby Unit in Cheshire and Wirral. Recruitment for the required posts has begun with the ward manager in post. The scheme has been delayed considerably due to increased costs from the contractor which Cheshire and Wirral Partnership have formally declined and a new tender process has commenced.

4.6 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio. Members noted that there have been some challenges with regards to robust consultant cover within the Intestinal Failure service. This is an issue which remains closely monitored via the commissioning assurance meetings held with Cardiff and Vale University Health Board

5.0 OTHER REPORTS RECEIVED

Members received reports on the following.

5.1 Services in Escalation Summary
Members noted the content of the report and a copy of each of the services in escalation is attached to the report at **Appendix 1.**

5.2 Quality and Safety Report - Ambulance and 111
A report providing an update on quality and safety matters for the Ambulance and 111 commissioned services was received.

5.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update
A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period June 2024 to July 2024 was presented to the committee.

5.4 Incident and Concerns Report
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

5.5 Joint Commissioning Committee Risk Register

The transitional amalgamated risk register for the JCC was presented to the committee, which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former EASC, NCCU and WHSSC predecessor organisation risk registers. This Risk Register was approved by the JCC in July 2024, and considered by the CTM Hosted Bodies Audit and Risk Committee (ARC) in August 2024. Members noted the significant amount of work done to bring this together, mindful there was still a lot of work to be done with scores and assessing risks to ensure consistency across the range of NWJCC services.

6. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- QPSC Distribution List.

7. ANY OTHER BUSINESS

None to note.

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

- Continuing health care and the impact on patients that receive commissioned services, as the concerns continue from the committee.
- Patient story forward to JCC on 17 September 2024.
- An update on the DBS Temporary Service Change was provided and would be relevant for HBs.
- It was important to note that the reset meeting was taking place for Neonatal Cot and PICU and the meeting will be an opportunity to discuss and agree actions/objectives in collaboration with the provider health board.

Summary of services in Escalation

- Attached (**Appendix 1**)

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	TBC

Executive Director Lead: Nicola Johnson
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23, 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

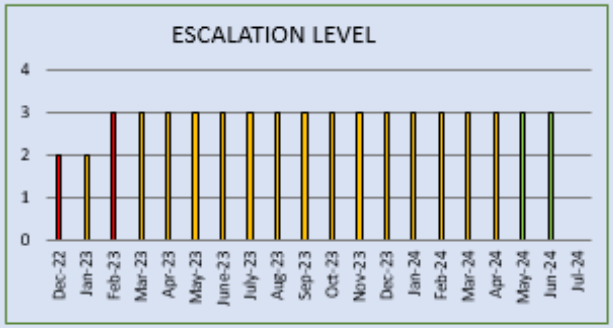
Service in Escalation: Paediatric Surgery

Current Escalation Level 0

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – JCC escalation	**3**
July 2024	**0**

Rationale for Escalation Status :
As a result of the service failing to engage fully with JCC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the JCC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan did not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

JCC assurance and confidence level in developments:

High – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in

Actions:

Action	JCC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives.	Director of Planning & Performance / Director of	16 May 2024	

implementation. The service has committed to deliver a 52-week inpatient waiting list position by year end. The delivery of this is against a robust plan of increasing day case surgery and outsourcing 37 cases to Nuffield. Nuffield contract has concluded. Monitoring progress on a monthly basis and the >52 weeks' position is improving as set out in the trajectories. Escalation status being discussed at executive level within the JCC. Following the assurances received from the Triple Escalation meeting on the 16th May 2024 where the Health Board stated that the 52-week target will be met by the end of June 2024 and with a robust plan to maintain this during 2024/25 in line with the 52-week waiting time agreed by the (previous JCC) Joint Committee in our Integrated Commissioning Plan. In the commissioning team meeting held in July 2024 we agreed to de-escalate the service from Level 3 to Level 0 in line with the previous WHSSC (now NWJCC) Escalation Framework. This escalation has been closed and removed from the women and children's risk register.		Nursing and Quality		

Issues/Risks:

May 2024 – Escalation status being discussed at executive level within the JCC.
July 2024 – De-escalation of paediatric surgery agreed in July W&C commissioning team meeting from level 3 to level 0. Closed on risk register.

Executive Director Lead: Nicola Johnson
Commissioning Lead:
Commissioning Team: Women and Children

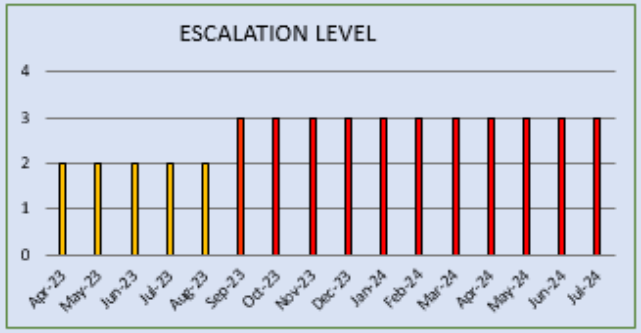
Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level		
Trend	**Rationale**	**Current Trend Level**
↓	Escalation level lowered	↔ July 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	**2**
September 2023 – Increased level from 2 to 3	**3**

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of JCC through various routes including HiW and the daily SITREP.

JCC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	-	17th July 2024
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	Next meeting to be arranged post re-set meeting

Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. JCC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC. The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.	Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	
Issues/Risks:				

Executive Director Lead: Nicola Johnson
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

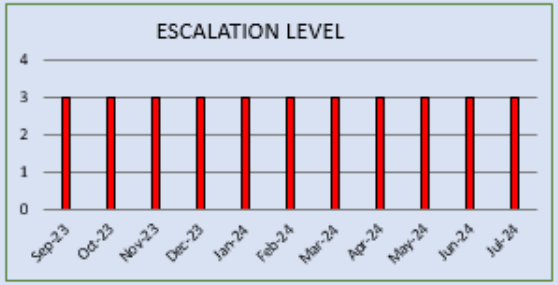
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

NWJCC assurance and confidence level in developments:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC.
The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	Next meeting to be arranged post re-set meeting
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	

the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.	

Issues/Risks:
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability
July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.

Executive Director Lead: Iolo Doull
Commissioning Lead:

Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

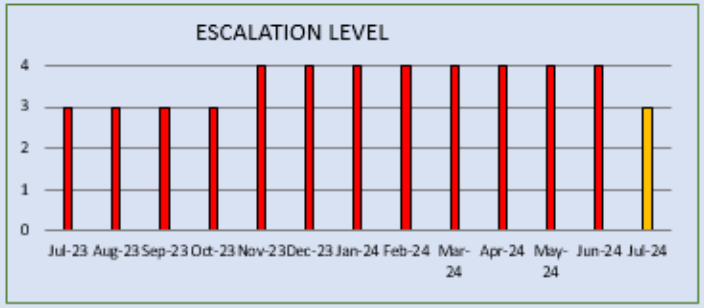
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – JCC escalation	3
November 2023 – JCC escalation	4
July 2024 – JCC escalation	3

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the JCC contract monitoring data submission; adherence to JCC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, JCC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

JCC assurance and confidence level in developments:

Actions:

Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024 14th March 2024 9th April 2024 8th May 2024	Assistant Specialised Planner	Monthly	13 June 2024

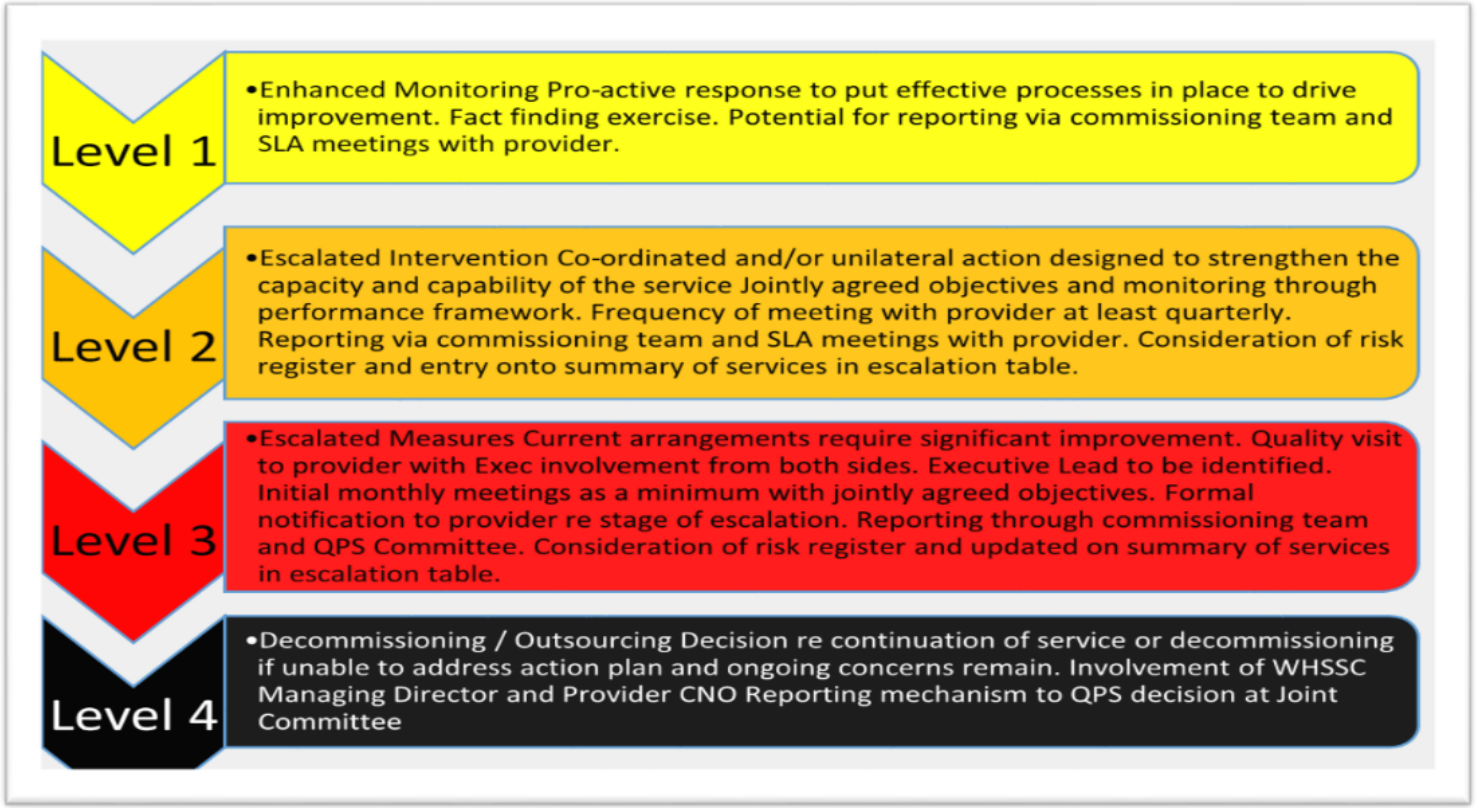
SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 2023
Regular Executive to executive meetings 16th November 2023 21st November 2023 1st December 2023 7th December 2023 21st December 2023	Executive lead SBUHB/ Medical Director JCC	16th November	Ongoing

Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to JCC data submissions, however, the service need to ensure time is given both internally and to JCC to allow for review and consideration of documentation.
The service submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission.
The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all suitable staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot.
Cardiff inspection took place in March 2024, following the inspection being considered by the HFEA licensing panel who agreed to changing the licence to a storage only facility. The Neath Port Talbot Inspection took place in May 2024.
A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board.
A new clinical service manager took up post at the start of May 2024.
The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. It was originally intended for the review to be completed by the end of January 2024 however this has been delayed with the review report due to be shared with the HB Board at the end of May 2024.
The Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital risk score reduced from 25 to 15. A positive report from the HFEA highlights there are no critical or major concerns within the service and the fact that four staff members have taken and passed the exam to be the person responsible (PR), the team agreed that the service has met the required standard to be de-escalated from level 4 to level 3. There remains an issue with receiving contract monitoring information, which is in the process of being resolved.

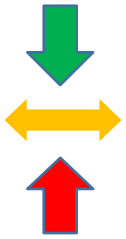
Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider

Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC 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 JCC 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 (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC 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 JCC 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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 November 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	3-year Welsh Government Assurance Report on Compliance with the NSLWA 2021-2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kelly Downes – Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Section 25A of the Nurse Staffing Levels (Wales) Act 2016 sets out the overarching responsibility of all Welsh Health Boards to have due regard for the duty on them to provide sufficient nurses to allow time to care for patients sensitively wherever they are receiving nursing services.

This 3-year Welsh Government Assurance report (6 April 2021- 5 April 2024) provides an overview of the measures taken to calculate and maintain nurse staffing levels throughout the 3-year reporting period and to provide assurance of the Health Boards compliance with the Act

Cefndir / Background

The Nurse Staffing Act Levels (Wales) Act 2016 includes:

Section 25A
Overarching duty to have regard to providing sufficient nurses time to care for patients sensitively (came into force April 2017).

Section 25B
Duty to calculate and take steps to maintain nurse staffing levels, including,

- Identification of a designated person to calculate nurse staffing level (Executive Director of Nursing).

- Take all reasonable steps to maintain the nurse staffing level.
- Make arrangements to inform patients of the nurse staffing level (came in to force April 2018).

Section 25C
Prescribes the triangulated approach to calculate the nurse staffing level (came into force April 2018).

Section 25D
Relates to statuary guidance released by Welsh Government about the duties under sections 25B and 25C.

Section 25E
Duty to submit a Nurse Staffing Levels report setting out the extent to which the nurse staffing levels have been maintained and the impact that not maintaining staffing levels has had on care provided to patients (came in to force April 2018).

Section 25E states that health boards must submit their 3-year reports to the Welsh Government within 30 days of the end of the reporting period (5 May 2024). However, investigations of serious incidents of harm can often take months to complete, meaning incidents from the latter quarter of the three years would still be open and the data in May 2024 incomplete. Therefore, health boards submitted a caveated reports in May 24 to ensure compliance with statute. The attached final report will be submitted October 2024.

Asesiad / Assessment

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses required and staff to whom nursing duties have been delegated by a registered nurse to deliver the planned roster. It is acknowledged there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment; however, these staff are not included within the data for this report.

2021-2022
The Autumn 2021 re-calculations identified a need to significantly increase the nursing establishments on seventeen of the 25B wards. The spring and autumn recalculations demonstrated a notable increase in patient acuity, particularly relating to level 4 and 5 enhanced care patients. The complexities of caring for enhanced care patients in single rooms was highlighted.

2022-2023
A total of 14 wards under s25B required amendments to previously agreed rosters. Recalculations revealed a further need to increase the Registered Nurses (RN) and Health Care Support Worker (HCSW) establishment by 34.39 WTE on 25B wards.

2023-2024
Changes to previously agreed rosters were required on 6 wards, 2 wards in Scheduled Care were approved and presented to Executive Committee in August

2023. The proposed changes of establishment to 4 wards in the Division of Medicine were put on hold whilst the reconfiguration of stroke services took place.
The Autumn calculations confirmed the majority of 25B wards as having the correct establishment to meet the needs of patients. Cost neutral amendments for 2 wards in Scheduled Care were agreed. The proposed establishment changes previously identified in the Spring calculations on the 4 wards in the Division of Medicine remained on hold.

The extent to which the planned roster has been maintained.

To date the health board has not had the digital capability to demonstrate the extent to which the planned roster has been maintained within 25B wards. As such, the Health Board has been unable to include this information in the annual assurance reports for this 3-year reporting period. Furthermore, the newly adopted Safe-Care system which has been successfully rolled out to all 25B wards is currently unable to produce the required data.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate.

Clear processes are in place to identify, investigate and escalate from ward to board any deviations from the planned roster and any potential harm as a consequence:

- **Hospital Acquired Pressure Ulcers**: throughout the 3-year reporting period there have been a total of 6 incidences where the planned roster was not met, staffing levels were a contributory factor in 3 of the incidences.
- **Patient Falls with serious harm**: over the 3-year reporting period there have been 3 incidences where it is considered nurse staffing levels have been a contributing factor, despite all reasonable steps taken to maintain staffing levels.
- **Complaints**: This is a complex metric to report as complaints are often multifaceted. Throughout the 3-year reporting period there have been 15 incidents where staffing levels were a contributory factor.
- **Medication Never events**: Nil to report.
- **Infiltration/Extravasation**: 8 incidences in total none of which were serious, staffing was not a contributory factor in any of the incidences.

There are no open falls or HAPUs to carry over to the next reporting period, 10 complaints remain open and will be carried over to the next reporting period.

Argymhelliad / Recommendation

The Committee is asked to formally receive and **NOTE** the information contained within the Nurse Staffing Levels (Wales) Act 2016 Three-Year Assurance Report.

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):	2. Safe Care 5. Timely Care 3.1 Safe and Clinically Effective Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
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

NURSING, MIDWIFERY, SCPHN WORKFORCE STRATEGY PRIORITY ACTION PLANS 2023-2026

Priority Action Plan – Recruitment Effectiveness

Action	What will this achieve?	Progress:
Develop an annual recruitment Plan	• Ensure a co-ordinated, sustainable flow of candidates linked to the Health Board's Workforce Plan • Ensure a planned approach to on-boarding and training needs	Annual planner in place that includes recruitment of: - 75 IENs per year - 20 nurse cadets (exceeded - 37 cadets for 23'24) - RCN connect students - Offers Coleg Gwent H&SC students' opportunity to join bank - Centralised HCSW recruitment to recruit to turnover
Continue to invest in internationally trained nurses	• Address long term vacancies and contribute to the ongoing supply of nurses into ABUHB	- 75 IENs being recruited each year until end of 2025, plan to recruit family / friends and local IEN's employed by AB. - Accommodation secured for next 2 years. - Support café - pastoral & educational
Recruit to the future nurse and midwifery academy	• Ensure a future pipeline of candidates to undertake under-graduate nursing and midwifery training • Attraction and Retention • Nursing career becomes a career of choice	- Internal HCSWs identified to progress to nurse training - Apprentice HCSW and HCSW adverts being advertised with the addition of a future nurse advert - Using social media platforms top advertise adverts/posters - Engaging early with H&SC students in schools and colleges and explaining the routes to nursing including the flexi route - RCN Healthcare Connect students – 4 in first cohort (one is exploring the flexi route) - 10 MH nurses supported to access K102 – OU flexible route
Develop succession and career planning approach for ABUHB	• Attract and retain nurses to work and stay within ABUHB • Offer developmental and career opportunities within all fields of nursing	• Future nurse adverts • Internal HCSWs identified to progress to nurse training • N&M Academy, LEAD6, N&M bespoke Academy for 8b's planned for Sept 24. JOE programme being rewritten – will incorporate leadership / succession of band 5 – 6. • Assistant Practitioner governance / developmental group - meeting being arranged with all Divisional representation

Priority Action Plan: Recruitment Experience

Actions	What will this achieve?	Progress:
Easy to find and refreshed Recruitment intranet and internet pages to include recruitment and selection training for managers	• Managers will know where to go for all things Recruitment	• In progress • Significant improvement in job advertising via social media platforms
Introduction of talent pools	• A space to hold appointable candidates that have already been interviewed to offer future posts for high turnover posts • Create a mechanism for the public to register their interest to work for the Health Board	• HCSWs are being recruited centrally into talent pools by location (to improve retention) • Plans to expand this to include a talent pool for those interested in a future nurse role (starting at apprentice or band 2 HCSWs level)
Engagement with local community	• Attract local population and develop Employer of Choice recognition	• Working with comms to link in with their communication strategy 2023 – 2026 to ensure job vacancies and career opportunities are published to our communities to develop a sense of employer of choice. • Work underway to visit schools and colleges to share the career opportunities available within N&M
Review and streamline recruitment processes to ensure they support equality and diversity for our local communities	• Supports our workforce to reflect the diversity of the community • More enjoyable experience for the candidate	• Undertaking events in various community locations such as schools, colleges and with job centres. In doing so we are offering unemployed residents an opportunity to gain employment.
Introduction of KPIs for Bank and continue to monitor General Recruitment KPIS	• Monitoring of time to hire and identify key areas for immediate intervention	• Bank KPIs in place • Monitoring time to hire and working on clearing old records in Trac (where people have started in post before checks complete)
Continued training and retention for Recruitment Teams	• Improvements for on-boarding leading to reduction in time to hire	• NWSSP training sessions and drop-in sessions in place. • Resource team to offer training to manager to reduce time to hire and best practice tips

Priority Action Plan: Brand and Marketing

Actions	What will this achieve?	Progress:
Uniform standardisation of brand	• Strong connection and promotion of ABUHB	• Posters developed with ABUHB colours and all in same format • Link with Comms to better incorporate recruitment into comms strategy ie HCSW week etc • Job of the week advertising being progressed
Increase attendance and visibility in the community	• Community awareness of ABUHB as an employer (for all jobs)and mutually beneficial links with partner HEI's • Improve relationships with key stakeholders	• Developed strong connections with Coleg Gwent, DWP and Careers Wales and have a strong presence at events being run across ABUHB patch. • Further work to be done with linking in with comms on this point for community awareness.
Review internal processes for staff engagement and feedback	• A greater sense of belonging and feeling valued	• NWSSP to re-design the manager and candidate surveys on the recruitment process
Review current advertising platforms and seek all opportunities	• Effective advertising and best value for money	• Social media platforms reach a large audience at no cost. • Advertising newly created RN vacancies to Bristol and Birmingham universities • Work on-going to review current platforms and other platforms available

Priority Action Plan: Career Development/Educational Opportunities

Actions	What will this achieve?	Progress:
Review service developments and potential opportunities for clinical nurse specialists, advanced practise and consultant nurse roles.	• Opportunities to develop, educate and retain existing workforce and attract staff form outside the Health Board.	• ACP role – JD standardisation. • Implementation of the multiprofessional framework – including network of ACP's, portfolio workshops, research workshop planned. • First multi-professional framework meeting to share and standardise practice across professions in line with framework. • Services now being developed around the role of Nurse Consultants/ANP's
Secure a fit for purpose education facility for nursing and midwifery education	• Provision for essential education, timely progression of IEN's to NMC registration, efficient use of resources	• Raised to Accommodation Committee – discussion to be picked up at Exec level in relation to equitable education resource for all Health Board staff.
Develop clear and ambitious pathways and opportunities.	• Will support individuals to reach their ambition, improve job satisfaction and ensure a skilled workforce.	• Future Nurse Academy – clear pathway from school to RN – ability to step in and step out.
Increase opportunity for professional support and development.	• A supportive culture.	• 12 PNA places secured to implement RCS framework • Current supervisors scoped as a priority for training • 2 courses supervision secured for MH/LD which will support 24 new supervisors • Constant flow of access to ILM coaching qualifications • Coaching conversations to be included as a master class at next Alumni – rolled out as "business as usual". • Prerceptorship programme under review to strengthen support for new registrants. • Support to undergraduate students strengthened through coffee and connect sessions, points of contact, education / support opportunities.

Priority Action Plan: Retention

Actions	What will this achieve?	Progress:
Implement exit questionnaires	• Feedback on what we need to do to be the employer of choice and improve retention of current staff.	• Questionnaires now on ESR and are autogenerated prior to individuals leaving the organisation. • Benchmarking across Wales taking place to design and implement 'stay conversation' to complement exit questionnaire process. • Retention group established with the purpose of identifying and designing support systems in retaining our staff. This includes interrogating data from multiple sources.
Encourage and support the use of self-rostering	• Increased staff satisfaction, reduce sickness absence.	• Retention self assessment plan being piloted within Community and Childrens Nursing. • Tracker developed for all Wales Retention Action Plan
Retire and Return Initiative	• Encourage experienced staff to return to work.	• Poster being developed to encourage retirees back to work on FTCs or bank
Optimise flexible working opportunities	• Work-life balance • Return to practice • Make the profession more attractive	• Poster being developed to encourage retirees back to work on FTCs or bank. • Retention engagement chat cafes across the organisation have taken place with engagement of over 500 staff. • Self rostering trial on ICU and NICU

Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government			
Health Board	**Aneurin Bevan University Health Board**		
Reporting period	**The reporting period is 6th April 2021 - 5th April 2024.**		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	25 May 2022	24 May 2023	29 May 2024
Number of adult acute <u>medical</u> inpatient wards where section 25B applies	Lowest: 19 Highest: 24	Lowest: 21 Highest: 21	Lowest: 21 Highest: 21
Number of adult acute <u>surgical</u> inpatient wards where section 25B applies	Lowest: 9 Highest: 13	Lowest: 12 Highest: 13	Lowest: 13 Highest: 13
Number of paediatric inpatient wards where section 25B applies	Lowest: 1 (50 beds) Highest: 1 (50 beds)	Lowest: 1 (50 beds) Highest: 1 (50 beds)	Lowest: 1 (50 beds) Highest: 1 (50 beds)
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	**adult acute <u>surgical</u> inpatient wards**	**adult acute <u>surgical</u> inpatient wards**	**adult acute <u>surgical</u> inpatient wards**
	4 (wards re-purposed to support Covid-19 pathways)	0	0
	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards**

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	4 (wards repurposed to support Covid-19 pathways)	0	4 Medical wards
	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0
Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	The second wave of the Covid-19 pandemic coupled with the early opening of the Grange University Hospital (GUH) in November 2020 proved a challenging time for the Health Board. Multiple re-purposing of wards across the Enhanced Local General Hospitals (ELGH's) sites was necessary to support the intended clinical futures model. In addition, many wards were re-purposed to manage complex Covid pathways, maintain patient safety and re-establish business as usual. In line with the Clinical Futures model: • Wards at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH) were closed permanently or re-purposed to become semi acute medical/older adult wards or elective surgery/step-down wards. • The Royal Gwent Hospital created green pathways to re-establish elective surgery services. • Ysbyty Ystrad Fawr (YYF) hospital was dedicated to accepting Covid 19 positive patients, consequently all wards underwent temporary re-purposing. Maintaining a record of the changing purpose of wards to manage Covid-19 pathways and the reconfiguration of services, as a consequence opening the GUH, proved to be extremely difficult as ward reconfigurations were rapid and frequent.		

Informing patients	The 2016 Act requires Health Boards/Trusts to inform patients of the nurse staffing level on each 25B ward. Following the 6 monthly recalculation cycles, the agreed planned rosters must be displayed at the entrance of each 25B ward using the All-Wales informing patients templates. Templates must be displayed in Welsh and English with the date recalculations were presented to Board. To note, the re-purposing of wards to manage the pandemic made this incredibly challenging and on occasions the Health Board was non-compliant. Compliance at times does pose a challenge when wards are re-purposed or temporarily move location. Additionally, wards must have available easy to read frequently asked questions (FAQ's) regarding the Nurse Staffing Levels (Wales) Act 2016 and information on how to raise a concern regarding nurse staffing levels. The Nurse Staffing Act Programme Lead ensures all 25B wards have access to the necessary leaflets, ward templates are updated following each presentation of recalculations to Board. Information on the Nurse Staffing Act and the FAQ's is available on the ABUHB website under Health & Advice, Patient Information Leaflets. For further assurance, future recalculation meetings will require ward managers and senior nurses to confirm ward templates are up to date and Nurse Staffing Act (Wales) 2016 leaflets are on display. Monthly confirmation of compliance is also built into the recently introduced ward accreditation programme. As from January 2024, all 25B wards in ABHUB are required to display the actual daily staffing levels alongside the planned roster template, it is anticipated this may take time to embed.
Section 25E (2a) Extent to which the nurse staffing level is maintained. As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.	
Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020.	Number of wards: **32**
	RN: **510.01**
	HCSW: **505.67**

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		2021/2022	2022/2023	2023/24
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards	**Required establishment (WTE) of adult acute medical and surgical inpatients wards <u>calculated</u> during first cycle (May)**	Number of wards: **32**	Number of wards: **33**	Number of wards: **34**
		RN: **538.24**	RN: **594.1**	RN: **601.1**
		HCSW: **553.61**	HCSW: **641.6**	HCSW: **713.85**
	WTE of required establishment of adult acute medical and surgical inpatients wards <u>funded</u> following first (May) calculation cycle	Number of wards: **32**	Number of wards: **33**	Number of wards: **34**
		RN: **538.24**	RN: **594.1**	RN: **595.47**
		HCSW: **553.61**	HCSW: **641.6**	HCSW: **700.46**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards <u>calculated</u> during second cycle (Nov)	Number of wards: **33**	Number of wards: **32**	Number of wards: **34**
		RN: **594.1**	RN: **582.31**	RN: **599.68**
		HCSW: **641.6**	HCSW: **695.33**	HCSW: **720.22**
	WTE of required establishment of adult acute medical and surgical inpatients wards <u>funded</u> following second (Nov) calculation cycle	Number of wards: **33**	Number of wards: **32**	Number of wards: **34**
		RN: **594.1**	RN: **582.31**	RN: **594.05**
		HCSW: **641.6**	HCSW: **695.33**	HCSW: **706.24**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 33**	**WTE: 33**	**WTE: 34**

Accompanying Narrative:
Following the 2nd wave of the Covid 19 pandemic and the associated challenges, health boards received a letter from the Chief Nursing Officer in December 2020 which confirmed the routine bi-annual All Wales Nurse Staffing Acuity audit would not proceed in January 2021. However, ABUHB, took the decision to progress with local acuity audits and the subsequent spring recalculations in view of the early opening of the GUH and the repurposing of the ELGH's.

Spring and Autumn 2021
The Spring 2021 calculations proved to be valuable and demonstrated a need for new establishments and the repurposing of wards to settle. It must be acknowledged the opening of GUH in addition to added complexities of re-purposing wards, opening of extra capacity beds, winter pressures, and maintaining Covid pathways made tracking of staffing establishments very challenging. The Autumn 2021 re-calculations identified a need to increase the nursing establishments on seventeen wards. The spring and autumn acuity audits demonstrated a notable increase in patient acuity, particularly relating to level 4 and 5 enhanced care patients. The complexities of caring for enhanced care patients in single rooms was highlighted.

Spring and Autumn 2022
Recalculations illustrated a further need to increase the Registered Nurses (RN) establishment by 4.25 WTE and the Health Care Support Worker (HCSW) establishment by 34.39 WTE on 25B wards.

Professional discussions in the recalculation cycles and data from the June acuity audit reflected the upward trend of increased patient dependency on care of the older adult wards in the ELGH's and the increased use of temporary staffing. There was a marked increase in level 3 complex care patients as well as an increase in level 4 and 5 patients requiring enhanced care, which was significantly higher than pre-pandemic levels.

One 25B ward in Scheduled care was temporarily closed, (D7E), staff were redeployed to support vacancy deficits in other wards until the ward re-opened in October 2022. A total of 14 wards under s25B required amendments to previously agreed rosters.

Spring and Autumn 2023
The Spring 2023 recalculation continued to highlight high levels of acuity/dependency in the older adult wards. Professional discussions included new initiatives to manage enhanced care patients and trialling new roles such as "activity coordinators." Changes to previously agreed rosters were required on 6 wards, 2 wards in Scheduled care were approved and presented to Executive Committee in August 2023. The proposed changes of establishment to 4 wards in the Division of Medicine were put on hold whilst the reconfiguration of stroke services took place. The Board recognised there was a need to support the proposed establishments in the interim period using temporary staffing.

Autumn 2023 calculations confirmed the majority of 25B wards as having the correct establishment to meet the needs of patients. Cost neutral amendments for 2 wards in Scheduled Care were agreed. The proposed establishment changes previously identified in the Spring calculations on the 4 wards in the Division of Medicine remained on hold.

In collaboration with the E-rostering team and finance partners, roster templates are changed, and budgets aligned for all 25B wards where changes to the agreed templates are approved by the "Designated Person" (Executive Director of Nursing) and presented to Board.

The variation in the required establishment verses the funded establishment in year 2023/2024 is related to the 4 wards in the Division of Medicine where the proposed staffing changes remained on hold.

Exceptional recalculation meetings for the 4 wards in the Division of Medicine, involved in the stroke reconfiguration, were undertaken early February 2024. Proposed permanent changes to establishments were further postponed, allowing the wards to settle, cognisant of the upcoming Spring 2024 recalculations.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. These staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Vacancy Position
Current Registered Nurse vacancies for ABUHB is reported as 290.01WTE. Workforce sustainability has been a significant corporate risk during this 3-year reporting period in the delivery of safe and effective care. This is not unique to ABUHB, with most health boards across Wales facing similar recruitment and retention challenges. Despite targeted efforts to reduce vacancies and offer incentivised pay rewards there has been a reliance on temporary staffing. However, it must be acknowledged over the last 12 months the Health Board has seen significant reduction in HCSW agency and Registered Nurse off-contract agency. The Health Board continues to take all reasonable steps to maintain staffing levels, the Executive Committee have given full support to convert temporary staffing into substantive posts and where necessary over recircuit into HCSW vacancies.

Recruitment and Retention
Staff well-being has been a major organisational priority following the Covid pandemic, developing a resilient, agile, and competent workforce to serve our communities is essential. Fully cognisant of the national shortage of registered nurses, the Health Board is committed to improving recruitment and retention and making ABUHB an employer of choice.

ABUHB is fully engaged in student streamlining and has committed to the recruitment of 75 International nurses annually for the next 3 years. Some of the approaches deployed to attract staff during the past 3 years include targeted recruitment events, promoting the health Board through social media, advertising career pathways, flexible working and continuous education and development opportunities.

In 2023 the Health Board launched its robust Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026 (appendix 1) sets out progress against the priority actions articulated within the strategy).

ABUHB aims to deliver its People Plan ambition of being an employer of choice and for nursing to be the career of choice.

The Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026 focuses on:

- Recruitment Effectiveness
- Recruitment Experience
- Brand and Marketing

• Career Development and Educational Opportunities – Growing our Own. • Attraction and Retention				
Required establishment (WTE) of paediatric inpatient wards prior to extension of the 2nd duty of the Act (October 2021)		Number of wards: 1 (50 Bedded)		
		RN: 70.22		
		HCSW: 17.66		
Extent to which the required establishment has been maintained within <u>paediatric inpatient wards.</u>		**2021/2022**	**2022/2023**	**2023/24**
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)		**Number of wards: 1**	**Number of wards: 1**
			RN: 70.22	RN: 70.22
			HCSW: 17.76	HCSW: 17.76
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle		**Number of wards:1**	**Number of wards: 1**
			RN: 70.22	RN:70.22
			HCSW: 17.06	HCSW: 17.06

	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second cycle (Nov) NB (*) The 1st calculation was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act on 1st October 2021.	**Number of wards:1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 70.22	RN: 70.22	RN: 70.22
		HCSW: 17.06	HCSW: 17.06	HCSW: 17.06
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following second (Nov) calculation cycle NB (*) The 1st calculation was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act **on** 1st October 2021.	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 70.22	RN: 70.22	RN: 70.22
		HCSW: 17.06	HCSW: 17.06	HCSW: 17.06
		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	WTE: 1	WTE: 1	WTE:1

Accompanying Narrative:

In February 2021, The Senedd extended the NSLWA to include Paediatrics and the regulations came into force in October 2021. The reporting dates remain aligned to the existing reporting schedule for adult acute medical and surgical wards. The three-year reporting period is tethered to the date of the Act's commencement, not the coming-into-force date of these regulations. Therefore, the information on paediatric wards will be missing for the first six months of this 3-year reporting period.

In preparation of the extension of the Act and the opening of GUH, the Paediatric team undertook a robust roster calculation, which was presented to the Executive Team in September 2021. The January 2022 acuity audit and subsequent Spring 2022 re-calculations confirmed the calculated establishment was appropriate. The themes from the professional discussions included:

- The time-of-day acuity levels are captured and the need to include High Dependency Unit (HDU) patients, to ensure accurate acuity capture.

- The recognition of a very junior nursing workforce within the Directorate.
- The once yearly Pediatric Registration Programme hampers recruitment.
- The Division is developing a different workforce model, to include Assistant Practitioners.
- The current establishment can facilitate fluctuating acuity levels and bed occupancy.

The 2023 acuity audits demonstrated a high level of acuity, alongside increased turnover, and length of patient stay. Professional discussion concluded the establishment did not require adjustment. Despite 19.48WTE RN vacancies, risk is reduced as RN deficits are covered by substantive staff via the nurse bank.

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical inpatients wards and paediatric wards.</u>	NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained, and to provide assurance that all reasonable steps have been taken to maintain the required nurse staffing levels. As such, extensive work has been undertaken to implement a national informatics system to enable health boards to meet the reporting requirements of the Act and the Once for Wales approach to ensure consistency. Each health board has implemented the Allocate Safecare system at different times during the 3-year reporting period and has therefore continued to rely on the Health Care Monitoring System (HCMS). Some health boards have been able to adapt and extract the data analysis to aid reporting. To date ABUHB has not had the digital capability to demonstrate the extent to which the planned roster has been maintained within 25B wards, as such, the health Board has been unable to include this information in the annual assurance reports for this 3-year reporting period. Furthermore, the newly adopted Safecare system is currently unable to produce the required data. Within this Health Board, the roll out of Safecare to all 25B wards was completed by June 2023, further support to embed the system into everyday practice is required on a few wards. It has recently become known that Allocate Safecare are required to undertake amendments to the Safecare reporting system to enable health boards to extract the data to meet reporting requirements. Unfortunately, the enhancements to the system have not been completed in time for this finalised 3-year report. It is anticipated the following information will be available for reporting in the ABUHB annual assurances report for May 2025: • Shifts where planned roster met and appropriate. • Shifts where planned roster met bot not appropriate. • Shifts where planned roster not met but appropriate. • Shifts where planned roster not met and not appropriate
Process for maintaining the nurse staffing	The Health Board has been proactive in considering ways of maintaining sufficient and safe nurse's staffing levels. The Health Board has a well-established process to manage and escalate nurse staffing deficits ensuring all reasonable steps have been followed to maintain nurse staffing levels, these include:

level for Section 25B wards	• A ratified Nurse Staffing Operational Framework, the purpose of which is to standardise and inform staff groups of their responsibilities and of processes and procedures for ensuring appropriate and carefully considered nurse staffing in all areas. Specifically, the overarching duty, s25A, is referenced within the Policy. • Staffing deficits across the Health Board are reported weekly to include: ➢ Filled and unfilled Registered Nurse (RN) shifts against planned rosters ➢ Filled and unfilled Health Care Support Worker (HCSW) shifts against planned rosters ➢ Percentage of substantive staff versus agency staff populating rosters to gauge quality, safety, and continuity of care. • A workforce tracker is presented to the Executive Team detailing progress on recruitment, bank and agency usage, turnover, and absenteeism. • A monthly Strategic Workforce (NSLWA) meeting is held with representation from all clinical Divisions, with the purpose of overseeing the implementation of the Act and monitoring key workforce and staffing metrics. • Daily review of nurse staffing levels by the divisional and site teams – to manage and mitigate risk. • The development of new and innovative roles has been crucial in maintaining nurse staffing levels across the Health Board. • The deployment of staff between wards and across sites to fill short notice deficits. • Senior nurses and site teams are encouraged to use the sunburst view in the Safecare system to assess staffing levels, staffing deficits and patient acuity. Red flags and professional judgements assigned to 25B wards help inform decision making when considering the deployment of staff. • Ratified Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026. • On occasion, there has been a requirement to reduce capacity to maintain appropriate staffing levels.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR
		TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
Number of closed incidents/complaints occurring during current year & those that were carried over from the previous year	**Year 1**	54	40	0	209
	Year 2	35 (including 7 carried over from year 1)	28 (including 8 carried over from year 1)	0	84 (including 18 carried over from year 1)
	Year 3	3 Avoidable (including 2 carried over from year 2)	9 (including 2 carried over from year 2)	0	65 (including 12 carried over from year 2)
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	**TOTAL**	0	0	0	10
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was <u>not</u> maintained	**Year 1**	3	0	0	6
	Year 2	2	3	0	18
	Year 3	1	0	0	19
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	**Year 1**	0	0	0	0
	Year 2	2	2	0	8
	Year 3	1	0	0	7

NOTE: There is a marked reduction in reportable incidents in year 3 for HAPU's and falls- the reasons for this are explained below.

Based on a review of the health boards/trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 requesting a review of the current reporting process. A sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process; standardise reporting in line with the Duty of Candour set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020 and to broaden the reporting scope of incidences of harm to provide more meaningful data.

The findings and recommendations of the Reporting Sub-Group were presented to the Executive Nurse Directors in August 2023 who approved the recommendations to take effect from the next reporting period i.e. 6th April 2024 – 5th April 2027.

The quality indicators for the adult in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm, or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (complaints refer to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR).

The measures going forward will include:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents / complaints not closed and to be reported on /during the next year.
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained.
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained.
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

Following the Executive Nurse Directors agreeing the recommendations in August 2023 it became apparent that the Duty of Candour (DoC), which came into force on 1st April 2023, would impact the reporting metrics.

Previous reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. This change to reporting is not specific to ABUHB but will impact on reporting from all health Boards.

Therefore, to align with patient safety incident reporting to Welsh Government from 6th April 2023 this report, and all future reports, will report on closed patient safety incidents which have been validated with a reportable level of harm (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

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Consequently, despite the broadening of reporting criteria, the number of incidents reported within this 3-year report, and subsequent, annual assurance reports may be lower than those in previous years.

ABUHB transitioned to the new reporting system, RL Datix, during 2021-2022, the start of this reporting period saw a notable increase in Health Care Acquired Pressure Ulcers (HAPUs) compared to the end of the previous reporting period. The reasons for this increase is multifaceted and attributed to:

- Increased acuity
- Increased length of stay
- Inclusion of avoidable HAPU reporting which ABUHB had not previously reported
- Reliance on temporary staffing to manage additional capacity and the pandemic winter surge

It must be acknowledged, the figures in year 1 and 2 include all hospital acquired pressure ulcers, (Avoidable and Unavoidable), following an in-depth root cause analyses by senior nurses in the divisions.

As explained above- year 3 of this reporting period shows a marked decrease in reportable incidences of HAPUs and Falls following the clarification on what constitutes a patient safety incident. Subsequently only HAPU's and patient injurious falls investigated and closed as avoidable will be reported on in in year 3 of this reporting period and all future reports.

Year 3: includes data closed by 23 August 2023

- A total of 25 Hospital Acquired Pressure Ulcers, including 4 open carried over from the previous year - all of which have now been investigated and closed. 3 HAPUs have been found avoidable but only 1 is attributed to staffing levels being inappropriate.

- Following the clarification of what a reportable safety incident is, ABUHB reportable falls have dropped significantly. ABUHB had previously included moderate harm incidents as opposed to only reporting severe and catastrophic harm.

- There has been a significant reduction in complaints in comparison to the previous 3-year reporting period, with 10 complaints remaining open and will be carried over to the next reporting period.

*__Investigations into incidents of harm can often take a period of time to conclude, there were incidents from the latter quarter of the May 2024 annual assurance report which remained open at the time of submission. Incidents initially reported as open and have since been closed are now reflected within the amended Annual assurance report for May 2024(Appendix 2). Those incidents which remain open (as of end of August 2024) will be included within the next reporting cycle.__

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards						
		Hospital acquired pressure damage (grade 3, 4 and unstageable)	**Falls resulting in serious harm or death (i.e. 4 and 5 incidents)**	**Medication errors never events**	**Infiltration and extravasation injuries**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR**
		TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of closed incidents/complaints occurring during current year & those that were carried over from the previous year	**Year 1(*)**	0	0	0	2	0
	Year 2	0	0	0	4	0
	Year 3	0	0	0	2	2
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	**TOTAL**	**0**	**0**	**0**	**8**	**0**
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was <u>not</u> maintained	**Year 1 (*)**	0	0	0	0	0
	Year 2	0	0	0	0	0
	Year 3	0	0	0	0	1
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	**Year 1 (*)**	0	0	0	0	0
	Year 2	0	0	0	0	0
	Year 3	0	0	0	0	0
NB (*) for year 1 paediatric inpatients only reported incidences and complaints the 1st October when the 2nd year duty of the Act was extended						

The work of the Reporting Sub-Group included the measures for the paediatric inpatient wards. Changes to the paediatric measures will come into effect at the beginning of the next reporting period i.e., April 2024.

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The quality indicators for the paediatric inpatient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm, or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received involving nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of closed incidents/complaints occurring during current year and those that were carried forward from the previous year.
- Total number of incidents/complaints not closed and to be reported on/during the next year.
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had not been maintained.
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained.
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

There have been very few reportable incidences in paediatrics. The incidences of Infiltration / extravasation indicated in the above table have not been serious and have been investigated as incidences of infiltration. There have been no extravasation injuries.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	By way of assurance, the Health Board has in place: • A well embedded process to investigate all Grade 3, 4 and unstageable Health Care Acquired Pressure Ulcers (HAPU's) through root cause analysis (RCA) which considers a range of variables which may have contributed to the incident. Any HAPU's deemed avoidable are reported to Welsh Government and are considered for Redress Panel, enabling a process of reflection and learning. • A Falls Review Panel is well established, where all variables are considered, to include nurse staffing levels. Falls closed as moderate level of harm or above on DATIX are considered for Redress Panel. Organisational shared learning events have taken place in relation to falls. The Division of Medicine has also introduced SWARM (immediately following a patient fall staff congregate to determine what has happened, why it happened, and what can be done to prevent further falls) rounds in some areas to reduce harmful falls. • Complaints is a complex metric to capture due to the multi-faceted nature of complaints, which rarely pertain to nursing care alone. For this reason, there are 43 complaints which have been deemed partially or wholly due to nursing which continue to be investigated and will be included in the next reporting period. • All medication Never Events are investigated as serious incidents and reported to Welsh Government.

Hospital Acquired Pressure Ulcers (HAPU)

- **2021/22:** Following investigation there were 3 HAPUs where the planned roster was not met. A failure to maintain the planned roster was not considered to be a contributary factor.

- **2022/23:** 9 closed HAPUs were deemed to be avoidable, with 1 HAPU attributed to the planned roster not being met, on close investigation there were other contributing factors involved which may have attributed to this.

- **2023/24:** 4 HAPUs were carried over from 2022 to the 2023/2024 report, 2 of which were deemed avoidable following root cause analysis. The planned roster was not met in 1 incidence and the staffing levels were a contributary factor. All of the HAPU's for 23/24 have now been fully investigated, 1 was found to be avoidable however staffing levels were not considered to be a contributory factor.

Patient Falls

- **2021/22:** Moderate harm as well as severe and catastrophic levels of harm which included all fractures and head injuries irrespective of whether the injuries were caused by an act or omission whilst in NHS care. The staffing levels were not considered to be a contributing factor in the 40 incidences reported.

- **2022/23:** Moderate harm as well as severe and catastrophic incidents of harm were again reported. The report included 12 hip fractures and 2 head injuries, 3 of which were attributed to the planned roster not being met. On these occasions all reasonable steps were taken to meet the required staffing levels, despite this, shifts remained unfilled. During recalculation meetings no specific themes were identified, it was noted that many of the falls occurred on the Care of The Older Adult wards. Divisional work has been undertaken to ensure all registered staff complete falls risk assessment training.

- **2023/24:** 9 incidences closed with a severe/catastrophic level of harm, 2 of which were carried over from 2022 and investigated as serious incidents. The planned rosters were met on all 9 incidences. Patients had been assessed to mobilise independently and in 2 cases the falls were witnessed.

Complaints

The NSLWA reporting requirements regarding complaints remains challenging, it is very difficult to report on open complaints as the question "Is this the complaint wholly or partially to do with nursing" is not asked until the investigation is complete. There remain a high number of closed complaints where the Nurse Staffing Act questions are incomplete within Datix. The Nurse Staffing Act question had been completed for 22 of the 53 closed incidents for year 3, there were 19 occasions where the planned roster was not met. The professional judgement referred to high temporary staffing, junior staff on duty and high vacancies.

More work is required to raise awareness regarding the importance of completing all sections of the incident reporting fields in Datix. The Nurse Staffing Act lead is working with the complaint teams to ensure moving forward there are steps in place to ensure the staffing Act questions are answered prior to closure of datix.

Infiltration/Extravasation

The paediatric senior nurse has confirmed all 8 incidences of infiltration injuries during this 3-year reporting period, pumps were

	sent to medical electronics to be checked, no issues were identified, and the planned staffing roster was met on each occasion.
Conclusion & Recommendations	**Conclusion:** • During the three-year reporting period the Health Board has continued to face unprecedented challenges. Increased demand in services, ongoing Covid-19 pressures, extra capacity, and workforce deficits, high use of temporary staffing which increases risk and patient safety. • Innovative ways of working to strength and stabilise the workforce have been introduced. • The Nursing, Midwifery and SCHPN Workforce Strategy has been implemented to strengthen and grow the workforce. • Clear processes are in place to identify, investigate and escalate from ward to board any deviations from the planned roster and any potential harm from the consequences. • Safecare informatics system has been successfully rolled out to all 25B wards. • It is envisaged the required amendments to the reporting elements in Safecare will enable the Health Board to comply with the reporting requirements of the NSLWA in future reports. **Recommendations:** • Continue to provide staff education and training sessions in relation to the requirements of the Act. • Improve compliance in closing incidents relating to the Nurse Staffing Act reported on Datix. • Ensure information is available and displayed on all 25B wards informing service users of the Nurse Staffing Levels (Wales) Act 2016. • Participate in the All-Wales Scoping of Multi Professional Workforce Models.

PATIENT QUALITY AND SAFETY LEARNING & IMPROVEMENT FORUM
Wednesday 18th September 2024
10:00am – 13:00pm
via MS Teams

Attendees:

Leeanne Lewis (Chair) (LL)	Jennifer Winslade (JW)	Jonathan Clarke (JC)
Tracey Partridge Wilson (TPW)	Tanya Strange (TS)	Rachel Trask (RT)
Karen Hatch (KH)	Joanne Hook (JH)	Jessica Scurr (JS)
Gemma Couch (GC)	Tom Grace (TG)	Veronique Hughes (VH)
Rhiannon Price (RP)	Howard Stanley (HS)	Joanna Doyle (JD)
Laura Bumpsteed (LB)	Richard Stubbs (RS)	Gwyneth Ratcliffe (GR)
Kylie Crook (KC)	Matthew Kvedaras (MK)	Helen Ronchetti (HR)
Caroline Rowlands (CR)	Susan Palmer (SP)	Michelle Jones (MJ)
Natalie Skyrme (NS)	Emma Heron (EH)	Donna Lafferty (DL)
Susan Dinsdale (SD)	Anne May (AM)	Rebecca Wallace (RW)
Jake Hartford-Beynon (JHB)	Donna Wetter (DW)	

No.	Agenda Item	Action
1. Organisational Learning and Sharing Internal		
1.1	**Update on enhanced care** – JH provided an update on the enhanced care framework, including training programs and implementation plans. The training is being delivered to Heads of Nursing, with a target of 85% compliance by October 4, 2024. The framework will be piloted in older adult mental health wards. JH raised the concern with patients being stepped down on enhanced care to eLGH and the risk of falls.	**JH**

	Dashboard is being used for falls in nursing homes. Link in with Karen Hatch with regards to falls work. Consider adding information about the enhanced care framework to the quality patient safety intranet page and add the framework to the learning repository. Attached links: Arrange Your Training Now for the New Enhanced Care Framework! Person-Centred Enhanced Observation Framework: Getting the Fundamentals Right! Enhanced Care Framework (padlet.com) **Action**: Add enhanced care framework to learning repository and links above **Action**: Link work on falls with Karen Hatch	**LL/TPW** **Chair**
2. Preliminary Matters		
2.1	**Welcome and Introductions** LL welcomed everyone to the meeting. The group introduced themselves via the Chat Bar.	
2.2	**Apologies for Absence** Clare Walters, Craig Roberts, Diane Ridley, James Calvert, Kelly Downes, Peter Carr, Roxanne Green, Scott Taylor, Stephen Edwards, Simon Hoad, Samantha Murray, Amanda Hale, Tracey Rich, Sarah Cadman.	
2.3	**Good News** TG - Announced the completion of consent animation videos in both English and Welsh. LL let the Group know that these videos will be launched by the Clinical Executives. TS – Announced the establishment of a staff bereavement collaborative to support staff dealing with loss. This is specific to staff who have lost colleagues and loved ones. Daniel Madge will be working with TS to look at staff wellbeing.	

	NS/KC – Shared success of the roundtable approach to SIs, resulting in a comprehensive report and action plan in a timelier manner. This was a positive outcome and a possible consideration to run other SIs in the future.	
	DL - Highlighted the positive impact of ward accreditation and various quality improvement projects within the surgery division. **Action:** Agenda ward accreditation for next meeting and share feedback from the ward accreditation process. RT - Highlighted the successful launch of the quality coach training program and its positive reception. This was progress towards the one million minutes of QI coaching. Share updates on the progress of the quality improvement initiatives TPW congratulated the QPS teams since the organisational change in Feb 2024. They have been working very hard to streamline processes, with work on SIs and complaints. TPW thanked them all and if anyone has any feedback, please let TPW and GC know.	**Chair** **RT**
	VH – Announced the success of Kayleigh Poulsom in obtaining a place in the Bevan exemplar program for medication reviews in nursing homes. AM - Shared the success of a project on enhancing emotional well-being for cancer patients, which has been shortlisted for the PENNOR Awards. The Chair asked if this was something that could be presented at a meeting in the future. The group wished AM luck in the upcoming awards.	
2.4	**Terms of Reference** LL presented the terms of reference for the forum and requested feedback from attendees. There was a request for everyone to review the membership to ensure no one was missing. **ACTION:** Attendees to review and provide feedback on the terms of reference.	**All**

3. Listening and Learning		
3.1	LL reiterated the importance of learning being brought to this forum to ensure shared learning and to support the development of any action plans. Divisional triumvirates have ben emailed to ensure they are aware of the forum dates and have been encouraged to consider what can be brought to the meetings in line with the listening and learning framework. LL, encouraged attendees to share learning and improvement initiatives for inclusion in the forum's agenda. **Falls Prevention** CR raised concerns about the step-down of enhanced care levels prior to transfer to community hospitals and suggested an audit to assess falls within 48 hours post-transfer. VH discussed the need for a trigger to monitor falls in nursing homes within 48 hours of transfer. TS suggested including sedative prescribing in the 48-hour snapshot audit for falls. **Action:** as above to link with Karen Hatch on falls work	**Chair**
	Complaints and Patient Feedback LB – shared a pilot project on a trauma and orthopaedic ward to encourage patients to provide feedback post-discharge. This is hoping to support early resolution of complaints. Information is being provided when patients are discharge to enable them to feedback in a timely manner. LB felt this demonstrated that a we are truly listening to feedback and acting on it. **Action:** Attendees to bring forward learning from their areas for discussion to future meetings.	**All**
4. Organisational Learning and Sharing Internal		
4.1	**Annual Quality Report** LL presented the Annual Quality report which has been approved at Exec Committee and PQSOC and was going to Public Board. She gave a summary of what was included in the report and how it had been written for lay members of the public. This report demonstrates how the Health Board had implemented the Duty of Quality and Duty of Candour. It is an honest and transparent report that	

	provided a look back over the past 12 months, detailing key achievements, challenges and work planned for the next year. The report has been mapped to the 'Six pillars of quality programme'. There is an appendix which reflects on the implementation plan which is aligned to the Health and Care Quality Standards. LL asked everyone to consider the workstreams for 2024/25- Refinement of reporting, human factors programme, sepsis and infection prevention and control. If there is any feedback on the report please reach out.	
4.2	**Audit Management and Tracking (AMaT) Uses** LL discussed the use of AMaT which is not just for audits. In the Clinical Audit Strategy, there is a clear steer that AMaT should be used for all local audits. This allows a proforma to be built, the audit to be carried out and results to be tracked. A SMART action plan could then be produced. For National Clinical Audits these are discussed and presented at Clinical Standards and Effectiveness Group and AMaT is used to track audit recommendations. LL went through the other functions of AMaT, including inspections. Other Health Boards are putting HIW action plans onto the system. Members felt this would be useful, but they would need basic training on how to use AMaT first before looking at other functions. The clinical audit team are happy to provide additional sessions. This can be run in sessions for directorates etc. **Action:** Those needing AMaT training to contact LL.	**ALL**
4.3	**PTR Annual Report** GC presented the PTR annual report, highlighting key statistics and improvements in complaints management and early resolution. There are continued efforts to improve complaints management and early resolution. Staff are encouraged to complete the duty of candour training.	
4.4	**World Patient Safety Day** LL discussed the theme of improving diagnosis for patient safety and sharing of related projects for inclusion in the learning repository. **Action:** Attendees asked to share ongoing projects and initiatives related to diagnosis improvement for inclusion in the learning repository.	**All**

5. Divisional Quality and Patient Safety Learning		
5.1	**Positive Patient Story and Rehabilitation** VH - A 63-year-old gentleman with Lewy body dementia and Parkinson's features showed significant improvement through ongoing rehabilitation. Recognising the importance of ongoing rehabilitation to prevent deconditioning in patients. Initiatives included the development of a Physio gym and multi-professional approach involving physiotherapists, occupational therapists, and nursing teams. Future Plans for the Health board will include aligning deconditioning work with the six goals framework and forming a multi-professional group to address this issue.	
	Learning from Incidents LB - A patient was discharged without adequate anticoagulation, leading to a review of the care pathway and development of an action plan. This included implementing safety netting for patients discharged with anticoagulation and ensure they are referred to the anticoagulation clinic. There is a need to educate staff across divisions on the importance of referring patients to the anticoagulation clinic. Develop and distribute an advice form for patients discharged with anticoagulation, ensuring they understand the advice given. LB discussed the work on early recognition of acute deterioration on ward C0. This looked at using a proforma / SBAR. Action is to continue the project on the escalation arm of the patient deterioration project and share immediate learning with the forum. GR – shared learning experience on the stepping up of gynae patients in a defined group of patients and learning from detection of deteriorating patients. The directorate will continue the shared learning experience in obstetrics and gynaecology for deteriorating patients and develop a categorisation of risk for patients. GR raised learning from the PSOW for a patient who was high risk of PR in family and therapies and correctly prescribed anticoagulation in hospital. However, on discharge information was needed on the importance on mobility and gentle exercise, this was raised by the coroner. Ensure that learning from the anticoagulation themes is shared across the division and discussed in the Medicine Safety group.	**LB** **LB** **GR** **GR**

	LL informed the group that there would be coordination with the Medicine Safety group to address issues related to anticoagulants. This included developing a task and finish group to look at themes and learning from incidents	**LL**
	Data Management and Quality Improvement RT discussed the continued efforts to automate data charts and improve accessibility of data for quality improvement. The progress and updates will be shared with the forum. LL and TPW shared the work with the information team / digital/ Data and technology to develop and standardise time series data and automate data charts for easier interpretation. This includes trying to streamline data presentation and reporting, making it more visual and efficient. The Safe Care Collaborative work for 2024/25 will focus on acute deterioration, particularly around deconditioning, this will be shared with the forum when more information is available. **Action:** Share workplan for Safe Care Collaborative with Forum	**RT** **RT** **RT**
	Learning from Serious Incidents CR shared an incident which involved a patient with learning disabilities who experienced a protracted hospital stay and ultimately passed away. This related to multiple professions and included escalated concerns. There will be a coroner's report in due course. Based on this a learning event will be held and is planned for November to focus on risk assessment, consent issues, and managing patients with learning disabilities. JW requested that the learning event in November is shared with the senior leadership group and frontline staff. This would be held as two separate events to cover both. There needs to be a broader learning event to include operational staff. JW suggested integrating the learning event with the Quality Improvement (QI) strategy discussion to emphasise the importance of QI across the organisation.	**CR** **RT**

	Medicines Management VH highlighted the ongoing work - collaboration with pharmacists and GPs to improve medicine management. This included monitoring and review medication use in care homes and at home.	
6. For Information		
6.1	Performance report and Quarterly Outcomes Report for Quarter One shared for information. Final QOF and performance re...	
6.2	LLais and HIW reports shared for information Llais Gwent - Hip and Knee Sur... Hip and Knee Planned Survey ... 03631 - Published Report.pdf 03631 - Llanfrechfa Gran...	
7. Final Matters		
7.1	**Draft minutes of the meeting held on 9 July 2024** Nothing reported. Agreed as a true reflection of the previous meeting and accepted.	
8. Any Other Business		
8.1	None	
9. Details of next meeting		
	Wednesday 13th November 2024 13.00pm – 16.00pm MS Teams	

Notes of Meeting
Inaugural Children & Young People Strategic Board

Monday 30 September 2024
2:30 – 4:00
Via TEAMS

Present	
Jennifer Winslade	Executive Director of Nursing
Tracy Daszkiewicz	Executive Director of Public Health
Gail Powell	Lead Nurse Health Visiting
Loredana Moruz	Head of Children's Services, Blaenau Gwent
Helen Morgan	Divisional Nurse Family & Therapies
Natalie Poyner	Head of Children's Services, Newport
Deb Jackson	Divisional Nurse Family & Therapies
Howard Stanley	Head of Safeguarding
Joanne Foley	Principal Public Health Practitioner
Alice Reed	Head of Dietetics
Gemma Burns	Joint Head of Child & Family Psychology & Therapies Service
Gareth Jenkins	Head of Children's Services, Caerphilly
Kavitha Pasunuru	Assistant Divisional Director F&T
Kelly Downes	Deputy Director of Nursing
Lisa Charles	Regional Director, Llais
Nicola Morgan	Consultant Paediatrics
Jacalyn Richards	Head of Children & Family Services, Torfaen
Sara Garland	General Manager F&T
Sian Chard	Assistant General Manager F&T
Suzanne Bryant	Head of OT
Victoria Bodger	Senior Nurse Public Health School Nursing
Yvette Cloete	Clinical Director Paediatrics
Alison Williams	Head of Speech & Language Therapy
Clare Lipetz	Divisional Director F&T
Sarah Carrington	Head of Physiotherapy Services
Joanna Doyle	Head of Nursing F&T
Pippa Cotterill	Designated Clinical Lead Officer F&T

1) Welcome and Introductions

Tracey Daszkiewicz welcomed everyone to the meeting and explained that this meeting was to broaden the conversations around children and young people and to talk about the issues that were impacting children. Allowing the group to think about how to start working system wide starting from the best start in life to all the way through the challenging things that disrupt children's happiness and ensuring transitions are safe towards a healthy and happy adulthood.

Introductions were made, and each member was asked what they would like out of the conversations at these meetings going forward.

2) Terms of Reference

The Group was made aware that the Terms of Reference would be a Health Focussed Strategic Board which would support the partnership agenda with an open invite to the local authority colleagues to ensure the linkage to children's services the integrated space can be made. This was to ensure as a Health Board that there is oversight of the issues and concerns for children and young people within the population from a preventative perspective through to the tertiary services that may be commissioned. This would not be a repeat of the operational business but an opportunity to think about strategically what the programmes may be for improvement.

JW raised the point around seeking a youth representative which she felt the group would need to consider and to think about the opportunities to bring in patient experience.

LC queried that the TOR did not feature Llais anywhere as a member or as an advisory capacity.

JW agreed to add this and informed the group that there was a representative for the Universities, but this had not been secured for the meeting.

GB enquired about the membership and felt that it would be more accurate for it to be changed from Psychological to psychology and therapy.

GJ informed the group that he would represent the Gwent Heads of Children Services and take back the discussion to the Regional Meeting to consider how best they might be represented at this meeting.

CL suggested in terms of the commitment from all service leads if they all would be required to attend this meeting and proposed that she would check the divisional meetings to make their commitments a lot tighter when having this meeting to enable them to attend.

JW was happy for the group to send who they felt appropriate to the meeting. It was agreed to have representatives from each Local Authority, from Education, Primary Care, GP representative, Llais and Urgent Care.

Action: JW

MH raised with the group about how they could best represent the Children and Young People. JW agreed to pick this up with TD.

Action: JW/TD

3 & 4 Existing Work Programmes/Structure of the Work Programme/Agree Workstreams

JC provided an overview of the existing work programmes which were:

- Best Start in Life
- Public Health Work Programmes
- Vaccination
- Maternity Improvement Plan
- HV Improvement Plan
- Transition

JW wanted to ensure that the group were clear on who was leading on these pieces of work and to make sure that this work was relevant and appropriate to come to this meeting.

JW raised the work that had been done on the early years transformation plan and asked if the principals agreed with the Heads of Service across Gwent in the summer were still relevant. As time had moved on JW asked the group whether the work was still required or if this had already been embedded in other work programmes.

TD explained to the group that there would be a joint strategic assessment that had been established to provide an overview of the data. The first area was around children and young people and due to the large amount of data they would face TD explained that they would be starting with maternity to seven years of age, and then seven- to sixteen-year-olds and then transition. The program would last for 18 months which would allow a good collection of evidence to work from. JW agreed that this work was important to help look at the programme moving forward.

AW queried the maternity improvement plan. JW explained having these discussions at this meeting would help reduce duplication and would help to create more clarity particularly around maternity and neonatal services.

KD also mentioned including the Health Child Wales Programme in the work plan. VB informed the group that the Healthy Child Wales school programme would be the biggest strategic transformation. There had been a delay with

Welsh Government in the HCWP work, so the work had started again in September.

HM raised the inclusion of mental health for children and young people. KV agreed that this was high on the agenda for both the Health Board with all the Ministerial priorities but also the Nest Nyth framework. KV felt that this would be important for this Board to have an overview of what is going on but also not to duplicate the work.

JW suggested to the group if it would be more helpful if the programme was to be structured by the areas of the joint strategic needs assessment. Focussing on the preconception to seven, which would pick up the transition from health listening to school nursing then school age. This would prove to be a lot of work to begin with. TD agreed that this would be helpful and would align with the delivery plans and professional disciplines.

JW explained that the transition age group was around 3 transition points which TD had mentioned previously and should be embedded throughout. Jo Doyle, Sara and Barbara Cannito were leading on this work.

The Best Start in Life leads were Sian, flying Start would be Gails successor and Maternity and Neonatal would be between Jane and Helen. Pippa – ALN, Health Child Wales Programme and vaccinations – Victoria Bodger. General principles of children's services – no specific lead due to multiple services.

HM queried if there would be a forum whereby adults could be included to help with the transition. JW explained that she would meet with Joe and Sara to have best representation at this meeting or draw it from the services that are already in place. Howard Stanley has also been asked to be part of this group particularly around some of the safeguarding data and metrics.

ACTION: JW to meet with Joe/Sara

JW informed the group that the Board has just approved a commissioning for quality framework which would start to pull together data around commissioned services and with oversight on where children's waits are. It was noted most of the data would be available via planning which JW agreed to ask them for support.

ACTION: JW

ACTION: JW also agreed to meet with NM and YC re non availability of services impacting on wait times.

5) Agree Metrics/Data

JW agreed to talk to Planning to see what could be drawn in, in terms of metrics to come up with a dashboard to have a broader view around children and young people's services.

There was a need to think about what exists in partnerships, Public Health and planning.

ACTION: TD/JW/Jo D

It was agreed that it was important to draw in experience data, and there was a need to think about children and young people not just adults. The Group also touched on health equity and the fairness and justice with the hope of this data being released.

JW thanked everyone for their contribution and explained that she would take all these suggestions to generate a programme of work.

6) Any Other Business

There was no Any Other Business.

7) Date of Next Meeting

These meeting will be held quarterly. Dates for the next 12 months will be sent out as soon as possible.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD (ABU HB)

CHILDREN AND YOUNG PEOPLE STRATEGIC BOARD (C&YPSB)

TERMS OF REFERENCE

1. INTRODUCTION

The Welsh Government expects Local Authorities, Local Health Boards and their partners, including third sector, to focus on outcomes for children and young people and to ensure that all their partnership working is safe, effective and person centred for children and young people. Children and Young People's (CYP) agencies/partners are accountable to one another for the delivery of all services for children and young people in their area and are expected to hold each other to account collectively as a partnership as well as individually as organisations.

The purpose of the Health Board Children & Young People's Strategy Board is to ensure the delivery of safe, effective, and person-centred care for children and young people. This will be across all levels of care from the promotion of health & wellbeing through to referral for specialist care. Services will be developed for children and young people that are fit for purpose now and for the future, clearly aligned with the Health Board's CYP Strategy and ensuring the Health Board's commitments for CYP in the Public Services Board Wellbeing Plans are monitored and delivered.

2. STATUTORY RESPONSIBILITIES

2.1 Remit

The Children & Young People's strategy board is the Aneurin Bevan Health Board strategic board for the planning and oversight of the delivery of the Children and Young People's services. Specific remit includes:

- Overseeing CYP risks, ensure appropriate escalation and prioritised actions;
- Ensuring an effective audit and review plan with clear reporting and escalation processes;
- taking forward the Health Board's commitments for CYP in the Gwent Regional Partnership Board Area Plan and Wellbeing Plans;
    - ensuring the delivery of a highly engaged approach which involves citizens, partner organisations and clinicians, to deliver health improvement and inequalities agenda to improve the health and wellbeing of Children and Young People;
    - To develop, and monitor compliance against a clear set of HB and multi-agency performance indicators in relation to CYP feeing into the Regional Children & Families Board;

- Contribute to effective planning on CYP services that align to IMTP / Annual planning priorities;
- Provide assurance on the Quality and Performance of Health Board provided and commissioned services
- Oversee the CYP elements of the HBs Annual Quality Statement;
- Ensure the involvement of children and young people and their families in the development and implementation of the plan.

2.2 Responsibilities

- To monitor the delivery of the early years transformation plan
- To ensure a safe and effective system that will support the strategic direction of developing rights-based health and social care in keeping with the United Nations (UN) Convention on the Rights of a Child across all relevant HB services.
- To share and debate developments, whether corporate or locally led, specifically related to the rights of the child to improve outcomes for children and young people and their families/carers and to improve access to services.
- To lead on the development of a Health Board implementation plan for the CYP commitments contained within the Public Services Boards Wellbeing Plans and RPB Children's Area plan.
- To monitor the implementation of the Child & Adolescent Mental Health Services Delivery Plan and related action plans from the Emotional Health and Wellbeing Planning Group.
- To monitor the quality and safety of care within commissioned and provided services for children and young people
- To produce timely high-quality plans for inclusion in the IMTP which directly address population needs, inequalities in health, local issues of clinical safety and quality.
- The Board may form subgroups to identify priorities, measures and alignment into all IMTP.
- Contribute to the IMTP Planning group to include representative from CYP Strategy group to ensure CYP focus.
- To make recommendations for approval by the Board on changes to systems/pathways which deliver prudent healthcare principals and support the health board to deliver effective & efficient services.
- Ensure Youth feedback is incorporated into core functioning of Health Board
- Provide oversight of the transition to Adult Services for Children and Young People.

2.3 Legislative Requirements

- To ensure that the Health Board complies with the statutory requirements of the Children Act 2004 Sections 25(8), 26(5) and 27(4) of the Act deal with local co-operation and leadership of change.
- To ensure that any safeguarding issues are submitted to the Safeguarding Committee for discussion and resolution to comply with Section 28 of the Children Act 2004.
- Looked after children – Corporate Parenting Charter

2.4 Partnerships

To lead the development of a robust, system wide implementation plan to support the overall CYP Strategy and to progress priority setting through horizon scanning & Planning with partners.

3. MEMBERSHIP

Joint Chairman: Executive Lead for Children and Young People (Director of Nursing)
Executive Lead for Public Health (Director of Public Health)

Vice Chair:

Members:
DECLO
Deputy Director of Nursing
Director of Strategy (Planning and Partnerships)
General Manager, Family & Therapies
Divisional Nurse Family & Therapies x 2
Divisional Nurse Urgent Care
Divisional Director Family & Therapies
Head of Maternity Services
Head of Safeguarding services
Clinical Director for Paediatrics
Head of Paediatric Speech and Language Therapy
Head of Paediatric Occupational Therapy
Head of Paediatric Physiotherapy
Head of Nutrition & Dietetics
Lead Nurse for School Health Nursing and LAC
Lead Nurse for Health Visiting
Psychology and therapy representative
Youth representative
Representative of the Head of Children's services Newport, Torfaen, Caerphilly, Blaenau Gwent, Monmouthshire Local Authority's
Representative from Cardiff University & Cardiff University
Third Sector representative
Education Representative
Llias representative

In the event of a member being unable to attend a representative must be identified to attend who must be fully briefed and able to act under full delegated authority.

DRAFT

Co-option - Other attendees may be invited by the chair in order to meet the core deliverables of the group or respond to particular areas of risk or development.

Secretary: Director of Nursing Executive Assistant

Quorate - There should be at least six in attendance including: the Chairman / Vice Chairman; at least four Units; one therapist; and one partner in attendance for a meeting to be quorate.

Frequency - Meetings shall be held not less than quarterly and otherwise as the Chairman of the Group deems necessary.

6. MEETING ARRANGEMENTS

Notes will be circulated for accuracy within 7 days of a meeting being held.

Agenda Items and papers are to be sent to the secretary 10 days before the meeting.

All meeting papers are to be circulated 7 days before each meeting.

7. REPORTING

The Aneurin Bevan Children & Young People Strategic Board will formally report through to the Executive Committee and to the Patient Quality and Safety Oversight Committee for assurance.

Version:

Date Agreed:

Review Date:

DRAFT

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 November 2024
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels (Wales) Act 2016: Spring calculations following January 2024 Acuity Audit and Review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade: Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kelly Downes: Deputy Director of Nursing

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

Er Gwybodaeth/For Information

This report is to set out the findings of January 2024 acuity audit and subsequent Spring Recalculations to provide assurance of the Health Board's compliance to the Nurse Staffing Act 2016 (NSLWA).

j

Sefyllfa / Situation

In accordance with the NSLWA, Health Boards and Trusts have a duty to use the triangulated approach to calculate the nurse staffing levels in adult acute medical, surgical, and paediatric wards. Health Boards must demonstrate that all reasonable steps have been taken to maintain nurse staffing levels. There is also a requirement to report compliance in maintaining the nurse staffing levels as a means of providing assurance to the public, the Board and Welsh Government.

Consequently, the All-Wales Nurse Staffing Group agreed a Once-for-Wales approach to provide consistency in reporting across all Health Boards. A clear governance process is required to inform the Board, or delegated committee, of any changes following the Spring recalculations.

The January 2024 acuity audit and recalculation has been presented to the Executive Team for assurance and noting.

Cefndir / Background

The NSLWA became law in 2016 and requires Health Boards to have regard for the provision of appropriate nurse staffing levels to ensure nurses have time to care for patients sensitively.

The NSLWA statutory guidance states that health boards should undertake a recalculation every six months for all wards that come under Section 25B of the Act. The acuity audits take place in January and June each year.

The Executive Team were appraised of the changes made to 25B Wards following the June 2023 acuity audit and subsequent Autumn re-calculations.

The Executive Team supported the amendments and subsequently presented to and agreed by the Board in November 2023.

Asesiad / Assessment

In accordance with the NSLWA - a systematic triangulated approach to review and recalculate the nurse staffing levels on all 25B wards (Adult and Paediatric) has been applied as stipulated in legislation.

Following the January 2024 acuity audit, in-depth discussions were held with the Divisional/Head of Nursing Nurse, Senior Nurse, Ward Manager, Nurse Staffing Act Programme Lead as well as representation from the e-rostering and finance teams throughout the months of March and April.

Discussions included the type of ward, bed base, funded establishment, aligned budget, e-roster housekeeping and Safecare compliance. The acuity levels taken from the January audit were scrutinised along with the staffing levels deployed, including bank and agency usage and variable pay. There was a deep dive of quality indicators from the previous 6 months which included incidences of hospital acquired pressure ulcers, patient falls with harm, medication errors, infection rates and complaints. All learning taken from the incidences was shared. PADR and mandatory training compliance was also reviewed.

Following these discussions, a professional judgement was made to determine if the staffing levels were appropriate to provide sensitive care. An agreed template for each 25B ward was subsequently completed by the Divisional Nurse and recommendations were presented to the Executive Director of Nursing, Deputy Director of Nursing and Nurse Staffing Project Lead in the form of a challenge and support meeting.

In total 34 wards are included under the reporting requirement of The Act for January 2024:

Acute Medical:	20 Wards
Surgical:	12 Wards
Gynaecology:	1 Ward
Paediatrics:	1 Ward (50 beds)

7 Wards in total have been identified as requiring amendments to previously agreed rosters (2 in the Division of Surgery and 5 in the Division of Medicine).

The Executive Committee were asked to note the following recalculations:

Surgery

C0: (31 bedded Head & Neck surgical ward + 5 Machen beds)

The Divisional Management Team have agreed to fund the necessary increase in staffing template for this ward to support the 5 Maccen beds (elective Head & Neck, ENT, and Maxillofacial urgent suspected cancer procedures). These beds are situated on ICU but staffed by Ward C0. The establishment is to increase by:

1 RN Tuesday - Saturday Day
1 RN Tuesday - Friday Night.
1 HCSW Tuesday – Friday Day
1 HCSW Tuesday – Friday Night.

Total Cost: £284,665 per annum. (RN £173,371 HCSW £111,294)
Funded by Directorate

D7E (20 bedded T&O ward)

This ward has been repurposed, the original plans and agreed establishment was for this ward to be an elective Trauma & Orthopaedic (T&O) ward. Due to bed pressures, since the opening of GUH, the ward has mainly operated as a step-down orthopaedic ward requiring increased staffing levels through variable pay to support the higher acuity and increased dependency of this cohort of patients.

The previous recalculation meeting recognised these issues (complex care pathways, spinal injuries, cognitive impairment, increase length of stay, complex discharge planning). The possible need for a change of purpose and review of establishment was discussed, however, the long-term plans for the ward were not determined, therefore the decision was to continue to staff the extra requirements though variable pay until a decision was made on the future purpose of the ward.

Following the spring calculations an SBAR was taken to the Divisional Management team in April, and D7E is to be redefined as a step-down orthopaedic ward.

There is a requirement to increase the establishment to reflect the change of purpose and to ensure the planned roster can meet the acuity and dependency of the patients.

The variable pay expenditure over a 3-month period from 1 April 2024 to 30 June 2024 is £170,962.

The new template is to increase by:
1 RN 7 days per week
1 HCSW 7 nights per week.

Total Cost: £240,896 per annum. (RN £124,351, HCSW £116,545)

Medicine

The Spring and Autumn calculations undertaken in 2023 identified the need to amend planned roster on 5 wards in the Division of Medicine. The agreed changes have been on hold pending the reconfiguration of Stroke services which is now complete.

The deep dive discussions and acuity data supports the activity coordinator role. However, it is recognised that a review and evaluation is required, this will include a national review and benchmark exercise prior to requesting the additional role across medicine. A lead within the division has been appointed to carry out this piece of work.

The Spring 2024 recalculations identified 5 wards require changes to the planned roster 2 of which are cost neutral.

Ward 3.2 (28 bedded integrated care ward, in constant surge to 32 beds)

This ward constantly operates at 32 bed capacity. A review of the acuity, dependency, quality indicators and variable pay usage (over the last 12 months) supports the need to increase to a 4th HCSW by night.

Therefore, proposing the nursing roster includes an increase of 2.8 WTE Band 2 HCSW.

This will reduce variable pay spend of band 2 HCSW which for the reporting period of 1 September 2023 - 5 April 2024 was £174, 657.

Total Cost: £120,734 per annum.

Ward 3.4 (Re-purposed to a 28 bedded COTE ward)
This ward was previously a 24 bedded stroke rehabilitation ward and has been repurposed to a COTE ward, in constant surge to 28 beds with the capacity to board a further 4 patients. Discussions with the ward manager, a review of the acuity, dependency, quality metrics and variable pay usage over the last 12 months has evidenced a need for an increase to a 4th HCSW at night. The proposed roster requires an increase of 2.8 WTE band 2 HCSW to meet patient needs and manage the constant use of surge beds. This will reduce variable pay spend of band 2 HCSW which for the reporting period of 1 September 2023 - 5 April 2024 was £196,779. **Total Cost: £120,734 per annum.**
Bargoed Ward YYF (Repurposed to 28 bedded Stroke rehabilitation ward)
This ward has been repurposed from a 28 bedded shared COTE/Stroke Rehabilitation ward to a 28 bedded Stroke Rehabilitation ward. Review of the acuity data and staff feedback over the last 6 months support the need to increase the nursing establishment by 1 band 2 HCSW 12hrs per day 7 days a week, this equates to an additional 2.8 WTE HCSW. The rationale for the additional HCSW is based on the increased dependency of patients who are transferred from GUH at an earlier stage of the pathway. This also impacts on the acuity of the patient and their medicine management which leads to an increased time spent administering medicines due to the number of patients with a percutaneous endoscopic gastrostomy (PEG) in place. This prevents the RN from being available to assist the HCSW with the delivery of the fundamentals of care needs. The addition of these substantive posts will reduce variable pay spend of band 2 HCSW which for the reporting period of 1 September 2023 - 5 April 2024 was £180,327. **Total Cost: £95,847**
EFU YYF (28 bedded Elderly Frail Unit)
Following review of the data and in view of high RN vacancies which are difficult to recruit to, a change to the core care model has been agreed.

A Band 2 Activities Coordinator Monday to Friday 7.5-hour shifts (no uplift) will be trialled.

This role will be funded by existing vacancies and offset some of the band 2 HCSW variable pay spend which for the reporting period of 1 September 2023 - 5 April 2024 was £150,847.

Cost neutral

Oakdale Ward YYF (Repurposed to 27 bedded Stroke Rehabilitation ward)

This ward has been repurposed from a 30 bedded COTE Rehabilitation ward to a 27 bedded Stroke Rehabilitation ward. There has been a reduction of 3 beds to enable stroke therapy space.

A band 2 Activities Co-ordinator Monday – Friday 7.5-hour shifts (no uplift) will be trialled and funded by existing vacancies.

The staff will need time to adjust to the change of purpose of this ward, acuity levels will be closely monitored over the next 6 months to determine if the staffing levels are appropriate.

Cost neutral

Financial Impact of Staffing Level Recalculations

The staffing level recalculations result in an overall cost pressure of £70,000 (see table below). This financial implication arises from the minimal difference in cost between bank and substantive HCSW. More costly agency HCSW have not been utilised for many months – these staff are only used by exception.

While the financial impact of the recalculated staffing levels is not significant, the very important advantages are:

- Enhanced continuity of patient care
- Improved patient and staff safety
- Increased assurance of consistently in meeting required staffing levels
- Reduced risk in delivering safe, timely, effective, efficient, equitable and patient centred care

The change underscores the Health Board's commitment to maintaining a stable and reliable workforce, prioritising quality of care over short-term cost reductions.

	Ward				
	Surgery	Medicine			
	D7E £'000	3.2 £'000	3.4 £'000	Bargoed £'000	Total £'000
Cost of Investment	245	121	121	96	582
Variable Pay Saving	230	94	94	94	513
Net Cost Increase	15	27	27	2	70

These costings are based on a full year value of expected variable pay saving based on 'actual' spend to date.

Inpatient Ward Reconfiguration

Any changes in the group of patients that are cared for on a ward, the number of beds being used, and/or the purpose of the ward must be formally reviewed to ensure nurse staffing levels are appropriate to safely meet the needs of patients.

The decision on what the nurse staffing level is for each ward must ultimately be made by the designated person (Executive Nurse Director) on behalf of the health board in line with the NSLWA (2016) Statutory Guidance.

Appendix 1: provides a summary of the required establishment for all 25B wards following the Spring 2024 recalculations.

Appendix 2: provides detail for the 7 wards identified following the Spring recalculations as requiring alterations to their agreed templates.

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Committee is asked to: -

- Note the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA.
- Note to the alterations of ward establishments and planned rosters for the 2 wards in the Division of Surgery and the 5 wards in the Division of Medicine.

- Note that the financial cost of increasing ward establishments should be weighed against the advantages in terms of safe care delivery.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 2. Safe Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	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. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	• Nurse Staffing Levels (Wales) Act 2016 • Health and Social Care (Quality and Engagement) (Wales) Act 2020.
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/	Choose an item. Choose an item.

APPENDIX 1: SUMMARY OF REQUIRED ESTABLISHMENT	
Health Board:	Aneurin Bevan University Health Board
Period reviewed:	**Column 1** = June 2023 Acuity Audit (Autummn Calculations) **Column 2** = January 2024 Acuity Audit (Spring Recalculations)
Number of Ward where section 25B applies:	June 2023 = 21 Med 13 Surg (1Gynae) 1 Paediatric = 35 January 2024: 20 Med 13 Surg (1 gynae) 1Paediatric total = 34

MEDICAL WARDS												
Ward	Required establishment at the start of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the start of the reporting period	Required establishment at the end of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the end of the reporting period	Bi-annual calculation cycle reivews and reasons for any changes made			Any reviews outside of bi-annual calculation, if yes, reasons for any changes made		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
C4E RGH	15.48	25.2	yes (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	yes	No	Discussions had arouind Substantive activities coordinator. Need more evidenc of benefits	No		
C5E RGH	15.48	16.78	YES (WTE RN figures include ward manager)				NO- C5E is no longer a 25B ward					
C5W RGH	15.48	25.22	YES (WTE RN figures include ward manager)				NO - C5W is no longer a 25B ward					
C6E RGH	15.48	22.4	YES (WTE RN figures include ward manager)	15.48	22.4	YES (WTE RN figures include ward manager)	YES	NO		NO		
C6W RGH	18.32	22.4	YES (WTE RN figures include ward manager)	18.32	22.4	YES (WTE RN figures include ward manager)	YES	NO		NO		
D4E RGH	15.48	25.2	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	NO		NO		
D4W RGH	15.48	25.2	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	No		NO		
D5W RGH				15.48	25.2	YES (WTE RN figures include ward manager)	YES	NO	Ward opened following Stroke reconfiguration	NO		
3.1 NHH	15.48	25.2	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	No	Discussions had arouind Substantive activities coordinator. Need more evidenc of benefits	NO		
3.2 NHH	15.48	22.42	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	YES	To offset variable pay Consistently in surge to 32 beds requiring 4th HCSW by night, high acuity	NO		
3.3 NHH	15.48	25.2	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	No		NO		
3.4 NHH	15.48	22.42	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	YES	To offset variable pay, Consistent use of surge beds, high acuity, requiring 4th HCSW by night.	YES 29.1.2024 Following Stroke Reconfiguration	NO	Suggested changes supported with variable pay- await Spring calculations to finalise

4.3 NHH	15.48	25.2	YES (WTE RN figures include ward manager)	15.48	25.2	YES (WTE RN figures include ward manager)	YES	NO		NO		
4.4 NHH	21.18	13.98	YES (WTE RN figures include ward manager)	21.18	13.98	YES (WTE RN figures include ward manager)	YES	NO		NO		
EFU YYF Previously Oakdale	18.32	22.36	YES (WTE RN figures include ward manager)	15.48	25.2 +	YES (WTE RN figures include ward manager)	YES	YES	Staff on Old Okdale ward moved to EFU-change to Core care Model, cost neutral	YES - 1.2.2024 Following Stroke Reconfiguration	No	
Oakdale YYF previously Bedwas	18.32	22.36	YES but not funded	15.48	25.2	YES (WTE RN figures include ward manager)	YES	YES	Bedwas closed & staff moved to Oakdale ward after Stroke reconfiguration-convert to Core care model, cost neutral	YES - 1.2.2024 Following Stroke Reconfiguration	No	
Bargoed YYF	15.48	25.2	YES (WTE RN figures include ward manager)	15.48	27.99	YES (WTE RN figures include ward manager)	YES	YES	High acuity- stroke rehab- extra HCSW by day	YES - 1.2.2024 Following Stroke Reconfiguration		Suggested changes supported with variable pay- await Spring calculations to finalise
Risca YYF	18.32	22.36	YES (WTE RN figures include ward manager)	18.32	22.36	YES (WTE RN figures include ward manager)	YES	NO		NO		
A2 GUH	21.16	16.78	YES (WTE RN figures include ward manager)	21.16	16.78	YES (WTE RN figures include ward manager)	YES	NO		NO		
A4 GUH	26.86	22.38	YES (WTE RN figures include ward manager)	26.86	22.38	YES (WTE RN figures include ward manager)	YES	NO		NO		
B4 GUH	24	22.37	YES (WTE RN figures include ward manager)	24	22.37	YES (WTE RN figures include ward manager)	YES	NO		NO		
C4 GUH	41.06	27.97	YES (WTE RN figures include ward manager)	41.06	27.97	YES (WTE RN figures include ward manager)	YES	NO		NO		

Health Board:	Aneurin Bevan University Health Board
Period reviewed:	**Column 1** = June 2023 Acuity Audit (Autummn Calculations) **Column 2** = January 2024 Acuity Audit (Spring Recalculations)
Number of Ward where section 25B applies:	June 2023 = 21 Med 13 Surg (1Gynae) 1 Paediatric = 35 January 2024: 20 Med 13 Surg (1 gynae) 1Paediatric total = 34

SURGICAL WARDS

Ward	Required establishment at the start of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the start of the reporting period	Required establishment at the end of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the end of the reporting period	Bi-annual calculation cycle reivews and reasons for any changes made			Any reviews outside of bi-annual calculation, if yes, reasons for any changes made		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
C7E RGH	15.48	22.4	yes (WTE RN figures include ward manager)	15.48	22.4	yes (WTE RN figures include ward manager)	YES	NO -Not at this time	? Need extra HCSW by night - await more acuity data & varaible pay and review in Autum calculations	NO		
C7W RGH	15.48	19.61	yes (WTE RN figures include ward manager)	15.48	19.61	yes (WTE RN figures include ward manager)	YES	NO		NO		
D2E RGH	15.48	8.38	yes (WTE RN figures include ward manager)	15.48	8.38	Yes (WTE RN figures include ward manager)	YES	NO		NO		
D2W RGH	12.23	3.59	yes (WTE RN figures include ward manager)	12.23	3.59	yes (WTE RN figures include ward manager)	YES	NO		NO		
D3E RGH	18.32	19.62	yes (WTE RN figures include ward manager)	18.32	19.62	yes (WTE RN figures include ward manager)	YES	NO		NO		
D3W RGH	15.48	22.46	yes (WTE RN figures include ward manager)	15.48	22.46	yes (WTE RN figures include ward manager)	YES	NO		NO		
D7E RGH	12.64	11.22	yes (WTE RN figures include ward manager)	15.48	14.02	yes (WTE RN figures include ward manager)	YES	NO	Change of purpose from elective T&O to step down T&O -very acute patients	NO		
4.2 NHH	15.48	22.42	yes (WTE RN figures include ward manager)	15.48	22.42	yes (WTE RN figures include ward manager)	YES	NO - Not at this time	? Need extra HCSW by night - always in surge beds, await more acuity data and variable pay, review in Autum calculations	NO		
OSU SWH	17.91	8.39	yes (WTE RN figures include ward manager)	17.91	8.39	yes (WTE RN figures include ward manager)	YES	NO		NO		
A0 GUH	26.85	27.99	yes (WTE RN figures include ward manager)	26.85	27.99	yes (WTE RN figures include ward manager)	YES	NO		NO		
B0 GUH	26.85	27.99	yes (WTE RN figures include ward manager)	26.85	27.99	yes (WTE RN figures include ward manager)	YES	NO		NO		
C0 GUH	26.85	25.2	yes (WTE RN figures include ward manager)	30.3	28.55	yes (WTE RN figures include ward manager)	YES	NO		NO		
A3 - Gynae GUH	21.16	13.98	yes (WTE RN figures include ward manager)	21.16	13.98	yes (WTE RN figures include ward manager)	YES	NO		NO		

Health Board:	Aneurin Bevan University Health Board
Period reviewed:	**Column 1** = June 2023 Acuity Audit (Autummn Calculations) **Column 2** = January 2024 Acuity Audit (Spring
Number of Ward where section 25B applies:	June 2023 = 21 Med 13 Surg (1Gynae) 1 Paediatric = 35 January 2024: 20 Med 13 Surg (1 gynae) 1Paediatric

Paediatrics											
Ward	Required establishment at the start of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the start of the reporting period	Required establishment at the end of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the end of the reporting period	Bi-annual calculation cycle reivews and reasons for any changes made			Any reviews outside of bi-an	
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**
C1	76.91	17.06	yes (WTE RN figures include ward manager)	76.91	17.06	yes (WTE RN figures include ward manager)	YES	NO		N0	

Recalculations)
total = 34

nual calculation, if yes, reasons for any changes made
Rationale

Appendix 2

Appendix 2- summary of amendments required to establishments post Spring 2024 recalculations						
Ward	Pre-Calculation			Post-Calculation		
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE
C0 GUH	26.85	25.2	52	30.3	28.55	58.85
D7E RGH	12.64	11.22	23.86	15.48	14.02	29.5
3.2 NHH	15.48	22.42	37.9	15.48	25.2	40.68
3.4 NHH	15.48	22.42	37.9	15.48	25.2	40.68
Bargoed YYF	15.48	25.2	40.68	15.48	27.99	43.78
EFU YYF	18.32	22.36	40.68	15.48	25.2	40.68 Cost neutral
Oakdale Ward YYF	18.32	22.36	40.68	15.48	25.2	40.68 Cost neutral