Patient, Quality, Safety Outcomes Committee

Mon 31 March 2025, 09:30 - 12:30

Microsoft Teams

Agenda

1. PRELIMINARY MATTERS

PQSOC 20250331 Agenda - Approved.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 20th January 2025

Attached *Chair*

PQSOC 20250331 1.4 PQSOC Minutes 20th Janaury reviewed BC.docx +HS.pdf (12 pages)

1.5. Committee Action Log

Attached *Chair*

PQSOC 20250331 1.5 Action Log March - Approved.pdf (2 pages)

2. ITEMS FOR DISCUSSION

2.1. Annual Review of Committee Terms of Reference 2024/25

Attached *Director of Corporate Governance*

PQSOC 20250331 2.1 PQSOC Terms of Reference Review 2025 Cover Report .pdf (3 pages)
PQSOC 20250331 2.1 Appendix 1 - PQSO Committee_Draft Dec 2024.pdf (12 pages)

2.2. Committee Annual Report 2024/25

Attached *Director of Corporate Governance*

PQSOC 20250331 2.2 PQSOC Annual Report 2024-25 Cover Report.pdf (4 pages)
PQSOC 20250331 2.2 Appendix 1 - 2024-25 PQSOC Annual Report.pdf (49 pages)

2.3. Committee Risk Report

Attached *Director of Corporate Governance*

PQSOC 20250331 2.3 Risk and Assurance Report - Cover report.pdf (5 pages)
PQSOC 20250331 2.3 Appendix A - PQSOC Dashboard and Risk Assessments.pdf (7 pages)

2.4. Performance Quality Interim Report

Attached *Director of Nursing*

A) Healthcare Inspectorate Wales Inspection Report

- PQSOC 20250331 2.4 Performance Report Cover Report .pdf (5 pages)
- PQSOC 20250331 2.4 Appendix 1 Performance Report .pdf (104 pages)
- PQSOC 20250331 2.4 HIW Inspection Report - ED GUH Cover report.pdf (7 pages)
- PQSOC 20250331 2.4 Appendix 1 TheGrangeEDEN.pdf (70 pages)

2.5. Healthcare Inspectorate Wales Annual Report

Attached *Director of Nursing*

- PQSOC 20250331 2.5 Health Inspectorate Wales Annual Report 2023_24 Cover report .pdf (6 pages)
- PQSOC 20250331 2.5 Appendix1 HIW Annual Report 2023-24.pdf (72 pages)

2.6. Medical Devices Annual Report 2023/24

Attached *Director of Allied Health Professions & Health Science*

- PQSOC 20250331 2.6 MDC annual activity report.pdf (23 pages)
- PQSOC 20250331 2.6 Appendix 1 Welsh Government Health and Care Standards Framework April 2015.pdf (41 pages)
- PQSOC 20250331 2.6 Appendix 2 The MDC Workplan as at October 2023.pdf (8 pages)
- PQSOC 20250331 2.6 Appendix 3 MDC agendas and minutes for quorate meetings held in reporting period 2023-2024 – Agenda 29.06.2023.pdf (2 pages)
- PQSOC 20250331 2.6 Appendix 4 - MDC agendas and minutes for quorate meetings held in reporting period 2023-2024 – Minutes 29.06.2023.pdf (4 pages)
- PQSOC 20250331 2.6 Appendix 5 - MDC agendas and minutes for quorate meetings held in reporting period 2023-2024 – Agenda 12.10.2023.pdf (1 pages)
- PQSOC 20250331 2.6 Appendix 6 - MDC agendas and minutes for quorate meetings held in reporting period 2023-2024 – Minutes 12.10.2023.pdf (6 pages)
- PQSOC 20250331 2.6 Appendix 7 - 2017 Medical Devices Audit Progress Tracker.pdf (2 pages)
- PQSOC 20250331 2.6 Appendix 8 - ARAC Reporting papers – February 2024 - 2017 Medical Equipment and Devices.pdf (6 pages)
- PQSOC 20250331 2.6 Appendix 9 - ARAC Reporting papers – February 2024 – 2017 Health and Safety, 2017 Medical Equipment and Devices.pdf (2 pages)
- PQSOC 20250331 2.6 Appendix 10 - Draft Executive Committee Paper and Health Board response to the Welsh Government's baseline check on preparedness.pdf (7 pages)
- PQSOC 20250331 2.6 Appendix 11 - Draft Executive Committee Paper and Health Board response to the Welsh Government's baseline check on preparedness - Worksheet C.pdf (2 pages)
- PQSOC 20250331 2.6 Appendix 12 - Incident Reports Spreadsheet Summarising the Period 01-04-2023 to 31-03-2024.pdf (3 pages)
- PQSOC 20250331 2.6 Appendix 13 - Summary of Activity by the FSCA Handling Combined Team.pdf (2 pages)
- PQSOC 20250331 2.6 Appendix 14 - Summary Table of PSA's and PSN's Covered within Reporting Period.pdf (1 pages)
- PQSOC 20250331 2.6 Appendix 15 - Summary of Internal Communiques Issued within Reporting Period.pdf (1 pages)
- PQSOC 20250331 2.6 Appendix 16 EBME Performance Review Report - March 2024.pdf (3 pages)
- PQSOC 20250331 2.6 Appendix 17 - QPS Infusion Training End-of-Year Report.pdf (3 pages)
- PQSOC 20250331 2.6 Appendix 18 – Terms of Reference.pdf (7 pages)

2.7. Nutrition and Hydration Committee Interim Report

Attached *Director of Allied Health Professions & Health Science*

- PQSOC 20250331 2.7 Nutrition Hydration interim activity report.pdf (11 pages)
- PQSOC 20250331 2.7 Appendix 1 Nutrition & Hydration strategic steering group draft terms of reference.pdf (5 pages)
- PQSOC 20250331 2.7 Appendix 2 Clinical (artificial) Nutrition & Hydration sub-group draft Terms of reference.pdf (5 pages)
- PQSOC 20250331 2.7 Appendix 3 Regulation 28 action plan.pdf (5 pages)
- PQSOC 20250331 2.7 Appendix 4 Terms of reference for fluid balance task & finish group.pdf (2 pages)
- PQSOC 20250331 2.7 Appendix 5 Terms of reference for escalation of nutritional needs task and finish group.pdf (3 pages)

3. FOR INFORMATION

3.1. NHS Wales Joint Commissioning Committee’s Quality Report

Attached *Director of Corporate Governance*

PQSOC 20250331 3.1 QSO Highlight Report Feb 25.pdf (6 pages)

3.2. Listening & Learning Forum Assurance Report

Attached *Director of Nursing*

PQSOC 20250331 3.2 PQSLI 11.02.25 - Assurance Report .pdf (2 pages)

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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: Tuesday 3rd June 2025

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

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE AGENDA	
Date and Time	Monday 31st March 2025 at 09:30AM-12:30PM
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 20th January 2025	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR DISCUSSION**		
2.1	Annual Review of Committee Terms of Reference 2024/25	Attached	Director of Corporate Governance
2.2	Committee Annual Report 2024/25	Attached	Director of Corporate Governance
2.3	Committee Risk Report	Attached	Director of Corporate Governance
2.4	Performance Quality Interim Report	Attached	Director of Nursing
2.5	Healthcare Inspectorate Wales Annual Report	Attached	Director of Nursing
2.6	Medical Devices Annual Report 2023/24	Attached	Director of Allied Health Professions & Health Science
2.7	Nutrition and Hydration Committee Interim Report	Attached	Director of Allied Health Professions & Health Science
3	**FOR INFORMATION**		
3.1	NHS Wales Joint Commissioning Committee's Quality Report	Attached	Director of Corporate Governance

3.2	Listening & Learning Forum Assurance Report	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: • Tuesday 3rd June 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 20th January 2025, 09:30am-12:30pm
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Independent Member, Committee Chair Paul Deneen, Independent Member Penny Jones, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Peter Carr, Director of Allied Health Professions & Health Science 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 Leanne Watkins, Chief Operating Officer (Item 2.2 only) Louise Turner, Divisional Director for Mental Health (Item 2.2 only) Jonathan Simms, Clinical Director of Pharmacy (Item 2.6 only) Jayne Beasley, Head of Midwifery & Gynaecology Karen Hatch, Assistant Director of Therapies and Health Science Kelly Downes, Deputy Director of Nursing Fern Woodhead, Committee Secretariat
OBSVERING	Star Moyo, Health Inclusion Service Senior Nurse Lyn Puckett, Trade Union Representative
APOLOGIES	James Calvert, Medical Director

PQSOC 2001/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 2001/02	**Apologies for Absence** The Chair noted the apologies for absence.
PQSOC 2001/03	**Declarations of Interest** There were no declarations of interest raised relating to items on the agenda.

PQSOC 2001/04	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 12th November 2024 were agreed as a true and accurate record of the meeting, subject to the following change: - • Page 11 change from "improvement violence and aggression within the workplace" to "reduce violence and aggression within the workplace". **Action: Committee Secretariat** The Committee **APPROVED** the minutes based on the change made.
PQSOC 2001/05	**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. Rani Dash (RD), Director of Corporate Governance, advised the Committee that it was not appropriate to report the SOP on Deep Dives to the Committee and therefore this action would be removed. Peter Carr (PC), Director of Allied Health Professions & Health Science, advised the Committee that the Health & Safety cover report for the Board meeting in January would include updated compliance performance and the performance report will include information on the continuous progress being made on the review of all Health & Safety policies.
PQSOC 2001/06	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. The Committee was advised that the Committee Risk Register included three high-level risks and three sub-risks, covering service delivery, transformation and partnership working, and compliance and safety. The risk environment had remained stable, and there were no changes to the risk scores for the monitored risks. Penny Jones (PJ), Independent Member, asked how the risk for the Health Board failing to build positive relationships with patients, staff and the public could be improved. Jennifer Winslade (JW), Director of Nursing,

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	advised that the Health Board were at the early stages of having an approach of engaging with patients and were making progress but were not in a postion to reduce the risk. Peter Carr (PC), Director of Allied Health Professions & Health Science, provided the Committee with assurance that the Health & Safety risk had reduced from a risk sore of 16 to 12 and they were continuing to deliver the improvement plan with the aim to reduce to the risk score to 8. The Committee **NOTED** the delegated strategic risks and the work being undertaken to ensure the Committee was included on all risks that have the potential to impact patient quality and safety.
PQSOC 2001/07	**Mental Health Act Monitoring Report** Leanne Watkins (LW), Chief Operating Officer, presented the Mental Health Act Monitoring report, advising that the report provided assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act. The Committee was advised that the Mental Health Act Monitoring Committee had been stood down and the report had been brought to the Committee to ensure compliance remained until the new Mental Health and Learning Disabilities Committee meets in March. Paul Deneen (PD), Independent Member, questioned if the staff were aware of the new Committee and changes to the new format of the report. LW advised that communications had been shared with the staff. Rani Dash (RD), Director of Corporate Governance, confirmed to the Committee that a pre meeting was in place to develop the forward work plan. Penny Jones (PJ), Independent Member, questioned why the tribunal hearings cancellation numbers were so high. Louise Turner (LT), Divisional Director for Mental Health, advised that on occasion it would be cancelled by the patients, but there was work in progress to analyse the data and understand the reasons for the cancellations. The Committee **NOTED** the information provided on the use of the Mental Health Act.
PQSOC 2001/08	**Quality Performance Report**

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Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Performance report for quarter 1 to 3 2024/25, advising that the Quality report was mapped across 6 domains of quality and the 6 quality enablers and structured under the Health Board's 6 Pillars of Quality.

The Committee was advised that work was ongoing to change the way the information within the report was reported to have more of a focus on quality rather than performance.

JW advised the Committee that the patient experience, and patient engagement and involvement strategy continued to progress to deliver person-centred care, which included patient participation panels, PALS and bereavement services.

The Committee was advised that the Learning and Improvement forum had now been set up with the aim to share the learning across the Health Board and strengthen the learning and listening infrastructure.

Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided the Committee with a progress update following a review by Welsh Risk Pool of the consent process, for patients having a medical procedure.

The Committee was advised that 5 consent forms were reviewed with the finding highlighting that most patients signed their forms on the day of the procedure, with some forms completed weeks in advance. However, there were issues with illegible signatures and missing clinician details.

LL outlined the areas of focus in order to implement improvements following the review:

- Policy review;
- Compliance with the All-Wales forms;
- Intranet update;
- The All-Wales Model policy for consent had been adopted;
- Governance process;
- Audit programme;
- Continuous monitoring.

The Committee was advised that 2 new videos had been created to help patients understand the process of obtaining consent for a medical procedure, with the aim to have the videos shared with the public via the internet.

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LL advised the Committee that Aneurin Bevan University Health Board was the only Health Board to gather feedback from patients when completing an audit on consent.

Paul Deneen (PD), Independent Member, asked what support was being provided to asylum seekers. LL advised that training was being provided to staff to help support a patient's understanding of consent forms.

JW provided the Committee with an update on the 2 areas currently in escalation - Urgent & Emergency Care and Mental Health & Learning Disabilities.

The Committee was advised that urgent & emergency care was still in the process of improving its position with the new operational framework continuing to develop, including:-

- Weekly Safety Flow cross divisional meetings
- Additional ED Consultants appointed
- Safe-to-Start meetings started on 13th January 2025
- Transfer Lounge going live in Feb/march

The Committee was advised about work being undertaken to look at a paid employee role to support patients checking in on the electronic system at the emergency department waiting room.

JW advised the Committee that work was on going to improve the position in Mental Health & Learning Disabilities, including engagement and workshops that would support the development of services and communication plans based on the feedback received.

The Committee was provided with assurance that there had been a focus on safeguarding level 1 & 2 training, with a 91.6% compliance at level 1. It was highlighted that further work was required to improve the level 3 training compliance.

PD questioned if the Health Board was developing a safe to leave process. JW advised that there was not a safe to leave process, but work was being undertaken to develop a discharge check list and a review of the discharge policy.

The Committee was advised that the Health Board remained in a positive position of 86% on CIVICA for patient feedback, exceeding the 85% benchmark and would continue to bring patients stories to Board.

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JW advised the Committee that there had been a focus on complaints, concerns and compliments with early resolution reporting at 67%. Work was underway to encourage reporting of compliments. It was highlighted that the 30day compliance for responding to complaints was currently 55%, below the target of 75%.

The Committee was advised that the Health & Safety team had significantly improved compliance with RIDDOR reporting at 86%. It was highlighted that work was ongoing to improve the manual handling training compliance, which remained low at 69%.

The Committee was advised that there was a programme of work focussing on sepsis management. The Health Board had been working with a family that had lost their son to sepsis to ensure that communication to the public was clear for families to know what to look for to identify early signs of sepsis.

JW advised the Committee that the ward accreditation had rolled out across several divisions. 3 accreditations had been awarded in December and these wards were now working toward their silver award.

The Committee was advised that there had been 2 never events between April to December 2024. 1 was within a non-theatre environment and the other being historical and found during a scan. Assurance was provided to the Committee that both events had resulted in no harm.

JW advised the Committee that the total number of fall incidents averaged 302 per month, with 99% being no or low harm.

Peter Carr (PC), Director of Allied Health Professions & Health Science, advised the Committee that he is leading a thematic review of falls with catastrophic and severe harm outcomes, looking back at such incident as far as 2019. The aim of the thematic review is to identify further action that can be taken to reduce the incidence of those type of falls.

Helen Sweetland (HS), Chair, questioned why there had been an increase in falls. PC advised that the increase in the overall number of hospital falls was most likely due to increased acuity of our inpatients, increased length of stay and when patients become more mobile when they are due to leave hospital.

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	JW assured the Committee that a safe to start assessment was completed twice a day on the wards, once before the start of a shift and then halfway throughout the day, which would highlight the patients at risk of a fall, so the team can provide extra support if needed. PC assured the Committee that once the thematic review of falls had been completed the findings and results it would be shared with the Executive Committee. Any action agreed from the thematic review will be shared with the Patient, Quality, Safety & Outcomes Committee for oversight at a future meeting. **Action: Director of Allied Health Professions & Health Science** The Committee **NOTED** the quality performance report.
PQSOC 2001/09	**Maternity Services: Organisational Improvement and Action Plan** Jayne Beasley (JB), Head of Midwifery & Gynaecology, provided the Committee with an update of the progress of the Maternity Improvement Plan. The Plan aimed to determine how the Health Board's maternity service would achieve high quality maternity care and detailed their approach to providing individualised care, reductions in health inequalities, improves, innovates and develops to meet the needs of those who access the service and those who work in it. The Committee was advised that the improvement plan included the areas of focus for the department throughout 2024 to 2027 with a colour coded system to highlight the status of each action. JB provided the Committee with an overview of the outstanding amber (in progress) and red (not yet started) actions from the plan. Paul Deneen (PD), Independent Member, questioned how the service user and paid role would work. JB advised that the Chair of the 'Bumps and Babies Improvement Group', would be not currently paid to undertake the role as the chair. JW relayed that the paid role was in relation to recompense for work undertaken. PD questioned if an impact assessment was being completed when training was being conducted by staff members and if an additional training request had come from Welsh Government. JB advised that the PROMPT and

	foetal training was mandatory with a target of 95% and there would be a need to take into account the impact going into 2025/26. Jennifer Winslade (JW), Director of Nursing, advised that maternity services have more training due to the risks of pregnancy and giving birth. Rani Dash (RD) Director of Corporate Governance advised the Committee there would be a report going to the Board on 29th January regarding statutory and mandatory training. The Committee **NOTED** the ongoing work to implement and embed improvements within maternity services.
PQSOC 2001/10	**Learning from Death Report** Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided the Committee with an overview of the Learning from Death report for the period January to June 2024. The Committee was advised that the risk adjusted mortality index (RAMI) had reduced from the last reporting period and the Health Board was now the second best performing Health Board in Wales. LL advised that there had been divisional learning, with divisions sharing and discussing their cases within their morbidity and mortality meetings. The Committee was advised that the mortality framework (MBRRACE) had helped with putting in place end to end processes in relation to how the Health Board reports on still births, neonates and maternal deaths. The Committee was advised that there had been challenges around the CHKS system (software) used to look at the mortality data. and were working with the system owners on how the Health Board could include a dashboard that NHS England had used. LL advised the Committee that more engagement from staff on mortality reviews would be required and a 'deep dive' would be undertaken once the correct data was available on the CHKS system. Paul Deneen (PD), Independent Member, questioned what the role of the Medical Examiner was and if they were external. LL advised that their role was external, provided by Shared Services and the role was to review all deaths.

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	Helen Sweetland (HS), Chair, asked if the Mortality Review Committee had been set up. LL confirmed that the aim was to set up the Committee this year. The Committee **NOTED** the development of a number of mortality indicators and the development of a Learning from Deaths framework.
PQSOC 2001/11	**Pharmacy and Medicines Management Annual Report 2023/24** Jonathan Simms (JS), Clinical Director of Pharmacy, provided the Committee with an overview of the Pharmacy and Medicines Management Annual Report, advising that there was an expectation from Welsh Government that an annual report showing the progress in priority areas of safe prescribing, antimicrobial stewardship and value was scrutinised. JS advised the Committee that the report included updates on the key developments which were mapped to the six domains of quality - safe, timely, effective, efficient, equitable and person centred. JS highlighted to the Committee the following areas identified within the annual report: • In January 2024, the Pharmacy Service published its Vision and Mission Statement; • The Value and Sustainability work programme established to deliver on the 13 national recommendations set by Welsh Government overseen by the Medicines Management Programme Board; • Service developments; • The contribution of pharmacy services to improved patient safety and medicines governance through direct patient care and the work of the Medicines and Therapeutics Committee, Medicines Safety Group, and the Controlled Drugs Local Intelligence Network; • The performance of the Health Board against the National prescribing indicators. The Committee was made aware that the Pharmacy robot had been approved in 2022/23 but was still in the process of being installed. Penny Jones (PJ), Independent Member, questioned why there had been a high turn over of staff. JS assured the Committee that the Health Board was below the all-Wales average. A business case had been created to address the vacancies within the hospitals, noting that the main reason

	for staff leaving was due to the weekend working and on-call. The Community pharmacies had seen a higher percentage of change in ownership but the Health Board was ensuring that pharmacies were opening for a minimum of 40hours per week. Paul Deneen (PD), Independent Member, questioned if hospital staff and paramedics were able to access the patients' medicine history on admission. JS advised there was a system currently being piloted with the plan to have a future roll out to other pharmacies and GPs. Rani Dash (RD), Director of Corporate Governance, advised there would be a paper on ePMA going to the Board on 29th January as an update. Helen Sweetland (HS), Chair, questioned if the risk within the transfer lounge had now been resolved. JS assured the Committee that there was now a pharmacist in the transfer lounge and there had been an improvement in this area. The Committee **NOTED** the Pharmacy and Medicines Management Annual Report.
PQSOC 2001/12	**Radiation Protection Committee Annual Report** Peter Carr (PC), Director of Allied Health Professions & Health Science, provided the Committee with an overview of the Radiation Protection Committee Annual Report, advising that the report aimed to provide assurance to the Committee that all activities related to the use of Ionising Radiation and the storage and disposal of radioactive substances in the Health Board had been carried out in accordance with National legislation, published guidance and local policies and procedures. The Committee was advised that the governance structure for the Radiation Protection Committee would report to the Director of Allied Health Professions & Health Science and then feed into the Executive Committee. PC advised the Committee that there were no areas of concern from the HIW report and thanked the radiation team and Karen Hatch for the work that had been done to complete the annual report. Penny Jones (PJ), Independent Member, questioned if the feedback from the staff regarding being understaffed had been considered. PC advised that staff feedback had been considered and formed part of the plan for next year on

	how to improve the staffing gaps and capacity to undertake training. Helen Sweetland (HS), Chair, questioned how much engagement from staff there had been at the workshops. Karen Hatch (KH), Assistant Director of Therapies and Health Science, advised any learning from the workshop or key learning from issues raised were shared with staff for oversight and to support with their learning. Paul Deneen (PD), Independent Member, questioned how often HIW would attend throughout the year. PC advised the inspections were yearly and there would be a short notice period to allow the department to prepare any paperwork they request. The Committee **NOTED** the annual report.
PQSOC 2001/13	**Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes** Kelly Downes (KD), Deputy Director of Nursing, provided the Committee with an overview of the Amendment to the six-monthly Nurse Staffing Act Report due to changes to respiratory service. KD advised that the report provided **ASSURANCE** that the Health Board was meeting the statutory requirements to calculate the Nurse staffing levels on all wards included in the recent reconfiguration of the Respiratory and General Internal Medicine Model effective from 11 November 2024. The Committee was advised that the Executive Committee approved the reconfiguration of the respiratory medicine service in September 2024 to deliver a general internal medicine model at the Grange University Hospital (GUH) to include the following:- • Closure of the Medicine inpatient beds on ward 4/4 at Nevil Hall Hospital (NHH) - inclusive of 22 Respiratory and 6 Endocrine & Diabetes beds; • Delivery of a phased Respiratory in-reach model at NHH and Ysbyty Ystrad Fawr (YYF); • Clear clinical accountability for 16 General Internal Medicine beds at GUH. KD made the Committee aware of the following wards that had been affected be the reconfiguration including C4 GUH -respiratory and general medicine, B4 Stroke at GUH and Ward 4.4- Non-invasive respiratory step-down beds at NHH.

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	The Committee was advised that additional funding had been approved to support the reconfiguration of the wards. The Committee **NOTED** the reconfiguration, funding change for the wards in GUH for respiratory and General medicine.
PQSOC 2001/14	**Review of Committee Programme of Business 2024/25** Review of Committee Programme of Business 2024/25 was provided to the Committee for information.
PQSOC 2001/15	**NHS Wales Joint Commissioning Committee's Quality Report** NHS Wales Joint Commissioning Committee's Quality Report was provided to the Committee for information.
PQSOC 2001/16	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no key risks or issues for reporting or escalation to the Board or other Committees.
PQSOC 2001/17	**Any Other Urgent Business** There was no urgent business.
PQSOC 2001/18	**Date of the Next Meeting:** Monday 31st March 2025

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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
January 2025	**PQSOC 2001/08**	**Quality Performance Report** As part of routine reporting on hospital falls, the Committee will be updated on action agreed from the thematic review of catastrophic and severe hospital falls.	**Director of Allied Health Professions & Health Science**	Routine reporting	**Complete** March Thematic review completed and presented to Executive Committee on 20th March 2025. Recommendations from the review will be used to inform the work programme of the Falls & Bone Health Committee.
February 2025	**ARAC 11802/05 -** Transferred from ARAC	Develop local audit plans for divisions and present them to the Patient, Quality, Safety and Outcomes Committee (PQSOC)	**Medical Director**	February 2026	**Complete** March Local audit plan will be created throughout the year with the divisions and shared with the Committee once complete.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					This has been included in the Committee Forward work plan.

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:	31 March 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Terms of Reference: Review**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

Aneurin Bevan University Health Board's Standing Orders state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

In line with the above, the Health Board has established a Patient Quality, Safety and Outcomes Committee with the purpose of providing evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

Asesiad / Assessment

The current Terms of Reference were approved by the Board in March 2022. The Terms of Reference were reviewed, with minor amendments to dates and titles proposed, and circulated to members during January 2025. No further comments were received.

The Committee is therefore requested to review and provide any further comment on the Terms of Reference (Attachment One), prior to submission to the Board for approval in May 2025.

Argymhelliad / Recommendation

The Committee is asked to **ENDORSE** the revised Terms of Reference for the Patient Quality, Safety and Outcomes Committee.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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. Enabler
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. Not applicable to this report

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	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. Not applicable to this report

Patient Quality, Safety and Outcomes Committee

Terms of Reference – ~~2022/23~~2025/26

Version: ~~Approved~~Draft

Date: March ~~2022~~2025

Document Title:	Patient Quality, Safety and Outcomes Committee Terms of Reference – ~~2022/23~~2025/26
Date of Document:	March 2025~~2~~
Version:	Draft
Previous version:	~~May 2021~~March 2022
Approved by:	Board
Review date:	March 2026~~3~~

1. INTRODUCTION

1.1 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Health Board has established a committee to be known as the **Patient Quality, Safety & Outcomes Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

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

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where

possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the 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.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Governance Arrangements** remain appropriate and aligned to the National Quality Framework and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on ABUHB's behalf;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
- the development of the Board's Annual Quality Priorities; and,
- performance against key quality outcomes focussed indicators and metrics.

D. Seek assurance on the arrangements in place to support **Research and Development** and **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health and Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
   - the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls, patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this

Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's ~~Assurance~~

~~Framework~~ Quality Framework and Board Assurance Framework/Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.
This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise of five (5) members:

Chair:	Independent member of the Board
Vice Chair:	Independent member of the Board
Other Members:	Three other independent members of the Board *[one of which should be the Vice Chair of the Health Board and the Chair of the Audit, Risk and Assurance Committee]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing
- Director of ~~Therapies~~Allied Health Professionals and Health Science
- Medical Director
- ~~Director of Primary, Community Services and Mental Health~~

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly (six times yearly)**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:
- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	31 March 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes Committee Annual Report 2024-25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Governance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the Patient Quality, Safety and Outcomes Committee Annual Report 2024-25, referred to as the Annual Report throughout this paper.

The Annual Report included as Appendix A is provided for endorsement prior to submission to the Board on 21 May 2025.

Cefndir / Background

Section 2 of Aneurin Bevan University Health Board's Standing Orders states that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

Asesiad / Assessment

The Patient Quality, Safety and Outcomes Committee has been established by the Board with the purpose of providing evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

Each Committee is responsible for developing an annual report for submission to the Board via the Chair, setting out its activities during the year and including the review of its performance.

The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles *"putting the citizen at the heart of everything and focusing on their needs and experiences; making the organisation's purpose the delivery of a high-quality service*."

The Annual Report seeks to provide a comprehensive evaluation of the business undertaken by the Committee throughout the 2024-25 financial year including any issues, and gaps in assurance that have required escalation to the Board.

Argymhelliad / Recommendation

The Committee is asked to:

- **CONSIDER** and **ENDORSE** its Annual Report 2024-25 prior to submission to the Board on 21 May 2025.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corffforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Failure to agree the reports would mean that the Health Board would not comply with Welsh Government and HM Treasury requirements.
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 objectives will be referenced to the IMTP.
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:	Explained within the report.
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/	Choose an item. Choose an item. Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the Well Being of Future Generations Act.

Patient Quality, Safety and Outcomes Committee

Annual Report for 2024-25

February 2025

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Chair's Foreword

I am pleased to present the Patient Quality, Safety and Outcome Committee's (the Committee's) Annual Report for the year ended 31 March 2025.

In this report we provide an overview of the work of the Committee, which extends to the full range of Health Board responsibilities and encompasses all areas of patient experience, quality and safety relating to patients, carers and service users.

Finally, I would like to express my personal appreciation to all who contributed to the patient quality, safety and outcomes agenda over the last 12-months, especially Pippa Britton as Chair and Louise Wright, Independent Member, as their time on the Committee comes to an end.

Diolch yn Fawr / Thank you

Helen Sweetland
Chair
Patient Quality, Safety and Outcomes Committee

1. Introduction

1.1 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of the Patient Quality, Safety and Outcomes Committee (referred to throughout this document as 'PQSOC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The Committee formally adopted its Terms of Reference, following the Board's approval, on 05 April 2022.

The purpose of the PQSOC is to provide: evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

1.4 This report describes how the PQSOC discharged its role and responsibilities during the period 1 April 2024 to 31 March 2025.

2 2024-25 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for PQSOC in 2024-25 is attached to this report (see **Appendix 2**).

2.2 A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive

agenda. This gives PQSOC flexibility to identify changing priorities or any need for further assurance or information.

3 PQSO Committee Meetings and Membership

3.1 During 2024-25, PQSOC met six (6) times via Microsoft Teams- in April 2024, June 2024, July 2024, September 2024, November 2024 and January 2025. Detail of the Independent Members and Executive Directors who attended these meetings is provided at **Appendix 3**.

3.2 The Committee comprised the following Independent Members:

Pippa Britton	Chair (Until December 2024)
Helen Sweetland	Vice Chair from May 2024, Chair from December 2024
Paul Deneen	Vice Chair until May 2024, member from May 2024
Penny Jones	
Louise Wright	Until May 2024

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually and this has therefore meant that the Health Board has not complied with its Standing Orders in this regard and this will be a key consideration for the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

3.4 The Committee's agenda and papers were made public, save where it was necessary to meet 'in private'. Private meetings are held where it would not be appropriate to discuss a matter in public, due to issues of patient or staff confidentiality, commercial confidentiality, or discussion of serious incidents or escalated concerns which would not be in the public interest. There were no 'in private' meetings held during 2024-25.

4 PQSOC Reporting Arrangements

4.1 Following each meeting, the PQSOC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link.

5. PQSOC Work Programme: 2024-25

5.1 During the year the Committee received updates in respect of the following items:-

5.2 The Committee received regular updates on the key risks allocated to the Committee and the position of each risk. At the end of the year the Committee's risk environment had remained relatively stable, with no changes in the risk score or exposure to the three strategic risks that the Committee monitors, with 3 risks reporting as a risk level of Moderate or High.

5.3 In September 2024, the Committee received the Covid-19 Nosocomial Investigation Report that outlined the Health Board's conclusion of its Nosocomial Covid-19 Investigation Programme on 31 March 2024, in line with the objectives set by Welsh Government.

The findings from the investigation 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, however the investigation found the restrictions were necessary to reduce the transmission of the Covid-19.

5.4 The Committee received the Listening and Learning Framework which complemented and built on Divisional and Directorate assurance arrangements by supporting the Health Board to learn lessons from a range of internal and external sources, with the framework acting as a learning repository for future use.

5.5 The Committee received the Primary Care Quality Report which outlined the areas of focus throughout the year including the following:-

- General Dental Services
- Urgent Access and Wait Times
- Orthodontic Services
- General Ophthalmic Services
- General Medical Services
- Enhanced and Supplementary Services
- Community Pharmacy Services

5.6 In July 2024, the Committee received a report on the investigation and subsequent improvement actions of the Mortuary Incident. The Health Board's investigation found that the root causes of the incident were due to failures in staff adherence to Health Board policies and procedures. Whilst the policies were deemed appropriate, they have since been strengthened and simplified for clarity.

5.7 The Committee received the Commissioning Assurance Framework which outlined the efforts to create a standardised process for collecting quality information from commissioned services with the aim to ensure consistent and rigorous data collection across the Health Board.

5.6 During the year, the Committee received quarterly reports on the Performance of Patient Quality and Safety Outcomes. During the year the following information was reported:-

Duty of Candour Triggers
Between December 2021 to March 2024 there had been 70,645 incidents reported on Datix and 29 incidents of duty of candour since April 2024. The Committee were assured that 95% of the unrejected incidents were closed, with 76% of closed incidents coded as no or low harm.

Infection Prevention and Control
During the year the Committee noted that the main areas of infection concern was C.Difficile with high levels being reported in June 2024. A multidisciplinary team had been established to address the increase and to return rates to within normal levels. This included the implementation of an action plan, with enhanced cleaning continuing and bespoke training in areas of outbreaks.

Enhanced Monitoring
At the last meeting of the year, the Committee was advised that there were 2 areas within the Health Board in enhanced monitoring, with assurance provided that action plans were in place to improve the position of each department – Urgent & Emergency and Mental Health & Learning Disabilities.

Falls incidents
Throughout the year the Committee received regular updates in respect of falls, noting that there had been a decrease in the total number of fall incidents, which averaged at 302 per month, with 99% being no or low harm. There were ongoing efforts to minimise harm, which included collaboration with Divisions to identify any anomalies or areas needing targeted intervention.

Complaints, concerns and compliments
At the January 2025 meeting, the Committee received an update on complaints and concerns, noting early resolution was reporting at 67%. The 30day compliance for responding to complaints was currently 55%, which was below the target of 75%. The Committee was assured that this was a focus for the Health Board.

Health, Fire and Safety
Throughout the year the Committee received regular updates on the progress being made on the Health Board's Health, Fire and Safety action plan. In January 2025, the Committee was advised that 16 incidents were reported to the Health and Safety Executive (HSE) in accordance with Reporting Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) and compliance with RIDDOR had significantly improved at 86%. It was highlighted that work was ongoing to improve the manual handling training compliance, which remained low at 69%.

Ward and Team Accreditation
At the November 2024 meeting, the Committee received an overview of the Ward and Team Accreditation that 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.

In January 2025, the Committee received an update on the Ward and Team accreditation programme, noting that there had been a positive roll out across several divisions and 3 accreditations had been awarded in December 2024. These wards were now working toward their silver award.

Health Inspectorate Wales (HIW) Inspection
In June 2024, the Committee noted that Health Inspectorate Wales had undertaken an inspection at Ty Lafant, Llanfrechfa Grange in April 2024, and no recommendations had been made. In November, it was noted that there had been a total of 8 Health Inspectorate Wales immediate assurance letter responses.

Never Events
In June 2024, the Committee received an overview of the never events performance noting that, since November 2023, the Health Board had not experienced any Never Events. In January 2025 the Committee was informed that there had been 2 never events between April to December 2024. 1 was within a non-theatre environment and the other being historical and found during a scan. Assurance was provided to the Committee that both events had resulted in no harm.

5.7 In July 2024, the Committee received the Maternity Services Organisational Improvement and Action Plan which outlined the plan to improve outcomes for women and babies and support staff, and innovations and improvement in practice for the future. It was noted that there were 95 actions in total as part of the improvement plan over a three-year period.

5.8 **Annual Reports**

Throughout 2024/25, the Committee received the following Annual reports: -

Pharmacy and Medicines Management Annual Report

The report confirmed progress in the priority areas of safe prescribing; antimicrobial stewardship and value was scrutinised.

The following areas were identified within the annual report:-

- In January 2024, the Pharmacy Service published its Vision and Mission Statement;
- The Value and Sustainability work programme established to deliver on the 13 national recommendations set by Welsh Government overseen by the Medicines Management Programme Board;
- Service developments;
- The contribution of pharmacy services to improved patient safety and medicines governance through direct patient care and the work of the Medicines and Therapeutics Committee, Medicines Safety Group, and the Controlled Drugs Local Intelligence Network;
- The performance of the Health Board against the National prescribing indicators.

Volunteering Annual Report

This report celebrated the key achievements over the past year and noted the valuable contribution made by volunteers, with the aim of improving the experience for patients, their families, and carers whilst ensuring volunteer experience.

The Committee noted that as a result of the pandemic the number of volunteers had reduced, and the Health Board was continuing to improve the volunteer provision including end-of-life champions in the community.

Hospital Transfusion Committee Annual Report

This report outlined several achievements, including the successful integration of a Primary Care representative into the HPC (Health Professional Council) and the introduction of a new clinical Standard

Operating Procedure (SOP) for the Haematological Management of Major Haemorrhage.

The programme had begun identifying staff who required essential transfusion practice training and continued to provide training on Blood Track Enquiry.

Quality Annual Report
This report outlined the quality journey throughout the year, a review of the past objectives and the new priorities for improving patient and staff safety, outcomes, and experiences.

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:-

- 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.

The Committee noted that the learning and improving approach had been approved with a meeting structure in place to provide regular updates to the Committee throughout 2024/25.

Putting Things Right Annual Report
This report had been prepared in accordance with the Putting Things Right (PTR) regulations and demonstrated the ongoing commitment to the population of the Health Board.

The report outlined the priorities for the annual work programme for 2024/25 including the following:-

- Putting Things Right Regulations and Health Board Concerns Management;
- Improving Quality Patient Safety experience, Learning and Improving;
- Partnership Engagement & Collaborative working.

Human Tissue Act Annual Report
The Committee received the Annuel Human Tissue Act report for assurance that the Health Board were meeting the standards required to maintain the licences within the following areas:-

- 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.

Organ Donation Annual Report
At the September 2025 meeting, the Committee received the Annual Organ Donation report for assurance which outlined what work had been completed throughout 2023/24, noting the following:-

- 8 organ donations over the past 12 months with 13 consented donors which resulted in 19 patients receiving a transplant;
- The Organ Donation Committee Chair, Shelley Bosson, had now retired and a new chair was being sought;
- The Health Board was continuing to raise awareness and encourage people to become donors;
- The Organ Donation team had looked at how they could develop training and protocols throughout the Health Board.

Dementia Care Annual Report
This report reviewed the progress made on the implementation of the dementia standards, noting 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 had been put 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 the Gwent Regional Dementia Board and Dementia Friendly Communities programme had delivered against the aims, objectives and priorities aligned to both the Dementia Action Plan for Wales.

Falls and Bone Health Management Annual Report
This report outlined the 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.

The report also outlined the following areas identified within the annual report:-

- The Health Board was represented nationally across a number of forums and were ensuring the Health Board were following the national guidelines when lifting a patient following a fall;
- A pilot for patients within a hospital setting to be allocated yellow wrist bands to identify which patients were at a high risk of falls and the aim was to roll out across all Health Board sites;

- Training of all staff members in relation to falls remained a challenge for the Health Board, to address this, a Falls Training Strategy was to be completed by March 2025.

Health and Safety Compliance Annual Report
This report identified the opportunities and challenges for the Health Board in ensuring and sustaining compliance within Health and Safety legislation, including specific compliance improvement action delivered in 2023/24.

The Health, Safety and Fire action plan had been created to focus on improving the following area:-

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Committee noted there had been challenges around the compliance of the Health and Safety policies, to address this, a plan was in place for 2024/25 to review the policies which were out of date.

Radiation Protection Committee Annual Report
This report provided assurance that all activities related to the use of Ionising Radiation and the storage and disposal of radioactive substances in the Health Board had been carried out in accordance with National legislation, published guidance and local policies and procedures.

The Committee noted that the governance structure of the Committee and was assured there were no outstanding areas of concern from the HEIW report from April 2023.

Research and Development Annual Report
This report outlined the Health Board's key achievements, progress and planned next steps in implementing the Research and Development Strategy, noting 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 noted that the focus for 2024/25 was to establish the Research and Development Committee as of the priorities.

Infection Prevention, Decontamination, and Antimicrobial Stewardship Annual Report

At the July 2024 meeting, the Committee received the Annual Infection Prevention, Decontamination, and Antimicrobial Stewardship report. The report confirmed improvements in cleaning standards and the successful use of Regional Integration Funds to enhance care across Primary and Secondary Care. It had been a challenging year with the Health Board reporting below the national average for reportable organisms and experiencing an increases in certain infections due to factors like antimicrobial resistance and suboptimal prescribing.

The following was highlighted within the report:-

- Low respiratory infection rate, below the All-Wales average;
- C-section rate had returned to pre-pandemic levels at 3.9%;
- The target to reduce antimicrobial prescribing by 25% in Primary Care had not been met achieving only a 14.8% reduction, partly due to challenges from Strep A outbreaks.

Safeguarding Annual Report

The Committee receive the statutory Annual Safeguarding report for assurance which outlined progress, performance, emerging trends, lessons learned, and the vision for 2024/2025, noting a significant increase in activity within child and adult cases, which was putting resources under pressure and delaying assurance and improvement work.

The Following was highlighted within the report:-

- Training for levels 1 and 2 safeguarding was exceeding 80% compliance;
- Training for level 3 training safeguarding remained low at 15%, falling short of the 50% target.

6. Patient Centred Care

6.1 On behalf of the Committee at Board level the presentation of Patient-Staff Stories continued. Topics presented included:

- Respecting patient’s wishes at end of life, improving communication with families and our bereavement offer;
- Hospital to Home Service;
- Children's Rights - Enabling Children's Voice and the Best Start in Life;
- My Medical Record App.

7. Self-assessment and Evaluation

7.1 As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

The self-assessment for the Patient Quality, Safety and Outcomes Committee was shared throughout January and February 2025 with both Committee members and lead Executive Directors. Five responses were received to the questionnaire. Members were requested to score their responses from 1-3, as per the table below.

Score	Measure	Description
1	**Room for improvement**	The Committee is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	**Meeting standards**	The Committee is performing to the required standard in this area. There may be room for improvement, but the Committee can be seen to be discharging its responsibilities effectively.
3	**Excelling**	This is an area where the Committee is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

Following completion of the self-assessments, the sections were analysed to provide an overall score for the section and recommendation for improvements for each section. A summary of the results is provided below. Further detail on the responses can be found at Appendix .

Overall rating based on scores	Areas for Improvement based on comments received	Action
Committee Processes: Composition, Establishment and Ways of Working (Q1 - 26)	**Self Assessment:** Current questionnaire is too long. Propose that a discussion is held at Committee with a survey to follow up. **Induction process**: New IMs to meet all the Execs and encourage conversations with other IMs. **Site Visits:** It would be helpful to be able to visit different areas of the Health Board, so that IMs can see the environment and talk to staff. This should be an ongoing role for IMs **Quality of Reports:** Reports should be shorter and the successes and challenges addressed under headings, with links only to the main reports **Committee meetings**: Try to ensure that there is 5 minutes left at end of meeting for final 'wrap up'	• Review Self Assessment process and introduce more discussion amongst members • Revised local Induction Programme being developed for the Health Board • Patient Safety Leadership Visits are in the process of being arranged • Report writing included within Development programme being developed with the Good Governance Institute • Review of agenda format to include a short feedback section at the end of each meeting to enable a 'wrap up'
Clinical Quality Governance Q27 - 31)	**Data/Information:** The committee would need more information about each pillar and its criteria and a mapping exercise in order to be able to fully scrutinise the information	
Patient Experience & Involvement (Q32 - 34)	Definite progress has been made in this area, but still need to address some clinical areas where response rates are low	

High Quality, Safe & Effective Healthcare (Q35 - 40)	n/a	
Research & Development and Improvement & Innovation (Q41 - 42)	n/a	
Compliance with H&S regulations and Fire Safety Standards (Q43)	n/a	
Overall Assessment		

The findings from the self-assessment will be used to inform a comprehensive annual assessment of the Board's effectiveness. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

8. Key Areas of focus in 2025/26

8.1 As a result of the work of the Committee in 2024/25 the following areas of focus were identified:

- Explore ways of ensuring greater assurance and opportunities for committee members to be better appraised of patient experience matters.
- Strengthened focus on reporting of Joint Committee activity to this Committee.
- Secure a greater understanding of those improvement projects through better reporting to the Committee and to capture this on the forward work plan for the Committee.
- Health and Safety Assurance reporting to be strengthened to include a focus on risk and assurance gaps.
- Agendas to include an item on reflection upon meeting to aid ongoing self evaluation.

9. Conclusion

9.1 This report provides a summary of the diverse and often complex work undertaken by the PQSOC during 2024-25, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2025.

Appendix One

Patient Quality, Safety and Outcomes Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

Document Title:	Patient Quality, Safety and Outcomes Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Version:	Draft
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.2 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.3 The Health Board has established a committee to be known as the **Patient Quality, Safety & Outcomes Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

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

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the 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.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Governance Arrangements** remain appropriate and aligned to the National Quality Framework and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on ABUHB's behalf;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;

- the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
- the development of the Board's Annual Quality Priorities; and,
- performance against key quality outcomes focussed indicators and metrics.

D. Seek assurance on the arrangements in place to support **Research and Development** and **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health and Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
   - the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls, patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.
This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise of five (5) members:

Chair:	Independent member of the Board
Vice Chair:	Independent member of the Board
Other Members:	Three other independent members of the Board *[one of which should be the Vice Chair of the Health Board and the Chair of the Audit, Risk and Assurance Committee]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing
- Director of Therapies and Health Science
- Medical Director
- Director of Primary, Community Services and Mental Health

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly (six times yearly)**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:
- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and

- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix Two

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	√D
Review of Committee Programme of Business 2024/25	Chair	SI	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN					√D	√D
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN					√D	√D
Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN						√D
Committee Annual Report 2023/24	Chair & DOCG	AN	√					
Committee Annual Report 2024/25	Chair & DOCG	AN						√D
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 (Deferred to March)	Clinical Executives	AN						**√D**
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 (deferred to March)	Clinical Executives	Bi-An				**√D**	**√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 (Deferred to March)	DoT&HS	AN					**√D**	**√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**	**√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**	**√**	**√**
SOP Deep Dives **PQSOC 1211/08**	DoN	Action						**√**
Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Macken Ward) **PQSOC 1211/17**	DoN	Action						**√**
Mental Health Act Monitoring Report	COO	Action						**√**

Appendix Three

Patient Quality, Safety and Outcomes Committee: Attendance at meetings in 2023-24

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	April	June	July	September	November	January
Independent Members						
Pippa Britton	X	X	X	X	X	X
Louise Wright	X					
Paul Deneen	X	X	X	X	X	X
Helen Sweetland	X	X	X	X	X	X
Penny Jones	X	X	X	X	X	X
Executive Directors						
Medical Director	X	X	X	X	X	X
Director of AHPs & Health Science	X	X	X	X	X	X
Director of Nursing	X	X	X	X	X	X
Chief Executive	X	X	X	X	X	X
Director of Corporate Governance	X	X	X	X	X	X

Appendix Four

PQSOC Committee Self Assessment

1. Does the Committee have written terms of reference and have they been approved by the Board?

2. Are the terms of reference reviewed annually?

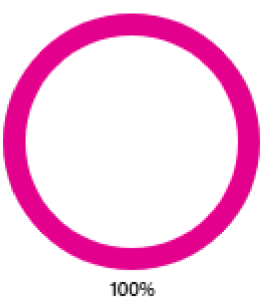
3. The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?

. 4. Has the Committee been quorate for each meeting this year?

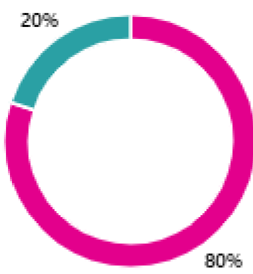
5. In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?

6. Members who have recently joined the PQSOC have been provided with induction training to help them understa nd their role and the organisation?

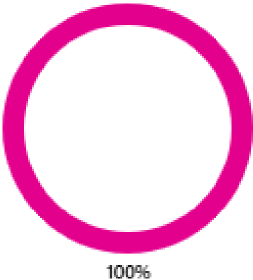
7. The Committee is clear about its role in relationship to other Committees that play a role in relations to patient qu ality and safety matters?



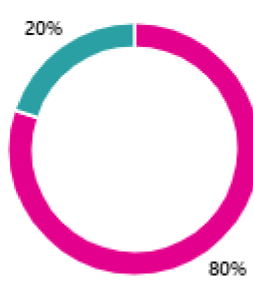
. 8. Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of in
terest?



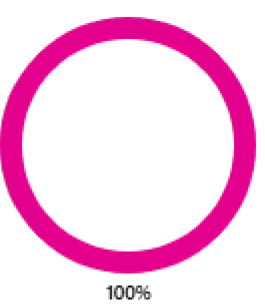
. 9. The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where n
o assurance is provided, or where the quality of the assurance is poor?



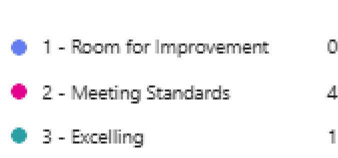
10. The Committee has an established a plan of matters to be dealt with across the year?

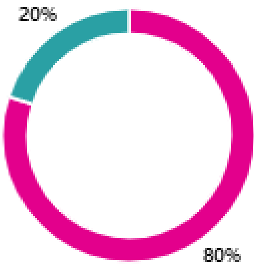


11. Does the Committee consider issues at the right time and in the right level of detail?

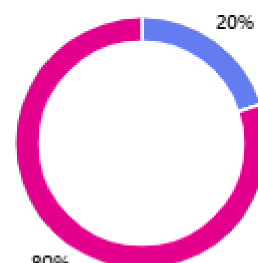


12. The Committee ensures that the relevant executive director(s) attends meetings to enable it to understand the re ports and information it receives?

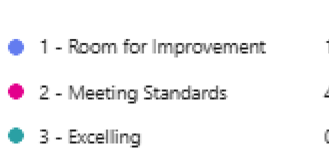


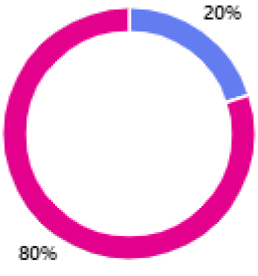


13. Are the Committee's papers distributed in sufficient time for members to give them due consideration?

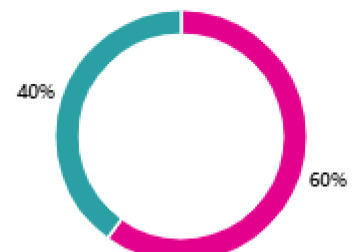


. 14. The quality of the Committee's papers received allows Committee members to perform their roles effectively?

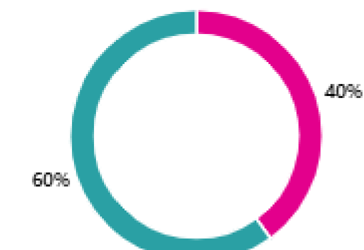




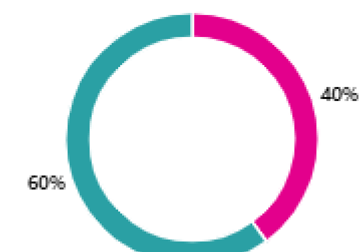
. 15. Committee meetings are chaired effectively?



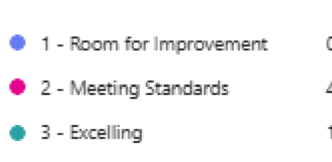
16. The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?

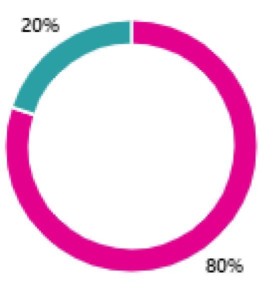


17. The Committee environment enables people to express their views, doubts, and opinions?

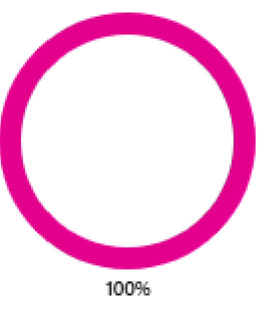


. 18. The Committee challenges management and other assurance providers to gain a clear understanding of their fin dings?

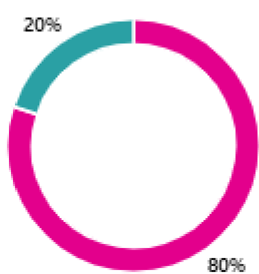




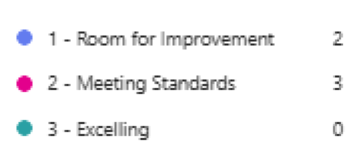
19. Members hold their assurance providers (management) to account for late or missing assurance?

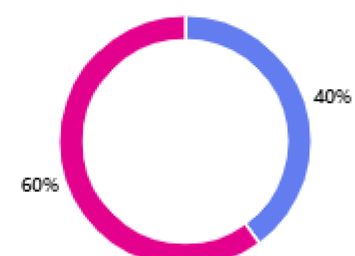


20. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing wha t, when and how and how it is being monitored?

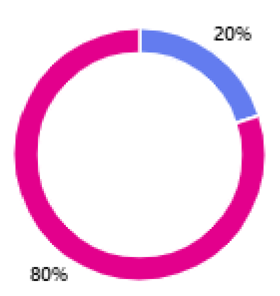


21. At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worke d well, not so well etc?



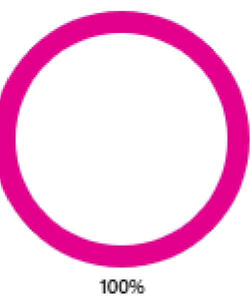


22. Decisions and actions are implemented in line with the timescale agreed?



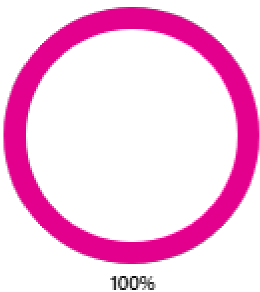
23. Are the outcomes of each meeting and any issues of concern reported to the next Board meeting?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



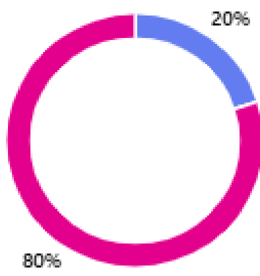
24. Does the Committee prepare an annual report on its work and performance for the Board?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	0

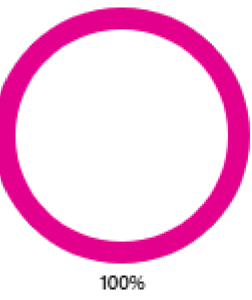


. 25. The results of the annual self-assessment are used to inform and influence succession planning and improve effe ctiveness.

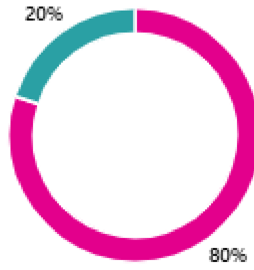
1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



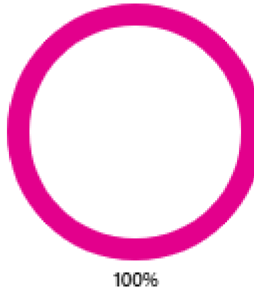
. 26. The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?



. 27. Is the Committee satisfied that there is a credible process for assessing, measuring and reporting on Clinical Qual ity Governance



. 28. Is the Committee assured that the Health Board's Clinical Quality Governance Arrangements remain appropriate and aligned to the National Quality Framework

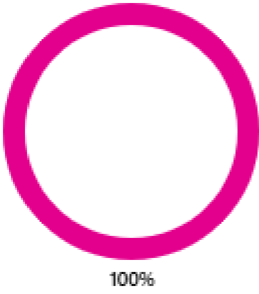


29. Is the Committee assured that Clinical Quality Governance is embedded in practice?

1 - Room for Improvement 0

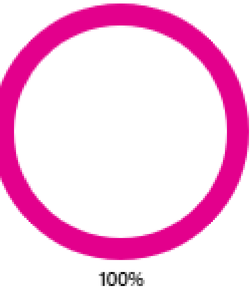
2 - Meeting Standards 5

3 - Excelling 0



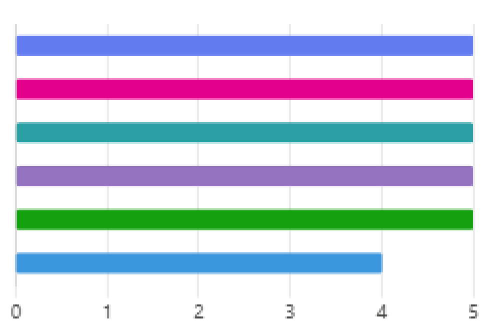
30. Does the Committee receive sufficient assurance that the systems, processes and plans to measure, monitor and enhance the quality of our healthcare services are fit for purpose

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



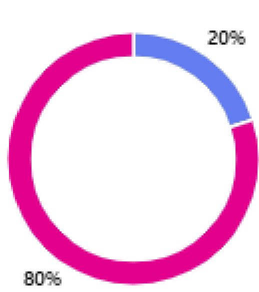
31. Does the committee effectively scrutinise the quality performance issues and key performance indicators (6 pillar s):

Person Centred	5
Safe	5
Timely	5
Effective	5
Efficient	5
Equitable	4

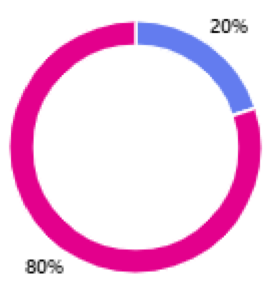


32. Does the Committee receive assurance that the arrangements for capturing the experience of patients, citizens a nd carers are sufficient, effective and robust?

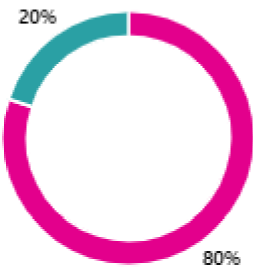
1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



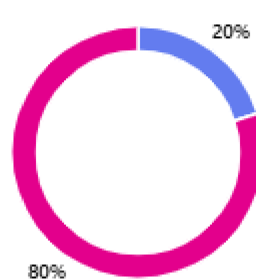
33. Does the Committee review progress against the Patient Experience and Involvement Strategy



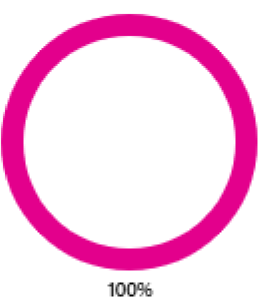
34. Does the Committee receive and consider sufficient information on compliance with Putting Things Right Regul ations, including trends and ensuring lessons are learned?



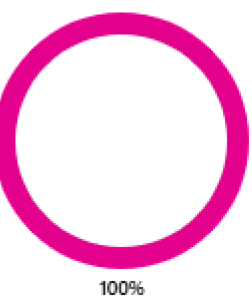
35. Does the Committee receive assurance that commissioning arrangements are in place to ensure the efficient, eff ective, timely, dignified and safe delivery of those services commissioned for delivery on behalf of ABUHB?



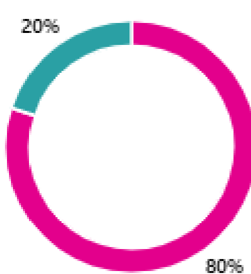
36. Is the Committee satisfied that arrangements are in place to undertake, review and act on clinical audit activity which responds to local and national priorities?



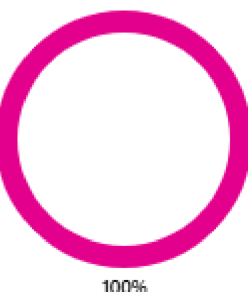
37. Does the Committee consider recommendations made by internal and external review bodies and ensure that a ction is taken in response?



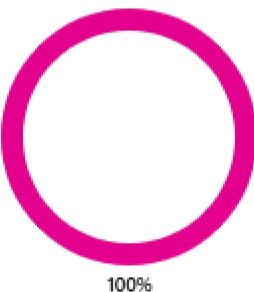
. 38. Does the Committee received sufficient assurance that arrangements are in place to ensure that there are robus t infection prevention and control measures in place in all settings?



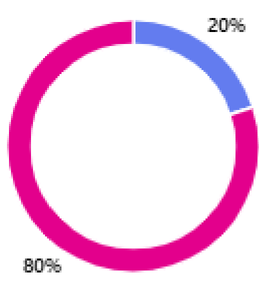
39. Does the Committee contribute to the development of the Health Board's Annual Quality Priorities?



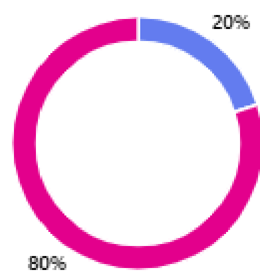
. 40. Does the Committee consider performance against key quality outcomes focussed indicators and metrics?



41. Does the Committee receive assurance in respect of the research and development activity within the organisati on?

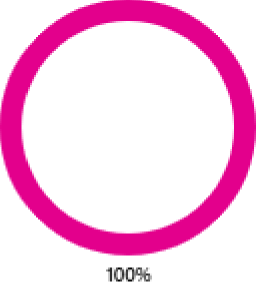


42. Does the Committee receive assurance in respect of improvement and innovation projects to improve the qualit y and safety of services?



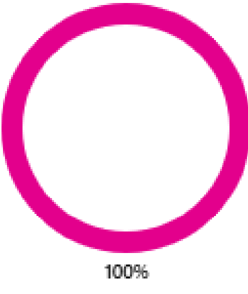
43. Does the Committee receive assurance in respect of arrangements in place for compliance with Health and Safe ty Regulations and Fire Safety Standards, including operating practices in respect of:

- Staff Health and Safety
- Stress at Work
- Patient Health and Safety (ie falls, patient manual handling violence and aggression)
- Fire Safety
- Risk Assessment processes
- Safe handling of loads·
- Hazardous substances



Overall Score

●	**Room for improvement** - The PQSOC is falling short of requirements and should consider how it can wo...	0
●	**Meeting standards** - The PQSOC is performing to the required standard in this area. There may be...	5
●	**Excelling** - This is an area where the PQSOC is performing beyond the standard expectations and i...	0



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	31 March 2025
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.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

As of March 2025, the Committee Risk Register includes three high-level risks, and three sub-risks, covering service delivery, transformation and partnership working, and compliance and safety.

At the January 2025 meeting, it was reported that the risk environment had remained stable, and there were no changes to the risk scores for the monitored risks. This stability has continued into the current reporting period.

Asesiad / Assessment

Committee Strategic Risk Register

Table 1 below provides the current status of the three strategic risks. In accordance with best practice, all risks are reviewed within the appropriate timeframe for their respective levels of risk. The review focuses on the control

environment, ensuring that the controls remain robust and adequate for managing the identified risks. Additionally, the assurances are tested to verify the robustness of the controls. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer **Theme** Service Delivery **Appetite** Open Score 17 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 17 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 Risk Assessments, and Work-based Risk Assessments.	**High** **3 x 4** **(12)**	**N**

For **SRR 005** and **SRR 008**, the risks remain within the Health Board's risk appetite, providing assurance that they are being effectively mitigated. Work will

continue with risk owners to ensure that the controls in place are sufficient in preventing the potential risk from occurring.

SRR 010 continues to be managed outside the agreed risk appetite, with the residual risk under regular scrutiny by the Executive Committee. Since the inception of this risk, significant efforts have been made to mitigate its likelihood and impact. The Health and Safety Improvement Plan has achieved substantial progress in ensuring the Health Board's legislative compliance and continued delivery.

Internal Audit has provided valuable support by identifying areas for improvement during a pre-audit, highlighting specific areas where the Health and Safety Team needs to strengthen its processes. An assurance audit is scheduled for April, which will provide the Committee and Board with the necessary assurance that the improvement plan and additional actions have been effective. We anticipate that the audit findings will reflect positively on the measures implemented to date.

Horizon Scanning

Recent media coverage has highlighted the potential reduction of nursing courses (excluding Midwifery) at Cardiff University, which presents significant risks to health bodies in Wales. These risks include workforce shortages, increased pressure on existing staff, loss of educational opportunities, and potential challenges to the quality of patient care. Given the already strained workforce, this development could exacerbate the healthcare crisis in Wales and lead to long-term sustainability issues for the health service.

While we currently manage a strategic risk (SRR 001A) related to workforce recruitment and retention, there is a growing concern about the impact on patient care quality and safety due to insufficient nursing staff to meet demand.

Cardiff University has opened a 90-day consultation, and, while there is no immediate impact on nursing students completing their studies in the short term, including those starting Cardiff nursing degree programmes in 2025, the future remains uncertain. Following the outcome of the consultation, the Director of Nursing and the Head of Corporate Risk and Assurance will determine the impact on the Health Board and the potential development of a strategic risk. If required, this will be brought forward to the Committee for oversight and discussion in the coming months.

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	**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/	Choose an item. Choose an item. N/A

Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
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						X		●		◊		
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		X			●					◊		
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.				X	◊			●				

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.

Key		
	Current Score	●
	Target Score	X
	Appetite Threshold	◊
	Current to Target	◄ ▬

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.	
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 February 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*		
Next Review (Quarterly based on risk score)	01 May 2025					

SRR 005 A

Risk Score: 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score; Target Risk Score; Appetite Threshold

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 • Operational 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.	• New developments and pathways coming online into FY25/26 o New expanded transfer lounge o New ED extension and reconfiguration o Additional ED consultants coming onboard o Safety Flow agenda delivering wider developments and improvements

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. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee	• Effectiveness of the Operational Framework	• Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.
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.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Nursing			
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 January 2025	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Low)*
Next Review (Six monthly based on risk score)	01 July 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 and National 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 • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	• 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. SMS provision to be implemented in Feb 2025 across ED and all MIU's. • 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. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped.

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)*		
• 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, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.	• Currently there is no SMS provision to increase the number of surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.	• SMS provision for patient experience feedback will be launching in ED and all MIU's in February 2025. • 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. Need to have discussions with facilities around rooms. • Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.
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)*		
• Bi-monthly 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	COMPLIANCE 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.	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**	
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 February 2025	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review (Quarterly based on risk score)	01 May 2025				

SRR 010

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score; Target Risk Score; Appetite Threshold

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 MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 March 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Performance – Interim Report
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 (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Health Board is continuing to develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance. This ensures we provide excellent standards of care and set quality goals to continuously improve the services we provide.

Cefndir / Background

Following the launch of the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy, we continue to develop and report quality metrics. This has been an iterative process and under constant development. The measures allow the Health Board to report and capture what is important for our patients, their families and the Public.

This is an interim report that provides quality metrics as mapped in the quality strategy. There is a focus on patient safety incidents, patient experience, health and safety, safeguarding and infection prevention and control activity. Data is available up until February 2025.

Asesiad / Assessment

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. These continue to be developed to enable delivery of our services around the six domains of quality and the six quality enablers. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

The quality outcomes framework 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. Providing data across these Pillars of Quality will enable us to review our performance. The pillars are 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.

Areas of Improvement

- Mortality - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator (RAMI), RAMI has been consistently lower than the Welsh Peer group for the majority of 2024. The Health Board now produced a report with a focus on Learning from Deaths reporting based on the English model.

- Since its launch, the PALS service receives around 481 enquiries per month. Work has been undertaken to review how the service supports the PTR process, allowing issues being resolved at an informal stage.

- Civica has been successfully implemented with a satisfaction rate over the 85% benchmark (for February 2025, 90% satisfaction). The new digital solution will increase uptake.

- Overdue NRIs decreased from 71% (July 2024) to 36% (February 2025) which is a 35% improvement. There continues to be a focus on the management of the PSI process.

- There have been no new Never Events reported.

- During January and February 2025, the Health Board have reported 6 incidents to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 83.3% of these cases were reported within the legal timeframes within the legislation.

- The Health Board continues to support a number of nationally recognised quality improvement projects which are significantly improving patient safety and patient experience. The Safe Care Partnership has a number of workstreams, this includes, projects within acute deterioration, deconditioning and improving quality management systems.

Areas of Focus:

There are a number of issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. The report details the analysis, actions and assurance. The areas are summarised below.

- Infection rates for C.Difficile have risen over the last 12 months, which is a picture seen across Wales. The reasons for this are complex with rates impacted by community prevalence, the number of people with complex co-morbidities, anti-microbial prescribing and poly pharmacy as well as a need to refresh basic good IPC practice. An improvement plan has been produced and is being enacted.

- The Health Board has seen variation in the number of inpatient Falls.

- Themes from incidents continues to include the deteriorating patient, which is part of the refreshed safer care collaborative.

- There is a focus on improving uptake of Level 1 and Level 2 Safeguarding training.

- Addressing PTR compliance within 30 days continues to be a challenge. The Health Board experienced an increase in concerns during January, followed by a return to average levels in February. Ensuring timely compliance remains a top priority for the Health Board.

- The Health Board continues to focus on sepsis awareness and prevention.

- Following the development of a Quality Assurance Framework for Commissioned Services a small working group is reviewing existing commissioning arrangements.

This report demonstrates the hard work and commitment from the Health Board to develop the quality strategy and our reporting obligation under the Duty of Quality.

The report demonstrates how the Health Board is striving to better understand our systems of care and continues to mature our Quality Management System to enable us to set meaningful targets to monitor, measure and report our performance. As part of this work, we are continuing to strengthen our governance structures through Ward-to-Board connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.
Argymhelliad/ Recommendation This report is to provide **ASSURANCE** to the Patient Quality, Safety and Outcomes Committee on the ongoing work to deliver the Duty of Quality and Duty of Candour, through implementing the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and 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:

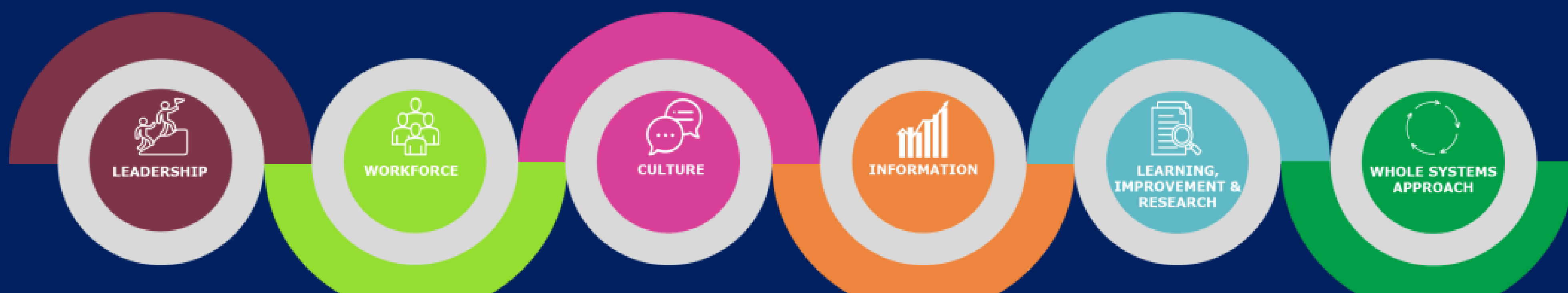
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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.

Patient Quality, Safety and Outcomes Committee

Performance Report

March 2025



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

Good Practice and Learning from Feedback

Section 1

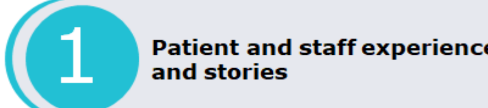
PALS Story

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 2

Pillars of Quality

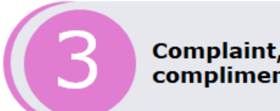


Patient and staff experience and stories

Health, Safety and Security

Incident Reporting – falls, pressure ulcers, medicines management, mortality

Infection Control and Prevention



Complaint, concerns and compliments

Safeguarding

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

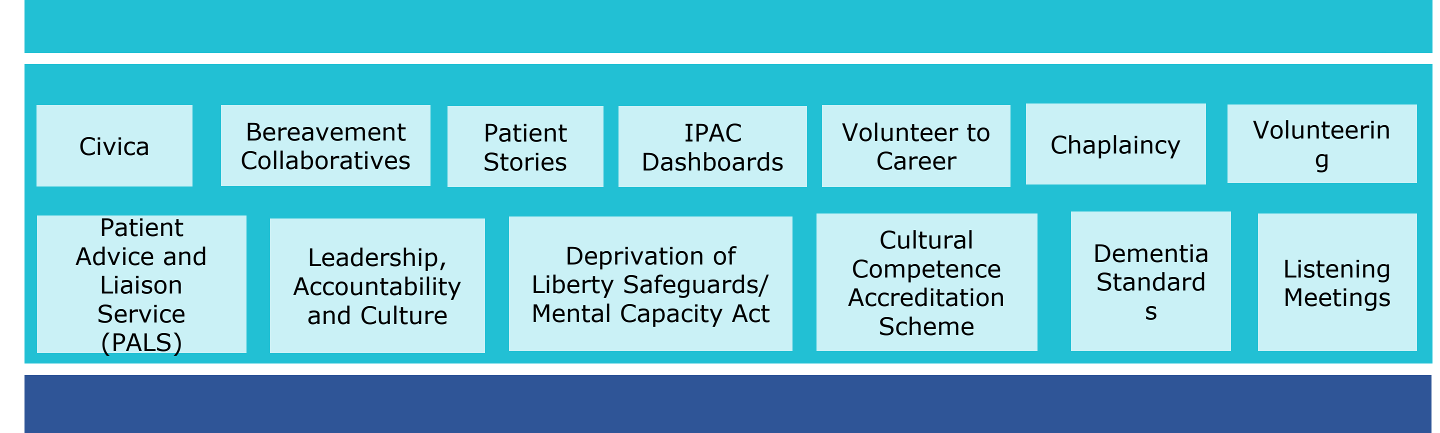
We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies 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.

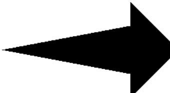
PILLAR 1

Patient and staff experience and stories



Patient Experience Feedback
April 2024 – February 2025

All Surveys



Number of Responses
Health Board Wide - 01/04/2024 to 28/02/2025
All Questions (Bereavement Survey/Arolwg Profedigaeth, Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , ED - Arolwg Adran Achosion Brys/Emergency

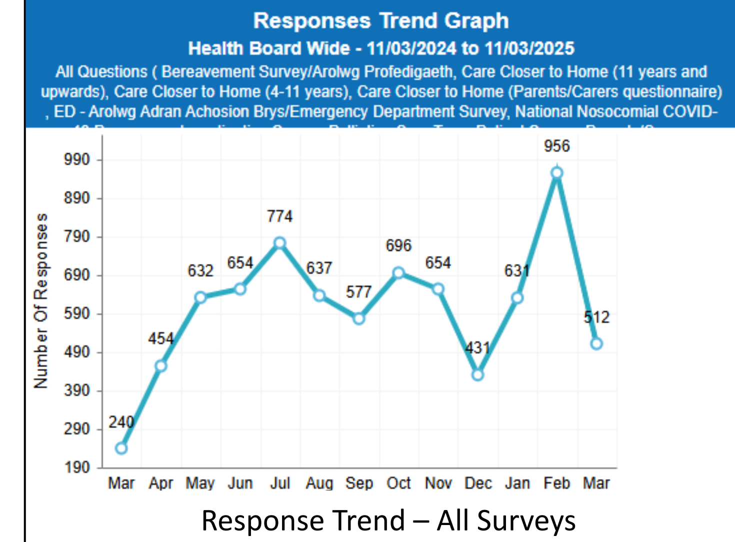
7096
Responses

Export Options

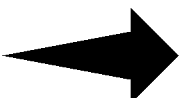
Satisfaction Score
Health Board Wide - 01/04/2024 to 28/02/2025
All Questions (Bereavement Survey/Arolwg Profedigaeth, Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , ED - Arolwg Adran Achosion Brys/Emergency

90%
Satisfaction

Export Options



Person Centred Care (PCC) Survey



Number of Responses
Health Board Wide - 01/04/2024 to 28/02/2025
All Questions (PCC - Gofal syn'n Canolbwyntio ar yr Unigolyn/Person Centred Care - Standard)

6211
Responses

Export Options

Satisfaction Score
Health Board Wide - 01/04/2024 to 28/02/2025
All Questions (PCC - Gofal syn'n Canolbwyntio ar yr Unigolyn/Person Centred Care - Standard)

92%
Satisfaction

Export Options

Emergency Department Survey

Number of Responses
Health Board Wide - 01/04/2024 to 28/02/2025
All Questions (ED - Arolwg Adran Achosion Brys/Emergency Department Survey - Standard)

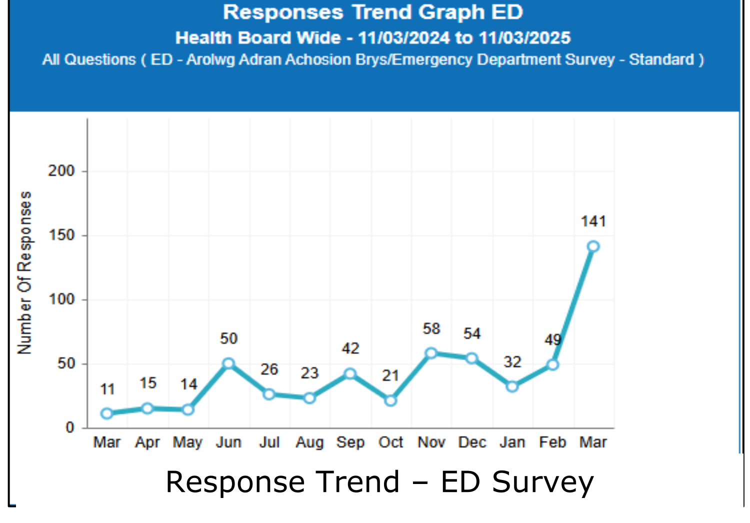
384
Responses

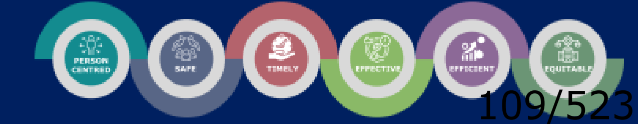
Export Options

Satisfaction Score
Health Board Wide - 01/04/2024 to 28/02/2025
All Questions (ED - Arolwg Adran Achosion Brys/Emergency Department Survey - Standard)

68%
Satisfaction

Export Options





Patient Experience Feedback
Emergency Department Survey April 2024 – February 2025

Monthly Heat Map

	2024	2024	2024	2024	2024	2024	2024	2024	2024	2025	2025	
Question:	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Benchmark
1. Did you feel that you were listened to?	84	55	78	72	87	86	60	70	80	77	74	85
2. Were you able to speak in Welsh to staff if you needed to?	-	100	38	44	66	53	50	40	54	33	42	85
3. From the time you realised you needed to use this service, was the time you waited:	53	24	40	55	55	51	30	26	39	59	37	85
4. Did you feel well cared for?	89	52	77	81	80	81	66	61	71	83	71	85
5. If you asked for assistance, did you get it when you needed it?	87	61	70	81	83	81	66	59	74	84	74	85
6. Did you feel you understood what was happening in your care?	71	48	75	68	85	78	70	71	69	76	64	85
7. Were things explained to you in a way that you could understand?	91	55	71	74	83	79	73	81	77	80	72	85
8. Were you involved as much as you wanted to be in decisions about your care?	87	59	71	73	80	80	63	75	73	79	71	85
9. Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	92	58	66	78	82	79	58	37	56	79	51	85
Overall:	81	51	68	72	79	77	61	60	67	77	64	85
Respondents:	15	14	50	26	23	42	21	58	54	32	49	

January 2025 – February 2025 - Emotions

January 2025 – February 2025 – Top Themes

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 **9** comments around **Compassion** **6** comments around **Emotional & Physical support** and **Friendliness**	**Top themes** **15** comments around **Waiting** **2** comments around **Emotional and Physical Support, Feeling Safe, Parking, Facilities** and **Comfort**

Patient Experience Feedback Emergency Department Survey
January 2025 – February 2025

- Completion of surveys limited to QR code and/or paper.
- SMS launched on the 3rd March 2025 to all ED and MIU patients and responses coming through.
- Increase in Satisfaction Score in January 2025 compared to previous few months at 77 but dipped back in February to 64.

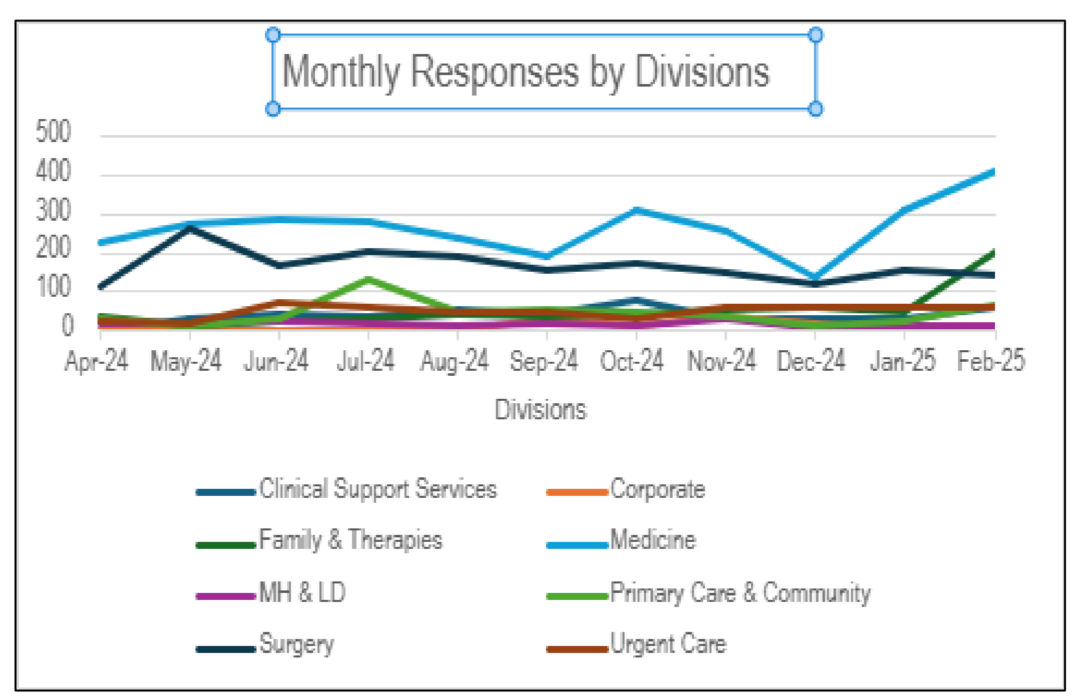
Satisfaction Score Survey Trend
April 2024 to February 2025

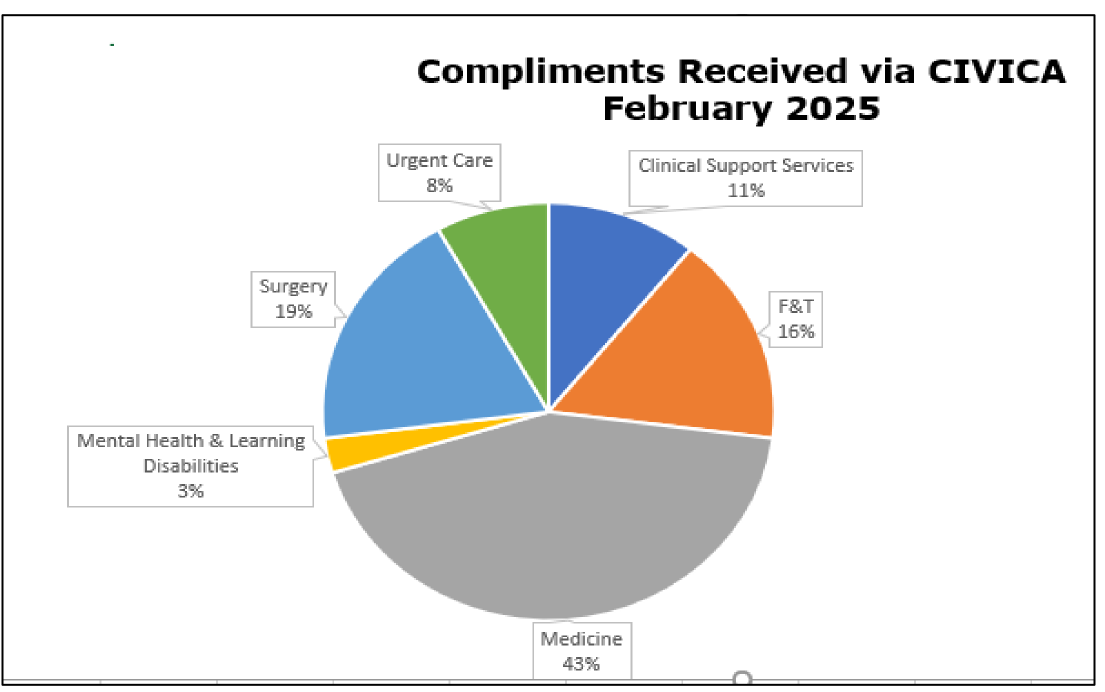
Survey Trend Graph

Health Board Wide - 01/04/2024 to 28/02/2025

All Questions (ED - Arolwg Adran Achosion Brys/Emergency Department Survey - Standard)

Patient Experience Feedback – All Surveys: January 2025 – February 2025





- There has been a significant increase in responses in February 2025, and the highest number to date with 957. Prior to this July 2024 was the highest month (759). The increase is noticeable with the Family & Therapies Division seeing a significant increase in feedback of 203, which in previous months was around 20 – 50 per month.
- Endoscopy Survey launched in January 2025 and has 68 responses in January 2025 vs 137 responses in February.
- SMS launched 3rd March 2025 for ED and MIU.
- A bespoke monthly report covering all Divisions concerning facilities, Infection Prevention and Infection Control, Dementia Care and Bereavement is sent direct to teams to highlight patient comments relating to these areas.
- A Volunteer has started to capture Civica Survey feedback in YYF and 155 completed.
- Positive comments continue to be higher than the negative with very little movement on the top themes.
- Introduction of reporting on Compliments from CIVICA to Datix.

Patient Experience Feedback April 2024 – February 2025

Shown by Division

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
		PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	PCC - Gofal sy'n Canolbwyntio ar yr Unigolyn/Person Centred Care	
Primary Care & Community	489	89	83	92	89	95	90	89	79	88
Medicine	2718	89	82	92	92	94	88	88	78	88
Surgery	1781	97	95	98	98	99	96	98	96	97
Complex & Long Term Care	41	87	84	93	91	97	88	96	88	91
Mental Health and Learning Disabilities	177	90	80	92	85	92	88	89	84	88
Family and Therapies	361	96	95	97	90	97	94	96	95	95
Clinical Support Services	449	98	93	99	98	99	95	99	93	97
Urgent Care	149	85	82	90	92	92	82	86	72	86
	Overall	92	87	94	94	96	91	92	86	92
	Benchmarks	85	85	85	85	85	85	85	85	85

Person Centred Care (PCC) Survey

Questions 1-8

Patient Experience Feedback - Trend Graph Report for Person Centred Care Survey - Showing Satisfaction Score by Division April 2024 – February 2025

	2024									2025	
Division / Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Clinical Support Services	95	97	99	98	98	97	94	97	95	99	96
Complex & Long Term Care	84	94	92	91	95	89	100	91	91	-	-
Family and Therapies	91	97	98	90	94	97	85	97	92	95	96
Medicine	87	85	86	86	89	89	87	88	86	90	92
Mental Health and Learning Disabilities	85	93	90	88	85	87	85	91	97	86	72
Primary Care & Community	85	90	90	96	97	91	83	83	72	76	80
Surgery	98	97	98	98	95	97	97	97	96	97	98
Urgent Care	80	88	91	88	84	85	92	94	22	93	75
Division Overall	90	92	91	92	92	93	91	92	90	92	93
Responses	420	607	591	724	581	487	637	541	339	512	726

Monthly Overall Satisfaction Score (PCC Survey) Covering Questions 1-8

Top 3 Themes from PCC Survey April 2024 – Feb 2025

What did we do well? **Q9**	What could we have done better? **Q10**
Top 3 themes	**Top 3 themes**
• **1131** comments around **Compassion** • **1059** comments around **Emotional & Physical support** • **869** comments around **Friendliness**	• **203** comments around **Waiting** • **158** comments around **Food & Beverages** • **106** comments around **Facilities**
Unchanged top three	*Top two unchanged – 3rd changed from Comfort*

Top 3 Themes from PCC Survey – January 2025 & February 2025 only

Positive Themes	Negative Themes
Compassion (233) compassionatesuch "helpful and patient" empathetic patience compassionate angels understanding "was patient" thoughtful reassured caring considerate reassurance kind reassuring sensitively gentle reassure supportive kindly compassionately empathy compassion considerateyou consideration "very patient" supportivenursing	**Waiting (42)** "not administered on time" "more than 10 hours" "long time to get" "another 8 hours" "long time to answer" "for 9 hours" "takes a long" "takes so long" delay wait ages "after five hours" "sat for hours" waiting waitseventually "take too long" waited "nearly 48 hours" "for hours" "for 6 hours" "not so early" "take a long" "minutes late" "spent 12 hours in" lengthy "left in a room for 9 hours" "for 3 hours" "left in a wheelchair for iver 2 hours"
Emotional and Physical Support (212) "provided reassurance" "put my mind at rest" "dealt with my concerns" "given reassurance" helpfulrency "help and support" "care and support" "assisted "lots of support" "put me at ease" helpfulmade "so understanding" supportive "amazing support" "held my hand" helping helpful encouragement "spend time with me" "good support" helped reassured "put at ease" "support me" supported supporting "really understanding" helpfulmum reassuring "support you" helpfulthe "great support" helpfulif "gave me great reassurance" "very understanding" "kindness and support"	**Food & Beverages (24)** "dont like the food" "tastes bland" "breakfast was not" "no hot water" "food could be better" unappetising "food is not" "no food" "food awful" "food was cold" "better food" "breakfast is awful" "more tea" "food not" inedible "more choice on menu" "choice on menu" "food isnt" "food choices" "food is dreadful" "menu is not" "food was not" "processed food" "food is often cold"
Friendliness (195) approachable friendliness relaxed personable jovial cheerful friendly friendlyward chatty welcoming talkative warm pleasant friendlyoutstanding	**Comfort (24)** "feeling so cold" "light on" discomfort overcrowding "the heating" uncomfortable "hard to sleep" noisy "room was cold" "ward was cold" "more blankets" "not comfortable" "i was cold" "never felt comfortable"

Patient Comments from PCC Survey – Jan/Feb 2025

Positive

all the staff are lovely. kind caring and compassionate from the kitchen cleaning staff all the way up to the consultantsi was made

explained everything to me and answered all concernsstaff very supportive and attentive and friendly

friendly approachable staff. prepared to spend time - listening and helping

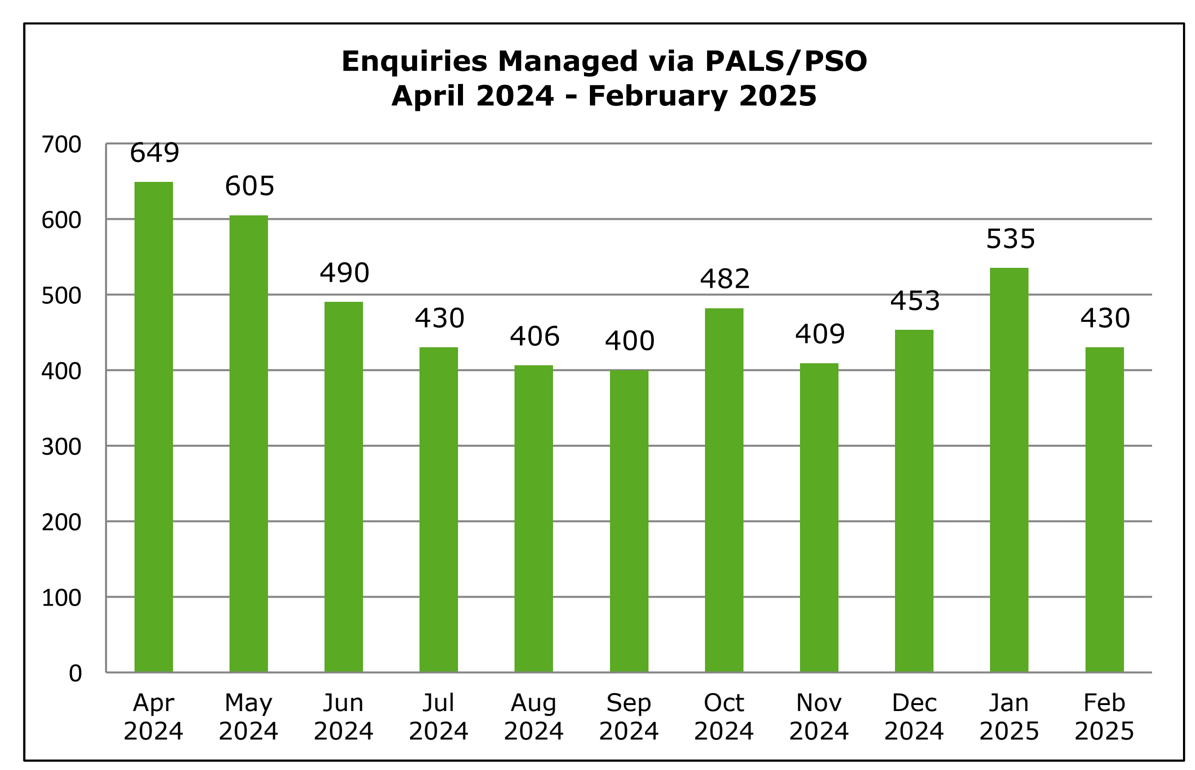
Not So Positive

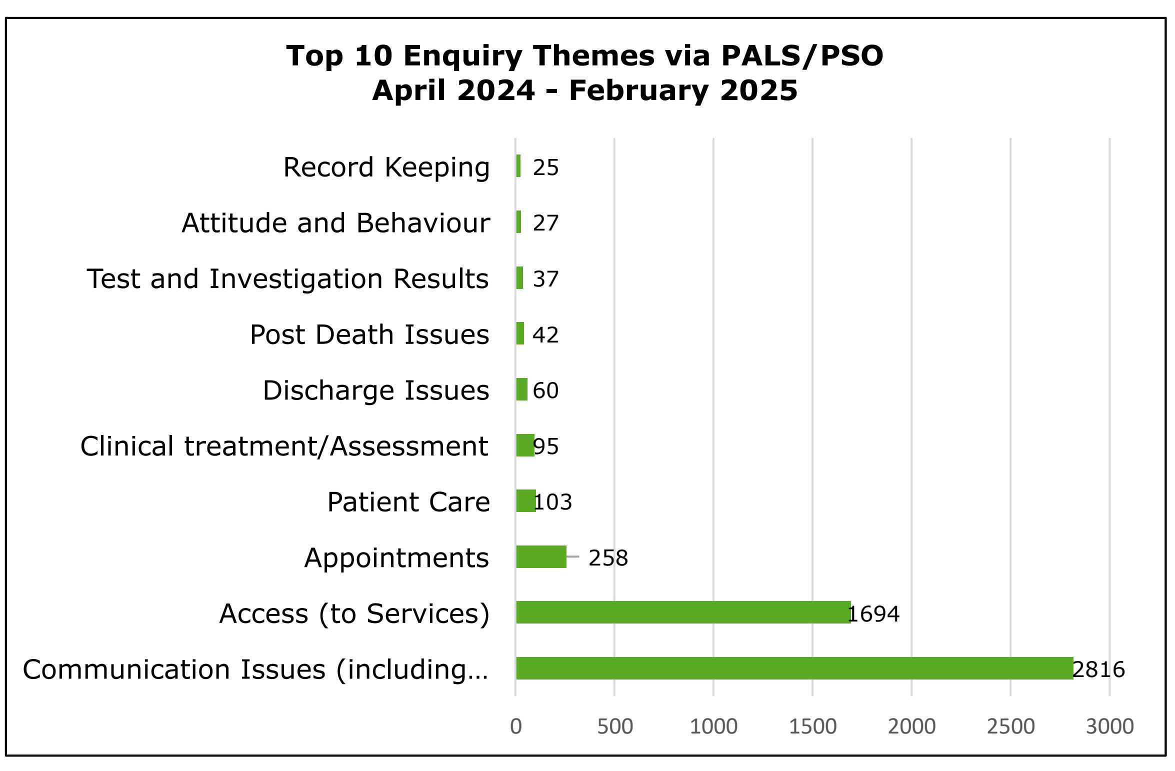
seven hours before going to surgery was hard- possible come into ward later

the food is dreadful when i get it it is always cold and i find it tastes bland

waiting to see someone. my wife is in a wheelchair and felt in pain and discomfort in sitting about. this is not a very pleasant experience

Patient Advice & Liaison Service: April 2024 – February 2025

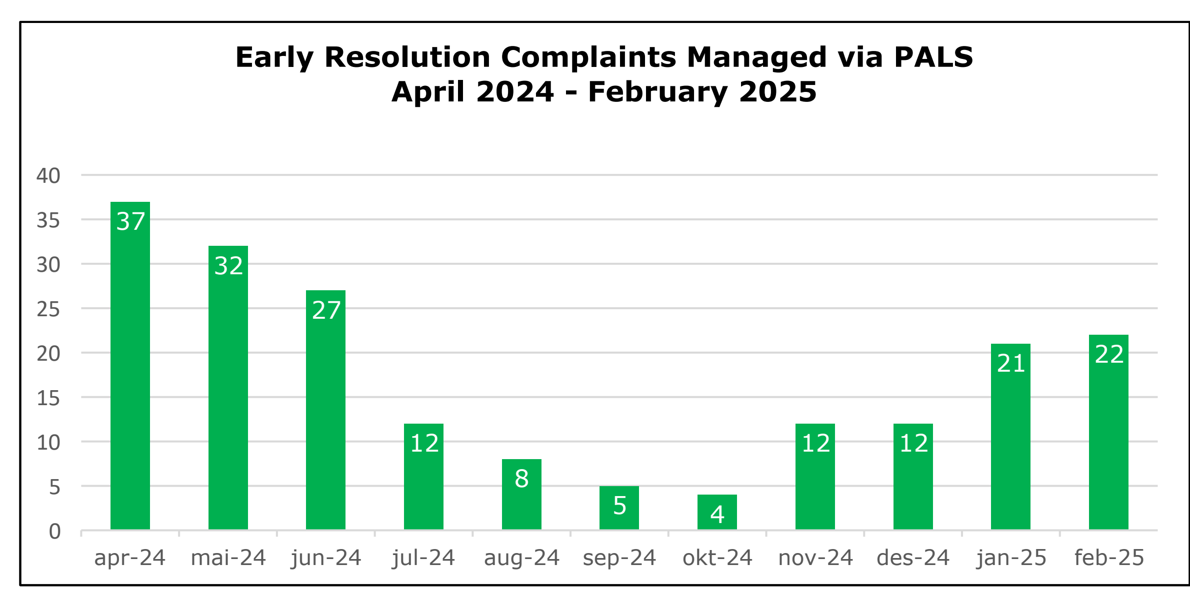


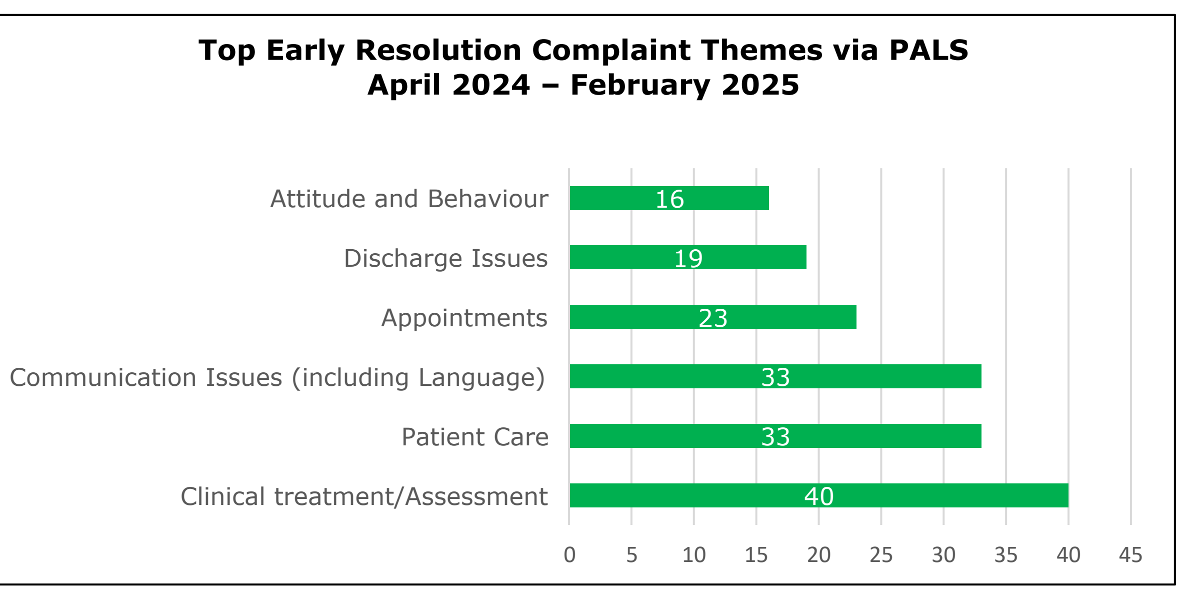


Enquires Overview: -

- **Average number of Enquiries - 481 per month.** The number of Enquires per month dropped after April due to duplication issues with logged enquiries. Therefore, May onwards is a accurate representation of data.
- **Top Theme** - Communication Issues make up for **52.2%** of the total Enquires for **April 2024 – February 2025**.
- **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 – April 2024 – February 2025





Early Resolution Complaints Managed via PALS

Concerns and Enquires received from Putting Things Right are opened as Early Resolution on Datix. July 2024 – November 2024 this guidance changed and PALS only logged Early Resolution's when service users had specified they were raising a complaint. However, from November 2024 guidance is now all calls transferred from PTR are logged under Early Resolution.

Average number of ER complaints: - 17 a month over April 2024 – February 2025

Top Theme: Clinical Treatment/Assessment 20.8% of Early Resolution Complaints.

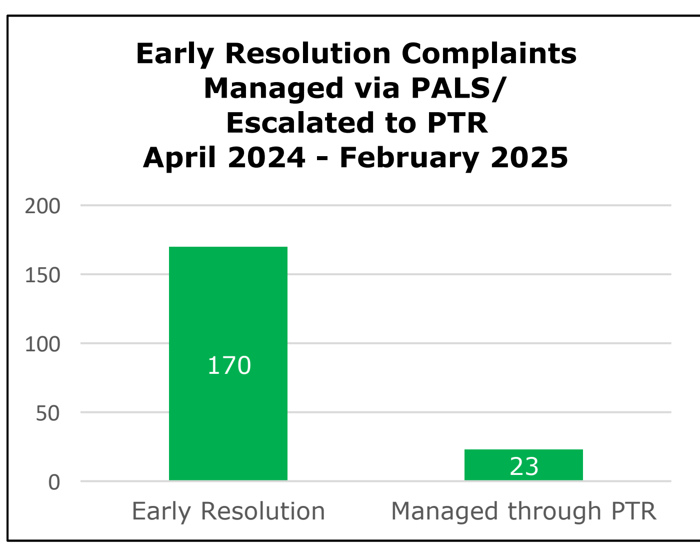
Patient Advice & Liaison Service – April 2024 – February 2025

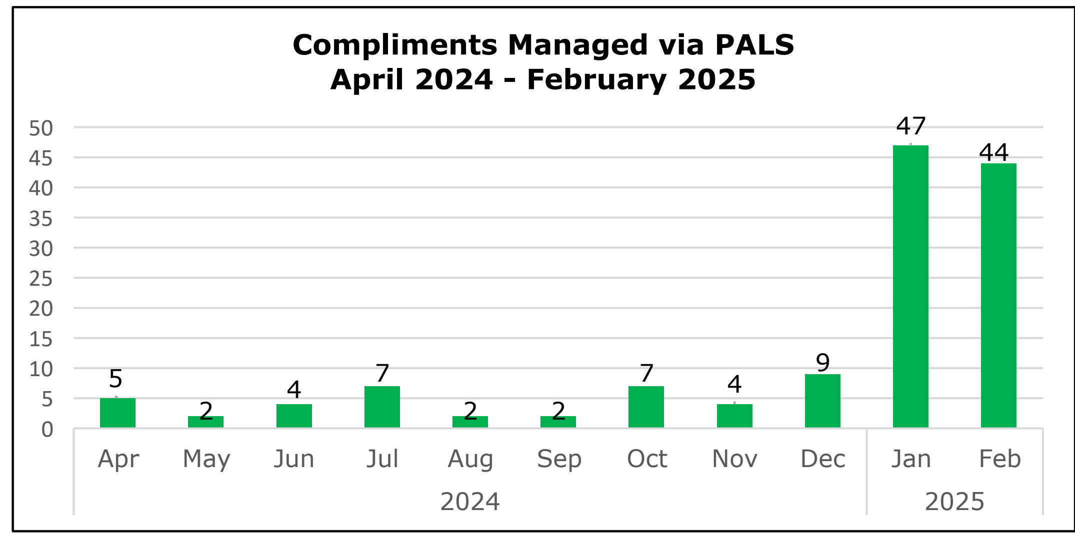
Early Resolution Complaint Themes by Division
April 2024 – February 2025

80
70
60
50
40
30
20
10
0

Clinical Support Services
Complex & Long Term Care
Estates & Facilities
F&T
Medicine
Mental Health & Learning Disabilities
Primary Care & Community Division
Surgery
Urgent Care

Test and Investigation Results
Privacy and Dignity
Post Death Issues
Personal Property/Finance
Patient Care
Other
Medication
Infection Control
Equipment
Environment/Facilities





As of January 2025 the PALS team now utilise CIVICA to log compliments for each divisions. Therefore, going forward the number of compliments managed by PALS will increase.

The CIVICA Surveys being utilised are:

- Emergency Department Surveys
- Person Centred Care Survey
- Endoscopy Survey
- Children’s Surveys

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 February 2025.

Case Study 1:

A patient on one of our hospital wards was medically fit for discharge but required a hospital bed at home, along with a package of care, in order to facilitate their safe return. While the care package was secured, the discharge was delayed due to the lack of an available hospital bed.

Complicating matters further, the patient's home was located on the border of two different health boards, which led to a communication breakdown regarding the provision of the bed. This resulted in significant delays.

Despite the ward team escalating the issue to their Senior Nurse, the problem remained unresolved. The patient's daughter contacted the PALS team for assistance. The PALS team took immediate action, collaborating with the Facilities team, the Discharge Team, and Heads of Service for the Community Teams. Through their efforts, they successfully sourced the required hospital bed and finalised the care package, enabling the patient to return home promptly.

Case Study 2:

A patient had concerns about his hospital stay and tried to submit a complaint to the Putting Things Right team but faced technical issues. He then contacted PALS, thinking we were the same team, to check if his complaint had been received.

A PALS Officer clarified the difference between the teams and expressed that as he was currently an inpatient – we would be best placed to help him. The patient, who had recently had a stroke, found it difficult to speak on the phone and requested an in-person meeting. The PALS Officer visited him in the hospital and listened to his concerns.

The PALS Officer consulted with senior teams, addressing each of the patient's concerns and making adjustments to improve his experience on the ward. Since then, PALS has maintained regular communication with the patient through messaging, which suits his speech difficulties. All his concerns have been resolved, and PALS will continue to support him until his discharge in a few weeks.

Case Study 3:

A concerned family member reached out to the Health Board in a state of desperation. They contacted Corporate Governance, Putting Things Right, and PALS. PALS quickly coordinated with these teams and took the lead in the case.

Their father was referred to the hospital on Monday by their GP and had spent 22 hours on a chair before finally being allocated a bed in the observation ward for a second night. Unfortunately, this was another busy night for the hospital, and the father had a second night without any sleep at all. The son was concerned that his dad had been assigned a bed on a dementia ward with patients who were shouting throughout the day and night. The son had to return to the hospital at 5 am in the morning as their dad was so distressed due to consecutive nights without any sleep.

The son expressed: "I am pleading with you to help me as I am watching my relative fade through lack of sleep when they desperately need it most."

PALS liaised with the family and the ward staff to address the situation. Following a call, they spoke to the son to explain the plan going forward. PALS managed to expedite both a CT scan and an ECHO for the patient to aid with discharge home. However, they were informed that the patient had been commenced on IV antibiotics and was no longer for discharge. Therefore, the plan was to move the patient to a quieter bay on another ward within the same hospital. PALS advised the family to be mindful that although the bay may be quiet now, situations or patients' conditions can change at any point in time, but PALS would be on hand to support. The son was appreciative of the swift support offered.

Case Study 4:

A concerned mother contacted PALS after experiencing difficulties during the pathway of an Autism Spectrum Disorder (ASD) assessment for her young child. Due to a complicated and traumatic recent family history, the mother felt extremely uncomfortable attending appointments, as she perceived off-hand judgemental comments had been made previously. She reached out to PALS seeking support and someone to accompany her to the appointments.

A PALS Officer assured the mother that they would attend her appointment the following week. The PALS Officer met the mother and child, discussed their previous experiences, and provided the mother with the opportunity to express her feelings. The PALS Officer then attended the ASD assessment, offering support throughout the session. The mother had provided PALS with a list of important points she did not want to forget to mention, enabling the officer to prompt and assist during the assessment.

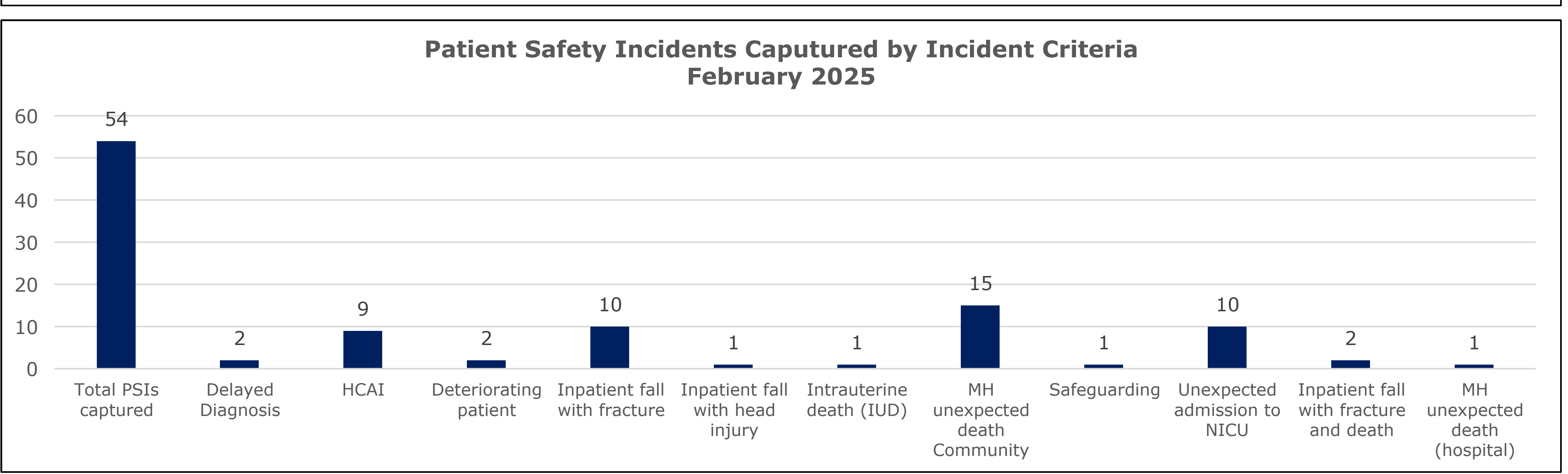
Following the assessment, the mother and her child expressed their gratitude to the team, as PALS transformed an appointment she had dreaded into a surprisingly positive experience.

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

Patient Safety Incidents



A total of 504 Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified between April 2024 and February 2025.
This is in comparison to 537 in the same period in 2023/24.

There were no unusual trends identified across the January and February PSI's captured

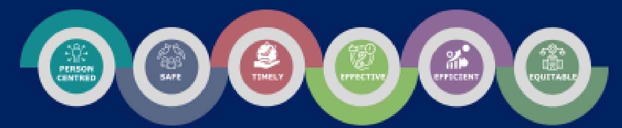
Patient Safety Incidents

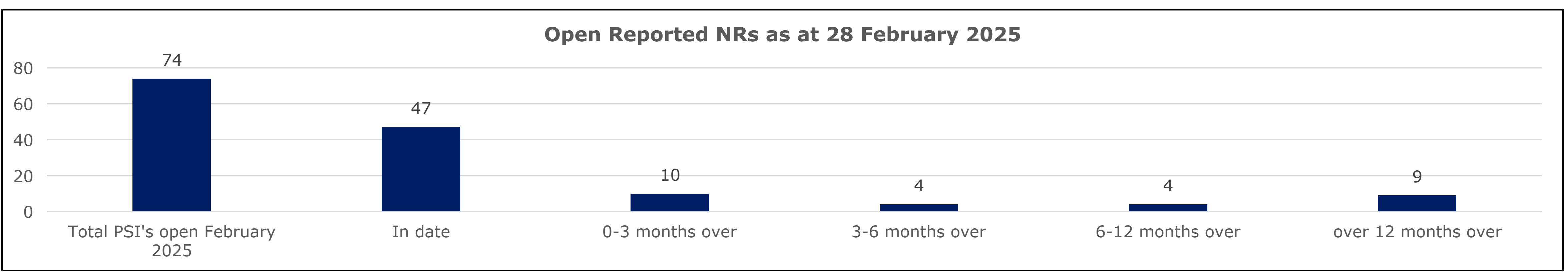
There were **123** Early Warning Notifications (EWNs) reported to Welsh Government (WG) April 2024 to February 2025. This is in comparison to **104** submitted for the same period in 2023/24. Themes included unexpected Mental Health deaths, absconsions, and practitioner concerns.

Welsh Government Early Warning Notifications submitted April 2024 - February 2025

Month	EWNs
apr-24	10
mai-24	11
jun-24	11
jul-24	17
aug-24	11
sep-24	5
okt-24	10
nov-24	14
des-24	7
jan-25	15
feb-25	12

Patient Safety Incidents





The above graph shows the number and status of compliance for open NRI's as of the end of February 2025.

The graph below illustrates the NRI compliance over time for comparison. Despite challenges in timely completion of NRI investigations the management of the PSI process remains a focus. 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.

Health Board Wide PSI Run Chart

140 120 100 80 60 40 20 0

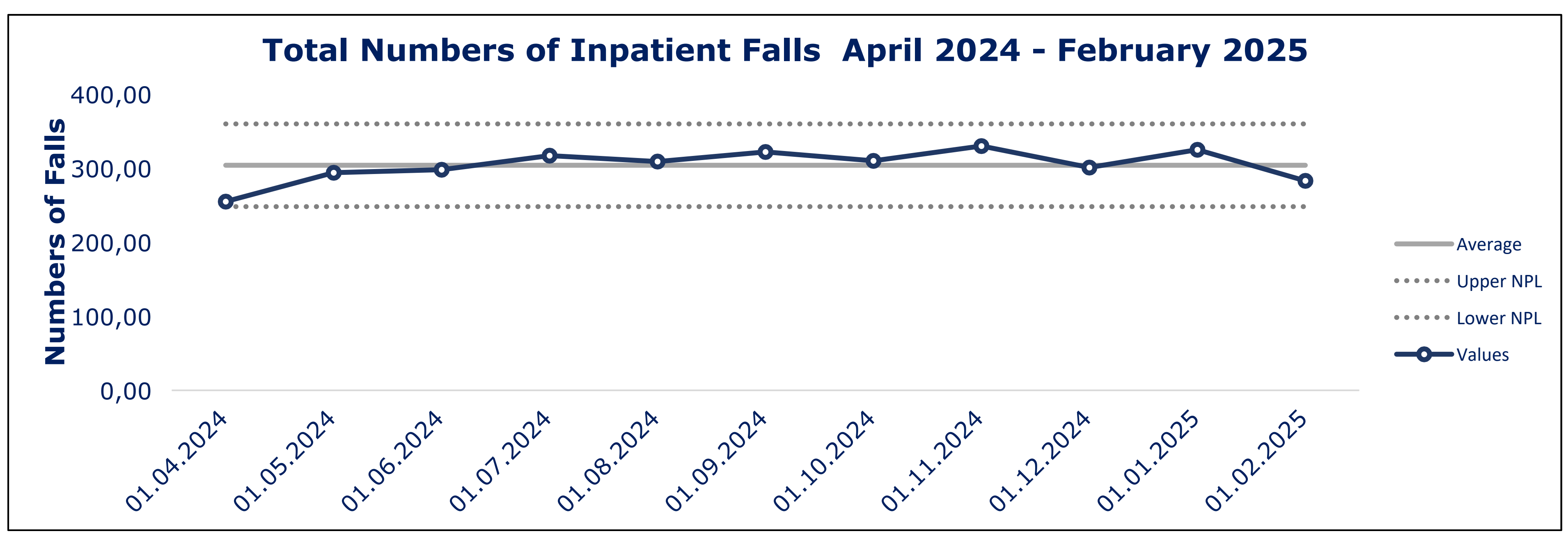
80% 70% 60% 50% 40% 30% 20% 10% 0%

50% 50% 29% 29% 29% 28% 26% 34% 45% 42% 45% 47% 61% 65% 71% 56% 51% 53% 39% 33% 23% 36%

mai-23 jun-23 jul-23 aug-23 sep-23 okt-23 nov-23 des-23 jan-24 feb-24 mar-24 apr-24 mai-24 jun-24 jul-24 aug-24 sep-24 okt-24 nov-24 des-24 jan-25 feb-25

Total Sis open — In date — Overdue 0-3 Months — Overdue 3-6 Months — Overdue 6-12 Months — Overdue >12 Months — % Overdue

Total Number of Inpatient Falls

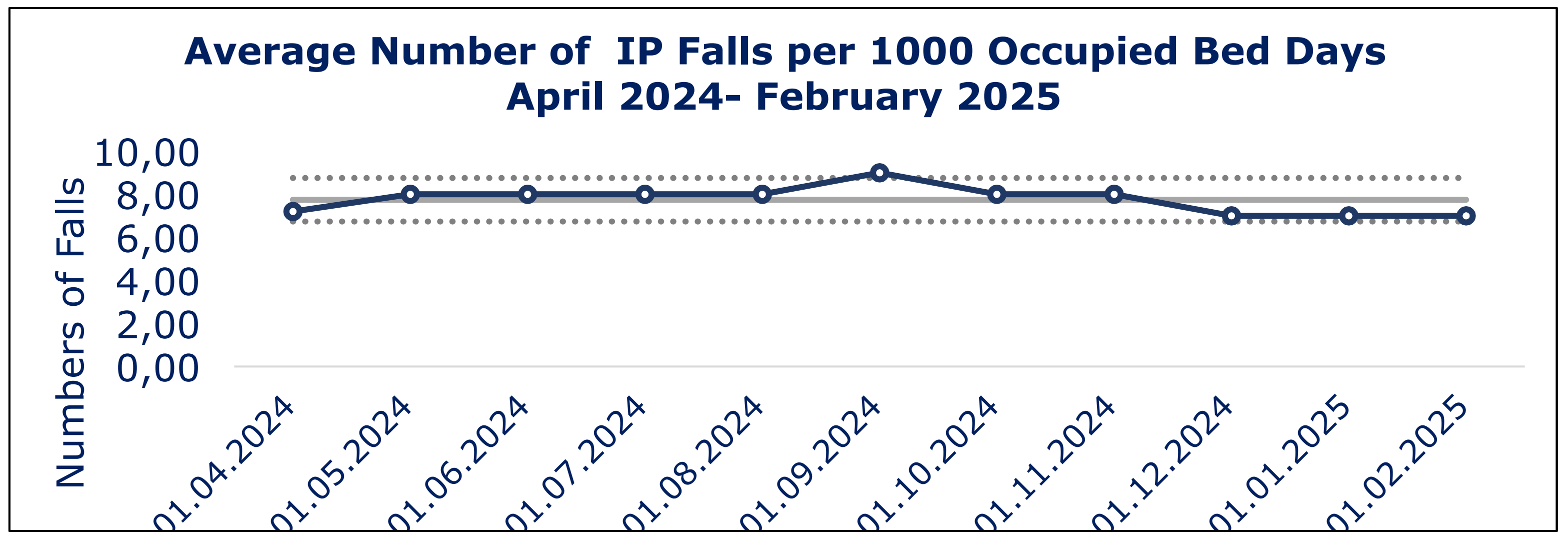


February 2025 - Context

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2024-February 25.

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 304 with minimal variation. • Given the data available for Q4 (January/ February 2025) the mean average is aligned to that for the overall period identified (April 24-February 25). • January 2025 saw a 6.9% increase from the December value with a subsequent 13% decrease for February 2025.	Minimal variation for period of analysis

Health Board Wide Inpatient Falls per OBD



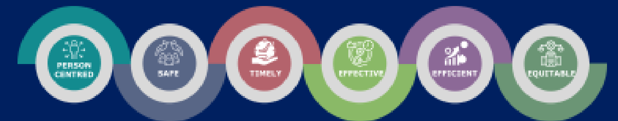
February 2025 - Context

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2024-February 25.

The figures are rounded for the purposes of the chart presentation.

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.	The value aligned to per 1000 Occupied Bed Days (ODD) is represented by a downward trend since November 2024. January and February 2025 have seen values of 7.3 and 7.1 respectively against a national average of 6.6.	Positive variation in that the values represented are below the mean average for the given period demonstrated by the chart.

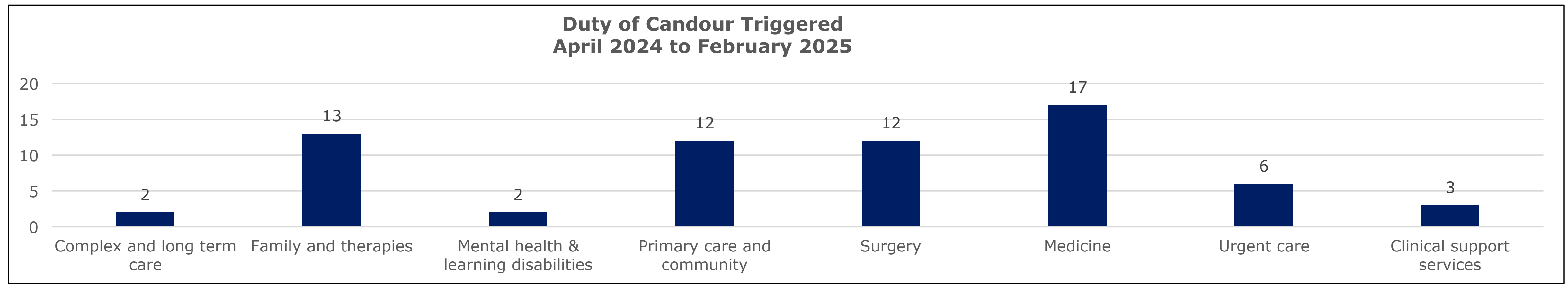
Duty of Candour



Between April 2024 and February 2025 there were **24408** incidents affecting patients reported on the Datix Cymru system. This is in comparison to **22863** incidents for the same period in 2023/24.

There have been **67** 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, prescribing, and maternity occurrences. All these incidents have undergone the formal DoC process.

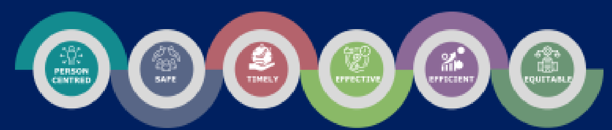


There is a significant amount of work done through creation of divisional dashboards for divisions to monitor their Duty of Candour compliance with statute. There is a plan for the Assistant Head of Patient Safety to give focus to working with the divisional representatives in an effort to increase compliance.

Never Events

There were no Never Events recorded in February 2025. Work remains ongoing across the organisation with improvement and prevention of such occurrences.

Hospital Acquired Pressure Ulcers – Extracted from RL Datix (not validated)



Surgery

Medicine

Pressure ulcer category 1
Pressure ulcer category 2
Pressure ulcer category 3
Pressure ulcer category 4
Suspected deep tissue injury
Unstageable pressure ulcer

Urgent Care

Complex & Long Term Care

Clinical Support Services

Family & Therapies

Mental Health & LD

Primary & Communoty Care

Avoidable & Unavoidable HAPU – Extracted from RL Datix (not validated)

Surgery

Medicine

Complex & Long Term Care

Urgent Care

Clinical Support Services

Avoidable
Unavoidable
No value

Family & Therapies

Mental Health & LD

Primary & Community Care

Apr 2024 | May 2024 | Jun 2024 | Jul 2024 | Aug 2024 | Sep 2024 | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025

Data Analysis

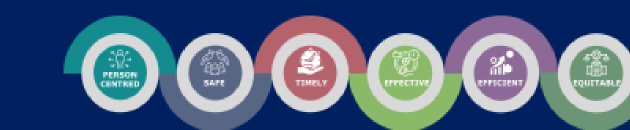
What does the data tell us?

- The data over the last few months has not identified any specific trends
- Most divisions have had some improvement in some categories during January and February.
- Further work is required to identify trends within each division.
- Further work is required to triangulate the data with details of avoidable and unavoidable pressure damage.

Next steps:

- Commence professional forum with divisional leads to discuss management of data, validation and shared learning.
- Review impact of current initiatives and share across divisions where appropriate.
- Identify themes and clinical areas where quality improvement is required. Source support from ABCi and quality improvement coach to support.
- Work through the identified issues and actions for each division.

Learning, Actions & Improvement



Issue	Action	Learning and Improvement	Who	When (RAG)
Quality of Datix Reporting – correct grading, duplication, multiple grades & worsening grades	Data to be validated Completion of Avoidable or Unavoidable Staff to attend tissue viability training via ESR	Grading guides & resources available on the Tissue Viability webpage to support improvement. Critical care have completed bite size training on the unit Share examples of correctly completed documentation	All Divisions	Ongoing
	Re-establish HB steering group to support divisional approach	Collating membership & aim to have first meeting by end of April.	Sue Pearce	30 April 2025
Documentation including skin assessment, nutrition	Carry out audit to identify any themes Support staff with new processes on WNCR with aim to phase out paper documentation	Implement use of symbols on PSAG boards to identify at risk patients Introduce daily huddles to discuss planned care for existing wound care PANDO App for imaging being used successfully Promote RADAR training	All divisions	Ongoing
Access to Datix dashboard	Email Lynne Davies to arrange access	Utilise dashboard information to improve validation	All divisions	Ongoing
Access to air mattresses Mattresses arriving in clean packaging – damaged or contaminated	Ensure staff are aware of how to access mattresses via Drive Report incidents of damaged or contaminated mattresses to Drive immediately	Posters & booklets available to support mattress choice. Education programme in place at YYF. Plan to roll out to other sites. Ensure staff are aware of how to contact Drive	All divisions	Ongoing
Timely investigation & sharing learning	Establish weekly review meetings. Complete investigations & Yorkshire contributory factors on Datix	Identify themes & actions to improve. Share via QPS forums & HAPU steering group	All divisions	Ongoing

Use of CTG monitoring:

Issue: Delay in recognising the severity of fetal distress during labour.
Insight: Prompt use of fetal scalp electrode (FSE) CTG monitoring following transfer to the labour ward is likely to have identified fetal distress earlier. The infant was discharged home on day 11 on oxygen and NG feeds with planned MDT follow up.

MDT approach:

Issue: A patient experienced a 9-month delay from referral to gastroscopy
Insight: A 6-week delay occurred from biopsies to MDT discussion. Reliance on tertiary centers for treatments which can lead to delays due to their waiting lists. MDTs should have local agreements to ensure staging procedures for patients with diseases requiring surgical intervention are performed in a timely manner, ideally within 2 weeks and formal surgery within 6 weeks. High-risk patients should be on specialist endoscopy lists, with Barretts surveillance ideally using sedation, high-quality endoscopy, and mucosal enhancement.

Strengthening Communication and Staff PMVA training:

Issue: Patient assault on two staff members in Mental Health ward
Insight: Missed opportunities in escalating and managing a patient's presentation. The patient's presentation could have been managed more effectively with the optimal number of PMVA trained staff available.

Transfer pathways and staff education:

Issue: Transfer delays and recognition of clinical deterioration.

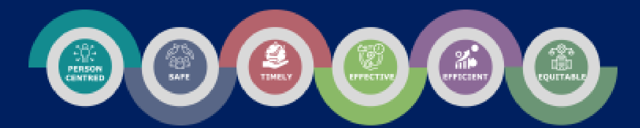
Insight: Ambulance Transfer arrangements and pathways to be shared via ABUHB Intranet page.
Transfer guidance to be reviewed and re-issued to flow navigators, with regular compliance reviews. Scenario-based training to test responses and identify learning needs.
Education for nursing staff on the importance of neurological observations and documentation for patients experiencing seizures.

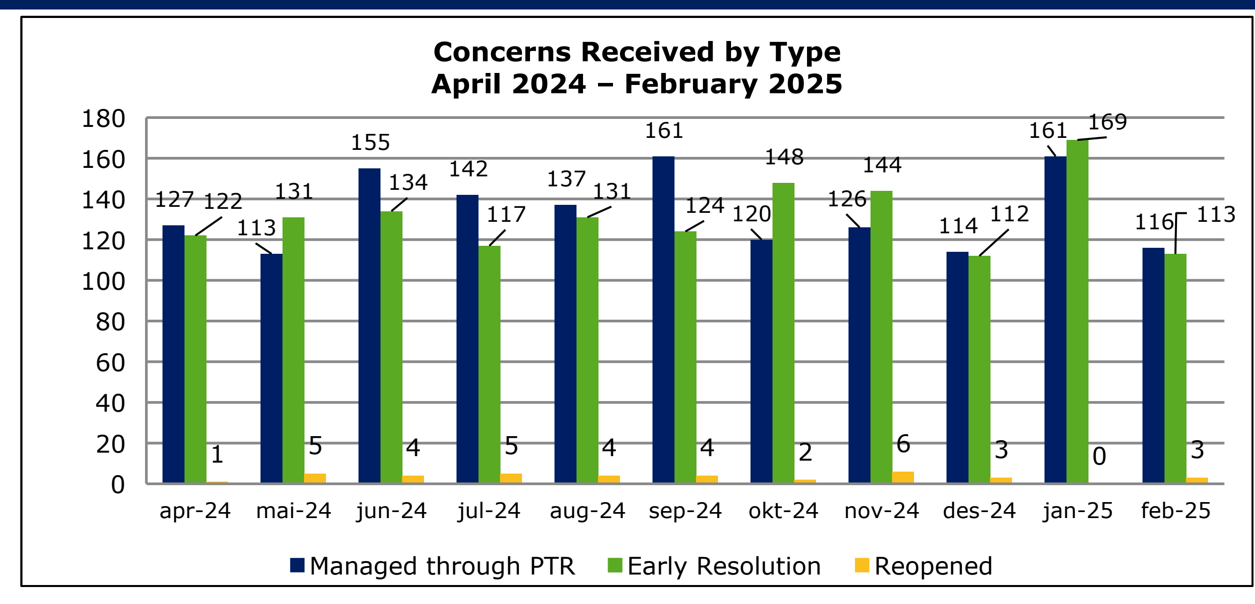
Tuberculosis (TB) Management:

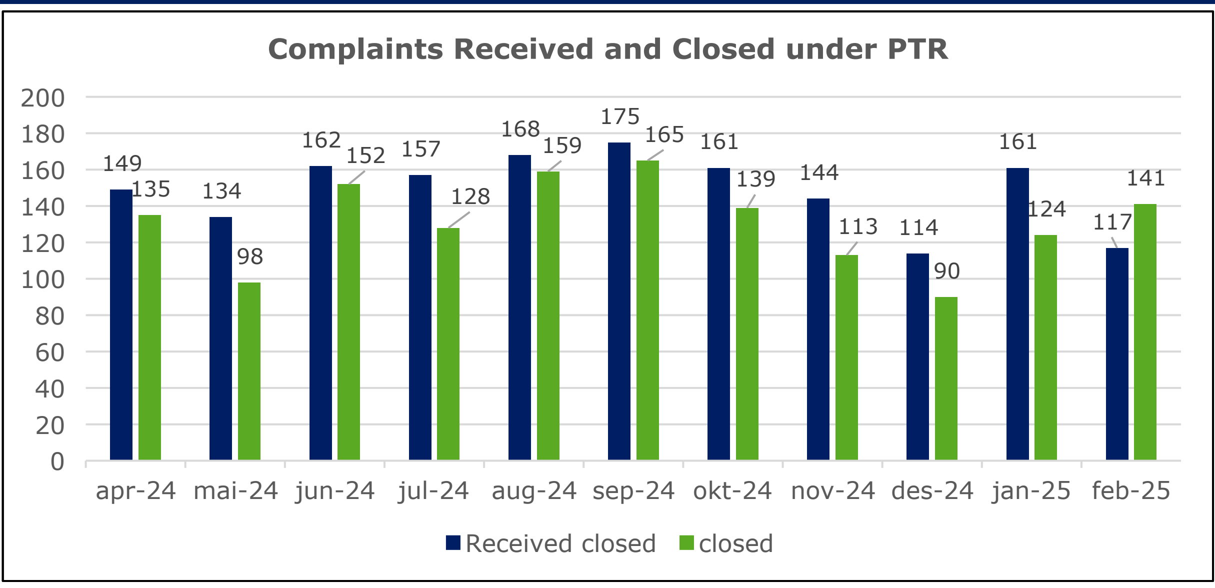
Issue: A child treated for a supraclavicular lump in August 2022 did not receive Ultrasound and TB tests. Diagnosed with miliary and extra-pulmonary TB in May 2023, leading to screening of over 100 individuals by Public Health.

Insight: Clinicians must notify Public Health Wales upon TB suspicion. Use sputum or pus samples for TB cultures, not swabs.

Complaints Performance

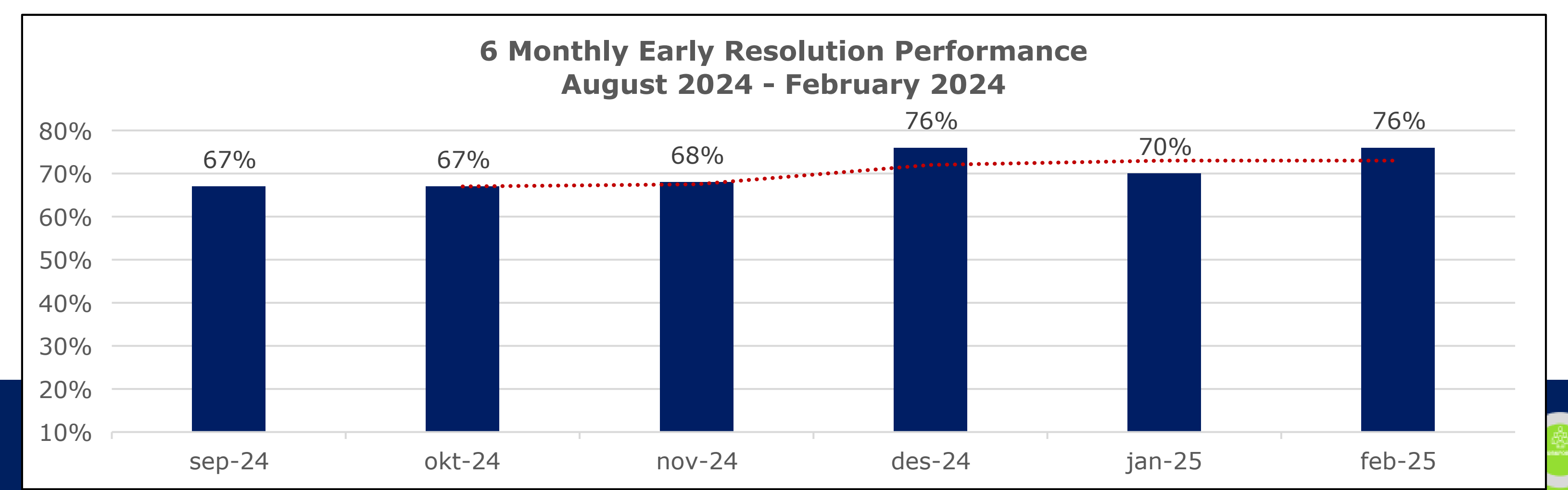




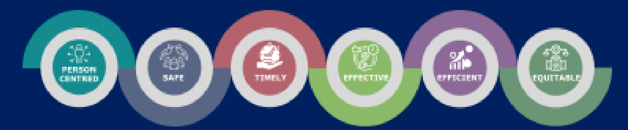


The number of concerns being managed by the Health Board via either Early Resolution or Managed under PTR has remained static with a 50/50 split. By allocating dedicated resources to identify and manage of Early Resolution matters across Divisions, the aim is to reduce the number of formal concerns will decrease and continue the trend since September 2024.

The consistent month-on-month closure of concerns by the Health Board highlights the ongoing dedication of all Divisions in balancing incoming concerns with those already open. In February, a tabletop exercise involving the Medicine Division, QPS, and complaints team led to the closure of 13% of their open concerns.



Complaints

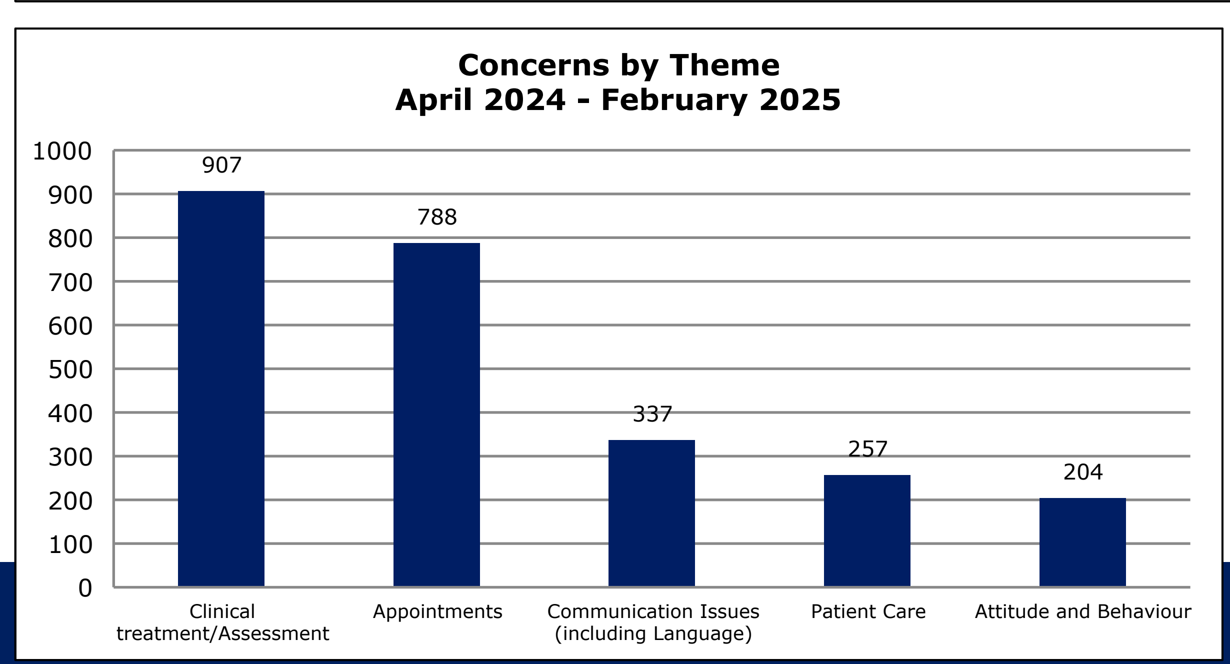


Concerns by Division
April 2024 – February 2025

90
80
70
60
50
40
30
20
10
0

Estates & Facilities
F&T
Mental Health & Learning Disabilities
Primary Care & Community Division
Surgery
Medicine
Urgent Care
Clinical Support Services
Complex & Long Term Care

Apr 2024 | May 2024 | Jun 2024 | Jul 2024 | Aug 2024 | Sep 2024 | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025



Clinical Support Services: The Division successfully closed two-thirds of the concerns received in February and improved their Early Resolution compliance to 100% from January.

Mental Health & Learning Disabilities: Despite staffing deficits, the Division improved Early Resolution performance from January to February, achieving 59%2.

Surgery: This Division now holds the most formal concerns, with a 17% increase in open formal concerns between January and February. Their Early Resolution performance has consistently exceeded the 75% target, averaging 98% during this period. An urgent deep dive is planned to review all open complaints.

Medicine: The Division saw a significant decrease in the number of concerns by 13% following a focused table-top session in February.

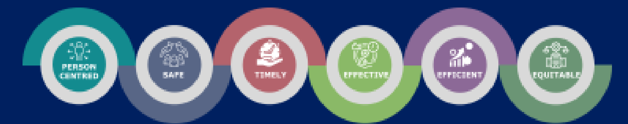
Urgent Care: The Division has continued to achieve and exceed compliance with managed PTR matters, averaging 84% across January and February. They achieved 80% and 90% compliance for Early Resolution in January and February, respectively.

Primary Care & Community: The Division's focused efforts resulted in a 26% reduction in the number of open concerns from January to February, while also achieving 100% compliance with Early Resolution in February.

Family & Therapies: The Division closed several older concerns in February and recorded 50 matters as Early Resolution in January.

Estates & Facilities: The Division received no formal concerns in February, with only one Early Resolution matter. This aligns with the goal of greater consideration for Early Resolution in Facilities matters where appropriate.

Compliments



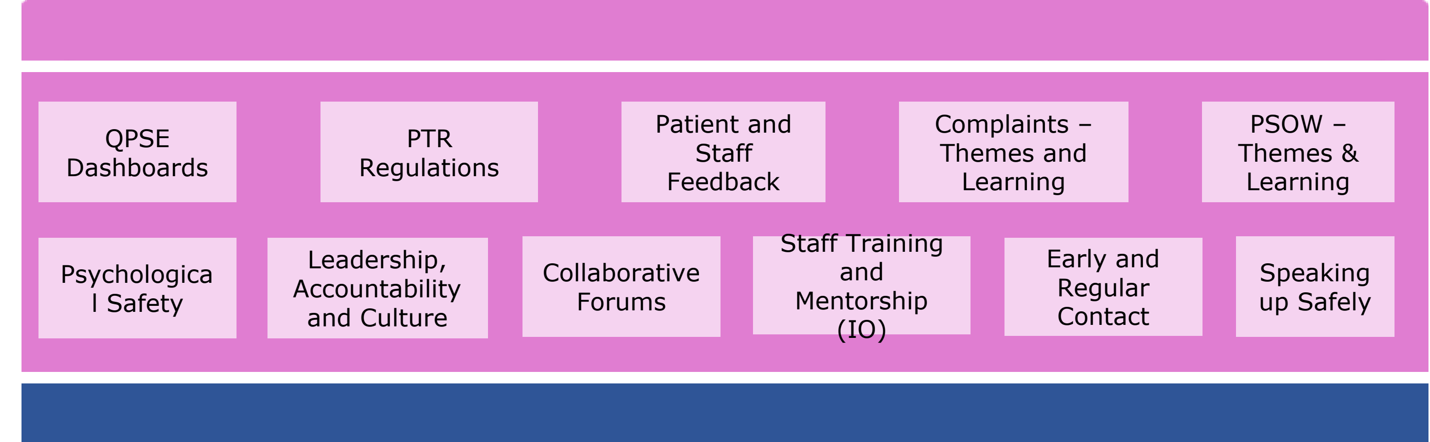
Feedback by Compliment Subject
April 2024 - February 2025

Month	TOTAL
apr-24	65
mai-24	70
jun-24	92
jul-24	84
aug-24	79
sep-24	106
okt-24	211
nov-24	78
des-24	85
jan-25	155
feb-25	158

Legend: Beyond duty of care, Communication, Environment, Listening, Understanding, TOTAL

PILLAR 3

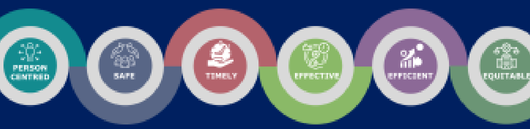
Complaints, Concerns and Compliments



PTR - Actions, Learning & Improvement

Achievements	Update	Next Steps
Quality Improvement and process mapping	The complaints team have been collaborating closely with ABCI to enhance processes using the LEAN Six Sigma approach. The aim is to streamline systems, reduce variation, and improve quality.	A further workshop will be held in March 2025
Datix validation and cleansing	An errors dashboard has been created to effectively oversee and monitor the complaints management system. Additionally, it will also support the training needs of the complaints team in using Datix and complying with PTR timelines.	The dashboards will be shared with the complaints co-ordinators in March 2025 for validation of historic data.
Medicine complaints tabletop exercise	In February, the Medicine Division, in collaboration with members of the QPS and complaints team, conducted an in-depth analysis of open complaints to gain a comprehensive understanding of the complaints position and to identify possible opportunities for resolution. As a result of the session, the number of open formal complaints decreased significantly from 129 to 112, representing a 13% reduction. Additionally, Early Resolution complaints were reduced to 3, which constitutes a 50% reduction.	A further debrief is due to be held in March 2025 to discuss the benefits, sustainability and next steps

Welsh Risk Pool Assessment: Putting Things Right

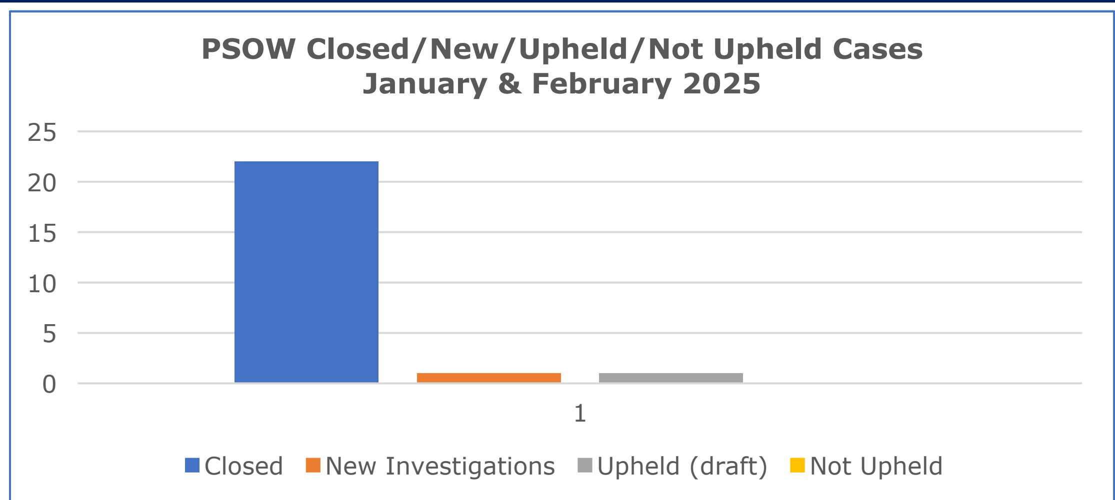


- The Welsh Risk Pool assessed Aneurin Bevan University Health Board's Putting Things Right processes to evaluate their effectiveness and provide recommendations for improvement.
- **Findings:**

Management of Concerns (Incidents)	Management of Concerns (Complaints and Enquiries)	Redress Case Management	Claims Case Management	Inquest Case Management	Organisational Learning and Learning from Events	WRP Reimbursement Process
▪ 7,900 incidents reported. ▪ Comprehensive policy but inconsistencies noted. ▪ Limited assurance.	▪ 861 complaints reported. ▪ Reasonable assurance.	▪ Delays in interim responses. ▪ Limited assurance.	▪ 430 claims opened. ▪ Substantial assurance.	▪ Challenges with workload and statement quality. ▪ Limited assurance.	▪ Implementation challenges. ▪ Limited assurance.	▪ Accurate local records but some delays. ▪ Reasonable assurance.
Recommendations: Introduce KPIs, ensure timely reviews, validate data.	**Recommendations:** Accurate recording, regular updates to patients.	**Recommendations:** Reduce delays, review data accuracy.	**Recommendations:** Regular audits, accurate data entry, staff training.	**Recommendations:** Improve statement quality, reduce late submissions.	**Recommendations:** Implement framework urgently, improve data accuracy.	**Recommendations:** Timely submission of reports, improve monitoring.

- An Action Plan has been developed and shared with the Welsh Risk Pool to monitor recommendations.
- SBAR and Action Plan presented to Executive Committee 20/03/25.
- The Action Plan will continue to be monitored via the Patient Quality Safety and Outcomes Committee.

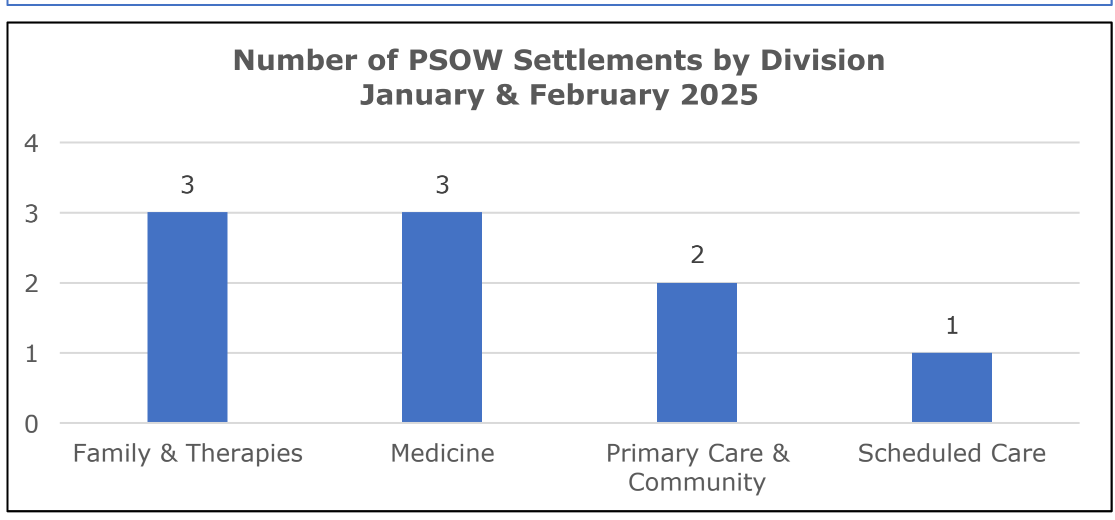
Ombudsman (PSOW)/Regulation 28

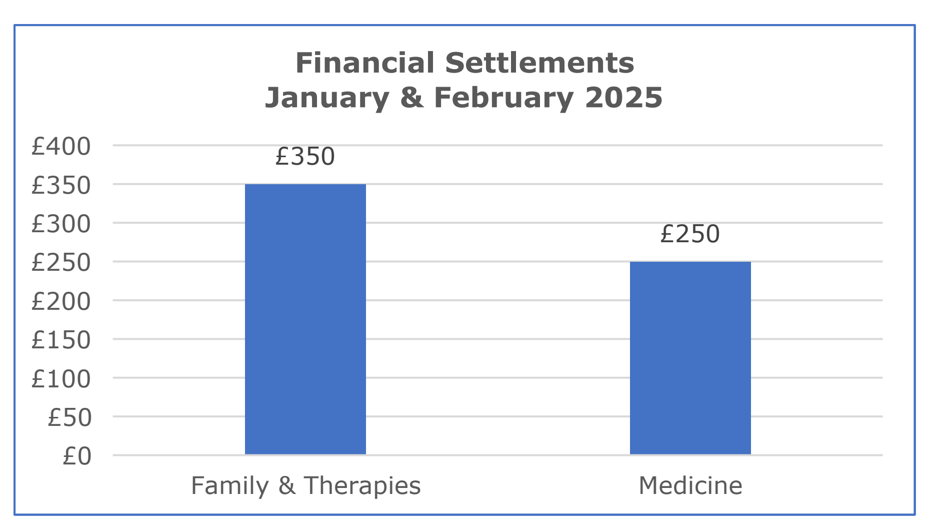


Learning and Completed Recommendations

The main themes across the reporting period related to delays in the issuing of responses and a lack of regular updates being provided to complainants.

From April 2025, supported by successful recruitment to vacant posts; systems and processes are being introduced to improve accountability along with focussing roles and responsibilities across the wider PTR team. This will be underpinned by clear and consistent guidance and governance This will ensure appropriate levels of escalation and monitoring oversight regarding concerns management.





Reg 28

No Reg 28: Prevention of Future Deaths Reports were issued by the Coroner during January & February 2025

Issue	Action Taken Position/ Learning & Improvement	Timescale
Meeting PSOW deadlines	Introduction of escalation process - A flowchart has been developed to support an agreed escalation process for PSOW matters that are approaching deadline. This ensures that the necessary levers are in place where requests are not being met. This will be shared with key stakeholders: PSOW & PTR team and Triumvirates.	March 2025

Claims and Redress – February 2025

Clinical Negligence:

- 110 new clinical negligence matters received during quarters 1 – 3 and to the end of February 2025.
- 413 total number of open clinical negligence matters as at the end of February 2025.

There was a further slight increase in clinical negligence matters received during January & February.

Personal Injury:

- 35 new personal injury matters received during quarters 1 – 3 and to the end of February 2025.
- 85 total number of open personal injury matters as at the end of February 2025.

Personal injury claims remained steady to the end of February 2025.

Redress:

- 34 cases were taken through the Health Board's Redress Panel during quarters 1 – 3 and to the end of February 2025.
- 19 Redress cases were settled to the end of February 2025.

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 – February 2025

Inquests:

- 306 new inquests received during Quarters 1 – 3 and to the end of February 2025.
- During January & February 2025, 80 new inquests were received.
- This represented a further increase, month on month, in the number of inquests received.
- 40 inquests were listed by the Coroner to be concluded within January & February 2025.
- Of the 40 inquests listed, 16 inquests were held in person by the Coroner and where Health Board witnesses attended in person to give their evidence. Legal Services attended all 16 inquests in support of staff attending.

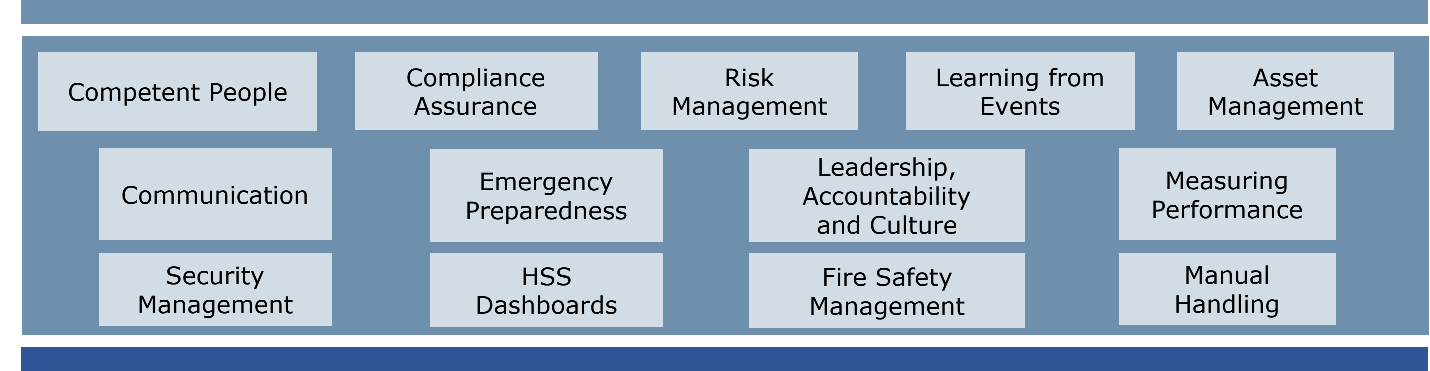
Of the 40 inquests listed in this quarter, 24 inquests were concluded in writing by the Coroner. This meant Health Board staff had prepared statements which were submitted to the Coroner but those members of staff did not need to attend the inquest in person to give oral evidence.

Coroner Update:

- The Coroner is due to advertise two new Area Coroner positions.

PILLAR 4

Health, Safety and Security



Health, Safety and Security

Health and Safety Executive Engagement

There has been no further engagement with the HSE during this period.

The Health Board have two active cases with the HSE, both relate to fatal patient falls reported in accordance with RIDDOR.

South Wales Fire & Rescue Service Activity

The has been no enforcement activity from South Wales Fire & Rescue Service during this period.

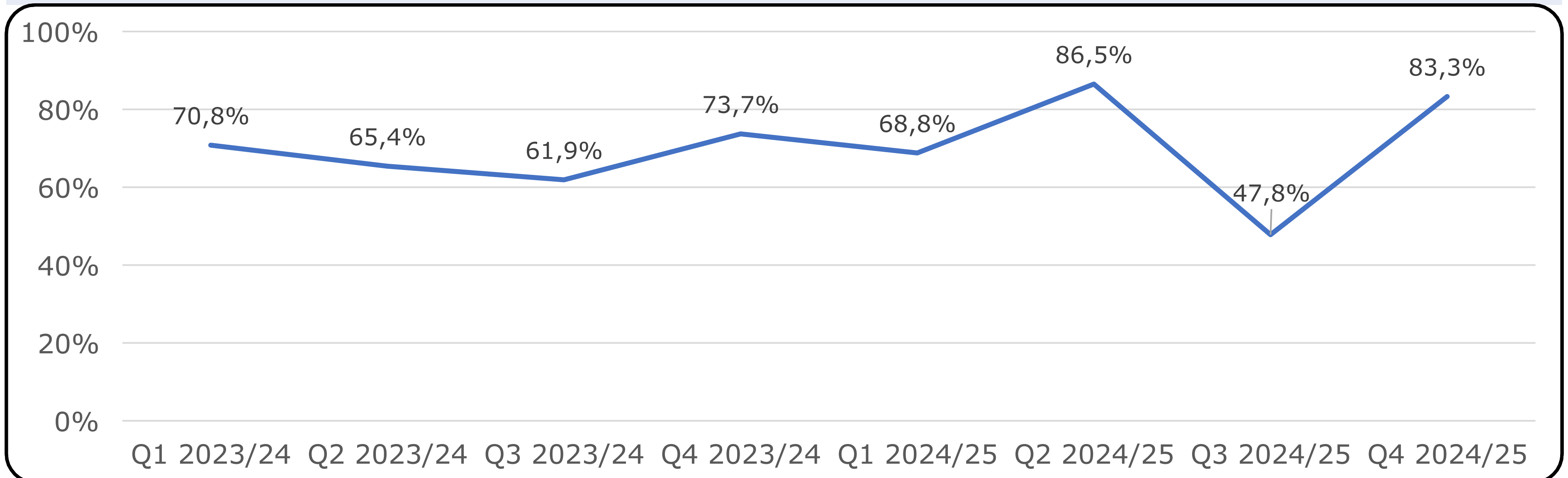
Health Board fire procedures are being reviewed and updated to ensure the forthcoming change of South Wales Fire & Rescue Service response to automatic fire alarms in healthcare buildings has minimal impact. The changes are planned for April 2025.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During Q4 (January and February 2025) the Health Board have reported **6 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

83.3% of these cases were reported within the legal timeframes within the legislation.

This is a significant increase on the previous quarter.



Health, Safety and Security

Health and Safety Statutory and Mandatory Training

At end of February 2025 training compliance for the Health Board was reported as:

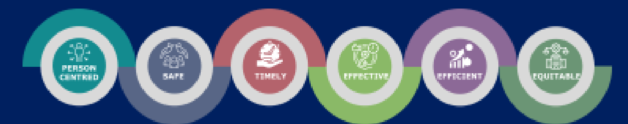
A programme of manual handling training is being implemented in April 2025 and the target is to increase compliance for high risk areas to at least 85% by December 2025

Training	Compliance
Health & Safety	86.7%
Fire Safety	82.9%
Violence & Aggression	86.0%
Manual Handling	69.8%

Health and Safety Training for Senior Leaders

Members of the Executive Team have completed the IOSH Safety for Executives and Directors training

Health, Safety and Security



Health and Safety Policies

A planned programme to review all existing health and safety policies has been developed. The plan will focus on the policies that overdue review.

Policy compliance will be significantly improved in Q1 2025/26.

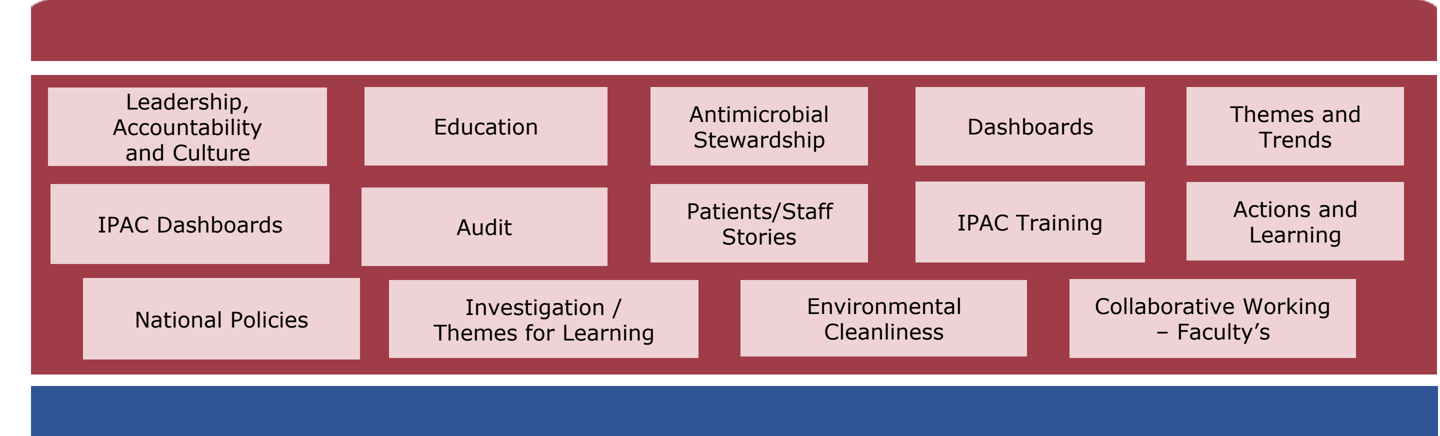
Health and Safety Audits & Inspections

The health and safety workplace inspections during 2024/25 has been targeted towards the Inpatient areas within Mental Health & Learning Disabilities and Primary Care & Community.

At the end of February 2025 a total of 60 inspections have been completed providing an average compliance score of 89.1%. 5 inspections are due for completion in March 2025

PILLAR 5

Infection Control and Prevention



Infection Prevention

Current count of cases for FY 24/25

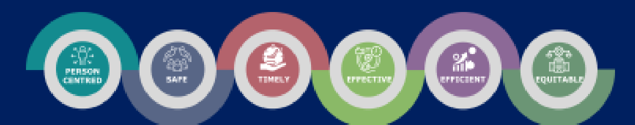
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	254	16	155	338	107	40
Betsi Cadwaladr UHB	317	11	151	485	126	21
Cardiff and Vale UHB	193	10	159	267	115	37
Cwm Taf Morgannwg UHB	150	10	112	325	98	11
Hywel Dda UHB	173	11	113	340	94	22
Powys THB	22	0	2	2	0	0
Swansea Bay UHB	253	5	113	207	109	17
Velindre NHST	5	1	3	11	8	0
Wales	**1367**	**64**	**808**	**1975**	**657**	**148**

Rate per 100,000 population

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	46.94	2.96	28.64	62.46	19.77	7.39
Betsi Cadwaladr UHB	50.34	1.75	23.98	77.01	20.01	3.33
Cardiff and Vale UHB	41.72	2.16	34.37	57.71	24.86	8
Cwm Taf Morgannwg UHB	36.92	2.46	27.56	79.99	24.12	2.71
Hywel Dda UHB	49.09	3.12	32.07	96.48	26.68	6.24
Powys THB	17.96	0	1.63	1.63	0	0
Swansea Bay UHB	72.11	1.43	32.21	59	31.07	4.85
Velindre NHST						
Wales	**47.7**	**2.23**	**28.2**	**68.92**	**22.93**	**5.16**

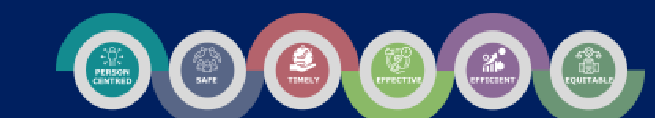
< than same period last FY
= same period last FY
> than same period last FY

Infection Prevention



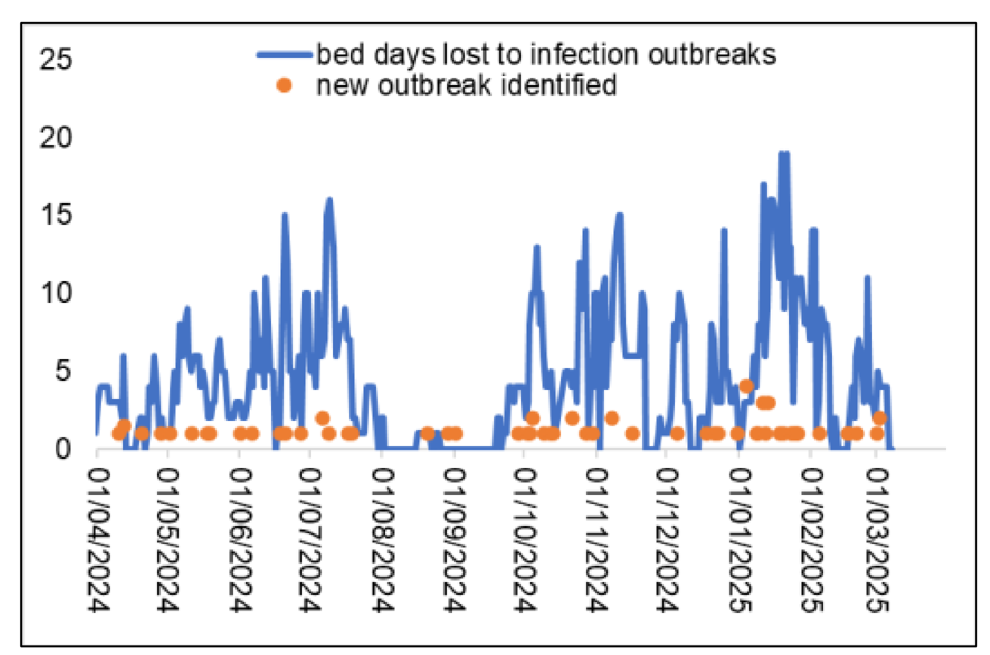
Issue	Action	Learning and Improvement	Who	When
C difficile infection Apr 24 – Feb 25 = 254 cases 125 x healthcare associated 101 x community acquired 28 x relapse/indeterminate	▪ QI projects spreading to wards - RGH ▪ Ongoing proactive enhanced cleaning ▪ Ongoing dashboard monitoring via AMAT ▪ Refreshed intranet resources ▪ ERADICATE Cdi webinar – 18th March 2025 ▪ Executive Strategy improvement group and action plan developed ▪ Review cleaning process and staff training	▪ Monitoring discussed with senior leadership ▪ IP standards incorporated in HB leadership programme ▪ Staff survey shared with senior leaders re culture and roles and responsibilities ▪ Additional mattresses purchase ▪ Slippage in proactive clean at YYF and GUH due to capacity ▪ Laundered of mops and replacement process ▪ No genosequencing linked	ALL	Ongoing
Wards closed due to C difficile Apr 24 – Feb 25 = 19 ward closures	• Outbreak control meetings convened • Samples sent for genomic sequencing • Decant HPV cleans	• Only one ward (D2E) linked via genomic sequencing • Inappropriate sample collection – raise awareness via ERADICATE webinar & posters on intranet • High level dust – raised with Facilities to pick up • Antibiotics not within guidelines • Not withholding PPI while on antibiotics	MDT team	Ongoing
Staph Aureus Apr 24 – Feb 25 = 170 cases 60 x healthcare associated 105 x community acquired 5 x relapse	▪ Webinar for line care implemented ▪ ANNT incorporated into ward accreditation ▪ Monitor MRSA screening and bundle compliance via AMAT ▪ Targeted MRSA screening in assessment ▪ One patient reported 5 times MRSA	• Overview of HB guidance for the management of lines • Compliance increasing several areas now able to achieve bronze accreditation	ALL ALL	Sept

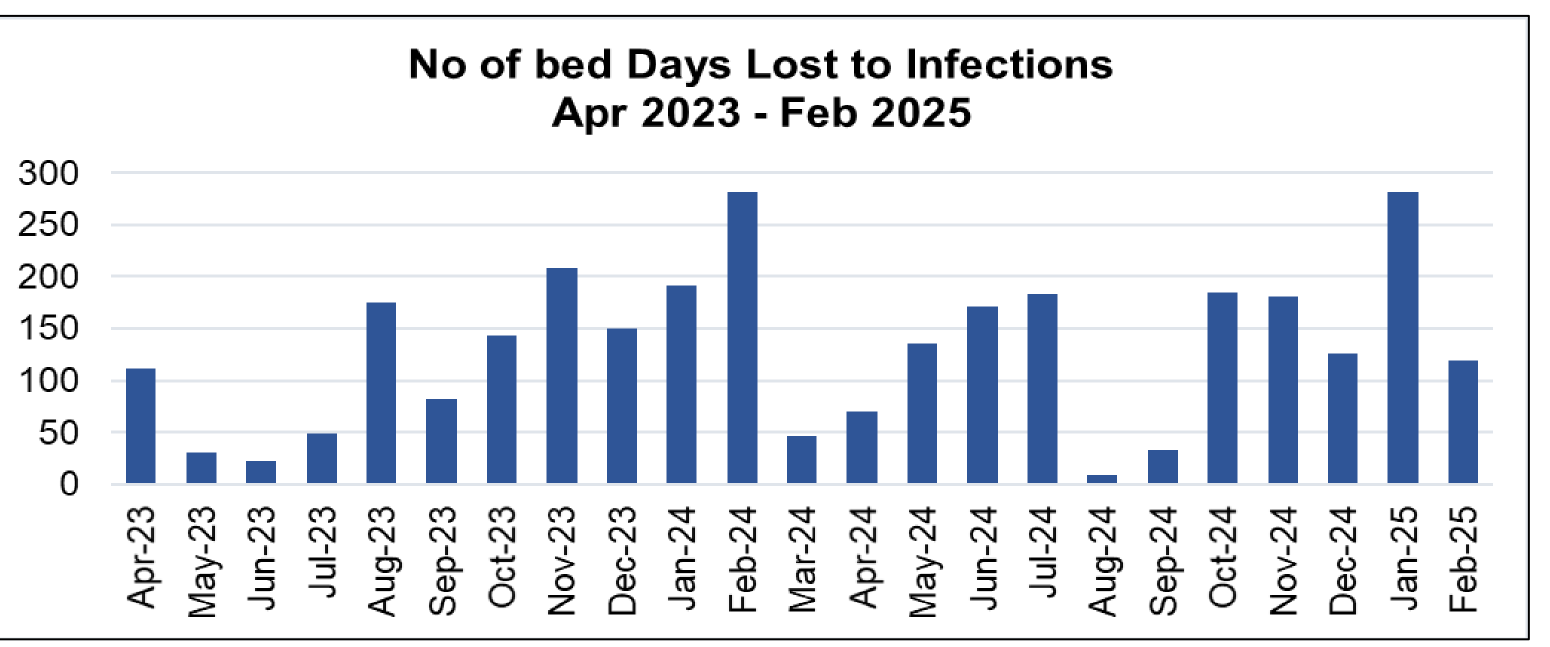
Infection Prevention



Issue	Action	Learning and Improvement	Who	When
E coli blood stream infections Apr 24 – Feb 25 = 337 cases 85 x healthcare associated 243 x community acquired 9 x re-isolate/indeterminate **Klebsiella blood stream infections** Apr 24 – Feb 25 = 107 cases 40 x healthcare associated 65 x community acquired 2 x reisolate/indeterminate **Pseudomonas blood stream infections** Apr 24 – Feb 25 = 40 cases 18 x healthcare associated 22 x community acquired	• Webinar implemented August promoting 9 key standards • "No Catheter November" campaign within Primary Care • Delivered training for Sepsis, Antimicrobial Stewardship and Infection prevention to new Doctors • Reviewed training resources for water flushing • Incorporated flushing onto the ward accreditation environmental audit	• Main source of infection is UTI • Improve compliance with completing insertion & maintenance care bundles via HOUDINI • Prescribing within policy • Increase staff awareness • Multi-drug resistance policy under review	ALL Clinical prescribers	Ongoing
Wards closed due Covid-19 Apr 24 – Feb 25 = 19 **Wards closed due to Influenza** Apr 24 – Feb 25 = 3	• Promoted respiratory safety measures • Enhanced cleaning of frequently touched areas • Patients cohorted on like to for like illness • Risk assessed staff working with symptoms • Wards closed to transfers & discharges • Symptomatic staff & visitors to wear face covering	• Impact of shared facilities • Need to improve ventilation. Promote opening window where & when suitable	ALL	Ongoing
Wards closed due to Norovirus Apr 24 – Feb 25 = 27	• Enhanced cleaning • Rapid isolation/cohort of affected patients • Visitors notices – not to visit if unwell • Wearing appropriate PPE including masks • Removed alcohol hand gel & promoted hand washing with soap & water	• Impact of shared facilities • Aged estates • Lack of isolation facilities • Less impact on staff due to mask wearing	Ward Staff	July

Infection Prevention – Bed Days Lost



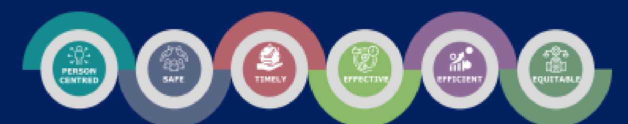


Norovirus outbreaks severely impacted on bed days lost during January & February 2025

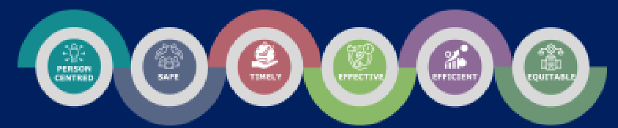
Jan = 12 ward closures

Feb = 5 ward closures

Infection Prevention – Decontamination



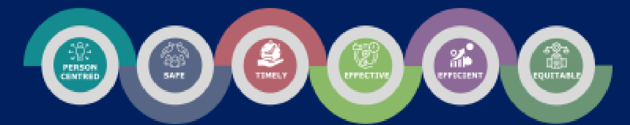
Issue	Cause	Remedial Action	Who	When
Community Dental Service (CDS) washers & autoclaves have not been serviced or tested indicating non compliance with required WHTM 01-05 standard.	Lack of works and estates staff to undertake the role and their focus on other decontamination testing, eg HSDU.	All Wales Authorised Engineer (Decon) AE(D) aware. Works & CDS have an agreement on release of monies for band 5 Works personnel to undertake dual role including CDS.	Works & Estates lead. CDS Directorate.	30th April 2025
The centralised endoscopy unit project build at the Royal Gwent Hospital (RGH) has commenced with 'first stage' works. The interim decontamination unit had to vacated.	An electrical overload occurred in the interim unit leading to unsafe ventilation and peracetic acid monitoring failure.	Scopes diverted to GUH HSDU and local support for scope decontamination at RGH Urology dept and theatre. Await outcome of Neqis and Getinge findings.	HSDU facilities with contingency plan. Endoscopy Directorate	7th March 2025
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D) for JAG accreditation and still seek JAG accreditation by 2nd April 2025.	Identified significant progress with works & estates input. Electronic track & trace (T&T) indicated requirement for green rating.	Ward staff have been trained in and undertake weekly testing for EWDs by Authorised Person (D) (APD). Accepted by AE(D) Wales. T&T should be in place by mid March. Awaiting report to decide JAG accreditation.	Directorate manager & Senior Nurse	2nd April 2025
AP(D) role not fully functioning from a governance aspect.	Lack of AP(D)s and decontamination works trained staff. Remains under review.	An operative decontamination staff member is near completion of AP(D) role therefore supporting the works decontamination strategy.	General Manager Facilities / Works & Estates	10th April 2025.
Urology department in RGH local decontamination unit environment not fit for use.	Significant damp and poor ventilation contributing toward fungi growing on low level walls.	Immediate closure of the unit by decontamination manager on advice by AP(D). Works & Estates remedial works to be undertaken and completion for fit for use.	Directorate local staff. RGH works lead.	31st March 2025
Risk of losing automated decontamination process for US probes in Radiology Units.	Trophon 1s HPV probe disinfectors are obsolete.	Replacement programme within Ultrasound directorate to be finalised by Directorate lead for Radiology.	Ultrasound Lead	31st March 2025

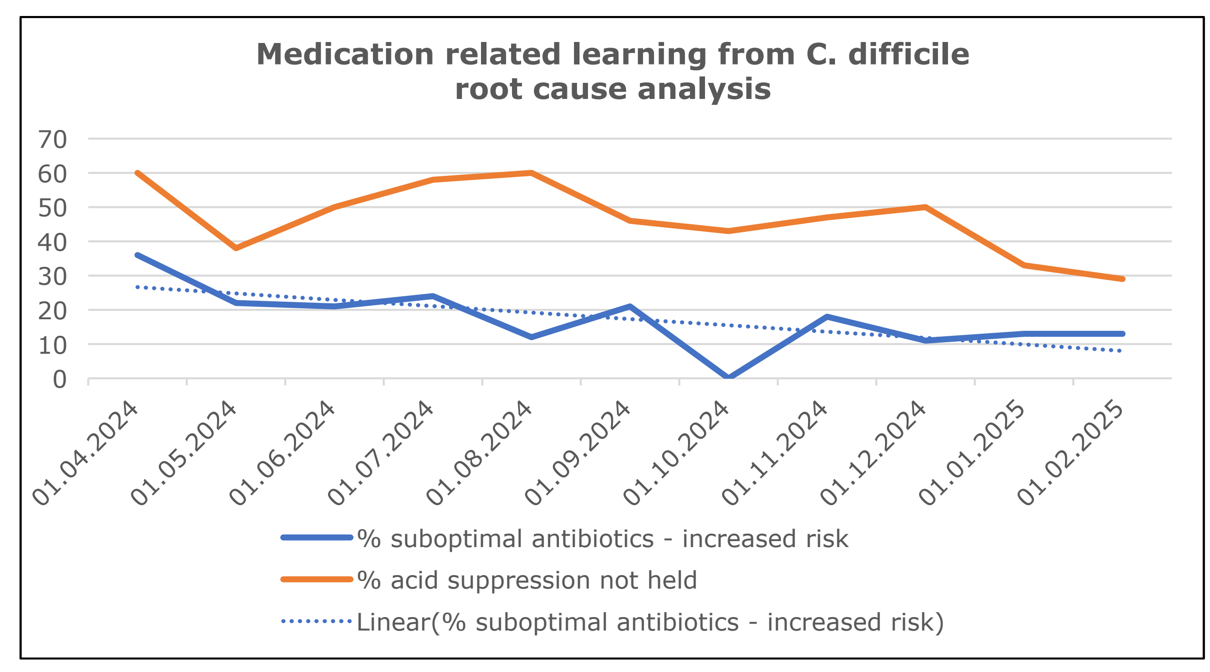


WG Targets – Healthcare Associated Infections (HAIs)

Issue	Cause	Remedial Action	Who	When
Above Welsh Government trajectory for reportable incidents	Increase in community acquired cases and hospital transmission	➢ Refreshed organisational HAI Action Plan ➢ Visit from Public Health Wales Consultant to review Action Plan ➢ Divisional Assurance reported via Infection Prevention & Antimicrobial Stewardship Committee ➢ Refresh internet page with information for public ➢ Re-established root cause analysis meetings	Infection Prevention Public Health Wales Divisions Infection Prevention/Comms Infection Prevention/Divisions	June 2024 July 2024 July 2024 Ongoing Ongoing
C difficile - Current rate per 100,000 population is 49.51% (73 cases compared to 45 cases the equivalent period 2023/24) 6 wards affected by period of increased incidence	➢ Antimicrobial stewardship ➢ Compliance with fundamental infection prevention measures ➢ Increase in community acquired and relapse cases ➢ 3 patients linked to onward transmission via geno-sequencing	➢ Ongoing Quality Improvement project within Medicine ➢ Enhanced cleaning paper approved & operational ➢ Raised awareness of mattress checking process with support from Facilities ➢ Targeted training & education	Unscheduled Care Facilities & Divisions Facilities & Infection Prevention Infection Prevention	Ongoing June 2024 June 2024 Ongoing
Staph Aureus – MRSA current rate per 100,000 population is 1.36 & MSSA 31.2% (48 cases compared to 22 for the equivalent period 2023/24)	➢ 3 line infections ➢ Largest burden is skin & soft tissue damage	➢ Deep dive to identify themes ➢ Promoting ANTT & Wound Care education ➢ Reviewing skin preparation ➢ QI project to improve admission screening ➢ Link with Procurement to standardise medical devices	Infection Prevention Infection Prevention & TVN Infection Prevention Infection Prevention/Admission Units Infection Prevention/Procurement	July 2024 Ongoing Ongoing August 2024 July 2024
Gram negative blood stream infections - Current rate per 100,000 population is **Ecoli** – 29.01% (87 cases compared to 91 cases the equivalent period 2023/24) **Kleb** – 21.7% (32 cases compared to 29 cases the equivalent period 2023/24) **Pseudo** – 7.46% (11 cases compared to 6 cases the equivalent period 2023/24)	➢ Over 50% linked to urinary tract infections ➢ Increase in antimicrobial resistance	➢ Established a working group for the 9 standards for UTI prevention ➢ Arranged a study session in collaboration with Bowel Services, Dieticians, Microbiology & Pharmacy linked to the 9 standards ➢ QI for oral hygiene ➢ Reviewing AMR guidance ➢ Promoting ANTT ➢ Developed an intranet resource page ➢ Raised awareness of Correct sample collection	 Infection Prevention, Bladder & Bowel services, Dieticians, Micro & Pharmacy Medicine/Carolyn Joyce Infection Prevention/Divisions Infection Prevention Infection Prevention/Micro	June 2024 August 2024 Ongoing Ongoing Ongoing

C. difficile Antibiotic Themes





Antibiotic finding	HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	0	0	1	0	1
No suboptimal antibiotics	7	1	2	0	10
Possible suboptimal use - no increased risk	3	0	1	0	4
Possible suboptimal use - increased risk of C. diff	5	0	0	0	5
Awaiting GP response	0	8	0	0	8
RCA pending	1	0	0	0	1
Total	**16**	**9**	**4**	**0**	**29**

January & February 2025 Learning:

- **4 suboptimal antimicrobials, majority in GUH:**
  - 2 patients prescribed piperacillin/tazobactam (Tazocin) instead of amoxicillin, metronidazole & gentamicin (wards A4 & B0, GUH)
  - Metronidazole for treatment of toxin-negative *C. difficile* infection in December as patient refusing guideline option (ward A4, GUH)
  - Prolonged ciprofloxacin course for otitis externa: 13 days compared with 5-7 days in guidelines (ward C0, GUH)
  - Use of piperacillin/tazobactam (Tazocin) for E. coli sepsis, when alternative, narrower spectrum antibiotics could have been used (ward C4E, RGH)
- **Fewer patients with acid suppression managed inappropriately**

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 – Duty to Report

	Quarter 1			Quarter 2			Quarter 3		
	2023/2024	2024/2025	Increase	2023/2024	2024/2025	Increase	2023/2024	2024/2025	Increase
Adult Duty to Report	72	102	41%	84	90	7.5%	98	145	48%
Children Duty to Report	963	1090	13%	928	1116	20%	971	999	3%

Refresh Of Safeguarding Strategic Meetings

Over the last twelve months the Corporate Safeguarding Team, supported by leaderships from Divisions, has firmly embedded the Strategic Safeguarding Group, which has met regularly and been well attended. As a result of its success, it has been noted that work needs to be supported by sub groups, in order to manage the growing agenda.

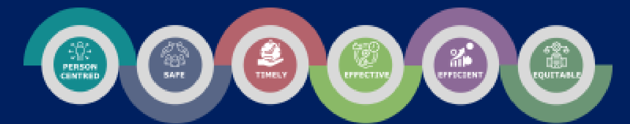
In light of the above, the following Sub Groups were formally introduced from January 2025:

- Safeguarding Adults Operational Group
- Safeguarding Children and Transitional Safeguarding Group
- Practitioner Concerns Steering Group

Both Children and Adult Groups will have a focus on Policy Development and embedding learning from Statutory Reviews.

Each of the Groups will be meeting quarterly and will provide a formal report to the Strategic Safeguarding Group, which is Chaired by the Executive Director of Nursing and Vice-Chaired by the Deputy Director of Nursing.

Safeguarding – Training Compliance



Training Module	Compliance %
Adult Safeguarding Level 1	82%
Children's Safeguarding Level 1	82%
Adult Safeguarding Level 2	82%
Children's Safeguarding Level 2	82%

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 has unfortunately dropped below the target of 85%. The Divisions where it is below 85% have been informed and a recovery plan requested

Level 3 Children's and Adults training have now been added to ESR and we are seeing a massive increase in uptake of the training. Compliance data will be available from April 2025.

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 2025/26 financial year.	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. This training has now been completed for three of the five boroughs	Corporate Safeguarding	Q4
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.	As activity continues to rise, a formal review of the scope and responsibilities of the safeguarding team is being undertaken to determine priorities and to look at strategies to mitigate risk	Increases in safeguarding activity are difficult to predict, so developing more robust methods of monitoring increased activity will facilitate early escalation. The Datix Safeguarding Module will be in place from 1st April 2025, which should provide a better quality of data.	Corporate Safeguarding	Q4

External Assessments

Section 3

External Assessments – January/February 2025

Health Inspectorate Wales

No inspections have taken place during the period

The two-day Inspection of the Emergency Department at the Grange University Hospital was published on the 15th of January 2025. The detailed recommendations and actions follow below

Llais Gwent Region

No inspection Reports have been received during January and February 2025.

Health Inspectorate Wales – Immediate Assurance Letters	
12780	Request for assurance regarding interim measures and actions taken in response to allegations of a sexual nature against a dentist previously employed by Aneurin Bevan UHB and currently contracted at 168 Dental Practice in Newport.
12780	Concerns about multiple security breaches at GUH, including unauthorised personnel working undetected, the sale of unauthorised access cards, unqualified staff working as nurses, and agency staff swapping ID cards to exceed shift limits.
12580	The request asks for details of the actions taken to investigate the allegations of neglect at The Grange University Hospital and the measures implemented to prevent similar incidents in the future.

HIW – Update on Outstanding Actions ED, GUH

Date of Inspection	No. of Recommendations	No. of Actions	No. of Outstanding Actions	% Completed Actions
2-4 October 2024	16	112	7	94%

Recommendation	Action	Original Due Date	Comments/Updates
The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.	Review of Flow Centre Pathways to ensure patients go to the right place first time.	3/31/2025	There is wider work being commissioned in the Flow Centre to develop a Single Point of Access. As part of this piece of work pathways of care will be reviewed.
The health board should develop a process where patients in the waiting area are regularly monitored, and patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.	New waiting room currently being built will provide improved patient visibility and availability of clinical space	5/30/2025	All patients are triaged and if falls risk to be moved an appropriate area in the department where a falls assessment will be undertaken New waiting room being built which will increase visibility but also provide an improved clinical area to manage the patient demand
The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.	Wellbeing assistant role to support waiting room	3/31/2025	New waiting room being built which will increase visibility but also provide an improved clinical area to manage the patient demand
The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Review of area to assess ability to make an assessment area ligature free	12/31/2024	Cubicle 16 has been assigned as the ligature free room. A "change of use form" has been completed via ABB Accommodation - awaiting outcome.
The health board must ensure the medicines management policy is reviewed and approved in a timely manner.	Medicines management policy is being reviewed.	2/28/2025	Review date extended while under review, as agreed with Chair of CSPG Medicines Management Policy Code of Practice
The health board must ensure that controlled drug checks are completed in all areas of the emergency department.	Regular monitoring of improvement plan via Patient, Quality, Safety, Learning & Improvement Forum (PQSLI)	4/1/2025	Update to be provided to PQSLI in April 2025 – ongoing
The health board must consider the staff comments and seek feedback more widely from ED staff and consider how improvements can be made in the interest of both patients and staff.	Formal Nurse Staffing Levels Assessment to be completed annually in line with the NSWLA	3/1/2025	Deep dives are undertaken twice a year. Going forward these will be formally presented to EDON/DDON

Escalated Risk Concerns

Section 4

Mental Health & Learning Disability

Mental Health & Learning Disability Programme of Work around Patient Flow:

- Digital solutions for ward data, pre-admission interventions, and alternatives to admission.
- Minimise ward time, focus on least restrictive care.
- Improve patient flow, address bed capacity.

Management of Variable Pay:

- Increase in variable pay, especially nursing.
- Impact on financial position and need for effective management.

Enhanced Care Framework:

- On track in older adults' directorate.
- Training done, implementation April.
- Expected care quality improvement.

Quality and Patient Safety:

- Improved review and timeliness of serious incident investigations.
- Effort to close open cases, identify learning points.
- Closed 10 serious incidents since January.

Workforce and Planning:

- Ongoing efforts with workforce and planning.
- LD well-being survey results, retention project for healthcare support workers, addressing overpayments.
- Nursing & HCSW workforce strategy is in development draft to be shared April.

Learning Forums:

- Sharing and disseminating learning across the division.
- Participation in national strategic programme for leadership exchange.

Continuous Improvement Plans:

- Ongoing quality improvement work.
- Positive feedback from Llais Report in March.
- Acknowledge ongoing work.

National MH & Wellbeing Strategy:

- Engaged in all workstreams of National Programme through NSPB – National Board.

Safeguarding Awareness and Training:

- Bespoke training well-received, 91.6% compliance at Level 1.

Challenges:

- **WCCIS Challenges:** Ongoing issues with the patient information system and user interface necessitate ongoing workarounds to ensure validated data.

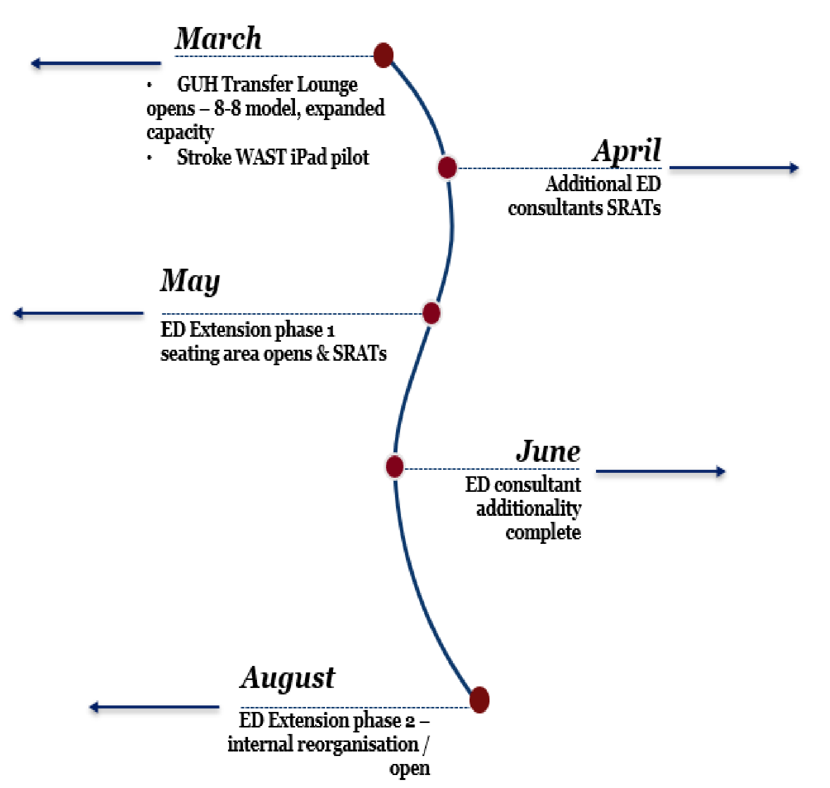
- **Recruitment and Retention:** Workforce and capacity challenges persist, but progress is evident with the arrival of the international nurse cohort and the initiation of formal workforce and organisation development programmes.

- **Estate:** Addressing the challenges of an aging estate and maintaining areas to ensure safe and therapeutic environments.

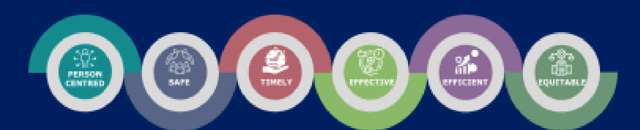
Urgent and Emergency Care

- **Performance Trajectories & WTBS @ GUH**
  - Implementation of the First Floor Step Down protocol, compliance audit of the Falls Pathway, the Stroke iPad pilot with WAST, and ongoing efforts to ensure dual pin compliance.
  - Median waiting times before seeing a consultant (WTBS) in January and February 2024, with a 40-minute improvement in February.
- **ED Consultant Recruitment Update**
  - The ED Consultant rota has been updated with new appointments and extra shifts covered, and remaining roster shift gaps have been offered to Locum with optimism for increased uptake soon.
  - The ED Directorate is progressing well with plans for the interim phase of the new build, ensuring timely transfers to appropriate Assessment Units and addressing challenges to improve the process.
- **ED Extension of Waiting Area & Internal Reconfiguration:**
  - The revised timeline is May for phase 1 and August for phase 2.
  - Discussions regarding the interim operating position between the opening of phase 1 and phase 2 are ongoing.
  - The work on revised models of care and reconfiguration is progressing rapidly.
- **Transfer Lounge Development:**
  - The lounge is on site, staff have been recruited, and it is targeted to be operational during the week commencing 24th March.
  - A Standard Operating Procedure (SOP) is in place for the new ways of working "pull model"
  - The current Transfer Lounge transitioned to the new model of working on 3rd March.
- **Safe to Start (S2S):** morning meeting in place with a plan to roll out to other sites.
- **Further Faster:** Progressing AFR & CAATT initiatives to better integrate services, especially at the front door.

Significant developments this year supporting U&EC



Urgent & Emergency Care



Issue	Cause	Remedial Action	Who	When
Medical Staffing: Medical Staffing to support the Emergency Department (Demand & Capacity modelling showing deficit for demand)	• Increased activity	• Locum processes in place and reviewed weekly with management team and monthly within Directorate • Ongoing recruitment • 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- 1.8 wte commenced Jan 25 , 1 wte Feb 25 , 1 wte may 25 • Medical deep dive completed and presented to COO		
	• Implementation of different models of care	• Exploring alternative roles e.g. ACPs and ANPs – ACP paper being progressed with executive support • Paper for PIP in progress		
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 • 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, vacancy position improved as of Feb 25 and no longer reliant on agency block booking • 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 • Deep Dives of Operational Teams commencing March 25 • Expansion of ED Main Wait in progress with anticipated completion date of June 2025. • Increased activity through SDEC GUH. SDEC 1st now for all medical referrals via Flow Centre. Additional pathways such as ED direct referrals, Haematology, AOS, ENT, returners & hot clinics n place • 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

Clinical Effectiveness

Section 5

Epilepsy12 - 2024 combined organisational and clinical audits: Report for England and Wales. Cohort 5 – The first year of care for children and young people after a first paediatric assessment between 1 December 2021 and 30 November 2022	**Clinical Lead(s): Dr Nadeem Syed – Consultant Paediatrician Dr Michelle Barber – Consultant Paediatrician -**
Rationale:	Epilepsy12, established in 2009, aims to improve the quality of care for children and young people with epilepsy. Epilepsy is the most common long-term neurological condition in childhood, affecting around 112,000 young people in the UK.
Objectives:	Epilepsy12 aims to enhance care standards for children and young people with epilepsy by auditing data on patient care and service organization. This data helps identify strengths and areas needing improvement.
CSEG date:	23rd January 2025

Key Messages from Cohort 3:

- **Care Plans**: 70% of children and young people (CYP) had updated and agreed comprehensive care plans.
- **Transition Support**: 65% of health boards involved adult epilepsy specialist nurses in transitioning young people to adult services.
- **EEG Timeliness**: 54% of CYP diagnosed with epilepsy received their EEG within 4 weeks.
- **Mental Health**: 5% of CYP aged 5-15 diagnosed with epilepsy had an identified mental health condition.
- **Surgical Referrals**: 36% of CYP with epilepsy who met criteria for surgical referral were referred for surgical evaluation.

Key messages from Cohort 4:

- Participation
- Description of Cohort
- Diagnostic status
- Performance Indicators
- Initial Referral and examination
- Description of episodes
- Investigations
- Treatment
- Care Planning
- Professionals and services involved in care

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
Low	Peripheral element of treatment or service suboptimal	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	YES/NO

Report Recommendations: (national)

1	Support epilepsy teams not yet participating in the audit to value and contribute through Epilepsy12 participation. Promote the audit, provide training, develop the workforce and teams, plan jobs, and address local barriers. Integrated Care Boards (ICBs) should identify support routes and engage with quality improvement programs like the Epilepsy Quality Improvement Programme (EQIP) to assess and improve care quality in non-participating services. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales, in collaboration with OPEN UK regional networks***
2	Increase the scope and breadth of the epilepsy team. Ensure sufficient provision of Epilepsy Specialist Nurses (ESNs) and other professionals to support population needs. Core and specialized competencies required within the team should match population needs, including mental health, transition from paediatric to adult services, learning difficulties, neurodisability, and medical complexity. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales***
3	Establish or enhance processes and pathways to ensure timely access to care for children and young people. Identify and understand gaps in care provision. Establish structured referral pathways with designated coordinators. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales.***
4	ICBs and local Health Boards should develop engagement models to enable groups facing inequalities to contribute to service improvement. Use the Core20PLUS5 framework to identify challenges and co-create alternative service models. Ensure equitable access and care for epilepsy, aligning with efforts supporting other long-term health conditions. ***Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales, in collaboration with OPEN UK networks***
5	Support participation and benchmarking against relevant ongoing quality improvement projects, in order to promote system-wide shared learning, collaboration and knowledge exchange. ***Action by: Integrated Care Boards (ICBs) in England and local Health Boards in Wales, in collaboration with OPEN UK regional networks.***

Report Concerns: (to be completed by the Clinical Lead)

1	Data entry not in job plans – admin support required
2	Waiting times for first seizure referrals and appointment – sickness within the team

Audit Title: National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024 **Data Collection Period: 1 April 2023 – 31 March 2024 Year 6**	**Clinical Lead: Dr Non Pugh – Consultant Rheumatologist**	
	NICE Guidance :	QS33 – Rheumatoid arthritis in over 16s

Rationale:	Inflammatory arthritis, including rheumatoid arthritis (RA), affects over 400,000 people in the UK. Treatment delays can cause significant disability, reduced quality of life, and loss of productivity. Rare autoimmune rheumatic diseases (RAIRDs) like systemic vasculitides also face adverse outcomes, including permanent disability, due to treatment delays.
Objectives:	The NEIAA aims to enhance care quality for people with rheumatic diseases by collecting data on newly diagnosed patients over 16 in England and Wales. It includes conditions like inflammatory arthritides, systemic vasculitides, and connective tissue diseases. This data helps recommend standardized, effective, and patient-centered care pathways.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

- Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis
- Measured against NICE quality standards 33
- Also assesses how inflammatory arthritis affects people's day-to-day function, mobility, sleep, wellbeing and ability to work
- Rheumatology clinical teams provide information about patient care over the first 3 months after diagnosis. This includes :
    - Referral times
    - Time to treatment
    - Clinical response to treatment
    - Patient Reported Outcome Measures (PROMs) - for 12 months

Key message 1

Increased engagement and data capture

- Engagement has improved however the number of cases that are not captured is likely to be greater
- Estimated that NEIAA captures approximately one third of cases eligible for enrolment.

Key message 2

Improved treatment timeliness

The key metric used for measuring care quality and determining outlier status is the proportion of people living with EIA who start DMARD therapy within six weeks of referral

Key Message 3

- Stable remission rates with geographic variation
- Remission rates within 12 weeks of treatment remain stable at 35
- Geographic variation in remission rates persists (see figure 5), There was also geographic variation in the proportion of patients receiving treatment within six weeks (see figure 6).
- Remission rates higher in Wales at 49 %

No Local data is available for Key Messages 4, 5 & 6

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	yes

Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	yes

THERE ARE NO OUTSTANING REPORT RECOMMENDATIONS FOR ABUHB

Audit Title: National Pregnancy in Diabetes Audit Dashboard 2023 (01 January 2021 to 31 December 2023)	Clinical Lead(s): Mrs Pinto & Mrs Lisa Pilkington, Consultants in Obstetrics and Gynaecology
Rationale:	The National Pregnancy in Diabetes Audit (NPID) is part of the National Diabetes Audit (NDA), managed by NHS England in agreement with the Healthcare Quality Improvement Partnership (HQIP). The NDA, in partnership with Diabetes UK, has been running since 2014.
Objectives:	The audit and dashboard measure the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes, supporting quality improvement at various levels. The latest dashboard includes data from pregnancies ending between January 2021 and December 2023, featuring continuous glucose monitoring (CGM) data for the first time. It answers three key questions: preparation for pregnancy, steps taken to minimize adverse outcomes, and occurrence of adverse outcomes. Data are submitted by antenatal services in England and Wales.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

Report Successes:	
1	**Lower rates of macrosomia**
2	**Lower rates of NICU admissions**
3	**Lower rates of preterm births**

Report Concerns:	
1	**Higher proportion of women not on the right dose of folic acid at the start of pregnancy**
2	**Higher proportion of women with suboptimal HbA1C at start of pregnancy**
3	**Higher proportion of women with suboptimal HbA1C in 3rd trimester**
4	**Deficit in data submitted to NPID**

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	**NO**

No National Report/Recommendations:

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsibleperson	Due Date: Progress:
1	**Quarterly meeting AN diabetes forum to continue**		AMP	ongoing
2	**Clinical pathways for pre-conception care –focussing on T2DM – in development**		LPP with primary care	Mar 2026
3	**Clinical oversight of data input**		AMP and LPI	ongoing

Conclusion..

As per the report, the HB has lower rates of macrosomia, SCBU admissions and Preterm labour, compared to England and Wales data. Data input to NPID database from GUH is incomplete. The HB has lower proportion of women starting and ending the pregnancy with optimal HbA1c. There is a need to improve data collection (capture all women) and improve successful uploading of data onto the NPID data base

- **for NHH- data now entered by clinical team**
- **for RGH- continuing with MD's audit office support**

Audit Title: Wales Primary Care Clinical Audit Report 2021–23. Publication year: 2024

Clinical Lead: Bethan Williams – Senior Nurse Primary Care

NICE 2023 QS10 (QS1): People aged over 35 years who present with a risk factor and one or more symptoms of COPD have post-bronchodilator spirometry.
NICE 2018 QS25 (QS1): People aged 5 years and over with suspected asthma have objective tests to support diagnosis

Rationale:	This report analyses asthma and COPD primary care data in Wales from the Welsh primary care audit component of the National Respiratory Audit Programme (NRAP). Data collected from 359 general practices in Feb 2024, covering activity from Aug 2021 to July 2023.
Objectives:	The audit builds on previous reports to support NRAP's healthcare improvement goals. It aims to help stakeholders use data to enhance care quality for asthma and COPD patients. The report includes key findings and national recommendations from the 2021–23 Welsh primary care audit, with 96% of Welsh practices participating.

Comparing results with previous reports should be done cautiously due to the significant impact of the COVID-19 pandemic on earlier audit periods. Additionally, younger children aged 1–5 were not included in this audit round.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

Recommendation 1

COPD - The percentage of people diagnosed with COPD in the last 2 years who have a post-bronchodilator test with an appropriate numeric value.

Name	Denominator (N)	Any spirometry ratio codes* ≥0.2 and <0.7 (n)	Any spirometry ratio codes ≥0.2 and <0.7 (%)	Post-bronchodilator code** with spirometry ratio ≥0.2 and <0.7 (n)	Post-bronchodilator code with spirometry ratio ≥0.2 and <0.7 (%)	Any post-bronchodilator code (n)	Any post-bronchodilator code (%)
Wales	13473	3653	27.1	644	4.8	2882	21.4
Aneurin Bevan LHB	2460	587	23.9	99	4	504	20.5

*Other 339 Read codes eg 339j, 339k, 339R
**Read code 339m

Adults with asthma

Name	Denominator (N)	Any FEV1/FVC code* (+ reversibility) test in the past 2 years (n)	Any FEV1/FVC code (+ reversibility) test in the past 2 years (%)	Any spirometry (+ reversibility) test in the past 2 years (n)	Any spirometry (+ reversibility) test in the past 2 years (%)
Wales	18032	116	0.6	840	4.7
Aneurin Bevan Local Health Board	3355	40	1.2	222	6.6

Children with asthma (6 years and above only)

Name	Denominator (N)	Any FEV1/FVC code* (+ reversibility) test in the past 2 years (n)	Any FEV1/FVC code (+ reversibility) test in the past 2 years (%)	Any spirometry (+ reversibility) test in the past 2 years (n)	Any spirometry (+ reversibility) test in the past 2 years (%)
Wales	7079	3	0.0	156	2.2
Aneurin Bevan Local Health Board	1426	0	0.0	50	3.5

*Read codes 339l, 339m and 339M

Recommendation 2

Results summary

0.7% of parents/carers of children with asthma were asked about their second-hand smoke exposure.

73.8% of patients with COPD had their smoking status recorded.

66.3% of adults with asthma had their smoking status recorded.

40.8% of children with asthma had their smoking status recorded.

Smoking

Percentage and status of people with COPD and asthma (adults and children) who were asked about tobacco smoking in the last 15 months and their smoking status

COPD

Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)	Not asked about smoking (n)	Not asked about smoking (%)
Wales	83529	7514	9	31080	37.2	23077	27.6	21858	26.2
Aneurin Bevan Local Health Board	15392	1536	10	5785	37.6	4470	29	3601	23.4

Adults with asthma

Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)	Not asked about smoking (n)	Not asked about smoking (%)
Wales	175752	60093	34.2	33931	19.3	22574	12.8	59154	33.7
Aneurin Bevan Local Health Board	33785	12287	36.4	6600	19.5	4250	12.6	10648	31.5

Children with asthma (6 years and above only)

Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)	Not asked about smoking (n)	Not asked about smoking (%)
Wales	8985	3294	36.7	94	1	278	3.1	5319	59.2
Aneurin Bevan Local Health Board	1638	626	38.2	13	0.8	46	2.8	953	58.2

Recommendation 3

Results summary

13.9% of patients with COPD with an MRC score of 3–5 have been referred to PR in the last 3 years.

Pulmonary rehabilitation (PR)
Percentage of people with COPD who are breathless (MRC scores 2–5) and have been referred to pulmonary rehabilitation in the last 3 years.

COPD (MRC score 2–5)

Name	Denominator (N)	Referred for PR (n)	Referred for PR (%)
Wales	64241	5783	9
Aneurin Bevan Local Health Board	11513	884	7.7

Percentage of people with COPD who are breathless (MRC score 3-5) and have been referred to pulmonary rehabilitation in the last 3 years.

COPD (MRC score 3-5)

Name	Denominator (N)	Referred for PR (n)	Referred for PR (%)
Wales	33518	4660	13.9
Aneurin Bevan Local Health Board	6154	713	11.6

Recommendation 4

Personalised asthma action plans
Percentage of people (adults and children) with asthma who have had a PAAP anytime in the last 15 months

Adults with asthma

Name	Denominator (N)	PAAP anytime in the last 15 months (n)	PAAP anytime in the last 15 months (%)
Wales	175752	49009	27.9
Aneurin Bevan Local Health Board	33785	11239	33.3

Children with asthma (6–18 years old)

Name	Denominator (N)	PAAP anytime in the last 15 months(n)	PAAP anytime in the last 15 months (%)
Wales	24214	5837	24.1
Aneurin Bevan Local Health Board	4731	1381	29.2

Assurance level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	√

Risk level	Description	Select
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)	YES/ NO

If not on a risk register, why not:
Diagnostic spirometry was recovering at the time of the audit. Health boards set up spirometry hubs, managed by the Primary Care Respiratory Nurse Team (PCRNT), to address the Covid-19 backlog. PCRNT delivered education and training programs on spirometry testing and result interpretation to General Practice Nurses (GPNs), Healthcare Support Workers (HCSWs), and GPs. Mentoring of staff in clinic settings as available and provided to support the process.

Report Concerns:

1	Incorrect/inaccurate coding on GP computer systems i.e. codes used not in keeping with codes used within NACAP audit.
2	Ongoing provision of spirometry in Primary care -Cost of ARTP training/ re accreditation, some GP practices not happy to incur the ongoing costs. Spirometer being undertaken in practices by those who are not ARTP accredited.
3	Staff retention and recruitment – home oxygen, Challenge staff with skills and training, On risk register.

Report Successes:

1	**Alignment and adoption of All Wales COPD and Asthma guidelines** (Asthma guidelines updated Feb 24) PCRNT providing education in partnership with IPCC Academy. Training provided to both new and existing GPN 34 practices supported with education and training
2	**Alignment of inhaler prescribing to decarbonisation strategy** - PCRNT supporting individual practices with education and training also providing education In partnership with IPPC Academy, ABUHB GPN nursing forums Green inhaler project undertaken by RNS team- Practices with highest carbon footprint identified by prescribing data supported with education and RNS clinics s. Team finalists in NHS Wales Sustainability Awards 2024
3	**Gold standard O_2 service** – Service redesign underway, team working as a pooled resource to support demand and needs of service. Single point of referral and contact achieved aligning to recommendation in Primary care model for Wales.
4	**Joint working projects with pharma – parallel working with AZ and Research innovation Wales – COPE template**. ABUHB leading the way with pilot, aimed to standardise COPD reviews and improve coding (as per recommendation 5 NRAP audit)

	Clinical Leads Local Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Spirometry Hubs in process of setup with plan to commence April 25	Number of hubs. No of patients assessed. No referrals received. Number of staff trained.	Primary and community care	April 25	Service implementation plan complete Clinic set up and planning in progress with team. Includes training of new staff
2	Incorrect/inaccurate coding on GP computer systems i.e. codes used not in keeping with codes used within NACAP audit.	Number of reviews undertaken using COPE. SNOMEd coding for Post BD spirometry. Number of referrals	GMS Primary and Community care	ongoing	COPE pilot undertaken in 5 GP practices

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Local health boards should implement a strategy to ensure that all patients have access to trained clinicians within primary care settings who can accurately diagnose COPD and asthma. This should ensure that 70% of patients with COPD have undergone quality-assured post-bronchodilator spirometry to confirm obstruction, and 70% of individuals diagnosed with asthma within the past 2 years should have documented at least one objective measurement by July 2025.	1 number of hubs. 2 No of patients assessed. 3 No referrals received. 4 Number of staff trained.	Primary and Community services Jan25	April 25	• Mapping work complete. • Service implementation plan complete. • Commence spirometry hubs April 24 • HCSW roles to support work.
2	Local health boards should ensure that tobacco dependency pathways are embedded in primary care, so that all children and young people with asthma have second-hand smoke exposure recorded, and parents/carers of children with asthma who smoke receive Very Brief Advice and are offered support to quit by July 2025. This will further support the Welsh government's ambition to be smoke-free by 2030.	Well established pathways in place for Smoking cessation across ABUHB and GMS This work stream is led by PHW Children with asthma pathways responsibility of GMS and secondary care Paediatric respiratory team			
3	Local health boards should provide training resources and increase engagement between providers and primary healthcare practitioners to reduce the identified barriers and increase referral to pulmonary rehabilitation (PR) for appropriate patients with COPD to 70% by July 2025.	**Responsibility for Pulmonary rehabilitation currently with secondary care respiratory medicine.** • Established pathways in place for referral in from GMS to Secondary care. • PR paused during covid due to this and backlog caused, referrals and communication to encourage referrals was limited • Discussion underway between secondary care and primary & Community care which includes a proposal of how we can work together to support delivery of programmes moving forward and improve uptake and referrals			
4	Local health boards should prioritise and promote the development and use of personalised asthma action plans within primary care settings to ensure that, by July 2025, 75% of patients diagnosed with asthma have the essential tools to help manage their condition.	1. Number of asthma patients coded with PAAP 2. Number of patients with access to NHS Wales APPs 3. Number of practices receiving support with training and education	GMS Primary and community	Aug 25	
5	Local health boards and DHCW should promote the use of preferred respiratory SNOMED CT codes as used within the NRAP audit to ensure accurate coding for patients with asthma and/or COPD thereby improving the quality of data available for services by the next data extraction in the NRAP audit in August 2025.	1. Number of reviews undertaken using COPE. 2. SNOMEd coding for Post BD spirometry 3. Number of referrals	Primary and community care	Ongoing	COPE pilot undertaken in 5 GP practices To increase pilot sites as guided by joint working group.

For Information

Section 6

Sepsis Progress Report – Update

National Drivers for Deteriorating Patient

- The Welsh Health Circular (WHC) 2024/035 standardises the use of Early Warning Scores (EWS) to identify and manage acute patient deterioration, aiming to improve patient safety and outcomes. The Health Board is working to implement these recommendations, with a deadline of 30th September 2025. The Safer Care Partnership, led by NHS Executive and Improvement Cymru, is focusing on this initiative, including the rollout of Martha's rule (Call for Concern).

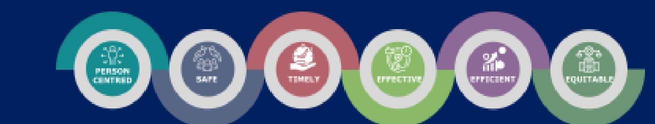
Local Implementation

- The Health Board's Sepsis Working Group has divided into smaller task groups to implement NEWS2, focusing on digital, education, implementation, escalation, and audit. Planning for PEWS is underway, with a target launch in September 2025 and monthly meetings to develop an education plan. For MEWS and NEWTT2, workshops and follow-up meetings have established groups to support implementation, with digital templates available in June and September. These efforts aim to improve sepsis awareness, treatment, and outcomes across the health board.

Sepsis Progress

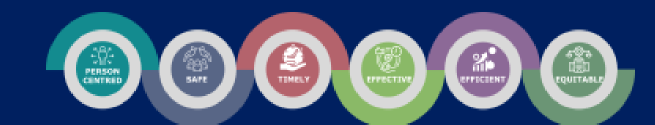
- A scoping exercise has been undertaken to review the health board's sepsis management to align with updated guidance. The Medical Director's Quality and Patient Safety team is collaborating with specialties to develop sepsis expertise, set performance targets, and support improvement initiatives, aiming to enhance sepsis recognition, response, and management. Scoping for primary and community care has begun, with an initial presentation to the Neighbourhood Care Network.
- A sepsis workshop in November, with multiple divisions represented, explored patient deterioration and barriers to effective responses. Collaborative discussions and a fishbone exercise with the Quality Improvement team identified improvement strategies. A follow-up workshop will take place and a primary and community care-focused workshop is scheduled.
- The Sepsis Trust UK tool is being tested and rolled out, using quality improvement methods and PDSA cycles, in the acute sector. After implementing the National EWS, the tool will be reviewed for compliance and effectiveness in improving patient outcomes across adult, paediatric, and maternity/neonatal environments.
- A sepsis awareness campaign was launched internally in November 2024, with public outreach planned for April 2025. It includes a new website, staff pulse page, and awareness resources.
- Nationally, the Health Board participates in sepsis forums and contributes to the national sepsis strategy, ensuring alignment with national mandates, including reviewing and providing eLearning materials for staff.

Sepsis



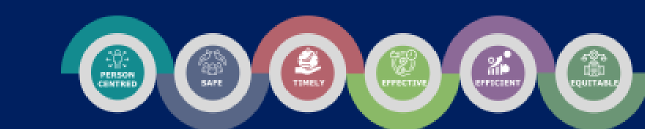
Action	What is needed?	How will this be achieved?	Who	When
Understanding Our Health Board's Position on Sepsis	Scoping in primary and community care has begun, with objectives similar to the acute sector exercise: reviewing sepsis education, examining clinical practices, and assessing the culture around sepsis management. This prepares for implementing the latest NICE guidelines and new Early Warning tools, crucial for improving sepsis management and ensuring high-quality, safe care in the community setting.	A new Assistant Quality and Patient Safety Assurance Lead has been appointed to focus on sepsis within the Health Board. Key actions include: **Scoping Exercise**: Meeting stakeholders and divisional leaders to assess current sepsis management and identify improvement areas. **Support and Collaboration**: Providing resources and collaborating on upcoming changes to enhance sepsis management. **Engagement**: Presenting to the Neighbourhood Care Network to review sepsis practices in community and primary care settings. **Review**: Evaluating current systems, resources, and education to ensure up-to-date guidance is provided. This initiative aims to strengthen sepsis management and ensure high-quality, safe care for patients.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Sept 2025
Standardise Sepsis education	To deliver high-standard sepsis care and comply with NICE guidelines, it's crucial to provide consistent education to all Health Board members. Reviewing and implementing standardised sepsis education will enhance monitoring and impact assessment, enabling opportunities for 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 Sept 2025
Assessment of Sepsis Education within the Health Board	Effective education is crucial for implementing the Sepsis strategy, NICE guidelines, and new Sepsis Early Warning monitoring tools. Ensuring that national eLearning resources are suitable and accessible to the ABUHB workforce will support this goa	An Education Task and Finish group will be established in Q4 to develop a robust training strategy for the workforce ahead of implementing Early Warning Scores and NICE Guidance. Representation at the national group will allow for reviewing and contributing to eLearning education materials.	Assistant Quality & Patient Safety Assurance Lead	To be completed by End of March 2025

Sepsis



Action	What is needed?	How will this be achieved?	Who	When
Public Awareness Campaign for Sepsis	Phase 1 has been launched internally, during January 2025 phase 2 to be initated which will provide sepsis awareness information to the public domain.	The Health Board maintains communication with the UK Sepsis Trust and uses evidence-based resources. The Comms team and QPS are collaborating on a Sepsis communication plan, with assets available on the internal sepsis pulse page. A social media campaign will provide sepsis awareness content and advice to the wider demographic on recognizing sepsis and seeking help.	QPS and Comms	February 2025
Working in Collaboration	Maintaining a collaborative approach in sepsis management is crucial for upholding best practices and mitigating risks. The Sepsis Working Group provides a forum for the multidisciplinary team (MDT) to discuss ongoing issues, identify areas for improvement, and share Health Board and national updates.	Maintaining the Sepsis Working Group will ensure a multidisciplinary approach to discussing and implementing solutions. The Assistant Quality and Patient Safety Assurance Lead will collaborate closely with Directorates, linking services, sharing best practices, and supporting quality improvement initiatives. Working directly with each area/specialty will provide a deeper understanding of the needs for improving sepsis recognition, diagnosis, and treatment.	Divisions and QPS	Ongoing
Continue working with UK Sepsis Trust and other health boards/trust	Founded in 2012, the UK Sepsis Trust is a valuable resource for NHS England and NHS Wales. It facilitates collaborative practices among Health Boards and Trusts across both countries. The charity offers a range of evidence-based resources, including Sepsis UK screening tools, educational materials, and signs and symptoms awareness posters/leaflets.	Representatives from the UK Sepsis Trust have previously supported the Health Board with the initial NEWS implementation and remain valuable contacts. Maintaining regular communication between ABUHB and UK Sepsis Trust allows for the continued sharing of evidence-based resources to enhance clinical practice.	Divisions and QPS	Ongoing
Develop Audit Strategy for Sepsis and ensure learning from incidents	It's essential to establish a consistent method for capturing sepsis data across the Health Board. Currently, varied monitoring approaches hinder the collection of reliable data needed for improvement. Standardising data capture methods will enhance the ability to support clinical practice and drive better outcomes.	Collaboration: Work closely with divisions to identify universal data requirements and agree on standardized methods for capturing patients with Sepsis. Efficiency: Use AMaT to develop a proforma, ensuring the audit process is efficient and the workforce can input data effectively. Learning System: Develop a system to learn from incidents where Sepsis was missed, including thematic reviews of Datix incidents.	Sepsis Working Group	April 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.	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.	Implementation groups to continue working towards implementation NEWS2, PEWS, MEWS and NEWTT2 across ABUHB, by September 2025. Ensure good communication with directorates and provide support around the new early warning scores.
Roll out of Deteriorating Patient Policy across Health Board	Develop 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. Extent to public domain January 2025.	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.

Quality Assurance for Commissioned Services

- A Quality Assurance Framework for Commissioned Services has been developed.
- A small working group has been formed to review existing commissioning arrangements.
- A list of commissioned services across all Divisions has been created.
- A review of all documented agreements needs to be undertaken to ensure adequate monitoring processes are in place.
- Target cancer services - satellite service as a starting point.
- Establishment of a wider commissioning group with the aim of building knowledge of commissioning across the Health Board and addressing any known risks.

Quality Assurance for Commissioned Services

Issue	Action	Learning and Improvement	Who	When
Need to ensure the Health Board is commissioning high quality, sustainable services, including the ability to recognise any early action and systematic deterioration in care within a provider organisation	Small working group has been created to review existing commissioning arrangement across Divisions	Inconsistencies identified in the information held by divisions regarding contracts, monitoring, and escalation processes. Need to tailor work to divisions and build knowledge around commissioning.	Tracey Partridge-Wilson Ann-Marie Matthews Leeanne Lewis	January 2025
Lack of information available on the commissioning arrangements /agreements held with providers across the Health Board.	Work has commenced to develop a comprehensive register of current agreements / commissioned services	Need to understand the scale of commissioning arrangements in place across all divisions and agreed a realistic target to make meaningful improvements.	Philip Meredith	April 2025
Inconsistencies identified in the information held across divisions regarding contracts, monitoring and escalation processes.	Cancer services will be targeted as a staring point to improve commissioning processes	Working across multiple divisions, addressing undocumented commissioning arrangements with the aim of quality improvement.	Tracey Patridge-Wilson Ann-Marie Matthews Philip Meredith Christopher Dawson-Morris Leeanne Lewis	May 2025 – ongoing
Engagement and understanding of commissioning issues.	Development of a commission group to identify areas where further support is required to the wider aspects of commissioning.	Development of best practice guides. Inclusion in the group will develop a pool of 'experts' through the building of knowledge as the work progresses	Ann-Marie Matthews / Philip Meredith	July 2025 - ongoing

Team Accreditation

Current Progress: Implemented in 78 areas

Phase 1 (Complete): Adult Wards GUH, MH & LD Wards, Paediatric wards
Ongoing support provided to all areas.

Phase 2: (Ongoing)
MAU, SAU, Theatres, Critical Care completed.

- Launched in Theatre areas February 2025.
- Currently reviewing roll out in Mortuary areas
- ED OPD MIU will be implemented by July 2025

Phase 3: (Planned)
HV, DN, Maternity Services, Specialised Teams: commencing July 2025

Independent Reviews:

- ✓ 8 bronze awarded
- ✓ 1 portfolio assessment (pending)

Work in Progress:

- Information resources on Padlet
- Review of SOP to include specialist areas / criteria for portfolio assessment.
- Clinical visits to support areas with audit quality and improvement projects.

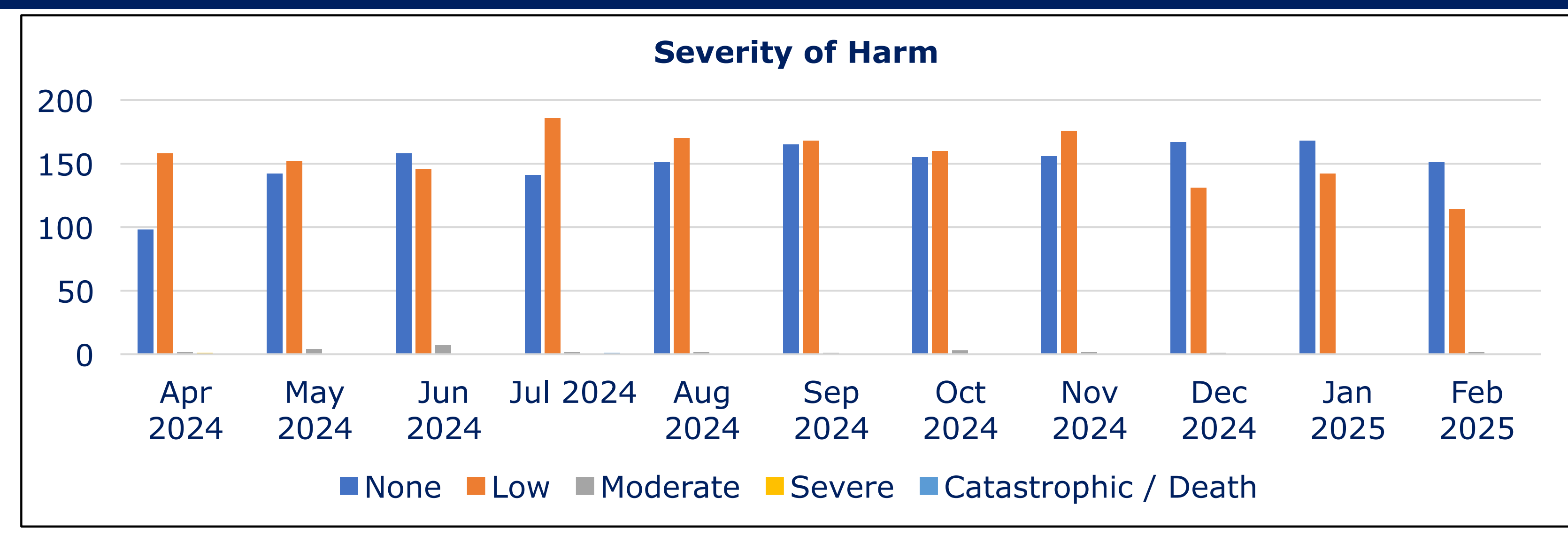
Building and maintaining accreditation momentum:

- *Continuous Improvement*
- *Engagement* with Divisions
- *Awareness Raising* – Communication of data analysis and progress of awards, case stories, attendance at key meetings, through resources (Padlet, News feed)

Team Accreditation

Theme	Action	Learning and Improvement	Who	When
Embedding accreditation	Feedback forms sent to clinical areas to evaluate current practice / staff needs.	More accessible information needed for staff. Padlet being produced. More support within clinical areas to undertake required audits.	Accreditation lead	July 2025
Maintaining audit compliance / quality	Senior nurse engagement - One Patient One Day monthly audit. Drive audit standards through clinical visits, standards, demonstrate data to improve patient experience.	Clarity needed to accurately audit care delivery.	Accreditation Lead / Senior Nurses	Ongoing
Understanding accreditation process	Update SOP and staff resources / padlet. Communication & Engagement	Review of supporting portfolio criteria to ensure quality indicators are assessed to a framework of standards.	Accreditation Lead	July 2025

Health Board Wide Inpatient Falls Severity of Harm



February 2025- Context

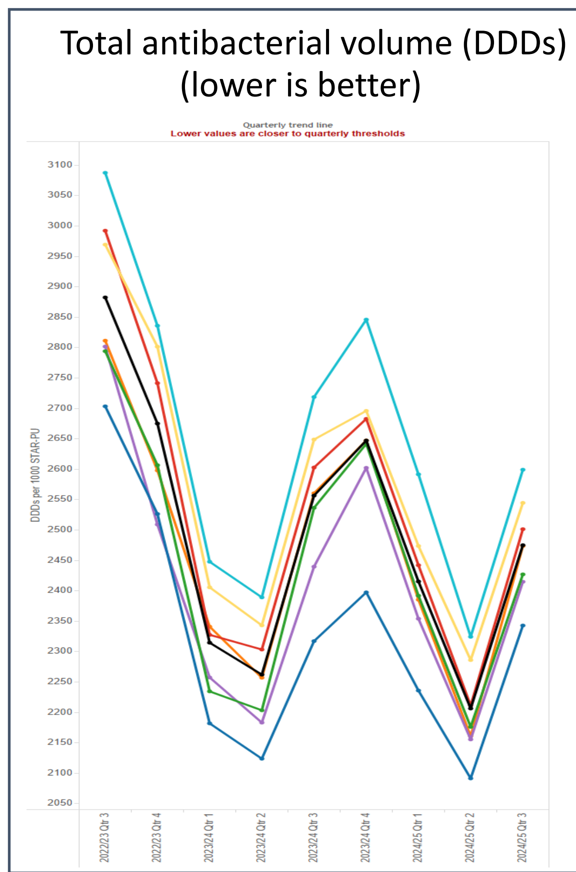
The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period April 2024 to February 2025

Definitions	What the chart tells us	Variation/ Analysis
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 severity of harm is categorised for the given period is 3490. January 325 = 9% of the total whilst February 2025 283 = 8%. For the period identified the following details the severity of harm: • 96% No or low harm • 0.8% - Moderate harm • 0.1% Severe harm • 0.1% Catastrophic • 3% await a conclusive severity of harm categorisation	The severity data is reflective of the identified level of harm recorded post investigation The figures are subject to variation post investigation.

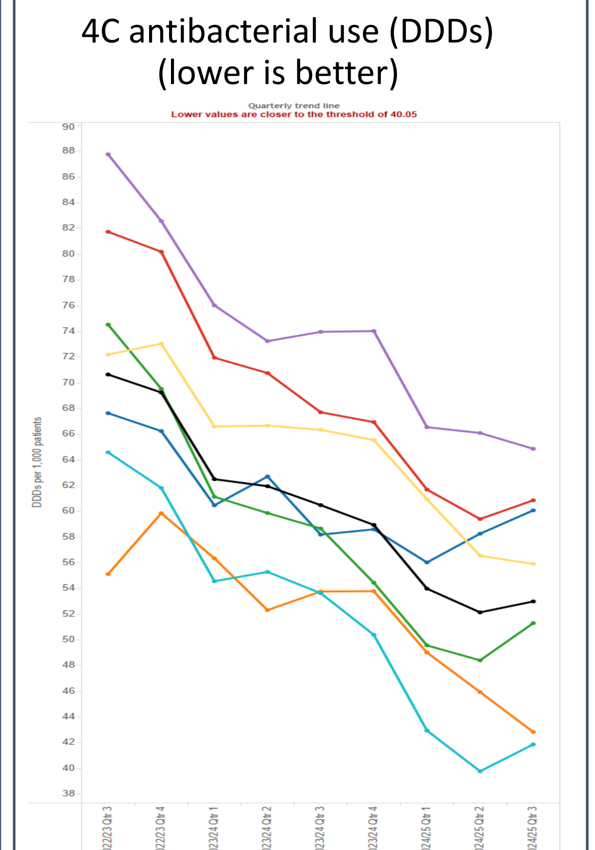
Primary Care Antimicrobial Performance

- Formal data from PHW are currently unavailable, therefore national prescribing indicator data are shared as a surrogate, but only include data from GP in-hours services. The black line denotes the all-Wales average
- Total antimicrobial use increased in Q3 24/25 as per seasonal pattern, however is 3.9% down on Q3 23/24
- Use of higher-risk 4C antibacterial use continues to reduce
- ABUHB has made significant improvements in reducing antibiotic course lengths from 7 days to 5 days across 3 of the highest volume antibiotics

Total antibacterial volume (DDDs) (lower is better)



4C antibacterial use (DDDs) (lower is better)

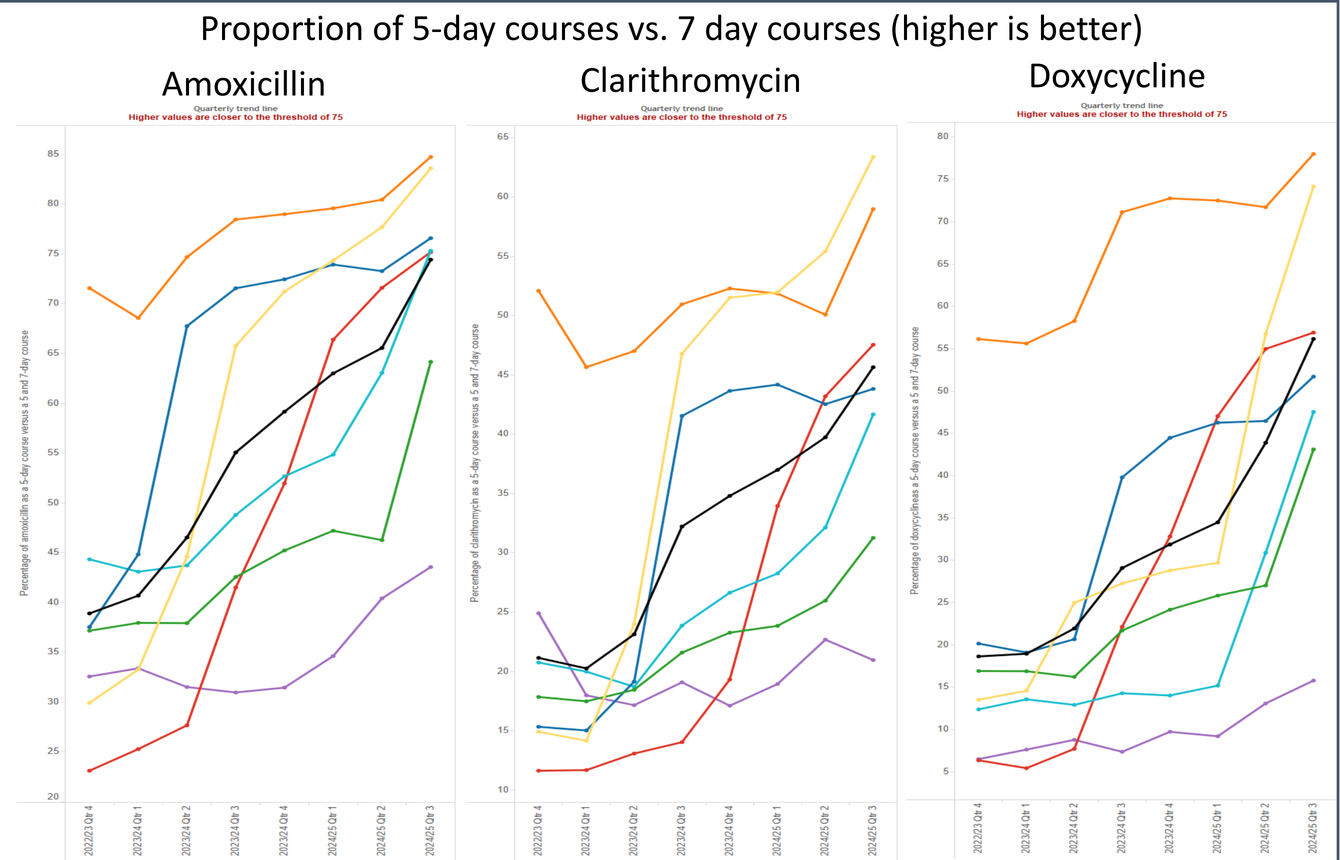


Proportion of 5-day courses vs. 7 day courses (higher is better)

Amoxicillin

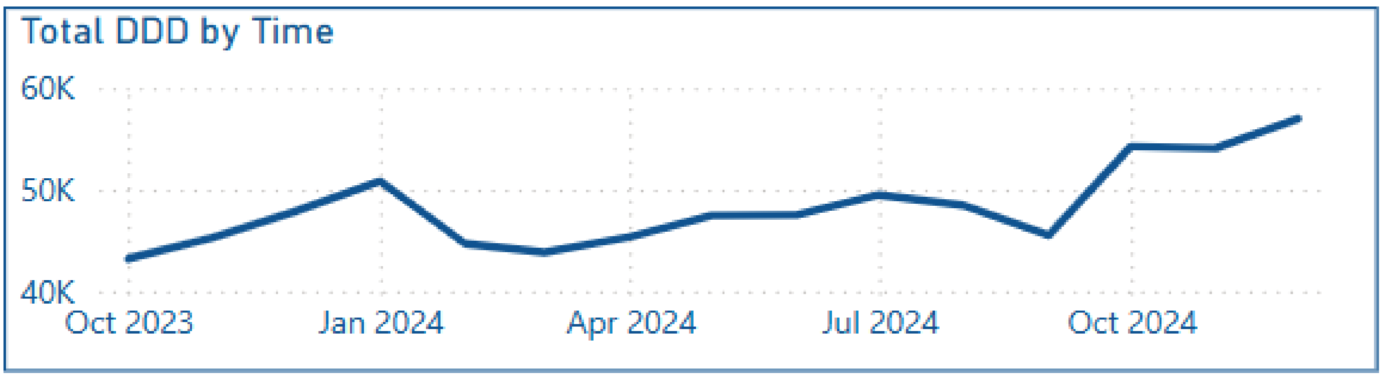
Clarithromycin

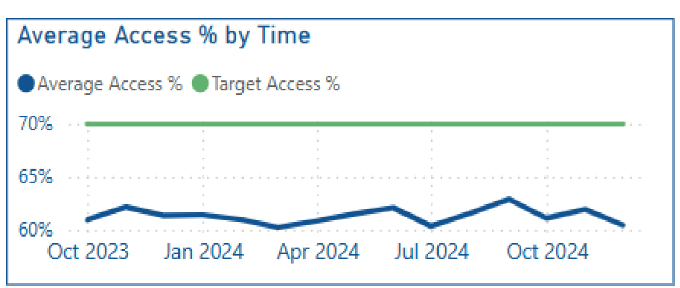
Doxycycline

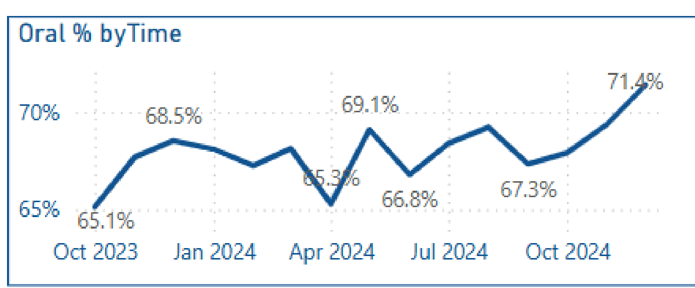


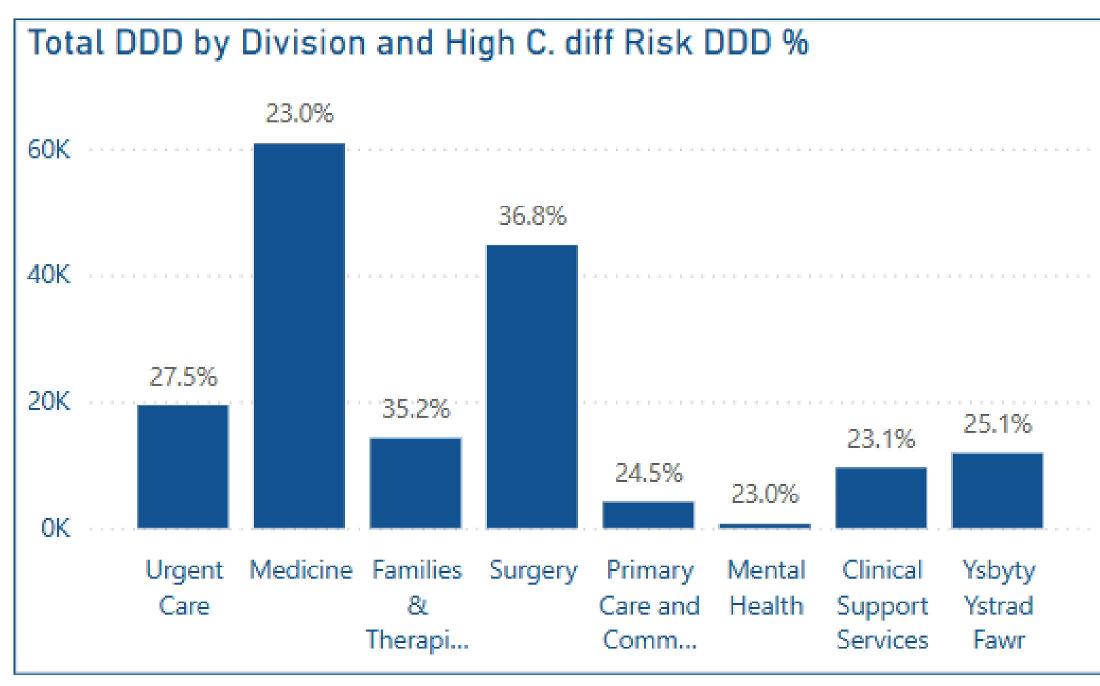
Secondary Care Antimicrobial Performance

- No new data available from PHW (still only to Q2)
- Local data suggest significant *increase* in use in numbers of days of treatment (DDDs) supplied in Q3
- No significant improvement in 'access' category use
- However increasing proportion of antimicrobials being given orally, reducing the risk of line infections, and saving nursing time
- Final graph shows the split of use across the divisions, and the percentage of antimicrobials used in that division that are thought to be higher risk of *C. difficile* infection
- Struggling to maintain business as usual antimicrobial ward rounds at some sites given current Medical Microbiology & antimicrobial staffing





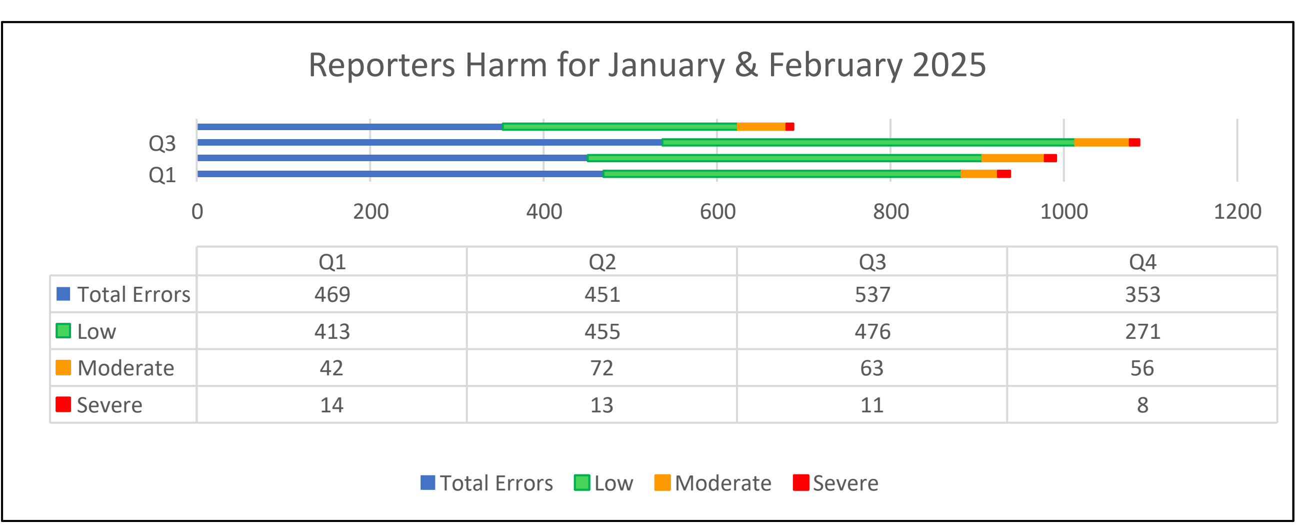




Medication Safety Group (MSG) 2024/25

Top 10 identified causes of medicines incidents from April 2024 - February 2025, as ranked by most frequent occurrence:

- Administration
- Medication supply
- Medication Storage, security and disposal
- Medical documentation
- Treatment or procedure
- Allergic reaction
- Preparation
- Monitoring
- Communication
- Discharge



	Q1	Q2	Q3	Q4
Total Errors	469	451	537	353
Low	413	455	476	271
Moderate	42	72	63	56
Severe	14	13	11	8

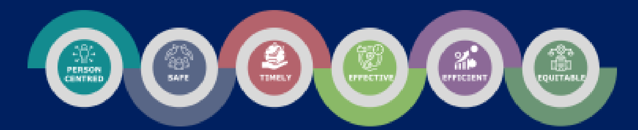
Incidents by Division
April 2024 - February 2025

250
200
150
100
50
0

Apr May June July Aug Sept Oct Nov Dec Jan-25 Feb

F&T MH+LD PC+C Surgery Medicine Urgent Care LT+CC CSS

Medication Safety Group (MSG) 2024/25



Item	Action	Learning and Improvement Progress	Who	When 10.3.2025
Meeting the HEIW Standards for Quality Assurance for all Non Medical (NMP) and Supplementary Prescribers (SP)	The Declaration of Scope of Practice is well established. Action plan for Nursing & Midwifery complete. A multidisciplinary group, including Independent Prescribers (IPs) and Supplementary Prescribers (SPs), has met to manage the action plan for all disciplines. Competencies have been converted into a self-assessment document to aid self-assessment via the Royal Pharmaceutical Society. A Portfolio document has been created to demonstrate competence.	Process standardised and embedded for Nursing & Midwifery leads MDT leads engaging and aligning within individual regulatory bodies and HEIW requirements.	KH, member of the short life working group	6 – 12 months.
Aligned to Medicines Safety Strategy (MSS) - categorise and report incidents related to high-risk medications	Priority 1 MSS – Anticoagulation incidents. Task and finish group leading on; a. The processes in place for prescribing and administering anticoagulation medication. b. The risks and barriers to target change.	Shared learning via an ERASE poster and Staff bulletin. MDT and organisational approach required to manage incidents. A deep dive is required to inform the action plan.	Task and Finish group. Divisional leads/ KH/Pharmacy lead CB/JT/JH	
Medicines Governance Audits	Discussion at Medicines Safety Group to develop a comprehensive medicines audit tool.	Review of audit tool is underway.	KH/JH	
Controlled Drug Standard Operating Procedure (SOP)s	All Controlled Drug SOPs need to be updated.	Review of SOPs underway.	CD LIN	

Medication Safety Group (MSG) 2024/25

Issue	Action	Learning and Improvement	Who	When
Administration errors	Review education, training and assessment of competence process provided by the Divisions Identify gaps and include training, education and assessment	Develop a standardised approach to education, training and assessment, with specific requirements for specialist areas Manage errors and incidents using an organisation and MDT approach	KH / MSO / Divisional leads	Over the next 12 months
Categorise the high-risk medication errors	Working with relevant teams and disciplines to enhance organisational education and training. Establishing training requirements for all staff involved with high-risk medication.	Understand the underlying causes for errors Develop a strategic action plan Reduce the occurrence of incidents related to high-risk medication	KH / MSO / Divisional leads	
Revalidation & management of staff following an incident	Review the current process to ensure it is inclusive for all MDT staff Standardise a structured meaningful revalidation process for the health board	Current revalidation processes are not standardise We aim to improve the process and ensure it is not punitive	KH / MSO / Divisional leads	

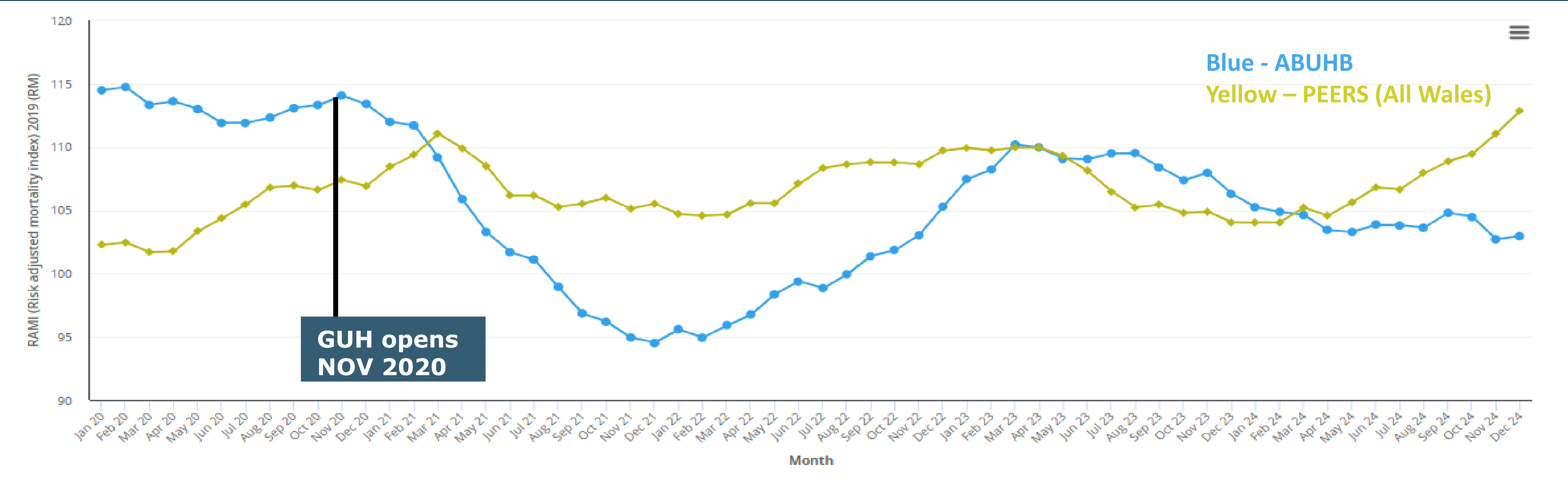
Achievements:

- Implemented medical gases training program on ESR.
- Shared medicine incident data with divisional education leads to enhance medicine safety.
- Currently reviewing revalidation, error management, and education provisions.

Progress Report:

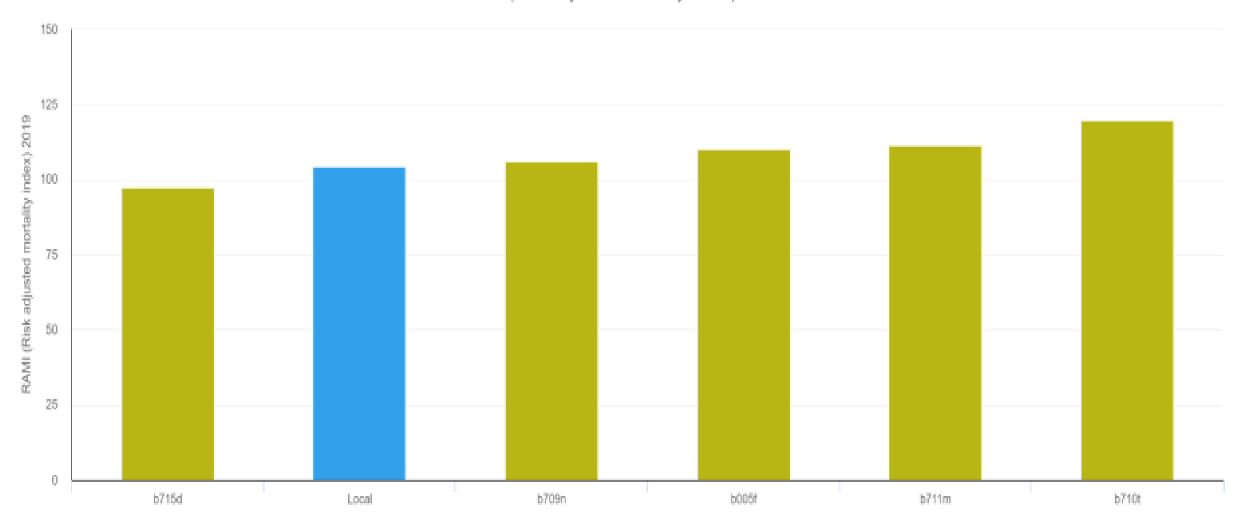
- Policy for Managing and Supporting Staff Following a Medication Error (BESS: Bennion Error Scoring System): Document review in progress. Education and Revalidation Review for N&M: Meeting with Divisional N&M Practice educators scheduled for March 2025.

RAMI (Risk Adjusted Mortality Index)



RAMI has been consistently lower than the Welsh Peer group for the majority of 2024

Currently performing 2nd of 6 within All Wales peer group



The Health Board's Risk adjusted Mortality Index (RAMI) is 103 for Q3. 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.

Crude Mortality in Hospital

Deaths per 1000 occupied bed days

Deaths per 1000 bed days
2 per. Mov. Avg.(Deaths per 1000 bed days)

Deaths: 6,50 6,00 5,50 5,00 4,50 4,00 3,50 3,00 2,50

Month	Deaths per 1000 bed days
jul-22	4,85
aug-22	4,49
sep-22	4,79
okt-22	6,03
nov-22	5,09
des-22	5,58
jan-23	5,95
feb-23	4,94
mar-23	5,13
apr-23	4,68
mai-23	4,51
jun-23	4,30
jul-23	3,88
aug-23	4,15
sep-23	4,18
okt-23	4,83
nov-23	4,91
des-23	5,23
jan-24	5,35
feb-24	5,02
mar-24	5,08
apr-24	4,09
mai-24	4,38
jun-24	4,35
jul-24	4,29
aug-24	3,85
sep-24	3,71
okt-24	4,03
nov-24	3,48
des-24	3,85
jan-25	3,73
feb-25	3,65

Month

Mortality Rate

Rolling Annual Total Mortality Rate
All Wales Rolling Annual Total ...
Provisional monthly data (last 90 days)
2.0%
1.5%
1.0%
0.5%
0.0%
Rolling annual total
2.0%
1.9%
1.7%
1.7%
1.7%
1.7%
1.7%
1.7%
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025
Year

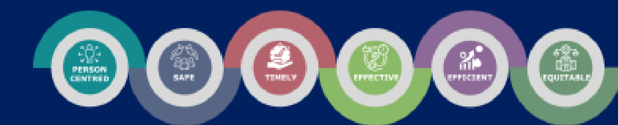
Our mortality rate remains stable and flat. Actual deaths in hospital have decreased over Q3 2024.

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.

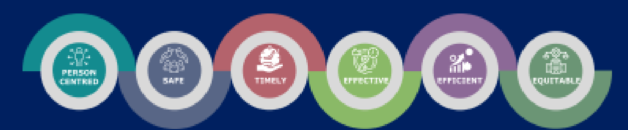
Addition of the Health Board’s learning from death report advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI). This is observed in the additional mortality indicators for reporting.

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. The Health Board has established a Learning from Death framework which enables a standardised mortality report.	The Health Board has presented a Learning from Death report PQSOC and will be reported every 6 months. It 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.		

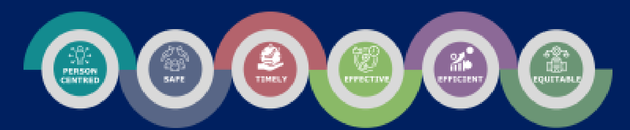


Nurse Staffing Levels Wales Act 2016



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 January -28th February 2025	Number of closed incidents/complaints 1st January -28th February 2025	Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	Number of incidents/ complaints when the nurse staffing level (planned roster4 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)	10	7 (All found to be unavoidable)	3 (plus 1 still open from previous reporting period)	0	0
Falls resulting in Moderate harm or death (i.e. level 3, 4 and 5 incidents)	12 (injurious falls)	0 (closed as moderate) 8 (closed as low/no harm)	4	0	0
Medication errors, level 3,4,5 & never events	47	30 (closed as low or no harm)	17	0	0
Any complaints about nursing care handled through PTR (excludes early res)	26 not just nursing	9 nursing (opened before this reporting period)	26	0	0
Infiltration/ extravasation injuries	0	0	0	0	0

Nurse Staffing Levels Wales Act 2016



Issue	Action	Learning and Improvement	Who	When
• Delay in undertaking RCA and focussed reviews of Hospital acquired pressure ulcers. • Occasional closure of DATIX without appropriate focussed review	• Divisional leads to speak to senior nurses to understand barriers to timely investigations. • NSA lead contacts senior nurses to recommend focussed review	• 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. • Monthly one to one discussions with senior nurse and ward managers
• Some falls in DATIX are closed prematurely as no injury sustained, however, following a CT / MRI there is often a fracture or head injury discovered	• NSA lead to attend senior nurse and ward manager meetings to explain issues of inaccurate detail in DATIX fields.	• Further training on DOC and assessing level of harm required.	Divisional Nurses Senior Nurses NSA Lead QPS Leads	• Monthly Divisional QPS meetings • Divisional senior nurse meetings
• Complaints are often complex and multifactorial and can involve nursing, medical and OHP's. Therefore, complaints managed through PTR are rarely closed within the same reporting period.	The All-Wales Nurse Staffing reporting Group are presenting an SBAR to EDON's to propose health Boards only report on complaints that have been fully investigated and closed within the annual reporting period. This is the only way to report accurately on nursing complaints and whether staffing levels contributed.	• NSA lead to continue to work with divisions to inform of any agreed changes nationally. • NSA lead to liaise with senior nurses and complaint hubs to ensure the NSA questions are completed timely and accurately in the Datix fields in complaints.	NSA Lead Senior Nurses Complaints Hubs	• Monthly QPS meetings. • Meetings / discussions with senior nurses

Quality Improvement

Quality Improvement Capability Strategy: Embedding Quality Improvement into Everything we do - 2025 – 2028

- The approach has been supported by AB Executive Team and the Public Board in November 2024
- Board Development Session – October 2024
- Discussion as part of workshop facilitated with Maxine Power – January 2025
- QI Capability Strategy presented to Paned Q – Welsh Q Community Members, Jan 2025

Outcome | Primary Drivers | Secondary Drivers

ABUHB QI Capability Driver Diagram

QI is the AB way: Embedding Quality Improvement into Everything we do

QI Capability

Capacity
building knowledge and skills

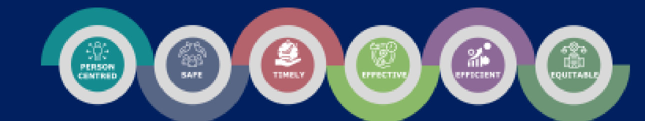
Conditions
Enabling factors

Connections
Sharing learning and Support

Capability for QI

- Workforce QI Skills Development Framework
- QI Tools and Resources
- Quality Management System – QI part of QMS
- Leadership for QI Capability
- Quality Improvement Coaches embedded
- Human Factors & Psychological Safety part of QI
- Systems to share learning
- Protected Time for Quality Improvement
- Patient involvement in quality improvement
- Access to data systems supporting QI
- Aligning QI to ABUHB priorities
- ABUHB QI Networks
- External QI Networks & Strategic Partners

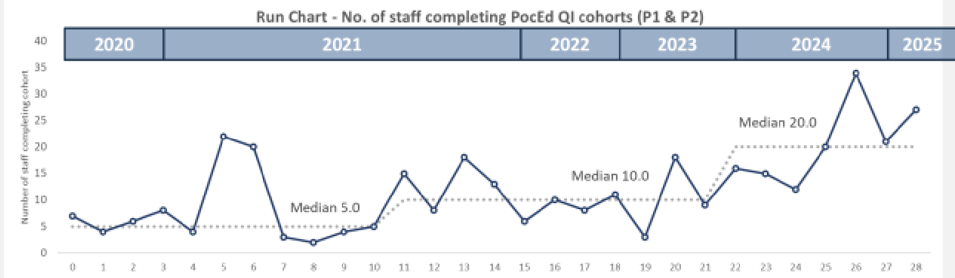
Quality Improvement



Workforce QI Skills Development Framework

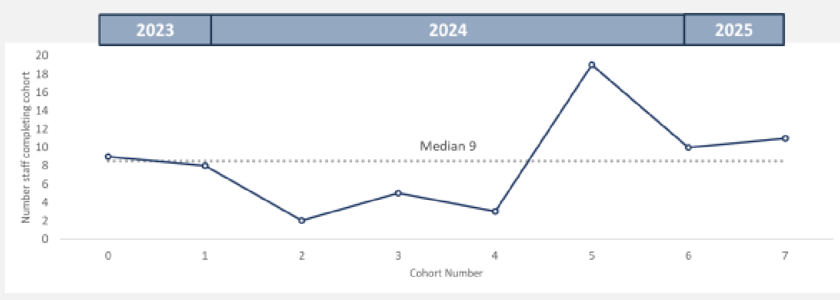
PocEd QI training (virtual) – 2 half days QI method/tools

- 349 New staff undertaken training in total
- 32% increase, 102 trained during 2024



PocEd Measurement training (virtual) – New course 1 half day around time series data. Runcharts and SPC

- 67 staff trained in total over 8 cohorts



Quality Improvement Coaches embedded

Quality Improvement Coach Programme (face to face training) – 2 half days, 3 full days very interactive programme. Coaches sign up to undertake half day coaching each month

- Cohort 2 started in February 2025
- 3 cohorts dates set up for 2025
- 31 coaches in total have completed the programme (inc. 3 external candidates). Further 6 in process

Aim – to unleash a million minutes of QI Coaching over the next four years to support our people to improve what matters to them and their patients

- 15,280/1000,000 minutes of QI Coaching delivered

Quality Management System QI Part of QMS

Ward Accreditation Programme

- Working with Ward/Team Accreditation Programme to develop QI Maturity matrix aligned to Accreditation Levels, Moving from single project to QI embedded into practice.

Jan – Feb 2025

Prepared by ABCi team

Patient Safety Alerts and Notices

Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	An SBAR has been produced to highlight the work that has been progressed as part of this PSN and actions that remain outstanding. Work remains ongoing.	In-progress OVERDUE

PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified

Situation:
- ABUHB remains non-compliant with PSN066

Background:
- This PSN was first released in February 2023.
- This PSN concerns providing a unique identity to each unknown patient. This is to ensure safe and prompt diagnostic testing and treatment, especially in the effort to prevent incorrect blood test results being allocated to the wrong patient with the potential to cause a fatal incompatible blood transfusion.
- Work has been on-going in the intervening time to work towards compliance, kindly led by Peggy Edwards.

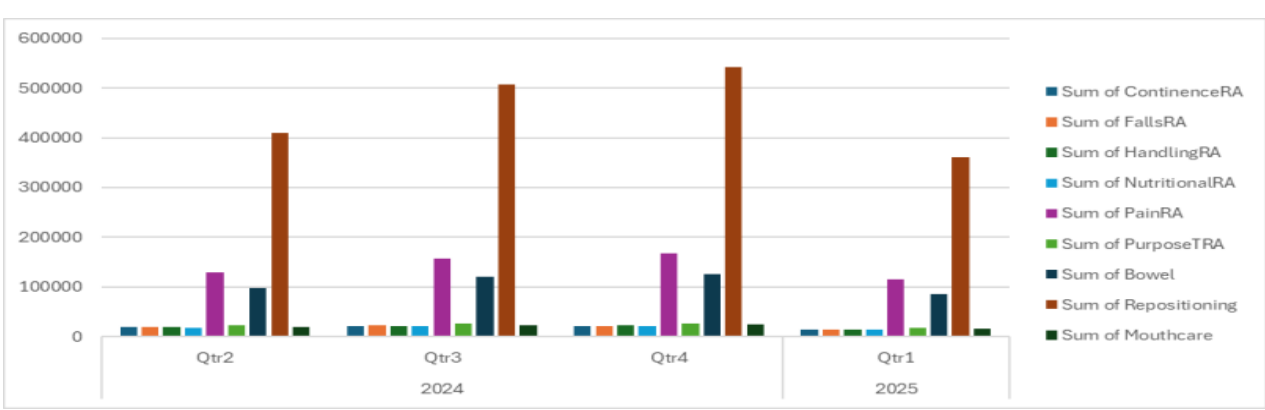
Assessment:
Current barriers for declaring compliance with this PSN are;

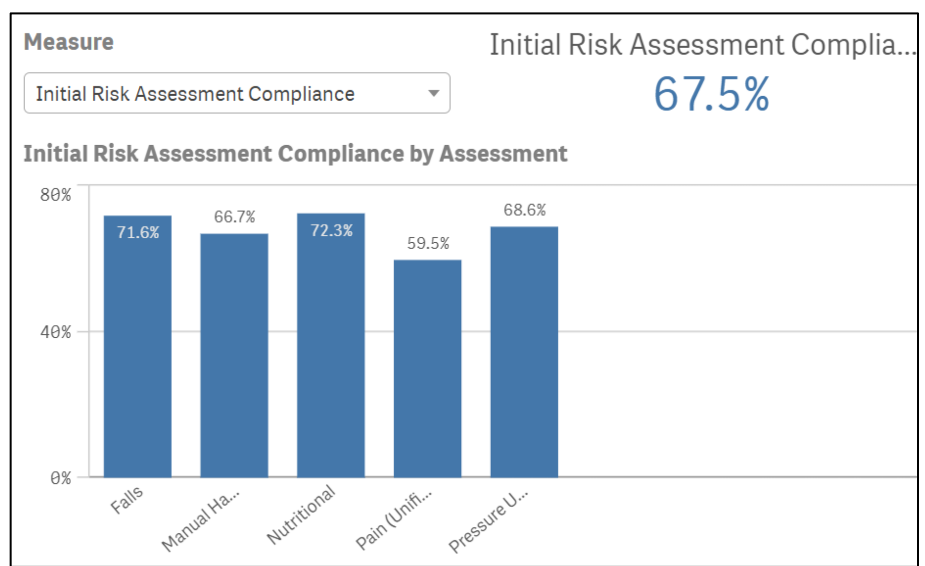
1. Merging patients in WPAS. There is a long standing issue where DHCW have changed the way the system works which has damaged the merging process. The DHCW are unable to resolve this issue, so it will need to be resolved in-house now. There is no clear time-line for this at present.
2. The age of the code which underpins and supports the admission, transfer and discharge process in CWS means we are unable to merge in-patient records until after discharge as the care episode is technically broken (therefore affecting information available to the clinician on viewing the record) – fix is within the development of CWS2 anticipated 2025. We have met with the technical team to establish how we can do this and it is to be included in the backlog of working.
3. Inability to link records within Masterlab for Blood transfusion purposes. Once WinPath is due to be implemented in Jan ’25 this should be resolved. Currently awaiting confirmation for this.

Recommendations:
The Health Board acknowledge the delay in implementation of all the requirements and the support the ongoing activity to ensure a ‘robust’ merger process is in place for all down stream systems requiring an appropriate patient identification.

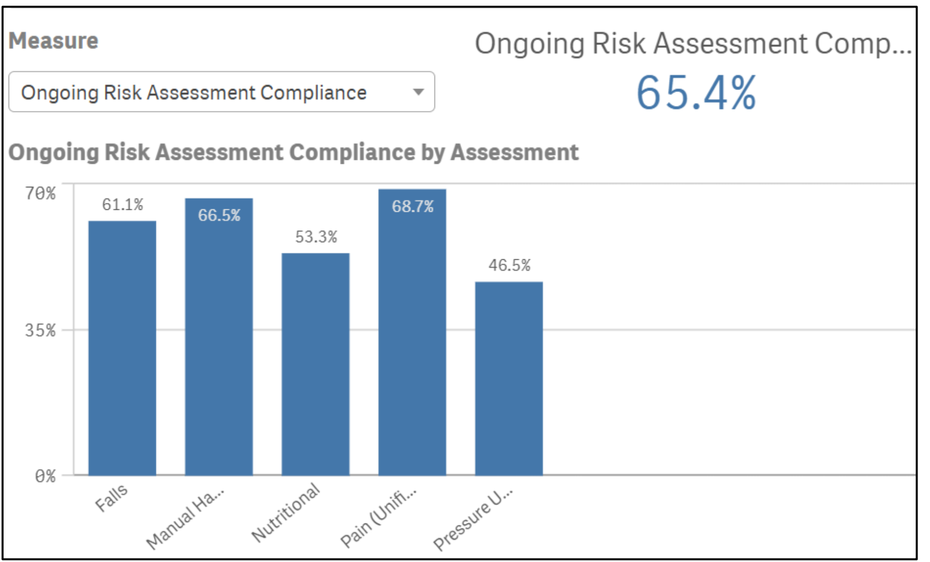
Welsh Nursing Care Record

- WNCR is now live across all adult in-patient wards (58 wards)
- Internal Audit report identified short fall in Ward Clerk training – training scheduled



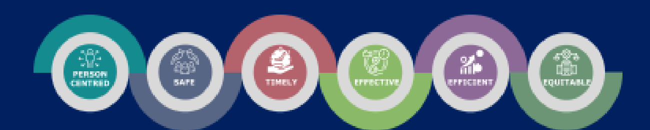


On time risk assessment on admission running at 67.5% (April24 - Feb25)



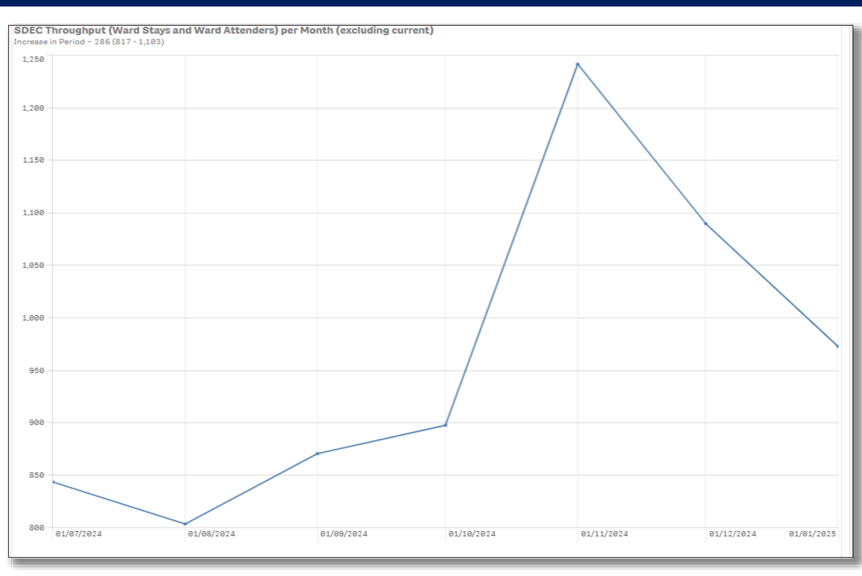
Re-assessment timeliness at 65.4% (however this data is influenced by a number of assessments being open when the patient has been discharged)

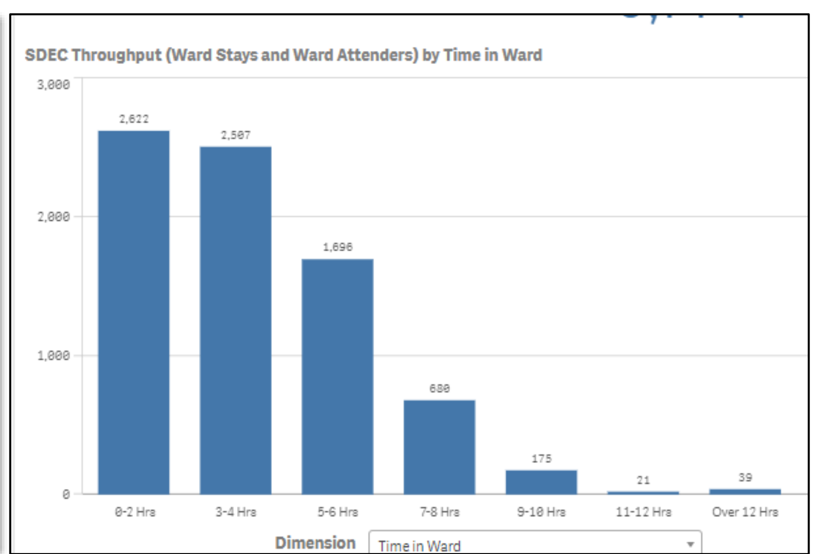
Welsh Nursing Care Record

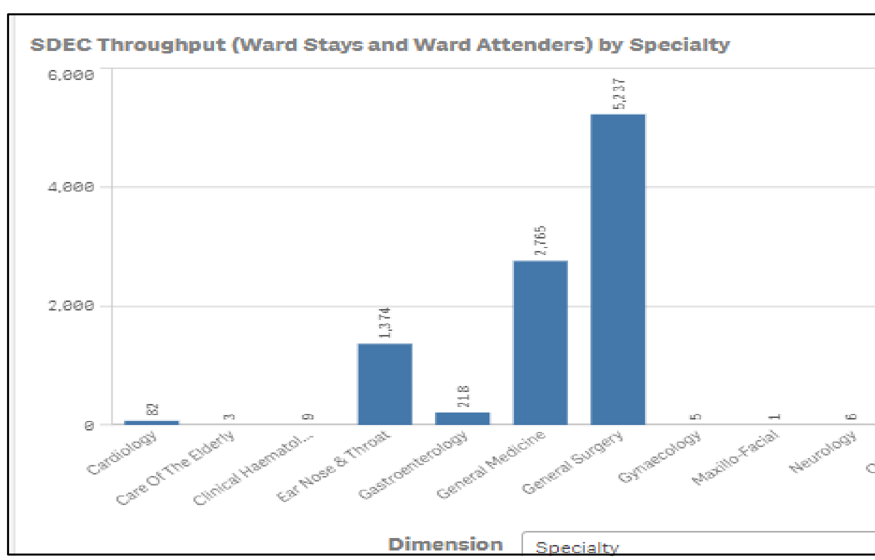


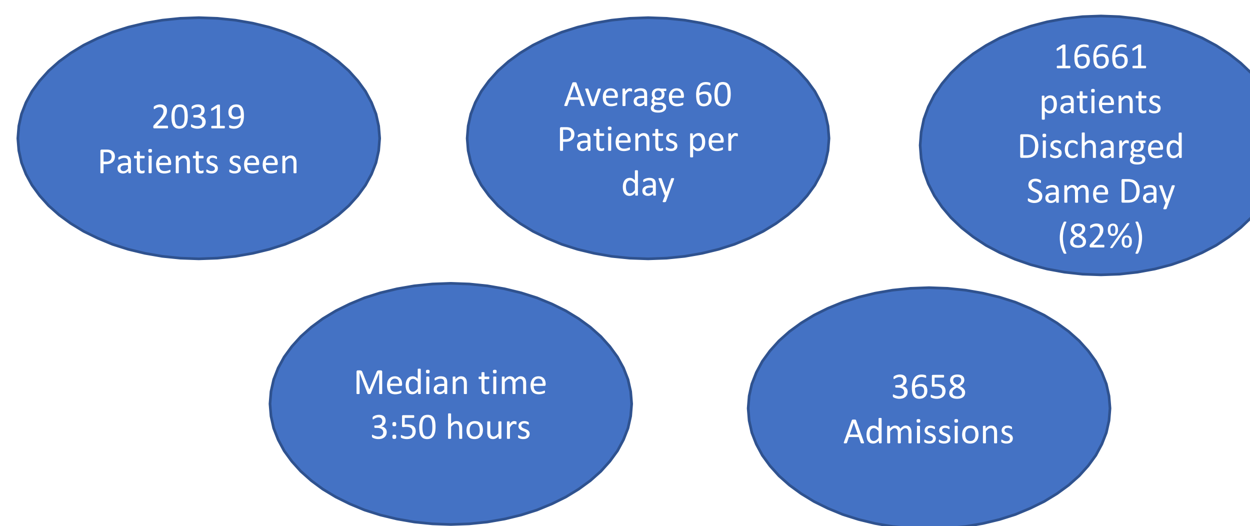
Issue	Action	Learning and Improvement	Who	When
Not currently providing quantitative data to wards to support service improvement due to lack of resources within information team	Contractor in place and requirements provided	Escalated to Assistant Director of Nursing and Director of Digital	DoD	Q2
Duplication of recording nursing information; Not all information requirements on WNCR. Impression all data needed on TCAB	Request for change process for WNCR Review of what data items recorded in multiple areas e.g. observations	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	Q2
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 Catheter care bundle delayed but nearing completion	Inability to support improvement activity due to the lack of digital data	DHCW	Q2
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
The retirement of the current Chief Nursing Information Officer means there will be no clinical lead for the application from April '25	4 month secondment to be advertised DoD developing overarching clinical strategy for digital to inform post	Need to align recruitment with planned retirement to ensure continuity of support	Escalated to Assistant Director of Nursing and Director of Digital	q2
The scope of the WNCR project has been reached. The opening of new wards presents a hardware and training challenge	Ward moves / openings need to be communicated to DDaT as soon as identified	DDaT was able to rapidly support D7W opening but any future changes may not be able to be accommodate these as quickly	Service	Ongoing

SDEC GUH at a Glance 8/8/22 – 5/1/25







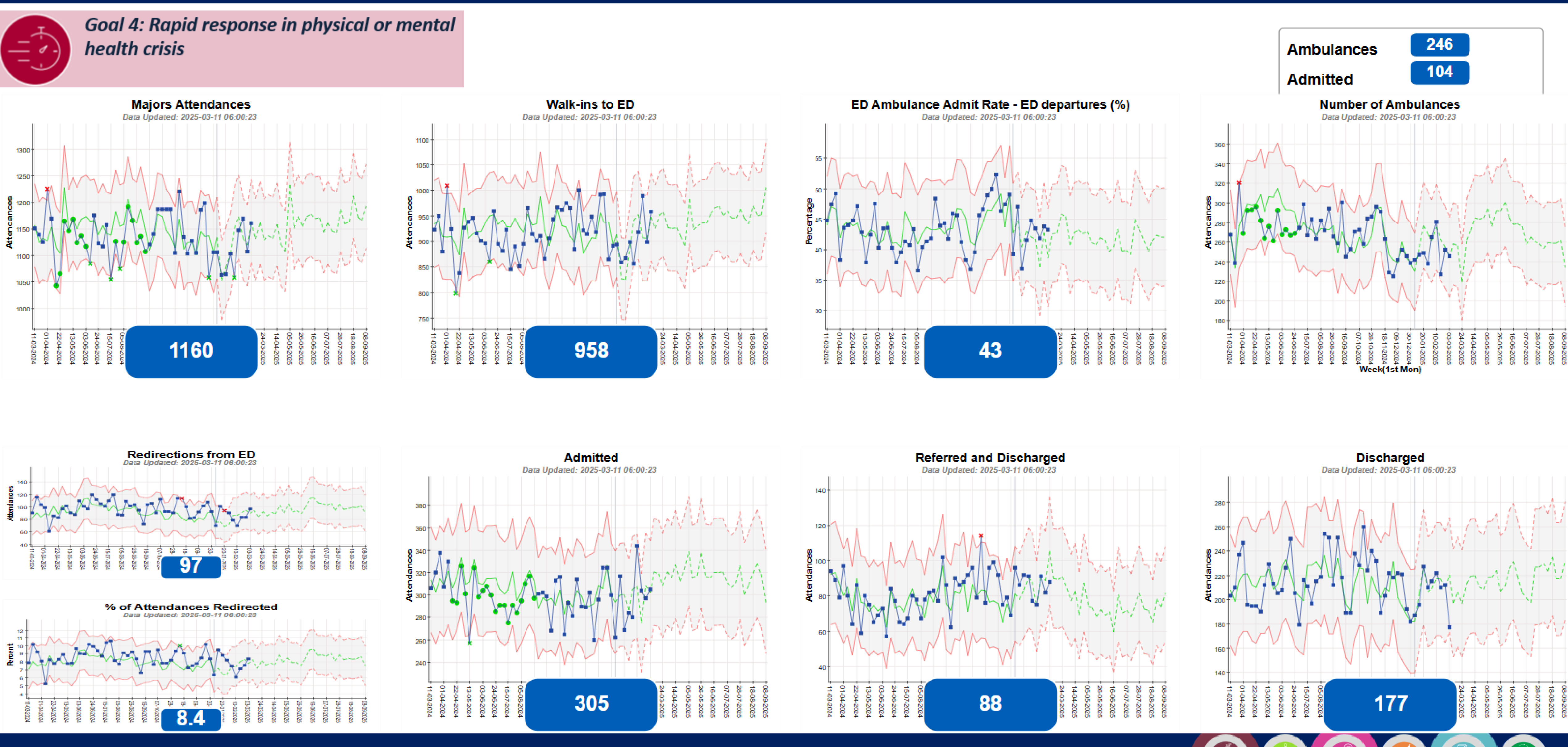


Progress Summary:

- An initial 'SDEC first' model implemented for medicine in Nov 2024
- Medicine reached 140 patients per week during November however this has reduced to around 90 patients per week in SDEC
- Further work required to direct additional medicine patients to SDEC via the flow centre (risk management of higher acuity patients discussions on-going)
- Overall throughput now regularly exceeding 200 patients per week across specialities in SDEC
- Working through the challenges of having a fully utilized SDEC ie shared spaces and shared staffing
- Surgical model working very well, great feedback from Primary Care
- Other Pathways remain including ENT, Gastro and T&O,
- Over 20,000 patients have been seen in SDEC since opening in Aug 2022
- Overall same day discharge rate is 82%
- Overall median Length of Stay in SDEC remains consistently around 3:52 mins

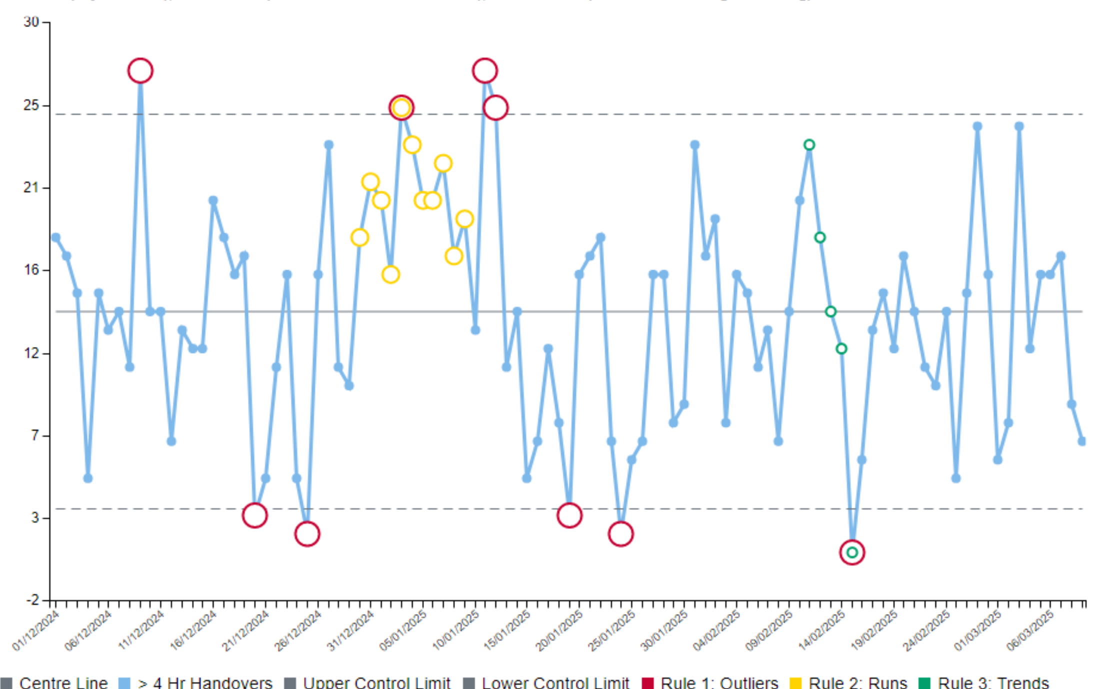
Urgent and Emergency Care – GUH ED Activity

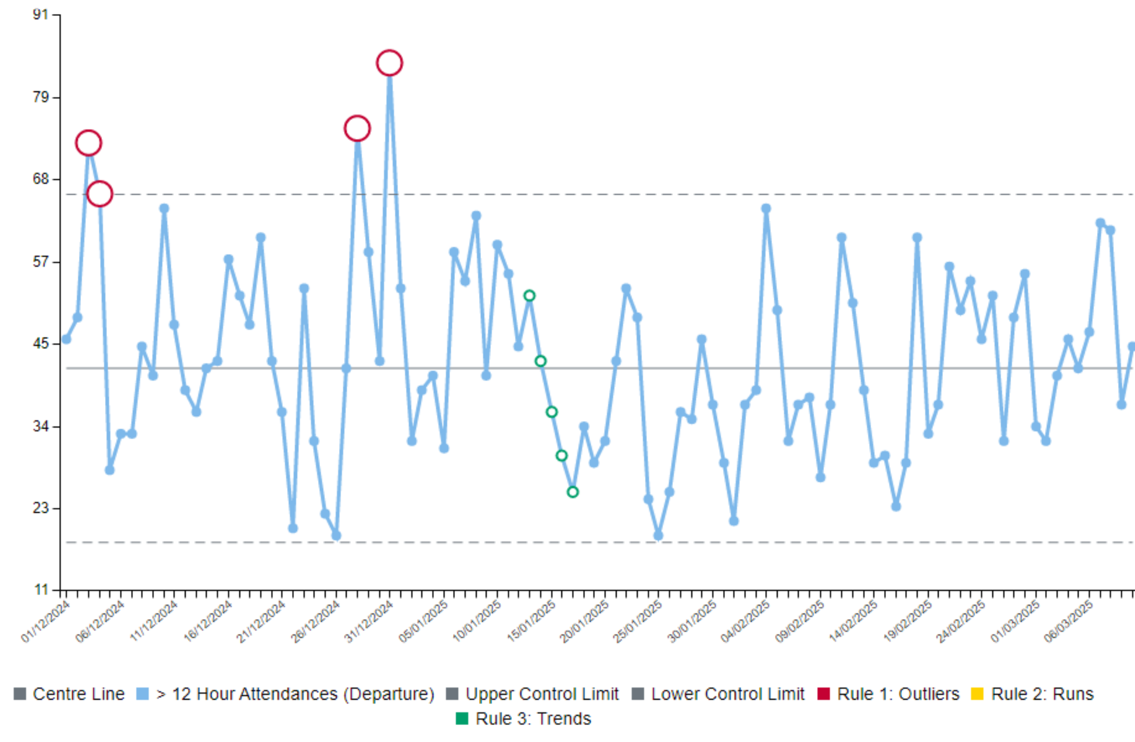
Goal 4: Rapid response in physical or mental health crisis



Urgent and Emergency Care

Goal 4: Rapid response in physical or mental health crisis





Data Updates & Forecasting:

- **Around 14 patients a day** waiting over 4 hours for ambulance handovers at GUH in the last 3 months
- **Around 42 patients a day** spending over 12 hours in ED in the last 3 months

Questions

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 March 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Healthcare Inspectorate Wales – Unannounced Inspection of ED, GUH Published Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	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 Grange University Hospital Emergency Department (ED) underwent an inspection from 2-4 October 2024. Several areas requiring improvement were identified, necessitating an action plan to address these issues and enhance patient care and safety.

Cefndir / Background

The inspection revealed significant challenges in patient flow, pain assessment, oversight of waiting areas, risk assessments, and medication management. The Health Board has developed an improvement plan to tackle these issues, with specific actions assigned to responsible officers and timelines for completion.

Asesiad / Assessment

Quality of Patient Experience:

Overcrowding and Privacy Issues:

- The waiting room and reception area were overcrowded, leading to a lack of privacy and dignity for patients discussing confidential information.
- Staff did not have good oversight of these areas, and risk assessments were not always completed.

Waiting Times:

- Patients expressed significant dissatisfaction with waiting times; only half felt they were assessed within 30 minutes of arrival.
- Extended waiting times were due to high patient volume and limited ward bed availability, affecting patient flow and discharge processes.

Patient Flow and Escalation Status:

- The department was experiencing high escalation status, with extended waiting times due to the volume of patients.
- Capacity was managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability.

Improvements Since Previous Inspection:

- Initiatives to improve patient triage times were implemented.
- Building work for an extended waiting area was underway, expected to be completed by spring 2025, providing more seating and better visibility of patients waiting to be reviewed.

Delivery of Safe and Effective Care:

Risk Management:

- Compliance with risk management was inadequate; risk assessments for falls and Visual Infusion Phlebitis (VIP) were not completed in a timely manner.
- Prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to patients.

Resuscitation Equipment Checks:

- The process for checking resuscitation equipment was not robust; records were incomplete, and expired single-use medical equipment was found.

Infection Prevention and Control:

- While appropriate processes were in place, staff occasionally failed to remove PPE when leaving infection areas, posing a risk of cross-infection.

Medicines Management:

- The health board's medicine management policy was not reviewed in a timely manner.
- Controlled drug stock checks were not routinely completed, and expired medications were found in the paediatric and majors departments.

Quality of Management and Leadership:

Staffing Levels and Support:

- Nurse staffing levels had improved, with less reliance on agency staff.
- Staff retention had improved, and new staff were supported appropriately.

Training and Development:

- A training and development program was in place, supported by a practice development nurse.
- Compliance with mandatory training was good, over 85%.

Complaints Management:

- A formal process for managing complaints was in place, aligned with the NHS Wales Putting Things Right (PTR) process.

Challenges with Patient Flow:

- Ongoing challenges with patient flow and overcrowding impacted patient care and staff morale.
- Weekly meetings were held by the executive team to discuss patient waiting times and address patient flow issues.

Action Taken to Address Concerns Raised:

Risk Assessments:

- **Action Taken:** All staff were reminded of their responsibility and the importance of timely completion of risk assessments via ED and paediatrics WhatsApp groups.
- **Monitoring:** Daily audits (1-patient 1-day audits) were implemented to ensure all risk assessments and cannula bundles are completed. Concerns regarding individual nursing practice are managed in line with Health Board policies and escalated to senior nursing team.

Medicines Management:

- **Action Taken:** Staff were reminded of their responsibility and importance of undertaking daily checks, including reviewing expiry dates of all products via ED and paediatrics WhatsApp groups.
- **Monitoring:** Daily Omnicell fridge temperature reports were monitored, and reinforcement of the 'ED safety checklist' was implemented. Monthly audits of all checklists were conducted to ensure compliance.

Resuscitation Equipment Checks:

- **Action Taken:** Staff were reminded of their responsibility and importance of daily checks of resuscitation trolleys. Monthly checks were implemented to include breaking of seals and drug expiry checks.
- **Monitoring:** Daily checks by the person on ED management and monthly audits by senior nurses and heads of nursing were conducted to ensure compliance.

Expired Medical Equipment:

- **Action Taken:** Immediate removal of expired single-use medical equipment during the inspection. Staff were reminded to check expiry dates before use.
- **Monitoring:** Regular reviews of the department were conducted to ensure all products are in date, and excess equipment was removed immediately.

Patient Flow:

- **Action Taken:** Weekly meetings with the executive board to review patient flow across the Health Board and implement improvement plans. Six consultants were appointed to improve wait times and implement rapid assessment and treatment models.
- **Monitoring:** Continuous monitoring of ED performance as part of Welsh Government Enhanced Monitoring. Development of further pathways for Same Day Emergency Care (SDEC).

Pain Assessment and Analgesia:

- **Action Taken:** Staff were reminded of their responsibility and importance of timely pain assessments and provision of analgesia. Rapid Assessment Nursing teams were deployed to ensure ongoing pain assessments.
- **Monitoring:** Daily audits and Dignity and Essential Care Inspections (DECI) were conducted to ensure compliance.

Clinical Oversight:

- **Action Taken:** Improved monitoring of the waiting area with video cameras and a team of nurses overseeing this area. New waiting room construction to provide better patient visibility.
- **Monitoring:** Regular spot checks by senior nurses and heads of nursing to ensure patient safety.

Staff Wellbeing:

- **Action Taken:** Regular staff wellbeing sessions were provided. Senior management staff were made visible daily in the department to address staff concerns.
- **Monitoring:** Staff feedback was collected through QR codes, and weekly meetings were held to review submissions and provide responses.

Training and Development:

- **Action Taken:** A training and development program was in place, supported by a practice development nurse. Staff induction and educational days reinforced the importance of accurate documentation and risk assessments.
- **Monitoring:** Compliance with mandatory training was monitored, and efforts were made to ensure all staff received annual appraisals.

Governance and Leadership:

- **Action Taken:** Strengthened governance processes to monitor action progress and ensure improvements are sustained. Regular updates and assurance on improvement plans are presented to senior management and divisional management teams.

Outstanding Actions:

Recommendation	Action	Original Due Date	Comments/Updates
The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.	Review of Flow Centre Pathways to ensure patients go to the right place first time.	31/3/2025	There is wider work being commissioned in the Flow Centre to develop a Single Point of Access. As part of this piece of work pathways of care will be reviewed.
The health board should develop a process where patients in the waiting area are regularly monitored, and patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.	New waiting room currently being built will provide improved patient visibility and availability of clinical space	30/5/2025	All patients are triaged and if falls risk to be moved an appropriate area in the department where a falls assessment will be undertaken New waiting room being built which will increase visibility but also provide an improved

Recommendation	Action	Original Due Date	Comments/Updates
			clinical area to manage the patient demand
The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.	Wellbeing assistant role to support waiting room	31/3/2025	New waiting room being built which will increase visibility but also provide an improved clinical area to manage the patient demand
The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Review of area to assess ability to make an assessment area ligature free	31/12/2024	Cubicle 16 has been assigned as the ligature free room. A "change of use form" has been completed via ABB Accommodation - awaiting outcome.
The health board must ensure the medicines management policy is reviewed and approved in a timely manner.	Medicines management policy is being reviewed.	28/2/2025	Review date extended while under review, as agreed with Chair of CSPG Medicines Management Policy Code of Practice
The health board must ensure that controlled drug checks are completed in all areas of the emergency department.	Regular monitoring of improvement plan via Patient, Quality, Safety, Learning & Improvement Forum (PQSLI)	1/4/2025	Update to be provided to PQSLI in April 2025 – ongoing
The health board must consider the staff comments and seek feedback more widely from ED staff and consider how improvements can be made in the interest of both patients and staff.	Formal Nurse Staffing Levels Assessment to be completed annually in line with the NSWLA	1/3/2025	Deep dives are undertaken twice a year. Going forward these will be formally presented to EDON/DDON

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the report.
- **NOTE** that 95% of the actions have been completed.
- **NOTE** the requirement to focus on monitoring the actions from the improvement plan.

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):	Governance, Leadership and Accountability 2. Safe Care 5.1 Timely Access 7.1 Workforce

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

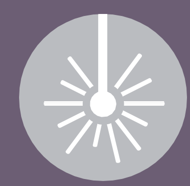
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	N/A
• **Service Activity & Performance**	Not Applicable
• **Financial**	N/A
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.

Hospital Inspection Report (Unannounced)

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

Inspection date: 02 to 04 October 2024
Publication date: 15 January 2025



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

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

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

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

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

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1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at The Emergency Department at the Grange Hospital, Aneurin Bevan University Health Board on 02 and 04 October 2024. The following hospital wards were reviewed during this inspection:

- Emergency Department (ED)- providing emergency medicine services to adults and paediatrics
- Majors – 16 beds
- Resuscitation – 8 beds
- Paediatric ED – 16 beds
- Medical Assessment Unit – 7 beds for respiratory isolation

Our team, for the inspection comprised of two HIW senior healthcare inspectors, three clinical peer reviewers and one patient experience reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 11 questionnaires were completed by patients or their carers and 61 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff were working hard under highly challenging conditions. We saw staff treating patients in a polite, professional and dignified manner. However, their efforts were often hindered by the number and high acuity of patients attending the department, and issues with the flow of patients into wards throughout the hospital.

There was overcrowding within the waiting room and reception desk area, resulting in lack of privacy and dignity for patients sharing and discussing confidential information. In addition, staff did not have good oversight of this area and risk assessments had not always been completed. We found that not all patients in the waiting area received timely analgesia where required.

Patients we spoke to, and survey respondents expressed significant dissatisfaction with waiting times. Only half felt they were assessed within 30 minutes of arrival. The department was experiencing high escalation status, and extended waiting times due to volume patients. Capacity was being managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability. This system-wide issue affected the discharge process, with 350 to 400 patients awaiting discharge across the health board.

Whilst the issues highlighted above remain an issue impacting on patient safety, experience and dignity, there has been some improvement since our previous inspection in 2022. This includes initiatives implemented to improve patient triage times. Building work was also underway for an extended waiting area, which is due for completion in spring 2025. This will provide more seating for ambulant patients, and staff are confident this will help improve the patient experience and will enable better visibility of those waiting to be reviewed.

Delivery of Safe and Effective Care

Overall summary:
There were significant challenges with patient flow through the department. On the whole, this was attributed to delays with discharging patients from other areas of the hospital. This meant the department was overcrowded, thus impacting on patient care. This should be regarded in the context of national pressures on emergency departments and is not unique to the Grange University Hospital.

Overall, compliance with risk management was not always adequate. We found several examples to determine this, and some areas were replicated to that found during our inspection in 2022. Consequently, we addressed some of these issues through our immediate assurance process.

Our patient record review found that risk assessments had not always been completed for patients where applicable, particularly for people at risk of falling. In addition, we found prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to some patients, yet there was no mitigation in place to help prevent this. Whilst patients waiting on ambulances appeared to have timely assessments for skin pressure points, within the department, risk assessments were not routinely undertaken or completed in a timely manner.

The process for checking resuscitation equipment was not robust in all areas of the department, and we found that records to indicate whether safety checks of the equipment were undertaken, were incomplete. This finding however is not unique to the Grange University Hospital.

It was positive to find appropriate processes in place to manage infection prevention and control, however we saw staff on several occasions, not removing PPE when they left an area of infection. This posed a risk for cross infection to other areas of the department.

The process in place for safeguarding was supported by the Wales Safeguarding Procedures, and staff demonstrated an appropriate knowledge of safeguarding children and adults, the deprivation of liberty safeguards, and mental capacity.

We found that processes for medicines management were not robust including the timely review of the health board’s medicine management policy. In addition, staff had not always completed daily controlled drug stock checks in line with policy.

Since our last inspection, initiatives were implemented to help improve the patient triage process, which included a new patient use eTriage system, with four digital stations based within the waiting area. Additionally, the level of communication between staff within the ED was appropriate and this was an improvement on the findings during the previous inspection.

Overall, staff were generally making the best use of available resources, such as medical equipment, supplies, and staff time, to maximize the benefit to patients, however the demands on the unit and overcrowding in the department, made this difficult to sustain.

Immediate assurances:

- Risk assessments for falls and Visual Infusion Phlebitis (VIP) were not completed in a timely manner
- Medicine management and administration of medicines was not robust to maintain patient safety
- Resuscitation equipment checks were not consistently completed
- We were not assured that all aspects of care were being delivered in a safe and effective manner and found that staff had failed to act on results of investigations
- Expired single use medical equipment was found.

Quality of Management and Leadership

Overall summary:

We found that maintaining nurse staffing levels was less challenging than that found during the previous inspection, and there was significantly less reliance on agency staff to fill vacancies or absences. We were told staff retention had improved and there was a focus on ensuring new staff were supported appropriately. Despite the department being very busy throughout our inspection, staff appeared to be coping well with the pressures and were mostly attentive and responsive to patient needs.

There was a training and development program in place for all staff, and this was supported by a practice development nurse. Processes were in place to identify staff training needs and help identify areas needing improvement. In addition, a staff induction pathway and Journey of Excellence process was in place, which new staff follow to ensure they gain all necessary competencies to work in the ED. Furthermore, compliance with the completion of mandatory training was good, over 85%.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were provided with information about current complaints and actions taken to resolve them.

The service is currently in Level 3 of the NHS Wales escalation and intervention arrangements, and staff explained their focus on improving the 12 hour waiting times in the department, and lost ambulance hours as they are held outside the ED. In addition, staff described the weekly meetings held by the executive team to discuss data on patient waiting times and meeting Welsh Government targets relating to addressing patient flow through the department and wider hospital.

We found good examples of partnership working between various staff disciplines, and professions from other departments, including pharmacy, occupational therapy and physiotherapy.

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

3. What we found

Quality of Patient Experience

Patient Feedback

Throughout our inspection we engaged with patients, and also received 11 responses to our patient survey. Responses were mixed and waiting times, and the waiting areas were noted as the most negative responses. Most respondents rated the service as 'very good' or 'good'.

We received some positive comments about the service, and others on how it could be improved. These included:

> *"Amazing service and care by the team."*
>
> *"I was very impressed by service provided since my time spent here as I've heard a few stories, but I cannot fault staff here today."*
>
> *"It was evident that the waiting area was inadequate for the numbers there. At one stage I was sure that the numbers present exceeded the safe capacity from a fire regulation viewpoint plus there was only one exit accessible which also served as an entrance. As a retired clinician I understand the ranking of patients need to be seen in turn has to be governed by the extent and or seriousness of their presenting conditions. There was no clock in the waiting room and there was no system to work out when I might be seen. This was somewhat frustrating for me and for others waiting. Healthcare is and always will be complex and it was clear that many of those there were desirous of some tangible system to know when they might be seen. I know that is asking a lot as the clinical ranking to be seen can change depending on what arrives at A&E during any waiting period but it would have been better to have some idea than none. Apart from that I can only state that the clinical handling, from triage, to diagnosis and treatment and to discharge was first class and all the staff are a credit to NHS Wales. The staff were wonderful despite working under very overwhelming patient numbers."*

Person-centred

Health promotion

Health related information was available in various parts of the department, many of which were bilingual. Information on sepsis was also displayed throughout the department.

We saw good interactions between staff and patients with staff attending to patients' needs in a discreet and professional manner. We saw staff spending time with patients and offering patients advice on how to improve and maintain their health and encouraging and supporting them to do things for themselves to maintain their independence.

Dignified and respectful care

We saw staff treating patients with dignity and respect, and confidentiality was maintained, as much as a crowded environment allowed. Most patients we spoke with reported positive interactions with staff and were generally happy with their care.

Whilst staff were striving to maintain the privacy and dignity of patients who were awaiting further assessment or treatment, this was clearly more difficult to achieve for patients who were waiting on chairs in the corridor area. However, staff were mindful of the need to maintain patient privacy and dignity and endeavoured to move them into more appropriate areas of the department when personal care was required.

There was overcrowding within the waiting room and reception desk area, resulting in lack of privacy and dignity for patients sharing and discussing confidential information. In the majors' section, fit to sit chairs have been introduced, and consequently, patients are sitting closer together, which impacts on their privacy and dignity. This was due to limited space as a result of overcrowding and lack of patient flow. We did not witness any overcrowding in the paediatric department.

Building work was underway for an extended waiting area, and we were told the expected completion date was spring 2025. This will provide more seating for ambulant patients, therefore helping to improve their experience, and will also enable staff to have better visibility of those waiting to be reviewed. We were told that the existing waiting room will be used for a rapid assessment and treatment zone (RATZ), with the aim to increase flow through the department.

We found areas of the department that were well decorated and appropriate for their intended use, for example the artwork within the paediatric area and the décor of the relatives' room.

We were told that staff in the paediatric ED have worked closely with the charity 'make a wish', and charitable funds have been used to build a shared bereavement room with Adult ED, which also has a viewing room, where families can see their loved one following their passing in a more appropriate environment.

The paediatric ED staff have also liaised with the charity '4Louis', which has donated bereavement packs for parents and siblings, for use when a child has passed away. They have also developed miscarriage packs for women and their families, including a specific one for those of Muslim faith. This was implemented following patient feedback and demonstrates learning and improvement from patients.

Individualised care
We reviewed a sample of patient records and found clinician entries were recorded on a multidisciplinary basis. Within the records we found examples where improvements were needed in the planning and delivery of care. This is discussed further later in the report.

Timely

Timely care

During our inspection, patients and survey respondents expressed significant dissatisfaction with waiting times. Only half felt they were assessed within 30 minutes of arrival, while many received treatment within four hours. However, some reported waiting over 12 hours, which negatively impacted their experience and safety.

Several comments highlighted the frustration with waiting times, which includes:

> "My mother spent 12 hours sat on a chair, with no observations during that time and was a suspected heart attack. She had no food or drink offered during that time. She never saw a member of staff. When she was finally seen she was admitted to another chair, where she spent another 12 hours. It was like a zoo in the Grange. I am embarrassed to work for the NHS."

> "Bad points were the amount of time waiting for a bed."

> "There was no sitting or standing room, and ambulances outside all had patients in - so although I had suspected heart attack, I decided after 12 hours to leave and drive to a different hospital. It was my decision as if I was going to keel over, I wasn't doing it there. Wales [is] going backwards."

Upon our evening arrival, the department was experiencing high escalation status, meaning it was experiencing a significant level of crowding and operational pressure. This resulted in overcrowded waiting areas and extended waiting times due to a high number of patients. Capacity was managed by site managers and the nurse in charge, but patient flow was challenging due to limited ward bed availability. This system-wide issue affected the discharge process, with 350 to 400 patients awaiting discharge across the health board.

Patients in the majors and ambulatory areas had experienced extensive waiting times. Patients we spoke with had been sat in chairs for approximately 18 hours whilst awaiting admission to a ward bed. It was disappointing to see that some of these were frail elderly patients who required assistance for personal care. When required, they were transferred to a dedicated cubicle to receive personal care.

The waiting area was cluttered, untidy, and unclean, further impacting patient experience. A screen intended to display waiting times was not always operational, leaving patients uncertain about their waiting time to be reviewed. Overcrowding was evident, with patients standing and some waiting outside. One patient reported waiting since eight o'clock that morning.

Significant challenges in patient flow persisted, often beyond the control of ED staff, primarily due to delays in discharging patients from other hospital areas. These delays were caused by patients awaiting further support, such as rehabilitation, care packages, or placements in other facilities. Some patients spent over 48 hours in the department, which is not equipped to accommodate them for such extended periods.

Whilst the issues highlighted above remain an issue impacting on patient safety, experience and dignity, there has been some improvement since our previous inspection in 2022. The health board remains aware of these challenges and continues to explore different initiatives to improve flow within the hospital.

Not all patients in the waiting area received timely analgesia, and those with long waits were not routinely followed up with pain scores and repeat analgesia. We were therefore not assured that all patients receive timely pain assessment and analgesia, and efforts to improve patient flow must continue.

The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.

The health board must develop a process where patients within the waiting room receive a pain assessment and analgesia if required.

An initiative to improve triage target times was implemented. Patients with time critical and high-risk conditions were being escalated promptly and moved to more appropriate areas within the ED for treatment. We were also told that there were good working relationships between the ED and ambulance staff in managing patient care. To manage timely triage of new patients and to address the backlog of patients waiting, more staff resource is deployed to reduce waiting times to meet the 15-minute target. This initiative has at times seen a reduction in triage time from 30 to 17 minutes. Staff endeavour to reducing triage times further to meet the 15-minute target.

Patients waiting in ambulances were well cared for, with ED staff providing care in the ambulance when needed. Patients were also taken off ambulances into the department to start treatment then returned to the ambulance. However, ambulance crew told us that diesel exhaust fumes and keeping patients warm during long waits were an issue.

Ambulance unloading times and the ability of ambulance crews to respond to patients in the community was negatively affecting the ED front door presentations. This meant that many clinically unwell patients were making their own way to the department.

When constructing the Grange Hospital, the ED was not designed for walk in patients, consequently leading to inadequate waiting areas and patient monitoring issues. There was a CCTV camera in place and the monitor screen was in the ambulatory area, however, it was difficult to determine the condition of the patient from a monitor, posing a risk that a deterioration in someone's condition may be unseen by clinical staff.

The health board should develop a robust process where patients in the waiting area are regularly monitored, in addition, that patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.

We were told that patients referred by GPs were directly admitted to a specialty service, such as the Medical Assessment Unit or Surgical Assessment Unit. This reduces the burden on ED staff and assists with the issues of overcrowding and patient flow through the department.

The ED is piloting e-triage, with self-triage screens located in reception, though privacy concerns were noted with the risk others nearby able to see the screen. Staff explained that a privacy screen was in place preventing others from reading the screen.

Equitable

Communication and language

We did not observe staff communicating in Welsh; however, we saw that Welsh speaking staff were identified by the 'Iaith Gwaith' symbol on their uniform. We were told that a language line was also used to provide translation services in other languages when required. Staff in the ED could also provide patient information in easy read format, large text and Welsh language.

Within our staff survey, most felt they always explain to patients what they were doing and listened to patients and answered their questions.

To support patient navigation through the department, a flow diagram was in place in the waiting area.

Rights and Equality

We saw that staff were striving to provide care in a way that promoted and protected people's rights regardless of their gender or background. This is aligned to Welsh Governments approach to deliver good quality patient-focused care in EDs.

Welsh Government's quality statement for EDs emphasises providing the right care, in the right place, at the right time, and staff endeavoured to do this to the best of their ability, in a high-pressure environment.

Delivery of Safe and Effective Care

Safe

Risk management

Overall, compliance with risk management was inadequate. We found several examples to determine this, which are highlighted throughout this section of the report.

Prolonged sitting on hard chairs in the waiting room posed a risk of skin pressure damage to frail or elderly patients, yet there was no mitigation in place to help prevent this.

Our patient record review found that risk assessments had not always been completed for patients at risk of falling, and for those with an intravenous cannula. This was dealt with through our immediate assurance process.

In addition, risk assessments had not been completed in the rooms used to assess mental health patients, to identify potential risks to both patient and staff safety.

The health board must ensure staff are adequately supported to identify potential risks to patient and staff safety and complete a risk assessment where applicable.

As highlighted earlier, the layout of the department resulted in inadequate oversight of the waiting area. Staff relied on reception personnel to alert them to any issues or unwell patients, with clinical staff's visibility limited to a CCTV screen in the ambulatory area.

Throughout our inspection there was insufficient oversight for patients in the waiting room and discussed this with clinical staff, recommending the presence of staff to maintain patient safety. We were informed that staff had not been assigned to the waiting room to assess patients to maintain staff wellbeing. Whilst we acknowledge the importance of staff wellbeing, we suggested that staff work in pairs, if necessary, to help minimise their anxieties. It is important to ensure that patient monitoring and safety is maintained.

The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.

We identified safety risks within the paediatric department. Notably, we found that staff had left a flask of hot water in the patient kitchen, within reach of patients, posing a risk to young children. This issue was escalated to the

management team, and the flask was subsequently relocated to a safer area during our inspection. We also found baby formula in unlocked cupboards, which were at risk of cross contamination or being tampered with by the public.

We accessed a dirty utility room (sluice room), which was unlocked and was therefore accessible to the public. Within this room there was an unknown substance in an unlabelled bottle, possibly a cleaning product, and tubs of bleach tablets. This was escalated to senior management and both items were removed and locked away.

The health board must ensure that all COSHH equipment is stored safely in a locked cabinet as stated in the COSHH regulations.

We noted there was no ligature free assessment space, toilet or wash facility within the paediatric ED and no risk assessment had been completed for this.

The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.

We reviewed the process for checking resuscitation equipment within the resuscitation area, paediatric department and major's department. We found that the records to indicate whether the emergency equipment and defibrillator had been checked, had not been completed on multiple occasions. This was dealt with through our immediate assurance process.

The department operated a 'red release' protocol, which means a space is maintained to offload a patient from an ambulance in the event of a community emergency, negating a need to release an ambulance immediately. Due to overcrowding within the department, we found that this was not always available.

Infection, prevention and control and decontamination
The hospital had a dedicated infection prevention and control (IPC) team, and the ED had an IPC link nurse.

We saw evidence that regular hand washing audits were completed and the high scores indicated good compliance with hand hygiene. Staff are provided with updates relating to IPC by leaders and feedback from audits are provided during handovers.

We saw staff adhering to unform policy, and clinical areas were visibly clean and generally free from clutter. The department had its own domestic cleaning team, who were present during our visit.

Individual cubicles were available for isolating infected patients where required, including a negative pressure room. There are also seven beds staffed by ED nurses within the Respiratory Assessment Zone (RAZ) within the Medical Assessment Unit for those requiring respiratory isolation. This is to minimise the risk of airborne transmission of infection, such as for those with COVID 19, Flu or other respiratory infections.

Personal Protective Equipment (PPE) was available in all areas however, we saw staff on several occasions, not removing PPE when they left an area of infection. This posed a risk for cross infection to other areas of the department.

The health board must ensure staff use and remove PPE appropriately to prevent the spread of infection.

Safeguarding of children and adults

The staff we spoke with demonstrated a satisfactory knowledge of safeguarding children and adults, and for the deprivation of liberty safeguards and mental capacity.

We found robust safeguarding procedures in place for referral, escalation and follow up of safeguarding concerns. This was supported by the Wales Safeguarding Procedures. We were shown staff training compliance records for safeguarding and found these to be appropriate.

Blood management

Staff described the process of safe blood product transfusion, which in the health board is a two registered nurse process, and a clear protocol was in place to support this. We were told that staff complete blood transfusion competency training before they are permitted to administer blood products, and the department held a register of competent staff.

Management of medical devices and equipment

Staff had access to a range of medical devices and equipment, to manage the needs of patients. The equipment appeared clean and was in good condition.

There were robust systems in place to ensure that medical devices and equipment were being regularly serviced and maintained to ensure they were safe to use.

Medicines management

We reviewed the health board medicines management policy and found its review date had expired.

The health board must ensure the medicines management policy is reviewed and approved in a timely manner.

We reviewed records for Controlled Drugs and saw that records were not routinely completed in all areas of the ED. This related to drug stock balance checks in line with the health board's policy. These checks had been missed in the majors and RAZ areas.

The health board must ensure that controlled drug stock checks are completed in all areas of the emergency department.

We found expired medication in the paediatric and majors departments. We escalated this to the nurse in charge and the medications were disposed of immediately. We were also not assured that regular stock checks are undertaken to identify medicines with near expiry dates. This may pose a risk to safety if administered to patients. This was dealt with through our Immediate Assurance process.

There were four designated pharmacists that covered the department, and support was available out of hours if required. This included suitable arrangements for accessing medicines that were not in stock.

We witnessed two occasions when medication was administered and not signed for on the prescription chart. This highlighted the risk that medication could be administered twice and potentially overdose the patient.

The health board must ensure staff sign the medication record promptly after administering medication, to avoid overdose or drug errors.

We found the process for medication fridge temperature checks was not robust to ensure messages regarding out-of-range temperatures was acted on promptly. We were told an email was sent to the nurse in charge if the temperature is out of range. However, staff said that messages are not always checked due to the nurse in charge providing clinical support. Therefore, we were not assured that the system was robust and efficient to ensure temperature-controlled medication was being stored appropriately.

The health board must ensure a robust process is in place to report issues with medication fridge temperatures to ensure these can be addressed promptly.

For those we checked, we found all patients had an identification band in place. However, allergy bands were not always worn by patients with known allergies, neither were falls risk bands worn where applicable.

The health board must ensure that allergy bands and falls risk bands are placed on patients where applicable.

Preventing pressure and tissue damage
We found that skin pressure area risk assessments were not undertaken routinely or in a timely manner. On review of patient records, we found that initial completion of a risk assessment was not always done and rechecks were not recorded. When rechecks were recorded, this was usually longer than advised by the risk identifiers. We also found that where a patient's risk assessment score was high, pressure relieving mattresses or cushions were not used in a timely manner. This exposed patients to risk of skin pressure damage.

Patients arriving by ambulance received a skin inspection on triage and the triage nurse had the responsibility to reassess the patient as indicated by the Waterlow. Regular skin inspections were performed, and Datix incident reports were made if a patient had an existing pressure area, or developed one during their care in ED. However, for older adult patients sitting on hard chairs in the waiting room, we were not assured they were receiving regular pressure relief or skin inspections. We were told that often, triage nurses are too busy managing triage wait times, to enable them to regularly check patients in the waiting room. We identified at least one elderly patient who had been in the waiting room overnight and had not received a skin inspection.

The health board must ensure that patients in the waiting room are assessed for their risk of pressure damage and re-evaluated as indicated by the risk assessment.

Falls prevention
Falls risks assessments were not routinely undertaken for patients where appropriate to do so. We found an example where a patient had been admitted following a fall at home, but staff had not completed a falls risk assessment. This patient subsequently suffered a fall in the department. This was addressed through our immediate assurance process.

Staff we spoke to lacked understanding and knowledge regarding the correct way to complete falls documentation. We found that risks assessments that had been completed were not always acted upon. We were later told that the documentation was new and training on these had not been carried out by all staff at the time of our inspection.
We were told the frailty team, physiotherapists and occupational therapists supported ED staff in caring for patients identified as being at risk of falls.

Effective

Effective care

Senior staff described the department's initiatives to develop and improve the service provided to patients. This included a new eTriage system in place, as highlighted earlier, where patients can self-triage using one of four digital stations based within the waiting area.

We found clinical pathways in place for stroke, ST Elevation Myocardial Infarction (STEMI) and neck of femur fracture, additionally, the hospital had ring fenced beds to support patients with these emergencies. Paramedics also had pre-hospital pathways in use, for vascular, trauma and cardiac issues, and can divert patients to regional centres if required.

Nutrition and hydration

Patients could access food and drink when needed, and in general, the nutrition and hydration needs of patients were being met within the department, however, our inspection found this was not consistent in the waiting area. This included meeting the needs of patients who were waiting on board ambulances. Patients who required assistance with eating and drinking were seen to be supported by staff and the Red Cross volunteers.

Patient records

We reviewed a sample of nine patient care records and generally found these to be organised and easy to navigate. Handwritten records were found to be legible. However, as highlighted earlier in the report, risk assessments were not routinely completed or reviewed.

Efficient

Efficient

Hospital meetings were held throughout the day to discuss patient flow, where an overview of the department was discussed, including ambulance delays, patients awaiting ward beds and concerns regarding acuity. Whole site meetings were held every two hours during the day. These were usually attended by the nurse in charge of the ED, however, staff felt that it was difficult at times to implement the patient flow actions set at the meetings, due to the frequency of meetings.

We found an appropriate level of communication between staff within the ED, which included the sharing of patient information during shift handover, and details of the actions to help achieve patient flow. This was an improvement on the previous inspection. However, as highlighted earlier, staff were not always ensuring that patients were receiving timely care or treatment based on test

results or presenting condition, which was impacted by the volume of patients throughout the department.

Staff were generally making the best use of available resources, such as medical equipment, supplies, and staff time, to maximize the benefit to patients, however the demands on the unit and overcrowding in the department, made this difficult to maintain.

Quality of Management and Leadership

Staff feedback

HIW issued a staff questionnaire to obtain their views and their experiences of working in the ED. In total, we received 61 responses; all but one respondent said they are permanently based in the department.

Staff responses were generally negative, with most comments relating to staffing issues throughout the department, and patient flow impacting on the ability to care for patients in a timely manner. Less than half the respondents felt satisfied with the quality of care and support they give to patients, and even less felt they would be happy with the standard of care provided by the hospital for themselves, or their friends and family. Just over half said they would recommend their organisation as a place to work (32/58).

Staff comments highlighted several key issues within the emergency department. This included overcrowding, long wait times, and the lack of appropriate clinical spaces, collaboratively compromising patient safety and care quality. Staff also sited poor communication and support from senior management, which was leading to low staff morale and burnout.

Despite the issues highlighted by staff, they generally described themselves as hardworking and dedicated, and were striving to provide the best care possible under difficult circumstances.

Staff suggestions for improvement included better management of patient flow, increased staffing, and more support from senior leadership staff.

Some comments we received were concerning, and include the following:

> *"Whilst I believe that teams on the ground are working very hard and keep patient safety paramount, the overall department is frequently unsafe due to capacity issues. The department itself is well equipped and fit for purpose but every trolley is filled with patients waiting for beds which means the ED area is not used correctly and we cannot assess our emergency patients in a suitable environment. This means that we cannot move patients out of Resus and so critically unwell patients are managed in inappropriate clinical areas eg triage and ambulances. Patients who should be being assessed on the trolleys are having to sit in the waiting room. This means that they are uncomfortable, their care is delayed as they are having to move in and out of spaces for assessments, investigations and treatments. And so whilst I am confident in the skills of staff and the*

overall level of care being provided, the environment in which we are having to deliver this care is not acceptable. If the emergency department could operate as an emergency department and every trolley was available for emergency assessment and care the facility would be incredible...”

“The Department itself is very new, spacious and generally well designed. The ongoing issue is that we are always massively over-capacity and forced to treat patients in inappropriate and unsafe areas (e.g. decontamination room, back of an ambulance, corridors). We often have elderly patients sitting >12 hours in the waiting room or on chairs within the Dept...”

“It is too small to cope with the amount of people that attend. This encumbers effective patient flow through the department. Minor injury departments should be on-site which will help with timely referrals of patients requiring alternative treatments, instead of them then having to travel miles to be treated more appropriately and /or quickly than in the ED setting, and vice versa when they attend a minor injury unit only to be told they have to travel further to attend ED. This would also rotate clinical staff more effectively, keeping skills maintained instead of them being lost because of insular treatment areas.”

The health board must consider the staff comments and seek feedback more widely form ED staff and consider how improvements can be made in the interest of both patients and staff.

Leadership

Governance and leadership
Despite the staff feedback relating to senior leaders and managers highlighted above, in general, we found the leadership and oversight within the ED was appropriate. It was evident that the ED leadership team was striving to improve the service, but the key issue relating to overcrowding was beyond their control, given the wider patient flow issues across the hospital.

Dring the inspection, staff responded positively when presented with areas requiring immediate action. However, several issues require ongoing work and time to implement improvements to fully reduce the risk to patients’ safety and wellbeing.

As highlighted earlier, we issued an immediate assurance letter to the health board regarding several areas where immediate improvement was required. It is concerning that some of these issues were replicated from our previous inspection

in 2022, therefore highlighting a weakness in the health board's governance processes and the ability of the department to sustain improvement.

More work is required from the health board to assure itself that staff understand what is required of them when implementing improvements. In addition, strengthening the governance processes in place is required to monitor action progress and to ensure improvements are sustained. Furthermore, robust executive oversight is needed regarding progress on improvement actions, and for the accountability of sustaining the implemented improvements. This was addressed through our immediate assurance process.

Workforce

Skilled and enabled workforce

We found that maintaining nurse staffing levels was less challenging than that found during the previous inspection, and there was significantly less reliance on agency staff to fill vacancies or absences. We were told staff retention had improved and there was a focus on ensuring new staff were supported appropriately. We were provided with the staff induction pathway and Journey of Excellence (JOE), which new staff follow to ensure they gain all necessary competencies to work in the ED.

Despite the department being very busy throughout our inspection, staff appeared to be coping well with the pressures and were mostly attentive and responsive to patient needs.

We saw regular meetings taking place and were provided with minutes from previous meetings. Processes were in place to share this information with ED staff and wider staff teams throughout the hospital. We were provided with copies of staff newsletters and Educating and Recommendations After Significant Events (ERASE) bulletins and saw these displayed in staff areas.

There was a training and development program in place for all staff, and this was supported by a practice development nurse, who was based in the ED. The practice development nurse was proactive and worked effectively to identify staff training needs and help identify areas needing improvement.

Compliance with the completion of mandatory training was good, over 85%.

We were provided with records of staff appraisals and saw that 67% of staff had received an up-to-date appraisal, processes need strengthening to improve this figure.

The health board must continue with its efforts to ensure all staff receive an annual appraisal in a timely manner.

Culture

People engagement, feedback and learning

Patients and their representatives had opportunities to provide feedback on their experience of the services provided. We saw QR codes displayed in staff and patient areas to encourage feedback.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were provided with information about current complaints and actions taken to resolve them.

Information

Information governance and digital technology

An electronic patient management and records system was in use within the ED to access patients GP records, order investigations such as blood tests and radiology and access investigation results. Staff, in general, commented positively on the system.

Learning, improvement and research

Quality improvement activities

The service is currently in Level 3 of the NHS Wales escalation and intervention arrangements, and staff explained their focus on improving the 12 hour waiting times in the department, and lost ambulance hours as they are held outside the ED. In addition, staff described the weekly meetings held by the executive team to discuss data on patient waiting times and meeting Welsh Government targets relating to addressing patient flow through the department and wider hospital.

We found formal processes in place for audit, and the reporting and escalation of issues within the ED, which were collectively driving forward quality improvement.

We were told that funding had been agreed for six ED consultant posts and a new model of rapid assessment and treatment is being planned. This aims to increase patient flow through the department, with more senior doctors reviewing patients and discharging patients as appropriate.

We were told the renovation work will be completed in the spring of 2025 with waiting room and triage room and existing waiting room becoming clinical treatment and assessment areas, bays and sitting area.

We saw evidence of staff wellbeing initiatives and leaders explained that since the service had received the status of Level 3 monitoring as highlighted above, there has been a focus on improving provisions for staff wellbeing.

Whole-systems approach

Partnership working and development

There were examples of good partnership working between various staff disciplines and professions from other departments, including pharmacy, occupational therapy and physiotherapy.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Hot water flask in paediatric area within reach of children.	Risk of scalds or burns.	Escalated to the nurse in charge.	Flask removed to a safe place not accessible to children.

Appendix B - Immediate improvement plan

Service: The Grange University Hospital Emergency Department (ED)

Date of inspection: 02 to 04 October 2024

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

Findings 1.
We looked at a sample of patient records and found that the risk assessments for patient falls and Visible Infusion Phlebitis (VIP) had not been undertaken in a timely manner.

- We found that some patients had been in the department for over 24 hours and were at risk of falling however a falls risk assessment had not been completed.
- We found examples where VIP risk assessment had not been completed.

Incomplete risk assessments pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action		Responsible officer	Timescale
1.	The health board must ensure that measures are in place to ensure risk assessments for both Falls and Visible Infusion Phlebitis (VIP) are completed promptly, to maintain patient safety.	Safe Care and Timely Care	1.	All staff have been reminded of their responsibility and the importance of timely completion of risk assessments via ED and paediatrics What's app groups	Senior Nurse	Actioned Immediately & Ongoing
			2.	HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed

		3.	ED Staff induction and educational days reinforce the importance of accurate nursing documentation. Also covered in corporate induction	Practice Educators & Senior Nurse	Actioned Immediately & Ongoing Next corporate induction November 2024
		4.	1-patient 1-day audits ensuring all risk assessments and cannula bundles are completed daily by person on ED management. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Actioned Immediately & Ongoing
		5.	Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Actioned Immediately & Ongoing
		6.	All learning to be shared with nursing staff at the time. Any concerns regarding individual	ED Management Team Daily / Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing

		nursing practice to be managed in line with Health Board policies and escalated to senior nursing team		
		7. Monitor MFRA compliance via 1-patient 1-day audits and DECIs. Improvements and learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Senior Nurse / ED Management Team / QPS Leads	Actioned Immediately & Ongoing
		8. Senior Nurse and Head of Nursing to undertake weekly spot checks of patients records and also undertake monthly DECI's	Senior Nurse / Head of Nursing	Weekly / Monthly
		9. ED falls poster shared across Division and is displayed within ED, to raise awareness of risk assessment interventions	QPS Lead / ED Sister Responsible for Falls Improvement work	Actioned Immediately & Ongoing
		10. ERASE bulletin on Cannula bundles developed and shared via email with ED team	Senior Nurse / QPS Team / ED Admin support	Actioned Immediately
		11. All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed

		12. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		13. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		14. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		15. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
		16. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
		17. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 2.
HIW is not assured that the management and administration of medicines is robust to maintain patient safety.

- We found examples of expired medication within the paediatric emergency department and in the resuscitation department
- We checked the medication fridges in all areas of the department and found that daily temperature checks were not recorded on multiple occasions
- We found examples on the controlled drugs register where the stock and medication checks had not been completed on a daily basis, in line with the health boards policy.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The health board must ensure that medication stock is checked, and any items where 'use by' dates have expired are disposed of appropriately. The health board ensure medication fridge temperature checks are completed regularly. The health board ensure controlled drugs stocks are checked and recorded daily.	Safe and Effective Care	18. All Staff have been reminded of their responsibility and importance of undertaking daily checks and that these checks include reviewing expiry dates of all products via ED and paediatrics What's app groups	Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing
			19. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
			20. Daily Omnicell fridge temperature report already in place for Majors and Resuscitation - emailed daily to ED Senior Nurse and Band 7 team. This is now in place in paediatrics and monitored	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing

		21. Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		22. The paediatric department has implemented a new allocation checklist to monitor completion of resuscitation trolley checklist and checking all drugs are in date	ED Band 7 Paediatric Lead	October 2024
		23. ERASE bulletin to raise awareness of CD checks, storage and disposal in development with wider Divisional and Pharmacy colleagues	QPS Lead	December 2024
		24. Senior Nurse and Head of Nursing will undertake monthly audits of all checklists to ensure compliance	Senior Nurse / Head of Nursing	Monthly
		25. All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed
		26. Improvement plan along with updates on actions will be presented to the ED Senior	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly

		Management Team (SMT) meeting and Divisional Management Team (DMT)		
		27. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		28. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		29. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
		30. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
		31. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 3.
HIW was not assured that all risks to health and safety were managed appropriately.

- We reviewed the resuscitation equipment checking process and records for the resuscitation department, paediatric emergency department and major's department and found that the emergency equipment trolley and defibrillator checks had not been recorded on multiple occasions.

- This meant that we could not be assured that the resuscitation equipment was being regularly checked to ensure that all required items were available and that they were safe to use in an emergency.

These pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The health board must ensure that checks of resuscitation equipment are undertaken and recorded on a regular basis in line with health board policy.	Safe and Effective care	32. All staff have been reminded of their responsibility and the importance of daily checks of the resuscitation trolleys. The person on ED management will check each morning that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	Senior Nurse / Head of Nursing / ED Band 7 Team	Actioned Immediately & Ongoing
			33. Monthly resuscitation trolley checks, as per ABUHB protocol, to be undertaken to include breaking of seal, and drug expiry check. The person on ED management will check the first day of each month that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing

		34. Reinforcement of ‘ED safety checklist’ which ensures safety checks are completed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing
		35. Internal Alert regarding the importance of resuscitation trolley checks to be added to the Health Board’s intranet carousel	Senior Nurse for Resuscitation Services	Completed
		36. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
		37. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		38. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		39. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		40. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025

		41. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

Findings 4.

HIW was not assured that all aspects of care were being delivered in a safe and effective manner.

- We looked at one patient's care notes and found that results of investigations were not acted on in a timely manner.
- We found an example of deterioration in a patient's condition due to the delay in commencing appropriate treatment.
- We were not assured that staff were appropriately monitoring the patient in a timely manner.

These can increase risk to patient safety.

Improvement needed		Standard/ Regulation	Service action		Responsible officer	Timescale
4.	The health board must ensure results of blood tests and investigations are reviewed and action is taken promptly to avoid delays in necessary treatment.	Safe and Effective care	42.	There is continued work across the Health Board to improve the flow of patients through the ED to ensure patients are cared for in the appropriate environments	Head of Operations	Actioned Immediately & Ongoing
			43.	Any delays to treatment due to system flow to be escalated to the Emergency Physician in Charge (EPIC) and Operations team to support flow	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Actioned Immediately & Ongoing
			44.	Any concerns regarding patient care and treatment to be escalated at the time to the speciality and the most senior clinician responsible and if required a Datix to be completed and appropriate actions undertaken	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Actioned Immediately & Ongoing
			45.	All referred patients in ED to be reviewed daily with a clear medical plan and appropriate reviews undertaken	Clinical Director's for Specialties	Actioned Immediately & Ongoing
			46.	If at handover medical plans or nursing care/assessments have not been implemented then reasons for this need to be identified and if required a Datix completed with appropriate investigation and outcomes	Senior Nurse / Clinical Director	Actioned Immediately & Ongoing
			47.	Staff induction and educational days reinforce the importance of ensuring	Senior Nurse / Practice Educators	Actioned Immediately & Ongoing

			clinical concerns are escalated timely as part of various clinical sessions and scenarios		
		48.	ERASE bulletin on the importance of checking bloods tests developed and will be shared across ED and wider Divisional teams	QPS Lead	December 2024 for ED
		49.	All ERASE bulletins printed and displayed in the ED	Senior Nurse / Head of Nursing	Completed
		50.	HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed
		51.	Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		52.	Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		53.	Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		54.	Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Head of Nursing / Divisional Nurse	January 2025
		55.	ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

			56. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

Findings 5.

HIW was not assured that the stock of single use medical equipment was being checked. This posed a risk to patient safety.

- We found examples of expired single use medical equipment within the paediatric emergency department and in the resuscitation department, such as male external urinary sheaths and some equipment from a 'Can't Intubate Can't Oxygenate (CICO)' pack which included a Cuffed Oral Endotracheal Tube (COETT), 5ml syringe and Rapi-fit Connector.

  These issues pose a risk to patient safety.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The health board must ensure that the stock of single use medical equipment is monitored and any items where 'use by' dates have expired, are disposed of appropriately.	Safe and Effective care	57. The grab bag was immediately removed from use during the HIW inspection	Senior Nurse / Head of Nursing	Actioned Immediately & Ongoing
			58. All staff will check expiry dates of equipment prior to use. This will be included in November's Nursing News	Senior Nurse	November 2024
			59. Several reviews of the department have been undertaken to ensure all products are in date / any excess equipment removed from use immediately	Senior Nurse / ED Band 7 Team	Actioned Immediately & Ongoing

		Action	Responsible	Timescale
		60. All staff have been reminded of their responsibility and the importance of daily checks of the resuscitation trolleys. The person on ED management will check each morning that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		61. Monthly resuscitation trolley checks, as per ABUHB protocol, to be undertaken to include breaking of seal, and drug expiry check. The person on ED management will check the first day of each month that all checks have been completed. Any concerns regarding consistent checking need to be escalated to senior nurse and appropriate actions put in place	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		62. Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Actioned Immediately & Ongoing
		63. Senior Nurse and Head of Nursing will undertake monthly audits of all checklists to ensure compliance	Senior Nurse / Head of Nursing	Monthly
		64. HIW Immediate Assurance Nursing News shared with staff	Senior Nurse	Completed

		65. Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
		66. Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
		67. Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
		68. Updates to be provided at Health Board Patient Quality and Safety Learning Improvement Forum	Executive Director of Nursing	January 2025
		69. ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
		70. Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

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

Service representative:

Name (print): Chris Morgan

Job role: Divisional Nurse - Urgent Care

Date: 20 November 2024

Appendix C - Improvement plan

Service: The Grange University Hospital Emergency Department (ED)

Date of inspection: 2 to 4 October 2024

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

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
1	There remains to be significant challenges in the flow of patients through the department.	The health board must maintain the efforts to improve patient flow through the department and across the wider hospital.	Timely care	1)	Ongoing - 24/4 to reduce congestion in ED and minimise crew delays (0 Patients >24hrs in ED & 0 Crews > 4hrs)	General Manager Urgent Care / Director of Operations	Completed /Ongoing
				2)	Continued monitoring of ED performance as part of Welsh Government Enhanced Monitoring	General Manager Urgent Care / Director of Operations	Completed/ Ongoing
				3)	Weekly meetings in place with members of the executive board to review patient flow across the Health Board & Implement improvement plans	Director of Operations	Completed/ Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			4) The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times	Clinical Director for Emergency Medicine	Completed / Ongoing
			5) X6 Consultants appointed to improve Wait to be Seen Time and look to implement early Rapid Assessment / Stream to Alternative pathways	Clinical Director for Emergency Medicine	Completed / Ongoing
			6) Review of Flow Centre Pathways to ensure patients go to the right place first time	Divisional Director Urgent Care / Medical Director	March 2025
			7) Development of further pathways for Same Day Emergency Care (SDEC)	Divisional Directors for Urgent Care / Medicine & Surgery	Completed / Ongoing
			8) Continued work with WAST to reduce conveyance rates and	Associate Director for Patient	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
					utilise alternative pathways to ED	Transportation Services	
				9)	Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
2	We found that patients in the waiting area had not had a pain score assessment and had not been given analgesia.	The health board must develop a process where patients within the waiting room receive a pain score assessment and analgesia if required.	Timely care	10)	All staff have been reminded of their responsibility and importance of timely pain assessments and provision of analgesia (via PGD or prescription)	Senior Nurse / Clinical Director	Completed / Ongoing
				11)	All patients are assessed at triage and where required analgesia provided	Band 7 Team / Senior Nurse	Completed / Ongoing
				12)	Rapid Assessment Nursing team to ensure all patients receive ongoing pain assessments and analgesia. Escalate to medical staff where required	Band 7 Team / Senior Nurse	Completed / Ongoing
				13)	1-patient 1-day audits ensuring all risk assessments are completed daily by person on	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			ED management/ Majors Lead. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			14) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			15) CIVICA data shared with wider teams	Senior Nurse / Head of Nursing	Completed and Monthly
			16) All referred patients to be moved to the respective assessment areas at the point of referral	Operations Team	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				17) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
				18) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing
				19) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				20) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
3	There was poor oversight of the waiting area and unwell patients	The health board should develop a process where patients in the	Timely care	21) All staff have been reminded of their responsibility and importance of timely risk assessments	Senior Nurse	Immediately & Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
were not regularly monitored or risk assessed.	waiting area are regularly monitored, and patients perceived to be more at risk of falls or developing pressure areas should be appropriately risk assessed.		22) All patients will be assessed at triage for falls risk and developing pressure areas and will be escalated to the NIC to try and find an appropriate clinical area within the main ED	Band 7 Team / Senior Nurse	Ongoing
			23) Rapid Assessment Nursing team to ensure all patients receive ongoing falls monitoring / Pressure Area Management	Band 7 Team / Senior Nurse	Completed / Ongoing
			24) Patients identified at triage to be a falls risk or potential deterioration in pressure areas to be prioritised for a space in the ED whilst balancing other clinical risks	Nurse in Charge / EPIC / Operations team	Completed / Ongoing
			25) Nurse in Charge (NIC) to escalate all clinical concerns to the operations team and the Emergency Physician in Charge (EPIC) of ED	Nurse in Charge / EPIC	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			26) All referred patients to be moved to the respective assessment areas at the point of referral	Operations Team	Completed / Ongoing
			27) ED Staff induction and educational days will reinforce the importance of accurate nursing documentation including risk assessments. Also covered in corporate induction	Practice Educators & Senior Nurse	Immediately & Ongoing
			28) 1-patient 1-day audits ensuring all risk assessments are completed daily by person on ED management or major's lead. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			29) Dignity and Essential Care Inspections (DECI) in place. All	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			30) All learning to be shared with nursing staff at the time. Any concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse / Head of Nursing	Immediately & Ongoing
			31) Monitor MFRA compliance via 1-patient 1-day audits and DECIs. Improvements and learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Senior Nurse / ED Management Team / QPS Leads	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			32) Senior Nurse and Head of Nursing to undertake weekly spot checks of patients records and undertake monthly DECI's	Senior Nurse / Head of Nursing	Completed Weekly / Monthly
			33) Continue to monitor Datix for potential learning opportunities	Senior Nurse / Head of Nursing	Completed / Ongoing
			34) New waiting room currently being built will provide improved patient visibility and availability of clinical space	Urgent Care Triumvirate	May 2025
			35) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			36) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				37) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				38) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
4	Risk assessments had not been completed in the rooms used to assess mental health patients, to identify potential risks to both patient and staff safety.	The health board must ensure staff are adequately supported to identify potential risks to patient and staff safety and complete a risk assessment where applicable.	Risk Management	39) Management of CAMHS and adult Mental Health patients is on departmental risk register	Divisional Management Team	Completed / Ongoing
				40) Patients will be assessed at the point of triage for any potential mental health concerns and then supported in an assessment room with direct vision of nursing staff and all risks removed	Band 7 Team / Senior Nurse	Completed / Ongoing
				41) If required enhanced staffing put in place based on clinical need and risk	Band 7 Team / NIC / Senior Nurse for ED or Paediatrics	Completed / Ongoing
				42) Crisis liaison service available 24/7 with CAMHS support	Crisis Liaison service	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				43) Mental Health & Deliberate Self harm Triage Assessment tool in development	Divisional Director / Senior Nurse	Feb 2025
5	We found that staff did not have an appropriate view of patients in the waiting area which meant patient safety was at risk.	The health board must consider how clinical oversight of the waiting area can be improved to maintain patient safety.	Risk management	44) Waiting room is currently monitored via a series of video cameras with a team of nurses overseeing this area	Nurse in Charge / EPIC	Completed / Ongoing
				45) X3 RN's & 2 HCSW's are assigned to oversee the waiting room along with an ECG technician. 46) X4 RN's & 1 HCSW also work in triage and these staff also support the waiting room	Nurse in Charge / Senior Nurse	Completed / Ongoing
				47) Catering staff provide a trolley service x3 times a day - tea/coffee/toast/ lunch / dinner and sandwiches also available on request	Facilities	Completed / Ongoing
				48) Red Cross provide support to the waiting room along with hospital volunteers	Nurse in Charge / Senior Nurse	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			49) Wellbeing assistant role to support waiting room	Executive Director of Nursing	March 2025
			50) All patients at clinical risk to be highlighted to the NIC or EPIC and moved to another area of the ED	Emergency Physician in Charge (EPIC) / ED Nurse in Charge	Completed / Ongoing
			51) New waiting room currently under construction will provide improved patient visibility	Urgent Care Triumvirate	May 2025
			52) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			53) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			54) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly

	Risk/finding/issue	Improvement needed	Standard / Regulation		Service action	Responsible officer	Timescale
6	We found COSHH equipment in areas that were accessible to patients and visitors which posed a threat to their safety.	The health board must ensure that all COSHH equipment is stored safely in a locked cabinet as stated in the COSHH regulations.	Risk management	55)	All COSHH equipment to be stored in cabinets within appropriate clinical areas	Senior Nurse / ED Band 7 Team	Completed / Ongoing
				56)	Sluices to be reviewed by Infection Prevention and Control (IP&C) & Works & Estates (W&E) to see if Locks or swipe card access is appropriate	IP&C & W&E	Dec 2024
7	We noted there was no ligature free assessment space, toilet or wash facility within the paediatric ED and no risk assessment had been completed for this.	The health board must ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Risk management	57)	Management of CAMHS and adult Mental Health patients is on departmental risk register	Divisional Management Team	Completed / Ongoing
				58)	Patients will be assessed at the point of triage for any potential mental health concerns and then supported in an assessment room with direct vision of the nurse's station and all risks removed	Paeds team / Band 7 Team / Senior Nurse	Completed / Ongoing
				59)	If required enhanced staffing put in place based on clinical need and risk	Band 7 Team / NIC / Senior Nurse for ED or Paediatrics	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				60) Crisis liaison service available 24/7 with CAMHS support	Crisis Liaison service	Completed / Ongoing
				61) Mental Health & Deliberate Self harm Triage Assessment tool in development	Divisional Director / Senior Nurse	Feb 2025
				62) Review of area to assess ability to make an assessment area ligature free	Estates Manager / Senior Nurse	Dec 2024
				63) This action will be reported through the Patient Quality Safety and Oversight Committee	Executive Director of Nursing	Quarterly
8	We witnessed staff failing to remove PPE when they left an area of infection which can cause infection to spread.	The health board must ensure staff use and remove PPE appropriately to prevent the spread of infection.	Infection, prevention and control and decontamination	63) All staff have been reminded of the correct process for using PPE	ED Band 7 Team / Senior Nurse	Completed / Ongoing
				64) IP&C spot check of Respiratory Assessment Area	IP&C Nurses	Completed / Ongoing
				65) Senior Nurse and Head of Nursing to undertake daily spot checks	Senior Nurse / Head of Nursing	Completed / Ongoing
9	We reviewed the health boards medicines management policy	The health board must ensure the medicines management policy is	Medicines management	66) Medicines management policy is being reviewed	Lead Pharmacist	Review date extended to Feb 2025 while under

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action		Responsible officer	Timescale
	and found this had not been recently reviewed.	reviewed and approved in a timely manner.					review, as agreed with Chair of CSPG Medicines Management Policy Code of Practice
10	We inspected records for Controlled Drugs and saw that records were not routinely completed in all areas of the ED. We saw controlled drug checks had been missed in the majors and Respiratory Assessment Zone (RAZ) areas.	The health board must ensure that controlled drug checks are completed in all areas of the emergency department.	Medicines management	67)	All Staff have been reminded of their responsibility and importance of undertaking daily checks	ED Band 7 Team / Senior Nurse / Head of Nursing	Immediately & Ongoing
				68)	Reinforcement of 'ED safety checklist' which ensures safety checks are completed daily by Nurse in Charge or ED area leads. This includes the requirement for appropriate CD checks as per ABUHB policy. This will be checked daily by person on ED management	ED Band 7 Team / Senior Nurse	Immediately & Ongoing
				69)	Improvement plan along with updates on actions will be presented to the ED Senior	Senior Nurse / Head of Nursing /	SMT Monthly / DMT Quarterly

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			Management Team (SMT) meeting and Divisional Management Team (DMT)	Divisional Nurse	
			70) Updates / Assurance on Improvement plan to form part of QPS agenda in Divisional Assurance with Chief Operating Officer	Head of Nursing / Divisional Nurse	Quarterly
			71) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Mid-Year (November 2024/ End of Year (March 2025)
			72) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			73) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
			74) Regular monitoring of improvement plan via Patient,	Head of Nursing /	Quarterly

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				Quality, Safety, Learning & Improvement Forum (PQSLI)	Divisional Nurse	
11	We witnessed two occasions when medication was administered and not signed for on the prescription chart. This means there was a risk that medication could be administered twice and potentially overdose the patient.	The health board must ensure staff sign the medication record promptly after administering medication, to avoid overdose or drug errors.	Medicines management	75) All staff will administer medication in line with Health Board policy. Any staff who do not will be managed in accordance with the Health Board's Policy for Managing and Supporting Staff Following a Medication Error	Senior Nurse / Practice Educators / Head of Nursing	Completed & Ongoing
				76) Staff induction and educational days reinforce the importance of medication management	Senior Nurse / Practice Educators	Immediately & Ongoing
				77) Datix to be completed for all medication errors	ED team	Completed / Ongoing
				78) Datix is reviewed daily and appropriate actions taken	Senior Nurse / Head of Nursing / Divisional Nurse	Completed / Ongoing
				79) 1-patient 1-day audits which will check medication charts. All learning to be shared with	ED Management	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	Team Daily / Senior Nurse	
			80) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			81) QPS slides presented monthly at Divisional Assurance to the COO	Head of Nursing / Divisional Nurse	Completed / Ongoing
			82) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
12	We found the process for medication fridge temperature checks was not robust to ensure messages regarding out-of-range temperatures was acted on promptly. We were told an email was sent to the nurse in charge if the temperature is out of range. However, we were told that messages are not always checked due to the nurse in charge providing clinical support. Therefore, we	The health board must ensure a robust process is in place to report issues with medication fridge temperatures to ensure these can be addressed promptly.	Medicines management	83) Daily Omnicell fridge temperature report in place for Majors and Resuscitation - emailed daily to ED Senior Nurse and Band 7 team. This is now in place in paediatrics and monitored	ED Band 7 Team / Senior Nurse	Completed / Ongoing
				84) All temperature faults reported to pharmacy/works & estates immediately so appropriate action can be taken	NIC / Senior Nurse / Divisional Pharmacist	Completed / Ongoing
				85) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
				86) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	were not assured that the system was robust and efficient to ensure temperature-controlled medication was being stored appropriately.			87) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				88) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
13	For those we checked, we found all patients had an identification band in place. However, allergy bands were not always worn by patients with known allergies, neither were falls risk bands worn where applicable.	The health board must ensure that allergy bands and falls risk bands are placed on patients where applicable.	Medicines management	89) Allergy bands are to be placed on all patients with a known allergy and documented on their medication chart	ED Band 7 Team / Senior Nurse / Head of Nursing	Completed / Ongoing
				90) All patients identified with an allergy or a falls risk to have the required identification band	ED Band 7 Team / Senior Nurse / Head of Nursing	Completed / Ongoing
				91) 1-patient 1-day audits which will check medication charts and falls risk assessments. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be	ED Management Team Daily / Senior Nurse	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			managed in line with Health Board policies and escalated to senior nursing team		
			92) Dignity and Essential Care Inspections (DECI) in place. All learning to be shared with nursing staff at the time. Concerns regarding individual nursing practice to be managed in line with Health Board policies and escalated to senior nursing team	ED Management Team Daily / Senior Nurse	Completed / Ongoing
			93) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			94) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Completed / Ongoing

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				95) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
				96) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
14	There was no assurance that elderly patients sitting in the waiting room had regular skin inspections.	The health board must ensure that patients in the waiting room are assessed for their risk of pressure damage and re-evaluated as indicated by the risk assessment.	Preventing pressure and tissue damage	97) Please refer to actions in Point 3	Please refer to Point 3	Please refer to Point 3
15	Staff responses to the online survey were mixed with some staff critical of staffing levels and patient flow.	The health board must consider the staff comments and seek feedback more widely from ED staff and consider how improvements can be	Staff feedback	98) Bi-annual review of ED staffing in place	Senior Nurse / Head of Nursing / Divisional Nurse	Completed / Ongoing
				99) Regular staff wellbeing sessions provided	Clinical Director /	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
	made in the interest of both patients and staff.			Senior Nursing / Divisional Management Team	
			100) Senior nursing, medical and Divisional management staff are visible daily in department so staff can raise concerns	Divisional Triumvirate Senior Nurse / Clinical Director / Head of Nursing / Divisional Management team	Completed / Ongoing
			101) Staff QR code in place for staff to raise concerns or ideas (this can be done anonymously). Weekly meeting in place to review submissions and provide staff with a response	Divisional Triumvirate Senior Nurse / Clinical Director / Head of Nursing / Divisional Management team	Completed / Ongoing

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
			102) Improvement plan along with updates on actions will be presented to the ED Senior Management Team (SMT) meeting and Divisional Management Team (DMT)	Senior Nurse / Head of Nursing / Divisional Nurse	SMT Monthly / DMT Quarterly
			103) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Head of Nursing / Divisional Nurse	Ongoing
			104) ED to work towards unit accreditation as part of the Health Board ward/ team accreditation process	Executive Director of Nursing	March 2025
			105) Regular monitoring of improvement plan via Patient Quality Safety Outcome Committee	Executive Director of Nursing	Quarterly
			106) Formal Nurse Staffing Levels Assessment to be completed annually in line with the NSWLA	Executive Director of Nursing	Annually

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				107) EDoN and Deputy EDoN visits with the Divisional Nurse	Executive Director of Nursing (EDoN)	Quarterly
16	Appraisal compliance rates were 67% meaning a significant number of staff had not received an appraisal within the last year.	The health board must continue with efforts to ensure all staff receive an appraisal.	Workforce	108) Monthly reports provided by workforce and reviewed at Senior Management Team (SMT) and Divisional Management Team (DMT) - 109) Improvement plan developed and in place	Band 7 team / Senior Nurse / Head of Nursing / Divisional Nurse / SMT / DMT	Completed / Ongoing
				110) PADR data presented monthly at Divisional Assurance with COO	Triumvirate team	Completed / Ongoing
				111) Updates / Assurance on Improvement plan to form part of QPS agenda in Mid-Year/ End of Year presentation with executives	Divisional Nurse/ Triumvirate Team	Completed / Ongoing

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

Service representative

Name (print):	Chris Morgan
Job role:	Divisional Nurse
Date:	12 December 2024

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	31 March 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Healthcare Inspectorate Wales Annual Report 2023/24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson – Deputy Director of Nursing

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Healthcare Inspectorate Wales (HIW) Annual Report 2023-24 highlights several key findings and areas of concern regarding the quality and safety of healthcare services across Wales. This report includes data from inspections, surveys, and reviews conducted during the year. It is crucial for Aneurin Bevan University Health Board to address these findings to ensure the highest standards of patient care and safety.

Cefndir / Background

Inspections and Surveys:

HIW conducted 172 onsite inspections across various healthcare settings, including hospitals, GP practices, dental practices, and independent healthcare providers.

A total of 2,319 staff surveys were completed, providing insights into the experiences and perspectives of healthcare workers.

HIW gathered feedback from 5,924 individuals through surveys, helping to understand the experiences of patients, families, carers, and the public.

Engagement and Collaboration:
HIW emphasised the importance of listening to those who use and work in health care services to gain a better understanding of what matters to people. This was achieved through patient experience surveys, in-person conversations during onsite visits, and social media engagement. HIW used social media channels and targeted newsletters to raise awareness and obtain further insights. The public-facing website received 255,000 views during the reporting period, with social media content driving click-through rates to key informative pages. HIW issued quarterly Insight bulletins to over 7,000 subscribers, summarising their work and sharing themes and learning emerging from their assurance activities. A Stakeholder Advisory Group, comprising a wide range of organisations representing people with protected characteristics, provided valuable insights to inform HIW's work. The group's membership grew during the year and influenced how HIW gathered patient feedback and designed their work.
Public Awareness:
Public awareness of HIW increased significantly, rising from 27% in 2018 to 51% in 2023. This was achieved through various channels, including TV, radio, online platforms and word of mouth. By increasing awareness and visibility, HIW aimed to foster trust and transparency, reassuring the public that care standards are being effectively monitored and driving accountability among healthcare providers.
Collaboration with other Organisations
HIW collaborated with Care Inspectorate Wales (CIW) to publish a joint strategic statement of intent focusing on EDI. This joint strategy aimed to reduce inequalities across services and improve the quality and safety of health care and social care services in Wales. HIW hosted two Health Care Summits in May and November 2023, involving partners from health care inspection, regulation, audit, assurance, and improvement bodies. The summits provided a forum for sharing intelligence on the quality and safety of health care services provided by NHS Wales.

Asesiad / Assessment

Workforce Shortages

Significant staffing shortages in maternity services are leading to increased stress among the workforce and potential safety issues. This shortage impacts the ability to provide consistent and high-quality care to patients.

There are ongoing challenges in recruiting and retaining General Practitioners (GPs), which affects the availability of primary care services. This shortage leads to increased workloads for existing staff and longer waiting times for patients.

Primary Care Access

Patients are experiencing considerable difficulties in accessing GP appointments, including challenges in contacting GPs by telephone. This issue is exacerbated by the high demand for services and the limited availability of appointments.

Similar challenges are faced in accessing dental care appointments, with patients reporting long waiting times and difficulties in securing timely appointments.

Urgent Care

There are significant concerns around long waiting times and overcrowding within Emergency Departments. These issues are driven by system-wide pressures, including patients attending Emergency Departments due to difficulties in accessing GP services.

The bottleneck at the point of discharge leads to unnecessarily long stays in hospitals, which impacts patient flow and overall staff wellbeing. This situation also affects ambulance response times and the quality of care in Emergency Departments.

Planned Care

Despite some improvements in performance figures for planned care, many patients still face very long waits for outpatient appointments and cancer treatments. This delay affects the timely delivery of care and treatment for patients.

Maternity and Neonatal Care

The shortage of staff in maternity and neonatal care is a significant concern, impacting the quality of care and patient safety. There is also a lack of compliance with mandatory training requirements, which further affects the standard of care provided.

Key concerns include the need for improved communication with patients, better support for women seeking sanctuary, and enhanced systems for those whose first language is not English.
Health Care Associated Infections (HCAIs)
Some Health Boards have reported increasing rates of HCAIs. There is a need for better compliance with infection control protocols and more rigorous monitoring of infection rates to ensure patient safety.
Mental Health Services
Long waiting times for Child and Adolescent Mental Health Services (CAMHS) are a significant concern. Young people are facing delays in accessing their first appointment and subsequent support or treatment. There are challenges in transitioning children from child to adult mental health services, which can lead to gaps in care and support during this critical period.
Neurodevelopmental Assessments
There are long waits for children and families waiting for assessments for conditions such as Autism and Attention Deficit Hyperactivity Disorder (ADHD). These delays impact the timely diagnosis and support for children with neurodevelopmental conditions.
Patient Flow and Stroke Pathway
Patient Flow Challenges: The National Review of Patient Flow highlighted the impact of patient flow challenges on the quality and safety of patient care, particularly in the stroke pathway. High demand for inpatient beds and complexities in discharging medically fit patients contribute to these challenges. **Stroke Pathway:** The review found that delayed discharges lead to longer hospital stays, increasing the risk of hospital-acquired infections and deterioration while awaiting discharge. This bottleneck affects emergency departments, ambulance response times, and overall staff wellbeing.
Deprivation of Liberty Safeguards (DoLS):
The joint review of DoLS identified long delays in allocating, assessing, and authorising applications. Many urgent authorisations expire before the required DoLS assessments can be undertaken. There is a need for local authorities and health boards to review their procedures for urgent authorisations to ensure timely assessments.

Child Protection Arrangements:
The Joint Rapid Review of Child Protection Arrangements highlighted the need for improved structures and processes to ensure children's safety. Recommendations were made to health care providers and multi-agency partnerships to enhance child protection measures. The review recommended the development of a centralised, accessible IT system to capture all health information relating to children, including the location of non-digitalised records.
Maternity Services Improvement Plans:
The follow-up on the National Review of Maternity Services assessed the progress made by Health Boards in addressing the recommendations from the previous review. While some improvements were noted, further work is needed to ensure the implementation of all recommendations.

Argymhelliad / Recommendation

Heading into 2024/25, the focus will be on continuous quality improvement. The report underscores the importance of continuous monitoring and improvement to ensure the delivery of safe and effective care to all patients.

The Health Board has examined the themes of this report to ensure that our own markers for Quality, Patient, Safety, and Experience and our existing improvement plans are in line with HIW priorities.

The Patient Quality, Safety and Outcomes Committee is asked to NOTE the content of the Annual 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):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.

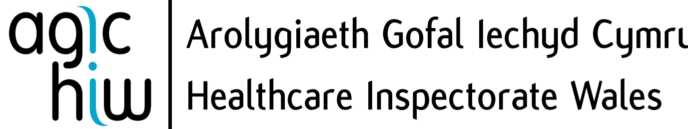
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24]()	Improve the Wellbeing and engagement of our staff Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services 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.

Annual Report

2023 - 2024



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

Our purpose

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

Our goal

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

Our values

We place people at the heart of what we do.

We have set four strategic objectives through which we deliver our goal of influencing and driving improvement in healthcare.

We will:

Focus on the quality of healthcare provided to people and communities as they access, use, and move between services.

We will:

Adapt our approach to ensure we are responsive to emerging risks to patient safety.

We will:

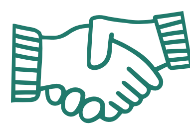
Work collaboratively to drive system and service improvement within healthcare.

We will:

Support and develop our workforce to enable them, and the organisation, to deliver our priorities.

What we do

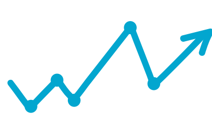
We inspect NHS services in Wales. We regulate and inspect independent healthcare services in Wales



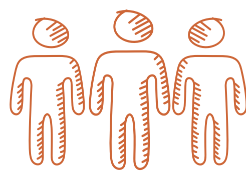
We undertake a programme of reviews to look in depth at national or more localised issues

We monitor concerns and safeguarding referrals

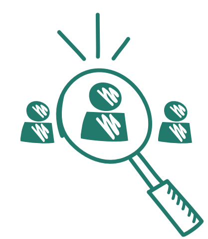
We take regulatory action to ensure registered independent healthcare services meet legislative requirements



We recommend improvements, immediate and longer term, to NHS services and independent healthcare services



We have a team of 87 staff who work for us, across Wales, supporting our functions and undertaking our assurance work



We have a team of specialist peer reviewers who we continually recruit to provide specialist, up to date knowledge about services and quality standards

We have specialists in Mental Health Act administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service

We have a panel of Patient Experience Reviewers and Experts by Experience to capture the voice of patients out on inspection

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01.

Foreword

Foreword

Alun Jones
Chief Executive

Each year Healthcare Inspectorate Wales (HIW) publishes an annual report setting out the key findings from the regulation, inspection, and review of healthcare services in Wales.

We seek to drive improvement by understanding the risks and challenges that are preventing services from operating effectively and impacting on the quality of care being delivered. We have continued to take an independent, balanced, and risk-based approach to our work. In delivering our assurance activity we have highlighted areas of improvement and good practice and have proactively shared key findings and themes to support and drive service improvement.

People are at the heart of everything we do, and listening to those who use and work within healthcare services across Wales remains a critical area of our work. By obtaining feedback on services, we can gather meaningful insight to better understand what matters to people. To reinforce our commitment to this area, I am pleased to say that earlier this year, in collaboration with Care Inspectorate Wales (CIW), we published a strategic statement of intent in relation equality, diversity, and inclusion (EDI). The statement is part of our commitment to developing an Equality, Diversity and Inclusion Strategy, which will ensure EDI is embedded throughout our work, helping us to understand the challenges communities face when accessing health and care services.

I am also immensely proud of the work of our newly established Stakeholder Advisory Group, which continues to provide valuable insight, reflection and direction for our work. Membership of the group is made up of a wide range of organisations which work with and represent people with protected characteristics.

The group has influenced the ways and methods by which we seek feedback from patients and has challenged us to think more critically about the way we work to further understand and embed EDI.

In a small country like Wales, collaboration with partner organisations is essential, and during this period we have led two Healthcare Summits of healthcare inspection, regulation, audit, and assurance bodies. The Summits highlighted the ongoing challenges in the Welsh healthcare system, which include workforce issues, access to services and the timeliness of care.

Overall, patients told us they were pleased with the care they received and that they valued the work and commitment of staff. Furthermore, our inspection and review work has shown a high standard of healthcare being delivered to most patients. We have also seen that innovation within the NHS, including the provision of a range of options for patients who require urgent and out of hours care, has helped the system to respond to very high demand. However, it was clear from our hospital inspections that there are times when the demand on services greatly exceeds capacity. This can lead to delays in providing urgent care and patients in Wales are often experiencing excessive delays in relation to planned care.

We acknowledge health boards in Wales continue to face challenges in the delivery of healthcare. However, it is critically important that whilst addressing their strategic and financial challenges, leaders in our health services do not lose sight of the need to provide safe, effective, and patient-centred care.

Our work has provided an insight into the impact of delays in patients being discharged from hospital in Wales. The challenges around delayed discharge are wide ranging, and unnecessarily long stays in hospital due to delayed discharge can place patients at risk. Our work within NHS hospitals has highlighted the reoccurring issue of poor patient flow, with intense daily pressures around patient admission and bed management. Within Emergency Departments across Wales, we have noted overcrowding, long waits for triage and long waits for treatment or admission into the most appropriate beds. The challenge is a complex one, especially in relation to health and social care service interaction, but our work has identified areas where settings can do more to tackle this sustained challenge.

Through our inspection and assurance work within GP practices, it was clear services are continuing to face significant pressure post-pandemic, due to practice closures, staff shortages and long hospital waiting lists for treatment.

Our national reviews have helped us to evaluate how healthcare services across Wales are delivered. Our reviews are often large scale and see us collaborating with other organisations to collectively come together, to pool our experience, insight and knowledge. Our work has focused on complexities involving some of the most vulnerable people within our communities, including investigating child protection arrangements, and how difficult medical decisions are being made in Wales such as ‘do not attempt resuscitation’ (DNACPR).

Our role in the independent healthcare sector in Wales is to register and regulate services. The independent healthcare sector encompasses a huge variety of services, from acute hospitals and mental health hospitals through to independent clinics and laser services. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry. Our work in relation to dental practices has highlighted issues around capacity and demand and how these impacts on the ability of patients to access timely care.

We place significant importance on the intelligence received from concerns and use it to drive forward and inform our inspection and assurance work. The main themes emerging from our concerns during this period were access to appointments for mental health, GP and dental care, increasing demand in emergency departments and low staffing levels.

Where we find service failings or inadequate care we will take action. Due to the severity and number of issues identified through some of our independent healthcare inspections, we have designated settings as a 'Service of Concern' in line with our Escalation and Enforcement processes. We have suspended registrations where serious failings have been identified and have investigated and instigated several criminal proceedings to ensure safe care is being delivered.

Our objectives are ambitious and through them we aim to make a difference to the people of Wales by contributing to improvements in healthcare. In this report you will find some examples of how we have used our work to further this aim.

I am proud of the organisation and our teams, as we continue to work towards our goal of being a trusted voice which influences and drives improvement in healthcare.

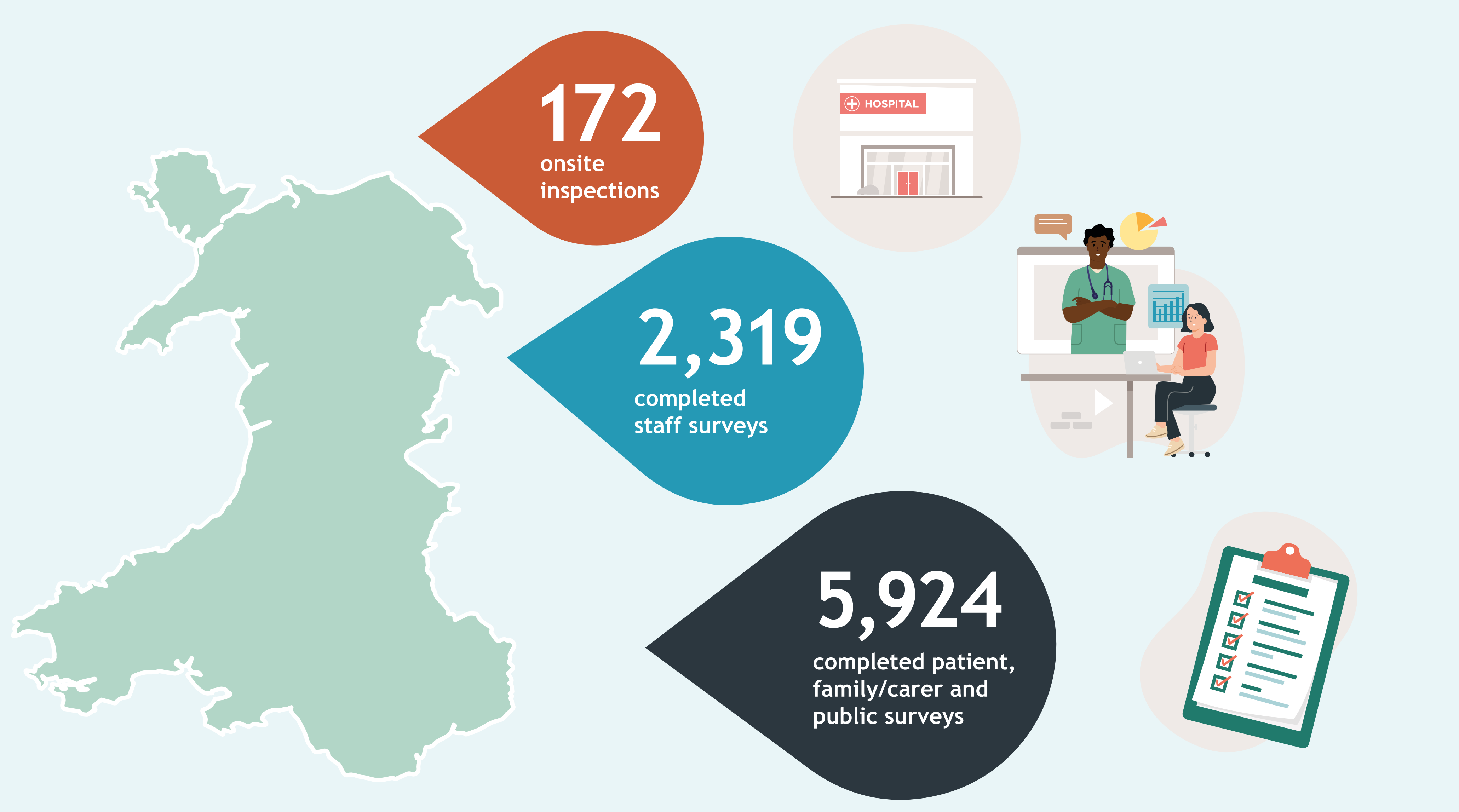
If you have any comments on this report, our work, or your experience of healthcare services in Wales, please do get in touch.

Alun Jones

02.

2023-2024 in Numbers

2023-2024 in Numbers



2023

April

- 10 inspections undertaken.

May

- 13 inspections undertaken.
- Insight Bulletin – May 2023 published.
- Joint review of child protection arrangements (JICPA) in Denbighshire.
- Published our Operational Plan.

June

- 12 inspections undertaken.
- Joint review of child protection arrangements in Wales – interim findings published.
- Vascular Services in North Wales are de-escalated as a service requiring significant improvement by HIW.

July

- 21 inspections undertaken.
- Published our Mental Health Monitoring Annual Report 2021-2022.

August

- 15 inspections undertaken.
- Equality, Diversity and Inclusion: A Statement of Strategic Intent published.

September

- 20 inspections undertaken.
- Published our National Review of Patient Flow a journey through the stroke pathway.
- Published our joint review of child protection arrangements (JICPA) in Bridgend.
- Rapid Review of Child Protection Procedures in Wales published.

October

- 18 inspections undertaken.
- HIW hosts European Partnership for Supervisory Organisations 35th Conference in the Welsh Capital.

November

- 17 inspections undertaken.

December

- 4 inspections undertaken.
- Annual Report published.

2024

January

- 14 inspections undertaken.
- Published our Mental Health Monitoring Annual Report 2022-2023.

February

- 14 inspections undertaken.
- Published our joint review of child protection arrangements (JICPA) in Powys.
- Joint Review: Deprivation of Liberty Safeguards (DoLS) published.

March

- 14 inspections undertaken.
- Insight Bulletin - March 2024 published.

03.

Engagement and Collaboration

Engagement

By listening to those who use and work in healthcare services, we can better understand what matters to people to gain greater understanding and insight.

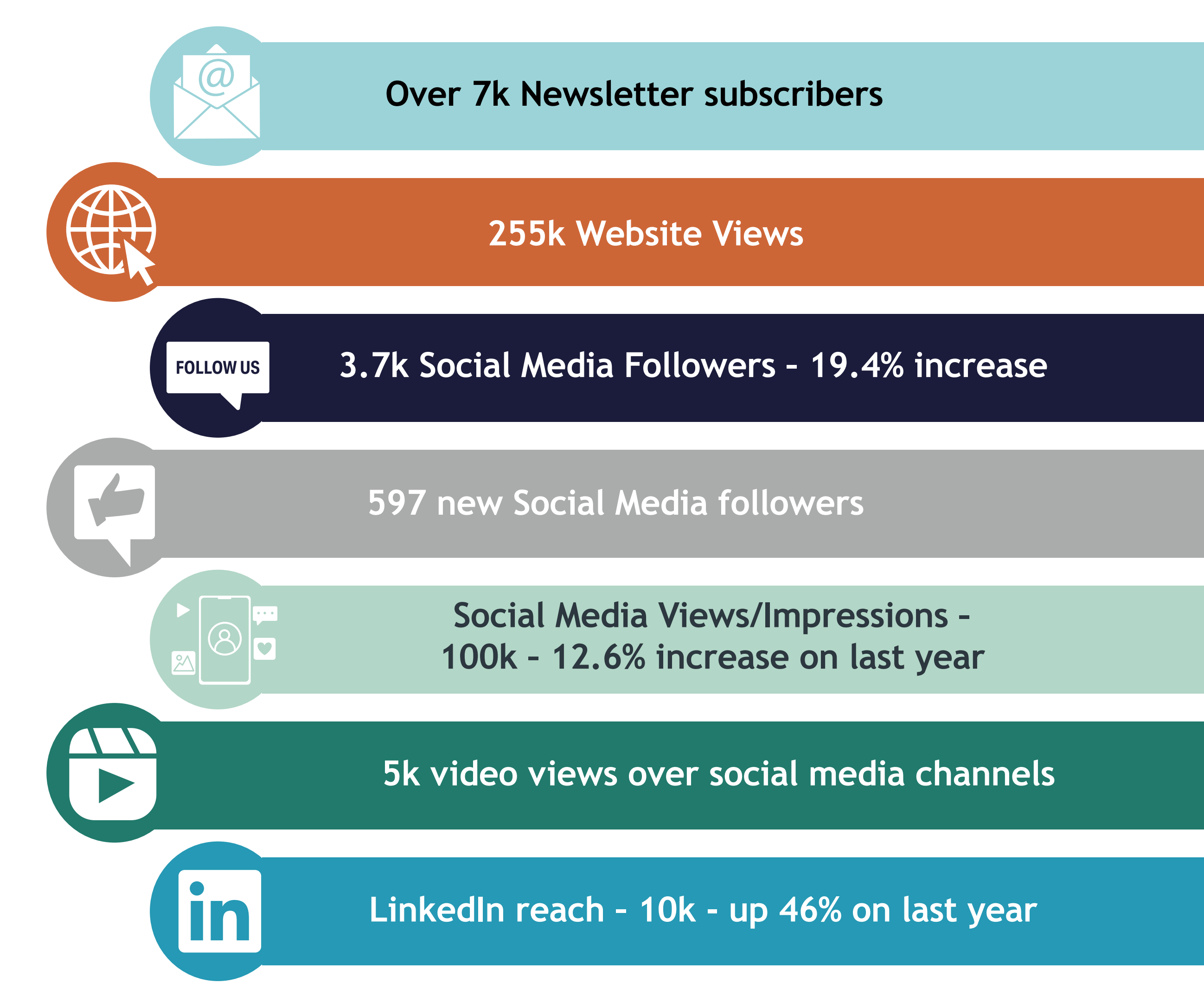
During our assurance work we ask patients to tell us about the care they receive by completing a short experience survey. When able to, we aim to speak in-person with patients during onsite visits, so that we can gather their views directly. We also regularly use our social media channels, alongside targeted newsletters, to raise awareness and obtain further insight.

Across our inspection and assurance work, 8,243 people gave us their views on the care they had received, or the service they work within. Of those responses, 7,695 related to our inspection activity, and 548 related to our review work.

In total we heard from:

- 5,856 patients
- 2,319 staff
- 68 Carers/family members

By obtaining feedback we can better understand, influence, and help drive forward improvement within healthcare services across Wales.



Proactively engaging with our stakeholders remains a priority, and our aim is to ensure engagement outcomes are reflected in our work. Engagement helps us to strengthen our partnership working, ensuring it is fully inclusive and representative. Our goal is to ensure equality, diversity, and inclusion (EDI) is embedded into the work we do, and to consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Engagement is broader and deeper than traditional consultation. It is about how we communicate, involve, listen, respond to and understand people and stakeholders. It is how we help people and conduct informed work by developing relationships to obtain insight; encouraging active participants to discuss and influence the things that matter to them.

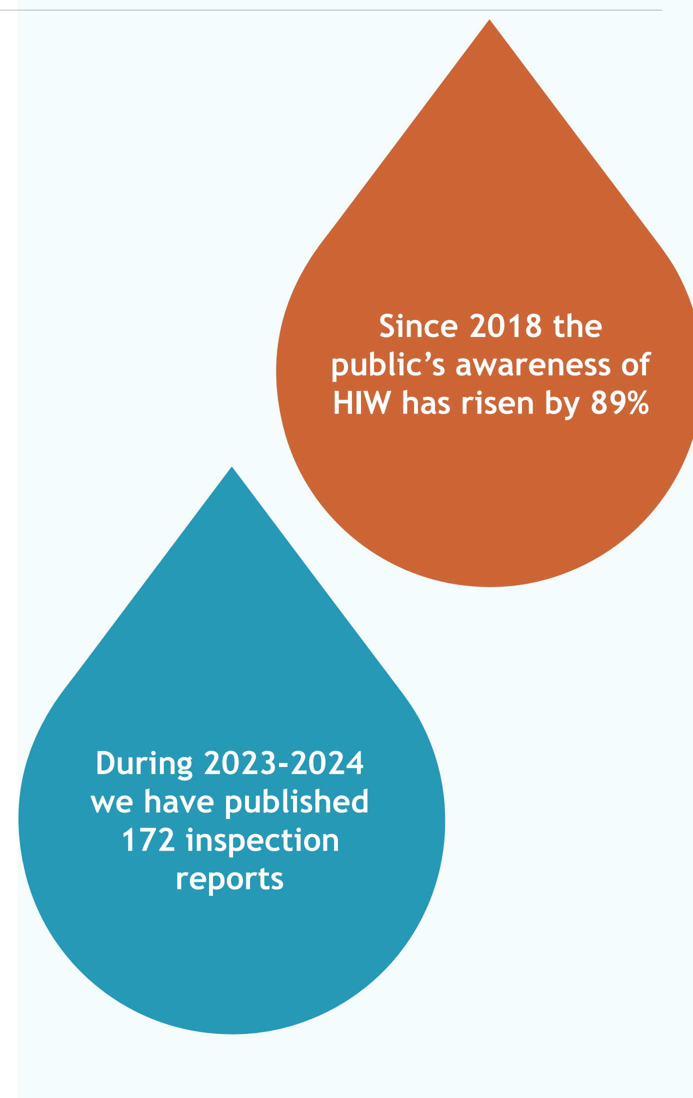
We have continued to use our social media channels to widely engage, and proactively encourage people to click through to our website, where they can find out more information about our work and role.
Our following on these channels has increased and analytics show our social media posts are reaching more people every month. Our public facing website has received 255,000 views during this period, where our social media content is driving click-through rates to key informative pages. We actively ensure our content is fully accessible by conducting regular checks, alongside developing and implementing an Accessibility Guide.

We have continued to issue our quarterly Insight bulletins, which we issue electronically to over 7000 subscribers on our mailing list. The bulletin summarises our work from the quarter and includes a Learning and Insight section, where we share themes and learning emerging from our work. We have also introduced a new Learning and Insight area of our website, where a series of themes and case studies emerging from our assurance work is shared. We believe there is significant value in sharing learning and experiences and want healthcare services to use our findings as a means of driving improvement within healthcare, in line with our purpose of 'maximising the health and wellbeing of people'.

Our Stakeholder Advisory Group continues to make a valuable contribution, providing insight to inform our work. Membership of the group is made up of a wide range of organisations which work with, and represent, people with protected characteristics. We are immensely proud of this group, and membership has grown during the year.

The group has influenced the way in which we ask patients for feedback during our work and has challenged us to think more critically about the way in which our work is both designed and delivered, so that we are able to capture as diverse a range of views as possible.

During 2023-2024 we have issued 172 inspection reports, some of which led to local and national news coverage including conducting live/pre-recorded interviews with major news providers. Through commissioning research via a national omnibus survey, we know the public's awareness of our organisation is continuing to grow.
We know that since 2018 the public's awareness of HIW has risen by 89%, from 27% to 51% in 2023. We also know that in 2023 34% people said TV or radio is how they became aware of HIW, with 17% stating online/websites, and a further 21% stating their awareness came via word of mouth. Through increasing awareness and visibility, we can foster trust and transparency, reassuring the public that care standards are being effectively monitored. It also drives accountability encouraging healthcare providers to maintain high levels of safety and quality.



Collaboration

We place considerable importance on collaboration and joint working with other organisations. The added insight and expertise we can draw on when we collaborate with others increases the impact of our work. Collaboration also helps us to work beyond the health care sector, taking a wider view of services in the way the that the public experience them.

Equality, Diversity and Inclusion: A Statement of Strategic Intent

During this period, we collaborated with Care Inspectorate Wales (CIW) to publish a joint strategic statement of intent focusing on equality, diversity, and inclusion (EDI). As the independent inspectorates and regulators of healthcare, social care, and childcare in Wales we aim to take action to improve the quality and safety of services for the well-being of the people of Wales. We came together, to pool experience and knowledge, to work on producing a joint EDI strategy which supports both organisations. The statement of intent shows our commitment to publish a joint strategy to provide new opportunities to help reduce inequalities across services.

Healthcare Summits

During 2023-2024, we hosted two Healthcare Summits, to enable discussion between key regulation and improvement bodies in Wales. The Summits, led by HIW were held in May and November 2023, and involved partners from healthcare inspection, regulation, audit, assurance, and improvement bodies. The purpose of the Summit is to provide a forum for sharing intelligence, on the quality and safety of healthcare services provided by NHS Wales.

The key issues identified from the 2023-2024 summits were:

- **Workforce:** there are significant staffing shortages in many areas, especially in maternity services leading to stress amongst the workforce and potential safety issues. There are also concerns regarding the impact on primary care services, due to problems in recruiting and retaining General Practitioners (GPs).
- **Primary Care:** there are challenges for patients accessing GP and dental care appointments. This includes the considerable difficulties patients experience when contacting GPs by telephone.
- **Unscheduled Care:** there are significant concerns around long waiting times and overcrowding within Emergency Departments, due to system wide pressures. These issues include patients attending the Emergency Department, as a result of not being able to access their GP.
- **Planned Care:** although some improvements were seen in the performance figures for planned care, many patients still face very long waits for outpatient appointments and cancer treatments.
- **Maternity and Neonatal Care:** key concerns include staff shortages and lack of compliance with mandatory training.
- **Healthcare Associated Infections (HCAIs):** for some health boards there were concerns around increasing rates of HCAIs. These are infections that patients contracted while receiving medical treatment.

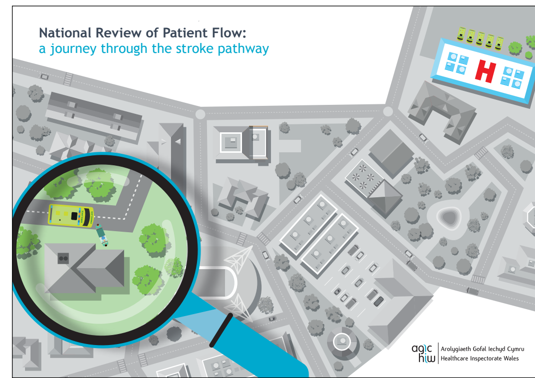
- **Child and Adolescent Mental Health Services:** there are concerns about waiting times for young people awaiting a first appointment, and any following support or treatment. There are also challenges where children transition from child to adult services.
- **Neurodevelopmental Assessments:** there are long waits for children and families waiting for an assessment for conditions such as Autism and Attention Deficit Hyperactivity Disorder (ADHD).

04.

Reviews

Reviews

All of our reviews help us to evaluate how healthcare services in Wales are delivered, and often see us collaborating with other organisations to pool our experience, insight, knowledge and regulatory powers.



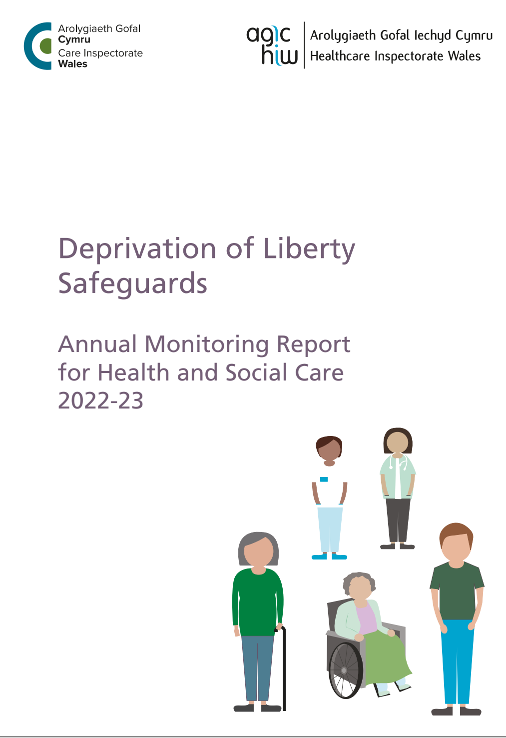
National Review of Patient Flow - A journey through the stroke pathway

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. Our national review of Patient Flow continued to explore this during 2022-2023. At a time when the NHS in Wales has continued to deal with significant pressure, staff shortages and huge demand for beds, the review explored the challenge of trying to provide timely care when resources are under such demand.

In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. National reviews are deep dive pieces of work which enable us to explore a service, care pathway, or department in depth. During the period from April 2022 to the end of March 2023, we gathered evidence about the care and treatment provided to patients on the stroke pathway across Wales, undertaking nine site visits in total. The site visits involved our review team working with health boards and the Welsh Ambulance Service Trust (WAST) and assessing the processes in place from the time an ambulance is called, through to arrival at an emergency department, admission of patients and discharge.

The review found a high demand for inpatient beds and complexities involved in discharging medically fit patients from hospitals leading to the acute hospital system in Wales operating under extreme pressure. Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections or deterioration whilst awaiting discharge. The bottleneck at the point of discharge has a knock-on impact on emergency departments, ambulance response times, inpatient care, planned admissions and overall staff wellbeing.

The full review was published in September 2023.



Joint Review: Deprivation of Liberty Safeguards (DoLS)

HIW and CIW have a joint role in monitoring the implementation of the Deprivation of Liberty Safeguards (DoLS) and our most recent monitoring report was published in February 2024.

DoLS were developed to ensure people's human rights are protected and maintained, and the care they receive is in their best interests and delivered in the least restrictive way.

The Safeguards apply to people over the age of 18 who cannot consent to treatment or care in a hospital or care home. They provide a legal framework for deprivations to prevent breaches of the European Convention on Human Rights.

The main areas for improvement included:

- There was an 18% increase in the number of DoLS applications assessed by the local authorities compared to the previous year.
- The number of DoLS applications assessed by health boards increased by 32% in 2022-23, compared to figures seen in 2021-22.
- The long delays in allocating, assessing and authorising applications continue to result in many people in Wales being deprived of their liberty, with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made.
- Many urgent authorisations expire before the required DoLS assessments can be undertaken. Some local authorities and health boards may benefit from reviewing their current procedures for urgent authorisation with managing authorities.
- Most local authorities and health boards are unable to allocate the volume of requests received for further authorisations. All supervisory bodies must ensure people's rights are protected and assessments for all applications are undertaken within stipulated number of days as set out in DoLS Code of Practice.
- The use of conditions by local authorities and health boards varies, with some regions using them more than others. Supervisory bodies should ensure conditions are used where necessary and are focussed on improving outcomes for people including reducing or removing the deprivation.

Joint Rapid Review of Child Protection Arrangements

In November 2022, in response to several tragic child deaths across Wales and England, the Welsh Government requested a multi-agency rapid review of decision making in relation to child protection. HIW contributed to this review which was undertaken jointly with CIW and Estyn.

The purpose of the review was to determine to what extent the structures and processes in place in Wales ensure children's names are appropriately placed on, and removed from, the child protection register (CPR), when sufficient evidence indicates it is safe to do so.

We engaged with four health boards which included:

- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Swansea Bay University Health Board
- Aneurin Bevan University Health Board

Following the review, recommendations were made across the multi-agency partnerships, but also specifically to healthcare providers.

These included the following:

- The Welsh Government should work alongside health boards to commission a centralised, accessible IT system that is able to capture all health information relating to children, including the location of any non-digitalised records.
- Health professionals must ensure every child has a robust assessment of their health needs, including emerging and potential health needs where there are child protection concerns. Any unmet health needs should be addressed via the care and support protection plan.
- GP practices hold key information in relation to children and their families. In line with Wales Safeguarding Procedures, they must provide a written report for all child protection conferences.

The full report was published in September 2023.

Joint Inspection of Child Protection Arrangements (JICPA)

Together with CIW, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Estyn, we conducted a joint inspection of the multi-agency response to abuse and neglect in children.

These took place in:

- January 2023: Denbighshire County Council, which sits within the boundary of Betsi Cadwaladr University Health Board
- June 2023: Bridgend County Borough Council which sits within the boundary of Cwm Taf Morgannwg University Health Board
- October 2023: Powys County Council which sits within the boundary of Powys Teaching Health Board
- January 2024: Cardiff Council which sits within the boundary of Cardiff and Vale University Health Board.

Key findings include:

It was positive to find that local authorities and partners exercised their functions under the Social Services and Well-being (Wales) Act 2014, endeavouring to make a positive contribution to the well-being and safety of children who need care and support.

Overall, systems and relationships were in place to facilitate effective partnership working where a child is at risk of abuse and neglect.

There were, however, areas of child protection which attention is required, including:

- Challenges in sharing information between relevant agencies
- Inconsistencies with the quality of care and support protection plans
- Instability with staffing levels, including an over reliance on temporary agency workers to meet statutory duties
- Inability to regularly access the child protection register (CPR) – both in and outside office hours
- Inadequate attendance at multi-agency strategy meetings to review and make effective conclusions.

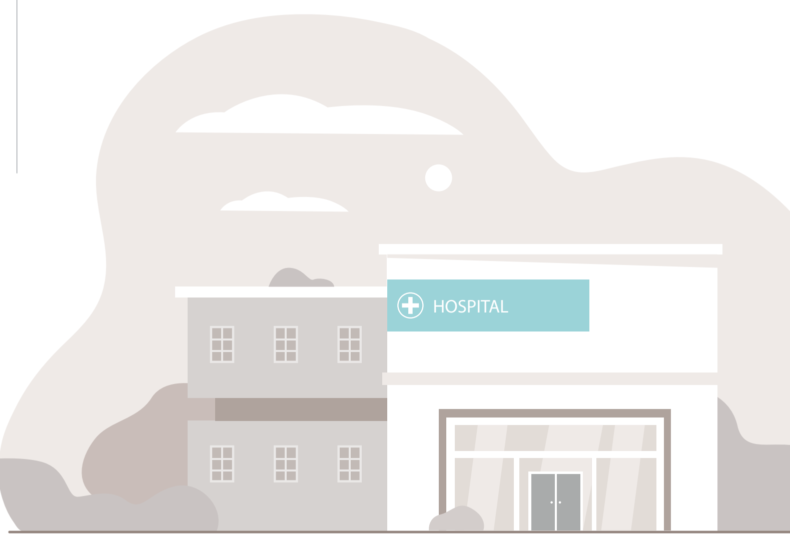
An overview report of themes arising from our JICPA work to date is set to be published in September 2024.

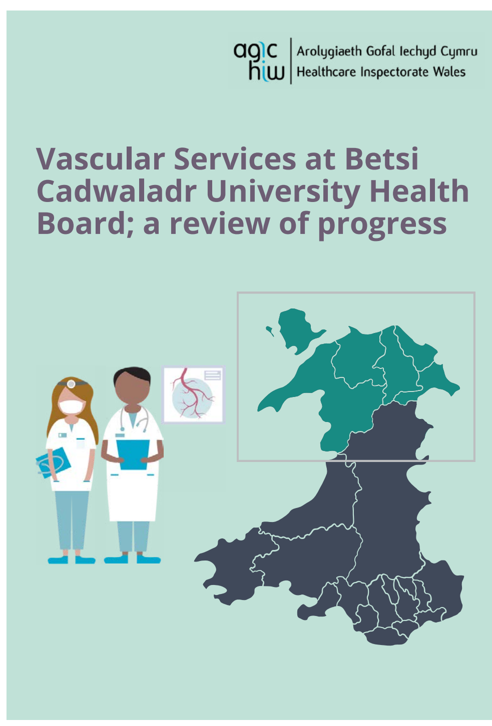
Cwm Taf Morgannwg University Health Board - Quality Governance Arrangements Joint Review Follow-up

In November 2019 we undertook a joint review with Audit Wales of the quality governance arrangements at Cwm Taf Morgannwg University Health Board. The joint report highlighted a number of fundamental weaknesses in leadership, strategic focus, patient safety and risk scrutiny, management of concerns and complaints, and organisational culture. The report included 14 recommendations for improvement.

In May 2021, a joint follow-up review found the health board made good progress on 2019 recommendations despite COVID-19 challenges. However, work was still needed in all areas, so the 14 recommendations remained open.

Our second follow-up review which commenced in March 2023 found the health board had made significant progress in addressing the concerns and recommendations. The report for this follow-up work was published in August 2023. We found a stronger strategic focus on quality and patient safety, with clearer roles and responsibilities compared to 2019. Based on the report, further detailed follow-up was deemed unnecessary. We maintained oversight of ongoing actions through our routine work programs.



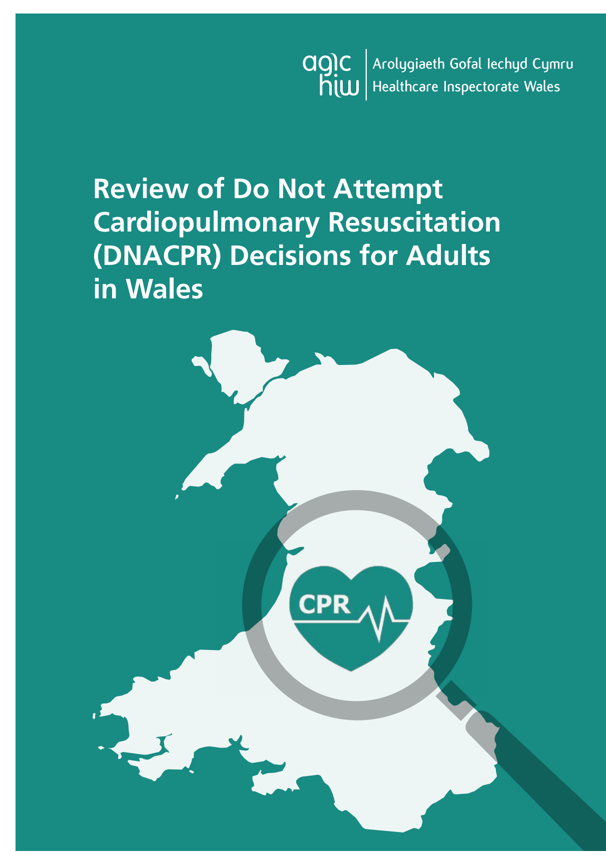


Local Review of the Vascular Service, Betsi Cadwaladr University Health Board

We undertook a local review of vascular services within Betsi Cadwaladr University Health Board. The review set out to consider the progress made by the health board in relation to the findings and the nine recommendations highlighted in the Royal College of Surgeons (RCS) of England Clinical Record Review Report, published in January 2022. Following this review, HIW designated the vascular service as a Service Requiring Significant Improvement (SRSI).

Overall, our review found that efforts had been made by the health board to implement processes and make improvements within its vascular services, with the aim to provide safe, timely and effective care to patients. Satisfactory progress had been made against all nine recommendations made by the RCS review team, and work to address the five urgent patient safety risks was commenced promptly by the health board. This resulted in the service being de-escalated as a SRSI. Our report noted that further work was still required to strengthen some aspects of clinical record keeping.

We published our report Vascular Services at Betsi Cadwaladr University Health Board; a review of Progress in June 2023.



All Wales Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions

DNACPR decisions are an important part of end-of-life care that can ensure a respectful and dignified death. It is therefore imperative that these decisions are handled and communicated sensitively and effectively. In 2023, we commenced a national review considering the arrangements in place across Wales when DNACPR decisions are made for adults. We explored whether DNACPR decisions reflect the priorities of an individual, including their preferences, and whether DNACPR decisions was clearly recorded and communicated between healthcare teams, and to the patient and those close to them.

The report, published in May 2024, found that there are examples of noteworthy practice across Wales regarding the DNACPR decision making process. However, we also identified opportunities to improve, including the need to strengthen the quality of communication with both patients and those close to them, including healthcare teams to clearly document discussions on DNACPR forms.

We found that staff need support and empowerment to hold honest conversations, and patients and families should be encouraged to discuss end-of-life wishes. Health boards and trusts must ensure DNACPR discussion resources are shared and used. Training also needs attention across Wales.

We concluded that closer attention to detail is needed when completing the all-Wales DNACPR form, ensuring it is fully completed and supported by clear, legible records of decision-making and conversations with patients and families.

We hope that our review leads to improvement in this area, particularly so that the right balance can be struck between clinical decision making and respecting the wishes of patients and families.

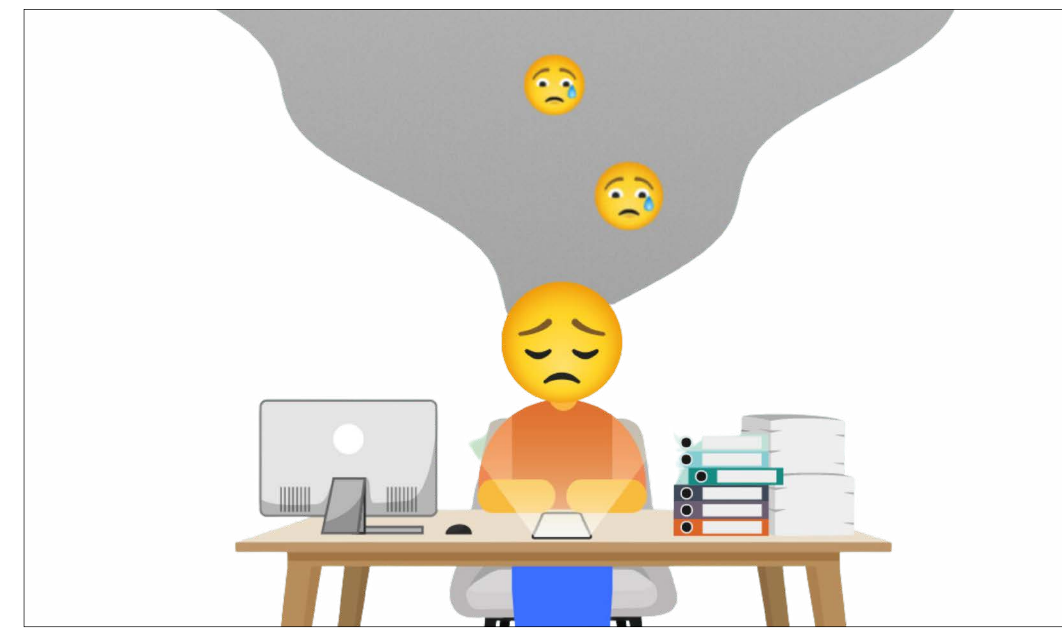
A summary of our findings can be found on our website.

Joint Review: How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales?

This joint review with Care Inspectorate Wales (CIW) and Estyn commenced during 2023 to consider whether children and young people are receiving timely and effective support for their mental health needs. The review focuses on children aged 11 to 16 in mandatory education and considers the services available to support their mental health needs within healthcare, education, and children's services, before referral to or assessment by specialist CAMHS.

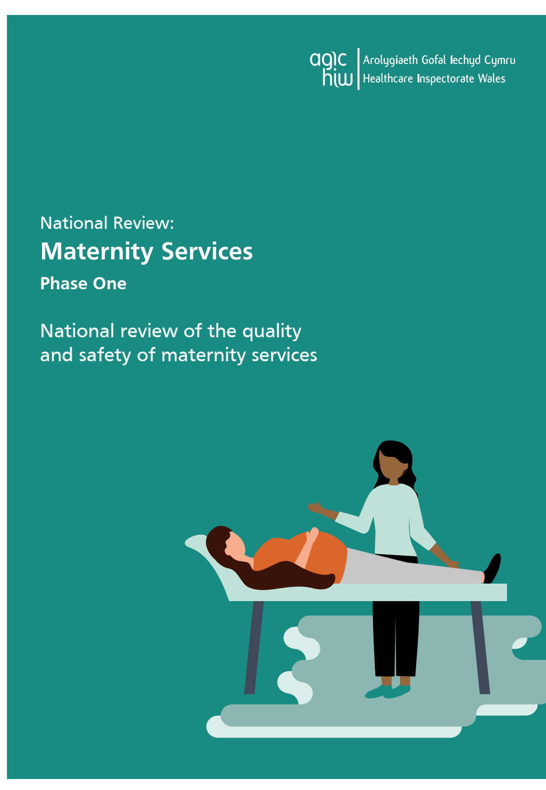
Our research and stakeholder engagement has helped inform the scope of our work to answer the question:

How are healthcare, education, and children's services in Wales supporting the mental health needs of children and young people, as they wait for assessment, or who do not meet the criteria for specialist CAMHS intervention?



Stage one of the review took place between January and March 2024. This stage helped inform the decision on where to undertake further scrutiny during onsite fieldwork in a selection of health board areas.

The report is due to be published in late 2024.



National Review of Maternity Services - A follow-up on improvement plans

In November 2020, HIW published the final report of its National Review of Maternity Services. The report highlighted 32 recommendations for health boards to consider and five for Welsh Government. Each health board and Welsh Government were asked to consider the findings from our review and the recommendations highlighted in the report. All were required to submit an improvement plan to HIW in response to the review's recommendations, to ensure that the matters raised by our review are being addressed.

During 2023-2024, we followed-up on the progress made by health boards in relation to their improvement plans. For this, we considered the details provided to us in our first follow-up, undertaken in February-March 2021, and updates provided to us during June and July 2023.

HIW is currently reviewing the findings from maternity inspections undertaken during 2022-23 and 2023-24, to identify key themes. The findings will be considered in the context of the recommendation made following the national previous national review. This work will be used by HIW to inform any future assurance work and key relevant findings will be shared with Welsh Government in order to support its wider oversight role.

05.

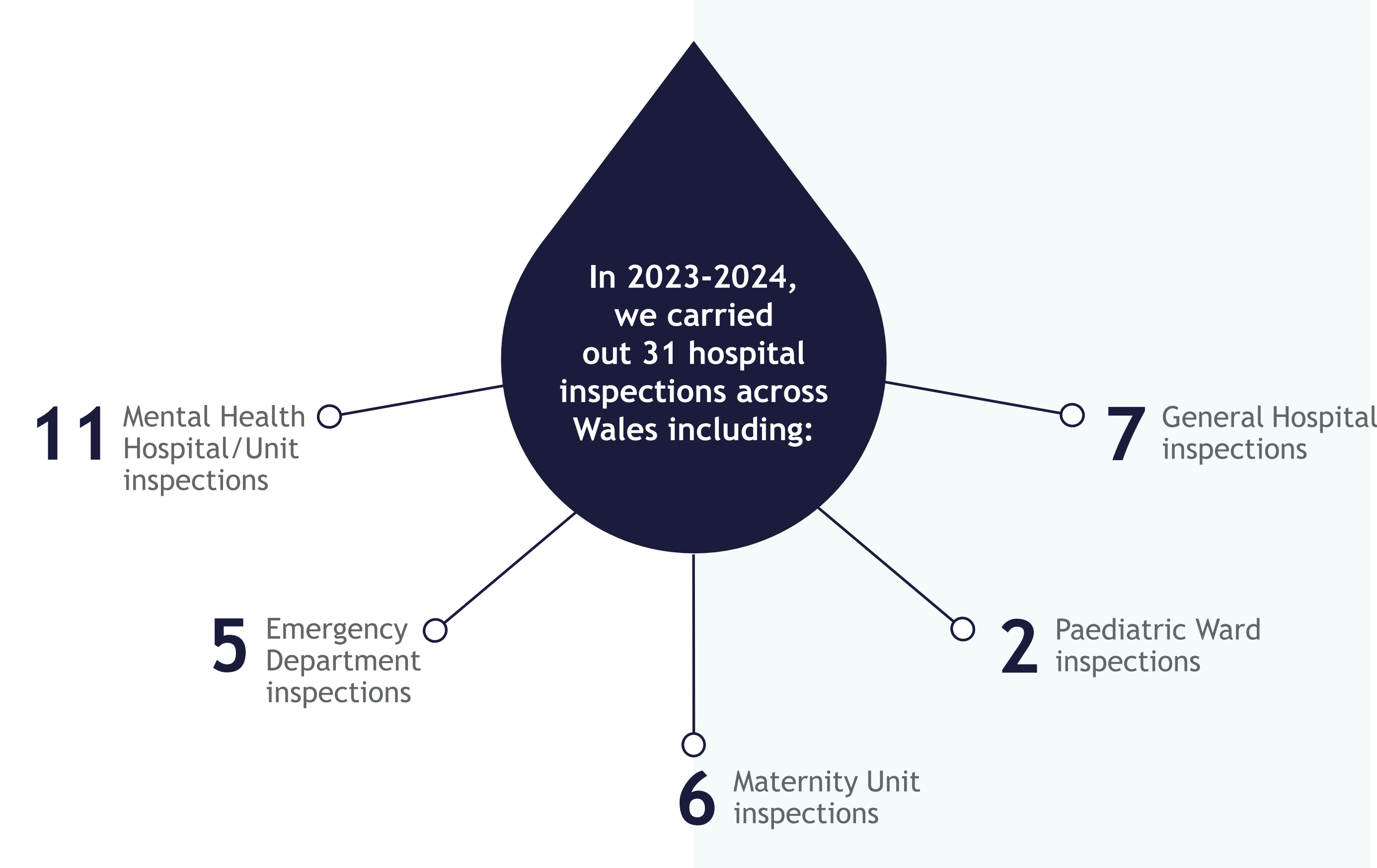
NHS Services

NHS Services

Our Findings

Our work within the NHS showed the demand for inpatient beds and maintaining safe staffing levels to manage the high number of patients remained a significant challenge. Assurance work within acute hospitals has shown the sustained pressure in patient admission areas and on inpatient wards. Within Emergency Departments across Wales, we noted overcrowding and long waits for treatment, alongside delays with patients being discharged. Overall, we found that patients generally received a safe level of care. However, despite efforts by health boards, the patient flow challenges meant that some patients did not receive timely care and treatment and remained in the Emergency Department for longer than expected.

Through our work we have once again seen a highly skilled and committed workforce, delivering care with dignity and compassion. Teams were professional, cohesive, and supportive, with staff working hard to provide patients with a positive experience and good levels of care despite extreme pressures.



Our findings on a national level, once again highlighted:

- Huge demand for services
- Compliance with mandatory training remains mixed and in general, across Wales, there are challenges in ensuring the workforce keeps up to date on training
- The quality of the discharge planning process needs to be improved
- There is an ongoing need to reduce patient safety risks within the clinical environment. For example, we continue to find medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

Emergency Care

Our work found evidence of significant pressures in the emergency care system. The increased pressure meant that we have continued to see overcrowded Emergency Departments, delays in ambulance handover of patients and long waits for triage and treatment to start. We are continuing to see the effect of poor patient flow due to the volume of patients awaiting discharge. This impacts on the quality of care and patient experience. This manifests in overcrowded waiting rooms, which leads to staff pressure, including:

- Inadequate privacy and dignity for patients
- Low levels of mandatory training compliance
- Poor infection prevention and control
- Incomplete tasks leading to risk
- Lack of risk assessments, poor oversight, and security.

It was positive to see hospitals are bringing in many new initiatives to manage the increased volume of walk-in patients at emergency departments, including environmental changes such as creating larger waiting areas and specialist frailty and dementia services.

Mental health care continues to be an extremely busy area within the delivery of emergency care across the NHS, with all but one of our emergency department inspections noting issues with areas for patients presenting with serious mental health issues. We have observed long waiting times and identified additional areas for improvement to reduce the risk of harms such as potential ligature, for patients with diverse needs.

Maternity Care

We found staff within the maternity wards were committed to providing a high standard of care to patients. There were many examples where the inspection team witnessed staff being compassionate, kind and friendly to patients and their families. Most patients we spoke to told us they were happy and receiving good care at the hospital.

Our inspections highlighted the importance of good communication, whether that is through birth choices or pain relief. We have also seen improvements in systems for women and birthing people whose first language is not English.

Through our inspection work within maternity units, we have highlighted how staffing and positive leadership can make a significant difference to the quality of care being provided.

Our inspection and assurance work noted an increase in the provision for women seeking sanctuary and survivors of harmful practice. Whilst this important work could always be strengthened, it was positive to see more staff involved in the delivery and championing of these important initiatives to improve outcomes for women with differing needs.

The case study below demonstrates how a challenged service has looked for different ways of working to prove outcomes for patients.

Case Study of Good Practice - Bronglais Maternity Unit

We conducted an unannounced inspection of the Maternity Unit at Bronglais General Hospital in Aberystwyth, run by Hywel Dda University Health Board. Inspectors completed the inspection across three consecutive days in August 2023, focusing on antenatal, labour, and postnatal care.

During this inspection, we found a dedicated team of staff, who were committed to providing a high standard of care to women, birthing people, and their families. Inspectors witnessed staff at all levels working well as a team to provide a positive experience, that was individualised and focussed on the needs of the women and birthing people they were providing care for.

Responses to our staff survey were positive, and this was reflected in the quality of care we saw.

Staff comments included:

"I truly do feel proud to work for this unit. There's such a sense of togetherness in our shared vision or providing excellent care for women and families in our community, and everyone takes genuine pride in the service we offer."

"A great work environment with excellent teamwork and morale."

"We are able to provide very safe and individualised care to our patients, putting their needs first and ensuring they are part of their care & the decisions that are made. We are able to provide one to one care on a regular basis, and due to being a small team there is often continuity which is not only positive & reassuring for those we care for but for us as staff too."

Governance and leadership within the unit was highlighted as good practice, which had had a significant positive impact on the wellbeing of staff, and in turn on the quality of patient care and patient experience.

Inspectors observed staff providing kind and respectful care to women and birthing people and their families. When asked, all women and birthing people were positive about their care, the staff, and the maternity environment. We saw evidence that those with communication difficulties were identified and supported to effectively access services through the maternity passport scheme. The scheme can be used for those who are neurodiverse, and those with learning difficulties or any other communication difficulties,. to record communication needs of those receiving care. Inspectors witnessed staff speaking in Welsh and we were told by people using the services that the active offer of Welsh made a positive impact on their care.

Staff were also kept informed through internal newsletters to keep them up to date with new developments and events etc. We also saw evidence of a wide range of teaching and learning opportunities, including lunch and learn sessions.

Staff described a positive culture with good, supportive leadership. A clear management structure was in place with clear lines of reporting and accountability. Managers were visible, approachable, and receptive to feedback. There was a stable midwifery staff team with a strong team ethos and compassionate leadership. It was noted the unit did not experience some of the significant staff shortages that have been experienced elsewhere in UK. A range of supportive initiatives were in place to ensure that more junior staff members are supported by senior staff.

All staff told us they felt they could raise concerns to midwifery staff and consultants.

This was achieved through a number of good cultural and governance processes. We saw a supportive culture around learning from incidents, such as the quick reporting of incidents, including those with no harm. Doctors and midwives led on sharing learning from incidents and communicating next steps widely. Themes were tracked and learning was encouraged through an open and supportive culture. Staff told us there was a culture of ‘closing the loop’, i.e. always fully responding to concerns and reflecting.

Further examples of good practice included the unit being part of the health board’s wider teams and networks, ensuring that the staff members who work in the smaller maternity unit are fully integrated and supported within larger networks.

Through our assurance work across the NHS in Wales we found a number of reoccurring thematic issues, these include:

Staffing

Resourcing and staffing remain an issue for NHS services across Wales. This in turn is often leading to staff burnout, low morale, and a high turnover, subsequently causing a cycle of added pressure on the remaining staff.

Through our work we have seen good practice in some maternity settings where they are more prudent in their approach to workforce planning, including overestimating sick and maternity leave, and planning shift cycles in advance for resilience purposes.

Equipment and Medicines Management

Following recent assurance work, we have reported on a number of issues relating to the availability or equipment and the management of medicines. In some circumstances we have needed to ask the setting to take immediate action to reduce risks to patient safety.

A recurring theme from our work is the availability and access to monitoring equipment for patients. When asked, a significant number of staff told us this is an issue where they work, causing delays and frustration.

Medication management also remains a consistent issue, where we have sought immediate assurance due to insufficient security of medicines, poor monitoring of fridge temperature checks and the poor disposal of out-of-date medicines.

Physical Environment

We regularly see the impact of a lack of capital investment within NHS sites, with many services running within older premises which often require maintenance leading to service accessibility issues and an increased risk to patients, staff, and visitors.

Technology

We have seen improved use of technology in some inspections, where some settings are using digitalised systems to check emergency equipment, including the monitoring of compliance with those checks.

Within some services, compliance with checking of emergency equipment had increased to nearly 100%. This is welcomed by HIW as it is more efficient and has a positive impact on the delivery of safe patient care.

Unfortunately, the poor checking of emergency equipment is still a regular finding throughout our NHS inspections. We have, however, seen good practice where services have demonstrated that innovation through the use of technology is benefiting their governance procedures. For example, using live digital data and information to track and improve patient flow, service user experience and risk monitoring.

Staff Feedback

Responses we received to our staff questionnaires at NHS hospital inspections indicated generally low staff morale. This is particularly related to challenges around staffing numbers and high demand for services.

The majority of staff told us they struggle to meet the demand and want to be able to provide better care. However, this did not generally seem to impact on the experience patients had of staff, who were often praised for their commitment to deliver quality person-centred care.

Patient Experience

Despite the challenges encountered by staff as noted above, overall, patients told us staff were kind and compassionate. They told us staff are making increased efforts to protect their dignity. However, we are concerned about the sustainability of this given the ongoing challenges in healthcare settings relating to the increase demand and staff shortages.

General Practice

During 2023-2024 we carried out 21 inspections of GP practices across Wales.

Our updated General Medical Practice (GP) approach considers the wider primary care landscape including referrals and signposting to other services.

We found GP practices remain under significant pressure post-pandemic and are continuing to face unprecedented demand. Due to practice closures, staff shortages and long hospital waiting lists for treatment the pressure on GP services continues to rise. Our immediate assurance process, which identifies significant concerns or risks, was used for 10 of these inspections.

The immediate assurance issues included:

- Incomplete safeguarding records and poor follow up of concerns
- Checks of emergency equipment and drugs not completed
- No DBS checks on staff including admin/reception staff
- Medicines not safely stored

- Medication fridge temperature checks not completed
- Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control
- Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles, some of which were dated 2006.

Our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but many patients told us they struggle to access an appointment. Difficulty in accessing GP appointments was a key theme to come out of Concerns raised with us during 2023-2024. The effects of delayed appointments on patients encompass physical health, emotional well-being, and overall healthcare experiences.

Frustrated by the inability to secure timely appointments, some patients may resort to using emergency services for non-urgent issues. This strains Emergency Departments and diverts resources away from patients with genuine emergencies.

It is crucial that leaders within this area consider the repeated concern from patients who are unable to access the service and consider what else can be done to alleviate the pressure on GP services.

Areas of good practice to emerge from our programme of work included:

- Larger centres providing more centralised services, including physiotherapists, social prescribers improving access to services for patients
- Specialist mental health associates to provide more local care
- Cluster paramedics conducting home visits to ease pressures on GPs
- Cluster pharmacists and psychological wellbeing practitioners available to improve outcomes for patients
- Upholding patient rights by using preferred names and pronouns when treating transgender patients
- Generally, a good level of health promotion including the 'Active Offer' of different languages
- Additional clinics working out of usual hours for vaccinations, making it easier for patients to access
- Patients told us that they are treated well when they do see a clinician.

Common improvements areas that featured across our inspection included:

- A need for improvements to privacy, especially for patients who need to discuss potentially sensitive matters regarding their health at a reception desk
- Incomplete or outdated risk assessments for physical environments including potential safeguarding risks and fire hazards
- Inadequate checks of emergency equipment
- Inconsistencies in following up when children missed appointments/clinics and potential safeguarding referrals
- Low levels of basic and critical mandatory training including basic life support.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation.

During 2023-2024 HIW completed eight IR(ME)R inspections, covering the three modalities of medical exposures. This included four diagnostic imaging departments, one of which was an independent hospital, three nuclear medicine departments, one of which was an independent provider, and one Radiotherapy Department.

HIW was assisted in these inspections by a member of the Medical Exposures Group (MEG), which is part of the UK Health Security Agency (UKHSA), acting in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys.

Feedback from patients was positive when asked about their experience attending the departments. Patients generally provided good feedback about their experiences. Whilst feedback from staff was generally positive, there were some negative responses and comments from staff relating to low resourcing issues.

There was generally good compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, within the majority of hospitals. Training records, both mandatory and IR(ME)R training, were good in most departments as well as compliance with the annual appraisal process.

In one department we were told that referral forms for exposures performed during surgical theatre cases were not being completed by the referrer but were completed by the radiographer. This was not in keeping with the requirements of the duty holder role and the responsibility of the referrer.

Whilst employer's procedures, required by IR(ME)R 2017, were generally well written, there were areas identified where these could be further improved.

Mental Health

During 2023-2024 we undertook a total of 26 mental health inspection visits to in-patient wards and two inspection visits to community services. During the reporting period we undertook onsite inspections to a range of healthcare settings of both NHS and independent hospitals. The wards and services inspected accommodated a range of patients which included:

- Adults with mental health issues
- Older persons
- Learning Disabilities
- Child and Adolescent Mental Health Services (CAMHS)

In relation to community services, we undertook one visit to a community mental health team (CMHT) and one visit to a community learning disability team (CLDT).

During the visits we consider a range of key areas under the three distinct headings of quality of patient experience, delivery of safe and effective care and the quality of management and leadership.

For the NHS we look at how the mental health care services meet the Health and Care Quality Standards 2023. For the independent providers we look at how these services comply with the National Minimum Standards for Independent Health Care Services in Wales 2011 and the Mental Health Code of Practice Wales (revised 2016). For both NHS and independent providers, we consider how these services comply with the Mental Health Act 1983 and the associated Code of Practice, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and the implementation of Deprivation of Liberty Safeguards.

We used our immediate assurance/non-compliance process on seven occasions. This represents a quarter of our inspections where issues found during an inspection carried the most immediate risk to patients.

A positive area across most of our inspections was the quality of staff and patient interaction. Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. Patients felt they could engage and provide feedback to staff on the provision of care at the hospital they were staying.

In relation to the monitoring of the use of the Mental Health Act we found that patients were legally detained according to guidance and legislation. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information. In addition, we observed that patient rights information was clearly documented with an assessment of patient understanding, in accordance with section 132 of the Act, and good systems were in place to support the automatic renewal of detention.

However, we identified several significant issues with the implementation of the Act, including Hospital Manager Hearings not being held in a timely manner, with a delay of 5 months in one instance. In addition, section 17 leave forms had the term 'cancelled' on them instead of 'no longer valid' where leave had been taken, and assessments of capacity had not been conducted and documented before carrying out the care and treatment of patients.

Patients who are in an acute and/or challenging phase of their illness may unfortunately require the use of seclusion for a limited period. In one of our visits where seclusion was being used, we observed that the area being used to seclude the patient did not conform to best practice standards or to the health board policy and procedures for the use of seclusion. Notably, a clock was not visible and there was no temperature control outside the area. The separate toilet facility being used by the patient had not been adapted for high-risk patients and we were concerned over their access to regular periods of fresh air. Lastly, there was no seclusion care plan in place for the patient which contravened the health board policy. In addition, in terms of patient observation; levels of observations had not been updated in care plans since the last care and treatment review meeting.

Unfortunately, in recent years, we have found little improvement in the following areas:

Staff and Patient Safety - issues included ligature risks that had been recommended for anti-ligature work in 2020 but still hadn't been completed, patient call bells were not easily accessible and appropriate for the patient group and staff were not wearing personal alarms.

Workforce challenges - issues with recruitment and retention of staff and the inadequate induction of agency staff.

Medicines Management - a range of issues with the storage, administration and recording of medicines.

Training - a lack of training on key areas including Restrictive Physical Intervention (RPI) training, Mental Capacity Act, manual handling and basic life support.

Patient Information - lack of information available for patients on key topics.

Care Planning Documentation - we were not always assured that the care and treatment arrangements in place were in line with the Mental Health (Wales) Measure 2010.

Risk Assessments - not always completed and the review of them not always timely.

Environment of Care - lack of a structured approach for timely repair, replacement and refurbishment of wards.

Governance - a lack of audit and oversight of key areas of quality and patient safety.

During our inspections we observed committed and determined staff, working hard but clearly under pressure from a shortage of mental health beds.

Delayed access to mental health services had become all too common and this was placing additional pressure on staff and patients.

Timely access to mental health services is crucial to ensure the best care pathway for an individual to achieve the best outcome. Without timely care and treatment, a patient may well experience crisis and risks that could be avoided.

Second Opinion Appointed Doctor (SOAD) Service for Wales

The Second Opinion Appointed Doctor (SOAD) service operates as a hybrid service. When requested by a patient's responsible hospital, the Review Service for Mental Health arranges for an independent doctor, called a Second Opinion Appointed Doctor (SOAD) to provide a second opinion if a patient is not able or willing to consent to their treatment. This is a statutory requirement undertaken by HIW on behalf of the Welsh Ministers.

Our methodology is set out in detail in our guidance to all SOADs and provided to all Mental Health Act Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

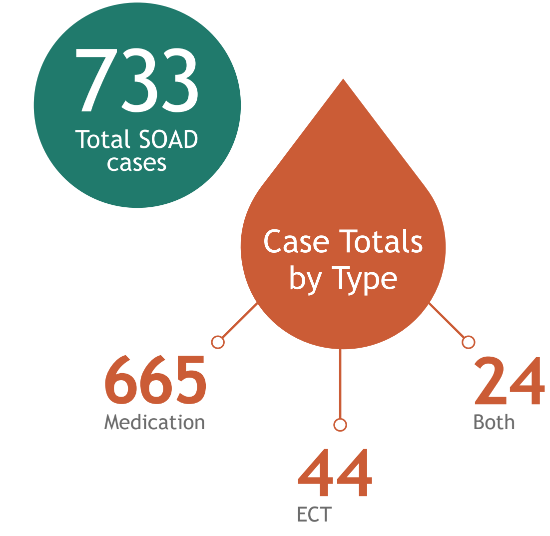
This year we amended our methodology to fully incorporate and utilise the benefits of hybrid methodology that has been in use since 2021.

One of the main changes we have implemented is that whilst SOAD visits should occur in person for the purposes of interviewing the patient for most cases, we have make us of a 'remote first' approach in relation to Community Treatment Order (CTO) cases. All patients are consulted by their clinical team prior to the submission of requests to confirm if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right, in all cases, to specifically request an onsite visit from a SOAD. Our forms are being updated to reflect these changes and will be published in late 2024. In addition, we are refreshing and redrafting our suite of guidance toolkits on all matters relating to the Review Service for Mental Health (RSMH) services, including the SOAD service. We are currently in the process of consulting with external stakeholders on these revisions and intend to publish our refreshed guidance toolkit suite on our website later in the year.

The SOAD must, and will, use their professional opinion and discretion to consider whether they can safely and confidently certify remotely, and the method of interviewing the patient should always be recorded as part of their reasoning on their Certificate of Consent forms.

Full advice on our methodology is available on our website and is currently being updated to reflect the changes we have made this year.

Total breakdown for SOAD cases between 01/04/2023 - 31/04/2024:

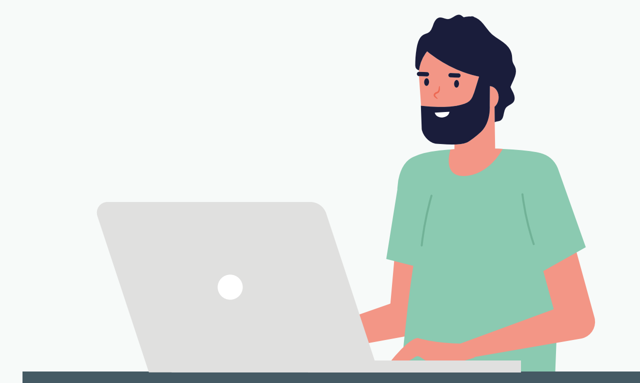


Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators (MHAA) office for all local health boards and independent settings for the Responsible Clinician to complete. For the eight consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the Mental Health Act 1983. This process is designed to add an additional layer of patient safety to those being treated under the Act and is in compliance with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous Annual Report continue in relation to the following areas:

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting and this resulted in several new SOAD certification requests.
- There remain minor discrepancies in relation to complex issues relating to the patient address as listed on the CO forms. This relates to patients mainly who have no fixed abode. HIW have produced guidance to MHAA's in relation to this subject to minimise these instances.



[1] The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.

The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

06.

Independent Healthcare

HIW's role in the independent healthcare sector in Wales is to register and regulate independent healthcare services. The independent healthcare sector encompasses a huge variety of services, from acute and mental health hospitals, to independent clinics and laser services. The mental health hospitals provide care for NHS funded patients with complex needs. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry. Consequently, the regulatory sector accounts for a significant proportion of our assurance work.

Independent healthcare services must register with HIW, and once they are successfully registered, they will be subject to ongoing regulation which is carried out through inspections and checks. This is to ensure providers are meeting the requirements of their registration, complying with the relevant regulations, and providing a safe service.

Our Findings:

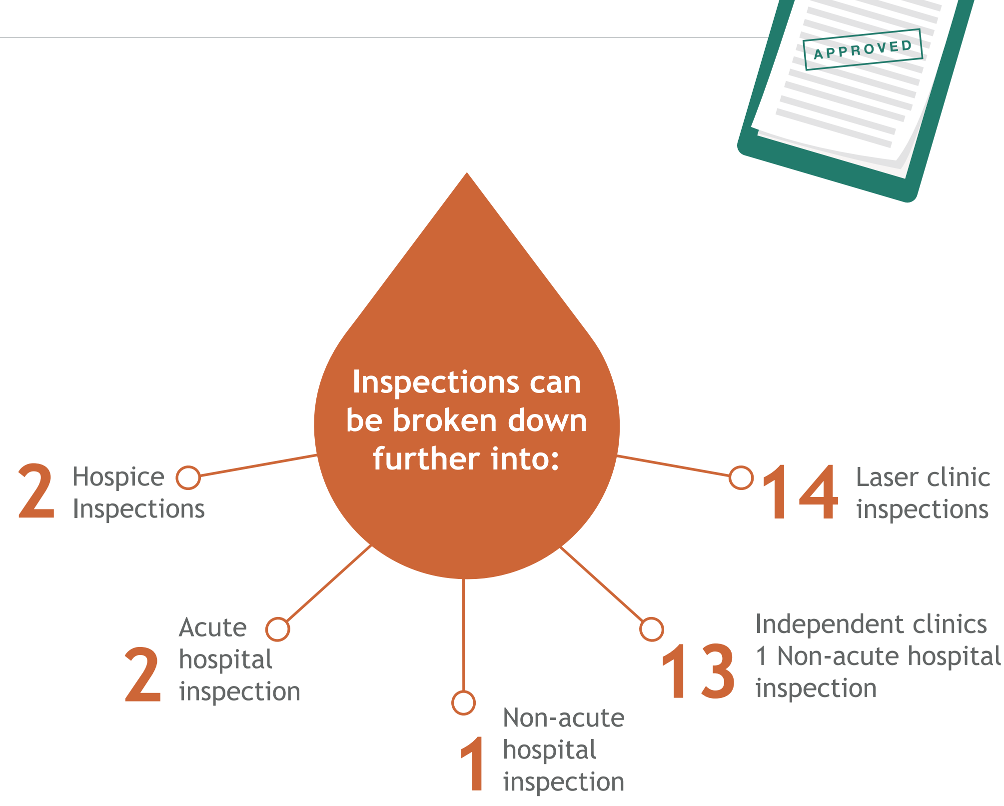
During 2023-2024, HIW completed 266 pieces of work associated with the registration of independent healthcare providers. This involved the registration of 101 new independent healthcare providers. This number included new dental practices and laser clinics.

Once registered, any changes a service intends to make to its conditions of registration, requires an application to vary what it is registered to provide. An application to vary a registration will not automatically be approved. Each application involves scrutiny by HIW as to the appropriateness of the proposed changes.

In addition to this, all independent healthcare services have a manager who goes through a registration process to enable them to run a service.

During 2023-2024, HIW processed and approved a total of 41 registration variations.

In 2023-2024, HIW processed and approved 124 new managers of independent healthcare services.



To check that services are continuing to meet the requirements of their registration, and providing a safe, quality service to patients, HIW undertakes a programme of inspection work each year.

In 2023-2024, we undertook a total of 32 individual pieces of assurance work to independent healthcare settings.

In addition to the above, 13 inspections to independent mental health services and 62 dental practice inspections were completed. These are discussed elsewhere in the report.

Independent Mental Health Services

Throughout our 13 independent mental health inspections, four non-compliance notices were issued. Our broader findings from our mental health assurance work can we found in elsewhere within this report, but we have specifically focused on key areas of non-compliance within this section.

The areas of immediate concern that emerged in relation to non-compliance were:

- Restraints not being appropriately reported and investigated, with insufficient analysis and investigation of the restraints to understand whether they could have been avoided and whether the restraint used was appropriate
- A lack of suitably qualified staff trained in immediate life support, on duty at all times
- Poor statutory recording of consent to authorise treatment administered to patients, along with incorrect type and dosage of medication
- Inaccurate recording of administered medication and a lack of audits to identify where mistakes are made, discrepancies identified and quickly rectified
- Capacity to consent to treatment for patients not being carried out in line with the framework set out in the mental capacity act and the Mental Health Act Code of Practice for Wales
- Areas of some hospitals in a very poor state of repair, requiring a deep clean to adhere to best practice Infection Prevention Control standards, inaccurate and ineffective audits.

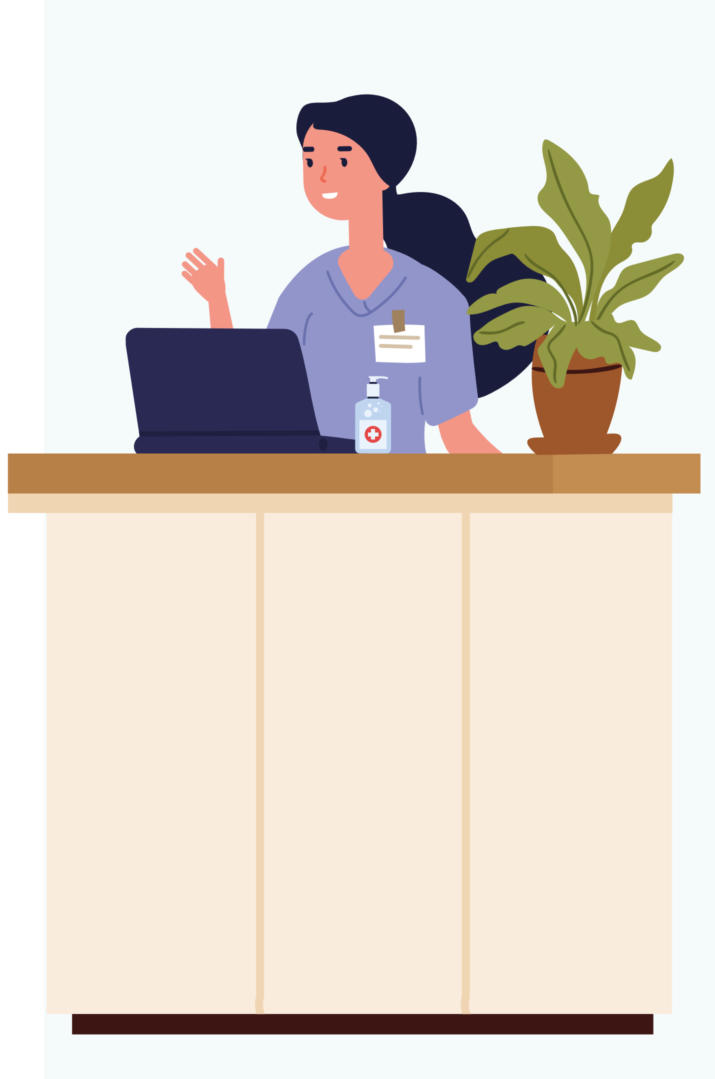
13 independent mental health inspections

Independent Hospitals, Clinics and Opticians

If, following an inspection, we find that a service provider is compromising patient safety and failing to comply with the terms of their regulatory requirements and registration, we will take immediate action by issuing a non-compliance notice. Through, our hospital, clinic and opticians' inspections four non-compliance notices were issued.

The key areas of immediate concern related to:

- Lack of daily and monthly checks of the emergency resuscitation trolleys
- Poor levels of mandatory staff training including safeguarding and first aid training
- In one inspection, the display of appropriate protocols such as the major haemorrhage protocol was insufficient
- Medical records were not always available for inspection
- The Statement of Purpose document was not updated to include additional services being provided at the setting since initial registration
- Inadequate of checks and audits to ensure expired medication is removed and replaced
- Lack of fitness to work checks including DBS checks for staff
- Lack of fire safety risk assessments, fire safety training, fire safety audits and drills.



Dental Practices

During 2023-2024, we undertook 62 pieces of assurance work to dental practices across Wales, including 15 pre-registration visits. These inspections were conducted onsite at the practices, where a HIW team including a qualified dentist working as dental peer reviewer spent time examining the practices, policies and procedures which governed the way each practice was run.

Access to dental care and treatment continues to emerge as a key theme this year. Factors such as the availability of dental providers and high demand have all impacted the ability of patients to access timely dental care.

Research shows delayed dental appointments can lead to the progression of oral health issues, i.e. a minor concern could develop into a more complex problem, requiring more invasive and costly treatments.

Across all our dental assurance work, we issued urgent non-compliance notices on 11 occasions. This meant we came across concerns which had the highest level of risk to patient safety and therefore needed action to be taken within 48 hours.

We also made a substantial number of recommendations for improvement.

The recommendations included the following themes:

- Low levels of compliance with staff mandatory training including Duty of Candour training in some practices providing NHS services
- Lack of pre-employments checks, such as Disclosure & Barring Service (DBS) checks and arrangements ensuring staff were fit-to-work within a practice
- Inadequate fire risk assessments, fire safety training and drills, arrangements for ensuring equipment relating to fire safety was maintained and stored correctly
- Out of date medication within emergency drugs boxes
- Medication including emergency drugs not being stored securely
- Resuscitation equipment required to be on site was not always readily available
- Inconsistencies with mandatory first aid training for staff, including not always having first aid trained personnel on site
- The equipment used for de-contamination and some treatments were found to be unsafe with no records of servicing or maintenance
- Damaged and unsafe X-ray equipment including no evidence of staff training, maintenance, or servicing
- Lack of audits such as infection prevention and control and clinical audits
- Patient records not being stored securely.

Independent Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured. During 2023–2024, we completed two onsite inspections to adult only hospices in Wales provided by the independent healthcare sector.

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Families and carers who provided us with feedback were positive about the care being provided, and the support they were being given. Staff were seen to engage positively, and patients told us that staff were kind and caring. We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner. There was a multidisciplinary approach to the provision of care with the staff team committed to provide patients with compassionate, safe, and effective care.

We found that improvement was required in terms of risk assessments and some aspects of auditing infection prevention and control procedures. Inspectors noted a lack of risk assessments including for falls and pressure sores being carried out effectively. We were also not assured all the staff had received updated mandatory training including basic life support.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

During the year 2023-2024, we conducted 14 onsite inspections to laser and IPL registered providers across Wales.

From these inspections we identified non-compliance with relevant regulations in six cases. This means that in 57% of these inspections, we found laser and IPL providers were not meeting all of the requirements to comply with their registration. The issues we found required us to issue urgent non-compliance notice to ensure immediate action was taken.

These included, using machines which they were not registered to use, treating patients outside of the age range they were licensed to treat and having no first aider.

The regulations under which laser and IPL providers are required to operated are specific and require them to comply with several areas to demonstrate their fitness to provide these services. We found several areas where we were repeatedly making recommendations for improvement through these inspections. In general, these related to the governance arrangements for these services.

Good governance helps to ensure services are safe for the public to receive.
Laser and IPL providers should therefore ensure they are familiar with their responsibilities against the regulations. The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

In several cases, we found that the correct documentation, such as written policies and procedures were not available, or were not kept up to date. Staff training records and recruitment records also needed improving in some cases. The provision of appropriately trained first aiders and an up to date first aid kit were also recommendations made in a number of these inspections.

Other areas of non-compliance were:

- Medical and treatment protocols were not complete or not being adhered to
- Lack of fire safety risk assessments, fire safety training, fire safety audits and drills.
- Settings providing treatment with a laser machine that was not included within the original registration
- Incomplete and inaccurate recording of patient notes and notes not being securely stored
- Electrical appliances had not been PAT tested.
- Staff not having up to date first aid training, not having completed or updated core of knowledge training
- Insufficient Policies and Procedures not adhering to the requirements set out in the regulations
- Lack of a Laser Protection Advisor (LPA) contract, or not having in place an annual review with the LPA and lack of local rules for the devices in use at the setting.

Escalation and Enforcement

The Escalation and Enforcement Team manage and lead all escalation and enforcement activity in relation to NHS, independent healthcare, and private dentistry in Wales. The team investigates and instigates criminal proceedings utilising the civil powers afforded to HIW to regulate registered providers.

In 2023-2024 the Escalation and Enforcement team held 85 Service of Concern (SoC) meetings with regards to private healthcare and dentistry in line with our escalation procedures. HIW's SoC process is used when there are significant service failures, or when there is an accumulation of concerns about a service or setting.

We encourage the reporting of unregistered providers. This year we have seen an increase in unregistered aesthetic providers being reported, with this informing our enforcement activity. We will continue to raise awareness of the need to register through proactive communications and engagement.

For NHS services, we held 13 SoC meetings during 2023-2024 because of concerns arising from our assurance work. These SoC discussions may lead to a service being designated a Service Requiring Significant Improvement (SRSI), a process we introduced in November 2021 in order to drive focused and rapid action by health boards and trusts to ensure safe and effective care is being provided. During 2023-24, no services were escalated to being a SRSI, however, we de-escalated one service from the SRSI designation. This is referred to within the reviews section of this report.

In total 12 registered settings were designated as a SoC in that period. The team also instigated three criminal investigations during 2023-2024.

Services with a SoC designation at 31st March 2024:
9 Independent Health
3 Private Dental
NHS Services monitored as part of the NHS SoC process in the year 2023-2024:
1 Emergency department
1 Minor injury unit
2 Paediatrics
4 Mental Health
2 Maternity
1 GP
2 other
Criminal Investigations/ outcomes:
3 warnings issued
3 criminal cautions issued
3 ongoing
Settings with a Service Requiring Significant Improvement (SRSI) designation at 31st March 2024:
1 NHS Service
Provider Meetings held in 2023-2024:
5 independent healthcare

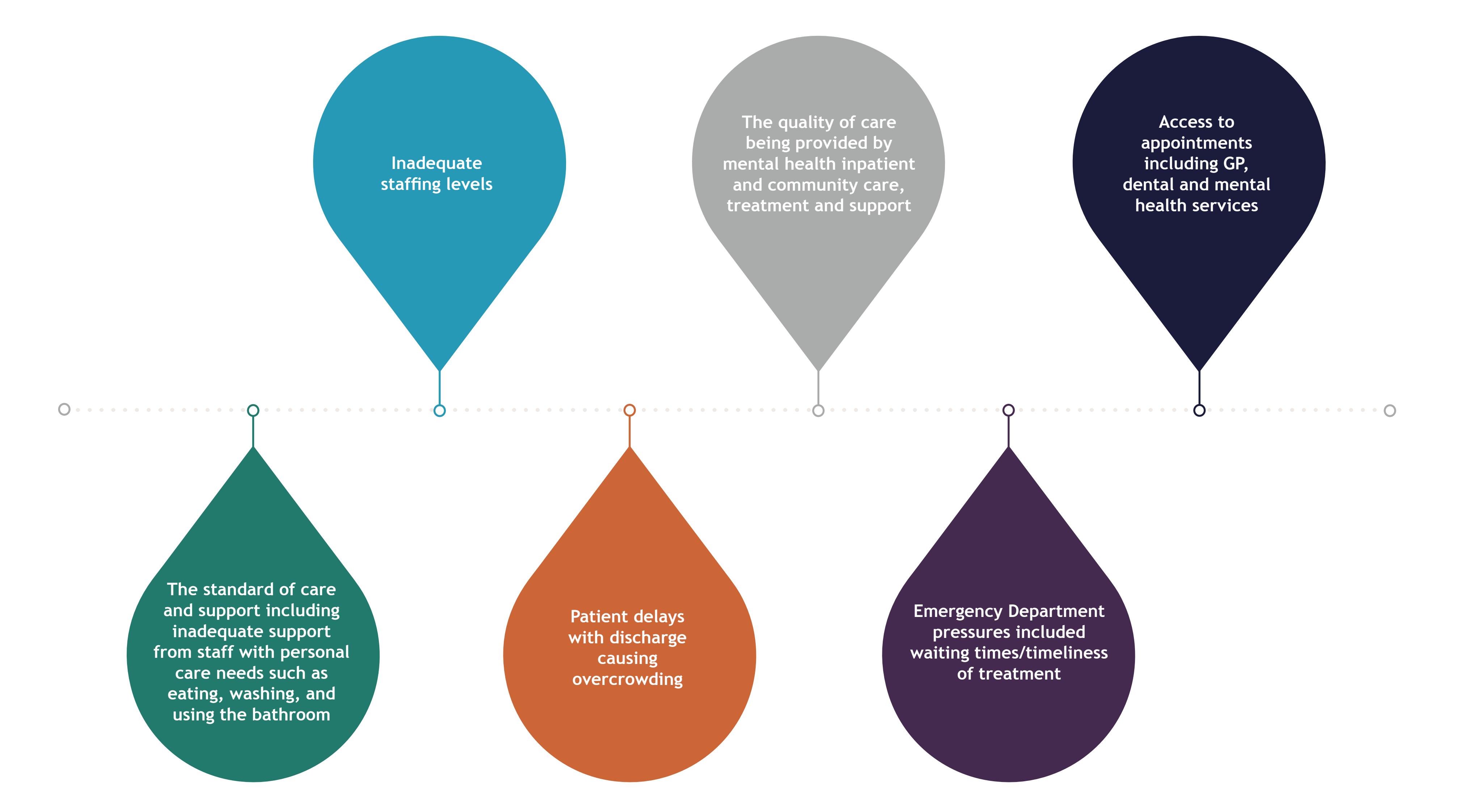
Hillview Hospital

Hillview Hospital in Ebbw Vale provided specialist mental health support to adolescents. Due to the severity and number of issues identified following a series of inspections, the service was designated as a 'Service of Concern' in line with HIW's Escalation and Enforcement process. Subsequently, the service's registration was suspended and adolescent mental health services are no longer provided there.

The most recent inspection took place over two consecutive days in May 2023, and focused on the areas of the hospital that affected the delivery of safe and effective care, as well as the leadership and governance. As a result of the severity of issues identified, a non-compliance notice was issued to the setting due to issues identified in several areas including a lack of detailed recording around then number and duration of restraints being carried out on patients. We had concerns that the service was not meeting care needs in line with the requirements of its registration, and this was having a detrimental impact on the wellbeing of the patients. HIW therefore took the decision to issue an 'Urgent Notice of Decision' to suspend the registration of Hillview Hospital and all patients were successfully moved by early June 2023.

Concerns, Investigations and Notifications

Key themes from concerns received

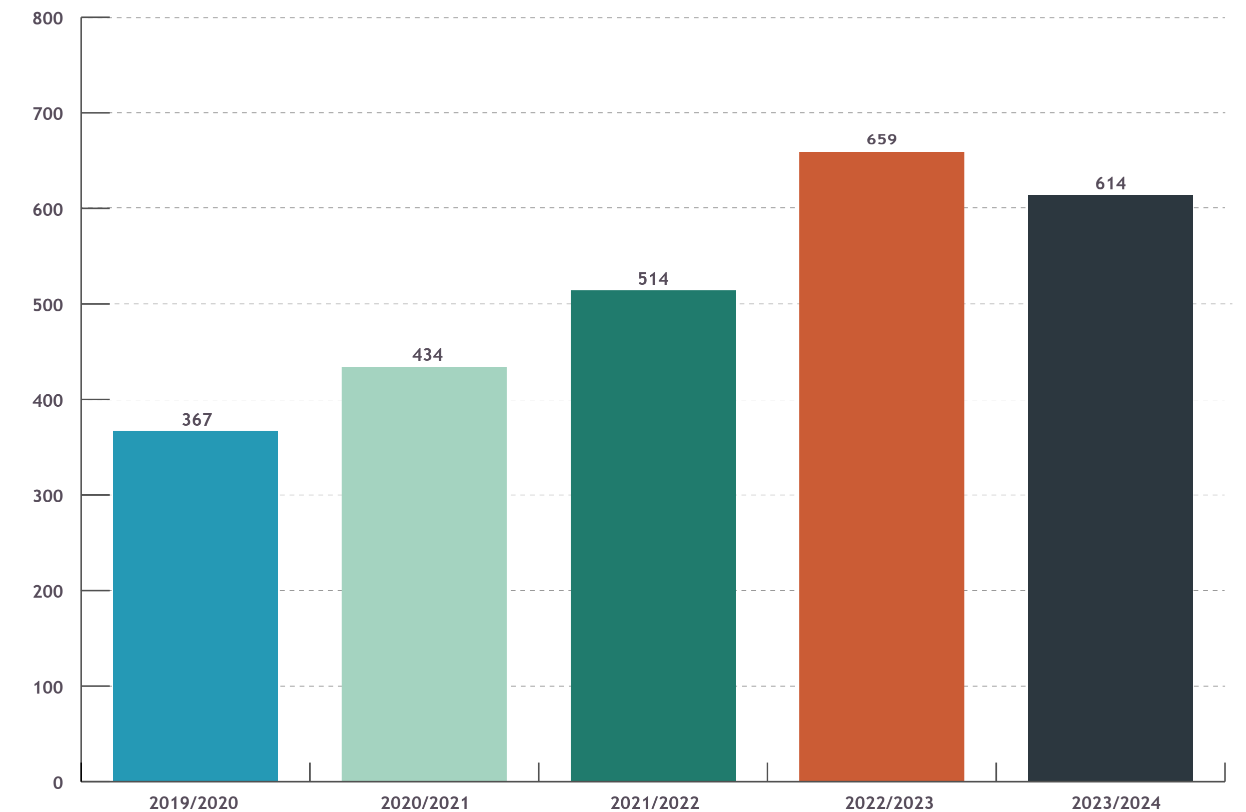


Total number of concerns received by HIW

As an organisation we are committed to managing concerns fairly, efficiently, and effectively. Concerns play a crucial role in identifying issues and driving improvement within the healthcare sector. Feedback, often conveyed through concerns, provides valuable insights into areas of risk, inefficiencies, and lapses in quality. These shed light on both systemic and individual problems, ranging from administrative processes to clinical care standards. By addressing and analysing complaints, healthcare organisations can pinpoint recurring patterns, root causes, and potential risks.

Whilst HIW is not a complaints body, the concerns we receive provide an important opportunity to identify problems within a healthcare service. We use this intelligence to inform our assessments of services and steer decisions on the assurance activities we undertake.

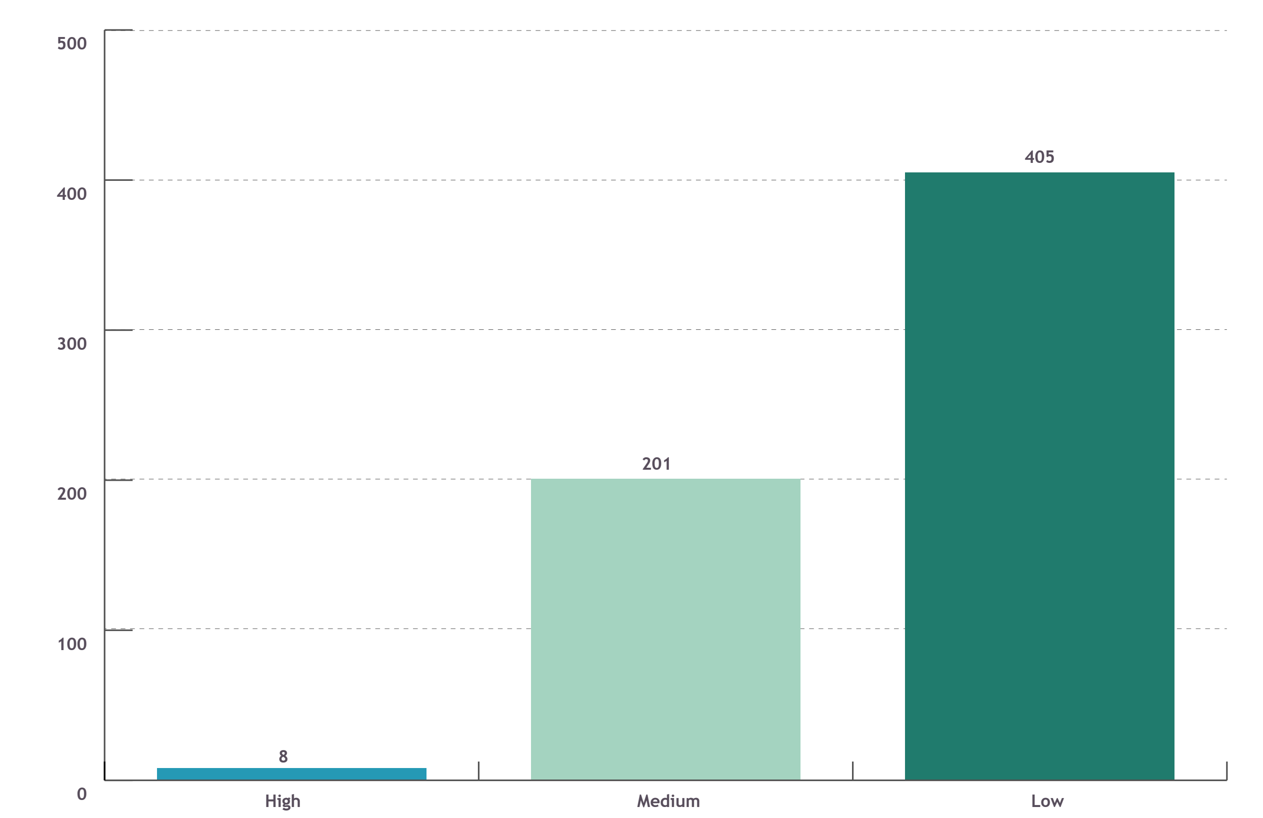
In total we received 614 concerns from 1st of April 2022 to 31st of March 2023. This represents a slight decrease of 45 concerns compared to the previous year.



HIW responds immediately to all high-risk concerns. This can be in the form of immediate escalation to the healthcare organisation for assurance, and/or immediate intervention via safeguarding structures or the police. In 2023-24, we requested further assurances from the relevant healthcare organisation in a quarter of the concerns we received.

The number of high risks concerns received has decreased this year, with an 87% decrease on the previous year. The drop is mainly due to changes in the way in which we triage concerns based on the level of the response required.

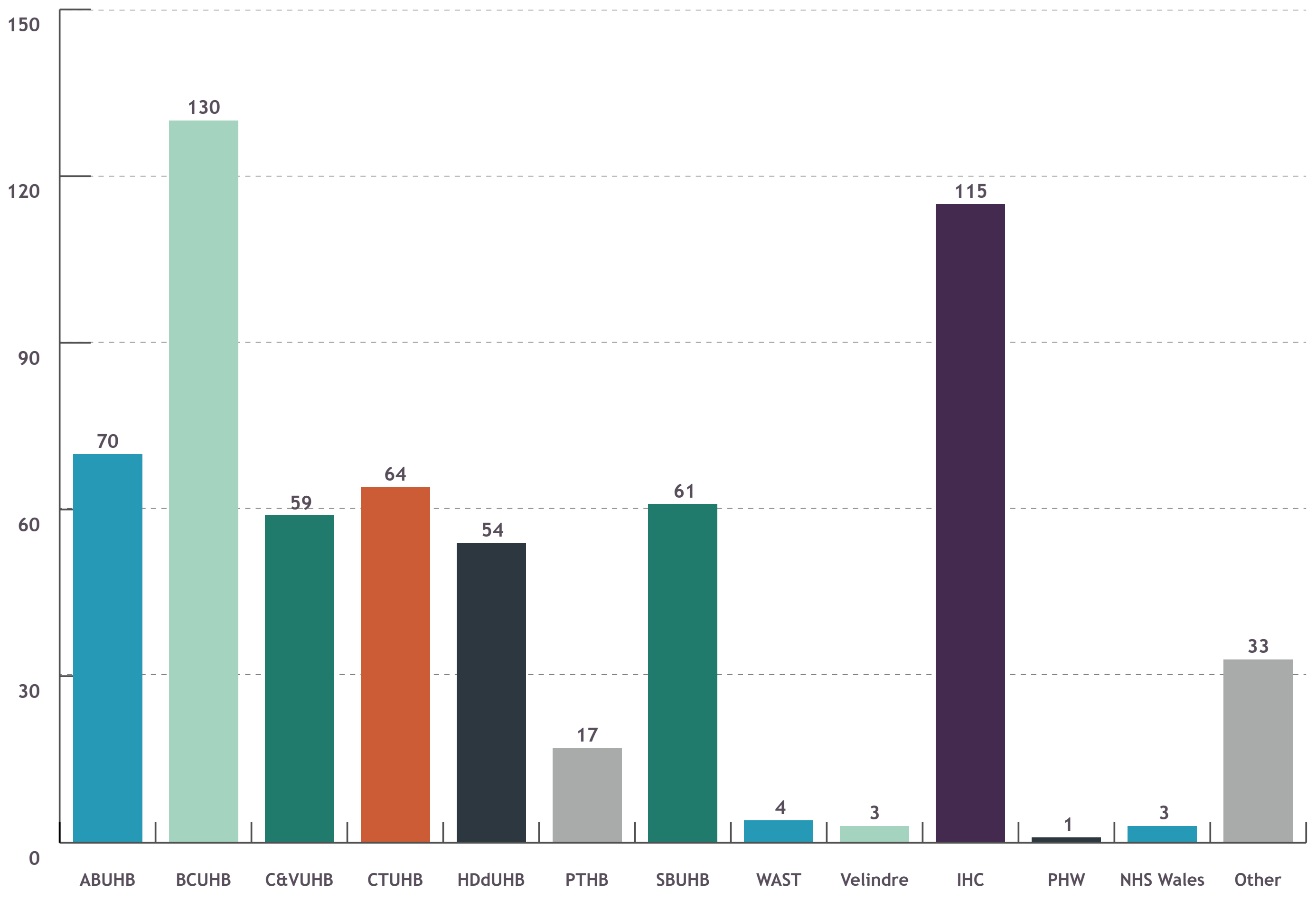
- High-risk concerns require immediate action and response within 2 working days, either by HIW or another agency.
- Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days.
- Low-risk concerns are those concerns that are generally dealt with by way of signposting towards NHS Putting Things Right processes or the respective local complaints process for independent health providers, with responses being actioned within by HIW within 7 working days.



Location of concerns

Abbreviations

ABUHB	Aneurin Bevan University Health Board (UHB)
BCUHB	Betsi Cadwaladr UHB
CVUHB	Cardiff and Vale UHB
CTMUHB	Cwm Taf Morgannwg UHB
HDdUHB	Hywel Dda UHB
IHC Settings	Independent Healthcare Settings
PTHB	Powys Teaching Health Board
SBUHB	Swansea Bay UHB
PHW	Public Health Wales
Velindre	Velindre University NHS Trust
WAST	Welsh Ambulance Services University NHS Trust



Whistleblowing Concerns

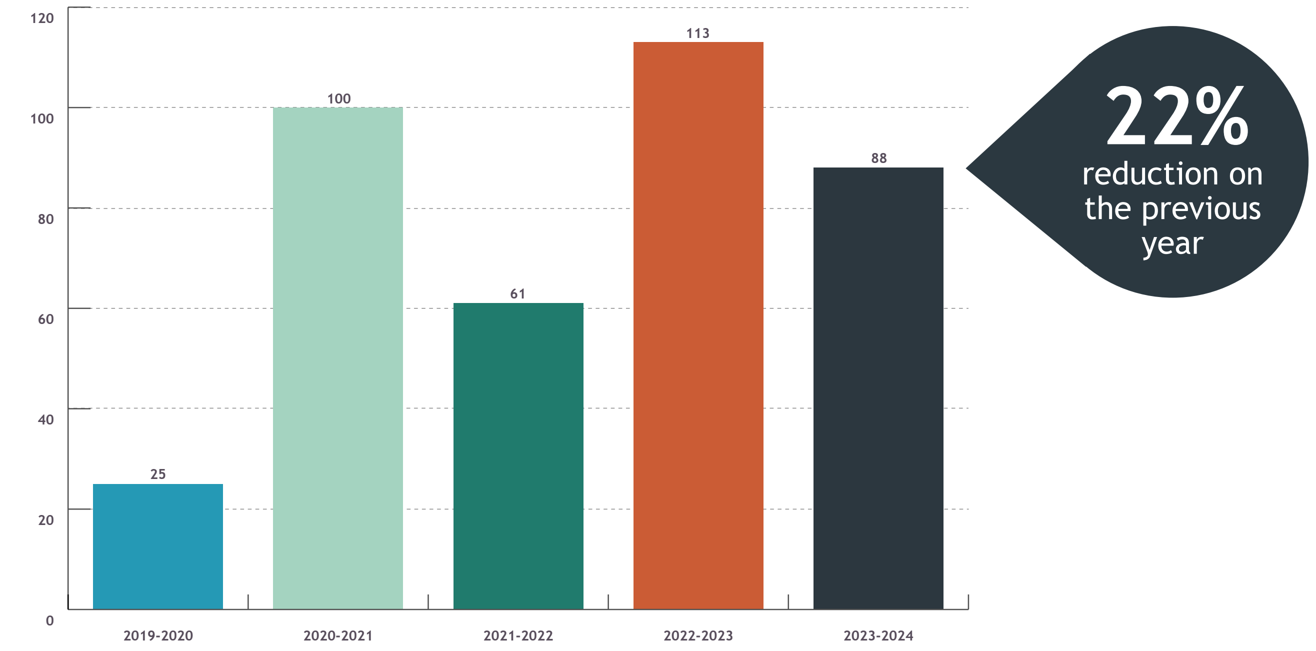
Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality, or risk in the organisation.
These concerns can affect patients, the public, other staff, or the organisation itself.

Whistleblowing applies to raising a concern within the organisation as well as externally, such as to a regulator like HIW. HIW has a special role for people who are thinking about "blowing the whistle" about concerns they have about wrongdoing in healthcare in Wales. HIW is a "prescribed body" under the whistleblowing legislation so employees, former employees, temporary agency staff or contractors who bring us concerns about their employer's activities can have some protection for their employment rights.

All healthcare professionals must follow their professional code of conduct and we would always recommend that they raise their concern within their own organisation first. However, if they feel unable to do this, or have already gone through this route, we will listen to the concern and explain how we can help.

We may need to pass on the information they give us to another organisation or regulatory body if it is more appropriate for them to investigate the concern.

Key themes for whistleblowing concerns received during this period have included issues relating to a service's culture and management, inadequate internal governance process, low levels of resourcing, and concerns regarding the standard of care and treatment provided to patients.



Death in Custody

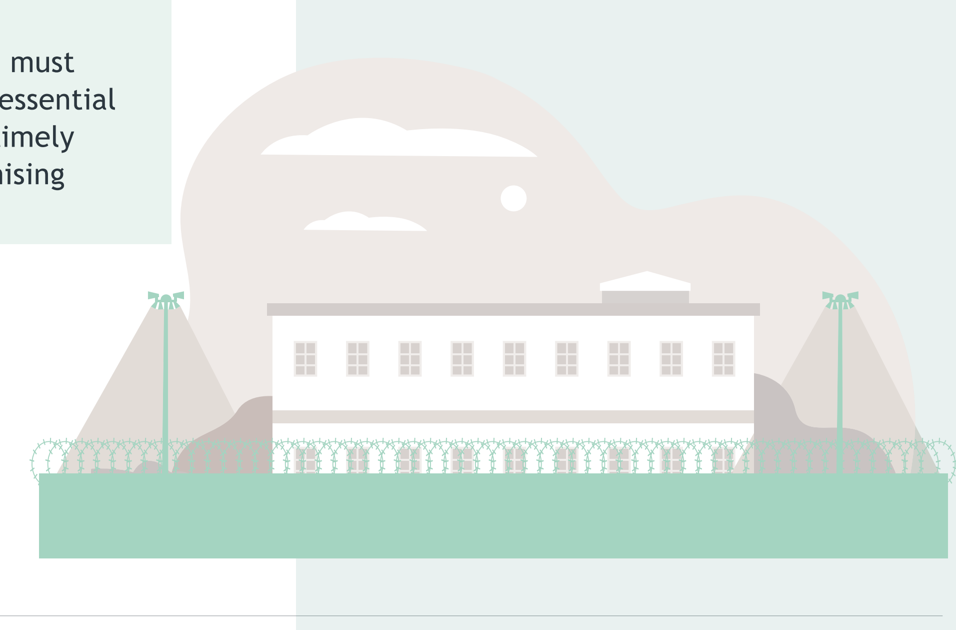
Every death that occurs in a prison or other authorised location in Wales is subject to an investigation by the Prisons and Probation Ombudsman (PPO). HIW contributes to the PPO's investigation by conducting a clinical review of each death that occurs in a Welsh prison or other authorised location.

The aim of our clinical reviews is to assess and evaluate the level of care and medical treatment given to inmates while they are in a prison or other authorised location. We aim to evaluate whether the care and treatment provided was equitable to what a person in the community could expect to receive.

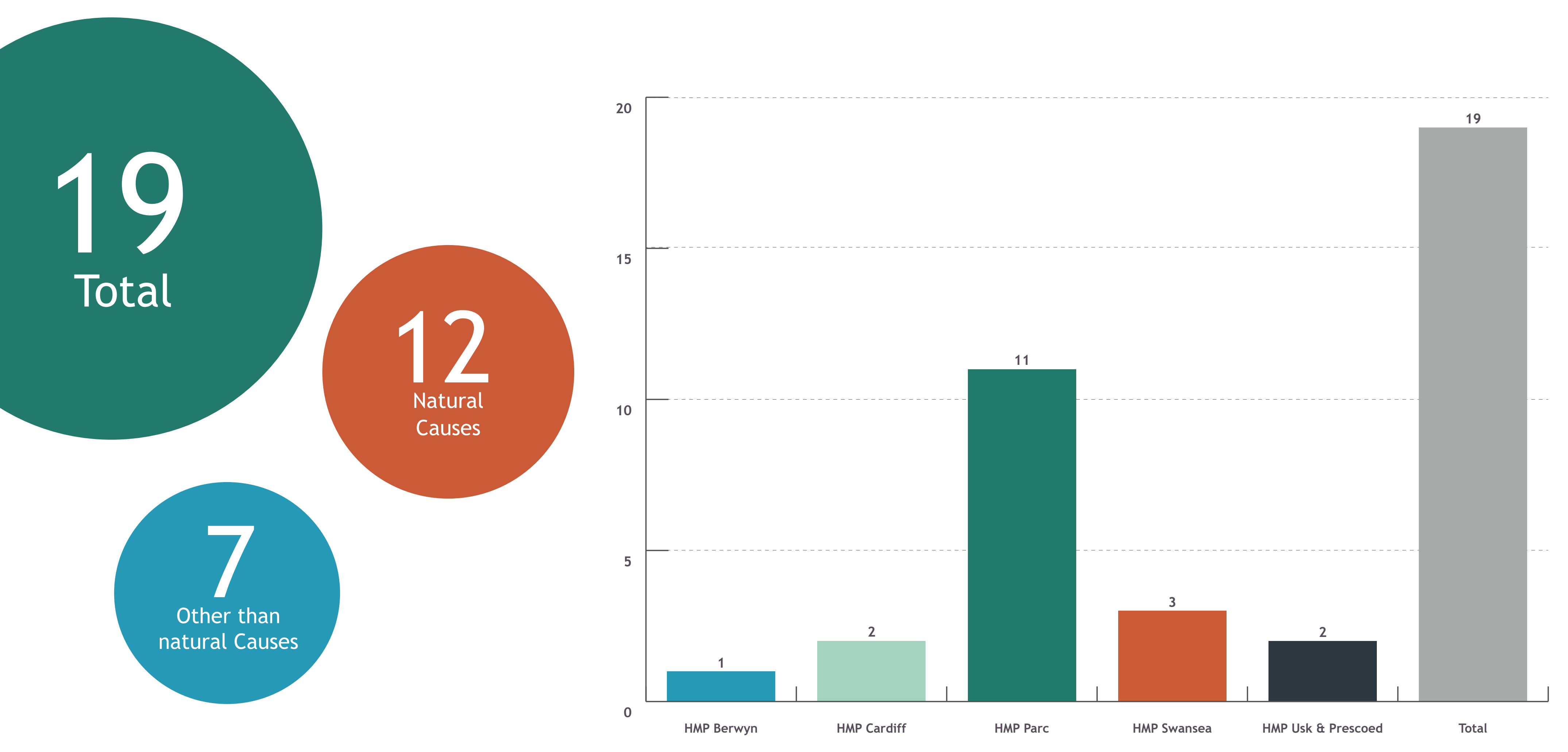
The past year's death in custody reviews have highlighted recurring trends and themes related to the treatment and care of individuals in custody.

These have included:

- The need for staff to prioritise comprehensive and timely documentation
- All staff need to be familiar with appropriate escalation procedures, to ensure concerns are identified and addressed promptly
- The need for timely healthcare requests, including blood tests, and the follow-up of any abnormal results
- Prison healthcare services must ensure the availability of essential medical equipment, in a timely manner to avoid compromising patient care.



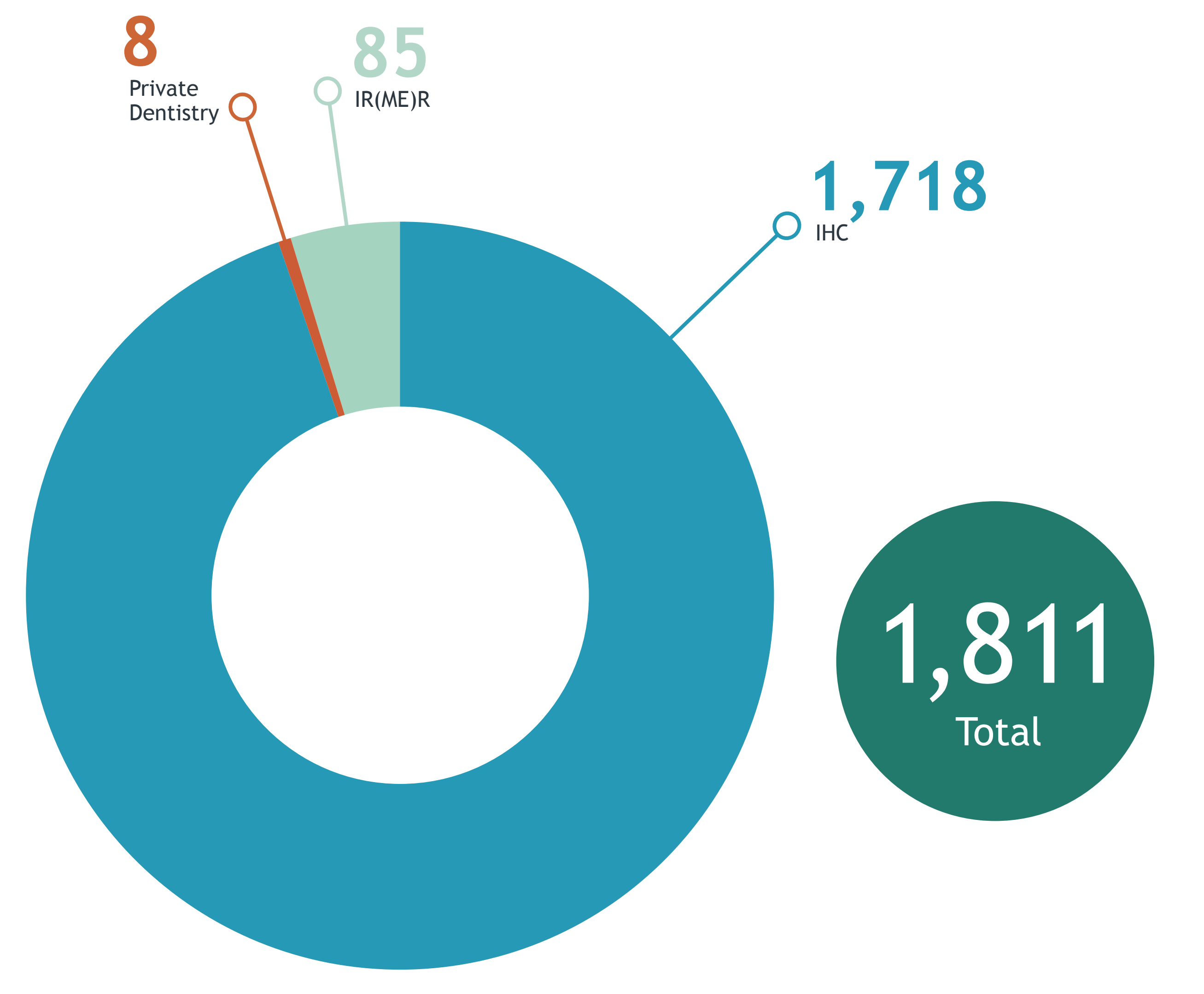
Number of Death in Custody Clinical Reviews



Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service, submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

The total number of regulatory notifications received in this reporting period was **1,811**. This figure includes notifications against the following set of regulations:



IHC regulatory notifications by subtype

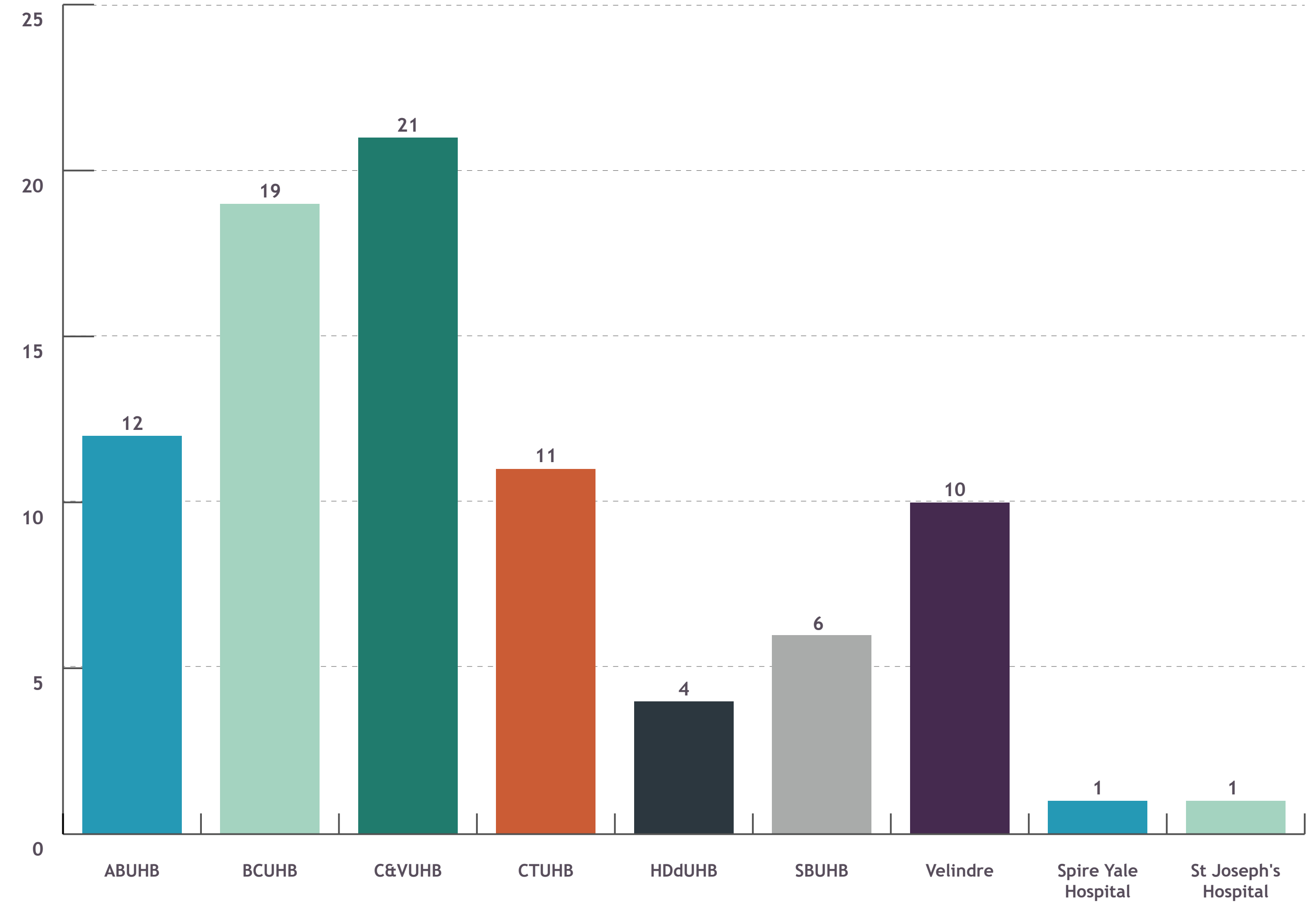
Subtype	Notifications
Death of Patient in Hospice	674
Death of Patient (Excluding Hospice)	14
Unauthorised Absence	140
Serious Injury	671
Outbreak of an Infectious Disease	25
Alleged Misconduct resulting in an Actual or Potential Harm to Patient	167
Deprivation of Liberty	27

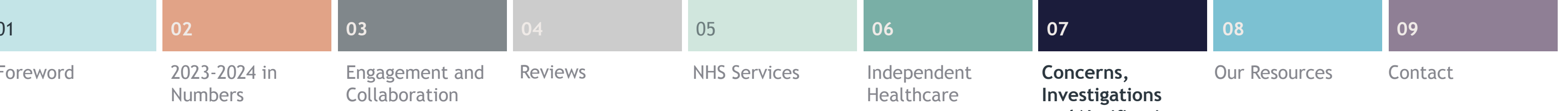
Dental regulatory notifications by subtype

Subtype	Number
Serious Injury	1
Outbreak of an Infectious Disease	7
Alleged Misconduct resulting in an Actual or Potential Harm to Patient	0
Death of a Patient	0

IRMER notifications received

The graph shows a breakdown of the number of notifications received against the IRMER regulations for this reporting period.





Safeguarding

The graph shows a breakdown of the number of safeguarding notifications received for this reporting period.

08.

Our Resources

Our Resources

Our people continue to be our most important resource. A programme of learning and development opportunities has once again been designed and delivered in accordance with feedback from staff. Our internal People Forum continues to provide a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development.

We rely on the clinical expertise of our pool of specialist Peer Reviewers, and we currently have a panel of over 200 with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service.

We have 44 Patient Experience Reviewers and Experts by Experience who have the critical role of assessing patient experience through talking to patients. Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

Team	Posts
Senior Executive	3
Inspection, Reviews, Regulation and Investigation	39
Partnerships, Intelligence and Methodology	14
Strategy, Policy and Engagement	7
Clinical advice (including SOAD service)	6
Corporate Services (including business support)	18
Total	**87**

Finance

For 2023-2024 we had a budget of approximately £5m.

We had the equivalent to 87 full-time staff as well as a panel of over 200 specialist reviewers.

In line with other public sector organisations, we continue and expect to experience sustained budgetary pressures. To respond to a very challenging budget situation, we spent part of 2023-24 working together as an organisation to prioritise and, where possible, make efficiencies to the way that we work.

The table below shows how we used the financial resources available to us in the last financial year to deliver our work in 2023-2024.

HIW Budget	£4,970,000
Expenditure	
Staff costs	£4,819,171
Travel and Subsistence	£33,178
Learning & Development	£30,768
Non staff costs	£72,421
Translation	£125,220
Reviewer costs	£615,419
ICT Non CRM costs	£95,391
CRM	£51,424
Total expenditure (a)	£5,842,992
Income	
Total income from Independent Healthcare (b)	£524,262
Total Net Expenditure (a-b)	£5,318,730

09.

Contact

This publication and other HIW information can be provided in alternative formats or languages on request.

There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 March 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Medical Devices Committee (MDC) – Annual Report 23/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr Executive Director of Allied Health Professions (AHP) & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Craig Roberts Assistant Director of AHP & Health Science (ADoAHPHS)

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The Medical Devices Committee (MDC) Annual Report 23/24 is intended to appraise the organisation of the effectiveness of the quality management systems in place across the Health Board's Medical Equipment and Devices Governance and Risk Management remit.

The intention of the report is to provide assurance to the Executive Team and Patient Quality, Safety and Outcomes Committee that the systems and processes are in place and operating effectively to achieve and maintain compliance with current and developing national Regulations, standards and guidance, under the constraints of what is practicable within available resources.

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Health Board's Executive lead for medical devices and equipment is the Clinical Executive Director of AHP and Health Science (DoAHPHS), with the management of devices, which is often consolidated within a dedicated Clinical Engineering department in organisations of comparable size, being shared across multiple teams situated within different directorates throughout the Health Board.

The MDC, established in 2019 and chaired by an ADoAHPHS, replaced oversight previously provided by the Board Health & Safety Committee. The Medical Director's Quality and Patient Safety (QPS) Risk Management team oversees regulatory governance. The Medical Electronics/Biomedical Engineering (EBME) department handles technical maintenance. Governance is dispersed across divisions, with the MDC acting as a hub to coordinate these efforts, though it faces challenges due to the lack of a consolidated Clinical Engineering department.

The MDC provides a structured approach to ensuring the organisation manages its medical devices in accordance with:

- The Medical Devices Regulations 2002 as amended
- The Health Board's Management of Medical Equipment Devices policy

As a sub-group/Committee of the Health Boards Quality and Patient Safety Operational Group, the MDC will be responsible for reducing risks associated with the purchase, deployment, management and use and decontamination of medical devices.

Membership of the group includes stakeholders from across the organisation who are involved with the strategic and operational management of medical devices and equipment, including:

- EBME
- Radiology
- Cardiology
- Divisional Leads
- Procurement
- Health and Safety
- Risk Management
- Hospital Sterilisation and Decontamination Unit (HSDU)
- Infection Prevention and Control/Decontamination
- Informatics
- Estates and Facilities
- Research and Development
- Clinical Education

Outcomes include

- Provision of assurance to the Health Boards Quality and Patient Safety Operational Group around appropriate governance relating to medical devices management and use.
- Provision of assurance around selection and procurement process, learning from incidents, safety communications and risk management.

This is the first annual report produced by the group

Cefndir / Background

The UK Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines, medical devices and blood components for transfusion in the UK. It operates within a statutory framework set by HM Government to direct overall policy under its regulatory remit.

Current guidance provided by the MHRA on the governance of medical Devices risk in healthcare organisations, 'Managing Medical Devices' February 2021 [https://www.gov.uk/government/publications/managing-medical-devices], strongly recommends these organisations to have in place a system of management incorporating:

- Appointment of a director or board member with overall responsibility for medical device management.
- Putting in place systems to ensure reporting of device issues including: the effectiveness of the medical devices management system, the condition and performance of medical devices, and the execution of investment, replacement and disposal plans.
- Establishment of a medical devices management group to develop and implement policies across the organisation, and which oversees improvement in communication about medical devices within the organisation through multidisciplinary involvement in the governance processes.

This guidance supports compliance with UK legislation relating to Medical Devices including:

- The Medical Devices Regulations 2002 (SI 2002 No 618, as amended)
- the General Product Safety Regulations 2005 (SI 2005 No 1803)
- the Medicines and Medical Devices Act 2021

Asesiad / Assessment

A comprehensive overview of governance activity is embedded in the main body of the report. The key assurance is the status of compliance with Internal Audit recommendations

Argymhelliad / Recommendation
The Patient Quality and Safety Outcomes Committee is requested to note the contents of this annual report for assurance

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care 3.4 Information Governance and Communications Technology 3.5 Record Keeping 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	MDC - Medical Devices Committee AHP - Allied Health Professions (Note: formerly termed as 'Therapies' in Health Board role titles) DoAHPHS - Director of AHP and Health Science ADoAHPHS - Assistant Director of AHP and Health Science UK – United Kingdom MHRA - Medicines and Healthcare products Regulatory Agency SI – Statutory Instrument QPS - Quality and Patient Safety EBME - Medical Electronics/Biomedical Engineering FSN - Field Safety Notice FSCA - Field Safety Corrective Action PCA - Pain Controlled Analgesia CPAP - Continuous Positive Airway Pressure (Therapy) MDSO - Medical Device Safety Officer RFID Radio frequency identification

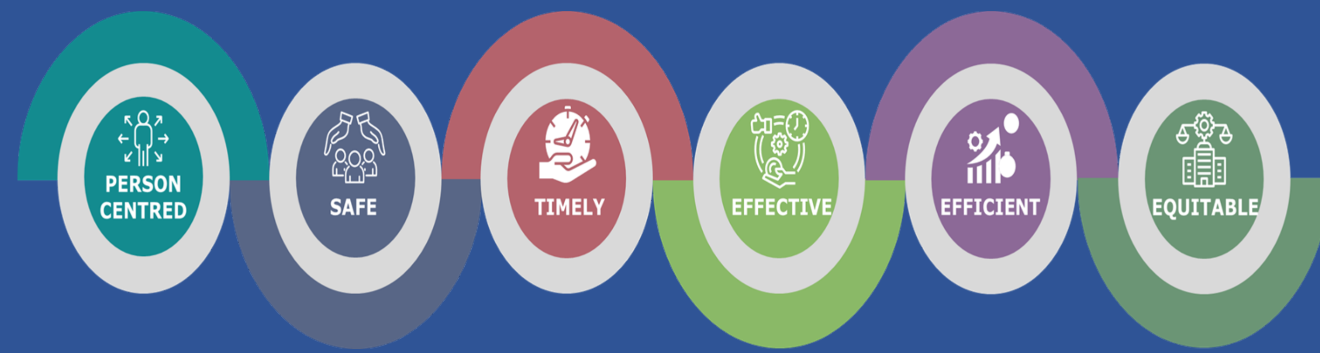
	ESR – Electronic Staff Records system ARAC - Audit Risk and Assurance Committee IHM&M - In-house Manufacture and Modification (of medical devices) QMS – Quality Management System WG-MDRG - Welsh Government's Medical Devices Regulations Group NWSSP - NHS Wales Shared Services Partnership PSA - Patient Safety Alerts PSN - Patient Safety Notices GUH - The Grange University Hospital ABUHB – Aneurin Bevan University Health Board
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable

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

Medical Devices Committee (MDC)

Annual Report 2023/2024



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2023/2024 Medical Devices Committee Report

Introduction

Welcome to the 23/24 Aneurin Bevan University Health Board's Annual Medical Devices Committee activity Report.

The Medical Devices Committee (MDC) forms part of the wider quality management system for the organisation and is in place to ensure and assure the organisation is meeting and maintaining the standards required to undertake activities involving medical devices and equipment across the Health Board.

The committee is chaired by the Health Board's ADoAHPHS as delegated by the Clinical Executive DoAHPHS, who is the Health Board's Executive lead for medical devices and equipment. Membership is made up of senior stakeholder representation from across the Health Board including but not limited to:

- EBME
- Radiology
- Cardiology
- Divisional Leads
- Procurement
- Health and Safety
- Risk Management
- Hospital Sterilisation and Decontamination Unit (HSDU)
- Infection Prevention and Control/Decontamination
- Informatics
- Estates and Facilities
- Research and Development
- Clinical Education

This is the inaugural report from the committee, which was established in 2019 and which replaced the oversight previously provided by the Board Health & Safety Committee.

This report covers the financial year from April 2023 to March 2024. It is intended to provide an update with respect to medical devices and equipment governance and risk management across the Health Board, in line with current legislation, standards and guidance, and with Welsh Government policy.

The committee sat only twice during the reporting period: there has been difficulty in convening a quorate group at meetings owing to prioritisation within the Divisions and Directorates in coping with their respective ongoing service pressures.

The main work of the committee this reporting period has been in supporting the implementation of the remaining measures to assure full compliance with the recommendations of the 2017 Medical Devices Audit.

The reporting period has brought a focus onto the strategic work aspects of the committee. The UK Government has embarked on a period of refreshing the legislation relating to the medical devices marketplace and product lifecycle safety surveillance. These both have impact on organisations acquiring and innovating devices. The committee has realised that to handle these changes, the committee will need to develop a stronger presence and position at the centre of medical devices and equipment governance within the Health Board.

The structure and terms of reference of the committee will be reviewed during the next reporting period with a view to improving its prominence and effectiveness.

Who are the MHRA?

The Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components for transfusion in the UK.

It carries responsibilities to:

- ensure medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy (effectiveness)
- secure safe supply chain for medicines, medical devices and blood components
- promote international standardisation and harmonisation to assure the effectiveness and safety of biological medicines
- educate the public and healthcare professionals about the risks and benefits of medicines, medical devices and blood components, leading to safer and more effective use
- enable innovation and research and development that is beneficial to public health
- collaborate with partners in the UK and internationally to support our mission to enable the earliest access to safe medicines and medical devices and to protect public health

MHRA is the designated authority that administers and enforces the law on medical devices in the UK. It has a range of investigatory and enforcement powers to ensure their safety and quality. To ensure that medical devices placed on the market and put into service in the UK meet these regulatory requirements it performs the following activities:

- assess all allegations of non-compliance brought to it, using a risk-based system
- monitor the activity of UK approved bodies designated by MHRA to assess the compliance of manufacturers
- investigate medical devices as a result of adverse incident reports or intelligence indicating a potential problem

These activities form part of its market surveillance obligations under Regulation 765/2008 in Great Britain and Regulation 2019/1020 in Northern Ireland. It undertakes them in accordance with the statutory principles of the Regulators' Code.

The MHRA interfaces with healthcare organisations though the following key routes:

- The issue of guidance documents and information to support safe deployment and use of medical devices.
- The issuing of National Patient Safety Alerts relating to medical devices via NHS England's Central Alerting System (CAS) and also to NHS Wales Executive.
- The reporting to it of adverse incidents involving medical devices experienced by healthcare organisations, and of defective or fake medical devices via its Yellow Card reporting system)
- The notification of Field Safety Notices (FSN) and Field Safety Corrective Actions (FSCA) by manufacturers
- The regulation of medical device Clinical Investigations during conformity assessment by manufacturers who may involve healthcare organisations as partners.
- Engagement with healthcare organisations at an operational level through their Medical Device Safety Officers (MDSO), though the National Medical Device Safety Network.
- Engagement with healthcare professionals in creation of guidance documents though its Trusted Advisor Groups.

Quality Metrics

The MDC coordinates its activity though its MDC Workplan, which is aligned to the Welsh Government Health and Care Standards Framework April 2015, which have applied up to the start of the reporting period.

- **Appendix 1 - Welsh Government Health and Care Standards Framework April 2015**

The Workplan was structured around the criteria for Standard 2.9 (see box below) and links secondary reference to the other relevant standards within these standards that cross with overall governance of medical devices.

Welsh Government: Health and Care Standards Framework April 20215

Standard 2.9 Medical Devices, Equipment and Diagnostic Systems

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- There is compliance with health, safety and environmental legislation, regulation and guidance
- Processes ensure that equipment, and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used.

- An ongoing programme of training and competence assessment covers staff and users.
- Timely reporting and management arrangements exist to address any device, equipment or system faults in use or in stock, including any alert or warning notices issued by appropriate agencies such as MHRA.
- Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.

Although these standards were superseded in May 2023 by the Health and Care Quality Standards 2023 (WHC/2023/013), the fundamental principles, systems and practice around medical devices and equipment governance and risk management are unchanged in the short term.

The tasks populating the Workplan were primarily linked with addressing the recommendations of the 2017 Medical Devices Audit and the existing Workplan structure serves to convey these tasks to the point of full compliance with the 2017 Audit recommendations.

- **Appendix 2 - MDC Workplan as at October 2023**

The Workplan is configured to handle the detail for tracking each of the criteria within Standard 2.9 as individual workstreams. Progress on these workstreams has been prioritised according to available resources, and owing to limitations of these, progress during this reporting period was limited across the aspirational representation of what is required within the Workplan.

Medical Devices Committee Meetings

The Committee has succeeded in sitting with quoracy only twice within the current reporting period. Although there has been a six-weekly calendar slot, owing to operational pressures being experienced by the membership, there has been a persistence of valid apologies for non-attendance that has slowed progress.

Nonetheless, the committee has made significant progress on actions to complete tasks to close off the 2017 Medical Devices Audit and to track forthcoming revision of the Medical Devices Regulations, planning and preparing for how theses are anticipated to impact upon the Health Board.

- **Appendices 3,4,5 & 6 - MDC agendas and minutes for quorate meetings**

Audit Response Work

A review of progress with actions to comply with the recommendations of the 2017 Medical Devices Audit re-assessed the original recommendations as originally written

and identified those that had been completed within more general activity. For example, the requirement to have accurate data on the deployment location of equipment had become lost in the timeline of installing a cross-system RFID system, which was wider and greater in scope than the original brief within this particular Audit.

- **Appendix 7 - 2017 Medical Devices Audit Progress Tracker**

There are two risks linked to the work being reported to the Health Board's Audit Risk and Assurance Committee (ARAC). Update reports to this committee have been periodically provided through the Executive Director of Allied Health Professions & Health Science.

- **Appendices 8 & 9 - ARAC Reporting papers**

Key pieces of work being actioned during the latter weeks of the reporting period included:

- Work in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate.
- Creation of user guide for the Customer Portal of the Medusa® medical equipment management database, and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment.
- Conducting of a local audit of non-electrical medical devices and equipment that is not currently captured in the Medusa® database.
-

Conclusion of these tasks enables basic compliance to be declared.

Work continuing into the next reporting period to strengthen compliance with the 2017 Medical Devices Aduit recommendations includes:

- Progressing on the roll-out of the Paragon® RFID system – once completed this will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually.
- Inclusion in future amendment to the Health Board's Medical Equipment and Devices Policy of the improvement in clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.

Regulatory Compliance Work

Throughout the reporting period, the MDC has been tracking news from the MHRA on the planned refresh of the UK Medical Devices Regulations. The MDC Chair and the QPS Risk Manager have attended meetings of the Welsh Government's Medical Devices Regulations Group (WG-MDRG). This group acts as a Welsh communication

network and lobbying group with the MHRA towards interpretation and managing the practical impact the new Regulations will have within Welsh Health Boards.

At the beginning of the reporting period, the enactment date for the new Regulations was set for July 2024 but this was pushed back by the MHRA by a year to July 2025. The Regulations will apply to new products first placed on the market or first put into use after the enactment date but with transition arrangements also in place.

A key concern is that the MHRA intends to Regulate In-house Manufacture and Modification (IHM&M) of medical devices in health institutions, where devices are both created and used within the same legal entity. This is anticipated to require services undertaking IHM&M to have in place a Quality Management System (QMS)to govern this process.

A paper was prepared at the end of June 2023 for tabling at next the Executives Committee meeting which summarised the Health Board's position on preparedness for the WG-MDRG's anticipated requirements around IHM&M for the new Regulations.

- **Appendices 10 & 11 - Draft Executive Committee Paper and Health Board response to the Welsh Government's baseline check on preparedness.**

The MDC set up a working group supported with a Microsoft Teams channel to convey activities to position the Health Board to comply with any new Regulatory requirements manifested in the new Regulations when they are published.

There have been discussions between the WG-MDRG and the MHRA on interpretation legal entities relating to Health Boards and their caring responsibilities with patents in a domiciliary setting, and on clarifying distinctions between 'in-house manufactured' devices and 'custom made' devices in the Regulations. This may limit the requirements to mandate QMS's in some services.

Incidents

The MDC keeps an oversight of trends and outliers in incident reports involving medical equipment and devices that are reported in the Datix incident reporting system from staff across the Health Board.

The MDC notes that the Health Board has gaps in Clinical Engineering expertise that, if resolved, would enable deeper analysis of the Health Board's incident data, to be linked with the more detailed engagement from manufacturers that will be required in the future. A forthcoming regulatory 'Surveillance' framework will support this with the intention of driving better product design and reducing the reliance of falling to endless layers of user training as a workaround for poor device design.

Figure 1: Incident Numbers by Division and Severity

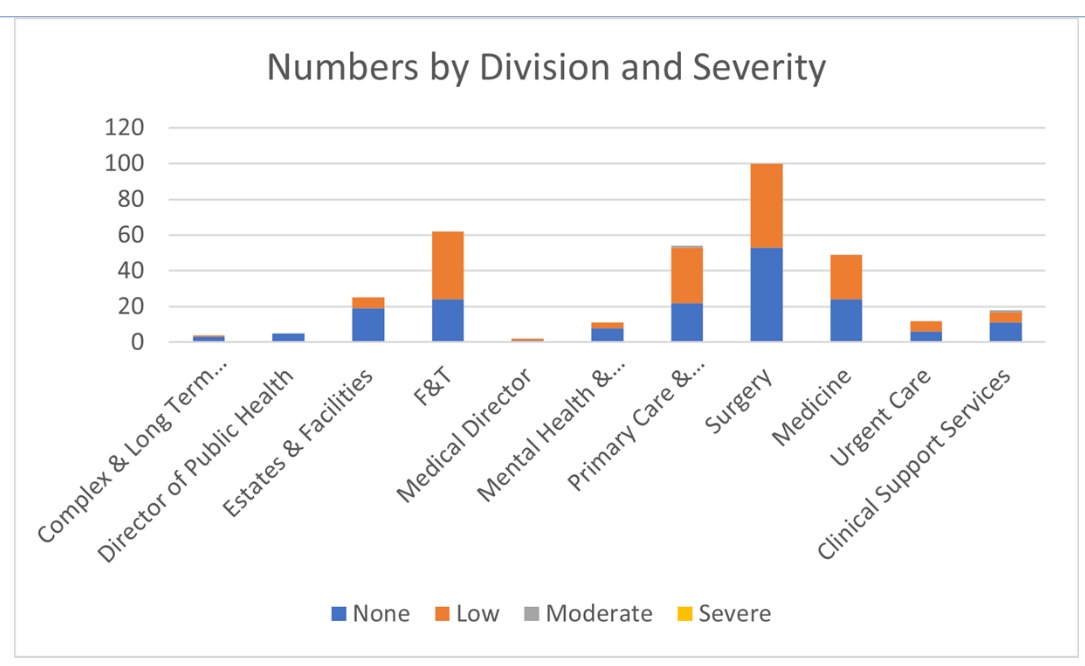
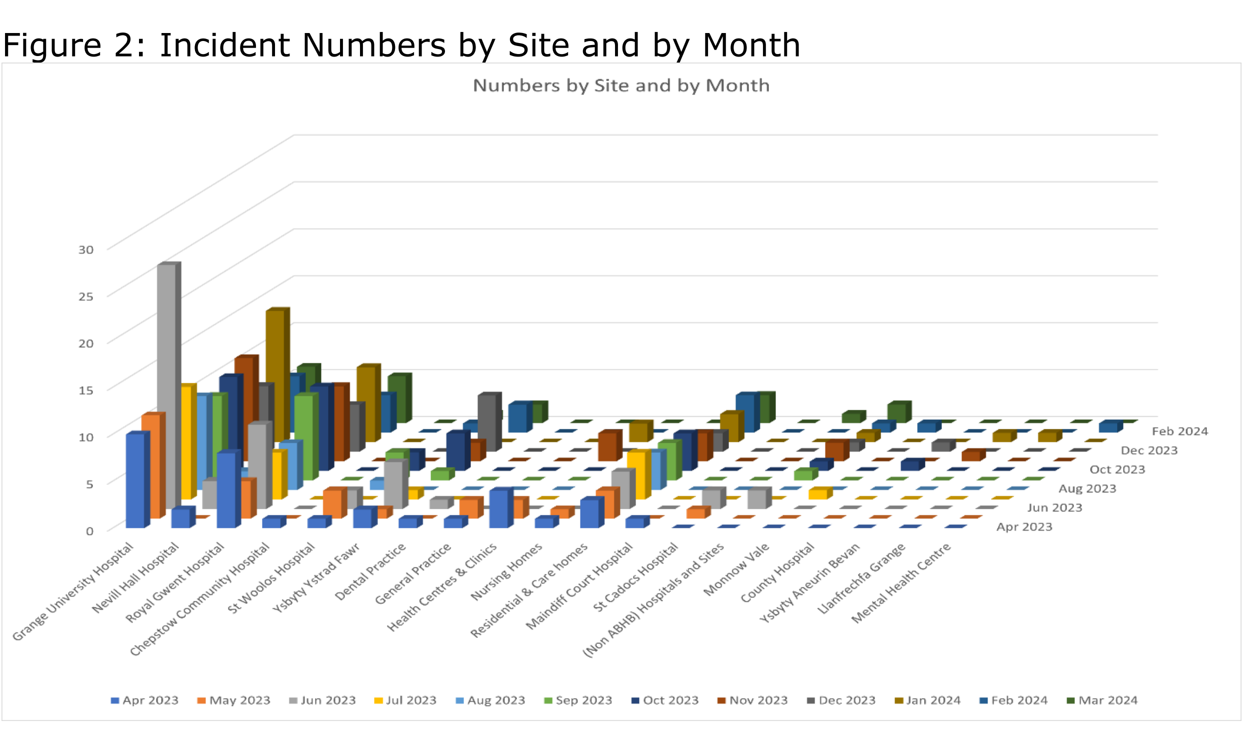


Figure 2: Incident Numbers by Site and by Month



- **Appendix 12 - Incident Reports Spreadsheet**

Field Safety Corrective Actions, Patient Safety Alerts & Notices, and Internal Communiques

Field Safety Corrective Actions

The Medical Directors QPS Risk Management Team, the EBME Department and local Procurement Officers for NWSSP Procurement Services work together to act on FSCA's relating to medical devices posted by the MHRA on its website and from discrete manufacturers by email and by letter. The combined team meet weekly to review and plan actions.

During the reporting period the team handled 477 FSCA's of which 292 were relevant to equipment used in the Health Board and shared locally to the appropriate staff and departments. There were no incidents recorded classified as 'Severe' during the reporting period.

- **Appendix 13 - Summary of Activity by the FSCA Handling Combined Team**

Patient Safety Alerts and Notices

The MDC Keeps an oversight of activity by the Medical Director's QPS Risk Management Team in steering compliance activity for Patient Safety Solutions issued by NHS Wales Executive, in the form of Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). The Team oversees the convening and work planning of Health Board working parties for each PSA or PSN and declares compliance when due to the NHS Wales Executive through the Medical Director.

A summary of activity by the Medical Director's QPS Risk Management Team on PSA's and PSN's published or having compliance dates within the reporting period is included below.

- **Appendix 14 - Summary Table of PSA's and PSN's Covered within Reporting Period**

Internal Communiques

The Medical Director's QPS Risk Management Team oversees the distribution of wide-audience messages; to share learning from local patient safety incident investigations and for internal messages relating to medical device safety information. For example, in response to a FSCA received from a manufacturer in relation to a production fault requiring recall of devices, or to new user instructions or a training action to mitigate an emerging risk posed by a device used within the Health Board.

The following table summarises this category of internal communiques issued during the reporting period.

- **Appendix 15 - Summary of Internal Communiques Issued within Reporting Period**

EBME Report

The Health Board's EBME Department is a support service within Estates & Facilities that provides a cross-system medical equipment management service.

These services include:

- Commissioning/Acceptance Testing New & Loan Medical Equipment
- Repair, Maintenance & Calibration
- Device Configuration
- Product Evaluation and Testing
- Contract Management
- First Line Technical Support
- Maintaining an accurate Medical Equipment Inventory
- Recording Life Cycle Costs and Service History
- Provide advice and guidance on Medical Equipment Standardisation
- Provide advice and guidance on Clinical Training
- Electrical Safety Testing to Medical Device Standards – IEC60601-1 & IEC62353
- Provide advice, guidance and action of Medical Device Alerts, and for Manufacturers' Field Safety Corrective Actions in relation to Medical Devices
- Condemnation and disposal of obsolete medical equipment and devices in line with ABUHB policies and procedures.

The department manages the provision of technical support covering 26,313 items of re-usable electronic patient-connected medical devices used throughout the Health Board at the end of the reporting period.

Within the reporting period the department commissioned 2590 new devices and decommissioned 983 devices reaching the end of their service life. This represents an annual growth in device numbers of 6.5%.

Key Projects

- Completed replacement program of new BD® Nexus Anaesthesia infusion Devices throughout ABUHB Theatres.
- Completed replacement program of Pain Controlled Analgesia (PCA) pumps, including Epidural & Nerve Block pumps.
- Completed transition and implementation of new Bodyguard T Ambulatory Syringe Drivers from McKinley T34 devices.
- Continued with the replacement program of 5000 Philips CPAP devices used predominantly by Respiratory patients as per manufacturer's FSCA issued in 2021.

Maintenance Activity

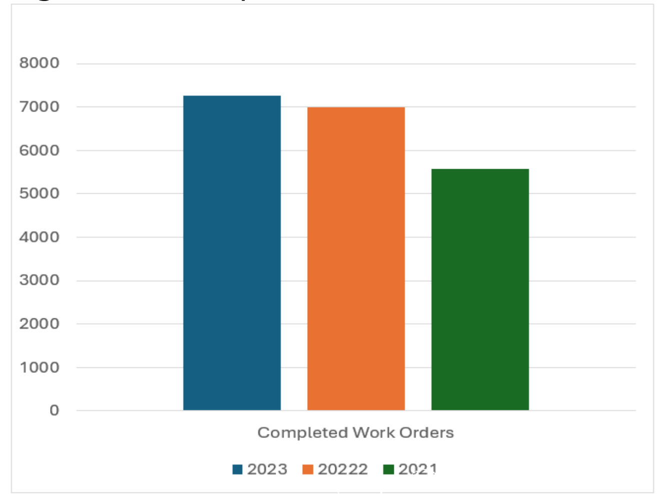
There are two key divisions in the department's activities:

- Planned work; including planned preventative maintenance, commissioning of replacement equipment and equipment for new clinical service initiatives
- Reactive work; including equipment breakdown repairs and in responding to managing implementation of FSCA's.

Over the reporting period, the allocation of resources between these two divisions has been evenly split.

Going into the next reporting period, the department has been managing to perform 50.74% of planned preventative maintenance within scheduled date with its present resources.

Figure 3: Completed Work Orders and Materials Expenditure by Year



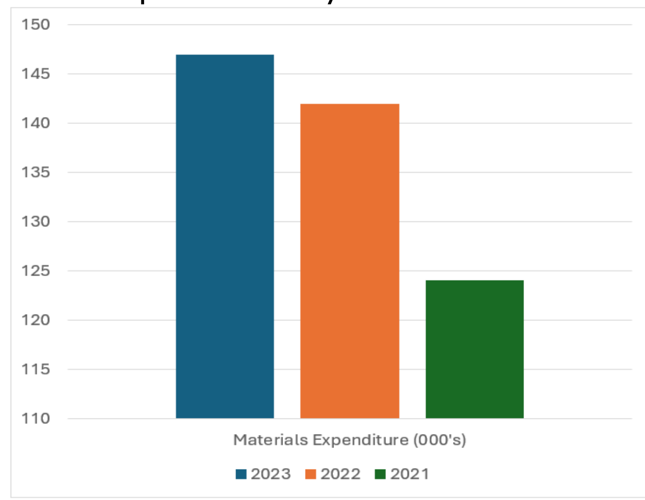
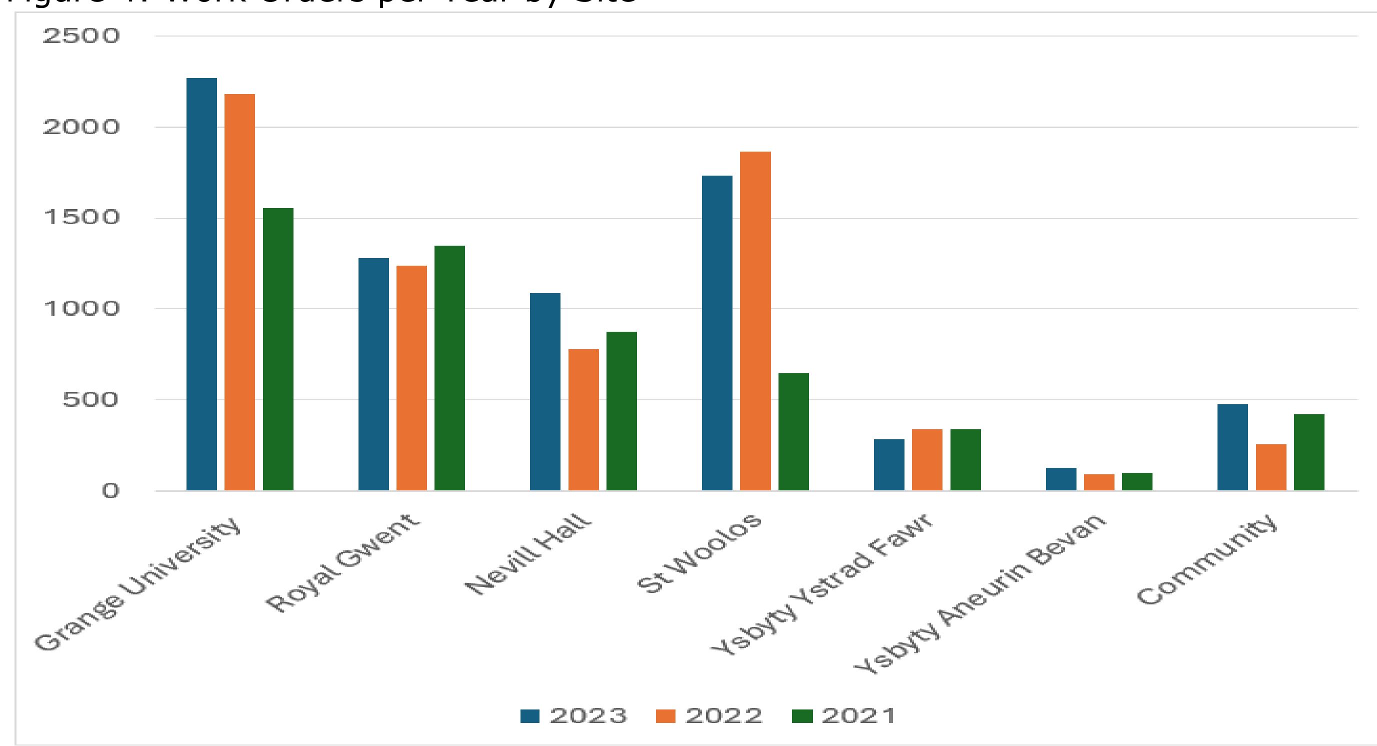


Figure 4: Work Orders per Year by Site



Inventory Management Activity

During the reporting period development of the Softpro® Medusa medical equipment management system database has been ongoing, A major barrier has been that the Health Board's financial asset register, hosted in RAM® Asset 4000®, was not linked with Medusa. Part of the Health Board's RFID tracking project to link Medusa and Asset 4000 to the third system involved: the Paragon RFID system, was completed in August 2023.

The work continues to progress with assets being tagged as and when EBME encounter them, though equipment commissioning work and during day-to-day planned and reactive equipment management activities. Efforts to rapidly complete the equipment tagging exercise have been restricted by the ongoing service pressures.

Whilst the aim is to tag all medical equipment and devices throughout the Health Board's hospitals, focus this reporting period has been on completing the Grange University Hospital (GUH) site. At stocktake in August 2023, of 3242 assets listed at GUH in Medusa, 1341 devices had been tagged, representing 41.3% of assets at the site. In total over 4100 medical devices were RFID tagged at that point across the Health Board. At the end of the reporting period, over 5000 devices had been tagged and registered in the system.

Goals for the Next Period

The department will be operating under reduced staffing pending recruitment of a new Head of Department to succeed the outgoing lead through retirement. Also the department intends to use the opportunity to streamline its skills stratification and utilisation by recruitment to junior positions being created.

Development of the Medusa database with a major software upgrade is anticipated to provide greater functionality to the system, including more comprehensive data structure, allowing more functional querying of data, and better access to the information, (for example, access to the Customer Portal for equipment users).

- **Appendix 16 - EBME Performance Review Report - 2023**

Devices Training Report

In the last quarter prior to the start of the reporting period, the QPS Risk Management Team recruited a new specialist to oversee infusion device training governance within the portfolio. This enabled significant progress to be made in redesigning the training set up and on training cascade-based training, in line with the work to compl**y** with the requirements of the 2017 Medical Devices Audit.

Detail is provided in the QPS Infusion Training End-of-Year Report below and in the Audit Response Work section above.

- **Appendix 17 - QPS Infusion Training End-of-Year Report**

Successes and Challenges 2023/24

Successes

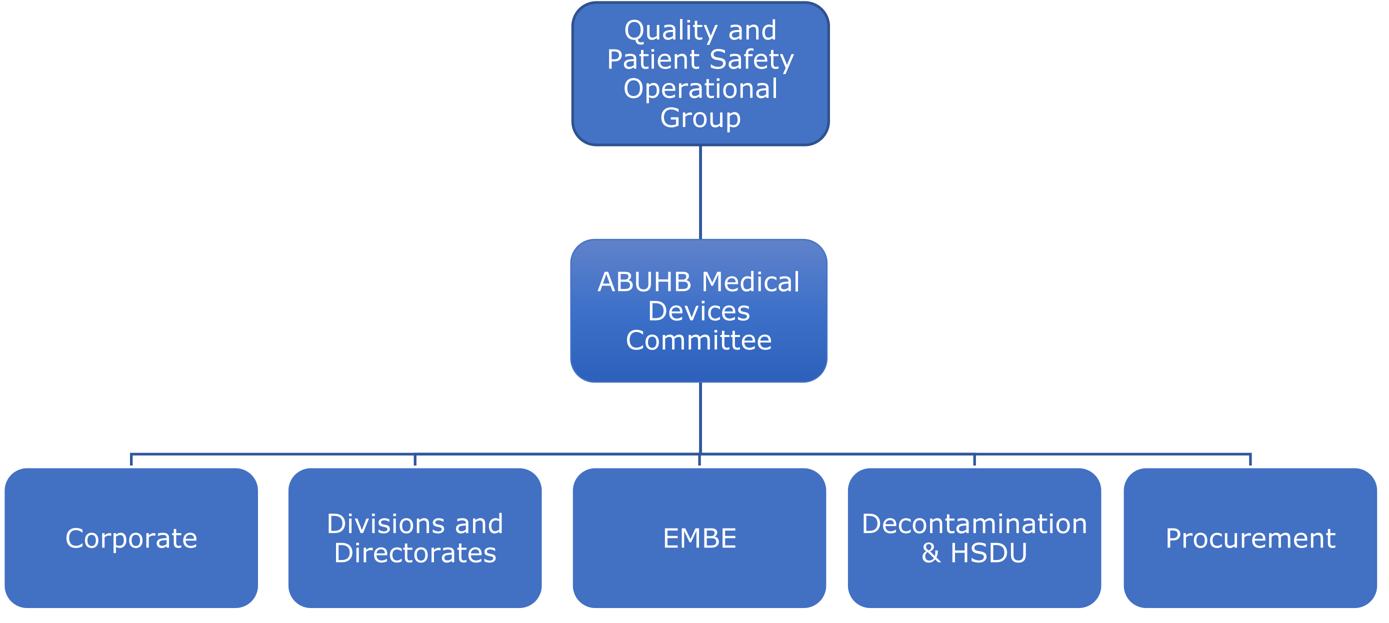
- Implementation of a cascade training system for infusion devices in line with the 2017 Medical Devices Audit recommendations significantly started to improve training rates towards the end of the reporting period
- Successful engagement with the Welsh Government and the Health Boards across Wales on preparedness for anticipated regulation of in-house medical device manufacture
- Rationalisation of the fundamental remaining tasks to close off the 2017 Medical Devices Audit and creation of a supporting progress tracker spreadsheet-based tool
- Starting of a sense-check project to assess the medical devices governance and risk management setup and staffing in similarly sized Health Boards in Wales and key health organisations in the UK

Challenges

- Rate of progress on completing the RFID tagging of EBME managed devices
- Poor engagement with Workforce in identifying staff requiring device training through ESR
- Poor attendance rate to diarised MDC meetings
- Limited capacity to handle multiple MDC workstreams owing to limited Clinical Engineering skill base within the organisation

Governance Structure

Committee Internal Interconnections



- **Appendix 18 – Terms of Reference**

Goals for 2024/25

Over the next 12 months the MDC team will work collaboratively with Divisions and the governance groups towards achieving the following:

- Complete actions to fully comply with 2017 Medical Devices Audit recommendations on Equipment asset management
- Complete actions to fully comply with 2017 Medical Devices Audit recommendations on Training
- Continue to track the Welsh Government's steer on in-house manufacture of medical devices
- Review the structure and terms of reference of the committee
- Develop a comprehensive table of divisions of responsibility for medical devices and equipment
- Revise the MDC Workplan to track activities for next reporting period
- Continue to build on effective relationships with the MHRA and other bodies and networks
- Produce and action a workplan for handling the 2024 Medical Devices Audit focussed on Ultrasound equipment

www.gov.wales

Health and Care Standards

April 2015

Foreword by the Minister for Health and Social Services

On the 9 July 2013 we gave a commitment to review and update the Standards for Health Services in Wales and the Fundamentals of Care Standards.

During November 2014 to January 2015 we consulted on a revised framework of standards to support the delivery of high quality services in the NHS in Wales. The consultation involved a broad range of stakeholders and gathered their views on the changes needed in developing our new Health and Care Standards. In order to maximise levels of engagement in the consultation amongst stakeholders and the public, Welsh Government arranged three consultation events.

The NHS Outcomes and Delivery Framework is one of three frameworks being published to help drive the continual improvement in the health and wellbeing of the people of Wales, the others relating to social services and public health. It identifies key population outcomes and indicators grouped under seven themes. The themes were developed through engagement with patients, clinicians and stakeholders and identify the priority areas which they wanted the NHS to be measured against. Although each of the three frameworks has its own separate function, they all recognise their interconnections and shared measures will be used to support partnership working and to deliver improvements in both health and wellbeing.

These Health and Care Standards have been designed to fit with the seven themes and the opportunity has also been taken in developing them to identify outcomes relating to social services and public health.

The Health and Care Standards have also been designed so that they can be implemented in all health care services, settings and locations. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for improvement. The public and patients themselves must take responsibility for helping the NHS help them through working with it and through taking prudent action to protect and promote their own health.

I am very pleased to commend the Health and Care Standards to you. They further demonstrate our continuous commitment to improving the health and wellbeing of the population of Wales and the quality of the healthcare provided.

Mark Drakeford AM

Minister for Health and Social Services

OGL

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Introduction

In 2013, Welsh Government agreed the need for a review of the Doing Well, Doing Better: Standards for Health Services in Wales (2010) and the Fundamentals of Care Standards (2003), which provided an opportunity to align standards underpinning the planning and provision of healthcare services. These new Health and Care Standards are designed to be implemented in all health care organisations, settings and locations, and by all teams and services.

Every person in Wales who uses health services or supports others to do so, whether in hospital, primary care, their community or in their own home has the right to receive excellent care as well as advice and support to maintain their health. All health services in Wales need to demonstrate that they are doing the right thing, in the right way, in the right place, at the right time and with the right staff. The Health and Care Standards provide the framework to help teams and services demonstrate this.

The public consultation on the revision of the Doing Well, Doing Better: Standards for Health Services in Wales and the Fundamentals of Care provided an updated and integrated framework of standards aimed at helping people in Wales to understand what to expect when they access health services and what part they themselves can play in promoting their own health and wellbeing. They set out the expectations for services and organisations, whether they provide or commission services for their local citizens, and need to be owned by them.

A summary of the main points made in response to the consultation is available on the Welsh Government website **(http://gov.wales/consultations/?lang=en)**. All responses to the consultation, including feedback received at the three consultation events, have informed the production of these Health and Care Standards.

The standards come into force from 1 April 2015 and bring together and update the expectations previously set out in "Doing Well Doing Better Standards for Health Services in Wales", and the "Fundamentals of Care" in conformity with the Health and Social Care (Community Health and Standards) Act 2003.

Legislative Framework

Welsh Ministers are permitted (Section 47 of the Health and Social Care (Community Health and Standards) Act 2003), to prepare and publish statements of standards in relation to the provision of health care by and for Welsh NHS bodies. The Welsh Government is required to keep the standards under review and may publish amended statements whenever it considers it appropriate.

Vision and Principles

Wales has strong systems in place to ensure quality and safety in the NHS. Safe Care, Compassionate Care: A National Governance Framework **(www.wales.nhs.uk/governance-emanual/opendoc/219549)** sets out the expectations that all services should be patient centred and driven by their needs. This committed Wales to ensure high quality, safe care whenever and wherever it is provided by:

- doing the right things well;

- knowing how well we are doing;
- being open and honest in all that we do;
- showing care, compassion and commitment;
- leading by example.

The Welsh Government Quality Delivery Plan for the NHS in Wales (2012 – 2016) (http://gov.wales/docs/dhss/publications/120517planen.pdf) sets out the clear vision for a quality-driven NHS Wales to achieve the triple aim of:

- providing the highest possible quality care and excellent experience;
- improving health outcomes and helping reduce inequalities;
- getting high value from all our services.

The Health and Care Standards will form the cornerstone of the overall quality assurance system within the NHS in Wales. Alongside the Framework for Assuring Service User Experience (2013) **(www.wales.nhs.uk/governance-emanual/document/214368)** it will help to ensure that people have positive first and lasting impressions, that they receive care in safe, supportive and healing environments, and that they understand and are involved in their care.

Co-production is central to the Social Services and Well Being Act and how health and social services are being developed. Everyone, adult or child, has a right and can be given a voice and the opportunity to be heard as an individual, as a citizen, in helping shape the decisions that affect them, and to exercise greater control over their day to day lives. This parallels the approach to prudent healthcare which the NHS in Wales is embracing, with its focus on: achieving health and well being with the public, patients and professionals as equal partners through co-production; caring for those with the greatest health need first, making the most effective use of all skills and resources; doing only what is needed and doing no harm, no more, no less; and reducing inappropriate variation using evidence-based practices consistently and transparently.

All of the principles outlined above are supported by the Welsh Government's commitment described in the strategy 'More than just Words' to ensure that access to services through the medium of Welsh becomes a reality for Welsh speaking patients and service users.

Purpose

The Health and Care Standards:

- embrace the principles of co-production and prudent health care;
- offer a common language to describe what high quality, safe and reliable healthcare services look like;
- can be used by people of all ages to understand what high quality safe healthcare should be and what they should expect from a well-run service;
- enable a person-centred approach by focusing on outcomes for service users and driving care which places people at the centre of all that the service does;

- create a basis for improving the quality and safety of healthcare services by identifying strengths and highlighting areas for improvement;
- can be used in day-to-day practice to encourage a consistent level of quality and safety across the country and across all services;
- promote practice that is up to date, effective, and consistent;
- promote accountability of health services to service users, the public and funding agencies for the quality and safety of services by setting out how providers should organise, deliver and improve services;
- enable people to contribute fully to their own health and wellbeing;
- recognise the quality standards for other care and support providers issued under the Social Services Regulation and Inspection Bill currently being considered by the National Assembly for Wales.

Terminology

People

Throughout the Health and Care Standards and supporting guidance the term ‘people' is used. This is intended to include:

- those who use healthcare services;
- their parents, guardians, carers and family;
- their nominated advocates;
- potential users of healthcare services.

The term ‘people' is used in general throughout this document but occasionally the term ‘patient' is used where it is more appropriate.

Health Services

This term is intended to include Welsh NHS bodies, independent contractors, and other organisations and individuals including the independent and voluntary sectors, which provide or commission health services for individual patients, service users and the public of Wales.

How the Health and Care Standards are structured

As figure 1 illustrates below, the seven themes are intended to work together. Collectively, they describe how a service provides high quality, safe and reliable care centred on the person.

Each theme includes a number of standards. These are not listed in priority order and there is some overlap across themes and standards. There are some standards that do not just stand alone but have a much wider influence they are, communicating effectively, quality improvement research and innovation, information governance and communications technology, record keeping, and people's rights.

Figure 1

Person centred care (illustrated in the centre of figure 1) refers to a process that is people focused, promotes independence and autonomy, provides choice and control and is based on a collaborative team philosophy. It takes into account people's needs and views and builds relationships with family members. It recognises that care should be holistic and so include a spiritual, pastoral and religious dimension. The delivery of person centred care requires both safe and effective care and should result in a good experience for people. This responds to the need expressed by NHS Wales to be able to describe the key determinants of a "good" experience to help both users and providers in assessing how people feel when they receive care and services.

Co-production can support the delivery of person-centred care, which prioritises putting patients, their families and carers at the heart of all decisions and plans about health care. It sees patients as equal partners in planning, developing and assessing care to make sure it is most appropriate for their needs. Co-production is an approach to public services which involves citizens, communities, and the professionals who support them, pooling their expertise to deliver more effective and sustainable outcomes and an improved experience for all involved.

The provision of high quality, safe and reliable care is dependent on good governance and leadership, and this is illustrated by placing them around the quality themes labelled as **Governance, Leadership and Accountability.**

The standard is detailed below:

Governance, leadership and accountability

Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Health services demonstrate effective leadership by setting direction, igniting passion, pace and drive, and developing people.
- Strategy is set with a focus on outcomes, and choices based on evidence and people insight. The approach is through collaboration building on common purpose.
- Health services innovate and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and delivery models, and manage performance and value for money.
- Health services foster a culture of learning and self-awareness, and personal and professional integrity.

The Health and Care Standards are set out in full in the pages that follow.

Each Health and Care Standard describes the high-level outcome required to contribute to quality and safety which is person centred and underpinned by governance, leadership and accountability.

There are three sections within each theme: a description of the key principle of the theme, what it means for a person when the standards within the themes are met, and the criteria for each standard. A criteria is defined as a principle or standard by which something may be judged or decided.

A range of supporting guidance to help services meet each standard is available on the NHS Wales Governance e-Manual (www.wales.nhs.uk/governance-emanual)

The principle of staying healthy is to ensure that people in Wales are well informed to manage their own health and wellbeing.

Organisations and people in Wales will work together to protect and improve health and wellbeing and reduce health inequalities. People will be empowered to make decisions about their own health, behaviour and wellbeing that impact positively throughout their lives.

What this means for me as a person when the standard within this theme is met:

- I will have a healthy and active long life.
- My children will have a good healthy start in life.
- I can access the support and information I need, when I need it, in the way that I want it.

Standard 1.1 Health Promotion, Protection and Improvement

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People know and understand what care, support and opportunities are available, locally, regionally and nationally, including community support and support for people from protected groups.
- People are supported to engage, participate and feel valued in society.
- People are supported to be healthy, safe, and happy, and to lead an active life.
- Children have a good, healthy, safe and nurturing start in life.
- Carers of individuals who are unable to manage their own health and wellbeing are supported.
- People are supported to make decisions about their health behaviour and wellbeing which impact on their health and the health and wellbeing of their children.
- Breast feeding is promoted and supported.
- Smoking cessation and smoke free environments are promoted and supported.

- People are supported to avoid harm to their health and wellbeing by making healthy choices and accepting opportunities to prevent ill health.
- There is active promotion of healthy and safe workplaces and communities.
- There is active promotion of the health and well being of staff.
- Systems, resources and plans are in place to identify and act upon significant public health issues so as to prevent and control communicable diseases and provide immunisation programmes; with effective programmes to screen and detect disease.
- Needs assessment and public health advice informs service planning, policies and practices.
- Health services have systems and processes in place that play their part in reducing inequalities and protect and improve the health and wellbeing of their local population.
- Relationships and allocations of responsibilities between the various organisations with public health responsibilities are clear and acted upon.

The principle of safe care is to ensure that people in Wales are protected from harm and supported to protect themselves from known harm

The health, safety and welfare of people are a priority. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers. Although the provision of care has some associated element of risk of harm to service users, safe care identifies, prevents or minimises unnecessary or potential harm. Therefore people will be kept safe and protected from avoidable harm through appropriate care, treatment and support.

What this means for me as a person when the standard within this theme is met:

- I am supported to protect my own and my families health.
- I am kept safe and protected from avoidable harm through appropriate care treatment and support.
- I receive a high quality safe service whilst in the care of the NHS.

Standard 2.1 Managing Risk and Promoting Health and Safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Best practice is applied in assessing, managing and mitigating risk which draws on people's experiences of the service.
- Risk management and health and safety are embedded within all healthcare settings and are monitored to ensure continuous improvement.
- Access to up to date and relevant information is readily available to identify, prioritise and manage real risks that may cause serious harm.
- Safety notices, alerts and any such communication are acted upon.
- Measures are in place to prevent serious harm or death where the required controls are well known.
- Issues relating to the environment such as security, safe and sustainable design, clear signage, planning, privacy, fire safety, age related general health and safety, and disability accessibility are considered.

- There is compliance with legislation and guidance to provide safe environments that are:
  - accessible;
  - well maintained;
  - fit for purpose;
  - safe and secure;
  - protect privacy;
  - sustainable.
- There is compliance with the requirements of the Civil Contingencies Act 2004 and supporting guidance. This will include undertaking risk assessments, having current and tested emergency plans and business continuity arrangements developed through collaboration with partner agencies. This will ensure delivery of a robust response and ensure continuity of essential health services in the event of a major incident or emergency situation.

Standard 2.2 Preventing Pressure and Tissue Damage

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People are assessed for risk of pressure and tissue damage and if considered at risk, they receive further assessment and a plan of care is developed and implemented.
- People are made aware of the risks of pressure and tissue damage and shown ways of preventing them. They and those caring for them are encouraged and advised on appropriate care procedures, including nutritional advice.
- Appropriate beds, chairs and other equipment are made available to reduce the risks of pressure and tissue damage and specialist preventative equipment such as special mattresses and cushions are also available if necessary. All equipment is clean and properly maintained.
- Correct moving techniques are encouraged, including regular turning and appropriate self-care, helping people to avoid pressure and tissue damage, increasing their well-being, independence and dignity.
- Risk assessments are in place to identify if a person is at risk, their skin is checked at least once daily, and preferably when their personal hygiene is attended to.

Standard 2.3 Falls Prevention

People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Falls prevention strategies are implemented based on national standards and evidence based guidelines.
- People are assessed for risks to their own safety and the safety of others. A plan for managing risk is agreed between the person being cared for and those caring for them.
- Staff receive appropriate information, training and supervision to ensure that people and their carers are safe.
- People are encouraged to develop or maintain the level of independence they wish, striking a responsible balance between risk and safety.
- People are able to summon help easily at all times, using a telephone, bell or other convenient means. If unable to do so their needs will be checked regularly.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- There are appropriate organisational structures and management systems for infection prevention, control and decontamination in place.
- Physical environments are maintained and cleaned to a standard that facilitates infection prevention and control and minimises the risk of infection.

- Suitable and accurate information on infections is available.
- Suitable, timely and accurate information on infections is provided to any person concerned with providing further support or nursing/medical care when a person is moved from one organisation to another or within the same organisation.
- Staff employed to provide care in all settings are fully engaged in the process of infection prevention and control.
- Adequate isolation facilities are provided to support effective infection prevention and control.
- Policies on infection prevention and control are in place and made readily accessible to all staff.
- So far as is reasonably practicable staff are free of and are protected from exposure to infections that can be acquired or transmitted at work.
- Staff are suitably trained and educated in infection prevention and control associated with the provision of healthcare.
- Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.
- Patients and visitors are supported to achieve and maintain high standards of hygiene.
- Proper arrangements exist for the segregation, handling, transporting and disposal of waste including human tissue and subsequent disposal appropriately and sensitively.

Standard 2.5 Nutrition and Hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People's nutritional needs and physical ability to eat and drink are assessed, recorded and addressed. They are reviewed at appropriate intervals and are referred to dietetic services as required for specialist advice and support.

- People are offered a choice of food and drink which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and is accessible 24 hours a day.

- People are encouraged to eat nutritious, varied, balanced meals, hygienically prepared and served at regular times.

- Food and drink are served in an acceptable setting, with minimal interruption and are at the right temperature and attractively presented. People have a positive eating experience.

- Carers and family members who wish to support people at meal times are encouraged and enabled to do so.

- If a meal is missed, alternative food is offered and/or snacks and drinks can be accessed at any time.

- Fresh drinking water is available at all times, and water and appropriate fluids are encouraged throughout the day for people to meet their hydration requirements, except when restrictions are required as part of treatment.

- People are provided with therapeutic diets in accordance with their medical needs.

- If eating and/or drinking cause people difficulties, they receive prompt assistance to eat or drink encouragement and appropriate aids or support.

- People with swallowing difficulties are assessed by a speech and language therapist and where necessary training in assisting people to swallow food or drink safely is given.

- People are supported who require artificial nutritional support via enteral or parenteral routes.

- Where food and drink are provided: a choice of food and drink are offered, which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and is accessible 24 hours a day.

Standard 2.6 Medicines Management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- There is compliance with legislation, regulatory and professional guidance and with local guidance for all aspects of medicines management.
- Health professionals are qualified, registered with their respective regulatory bodies and fit for practice to prescribe, dispense and administer medicines within their professional competence and appropriate to the needs of the patient.
- There is timely, accessible and appropriate medicines advice and information for patients, carers and staff. Patients are provided with sufficient information to meet their needs regarding the purpose and correct use of their medication and alternate treatment options. All patients have an opportunity to discuss and agree their treatment plan.
- Adverse drug reactions and medicine related adverse incidents are reported and investigated where appropriate.

Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- There is compliance with legislation and guidance to include:
  - All Wales Child Protection, and Vulnerable Adult procedures.
  - Mental Health Act 1983 in relation to persons liable to be detained, and the Mental Capacity Act 2005 regarding Deprivation of Liberty Safeguards.

- Assurance of safeguarding services and processes is evident across all levels of the organisation.
- Effective multi-professional and multi-agency working and co-operation are in place complying with the Social Services and Well-being (Wales) Act.
- Staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning.
- People are informed how to make their concerns known.
- Priority is given to providing services that enable children and vulnerable adults to express themselves and to be cared for through the medium of the Welsh language because their care and treatment can suffer when they are not treated in their own language. (They are recognised as a priority group in More than just Words).
- Suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect.
- Risk is managed in ways which empower people to feel in control of their life.
- Arrangements are in place to respond effectively to changing circumstances and regularly review achievement of personal outcomes.

Standard 2.8 Blood Management

People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Health services have robust governance systems in place to maintain a safe sufficient supply of blood, blood components and blood products to support timely appropriate and effective use for all.
- There is compliance with legislation and national guidance on the supply and appropriate use of blood, blood components and products.

- Effective schemes and systems are in place to actively manage stock, minimise wastage, and plan effectively for shortages.
- A continuous innovative programme of education, training and competence assessment covers all staff involved in the transfusion process in line with national strategy.
- Processes are in place that enhance the safety of blood transfusion and support the recognition and reporting of, and shared learning from all incidents, adverse blood events and reactions.
- There is a collaborative approach to optimal blood management.

Standard 2.9 Medical Devices, Equipment and Diagnostic Systems

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- There is compliance with health, safety and environmental legislation, regulation and guidance.
- Processes ensure that equipment, and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used.
- An ongoing programme of training and competence assessment covers staff and users.
- Timely reporting and management arrangements exist to address any device, equipment or system faults in use or in stock, including any alert or warning notices issued by appropriate agencies such as MHRA.
- Suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.

The principle of effective care is that people receive the right care and support as locally as possible and are enabled to contribute to making that care successful.

If people receive the right care and support they will be empowered to improve or manage their own health and wellbeing. Interventions to improve people's health must be based on best practice, derived from good quality research. Data relating to care delivery should be maintained in structured, accurate and accessible records. The ability to manage data and information and to communicate effectively will contribute to the delivery of safe and effective care.

What this means for me as a person when the standard within this theme is met:

- Health care and support are delivered at or as close to my home as possible.
- I receive the right care and support to either improve or manage my own health and wellbeing.
- Interventions to improve my health are based on good quality and timely research and best practice.

Standard 3.1 Safe and Clinically Effective Care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People are safe and protected from avoidable harm through appropriate care, treatment, information, support and early detection of risks.
- People are supported to protect their own and their families' health.
- Welsh speakers are able to use the Welsh language to express themselves and information is communicated effectively.
- Practice evolves to reflect new evidence and provides an efficient and effective response to promote safe and clinically effective care.
- Systems and processes comply with safety and clinical directives in a timely way, including alerts.
- Systems ensure that non-compliance or variance from best practice is properly recorded and audited and any risks identified are managed appropriately.

- People receive a high quality, safe and effective service whilst in the care of the NHS which is based on agreed best practice guidelines including those defined by condition specific Delivery Plans, National Institute for Health and Clinical Excellence (NICE), NHS Wales Patient Safety Solutions, and professional bodies.

- Practice keeps up to date with best practice, national and professional guidance, new technologies and innovative ways of working.

Standard 3.2 Communicating Effectively

In communicating with people health services proactively meet individual language and communication needs.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Welsh speakers are offered language services that meet their needs as a natural part of their care.

- Open and honest communication is emphasised in the spirit of co-production.

- Special care is taken in communicating with those whose mental capacity may be temporarily or permanently impaired.

- Language and communication needs are addressed for people with specific care needs including: learning disabilities, dementia, stroke, sensory loss, neurological developmental problems and brain injury.

- Effective, accessible, appropriate and timely communication is tailored to the needs of each individual person and reasonable adjustments are made as defined in the Equality Act 2010.

- Methods of on and off line communication in various languages and accessible formats are used.

- Communication is age appropriate and considers people's ability to engage in health related conversations.

- Support is given for carers and advocates who in turn are supporting the needs of people with communication needs.

- There is compliance with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing. The purpose, effectiveness, methods, security and appropriateness of communication is considered internally and externally with patients, service users, carers and staff, and about patient, service users and carers using a range of media and formats.

Standard 3.3 Quality Improvement, Research and Innovation

Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Local capacity and capability is developed to support and enable teams to identify and address local improvement priorities, including participation in audit and recognised quality improvement methodologies, activities and programmes.

- Progress is measured, recorded and learning is shared.

- There is consistent application of the principles and requirements of the Framework for Health and Social Care Research and Development.

- Research and innovation has a direct impact on improving the efficiency and effectiveness of services, delivering better health and well being outcomes for people, and improving the experience of care.

- There is a structured approach to promoting and supporting research and Innovation and it is applied in every day practice.

- There is clear visible leadership and a strong collaborative approach with university and industry partners.

- Quality of clinical records is improved through implementing standards which enable re-use of the data for research.

Standard 3.4 Information Governance and Communications Technology

Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services.

Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Safe and secure information systems are developed in accordance with legislation and within a robust governance framework.
- Processes exist to operate and manage information and data effectively, to maintain business continuity and support and facilitate patient care and delivery.
- Data and information are accurate, valid, reliable, timely, relevant, comprehensible and complete.
- Information is used to review, assess and improve services.
- Information is shared with relevant partners using protocols when necessary to provide good care for people.

Standard 3.5 Record Keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Paper and electronic clinical record quality is improved through adoption of the Academy of Medical Royal Colleges standards for the clinical structure and content of patient records.
- Clear accountability for record keeping supports effective clinical judgements and decisions.
- There is effective communication and sharing of information between members of the multi-professional healthcare team and the patient.
- Record keeping supports clinical audit, research, allocation of resources and performance planning.
- Evidence shows how decisions relating to patient care were made.
- Identification of risks enables early detection of complications.
- Record keeping supports the delivery of services, patient care and communications.
- Records are designed, prepared, reviewed and accessible to meet the required needs.
- Records are stored securely, maintained, are retrievable in a timely manner and disposed of appropriately.
- Records are accurate, up-to-date, complete, understandable and contemporaneous in accordance with professional standards and guidance; and shared when appropriate.
- People's personal records are regularly updated and available to them. To ensure confidentiality, they are kept secure and comply with the Data Protection Act 1998.
- Care, treatment and decision making is supported by structured, accurate and accessible patient records documenting the conversations between people and health professionals and the resulting decisions and actions taken and reflects best practice founded on the evidence base.

The principle of dignified care is that the people in Wales are treated with dignity and respect and treat others the same. Fundamental human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

What this means for me as a person when the standard within this theme is met:

- I receive a quality service in all care settings.
- My voice is heard and listened to.
- I experience a care system where all participants are treated with compassion, dignity and respect.

Standard 4.1 Dignified Care

People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People are treated with respect, courtesy and politeness.
- People are able to access free and independent advice so they can make choices about their care and lifestyle.
- Individuals are addressed by their preferred name.
- Welsh Language needs are responded to sensitively.
- Confidentiality, modesty, personal space and privacy are respected especially in hospital wards, public spaces and reception areas.
- People's feelings, needs and problems are actively listened to, acknowledged and respected.
- All care is recognised as holistic and includes a spiritual, pastoral and religious dimension.
- Information and care are always provided with compassion and sensitivity. Ensuring that people and their carers have the freedom to act and decide based on opportunities to participate and on clear and comprehensive information.

- Consideration is given to people's environments and comfort so they may rest and sleep.
- People are helped to be as comfortable and pain free as their condition and circumstances allow.
- People are supported to be as independent as possible in taking care of their personal hygiene, appearance and feet and nails.
- People are supported to maintain a clean, healthy, comfortable mouth and pain-free teeth and gums, enabling them to function as normal (including eating and speaking) and prevent related problems.
- Continence care is appropriate and discreet and prompt assistance is provided as necessary taking into account peoples' specific needs and privacy.
- People are supported to feel confident to talk through all aspects of their care including sensitive areas such as life expectancy. Advanced care planning, end of life care and addressing the needs of the dying and as good a death as practical for the individual and their family is a key part of dignified care.

Standard 4.2 Patient Information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People's rights and individual circumstances are respected so they have a voice and control, empowering them to make decisions that affect their lives.
- Welsh speakers are empowered to express their needs and they are able to fully participate in their care as equal partners. Where needed people are provided with access to a translator or a member of staff with appropriate language skills.
- Health, personal and social care needs are assessed and set out in regularly reviewed plans of care.

- Assistance or specialist aids are provided to those with speaking, sight or hearing difficulties, special needs such as memory problems or learning disabilities, enabling them to receive and respond to information.

- People are consulted about any treatment and care they are to receive and opportunities provided to discuss and agree options.

- People's personal records are kept safe regularly updated and available to them.

- Time is taken to listen and actively respond to any questions and concerns that the individual or their relatives may have, treating their information confidentially.

- Valid consent is obtained in line with best practice guidance; and assessing and caring for people in line with the Mental Capacity Act 2005, and when appropriate the Deprivation of Liberty Safeguards 2009.

- Timely and accessible information is provided on people's conditions and care, medication, treatment and support arrangements.

Timely Care

The principle of timely care is that people have timely access to services based on clinical need and are actively involved in decisions about their care. Not receiving timely care can have a huge impact on individuals' experience of health services and their ability to achieve the best health outcomes. To ensure the best possible outcome people's conditions should be diagnosed promptly and treated according to clinical need.

What this means for me as a person when the standard within this theme is met:

- I have easy and timely access to primary care services.
- To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need.

Standard 5.1 Timely Access

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People's health outcomes are monitored in order to ensure they receive care in a timely way.
- All aspects of care are provided, including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with national timescales, pathways and best practice.
- Conditions are diagnosed early and treated in accordance with clinical need.
- Accessible information and support is given to ensure people are actively involved in decisions about their care.
- There is compliance with the NHS Outcomes and Delivery framework relating to timely care outcomes.

The principle of individual care is that people are treated as individuals, reflecting their own needs and responsibilities. All those who provide care have a responsibility to ensure that whatever care they are providing includes attention to basic human rights. Where people are unable to ensure these rights for themselves, when they are unable to express their needs and wishes as a result of a sensory impairment, a mental health problem, learning disability, communication difficulty or any other reason, access to independent advocacy services must be provided. Every person has unique needs and wishes. Individual needs and wishes vary with factors such as age, gender culture, religion and personal circumstances, and individual needs change over time, respecting people as individuals is an integral part of all care.

What this means for me as a person when the standard within this theme is met:

- Inequalities that may prevent me from leading a healthy life are reduced.
- My individual circumstances are considered.
- I get care and support through the Welsh language if I need it.

Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- People are supported to engage and participate in their care and feel valued in society.
- People are treated with the understanding that they have the right to be who they are, to be understood, considered and recognised as an individual.
- Sufficient time is available to support and encourage people to care for themselves, and supporting carers where individuals are unable to care for themselves.
- Support is given to ensure that people have the right to make decisions about their life.
- The care that people receive will respect their choices in making the most of their ability and desire to care for themselves.
- Ongoing assessment and individual care planning involving all those relevant to the person's care, forms the basis of the plan of activities and care. This takes account of the person's requirements, strengths, abilities and potential.

- Patients receiving secondary mental health services subject to the Mental Health (Wales) Measure 2010 must have a statutory outcome focussed care and treatment plan that must be regularly reviewed.

- Where possible, people are shown different ways of doing things to help them to be independent.

- If appropriate, people are offered equipment to help them walk, move, eat, hear and see. This equipment is well maintained, and if provided for a specific person is kept for their own use.

- People's ability to care for themselves is fostered and their NHS/care environment is as accessible, comfortable and safe as possible.

- People are encouraged to be active taking appropriate exercise and/or recreation as far as their condition allows.

- Healthcare workers are sensitive to people's linguistic needs and people will receive services through the medium of Welsh as a natural part of their care. People are shown respect for their cultural identity and are able to access Welsh language services without any obstacles, although not everyone responsible for their care will speak Welsh.

- Public information will be easily accessible to ensure people take responsibility to access care appropriately.

- There is effective transition from children to adult services.

- Health, personal and social care needs are assessed and set out in regularly reviewed plans of care agreed by the individual and the people caring for them. The plan is only shared with others with the service user's consent.

- People are supported to get help, when they need it in the way they want it.

- Support is provided to develop competence in self-care and promote rehabilitation and re-enablement; and achieve effective partnership working with other services and organisations, including social services and the third sector.

- Health services will work with community groups for example those who can help support people with protected characteristics.

Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Needs of individuals are recognised and addressed whatever their identity and background, and their human rights are upheld.
- Discrimination is challenged, equality and human rights are promoted and efforts are made to reduce health inequities through strategies, equality impact assessment, policies, practices, procurement and engagement.
- Strategic equality plans are published setting out equality priorities in accordance with legislation.
- Care is consistent whatever the age of the person being cared for, so that for example for younger people with serious illnesses should expect an efficient transition from child services to adult services with good communication between those agencies.
- The rights of children are recognised in accordance with the United Nations Convention on the Rights of the Child (UNCRC).
- The rights for older people in Wales are recognised in accordance with the Declaration of Rights for Older People in Wales and the UN principles for Older Persons.
- The spiritual and pastoral care needs of people and their carers are recognised and addressed.
- People are encouraged to maintain their involvement with their family and friends and develop relationships with others, according to their wishes.

Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

The health service will need to consider the following criteria for meeting the standard:

Criteria

- Health services and boards demonstrate how they are responding to user experience to improve services.
- Partners are engaged in supporting and enabling people to be involved in the design planning and delivery of services.
- The patient's and carer's voice is heeded by health services and boards, including through the use of patient stories.
- Feedback is captured, published and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement.
- Service delivery improvement for all people is captured and demonstrated which includes as a consequence meeting statutory responsibilities for children and young people, equality and diversity, and the Welsh language.
- It is clear how data reported in national surveys and audits are used and applied.
- There are processes in place that assure a good experience for people which include:
  - assessing and evaluating service user experience, especially for those who are vulnerable;
  - provision for people who are less able to speak for themselves;
  - delivering and measuring improvement;
  - using patient feedback to influence/drive changes to service provision and delivery;
  - recognising the spiritual, pastoral and religious dimension of care.

- There is compliance with legislation and guidance to deal with concerns, incidents, near misses, and claims as set out in the "Putting Things Right" arrangements.
- Concerns are reported, acted upon and responded to in an appropriate and timely manner and are handled and investigated openly, effectively and by those appropriately skilled to do so.
- Patients, service users and their carers are offered support including advocacy and where appropriate redress.
- Health services are open and honest with people when something goes wrong with their care and treatment.
- Appropriate support is provided to health staff and learning and services improve through sharing lessons from local and national reviews.

The principle is that people in Wales can find information about how their NHS is resourced and make careful use of them. Health services in Wales have a clear responsibility to secure the efficient and economic use of resources, and people in Wales need to understand how the resources are used and how they can be improved. The governance, leadership and accountability standard set out at the start of this document sets out how this should be demonstrated.

A significant resource is the NHS workforce in Wales which consists of all the people who work in, for, or with the service and they are all integral to the delivery of a high quality, person-centred and safe service. Health services must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service. The health service must determine the workforce requirements to deliver high quality safe care and support. The individual members of a workforce must be skilled and competent and the workforce as a whole must be planned configured and managed.

What this means for me as a person when the standard within this theme is met:

- Financial resources are used efficiently and effectively to improve my health outcomes.
- I work with the NHS to improve the use of resources.
- Quality trained staff who are fully engaged in delivering excellent care and support to me and my family.

Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

The health service will need to consider the following criteria for meeting the standard:

Criteria

Staff are enabled to learn and develop to their full potential. The leaders of any NHS organisation have a duty to set the appropriate tone and promote the right culture, and ensure that individual members of staff can fulfil their responsibility to deliver high quality and safe services.

Health services work with partners to develop an appropriately skilled safe and sustainable workforce by:

- having effective workforce plans which are integrated with service and financial plans;
- meeting the needs of the population served through an appropriate skill mix with staff having language awareness and the capability to provide services through the Welsh language;

- promoting the continuous improvement of services through better ways of working;
- enabling the supply of trainees, students, newly qualified staff and new recruits and their development;
- ensuring plans reflect cross organisational/regional/all Wales workforce requirements where appropriate.

The workforce:

- have all necessary recruitment and periodic employment checks and are registered with the relevant bodies;
- are appropriately recruited, trained, qualified and competent for the work they undertake;
- act, and are treated, in accordance with identified standards and codes of conduct;
- The workforce: are able to raise, in confidence without prejudice, concerns over any aspect of service delivery, treatment or management;
- are mentored, supervised and supported in the delivery of their role;
- are dealt with fairly and equitably when their performance causes concern;
- are provided with appropriate skills, equipment and support to enable them to meet their responsibilities to consistently high standards.

The workforce:

- maintain and develop competencies in order to be developed to their full potential;
- attend induction and mandatory training programmes;
- have an annual appraisal and a personal development plan;
- develop their role;
- demonstrate continuing professional development;
- access opportunities to develop collaborative practice and team working;
- work closely together, preventing duplication of effort and enabling more efficient use of resources.

Using the Health and Care Standards

The Health and Care Standards are not intended to layer additional requirements on health services, but rather to provide the framework for how services are organised, managed and delivered on a day-to-day basis. Health services will be expected to understand where they currently are in relation to meeting these standards. There are many ways that this can be achieved, including:

- through honest self assessment, well tested through use of mechanisms such as internal audit and clinical audit;
- participation in peer review processes;
- encouraging and responding to external review from bodies such as Healthcare Inspectorate Wales;
- acting on feedback from bodies such as Community Health Councils and the people they serve.

The criteria described under each standard are designed to help with this though healthcare organisations may demonstrate that they meet the requirements of the Health and Care Standards through other valid ways, and then put in place progressive improvement plans to address any gaps. On contracting services from independent providers health services must be explicit in agreements regarding expectations to meet these standards and have systems in place to monitor compliance and identify any necessary improvements.

To drive improvements in the quality and safety of healthcare it is important that decisions, including clinical decisions, are based on the best available evidence and information.

Implementing clinical guidelines and audit is an internationally recognised way of getting evidence into practice. The Health and Care Standards are an important driver for the implementation of national clinical and professional guidelines and participation in audit at all levels of healthcare.

The Health and Care Standards will be underpinned by supporting guidance produced for health services. This will be posted on the NHS Wales Governance e-Manual website and will include:

- identification of the theme;
- a description of the principle of each theme;
- what the themes mean for people;
- a description of the standard relevant to each theme;
- criteria for each standard;
- signposting to relevant legislation, requirements, tools and supporting information.

Guidance will be updated as necessary to reflect new areas for improvement and national priorities. The NHS Wales Governance e-Manual can be accessed by clicking on this link: **www.wales.nhs.uk/governance-emanual/**

Glossary

Access

The extent to which people are able to receive the information, services or the care they need.

Benchmarks

Benchmarks are used as comparators to compare performance between similar organisations or systems.

Carer

A person who provides the physical or emotional support to enable another individual to participate in daily life. Families or friends are the biggest group providing care and are sometimes called ‘informal carers’ or ‘family carers’.

Citizens

Anyone who receives or is affected by public services. In the NHS, patients are the obvious citizens; but there are others whom the NHS has to consider – patients’ relatives, for example. Organisations may define this in different ways – patient, service user, service recipients, etc.

Clinical Audit

A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in health care delivery.

Clinical governance

A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

Clinicians

Professionally qualified staff who provide clinical care to patients.

Co-production

Co-production is an approach to public services which involves citizens, communities, and the professionals who support them, pooling their expertise to deliver more effective and sustainable outcomes and an improved experience for all involved.

Contemporaneous

Existing, beginning, or occurring in the same period of time.

Dementia

Dementia is not a disease in itself. Dementia is a word used to describe a group of symptoms that occur when brain cells stop working properly.

Equality impact assessment

An equality impact assessment (EIA) is a tool that helps organisations make sure their policies, and the ways they carry out their functions, do what they are intended to do and for everybody.

Governance

A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives.

Health service

Welsh NHS bodies, independent contractors and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients, service users and the public.

Healthcare professional

A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Healthcare

Services provided for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

Healthcare associated infections

All infections acquired as a direct or indirect result of health care.

Health Inequities

Differences in people's health between geographical areas and between different groups of people.

Health Promotion

Includes the provision and information on healthier lifestyles and how to make the best use of health services, with the intention of enabling people to make rational health choices and ensuring awareness of the factors determining the health of the community.

Independent Contractor

A person or body who provides care under arrangements with an NHS body, such as, general dental services contractor, general medical services contractor, optometry and pharmacist contractors.

Infection prevention and control

Policies and procedures used to minimize the risk of spreading infections, especially in hospitals, and in the community.

Legislation

The act or process of making or enacting laws.

Learning Disabilities

Significantly reduced ability to understand new or complex information, to learn new skills. A reduced ability to cope independently which starts before adulthood with lasting effects on development.

MHRA

The Medicines and Healthcare Products Regulatory Agency.

Medical Devices

All products except medicines, used in health care for diagnosis, prevention, monitoring or treatment. The range of products is very wide it includes contact lenses and condoms; heart valves and hospital beds; resuscitators and radiotherapy machines; surgical instruments and syringes; wheelchairs and walking frames.

Neurological

The branch of medicine or biology that deals with the anatomy, functions, and organic disorders of nerves and the nervous system.

NICE

The role of The National Institute for Health and Clinical Excellence is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

NICE guidance

Includes:

- Clinical guidelines cover the appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales.
- Technology appraisals cover the use of new and existing medicines and treatments within the NHS in England and Wales.
- Interventional procedures which cover whether the procedures used for diagnosis or treatments are safe enough and work well enough for routine use.

Person Centred care

Aims to be people focused, to promote independence and autonomy, provide choice and control and are based on a collaborative team philosophy.

Primary Care

First-contact health services directly accessible to the public.

Protected Groups

Personal characteristics that are protected by the law (Equality Act 2010). The 9 characteristics are: Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Public Health

Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. Public health functions include:

- Health surveillance, monitoring and analysis.
- Investigation of disease outbreaks, epidemics and risk to health.
- Establishing, designing and managing health promotion and disease prevention programmes.
- Enabling and empowering communities to promote health and reduce inequities.
- Creating and sustaining partnerships across government, health and social care to improve health and reduce inequities.
- Ensuring compliance with regulations and laws to protect and promote health.
- Developing and maintaining a well educated and trained, multi-disciplinary public health workforce.
- Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequities.
- Quality assuring the public health functions.

Quality assurance

A systematic process of verifying that a product, or service being developed, is meeting specific requirements.

Quality Requirements

Quality requirements will be established through the Health and Care Standards they describe the care which clinicians and others will use to guide their practice.

Research governance frameworks

Defines the broad principles of good research governance and is important in ensuring that health and social care research is conducted to high scientific and ethical standards and applies to all research undertaken within the remit of the Minister for Health and Social Services.

Risk management

Covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

Service user

An individual who uses NHS services and who may also be deemed a patient.

Sensory loss

Sensory loss takes place when a person's sight or hearing becomes impaired.

Standards

Standards are a means of describing the level of quality health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.

Stroke

The sudden death of brain cells in a localized area due to inadequate blood flow.

Welsh NHS body

NHS Trusts and Local Health Boards in Wales.

Wellbeing

Well-being is a broad concept that relates to all areas of a person's life.

Workforce

The total number of persons employed or contracted to deliver NHS services or contractors or those with practising privileges.

	RAG	Responsible person	Anticipated delivery date	Progress	Update Notes
1. Compliance with health, safety and environmental legislation, regulation					
Health & Care Standards **- 2.1 Managing risk and promoting Health and Safety** **- 2.9 Medical devices, Equipment and Diagnostic Systems** **- 3.1 Safe and Clinically Effective Care** **- 3.4 Information Governance and Communications Technology**					
Identification of all in house manufactured medical devices including software as a medical device		Richard Stubbs	01/07/2025	Encactment date set for new Regulatons as 01/07/2025 Scope will be clear once draft of new regulations is published by MHRA 60-days prior to thier coming into force MDR Subgroup to scope extent of software historically written	
Support implementation of Quality Management Systems to underwrite compliance with new Medical Devices Regulations that are expected in July 2025		Richard Stubbs	24 months from implementation of UK Regs	MDR Subgroup to drive	
2. Equipment, and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used					
Health & Care Standards **- 2.1 Managing risk and promoting Health and Safety** **- 2.9 Medical devices, Equipment and Diagnostic Systems** **- 3.1 Safe and Clinically Effective Care** **- 3.5 Record Keeping**					
Review overarching governance around risk based prioritisation of equipment replacement and funding routes		Richard Stubbs/Mark Francis	01/12/2022	Needs a working group under MDC to take forward Mapping out options to consider	
Engage the Health Board in the All Wales Scan4Safety Programme		Mark Francis		Seeking national timeline update from Welsh Programme Lead: RS contacted Andrew Smallwood NWSSP for an up date on the national position - awaiting reply	
Roll out RFID tagging of all medical equipment managed under the Medusa overarching equipment register		Richard Stubbs/Mark Francis		Awaiting full plan update from Mark Francis Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our EBME commissioning checks.	
3. An ongoing programme of training and competence assessment covers staff and users.					
Health & Care Standards **- 2.9 Medical devices, Equipment and Diagnostic Systems** **- 3.4 Information Governance and Communications Technology** **- 3.1 Safe and Clinically Effective Care** **- 3.5 Record Keeping** **- 7.1 Workforce**					
To further develop a more resilient process for training and competency assessment associated with medical devices utilising cascade trainers across the Health Board		Richard Stubbs / Claudia Ivins	01/10/2024	Draft Infusion Training Strategy created New devices Training lead now in post Building case for the necessary supporting resources Consolidation of the infusion device training records achieved end of Sept 23 Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies. Need for fixed infusion device training base escalated and venue being sought.	
To work with the Electronic Staff Record (ESR) Team to support a standardised process of recording staff training and competency associated with all medical devices.		Leeanne Lewis / Richard Stubbs / Claudia Ivins	01/07/2025	Long term project (2yrs +) - Workplan will be produced to outline process to achieve. Investigate use of Health Roster as per Nottingham model	
4. Timely reporting and management arrangements exist to address any device, equipment or system faults in use or in stock, including any alert or warning notices issued by appropriate agencies such as MHRA					
Health & Care Standards **- 2.1 Managing risk and promoting Health and Safety** **- 2.9 Medical devices, Equipment and Diagnostic Systems** **- 3.1 Safe and Clinically Effective Care** **- 3.5 Record Keeping**					
A programme of clinical audit will be developed to provide the necessary assurance that ABUHB maintains ongoing compliance with National Patient Safety Solution's Alerts and Notices for which compliance has been initially declared. Performance levels will be reported to the MDC		Richard Stubbs / Grace Hargreaves	30/04/2022	Action Completed: The programme for next 12-month period has been produced	
The Management and Distribution of Alerts Policy will be reviewed during the financial year		Richard Stubbs / Grace Hargreaves	20/10/2023	Policy review in progress and aiming for presentation at Clinical Standards & Policy Group in Oct 2023. Amended version tracking through approval process	
5. Systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.					
Health & Care Standards **- 2.1 Managing risk and promoting Health and Safety** **- 2.4 Infection Prevention and Control (IPC) and decontamination** **- 2.9 Medical devices, Equipment and Diagnostic Systems** **- 3.1 Safe and Clinically Effective Care**					
Scope the coverage of HSDU's existing and externally Accredited ISO13485 QMS		Nicola Merry	TBC	Link HSDU QMS elements to the audit standards RS to work with Sam Murray to produce narrative	

	RAG	Responsible person	Anticipated delivery date	Progress
1. Compliance with health, safety and environmental legislation, regulation				
Identification of all in house manufactured medical devices including software as a medical device		Richard Stubbs	01/07/2025	Encactment date set for new Regulatons
Contribute to All Wales Medical Devices Regulations Group audit of current position re adoption of in house manufacturing QMS's across specialisms within Welsh Health Boards		Richard Stubbs	12/07/2022	Action Completed: Survey form re ABUHB rehurned and Welsh MDR Group has complied all heath Bpard returns into a summary spreadsheet to inform development of its strategy.
Convene a Health Board QMS implemetation working group via local stakeholders connected with the from the national working groups on Medical Devices Regulation		Richard Stubbs	01/11/2023	Group membership identified, agenda pending and dependent on output from All Wales MDR group
Support implementation of Quality Management Systems to underwrite compliance with new Medical Devices Regulations that are expected in July 2025		Richard Stubbs	24 months from implementation of UK Regs	MDR Subgroup to drive
Create Health Board policy on creation and governance of software that classifies as software as a medical device to underwrite compliance with new Medical Devices Regulations that are expected in July 2025		MDC	24 months from implementation of UK Regs	An All-Wales policy may emerge on this

	RAG	Responsible person	Anticipated delivery date	Progress
2. Equipment, and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used				
Review overarching governance around risk based prioritisation of equipment replacement and funding routes - Propose possible models for adoption for consideration by Director of Finance		Richard Stubbs/Craig Roberts/Mark Francis	01/04/2024	
Engage the Health Board in the All Wales Scan4Safety Programme		Mark Francis		Seeking national timeline update from Welsh Programme Lead: RS contacted Andrew Smallwood NWSSP for an up date on the national position - awaiting reply
Roll out RFID tagging of all medical equipment managed under the Medusa overarching equipment register		Richard Stubbs/Mark Francis	TBC	Awaiting full plan update from Mark Francis Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our EBME commissioning checks.
Engage with a national benchmarking exercise to review EBME resource and to support management of risk and mitigation		Mark Francis	TBC	Awaiting plan from Mark Francis
The population of location fields on the Medusa Medical Equipment Management Database		Mark Francis	TBC	The system is being updated as repair and maintenance work is completed

	RAG	Responsible person	Anticipated delivery date	Progress
3. An ongoing programme of training and competence assessment covers staff and users.				
To further develop a more resilient process for training and competency assessment associated with medical devices utilising cascade trainers across the Health Board		Richard Stubbs / Claudia Ivins	01/10/2024	Draft Infusion Training Strategy created New devices Training lead now in post Building case for the necessary supporting resources Consolidation of the infusion device training records achieved end of Sept 23 Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies. Need for fixed infusion device training base escalated and venue being sought.
To work with the Electronic Staff Record (ESR) Team to support a standardised process of recording staff training and competency associated with all medical devices.		Leeanne Lewis / Richard Stubbs / Claudia Ivins	01/07/2025	ong term project (2yrs +) - Workplan will be produced to outline process to achieve. Investigate use of Health Roster as per Nottingham model
A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training, aligned to medical equipment and devices. Training records should also be uploaded onto ESR.				
The recording of training on ESR needs to be mapped to training need analysis to support recording of training compliance rates. A short term action to upload all training to ESR will be explored in the immediate term.				
Workplan will be produced to outline process to achieve.		Richard Stubbs / Leeanne Lewis	01/04/2024	Investigate use of Health Roster to facilitiate this
The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.				
Consolidate existing infusion devices training record databases		Richard Stubbs/Claudia Ivins	31/09/2023	Completed
Identify training needs for each clinical area through the ward/department managers		Richard Stubbs	31/01/2023	Audit all ward and department managers for up-to-date lists of staff they require to be trainined in use of infusion devices
Produce a dashboard illustrating the current compliance baseline		Richard Stubbs	01/04/2024	Requires definition of individuals that require training as essential for job function from Workforce
Create a Health Board strategy under which to remodel delivery and assurance of infusion devices training		Richard Stubbs / Linda Jones	Completed	Completed
Produce an implemetation plan that is in-line with the strategy		Richard Stubbs / Linda Jones / Claudia Ivins	01/04/2024	
Produce appropriate business cases as required to support resource impact of the implementation plan			01/04/2024	

	RAG	Responsible person	Anticipated delivery date	Progress
4. Timely reporting and management arrangements exist to address any device, equipment or system faults in use or in stock, including any alert or warning notices issued by appropriate agencies such as MHRA				
A programme of clinical audit will be developed to provide the necessary assurance that ABUHB maintains ongoing compliance with National Patient Safety Solution's Alerts and Notices for which compliance has been initially declared. Performance levels will be reported to the MDC		Richard Stubbs / Grace Hargreaves	30/04/2022	Action Completed: The programme for next 12-month period has been produced
The Management and Distribution of Alerts Policy will be reviewed during the financial year		Richard Stubbs / Grace Hargreaves	20/10/2023	Policy review in progress and aiming for presentation at Clinical Standards & Policy Group in Oct 2023. Amended version tracking through approval process

	RAG	Responsible person	Anticipated delivery date	Progress
5. Systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment.				
Scope the coverage of HSDU's existing and externally Accredited ISO13485 QMS		Nicola Merry	TBC	Link HSDU QMS elements to the audit standards

NB: next lines pending input from Sam Murray on Decontamiantion

Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Revised Deadline Approved by Audit Committee
Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science	N/A	High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	Mar-18	Mar-24	Aug-22
Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science	N/A	High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	Mar-18	Mar-24	Aug-22

Due	No. of months past original agreed deadline	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the recommendation?	Reporting Date
Overdue	64	Nov 2022: This recommendation is monitored regularly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assets however, further work is required to physically tag the equipment and ensure compliance and traceability.	The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	Medical Electronics (EBME) & Capital Finance still record all of the equipment details on their independent systems. Medical Electronics (EBME) update the latest location on their database as equipment passes through the department. Capital Finance undertake walk about audits to tag and update locations of assets. All new assets are RFID tagged as part of our EBME commissioning checks.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH.	14/08/2023
Overdue	64	Nov 2022: An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. • Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment. Aug 2023: • New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.	H	This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post. Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates. Need for fixed infusion device training base escalated and venue being sought.	New QPS Infusion Device Service Training Manager now in post. Consolidation of the infusion device training records aim to be achieved by end of Sept 23 Development of a dashboard to indicate compliance levels aim to be achieved by December 2023. Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.	16/08/2023

Medical Devices Committee

Date 29.06.23

Microsoft Teams

Time 14:00 – 15:30

Agenda

	Item	Lead	Attachments
1.	Welcome and Apologies for absence	Chair	
2.	Previous minutes and actions	Chair	Medical Devices Committee Gro...
.	Medical devices regulation and Guidance		
3	Progress report on Medical Devices Regulations • Paper to exec team • Collaboration with SBUHB – see attached presentations for context	Risk Manager	Board and Committee Report - 2023_06_08 Presentation to DoT MDR compliance_Summer
	Maintenance Calibration and decontamination of equipment		
4	Decontamination and update from IP&C committee	CSSD/IP&C	
5	Servicing Maintenance and Calibration of Medical Equipment • Asset Tracking Update	EBME	
7	Replacement programme and procurement of new devices	Procurement	
	Training and Competence		
8.	Compliance with MD training and competence	Risk Manager	

	Risks and Incidents		
9	Medical Device Incidents	Risk Manager	
10	Alerts	Risk Manager	
11	Divisional Feedback	Divisional Leads	
11	AOB Next Meeting: 10.08.23	All	

Medical Devices Committee (MDC) Meeting:

29th June 2023, Via Microsoft Teams

Present:
Craig Roberts – Assistant Director of Therapies & Health Sciences (CR) – Chair
Leeanne Lewis – Assistant Director of Quality & Patient Safety (Corporate Services)
Richard Stubbs – Risk Manager, Quality & Patient Safety (RS)
Joanna Anstey – Service Improvement Manager - CSSD -HSDU
James Stevens – PACS Manager Cardiology (JS)
Linda Turner – Point of care testing Manager - Biochemistry
Geraint James – Health & Safety Manager
Rob Morris – NWSSP Procurement Manager
Mark Arscott – Head of Operations – Works & Estates
Alison Kirton - Senior Nurse, Nursing & Midwifery Education

1. **Welcome and Apologies for absence:**
   Peggy Edwards, Mark Francis, Gwawr Evans, Andy Warburton, Samantha Murray Celia Satherley, Karen Hatch, Dave Gamble, Craig Gane, Karen Hatch, Chris Edwards, Linda Turner, Rhian Morgan, Helen Jones, and Vanessa Williams

   Introductions were made due to new faces.
   Pam Price to do future minutes for the MDC.

2. **Previous minutes and Actions:**
   Minutes from previous minutes recorded as accurate.

CR noted not Quorum today and the meeting was for information only as there were no decisions to be made, only a reflection of quality work going forward.
CR ran through table of actions below:

Meeting date	Owner	Action	Update
29/6/23	KH	RS and KH to discuss RS has set up a meeting with SM to come up with a proposal in terms of a new model	Not much progress made, agreed to close but to capture somewhere that we need to do that piece of work as an organization as opposed to this group. **Closed** Action: RS to discuss with Carol Phelps.
29/6/23	CR/RS	CR/RS to discuss rolling replacement of equipment with RM first. Then discuss further programmes that shared services may have running.	This is an operational issue and not RM's remit, to be picked up as a separate workstream, will be discussed later in agenda. **Closed**
29/6/23	RS	To share MDRG invitation	Invitation circulated. **Closed**

CR & **RS** are to review, update and agree a workplan and put a section in the spreadsheet so that the group are aware of where we are focusing over the next 12 months in terms of work, we are trying to achieve. **Noted**: RS & CR agreed to reword healthcare standards to duty quality.

3. Medical Devices Regulations and Guidance

CR EU are bringing in new regulations in UK, RS attends the National Medical Devices Regulations Group and has prepared a document that firstly will go to the Board & Committee Report then onto the Executive.

RS explained that there are three pieces of legislation which the UK Government is going to put in place to fill the gaps, which resulted in us dropping back onto the 2022 regulations because of Brexit. The first piece will go live tomorrow and that pushes the dates back**.** With the existing regulations on standstill periods to May 2025. There will be transitional arrangements around people still selling EU marked devices in the UK, we don't have a date for when the second piece and rest is around regulations, the date for the regulations have been pushed back until July 2025. What I should say is that the two things that we're expecting to be different in the regulations, the new regulations and what the existing ones are around in House manufacture and medical devices and these I've got definite confirmation from MHR and David Grainger emailed me when I'm on a question to say, what's going to happen, and he said in house manufacturer will be regulated. The MHRA raised reviewing the yellow card system and legally reporting back about things that aren't right with equipment.

RS shared letters with the Group…

CR, we have some challenges outlined in the paper and it is basically understanding what QMS needs to be in place, getting the QS in place, maintaining it going forward so that it's not one-time requirement and all our potential people that are engaged and potential services are also engaged.

LL explained that the QS is being looked at as an annual operating framework with measurements in and that will form a quality management system, and this could be very challenging.

CR highlighted although we have an extra year on quality management systems, we need to aim for this time next year. More conversation to be had and possibly consternation is the governance around AI.

Board and Committee Report -

2023_06_08 Presentation to DoT

MDR compliance_Summer

4. Decontamination Update from RNTG:

Nothing to report.

5. Servicing Maintenance & Calibration of Medical Equipment:

Trying to monitor where our medical device assets are within the organisation, this is a difficult process. Requires 3 separate IT systems to talk to each other, requires us to tag as much equipment as possible and then go around and find where it is. Trying to get this rolled out and is proving problematic, mainly down to human resource. We are going to re-engage with Mark Francis and try to understand what needs to happen to get some traction behind this. Nothing further to report, hopefully will obtain an update from Mark.

6. **Replacement programme and procurement of new devices:**

This is a 12-month programme, not within RM 's area. There needs to be some consideration on how this is approached organisationally, some organisations centralise the capital fund and is then managed by a group, a wider group than we are now potentially with leads from different key sectors. Can have a deregulated system where money is actually handled. This is in early stages at the moment.
Action: CR & RS to speak to SM and RM to produce a proposal to which model we might try

LL attending today to discuss AI, there has been a need to sort out what our process is, trying to look at governance structure so can look at data, so data is valid and reliable. What happens if there is an inaccuracy, all of that should be built into the assurance framework for AI. Now testing two AI products that have come forward with a royal stamp, saying they are viable and cost effective. Need to give assurance it is as reliable as the current processes we have.
RS, note is that if you are buying a commercial product that is AI based, currently the regulation around what the manufacturers must do to prove that it is safe are not particularly detailed. That will change down the line when you have new standards and the regulations hopefully cover it, but there is a gap at the moment, so we have to be extra vigilant about this issue.

Training and Competence:

Last time we met, we were recruiting our new using device service manager and trainer, who has done a lot of work to get the viewing device training program up and running again. Struggling at the moment to get accommodation to be able to commence the training, although we have interim fixes for that but so it is moving forward.
A little unsuccessful last time, as struggled to get data from all lead nurses as to who in their department they felt needed to be trained on reviewing devices so we can compare against our records, then try and get a more proactive plan to get those staff through the process (this is on infusion devices). RS is hoping to find out how they do this in Nottingham, where they are using health roster combination of the ESR, they have a very good system in place. Not complete on every type of device but has potential, fact finding to be done over the next 6 months. Plan to be updated accordingly with the requirement for this to happen.

7. **Medical Device Incidents:**

RS explained, shared and ran through spreadsheet with the summary of incidents over the last 12 months. This is a table where it has been noted that a medical device has been some sort of a factor. Highest severity incidents that have been recorded this way have been moderate. If moderate and no harm, then this would not be duty of candour, if moderate and have unexpected and attended harm and is after 1st April, then would need to be validated and then consider if this triggers duty of candour.
Going forward from the 1st of April, Directorate should be validating their data straight away to ensure it is being coded correctly as the severity been given correctly. If not then the reviewer or handler should be pushing back, or peer reviewing to decide if it is actual harm/subjective harm.

8. **Alerts:**

In form of power-point, on charts ones in green are where it is compliant, but action plan still needs to be worked through. RS ran through sheet with group.

- PSN 066 – this is relating to unidentified patients being admitted, about having a more robust process in place. Pretty much on track with this at the moment.

- PSAO8 – NGC gastric tube misplacement, this is very old, a problem came up with the universal indicator paper. There is be a huddle of key people to try and brainstorm how we get around the governance of this, deadline has been extended to the end of September.

9. Divisional Update:

No divisional representatives on the call.

10. AOB

- RS, these quality management systems for manufacture in the European regulations it does not say they have to be accredited, but we do not know what the UK regulations are going say on this at the moment.

Meeting date	Owner	Action	Timescale
29/6/23	RS	RS and KH to discuss. RS has set up a meeting with SM to come up with a proposal in terms of a new model. RS to speak to Carol Phelps	Next Meeting
29/6/23	CR/RS	CR & RS to speak to SM and RM to produce a proposal to which model we might try, re: rolling replacement of equipment.	Next Meeting
29/6/23	CR/RS	Next meeting put a section in the spreadsheet, so the Group are aware where we are focusing over the next 12 in terms of the work that we are trying to do, and it would be useful to get expert opinions	Next Meeting **10th August 2023**

Medical Devices Committee

Date 12.10.23

Microsoft Teams

Time 14:00 – 16:00

Agenda

	Item	**Lead**	**Attachments**
1.	Welcome and Apologies for absence	Chair	
2.	Previous minutes and actions	Chair	Minutes Medical Devices Committee (
.	Medical devices regulation and Guidance		
3	Progress report on Medical Devices Regulations • Medical Devices Audit • Collaboration with SBUHB	Risk Manager	
	Maintenance Calibration and decontamination of equipment		
4	Decontamination and update from IP&C committee	CSSD/IP&C	
5	Servicing Maintenance and Calibration of Medical Equipment • Asset Tracking Update	EBME	
	Training and Competence		
8.	Compliance with MD training and competence	Risk Manager	
	Risks and Incidents		
9	Medical Device Incidents	Risk Manager	
10	Alerts	Risk Manager	
11	Divisional Feedback	Divisional Leads	
11	AOB Next Meeting: 14.12.23	All	

Medical Devices Committee (MDC) Meeting:

12th October 2023, Via Microsoft Teams

Present:
Craig Roberts – Assistant Director of Therapies & Health Sciences (CR) – Chair
Richard Stubbs – Risk Manager, Quality & Patient Safety (RS)
Alison Kirton - Senior Nurse, Nursing & Midwifery Education
Karen Hatch – Assistant Director of Therapies and Health Science
Peggy Edwards - Chief Nursing Information Officer, Informatics – ICT
James Stevens – PACS Manager Cardiology (JS)
Mark Frances - EBME Manager, Medical Electronics EBME
Mark Arscott – Head of Operations – Works & Estates
Linda Turner – Point of care testing Manager – Biochemistry
Rob Morris – NWSSP Procurement Manager
Joanna Anstey – Service Improvement Manager - CSSD -HSDU
Samantha Murray - Infection Control Decontamination Manager (SMy).
Celia Satherley - Service Manager Paediatrics & Neonates representing Families Division (CS)

1. **Welcome and Apologies for absence:**
   Leeanne Lewis, Andy Warburton, Dave Gamble, Julie Gilbert

Julie Gilbert is now part of Clinical Support Services Division and is an assistant general manager.

2. **Previous minutes and Actions:**
   Minutes from previous minutes recorded as accurate.

CR noted this is the first meeting since June.

CR ran through table of actions below:

Meeting date	Owner	Action	Update
12/10/23	**RS**	**RS** and **KH** to discuss. **RS** has set up a meeting with **SM** to come up with a proposal in terms of a new model. **RS** to speak to Carol Phelps	**RS** to look at previous minutes, to identify what this specifically relates to. **CR** will add a reference number, from this point actions to have a reference number to capture in right place.
12/10/23	**CR/RS**	**CR/RS** to discuss rolling replacement of equipment with RM first. Then discuss further programmes that shared services may have running.	Can close but need to continue with working up of the plan around risk- based procurement **Closed**
12/10/23	**CR/RS**	Next meeting put a section in the spreadsheet, so the Group are aware where we are focusing over the next 12 in terms of the work that	

		we are trying to do, and it would be useful to get expert opinions	

RM explained that in an ideal world every division should have a Risk Register and have a rolling plan to replace equipment. **CR** Risk based approach is the way to go especially as Procurement can be prudent through a risk- based approach, it is within the workplan to look at this

RM, Rob Holcombe is looking at a non-pay and equipment contracts across the Health Board, trying to capture them and have one service contract for example all trolleys**. CR&RS** will link with Head of Procurement and team for the non-pay group. Ranking the risk element, that's where we come into this, risk element tells you how to prioritize and we can advise the finance teams. Can describe that in risk mitigation terms. Scotland use something similar and it's quite effective, doing the same in Cambridge as well, and various places, Swansea is having a go also. Risk based approach to anything is the way to go, procurement, especially as you can be more prudent through a risk-based approach. **CR** agreed.

CR & RS Will schedule next meeting to discuss the workplan in more detail, the findings from 2017/ 2018 audit in the review last year and discuss the upcoming audit and asset tracking.
Look at what's the strategic replacement plan for our whole tranche of equipment across the whole organization that can be aggregated into one big contract and thereby maybe a national contract and get the saving on volume.
The training on medical devices, and the implementation of the Medical Devices Regulations, we know enough about those areas.

3. Medical Devices Regulations and Guidance

RS & CR agreed to reword healthcare standards to duty quality.
RS looking at larger agenda regulations and their propagation through the process.
MHRA put the date back another year to 1st of July 2025 for the new regulations to be published, to try and get the focus groups together to help inform the guidance and thereby probably influence what is going to go in the regulations.
The alerts and incidents FSN reporting aspect, on the 2002 regulations and will be until at 2025 date, there was an amendment that is just about to come into force. Worldwide public notice period 60 days through the World Trade Association. Have seen it and commented on that around the surveillance system, revisions for the 2002 regulations, this still applies to the 2002 regulations, so does not affect anything we build in house as not scoped by the 2002 regulations. Most of it is around the reporting processes, regular updates or 12 monthly updates manufacturers must do around MHRA and safety notice and just centralise some of this.
Some new definitions such as equipment life span, more clarification to be had.

The All-Wales MDC group has sent question to MHRA re: where in-house money would be regulated. Awaiting clarification as has an implication for us depending on which way it goes in terms of what QMS we are mandated to have.
For Wales there is a 2-week extension to reply, not replied yet.
Swansea Bay and Betsi have collaborated to get their QMS in place and will share their process for doing this but will be a cost. At healthcare science network meeting Welsh Government has said there is a possibility they would be able to write some financial support for this across Wales.
Any software that stands alone could be described as a medical device and would need the conformity certificate if it is manufactured and placed on the market. If we do this in-house it does not apply, there is an exemption for in-house although not an explicit exemption. We are quite light on expertise around the stand- alone medical device software side of things, have a collective of people involved and may bring them in under a software group. Separate conversation with Peggy Edwards suggested.

Medical Devices Audit:

Notice received from internal audits team that we are due audit; this will be a fresh audit not review. We had a review of actions against findings of last formal audit in 2017/18 last year. Did not give an assurance so reviewing what we have done to point. Will look at findings from last time but have also tagged on some software. What they will look at within scope of this audit, we still have to agree, they were going to predominately look at ultrasound devices. **KH** has the briefing but seeking some clarification of how we got to ultrasound in the first instance and that assurance would purely be around that element. **CR** has asked if there will other subsets they are looking at, but might focus mainly on ultrasound, will feedback as soon as reply received. In terms of the scope of audit, if focused on ultrasound **KH** keen to b part of discussions around the scope that is awarded. **CR** now to send questions back, if there is anything **KH** wants included, information to be sent to **CR** or Chris and the audit team.
Will forward copy of audit brief to **CS** when agreed by directors, and can provide all members of group with 2017/18 and last year's review.
Timelines, want to start as soon as possible so probably looking towards end of October/November, November for the field work.
RS hoping to bring a piece of work together to look at medical equipment inventory in more detail, once he has the basic information. Will be a huge task and will require maintaining and updating.

4. **Decontamination Update from RNTG:**

Recently attended lead roles and responsibilities of decontamination manager meeting, **SM** is a manager. Looking at everything from laundry, decontamination of medical devices, including mattresses to surgical instruments, ultrasound equipment etc. expectation coming out of this role is better operational and strategic level.
Expectation is that we are heading towards these roles and responsibilities embedded within divisions. **SM** is helping to contribute towards this, central sterilisation club will be looking at this next Monday and also decontamination is taking a lead with medical devices within infection prevention as part of competencies and infection prevention nurses.
Will be running parallel as advisory but expectation of monitoring and auditing, supporting directors and whatever piece of kit they need, whether it is NHS, HSDU or community. Also link in with procurement.
From 1st October opening up an acutely contamination unit, **SM** linking in with Tracey Redwood and Andy Walsh, mattresses will be taken off site and there will be an expected standard of validation, validated process of cleanliness.**SM** will support where they can.

5. **Servicing Maintenance & Calibration of Medical Equipment:**

Asset Tracking is progressing, meeting with Kelly to see where we are and drive forward. Have 5,500 items between the 2 of us being tagged and flowing into RFID discovery, 4,500 of those on our database in medusa, 100 on a capital asset register. Software requires update, Kelly will organise, when completed can have a combined approach and spend some time on for both departments at GUH to get completed.
45% of our assets are on the GUH medusa which have been tagged, hoping to get together and sign off in next couple of weeks to get GUH complete. Will engage with Jane in the equipment library as she will need training. Not going as quickly as everyone would anticipate but have a fair chunk of GUH equipment tagged, hope to complete before next meeting in December.

6. **Replacement programme and procurement of new devices:**

7.

8. **Compliance with MD Training and Competence**
NAMDET, National Association of medical device education trainers, which is a voluntary charitable organization of which **RS** is the Welsh Co chair for in the Welsh region, has recently published the Medical Gases Awareness Course on e-learning, should be accessible through ESR imminently.
Also linking back to the issue with ultrasound and training, the question that might come up in the audit and everything but NAMDET conference on the 15th of November in Cardiff, the afternoon session is quite focused on ultrasound training. Whole theme of conference is on compliance, particularly training, compliance and trying to set a new universal standard for what level of compliance should we actually have and how do we measure.
Claudia has been working with team in QPS on consolidation of our training records into one place and is now complete.
Working towards moving training records to a better space, ESR, ASR and health roster can link together.
AK noted some concerns around moving to a different platform as some staff reluctant to use ESR and there is a new ESR platform coming out. **RS** confirmed would not a be move to a different platform, just a link between the two.
AK, still battling to get a room for Claudia to house her devices, Linda Alexander has contacted Joe Madine again to see if this can be moved along. This will ensure can train and have all the equipment in one place.
RS to involve AK in conversations regarding learning platform to ensure it is all linked.

9. **Medical Device Incidents:**

RS shared spreadsheet with group, dashboard has been set up in DATIX to give us a breakdown or overview of the medical device incidents that has occurred in the last 12 months. **RS** ran through sheet, surgical have a few more incidents than elsewhere, but there is nothing that jump out at you as being a massive issue and no catastrophic/death. There is an educational need around the way people report the device incidents.
PE conscious we are going to have more software that is a medical device, but people record this as ICT.
CR suggested discussing with Leanne as to how this information is thread to forums such as PQSOC as well. Conscious we not feed this information anywhere else.
Now need to decide on what to use data for.
CR will share incident spreadsheet with group for them to look at more closely post meeting.

10. **Alerts:**

- PSAO-8, we are not compliant, this is nasogastric tube replacement. Issue with this is around assurance of training competence on the part of the staff doing exertion. There is a plan being created to achieve compliance.
- PSN error 6066, identifying or placing identifier on unidentified patients, **PE** is lead on group for this, very close to completion of this.
- PSA 1/6 on calcium gluconate, has a compliance date of 15th December, moving along.
- NPS/NAT PSA, reissued in Wales.

RS attended Welsh Government's Delivery Unit (DU) Patient Safety Solutions meeting. The DU has been pressing for a while to get some sort of control over how in Wales, English notices that Welsh Government think we should be following actually get circulated and monitored. Very close to the delivery unit having responsibility for this. **RS** setting out on bringing together group that will carry notice forward. Expecting NHS England notices to have a better mandate.
PE sits on All Wales Fall group, they have been charged with standardising bed rails policy across Wales. Gap analysis shows there is quite a diversity so will be quite hard, there could be a national standardised policy rather than ABUHB one.

MF clarified at least closure around NPSA alerts, BS60 ventilators, these had to be withdrawn from service 30th September. Have complied and conformed, they were withdrawn on 29th and have now been physically removed off site yesterday by Hugo Technology.
Being led by respiratory nurses, contingencies put in place and Phillips are arranging training on the new EVO 3000s.
RS has tracker where safety notices are tracked and there is a link through to the actual notice. Shared tracker on screen with group.

11. Divisional Update:

- **CS** - Nothing to report, gastrostomy issue already discussed.

- Historically not been great at getting divisional representation and this would be useful. **CR** to have another conversation with QPS team and mostly through nursing team with Jenny and Tracey Partridge-Wilson around how we can get more divisional representation here and through the QPS channels.

12. AOB

- Injury to balloon pumps conversion, already discussed.
- **PE**, we are not dating when we actually procure software, that's medical devices. Recent items done is AI, radiology software that reads X-rays, trial done with this and pilot has come to an end. Critical care system potentially going live in next few weeks and that is mentioned as a medical device.
- Intra-Aortic Balloon Pump (IABP) catheters, **RM** has emailed to see if company have any order evidence, Holly has searched our system and no lot numbers identified.
- **JS** noted we do not use that brand in cardiology, thinks it is Arrow. **RM** has sent information to Aron Payne, when it comes to "stock" he is the person to contact, if anything needs chasing **RM** is happy to help.

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12/10/23	**CR/RS**	Next meeting put a section in the spreadsheet, so the Group are aware where we are focusing over the next 12 in terms of the work that we are trying to do, and it would be useful to get expert opinions	Next Meeting
12/10/23	**RS**	**RS** to involve **AK** in conversations regarding learning platform to ensure it is all linked.	Next Meeting

12/10/23	**CR**	**CR** will share incident spreadsheet with group for them to look at more closely post meeting	Next Meeting

QPS Risk Management
Infusion Devices Training Compliance Assurance Action Plan

Ref	Recommendation	Goal statements	Compliance Status	Summary of work to date	Current situation	Residual risks identified	Enablers for achieving full compliance	Mitigating actions in place	Summary of barriers that have caused delay in implementation	Revised implementation and compliance timeline
1a	Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details	A centrally managed industry standard pan-organisation medical equipment register is in place and operational	Compliant at a practicable minimum level	The Health Board acquired and commissioned its Softpro Medusa medical equipment management database that is pertinent to national guidance for medical equipment management functionality. This database is managed by the Medical Electronics EBME service. The Health Board has also acquired a passive RFID Discovery tracking system from Paragon, this is linked with Medusa and also with the RAM 4000 hosted capital asset register operated by the Finance Department. The three systems provide a linked and integrated database system for managing and monitoring operational activities over the Health Board's fleet of re-usable medical equipment and devices.	Medical equipment management information on each item of equipment, including the location where each item is deployed, is recorded in Medusa. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Each item of equipment is recorded in Medusa under a locally unique identification number, which acts as it's database index key. The EBME service oversees management the Medusa database in partnership with Finance's oversight of the capital asset register, and with Procurement Services oversight of purchasing activity. At commissioning, EBME and Finance control actions to record newly acquired items of equipment in these databases, allocating their identification numbers. EBME, Finance and Procurement collaborate in capturing introduction of new medical equipment and devices at source. Medusa is used to manage work orders for life-cycle medical equipment management actions. A programme of work is underway to fully commission the Paragon RFID Discovery tracking system. When this is completed, it will automate the current manual system for periodic equipment verification and deployment location updates and will allow end users to view the current locations of Assets throughout the Health Board.	Ward and departmental managers require training on how to access and interrogate the Medusa database via the Customer Portal Ward and departmental managers need time allocation to oversee and to routinely verify their allocation of medical equipment and devices	Provision of appropriate training for ward and departmental managers on using the Medusa Customer Portal Ward and departmental managers need appropriate resources to carry out their full duties Full operation of the Paragon RFID system would significantly reduce staff time burden in keeping the equipment location information held in Medusa up to date	Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually	The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle.	Anticipating end of March 2024
1b	The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed	The dataset, structure and format of the register allow centralised oversight of operational equipment management There is a system for reviewing the accuracy of data	Fully Compliant	The Medusa database in use is industry standard in its structure and functionality for managing medical equipment within a UK health institution. Management of Medusa, including data accuracy checking, is overseen by the Health Board's EMBE service as part of their pan-organisation Medical Equipment Management and technical support role.	The Medusa database records centralised information on circa 20,000 re-usable medical equipment and devices. Medusa's functionality covers record keeping for commissioning, routine inspection/maintenance and decommissioning/disposal of re-usable medical equipment and devices. Equipment status information and management history is captured within the database at these and at relevant intermediate points in its life-cycle.					
1c	Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register.	Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralised register Ward and departmental managers are familiar with the cohort of equipment used by their staff in their duties and understand their responsibilities around managing this equipment	Partially compliant	Medusa's Customer Portal is available through the ABUHB Applications intranet page. The Health Board's Medical Devices Committee has been responsible for and put in place the pan-organisation Management of Medical Equipment and Devices Policy.	EBME provide centralised control of the physical entry of records on individual items of equipment within the Medusa register database Ward and departmental managers can access a list of equipment in the register that is allocated to their work area via the Customer Portal. Ward and departmental managers act according to their responsibilities detailed in the Management of Medical Equipment and Devices Policy linked to the equipment registered to their work area	There is risk of unbalanced investment in portable medical equipment and devices owing to baseline purchasing of excess equipment in compensation for users having difficulty finding the equipment they need efficiently Ward and departmental managers have difficulty accessing the Medusa Customer Portal Assurance that ward and departmental managers are fully conversant with their responsibilities as stakeholders in the management of medical equipment and devices, intended by the Management of Medical Equipment and Devices policy, is weak	Instructions for ward and departmental managers to access and check their lists of equipment by ward/ department and so be better informed for the reporting of discrepancies and variations SOP linked to the Health Board's Management of Medical Equipment and Devices Policy, re responsibilities of nominated ward/department equipment controllers	Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.	EBME have not had the resources to create the Customer Portal instructions and disseminate them	Anticipating end of March 2024
1d	Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded	There is a programme of periodic register accuracy reviews and of auditing the review processes A mechanism is in place for ward and departmental managers to audit the equipment deployed in their work areas against the register and to report discrepancies for correction action	Fully Compliant	The Finance department has put in place a system for asset verification of deployed items that are classed as capital assets, including medical equipment and devices. EBME verify the records on individual equipment items at points of contact with it during its operational lifespan and from ad hoc updates received from ward and departmental managers.	Discrepancies in data accuracy noted by ward and departmental managers are communicated to the EBME service for any necessary corrections to be made. The EBME service makes record updates and corrections to the register that it notes or that are noted to it during EBME's routine process work on individual items of equipment or when responding to breakdowns, adverse incidents or field corrective actions Capitalised medical equipment is verified through the Finance department's annual asset verification process					
1e	Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues	The register captures equipment lifecycle stage events and changes to the departments to which particular equipment is allocated	Compliant at a practicable minimum level	Data accuracy of information held on individual items is managed under a rolling review programme and applied during EBME's routine planned preventative maintenance actions.	Deployment location updates rely on manual reporting by ward and departmental managers or by routine data verification by EMBE or Finance's routine Asset Management activities. This will be automated once the RF tracking system is fully implemented.	Temporary movement of equipment between departments with the flow of patients may go unrecorded	Full implementation of Paragon RFID system	Consideration in the merit of adding temporary resource to support EBME in completing RF tagging of the remaining equipment	EBME have not had the resources to prioritise the tagging exercise over it's other workstreams	Anticipating end of March 2024

QPS Risk Management
Infusion Devices Training Compliance Assurance Action Plan

Ref	Recommendation	Goal statements	Compliance Status	Summary of work to date	Current situation	Residual risks identified	Enablers for achieving full compliance	Mitigating actions in place	Summary of barriers that have caused delay in implementation	Revised implementation and compliance timeline
2a	A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training, aligned to medical equipment and devices.	There is a pan-organisation strategy on device training which acts as a framework for the operational governance and implementation of training on medical equipment and devices Reports on the equipment in use in a particular ward or department, pulled from the centralised register, detail the respective extent and frequency of user training required for each device type Ward and departmental managers specify which device training they require each member of their staff to undertake where it is essential for job function. They provide and periodically update this information with pan-organisation training managers to allow accurate organisational compliance extent assurance	Partially compliant	A draft pan-organisation strategy on infusion device training has been created to act as a framework for the operational governance and implementation of training on infusion devices. The strategy moves the setup from centralised one-on-many teaching to a devolved yet quality assured cascaded training model in line with national standard approaches.	There is a draft pan-organisation strategy on infusion device training which acts as a framework for the operational governance and implementation of training on infusion devices Lists of the equipment in use in a particular ward or department can be pulled from the centralised register for reference by the ward and departmental managers to determine the respective extent and frequency of user training required for each device type in use in their work area Ward and departmental managers have been queried as to which device training they require each member of their staff to undertake where it is essential for job function, but with limited response. Ward and departmental managers in partnership with the Nursing Practice Educators provide information on new starters to the Health Board to pan-organisation training managers to allow accurate organisational compliance extent assurance. This links with the Journey of Excellence (JOE Programme for new starters.	Detached coordination of training for wider device categories makes coherent governance of training challenging. Although EMBE underpin identification of the needs for specific user training for new models of equipment being commissioned, institutional fragmentation in the overall governance of ongoing medical equipment and devices training is limiting the present degree of compliance assurance possible. There is no consolidated national standard on the extents and frequencies of training required per device type. This means there is local variability in decisions on the extent of user training required per device type.	Ratification of the draft Infusion Training Strategy Infusion Device Training strategy would enable roll out of the methodology across other device categories with support for the resource requirement to operate according to it in full Possible All-Wales steer on risk-based categorisation of training extents for different equipment generic types Ward and departmental managers to identify which of there staff require training on what equipment plus a mechanism for them to report this centrally Provision of accessible fixed training spaces that can remain securely set up with the necessary training equipment for training and assessing first tier cascade trainers Acquisition of the add-on Competency Module for the Medusa database would provide an accessible repository for setting extents and frequencies of training per device type, linked to ESR competency tracking Centralised multidisciplinary corporate oversight of competency management for medical equipment and device user training (ref. the model used in Nottingham)	Temporary space is being utilised for training and assessing first tier cascade trainers Nursing Practice Education team supported covering gaps in one-on-many training capacity for a period but this was not a sustainable approach without additional resources. Programme of work to ratify the strategy and roll out the methodology	Handling of a vacancy gap in the Health Board's Infusion Devices Service and Training Manager role (now redressed) reduced traction on progressing the strategy impementation Ward and departmental managers have provided limited response to queries to identify which device training they require each member of their staff to undertake	Anticipating end of March 2024
2b	Training records should also be uploaded onto ESR.	Individual staff member training compliances are recorded in ESR Pan-organisation training managers maintain centralised training record databases covering their respective jurisdictions	Non-compliant		Individual staff member training compliances can be recorded in ESR provided that the ESR Customer Services Team upload the relevant competency courses into ESR, and the ward and departmental managers or the centralised training managers assign and update the individual staff members' competency status in ESR Pan-organisation training managers maintain centralised training record databases covering their respective jurisdictions	Competencies for each model of equipment need to be created in ESR Reliance and burden on ESR Customer Services Team Capacity of the training teams to upload information on an individual staff member basis	Creation of competencies within ESR for each separate model type or group of these that can then be selected by managers as appropriate for their respective staff Instructions for ward and departmental managers to populate ESR records for individual staff with the competencies linked to the specific equipment the staff are directed to use on their roles	Pan-organisation training managers maintain centralised training records for ubiquitously deployed equipment that is considered as high-risk nationally	There are currently 300 separate device types represented in Medusa	Dependant on traction with ESR Customer Services team and All-Wales operational constraints
2c	The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	Infusion training compliance levels reflect that adequate numbers of staff being current in their training to guarantee that sufficient numbers of trained staff are on the duty rosters for all shifts to administer infusions	Compliant at a practicable minimum level	Reflect Infusion Device training risk on risk register Consolidation of training records Centralised repository of training certificates Cascade model for infusion device training launched February 2024	The consolidated Infusion Devices Training Database is capable of providing compliance level data given an accurate training numbers denominator A full audit to identify ward by ward training needs sent out Jan 2023 was met with a delayed and limited response from wards and departmental managers Known infusion training compliance levels reflect that adequate numbers of staff are current in their training to guarantee that sufficient numbers of trained staff are available for the duty rosters for all shifts to have capacity to administer infusions. Wards and departments have access to sufficient numbers of trained staff to provide the infusion therapy required: there have been no incident reported citing lack of sufficiently trained staff preventing appropriate infusion therapy, however central oversight of this is currently problematic making corporate level assurance challenging	There is a risk that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster Ward and departmental managers have limited capacity to respond to audits by centralised training managers scoping the training requirement of their staff There is no published national standard on how to set or measure appropriate levels of training compliance	Development of a local method for ward and departmental managers to determine which of their staff need to fully trained and current on specific devices to allow any shift to be rostered with a sufficient number of qualified staff for their department to function within its on-duty professionals' scopes of practice Representation within the consolidated infusion training record database of the denominating minimum number of staff that should be current in their training on infusion devices, derived from the ward and departmental managers Development of a new national standard for setting and measuring appropriate training compliance levels	Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update consolidated infusion training database accordingly - this would give assurance the organisation is running at an appropriate infusion training compliance level by providing an accurate denominating figure Increase capacity for provision of infusion device training, including using manufacturer's training resource for revalidation training using a cascade training model	Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale	Anticipating end of March 2024

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

2017 Medical Equipment and Devices	Assurance Rating Limited	Priority Rating High

Executive Lead: Director of Therapies and Health Science

Recommendation 1: Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed. Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.

Management Response: The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.

Final Report Agreed Implementation Date: 31/03/2024

Assurance Summary

Current situation and summary of work to date:

(a) Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details

The Health Board is compliant with this part of the recommendation at a practicable minimum level. A centrally managed industry standard pan-organisation medical equipment register is in place and operational.

The Health Board acquired and commissioned its Softpro Medusa medical equipment management database that is pertinent to national guidance for medical equipment management functionality. This database is managed by the Medical Electronics and Bio-Medical Engineering (EBME) service.

Medical equipment management information on each item of equipment, including the location where each item is deployed, is recorded in Medusa. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Medusa is used to manage work orders for life-cycle medical equipment management actions.

(b) The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed

The Health Board is fully compliant with this part of the recommendation. The Medusa database in use is industry standard in its structure and functionality for managing medical equipment within a UK health institution. Management of Medusa, including data accuracy checking, is overseen by the Health Board's EMBE service as part of their pan-organisation Medical Equipment Management and technical support role.

(c) Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register.

The Health Board is partially compliant with this part of the recommendation. Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralised register. Ward and departmental managers are familiar with the cohort of equipment used by their staff in their duties and understand their responsibilities around managing this equipment.

EBME provide centralised control of the physical entry of records on individual items of equipment within the Medusa register database. Ward and departmental managers can access a list of equipment in the register that is allocated to their work

area via the Customer Portal. Ward and departmental managers act according to their responsibilities detailed in the Management of Medical Equipment and Devices Policy linked to the equipment registered to their work area

- There is an identified need to create a user guide for the Medusa Customer Portal so that ward and departmental managers can view and print reports on their allocated equipment so as to be better informed for their reporting of discrepancies and variations. Provision of appropriate training for ward and departmental managers on using the Medusa Customer Portal would support them in this activity.
- There is an identified need to support ward and departmental managers, though creation of a standard operating procedure, linked to the Health Board's Management of Medical Equipment and Devices Policy, to guide them in their responsibilities for nominating and delegating local day-to-day oversight of medical equipment and devices to ward/department equipment controllers

(d) Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded

The Health Board is fully compliant with this part of the recommendation. There is a programme of periodic register accuracy reviews and of auditing the review processes. A mechanism is in place for ward and departmental managers to audit the equipment deployed in their work areas against the register and to report discrepancies for correction action

The Finance department has put in place a system for asset verification of deployed items that are classed as capital assets, including medical equipment and devices. EBME verify the records on individual equipment items at points of contact with it during its operational lifespan and from ad hoc updates received from ward and departmental managers.

(e) Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.

The Health Board is compliant with this part of the recommendation at a practicable minimum level. The register captures equipment lifecycle stage events and changes to the departments to which particular equipment is allocated. Data accuracy of information held on individual items is managed under a rolling review programme and applied during EBME's routine planned preventative maintenance actions.

Deployment location updates rely on manual reporting by ward and departmental managers, by routine data verification by EMBE or under Finance's routine Asset Management activities. This will be automated once the RF tracking system is fully implemented. The temporary movement of equipment between departments with the flow of patients may go unrecorded prior to this.

Consideration in the merit of adding temporary resource to support EBME in completing RF tagging of the remaining equipment would be advantageous in accelerating this project.

Mitigating actions pending delivery of recommendation:

The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified:

- Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate.

- Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment.
- Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually.
- Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.

Barriers to compliance causing implementation Delay:

The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff.

Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle.

EBME have not had the resources to create the Customer Portal instructions and disseminate them.

Revised Timeline:

Anticipate completion of the remaining mitigation actions by the end of March 2024

2017 Medical Equipment and Devices

Executive Lead: Director of Therapies and Health Science

Recommendation 2: A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training, aligned to medical equipment and devices. Training records should also be uploaded onto ESR. The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.

Management Response: From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on-site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.

Final Report Agreed Implementation Date: 31/03/2018

Revised Implementation Date(s) - 31/05/2024

Assurance Summary

Current situation and summary of work to date:

(a) A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training, aligned to medical equipment and devices.

The Health Board is partially compliant with this part of the recommendation. A draft pan-organisation strategy on infusion device training has been created to act as a framework for the operational governance and implementation of training on infusion devices. The strategy moves the setup from centralised one-on-many teaching to a devolved yet quality assured cascaded training model in line with national standard approaches.

Lists of the equipment in use in a particular ward or department can be pulled from the centralised register for reference by the ward and departmental managers to determine the respective extent and frequency of user training required for each device type in use in their work area

Ward and departmental managers have been queried as to which device training they require each member of their staff to undertake where it is essential for job function, but with limited response.

Ward and departmental managers in partnership with the Nursing Practice Educators provide information on new starters to the Health Board to pan-organisation training managers to allow accurate organisational compliance extent assurance. This links with the Journey of Excellence (JOE Programme for new starters).

- Ratification of the draft Infusion Device Training Strategy would enable roll out of the methodology across other device categories with support for the resource requirement to operate according to it in full.
- Possible All-Wales steer on risk-based categorisation of training extents for different equipment generic types
- Ward and departmental managers to identify which of their staff require training on what equipment plus a mechanism for them to report this centrally.
- Provision of accessible fixed training spaces that can remain securely set up with the necessary training equipment for training and assessing first tier cascade trainers.

- Acquisition of the add-on Competency Module for the Medusa database would provide an accessible repository for setting extents and frequencies of training per device type, linked to ESR competency tracking.
- Centralised multidisciplinary corporate oversight of competency management for medical equipment and device user training (ref. the model used in Nottingham).

(b)Training records should also be uploaded onto ESR.

The Health Board is non-compliant in this part of the recommendation. Individual staff member training compliances can be recorded in ESR provided that the ESR Customer Services Team upload the relevant competency courses into ESR, and the ward and departmental managers or the centralised training managers assign and update the individual staff members' competency status in ESR. Pan-organisation training managers maintain centralised training record databases covering their respective jurisdictions.

- Creation of competencies within ESR for each separate model type or group of these that can then be selected by managers as appropriate for their respective staff, is required.
- Instructions for ward and departmental managers to populate ESR records for individual staff with the competencies linked to the specific equipment the staff are directed to use on their roles, are required.

(c)The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.

The Health Board is compliant with this part of the recommendation at a practicable minimum level.

The consolidated Infusion Devices Training Database is capable of providing compliance level data given an accurate training numbers denominator.

A full audit to identify ward by ward training needs sent out Jan 2023 was met with a delayed and limited response from wards and departmental managers.

Known infusion training compliance levels reflect that adequate numbers of staff are current in their training to guarantee that sufficient numbers of trained staff are available for the duty rosters for all shifts to have capacity to administer infusions. Wards and departments have access to sufficient numbers of trained staff to provide the infusion therapy required: there have been no incident reported citing lack of sufficiently trained staff preventing appropriate infusion therapy, however central oversight of this is currently problematic making corporate level assurance challenging.

Mitigating actions pending delivery of recommendation:

The dominant risk factor related to this recommendation is that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster, this is assessed as a having a current risk exposure level of 9 (high). The following mitigation actions are identified:

- Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update consolidated infusion training database accordingly - this would give assurance the organisation is running at an appropriate infusion training compliance level by providing an accurate denominating figure
- Increase capacity for provision of infusion device training, including using manufacturer's training resource for revalidation training using a cascade training model

Barriers to compliance causing implementation Delay:

Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training

Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny

Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale

Revised Timeline:

Anticipate completion of the remaining mitigation actions by the end of May 2024

2017 Health and Safety

Audit Recommendation Description	**Recommendation 1:** The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon. In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high-risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.
Potential risks due to the outstanding recommendation	

Assessment	Risk Score	Overall Score	Overall Risk	Timeframe for Implementing Actions
Risk Exposure	Current Level	1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood		4 - 8	Moderate	Actions implemented as soon as possible but no later than a year
Impact		8 - 12	High	Actions implemented as soon as possible but no later than six months
Risk rating		15 - 25	Extreme	Requires urgent action

Audit Recommendation Description	**Recommendation 2:** The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy. In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update. The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.
Potential risks due to the outstanding recommendation	

Assessment	Risk Score	Overall Score	Overall Risk	Timeframe for Implementing Actions
Risk Exposure	Current Level	1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood		4 - 8	Moderate	Actions implemented as soon as possible but no later than a year
Impact		8 - 12	High	Actions implemented as soon as possible but no later than six months
Risk rating		15 - 25	Extreme	Requires urgent action

2017 Medical Equipment and Devices				
Audit Recommendation Description	**Recommendation 1:** Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed. Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.			
Potential risks due to the outstanding recommendation	There is risk of unbalanced investment in portable medical equipment and devices owing to baseline purchasing of excess equipment in compensation for users having difficulty finding the equipment they need efficiently There is risk that ward and departmental managers have difficulty accessing the Medusa Customer Portal: ward and departmental managers require training on how to access and interrogate the Medusa database via the Customer Portal Ward and departmental managers need time allocation to oversee and to routinely verify their allocation of medical devices and equipment Assurance that ward and departmental managers are fully conversant with their responsibilities as stakeholders in the management of medical equipment and devices, intended by the Management of Medical Equipment and Devices policy, is weak			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	*Likely (4)*	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*Moderate (3)*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	***12 - HIGH***	**15 - 25**	**Extreme**	Requires urgent action

Audit Recommendation Description	**Recommendation 2:** A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training, aligned to medical equipment and devices. Training records should also be uploaded onto ESR. The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.			
Potential risks due to the outstanding recommendation	There is a risk that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster Ward and departmental managers have limited capacity to respond to audits by centralised training managers scoping the training requirement of their staff There is no published national standard on how to set or measure appropriate levels of training compliance			
Assessment	**Risk Score**	**Overall Score**	**Overall Risk**	**Timeframe for Implementing Actions**
Risk Exposure	**Current Level**	**1 - 3**	**Low**	Quick, easy measures implemented immediately, and further action planned for when resources permit
Likelihood	*Possible (3)*	**4 - 8**	**Moderate**	Actions implemented as soon as possible but no later than a year
Impact	*Moderate (3)*	**8 - 12**	**High**	Actions implemented as soon as possible but no later than six months
Risk rating	***9- HIGH***	**15 - 25**	**Extreme**	Requires urgent action

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 June 2023
CYFARFOD O: MEETING OF:	Executive Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Regulation of In-house Manufacture of Medical Devices
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr
SWYDDOG ADRODD: REPORTING OFFICER:	Craig Roberts

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

Er Sicrwydd/For Assurance

This paper updates the Executive Committee on the latest position on the anticipated impact of new Medical Devices Regulations on in-house manufacturing and modification of Medical Devices that are anticipated in the next twelve to eighteen months' time.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In the UK, new Medical Devices Regulations are currently being drawn up by the Medicines and Healthcare products Regulatory Agency (MHRA) which, after being delayed by 12-months, are now scheduled to come into force in the summer of 2024. Preliminary discussions with the MHRA on the scope of the new Regulations indicate that there will be new requirements around in-house manufacture (including off-label modification) of Medical Devices, including software-based devices, that will require Health Institutions to use appropriate Quality management Systems (QMS) to manage these operations if they engage in them.

The Executives are asked to give support to activities to put in place the necessary QMS and governance frameworks, and to provide the financial approval warranted for the Health Board's medical device manufacturing activities to be compliant with the Regulations, where continuation of these activities are essential to balance business continuity and patient quality and safety risks.

Cefndir / Background

- Summary

Medical Devices Regulations in the UK are in the process of being revised, and it is largely expected that they will closely follow the European Union (EU) Regulation of 2017; (EU) 2017/745. The new UK Regulations are currently timed to come into force on 1st July 2025.

There are to be three Statutory Instruments (SI's) revising the UK Regulations:

- the first, coming into force in June 2023, to amend the standstill date in the current UK Regulations and to lay the transitional arrangements extending the periods for which certain medical devices that comply with EU legislation can be placed on the market in Great Britain,
- the second, currently expected during 2024, to put in place new post-market surveillance (PMS) requirements, and
- the third, coming into force on 1st July 2025, to fully implement the new Regulations framework.

The latter two SI's will be laid before Parliament 6-months prior to their coming into force. Additionally, in compliance with World Trade Organisation (WTO) rules, the content of these two SI's will be published 60-days before the respective dates they are laid.

These Regulations will affect all businesses and public institutions that manufacture or modify, and either *place on the market*, or *put into service*, *medical devices* - including software and Artificial Intelligence (AI) based devices - as they are defined within the Regulations.

In-house manufacture is currently unregulated in the UK, however, national expert groups anticipate that the new UK Regulations will extend Regulation to cover in-house manufacture of medical devices, i.e. devices that are both produced and used within the same legal entity. The MHRA has now confirmed that it intends to regulate all in-house manufactured devices with future regulations.

- Issues of significance to the Health Board

Appropriate QMS's will be needed to govern manufacturing processes in any Health Board departments and services that undertake the manufacture of medical devices, either for in-house deployment, or for marketing to other legal entities. This will only apply to new products being placed on the market or put into service after the enactment date of the new Regulations.

It is anticipated that the Regulations will not be prescriptive on which quality standard(s) to employ, or that accreditation of QMS's will be mandated, but best practice points to use of the ISO 13485 QMS standard. However, there are expected to be some costs involved, depending on the level set.

The governance of in-house produced software-based medical devices will need detailed attention. In England this this is already regulated under Section 250 of the Health and Social Care Act 2021 through the two Information Standards; DCB 0129 and DCB 0160. These standards specify that organisations must have in place digital *Clinical Safety Officers* (CSO), who are responsible for overseeing

the clinical risk management activities and signing off the documentation in the creation of such software. Although not mandated in Wales, best practice at present would be to work towards working to these standards.

- National / local objectives involved

The All-Wales Medical Devices Regulations (MDR) Group conducted a survey of the services in each of the Welsh Heath Board and Trusts in July 2022 to capture the current baseline status of QMS use, and to track development of these in the run up to the new Regulations being published.

Health Education and Improvement Wales (HEIW) is considering offering its learning platform to host creation of a toolkit for setting up QMS's for in-house manufacture.

The MHRA is creating and launching focus groups to produce its guidance on the new Regulations. It has indicated that the first topic to be addressed relates to requirements for *post market surveillance*, and a regulatory update on this is due in January 2024, 6-months in advance of the main Regulations. The All-Wales MDR Group has engaged with the MHRA in this process.

The Health Board's Medical Devices Committee (MDC) will engage in a project to convey the affected services to have the appropriate QMS's in place in the run up to the new Regulations coming into force.

- There is a Welsh collective approach to this, following the good examples of similar work in Swansea Bay University Health Board and in Betsi Cadwaladr University Health Board.
- The MDC is currently convening a working party and action plan to carry the project forward.

Asesiad / Assessment

Departments and Services Affected

The All-Wales MDR Group survey established the following services in the Health Board that are affected:

- Occupational Therapy
- Maxillo-facial
- Podiatry
- Physiotherapy, re Rehabilitation Engineering
- Informatics – ICT, re Software as Medical Device (incl. Artificial Intelligence (AI))

Currently, none of these departments are operating under Accredited QMS's; they are working to local protocols and standard operating procedures and have been making progress to align with QMS operation.

- Podiatry, and Physiotherapy (re Rehab Engineering) are already close to having accreditable QMS's in place.
- Occupational Therapy, and Maxillo-facial have well defined and documented processes and will need support to progress towards operating an accreditable QMS.

- Software-as-Medical-Device Health Board stakeholders, led by ICT, will need an appropriate governance framework to be created in-line with the Digital Standards. There is volatility in what is expected on the future Regulation (and possible Government Licencing) of AI use and how this will be represented in the new Medical Devices Regulations: the detail is currently an unknown and we may require the convening of a separate dedicated working group to handle this, owing to its complexity and spread across multiple Health Board departments and services.

Please note that departments and services scoped nationally by the All-Wales MDR Group survey but which are not engaged in in-house manufacturing activities in ABUHB are:

- Radiology, re the Medical Physics remit
- Medical Electronics (EBME), re the Clinical Engineering stand-alone devices remit

It should also be noted that in services that only deploy and or configure *custom-made devices* (as defined within the Regulations), manufacturing-process-orientated QMS's are not expected to be mandated, with the exception of implantable *custom-made device* for in-house use. For unaffected *custom-made devices*, accreditation would be captured an appropriate pathway-orientated clinical services accreditation programme rather than under the MDC working party. A full audit of each affected department's activities will differentiate these practices and shall be the first step in the working party's project plan.

(See the attached tables detailing the status of each ABHUB department and comparison across the Health Boards).

Project Support Challenges

- Selection and provision of a suitable software platform for hosting the QMS's
- Access to Standards publications through the necessary readership licenses/memberships
- Training and potential recruitment of key personnel in QMS management and its audit
- Identification, training or recruitment, or out-sourcing of CSO's and their governance
- Accreditation of services, where due
- Future financing of ongoing accreditation costs

Argymhelliad / Recommendation

Assurance

The MDC wishes to assure the Executive Committee that the Health Board's current position is on track to put in place the necessary arrangements to continue with its current in-house medical device manufacture and modification activities in the timeframe of the full enactment of the new Medical Devices Regulations in July 2025.

Any specific requests for the Executives' direct support will flow from the work of the MDC Working Party.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care 3.4 Information Governance and Communications Technology
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Research, Innovation, Improvement, Value
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:	Institute of Physics and Engineering in Medicine (IPEM) produced best-practice guidance for the in-house manufacture of medical devices and non-medical devices, including software in both cases, for use within the same health institution. This consolidates the best available knowledge from its expert group in anticipation of new UK Medical Devices Regulations.

	See: https://www.ipem.ac.uk/media/vp0ewy01/ipembe-1.pdf
Rhestr Termau: Glossary of Terms:	QMS Quality Management System MHRA Medicines and Healthcare products Regulatory Agency IPEM Institute of Physics and Engineering in Medicine MDC Medical Devices Committee CSO Clinical Safety Officer MDR Medical Devices Regulations AI Artificial Intelligence
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The All-Wales Medical Devices Group that was formed to govern enactment of the 2017 European medical devices regulations, which arrested under 'Brexit', has been reconvened to provide coordination for enactment of new UK Regulations. Its output has informed the Health Board's courses of action.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the 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**	Not Applicable Choose an item.

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

Health Board/Trust/Organisation	Service	Relevant Activity	ISO 13485 Status	ISO 9001 Status	Notes	Local Specialty Lead
ABUHB	Occupational Therapy	Upper Limb Splinting for Children and Adults	None	None	Local Protocols / SOP's in place supported by: Paitent Information Leaflets, Risk Assessments/Safety Guidance, Material Specifications, Professional Guidelines. Work on-going towards QMS	Suzanne Bryant
ABUHB	Prosthetics	Prosthetics is N/A within this Health Board (Tertiary service within Cardiff & Vale)				N/A
ABUHB	Maxillo-facial		Currently a long way off being ISO13485 compliant	None	Currently running in line with DAMAS regulations	Sarah Jenkins
ABUHB	Podiatry	Manufacture and custom modification of foot orthoses (insoles)	None	None	Unaccredited Quality Management System, based on Article 5 Health Institution Exemption	Heather Barne
ABUHB	Rehabilitation Engineering	Under the governance of Physiotherapy in ABUHB	None	None	Local Protocols / SOP's in place supported by: Paitent Information Leaflets, Risk Assessments/Safety Guidance, Material Specifications, Professional Guidelines. Work on-going towards QMS to standardise processes across sub-specialities in line with Article 5 Health Institution Exemption	Heather Barne (Physiotherapy / Orthotics / Prosthetics)
ABUHB	Medical Physics	Within ABUHB's Radiology scope of operation, including; MRI, Radiotherapy and Nuclear Medicine. There is no in-house manufacturing activity.	None	None		Andrew Carter (Radiology re MRI, Radiotherapy and Nuclear Medicine)
ABUHB	Clinical Engineering	Medical Electronics (EBME) does not undertake any in-house manufacture of Medical Devices	None	None	Medical Electronics (EBME) adheres to local SOP's for its repair & maintenance work activities	Mark Francis (EBME)
ABUHB	Software as Medical Device	None at present	Not considered	None		Peggy Edwards (Informatics - ICT)

Service	Issues of Significance / obstacles encountered
Prosthetics	Copy of standards not readily available to monitor progress towards compliance.
Maxillo-facial	Engaged with an all-Wales forum who are working together to ensure all the max fac labs will be compliant. Morriston hospital have been compliant for over twelve months and have kindly offered to assist smaller labs such as ourselves.
Podiatry	• Lack of accredited training programs for orthotic technicians • Lack of software program to enable digital ordering process for prescription insoles • Query re requirements for certain items that are manufactured by clinicians during appointments, temporary insoles, custom props
Rehabilitation Engineering	• Different sub-specialities of the service work to different SOP – needs to be standardised across physiotherapy to ensure QMS is compliant with Article 5 Health Institution Exemption
Software as Medical Device	We currently have no quality management approach in the department

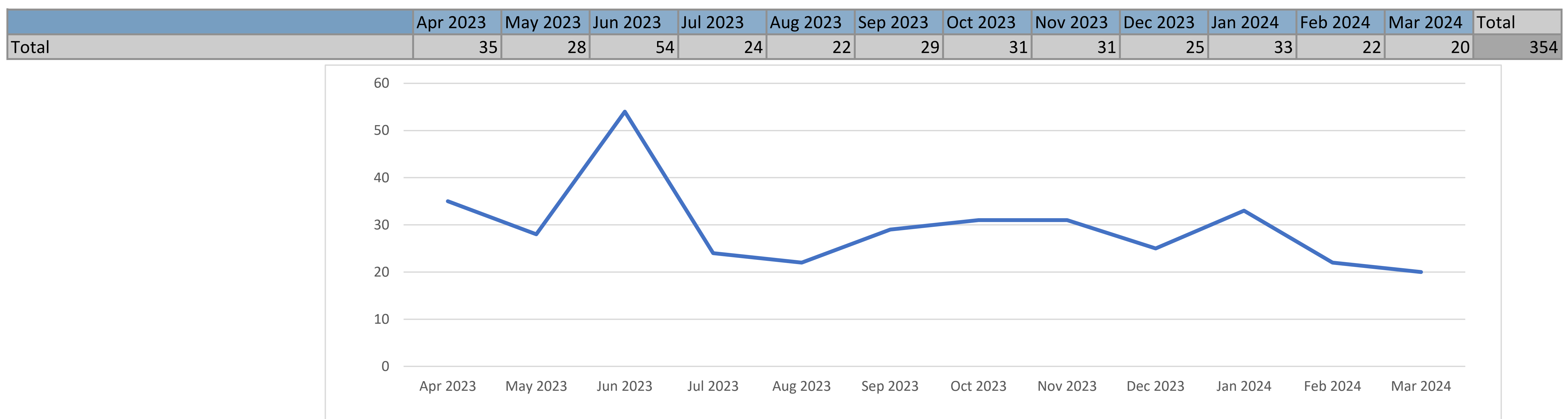
Medical Device Incidents (01/04/2023 to 31/03/2024)

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
None	12	10	28	11	12	17	17	15	12	21	12	9	176
Low	23	17	22	12	10	12	12	15	12	9	9	11	164
Moderate	0	0	0	0	0	0	0	0	0	2	0	0	2
Severe	0	0	0	0	0	0	0	0	0	0	0	0	0
No value	0	1	4	1	0	0	2	1	1	1	1	0	12
Total	35	28	54	24	22	29	31	31	25	33	22	20	354

Incidents by Location of Incident - Site (tag) and Reported Date (Month and year)

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
Grange University Hospital	10	11	26	12	10	9	10	11	7	14	6	6	132
Nevill Hall Hospital	2	0	3	0	2	2	0	1	3	3	1	0	17
Royal Gwent Hospital	8	4	9	5	5	9	9	8	5	8	4	5	79
Chepstow Community Hospital	1	0	0	0	0	0	0	0	0	0	0	0	1
St Woolos Hospital	1	3	2	0	1	3	2	0	0	0	1	1	14
Ysbyty Ystrad Fawr	2	1	5	1	0	1	4	2	6	0	3	2	27
Dental Practice	1	0	1	0	0	0	0	0	0	0	0	0	2
General Practice	1	2	0	0	0	0	0	0	0	0	0	0	3
Health Centres & Clinics	4	2	0	0	0	0	0	3	0	2	0	0	11
Nursing Homes	1	1	0	0	0	0	0	0	0	0	0	0	2
Residential & Care homes	3	3	4	5	4	4	4	3	2	3	4	3	42
Maindiff Court Hospital	1	0	0	0	0	0	0	0	0	0	0	0	1
St Cadocs Hospital	0	1	2	0	0	0	0	0	0	0	0	1	4
(Non ABHB) Hospitals and Sites	0	0	2	0	0	1	1	2	1	1	1	2	11
Monnow Vale	0	0	0	1	0	0	0	0	0	0	1	0	2
County Hospital	0	0	0	0	0	0	1	0	1	0	0	0	2
Ysbyty Aneurin Bevan	0	0	0	0	0	0	0	1	0	1	0	0	2
Llanfrechfa Grange	0	0	0	0	0	0	0	0	0	1	0	0	1
Mental Health Centre	0	0	0	0	0	0	0	0	0	0	1	0	1
Total	35	28	54	24	22	29	31	31	25	33	22	20	354

Incidents by Post Investigation harm assessment and Incident date (Month and year)



	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
Total	35	28	54	24	22	29	31	31	25	33	22	20	354

Month/Year	Total
Apr-May 2023	59
Jun-23	86
Jul-Aug 2023	85
Sep-Oct 2023	50
Nov-Dec 2023	73
Jan-Feb 2024	83
Mar-24	41

Total	**477**

FSCA Type	01/04/2023-31/03/2024 TOTAL
Omnicell	78
Procurement	8
Radiology	46
Pathology	103
EBME	37
Endoscopy	3
Opthalmology	5
Resus Team	2
IR	5
Diabetes Team	3
Medical Gases	2

Total Relevent to ABUHB	**292**

PSN/A	Compliance Declared
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Work on-going
NaPSA Risk of Oxytocin Overdose During Labour and Childbirth	20/01/2024
PSA008 Nasogastric tube misplacement: continuing risk of death and severe harm	08/12/2023
PSA017 - Identified safety risks with the Euroking maternity information system	Not relevant for ABUHB

PSN002/NR Fit	29/04/2024

Relevant to Medical Devices
PSA008 Nasogastric tube misplacement: continuing risk of death and severe harm
PSN002/NR Fit

1st April 2023-31st March 2024

Title	Date of Issue	Link	Comment	Comment
IV Set Savings	13/02/2024	..\Procurement\2024\IV Administration Set Savings V2.docx	Advice from procurement for cost savings on giving sets	Re-released in June 2024
Patient ID when using POC Testing	13/02/2024	..\INT ALERT\2024\POC ID Expectations ALERT.docx	The importance of using Correct Patient ID on All Point of Care Testing devices	n/a
Supply Issue of BD ProSafety IV Cannulas Across Wales - supplies will run out	06/03/2024	Safety Memo\2024\ABUHB Safety Memo 06.03 IV Cannula Supply Issue.docx	Supply chain issues with current peripheral cannula supplier leading to temporary change of device	n/a
The Oxywipe S wipes do NOT meet the required standards for disinfecting Clostridioides-Difficile	07/03/2024	Safety Memo\2024\ABUHB Safety Memo 07.03 Oxywipes S Actichlor.docx	Update on disinfecting requirements for cleaning in areas of confirmed or suspected C-Diff	n/a
Welsh Resuscitation Forum 2023 Update on PPE and Cardiopulmonary Resuscitation (CPR)	09/05/2023	Welsh Resuscitation Update Spring 23.docx	Released at the request of the Resus Team	n/a
NEW Out of Hours process for accessing infusion devices in RGH	19/05/2023	OOH pumps at RGH.docx	Released at the request of Claudia Ivins	n/a
IA/2023/10: Safety Precautions for the use of the GEM 5000 Blood Gas POC Machines	07/06/2023	INT ALERT\2023\IA 2023 10 Blood Gas Machine.doc	Released on request of POC due to issues with machine damage from improper use.	n/a
Freestyle Libre Continuous Glucose Monitoring Sensors for Patients Undergoing Surgery	07/06/2023	Safety Memo\2023\MEMO 07062023 Freestyle Libre.docx	The FreeStyle Libre 14-day Flash Glucose Monitoring System may NOT be used when the patient is due to be exposed to high frequency electrical heat (diathermy) treatment, MRI or CT.	n/a
Portable Suction Unit Safety Bulletin	16/08/2023	INT ALERT\2023\Portable Suction Unit Safety Bulletin-IA202312.docx	During recent resuscitation trolley checks on several wards and departments within ABUHB a number of issues regarding the portable suction units (LSU) were identified.	n/a
Ethypharm Aurum Pre-Filled Syringe Incompatibility	26/10/2023	Safety Memo\2023\MEMO 26102023 incompatible syringes\MEMO 26102023 Incompatible syringes V2.docx	There have been reports of cases where pre-filled syringes of this type have been found to be incompatible with some of the needle free connectors on intravenous access devices.	n/a

Medical Electronics (EBME) - Performance Review 2023

•

EBME Financial Position 2023:

EBME Budget £347K – On track to achieve breakeven forecast – Even after a £38K reduction on 2022 budget.
Non Delegated Equipment maintenance Budget £1,101K – Likely to see a slight overspend, mainly down to increased Maintenance Contract costs and increased material costs – Budget reduced by £25K against 2022 budget.

Key Projects 2023:

- Completed replacement program of new BD Nexus Anaesthesia infusion Devices throughout ABUHB Theatres.
- Completed replacement program of Pain Controlled Analgesia (PCA) pumps, including Epidural & Nerve Block pumps.
- Completed transition and implementation of new Bodyguard T Ambulatory Syringe Drivers from McKinley T34 devices.
- Continued with the replacement program of 5000 Philips CPAP devices used predominantly by Respiratory patients as per manufacturers Field Safety Notice issued in 2021.
- Continued Implementation of passive RFID system/tagging of Medical Equipment & Devices in association with Capital Finance Team to enabled better tracking and locating of devices throughout ABUHB. Over 5000 now RFID tagged and registered by EBME.

Equipment Management Inventory Database:

- Currently have 26313 Medical Equipment & Devices registered on our Equipment Inventory database for ABUHB
- Commissioned 2590 new devices in 2023
- Decommissioned 983 devices in 2023

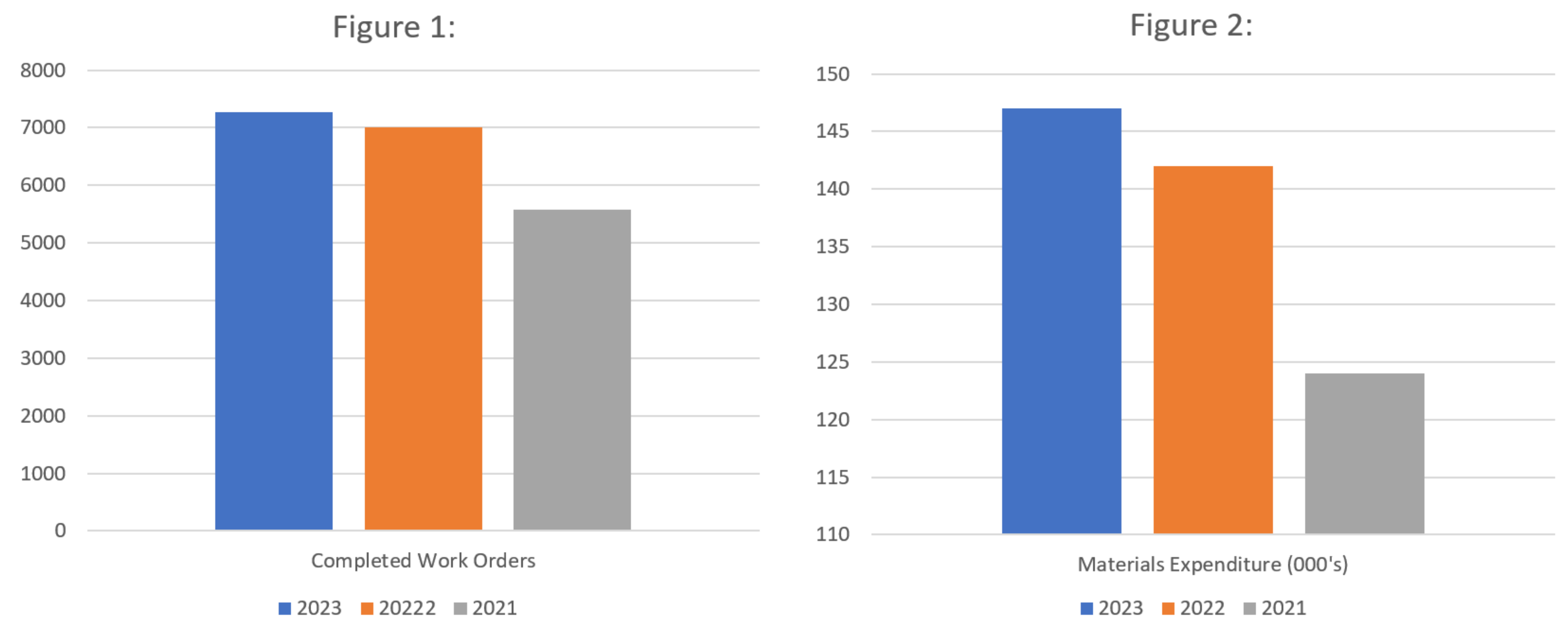
Activities & Materials Expenditure 2023:

Completed Work Orders – 7263

Spare parts/materials expenditure for in-house (EBME) repairs/service work – £147K

The graph in Figure 1 show how the number of completed work orders compares with the previous 2 years:

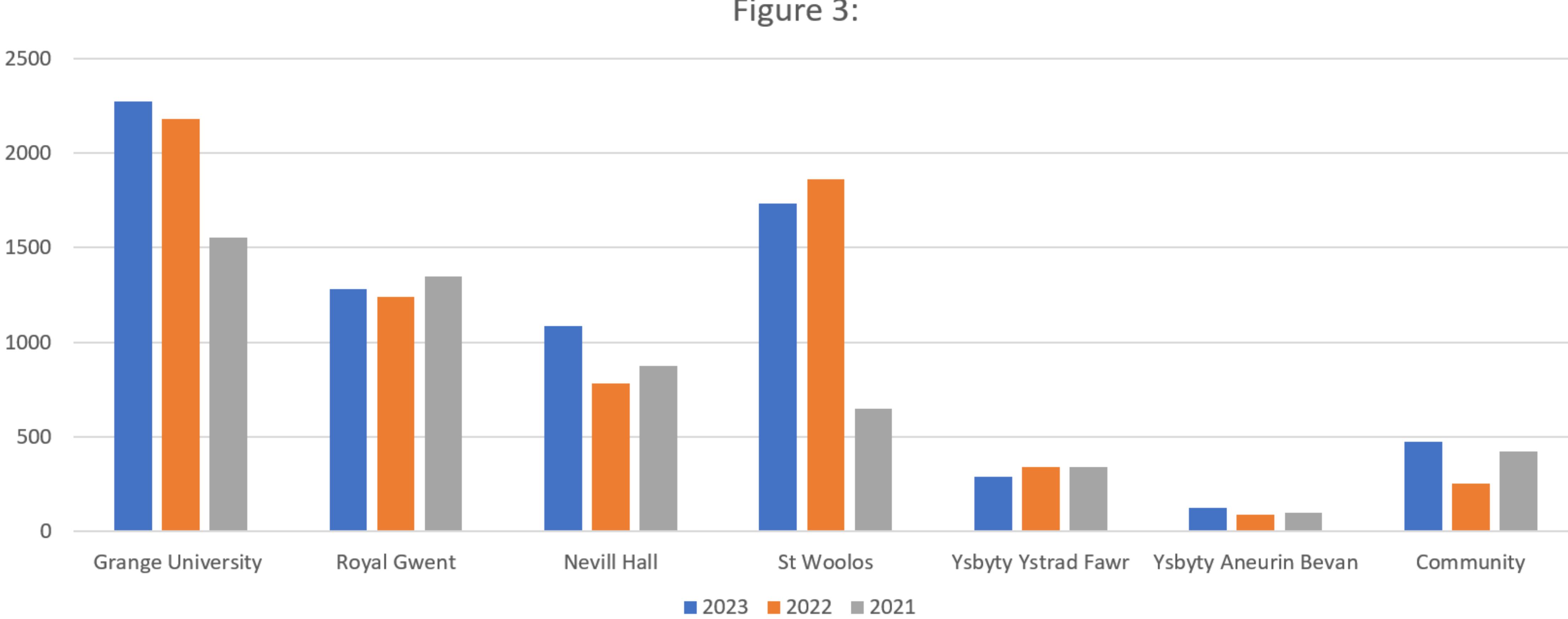
The graph in Figure 2 show how our spare parts/materials expenditure for in-house repairs compares with the previous 2 years:



Work Order Activities per site:

The following graph in Figure 3 show the number of work orders per the main sites and how they compare with the previous 2 years:

Note: The spike in St Woolos work orders in 2022/23 is down to the Philips CPAP replacement program for Chest Clinic (Home Respiratory Patients).



ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The training strategy for infusion devices for the organisation currently has the following streams-

- Ambulatory syringe driver cascade training
  - End users trained by cascade trainers
- 'New starter' Fresenius training which recommenced in April 2023
- JOE (Journey of Excellence) programme Fresenius training which commenced in Jan 2024
- Fresenius cascade training which commenced Feb 2024
  - Update competency assessments delivered by cascade trainers

Ambulatory syringe driver cascade training

This training is delivered by the Primary Care team and trains experienced nurses who are familiar with using the devices regularly to deliver the initial training for the ambulatory syringe drivers to end users. These cascade trainers can also deliver the periodic updates/competency assessments.

First time cascade training is delivered in person. Annual updates are required for cascade trainers, and these can be delivered virtually.

'New starter' Fresenius training

The 'new starter' training for the Fresenius devices is for all staff who are new to the Health Board and delivers ABUHB initial training on Volumats and syringe pumps (injectomats). It is currently delivered by the Infusion Device Service and Training manager. Staff can book this training themselves by accessing the booking form on the Infusion Device Training intranet page.

JOE (Journey of Excellence) programme Fresenius training

The JOE programme Fresenius training is the same as the 'new starter' training but is designed with dates immediately following the intravenous (IV) administration study day for the JOE students so they can have infusion device training at the earliest opportunity following their IV training. Staff book onto this using the link on their IV administration study day confirmation email.

Fresenius cascade training

This training is delivered by the Infusion Device Service and Training manager and trains experienced nurses who are familiar with using the devices regularly and meet the cascade trainer criteria, to deliver the periodic updates/competency assessments.

Updates/competency assessments are due dependant on frequency of use

- Frequent users (those using the device at least once a week when in work) need to have updates/assessments every 3 years
- Infrequent users (those using the device less than weekly) need to have updates/assessments annually.

Cefndir / Background

This training strategy has moved away from the previous model which proved inefficient as it was reliant on one individual providing initial training and updates to all staff in remote locations across the Health Board.

Asesiad / Assessment

Achievements

- Since commencing the cascade training model in February 2024, we now have 12 nominated cascade trainers to date (31-03-2024) who are trained and active and steady progress is being made on building the numbers.
- The number of training dates per months has increased
- A new stream for the JOE staff has been initiated to decrease the wait time for staff to attend infusion device training following their IV administration study day. This decreases the amount of time it takes for new qualified nurses to become independent in their areas.

Challenges

- Difficulty in obtaining the missing training data and staff lists from ward managers means producing an accurate ward level compliance value is not yet possible. To obtain this missing data, a spreadsheet for completion, which was originally circulated for completion by ward managers in January 2023 but did not receive any response, has been escalated to senior nurses. Compliance cannot be accurately measured without a true figure for the denominator of people that should be trained, it can only be estimated using the available information.
- Lack of designated training room means that training is delivered from an office space which is not an ideal learning space and set up/take down of training materials can be inefficient.

Argymhelliad / Recommendation

Ongoing goals

- For trainers and ward managers to upload all compliance data to ESR to provide a centralised compliance dashboard
- To obtain a designated, fit for purpose, training space to increase training efficiency
- To increase team members to provide resilient and consistent delivery of service in the event of unexpected absence.

Terms of Reference (ToR)

Medical Devices Committee (MDC)

Version	Date	Comment/Changes	By whom
1	June 2019	Medical Devices Committee terms of reference – Initial document	Chair
2	February 2020	Update to reflect governance arrangements	Chair
3	May 2021	Annual review and update to reflect governance arrangements	Chair
4	**July 2021**	Update to reflect current Medical Devices Regulations	Chair

1. PURPOSE

The purpose of the Medical Devices Committee is to provide a structured approach to ensuring the organisation manages its medical devices in accordance with:

a)

The Medical Devices Regulations 2002 and The Medical Devices (Amendment etc.) (EU Exit) Regulations 2020

b)

ABUHB Management of Medical Equipment Devices policy

As a sub-group/Committee of the Health Boards Quality and Patient Safety Operational Group, the MDC will be responsible for reducing risks associated with the purchase, deployment, management and use and decontamination of medical devices

2. MEMBERSHIP

Chair	
Craig Roberts	**Assistant Director of Therapies and Health Science**
Vice Chair	
Alex Scott	**Assistant Director for Quality and Patient Safety**
Organisational leads	
EBME	**Mark Francis**
Radiology	**Mark Wilkes**
Cardiology Clinical IT Manager	**James Stevens**
Divisional Lead - Therapies	**Heather Barne**
Divisional Lead – Urgent Care	**Angela Downward**
Divisional Lead – Family	**Celia Satherley**
Divisional Lead – Scheduled Care	**Gwawr Evans**
Divisional Lead – Medicine	**Angela Downward**
Divisional Lead – Primary Care and Community	**Rhian Morgan**
Divisional Lead – Mental Health and LD	**TBC**
Procurement Lead	**Rob Morris**
Health and Safety	**Gavin Williams**
Risk Management	**Richard Stubbs**
HSDU	**Denise Cressey**
IPAC/Decontamination	**Sam Murray**
Informatics	**Peggy Edwards/Andy Warburton**
Estates and Facilities	**Ivor Jones**
R&D	**TBC**
Clinical Education	**Sharon Morris**

The MDC may also co-opt additional members or independent 'external' members from outside the organisation, to provide specialist knowledge and skills.

In attendance: Any Senior Manager of Aneurin Bevan University Health Board (ABUHB) or partner organisation will, where appropriate, be invited to attend.

Secretary: Susanne Kelly, Pathology Business Support Officer

Should a member be unavailable to attend, they may nominate an alternate to attend in their place subject to the agreement of the Chair or Vice Chair

Member appointments:

The membership of the MDC shall be determined by the members, based on the recommendation of the Chair – taking account of the balance of skills and expertise necessary to deliver the MDC's remit and subject to any specific requirements or directions made by ABUHB

3. Principle Duties

3.1 Provide assurance to the Health Boards Quality and Patient Safety Operational Group around appropriate governance relating to medical devices management and use

3.2 Provide assurance around selection and procurement process, learning from incidents, safety communications and risk management

4. Key Responsibilities

4.1 MDC priorities will be based on the principles of clinical governance

4.2 The MDC will ensure process is in place to register and manage medical device assets , whether leased or owned

4.3 The MDC will review and approve strategic medical devices plans

4.4 The MDC will review medical devices risk management and associated risk register entries, ensuring any risk mitigation is being addressed by the risk owners

4.5 The MDC will review and monitor medical device incidents and related themes

4.6 The MDC will review internal and external safety communication, including local safety notices, safety notices

and alerts and receive assurance that all communications are being appropriately disseminated and acted upon

4.7 The MDC will review and monitor compliance with relevant standards issued by external bodies, including WG, HSE, MHRA, Health Technology Wales, HIW, NICE etc

4.8 The MDC will establish priority areas and targets for medical devices training and monitoring performance

4.9 The MDC will approve strategies, policies (including the medical devices management policy) and procedural documents relative to medical devices and monitor their application

4.10 The MDC will commission new policies and procedural documents relative to medical devices management

4.11 Receive Sub-Group assurance reports from any Sub-Groups it has established and undertake an annual review of their Terms of Reference

4.12 Ensure that the procurement process for new Medical Devices, including the development of specifications and tender evaluations, is conducted in accordance with the Health Board policies and procedures.

4.13 Provide an annual report to the Quality and Patient Safety Operational Group

5. AUTHORITY

These ToR achieve this authority by compliance with the following:

	The Medical Devices Regulations 2002 and The Medical Devices (Amendment etc.) (EU Exit) Regulations 2020
Health and Care Standards for Wales (Welsh Government: 2015) Standard Governance Leadership and Accountability.	
Safe care	Standard 2.1 Managing Risk and Promoting Health and Safety Standard 2.4 Infection prevention and control and decontamination Standard 2.9 Medical Devices, Equipment and Diagnostic Systems.
Effective care	Standard 3.1 Safe and Clinically Effective Care. Standard 3.4 Information, Governance and Communication technology Standard 3.5 Record Keeping
Timely care	Standard 5.1 Timely Access
Staff and resources	Standard 7.1 Workforce

6. ACCESS

The Chair and Vice-Chair of the MDC shall have reasonable access to Executive Directors, Service Leads and other relevant senior staff in order to execute their duties

7. MEETINGS

Quorum

The quorum for the meeting will be no less than eight of the membership and must include as a minimum the Chair or Vice-Chair of the MDC, representatives from three divisions, clinical and procurement representation

Frequency of meetings

The MDC will meet bimonthly, with a schedule of meetings confirmed in advance. Additional meetings will be arranged as determined by the Chair as required.

Papers

Agenda and papers will be disseminated to MDC Committee members at least seven working days before the date of the meeting and wherever possible electronically. The minutes and actions will be circulated to members within ten days to check for accuracy

Meeting arrangements

The Chair of the MDC in discussion with the Secretary shall determine the time and place of meetings, together with the agenda taking account of items recommended for discussion by the membership

Withdrawal of individuals in attendance

The MDC may request for a member to withdraw from a meeting to facilitate open and frank discussion on particular matters.

8. Feeder Groups

The MDC will establish task & finish groups as required to enable necessary links into existing HB structures and processes, to ensure appropriate governance assurance.

9. Reporting

The MDC is accountable to Board for its performance in exercising the functions set out in TOR via the Executive Quality and Patient Safety Committee. Through its Chair and members, the MDC work closely with the HB's other Committees, to provide advice and assurance to the HB through the:

- Joint planning and co-ordination of Board and MDC business.

- Sharing of information

In doing so, the MDC shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the HB's overall risk and assurance framework.

The Chair shall:

- Report formally, regularly and on a timely basis to the Executive Quality and Patient Safety Operational Group. This includes verbal updates as requested on activity, the submission of minutes and written reports, as well as the presentation of an annual report.

- Bring to the Quality and Patient Safety Operational Group's specific attention, any significant matter under consideration by the MDC

10. APPLICABILITY OF STANDING ORDERS

The requirements for the conduct of business as set out in the HB's Standing Orders are equally applicable to the operation of the MDC

11. REVIEW

These TOR and operating arrangements shall be reviewed on at least an annual basis.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 March 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nutrition & Hydration (N&H) – Interim update report 24/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr Executive Director of Allied Health Professions (AHP) & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Craig Roberts Assistant Director of Allied Health Professions (AHP) & Health Science

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance This Nutrition & Hydration (N&H) Interim update report is intended to appraise the organisation of the current and future quality, patient safety and governance activity being undertaken across the organisation This is not a comprehensive annual report given that the newly established N&H steering group met for the first time in February 2025. This document will outline re-establishment of the N&H strategic steering group, sub-groups and ongoing task and finish work. The report will also outline the intended work plan for the next 12-months as well as highlighting any ongoing or perceived future challenges The intention of the interim report is to provide assurance to the Executive Team and Patient Quality, Safety and Outcomes Committee (PQSOC) that the systems

and processes are now established to achieve a multidisciplinary, timely approach to patient safety and quality within the N&H agenda.

A formal annual report will be produced at the conclusion of the 25/26 year

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

Malnutrition affects between 20% and 50% of hospital inpatients on admission, with further declines expected during hospitalisation. Hospital malnutrition is a predictor of increased length of stay, impaired wound healing, increased risk of infection complications, and increased morbidity and mortality. Malnourished patients have more substantial care needs with a greater reliance on hospital resources resulting in higher healthcare costs.

The multiple consequences of malnutrition and dehydration must be managed and minimised to the lowest possible level and causation should be understood and where possible, prevented.

Appropriate feeding and hydration is a fundamental expectation and right of patients and their loved ones.

In order reduce incidence, the organisation requires a N&H structure that puts the patient at the centre of all decision making and actions.

The governance structure around this agenda needs to be efficient, effective and timely with respect to N&H matters and to this end, a significant organisation focus has been placed on the ABUHB management of N&H to ensure best possible quality of nutritional care for the population we serve

The Health Board's Executive lead for N&H is the Clinical Executive Director of AHP and Health Science (DoAHPHS).

Oversight of the N&H agenda is provided through the newly established N&H strategic steering group chaired by an assistant DoAHPHS with deputy DoN acting in the vice chair position.

The purpose of this multi-disciplinary, clinically led group is to oversee nutritional care of inpatients and reduce the incidence of malnutrition and dehydration in our healthcare settings. To actively monitor compliance with Health Board and Welsh Government standards and policies for nutrition and catering, directing action where necessary and escalating matters to the Patient Quality, Safety & Outcomes Committee (PQSOC) as appropriate.

The key function of the Nutrition and Hydration Steering group is to review evidence and provide advice, guidance and direction to:

- Improve patient outcomes and patient safety
- Enhance patient experience
- Promote safe, effective and timely nutritional care
- Monitor compliance with Welsh Government healthcare associated standards for nutrition and catering
- Update and review Health Board risk register
- Review and endorse new and existing associated policies
- Review and endorse the annual programme report and future work programme
- Development and dissemination of guidance to assist services for local implementation

The steering group is supported by two operational sub-groups. The food services group and the clinical (artificial) N&H group (ToR appendices).

Task and finish groups may also be stood up to undertake timely actions against identified risk

The strategic steering group and clinical N&H group sub-group had their inaugural meetings in January 2025. The food services sub-group has operated in isolation in lieu of a formal strategic steering group for several months.

Attendance and enthusiasm to be involved in the multi-disciplinary workstreams has been abundant and this bodes well for ensuring patient focussed N&H quality improvement projects can progress at pace.

Cefndir / Background

Whilst N&H has always been recognised as an essential element of positive patient outcomes and experience, the ambition to bring together an effective multi-disciplinary approach has proved problematic.

Previous iterations of the N&H group have demonstrated that a single group providing strategic guidance as well as focussing on operational issues is unmanageable and largely ineffective.

Whilst there has always been an intent to provide effective direction, the group found that operational, mainly catering, related issues dominated the agenda.

The Covid pandemic interrupted the rhythm of these meetings and there has been a hiatus in a formal assurance mechanism since that time.

A substantial amount of work has been undertaken, but in isolation. Whilst this work has undoubtedly been engaged with the best of intentions, there has been

no monitoring to understand the wider implications and effects. Unintended consequences have included duplication of effort as well as confusion around who is responsible for investigating and providing action when incidents have been identified

This disconnect was brought starkly in to focus when several incidents were reported highlighting lack of nutritional input for individuals, some with learning difficulties, for up to 12 days in one instance.

Review of these incidents demonstrated that there is no one cause but a classic Swiss cheese effect.

These incidents prompted the clinical executive to commission a task and finish group together with a review of governance arrangements for N&H related business. The review has resulted in establishment of the steering group, sub-groups and resultant organisational awareness that N&H is an essential aspect of high-quality patient care.

Asesiad / Assessment

This section of the report highlights ongoing work as well as intended future workplan. An overview of incident metrics is also included the period April 1st 2024 to March 1st 2025

Task and finish group 1 – Fluid balance monitoring

In October 2024 the health board received a 'Preventing future deaths - regulation 28 report in which the coroner raised concerns about failure to monitor a patient's fluid balance by failing to complete and monitor fluid balance charts during admission to ward AO in at GUH on 21-26/10/23.

The coroner mentioned in court that she was issuing the report partly because she had seen failures to complete balance charts before and was concerned that this appeared to be an ongoing problem.

The subsequent action plan (appendices) outlined actions that would require a multi-disciplinary task and finish group (appendices).

The group was set up under the direction of a deputy director of nursing and an assistant director of AHP and health science

The purpose of the task and finish group is to provide organisational clarity and consistency in the use of fluid monitoring charts. This includes developing criteria for the commencement and discontinuation of fluid balance charts.

Progress

Actions have focussed on education and ensuring clear guidance is in place.

- Fluid balance audit on AMAT – being trialled on A0 for wider roll out. Audit will be conducted weekly on-wards. Baseline measurement audits have commenced
- SOP being produced – Use and completion of fluid balance charts across ABUHB
- Educational tool being developed (7-minute briefing). Used to deliver short briefings to staff on a daily basis
- Action cards being developed to capture additional educational material
- Repeat audits once educational aids introduced. Any requisite improvements may be identified and PDSA cycle commenced
- Fluid balance monitoring compliance is a standing agenda item on the strategic steering group agenda
- Task and finish work will move into Clinical sub-group management once established baseline and first round of follow up audits

Task and finish group 2 – Escalation of nutritional needs

A task and finish group was commissioned as a result of several unacceptable DATIX incident reports highlighting patient's nutritional needs not being met, in some cases, patients waited 12 days for this to be resolved.

The task and finish group undertook a thematic review of N&H incidents to try and identify recurring patterns. Whilst there is no clear trend identified, cross organisation communication and escalation action to be taken in the event of a delay in nutrition was absent in most of the long wait incidents.

The task and finish group membership was repurposed with more senior members included who could influence change. The purpose of the renewed task and finish group is to ensure adequate controls are in place to reduce the potential for these events happening in the future. This work will be influenced by learning from previous incident reviews

Several key members of the fluid balance T&F are also members of this group therefore a decision was made to merge the groups given that improvement processes, specifically education, largely related to both workstreams.

Priority has currently been provided to the fluid balance work given that an implementation deadline exists

Progress

- Draft escalation process produced. Additional information to be added following group review
- Reviewing handover of patient documentation to ensure N&H are appropriately captured
- Progress will be monitored through the clinical sub-group to ensure progress is maintained

- DATIX incidents will be monitored and reported through to the strategic steering group on a two-monthly basis

N&H Steering Group

The inaugural meeting sat in February and will continue to meet at two monthly intervals.

All three clinical executives are represented by Deputy and Assistant directors

The risk register will be populated with the following risks/issues

- Escalation protocol – Issue: management through T&F
- Fluid balance monitoring – Issue: management through T&F
- PSA 008 – Nasogastric tube misplacement – Risk: for sub-group action
- Lack of resource in information services team to support digital set up of required reports for N&H group to monitor performance – Risk: working with chief nursing information officer to mitigate risk

Food standards sub-group

The food standards sub-group is well established and is composed of a broad range of stakeholders from across the organisation.

Current workstreams include:

- Regulatory compliance: Environmental health & trading standards
- Food safety – patient meal ordering, the food service, temperature control
- Allergen control process
- Provisions

Clinical (artificial) nutrition & hydration sub-group

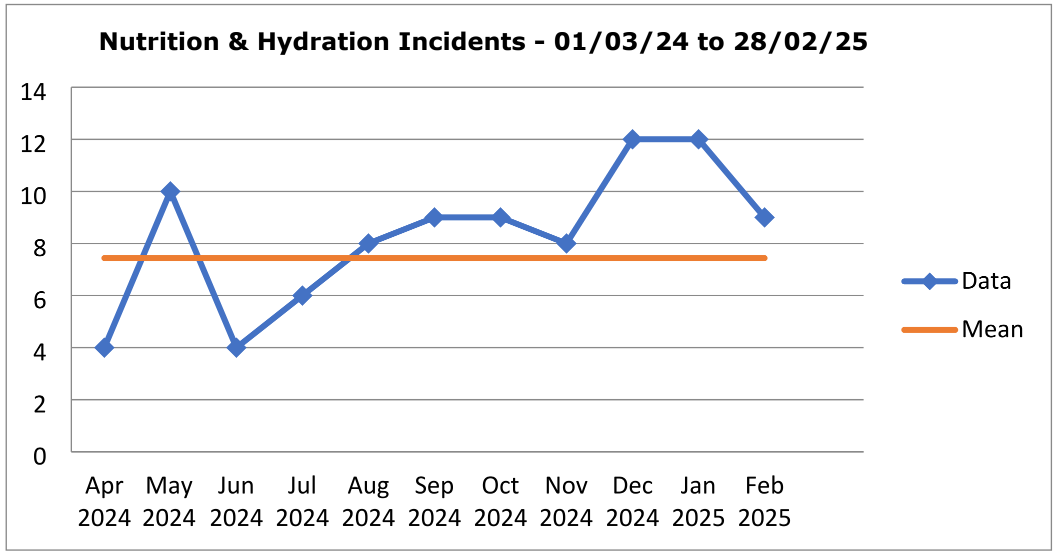
The clinical sub-group has been established to work alongside the food standards group. There is overlap between the work of the two groups and several members sit across both groups.

The first meeting took place in February 2025 and will meet on a monthly basis for the first year to ensure traction is maintained as the workstreams develop

Current workstreams include:

- Documentation: review of N&H related policies. Identification of requirement for new policies
- Readiness to implement new All-Wales N&H standards

N&H related incidents reported 01/04/24 to 28/02/25



Total of 91 incidents in year. Mean of 7.83 per month

17 incidents classified as 'other'

11 incidents classified as 'lack of availability of nutritional products

2 incidents classified as moderate harm – related to nutritional requirements not being met

No incidents classified above moderate harm

Incidents classified as 'Nutrition, hydration' related will be reviewed by the clinical sub-group on a monthly basis. Trends will be analysed to form potential improvement projects

Goals for 25/26

Over the next 12 months the Nutrition & Hydration groups will work collaboratively with Divisions and the governance groups towards achieving the following:

- Implement actions proposed by the fluid balance task and finish group
- Implement actions proposed by the nutrition escalation task and finish group
- Produce and track progress against future work plan for food standards and clinical sub-groups
- Update out of date N&H related policies

Progress education agenda related to safe fitting of naso-gastric feeding tubes

Align N&H quality monitoring to organisational quality strategy

Argymhelliad / Recommendation

The Patient Quality and Safety Outcomes Committee is requested to note the contents of this Interim report for assurance

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.5 Nutrition and Hydration 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation 3.5 Record Keeping 4.1 Dignified Care 5. Timely Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities	Not Applicable Not Applicable

Link to IMTP	
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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	ABUHB – Aneurin Bevan University Health Board AHP - Allied Health Professions (Note: formerly termed as 'Therapies' in Health Board role titles) ADoAHPHS - Assistant Director of AHP and Health Science DoAHPHS - Director of AHP and Health Science N&H – Nutrition & Hydration PSA - Patient Safety Alerts ToR – Terms of reference
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y	

Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Appendices

1. **Nutrition & Hydration strategic steering group draft terms of reference**

V2 Draft TOR
Nutrition and Hydrat

2. **Clinical (artificial) Nutrition & Hydration sub-group draft Terms of reference**

Draft TOR NH
Clinical Subgroup Nc

3. **Regulation 28 action plan**

reg 28 fluid balance
action plan (002) (00:

4. **Terms of reference for fluid balance task & finish group**

Terms of Reference
(002).pdf

5. **Terms of reference for escalation of nutritional needs task and finish group**

Terms of Reference
(002) (1).pdf

Nutrition and Hydration Strategic Steering Group

Terms of reference

Document History:

Amended by	Version	Status	Date	Purpose of Change
Craig Roberts	1	Draft	January 25	Initial Draft for comment and sign off by membership

Version DRAFT

DATE: December 2024

Owner: Nutrition & Hydration Steering Group Chair

DRAFT

INTRODUCTION

Malnutrition affects between 20% and 50% of hospital inpatients on admission, with further declines expected during hospitalisation. Hospital malnutrition is a predictor of increased length of stay, impaired wound healing, increased risk of infection complications, and increased morbidity and mortality. Malnourished patients have more substantial care needs with a greater reliance on hospital resources resulting in higher healthcare costs.

PURPOSE

The purpose of this multi-disciplinary, clinically led group is to oversee nutritional care of inpatients and reduce the incidence of malnutrition and dehydration in our healthcare settings. To actively monitor compliance with Health Board and Welsh Government standards and policies for nutrition and catering, directing action where necessary and escalating matters to the Patient Quality, Safety & Outcomes Committee (PQSOC) as appropriate.

The key function of the Nutrition and Hydration Steering group is to review evidence and provide advice, guidance and direction to:

- Improve patient outcomes and patient safety
- Enhance patient experience
- Promote safe, effective and timely nutritional care
- Monitor compliance with Welsh Government healthcare associated standards for nutrition and catering
- Update and review Health Board risk register
- Review and endorse new and existing associated policies
- Review and endorse the annual Programme report and future work Programme
- Develop and dissemination of guidance to assist services for local implementation

The Nutrition and Hydration Steering Group will receive reports or exceptions from the following sub-groups and will be responsible for monitoring progress against actions and supporting resolution where barriers exist :-

- Clinical (Artificial) Nutrition & Hydration Group
- Food Service Group

DRAFT

AIMS

The Quality Domains 'STEEEP'—safe, timely, effective, efficient, equitable, and person-centered—will underpin the work of the group, which will embrace a whole-systems approach. This approach recognises the quality enablers of leadership to develop a compelling vision for improved quality of nutritional care through a nutrition-first culture across the organisation.

Via the actions of the sub groups the steering group will:

- Provide accurate, evidence based (where possible) and timely advice to the PQSOC and other appropriate stakeholders in respect of the Quality and Safety of nutrition and hydration care and services
- Oversee an Aneurin Bevan University Health Board Strategic Nutrition and Hydration Programme; to influence the organisational culture to recognise nutrition and hydration as fundamental aspect of an employee's role in health care
- Oversee the delivery of a Nutrition and Hydration Work Programme; led by the Clinical Nutrition and Hydration Group and the Food Service Group
- Ensure that the Health Board adopts clinical standards, policies and legislation that demonstrates best practice in nutritional and hydration care for patients
- Develop local policies and procedures to deliver full compliance to patient nutrition and hydration needs
- Inform and influence ABUHB on all matters related to nutrition and hydration in a proactive manner
- Adopt, monitor and report on compliance with Welsh Government healthcare associated standards for nutrition and catering, reporting deficits and progress to PQSOC
- Respond through service improvements to either internal audit or Wales Audit Office Reports
- Develop robust procedures to monitor compliance with Food Safety requirements (including allergen safety)

MEMBERSHIP

- The group will be chaired by a clinical deputy/assistant executive director of the health board
- Members are considered to be senior leaders and hold expertise within their professional field
- Clinical representation and input will be sought through sub-groups.

DRAFT

- Additional representatives will be co-opted as required

Nutrition and Hydration steering Group Standing Membership Role	Name	Role
Chair	Craig Roberts	Assistant Director, AHPs & Health Science
Vice-Chair	Kelly Downes	Deputy Director of Nursing
Lead Nurse for Quality/Nutrition	Sue Pearce	Senior Nurse, professional standards
Lead Nutrition Support Dietitian	Alice Reed	Head of Dietetics service
Food Service Sub Group Chair	Rhys Shorney	Head of Facilities
Clinical (Artificial) Nutrition & Hydration Group Chair	Julie Morris/Emma Jenkins	Professional head – Acute. Dietetics/Deputy Head, nutrition and dietetics
Finance Lead	Greg Bowen	Professional expertise and financial reporting – Ad Hoc
Value Based Healthcare	Daniel Davies	Professional expertise – Ad Hoc
Clinical Support Services (Pharmacy)	Jonathan Sims	Professional expertise – Ad Hoc
Medical	Dr Steve Edwards	Deputy Medical Director
Facilities	Jamie Marchant	Divisional Director E&F
Operations Team	Richard Morgan-Evans	Deputy director of operations
Planning	TBC	Professional expertise – Ad Hoc
Patient Safety & Quality	Gemma Couch	Head of Quality & Patient safety, and learning
Infection prevention and control	Moira Bevan	Head of IP&C
Digital, Data and Technology	Peggy Edwards	Chief Nursing Information Officer
Quality & Patient safety	Leeanne Lewis	Assistant Director of Quality and Patient Safety
Llais	TBC	Llais patient voice rep

The membership of the subgroups (Clinical Nutrition and Hydration Group and the Food Service Group) are shown in appendix 1.

Meeting Frequency and Secretariat

Quarterly meetings supported by IPC admin function

DRAFT

APPENDIX 1

Proposed Structure for Clinical Nutrition and Hydration Group

Exec Board

Patient Quality, Safety & Outcomes Group (PQSOC)

Clinical Nutrition & Hydration Steering Group

Chaired by Deputy/Assistant Director

Food Service Group

- Nutrition & Hydration Lead Dietitian
- Food Safety Officer
- Lead Nurse – Nurses Divisional reps for Adults and Paeds
- Catering Officer
- Facilities Comm. Officer
- SLT
- OT
- IT (Synbiotix) rep
- Patient Voice rep
- Staff rep / junior dr
- Industry rep
- VBHC/Finance

Membership

Clinical (Artificial) Nutrition & Hydration Group

- Lead Physician
- Lead Clinical Dietitian (Acute & Comm)
- Pharmacist
- Lead Nurse/divisional reps/Acute Nutrition Nurse
- Pt Safety rep
- SLT
- EBME
- HSDU
- Infection Control
- Patient Voice Rep
- Radiology
- VBHC/Finance

Version DRAFT

...n Steering Group Chair

DRAFT

Nutrition and Hydration Clinical Sub Group

Terms of reference

Document History:

Amended by	Version	Status	Date	Purpose of Change

Version

DATE: November 2024

INTRODUCTION

The Nutrition and Hydration Strategic Steering Group is a multi-disciplinary, clinically led group with the purpose of overseeing the nutritional care of inpatients and to reduce the incidence of malnutrition and dehydration in our healthcare settings. The Strategic Steering Group will actively monitor compliance with Health Board and Welsh Government standards and policies for nutrition and catering, directing action where necessary and escalating matters to the Patient Quality, Safety & Outcomes Committee (PQSOC) as appropriate.

This **Clinical Nutrition and Hydration Group** will run as one of two sub-groups of the Nutrition and Hydration Strategic Steering Group. The second sub-group being the Food Service Group. Both of these sub-groups will report to the Nutrition and Hydration Strategic Steering Group and will be responsible for monitoring progress against actions and supporting resolution where barriers exist

AIMS

The Pillars of Quality will underpin the work of the Strategic Group with the actions of this sub-group informing this. In order to help achieve the Strategic Steering Groups aim of achieving an improved quality (of nutritional care) through a nutrition first culture across the organisation, the Clinical Nutrition and Hydration Group will:

- 1.0.1 embrace a whole systems approach,
- 1.0.2 collaborating at a multiprofessional level,
- 1.0.3 that seeks service user input and feedback

The actions of this group will be to:

- 1.0.4 Provide accurate, evidence based (where possible) and timely information to the Strategic Steering Group, in respect of the Pillars of Quality, in relation clinical nutrition and hydration care and services
- 1.0.5 Deliver on key tasks within the Nutrition and Hydration Work Programme agreed by the Strategic Steering Group
- 1.0.6 Review and monitor adherence to clinical standards, policies and legislation that demonstrates best practice in nutrition and hydration care for patients
- 1.0.7 Develop local policies and procedures to deliver full compliance to patient nutrition and hydration needs

MEMBERSHIP

The group will be chaired by the Dietetic Lead for Nutrition & Hydration.

In the absence of this post holder, the group will be chaired by a member of the dietetic management team

Attendees will be nominated by relevant leads within the Strategic Group.

Additional representatives will be co-opted as required.

Nutrition and Hydration Clinical Sub Group Standing Membership		
Role within Sub-Group	**Name**	**Role**
Chair	(vacant so Julie/Emma as interim)	Dietetic Lead for Nutrition & Hydration
Vice-Chair	To be agreed	
Lead nurse/divisional reps/Acute nutrition nurse	Sue Pearce, Laura Bumpsteed Laura Thomson	
Lead Physicians	Ifor Capel Andrew Harris Mark Reynolds	
Clinical Dietitian - Acute	Lucy Morgan & Elena Stamp	
Clinical Dietitian – Community (HEF)	Annalisa Owen	
Clinical Dietititan – Paediatrics	Hannah Hughes Claire Baker	
Speech & Language Therapy	Laura Banci Jenna Adams	
Pharmacist	Yaw Twum-Danso	
Patient Safety & Quality	Caroline Rowlands	
Infection control	Helen Ronchetti	
Patient voice rep (Llais)	Claire Starmore	Regional Operations Manager at Llais - Gwent Region
Safeguarding	Howard Stanley	
Co-opted members/Optional as needed		
EBME	David Bowkett if required	

HSDU	Craig Gane if required	
Radiology	Name outstanding	Rebecca Wallis
VBHC/Finance	Name outstanding	

Meeting Frequency

The group will meet monthly initially; however, meetings may progress to alternate months as initial high priority task and finish groups come to a conclusion.

CONFIDENTIAL

Aneurin Bevan University Health Board

Action Plan

Ref:

NOT TO BE SHARED EXTERNALLY UNTIL APPROVED BY EXECUTIVE LEAD & EXECUTIVE DIRECTOR

(VIA PTR TEAM)

Investigation Report approved by:		
Division	**Title**	**Date**
Surgery		
Executive Lead	**Title**	**Date**
Executive Director	**Title**	**Date**

Serious Incident Investigation Action Plan
ABHB

Recommendation 1					
Improve monitoring of patient fluid balance across the organisation					
Action	**Responsible Officer**	**Lead**	**Completion Date**	**Interim Review Date**	**Progress and/or action at review date**
Pilot fluid balance monitoring project on a surgical ward (including education / information boards / auditing). Plan to spread and scale project after PDSA (Plan Do Study Act) shows improvement in the pilot area.	Senior Nurse Surgery GUH	Senior Nurse Surgery GUH	1/6/25	1/3/25	9/12/24 – First meeting and scoping exercise completed. Further meeting to be arranged by Senior Nurse to plan and roll out project on identified Surgical ward.
Standardisation of fluid balance monitoring documentation across the organisation. SOP to be developed by FB task / finish group.	Fluid Balance task Finish Group	Nursing lead Medical lead Therapies lead	1/6/25	1/3/25	19/11/24 - First meeting FB task / finish group. Agree standard and model for improvement. This will feed into the nutrition hydration committee. 4/12/24 - Divisional representatives requested to be nominated and attend next meeting where SOP and guidelines will be agreed. Questionnaire for staff and audit in progress. A Multidisciplinary approach has been adopted with designated leads from

					Medicine, Nursing & Therapies.
Education programme for the multi-disciplinary team members to understand their key responsibilities for managing patients' fluid balance, in line with NICE guidelines. Recommendations | Intravenous fluid therapy in adults in hospital | Guidance | NICE	Practice Educators Medical Education Lead Ward Managers	Practice Educators Medical Education Lead Therapies lead	Ongoing	Ongoing	The foundation Doctors receive fluid balance within their teaching programme and in addition a bespoke foundation study day is provided with a particular focus on fluid balance.
Attachments					
Recommendation 2					
Improve management of patient's fluid balance by multi-disciplinary team.					
Action	**Responsible Officer**	**Lead**	**Completion Date**	**Interim Review Date**	**Progress and/or action at review date**
Fluid Balance monitoring to be included as a standing item in the nutrition and hydration group agenda.	Nutrition hydration committee lead.	Nutrition hydration committee lead.	9/2/25	10/12/24	Fluid balance monitoring is included in the steering group meeting agenda for February 9th 2025 and will be included on all subsequent agendas

Deputy Medical director and medical education lead identifying the learning needs and clinical expectations for the medical staff	Medical Education Lead	Medical Education Lead			
Updated HB fluid balance monitoring policy in line with NICE guidelines.	FB Task & Finish Group				Policy to be approved by the Nutrition & Hydration Committee
Attachments					

Recommendation 3

Review quality and compliance of fluid balance monitoring as ongoing quality indicator

	Responsible Officer	Lead	Completion Date	Interim Review Date	Progress and/or action at review date
Use AMAT tool to standardise the audit of fluid balance compliance across the health board	QPS leads	Nursing Lead for Fluid Balance task Finish Group	1/6/25	1/3/25	Audit template to be standardised on AMAT: agreed template by FB task / finish group.
Add fluid balance monitoring to Nutrition & Hydration Committee risk register, to provide oversight and agree mitigation until standards have consistently improved	Nutrition hydration committee lead FB Task & Finish Group	Nutrition hydration committee lead	9/2/25	10/12/24	This will be an agenda item at the next N&H steering group meeting and will form part of the steering group risk register. Expectation that the T&F group provides mitigation solution. This will

					be monitored as part of the standing risk register review
Attachments					
Attachments					

Terms of Reference

Task and finish group: fluid balance monitoring

The Purpose:

The purpose of the task and finish group is to provide organisational clarity and consistency in the use of fluid monitoring charts. This includes developing a criteria for the commencement and discontinuation of fluid balance charts.

Representatives:

The group will be chaired by and consist of representatives from the following:

- Medical lead
- Therapy lead
- Nursing lead
- Dietetic lead
- Representative from division of Surgery
- Representative from division of Medicine
- Representative from Family and Therapies Division
- Representative from Mental Health Division
- Representative from Community and Primary Care Division

In the absence of the chair a respective lead will be nominated to chair the meeting on that occasion

Responsibilities:

The task and finish group will be responsible for:

- Ensuring that there is one standardised fluid balance chart used across the Health Board
- Reviewing and agreeing the standard for use and associated guidelines
- Lead a quality improvement initiative to improve the use and completion of fluid balance charts
- Support divisions to undertake an audit using AMaT and produce a staff questionnaire in relation to fluid balance management
- Provide feedback to the nutrition and hydration group on audit findings, progress with QI project and any general concerns or issues that may necessitate further intervention or escalation.

Frequency of meetings:

Due to the requirements set by the regulation 28 the task and finish group will meet initially on a fortnightly basis and then frequency to be agreed once QI project commences.

Terms of Reference

Task and finish group: Escalation of nutritional needs

The Purpose:

The clinical executive requested formation of a task and finish group following several incidents where nutritional needs of patients weren't met.

The purpose of the task and finish group is to ensure adequate controls are in place to reduce the potential for these events happening in the future. This work will be influenced by learning from previous incident reviews

The group will report to the Nutrition and Hydration Steering group through collaboration with the Food Service and Clinical (artificial) nutrition & hydration sub-groups

Representatives:

The group consist of representatives from the following:

- Clinical Executive - Chair
- Medical lead
- Therapy lead
- Nursing lead
- Dietetic lead
- Representative from Operations team
- Representative from division of Urgent Care
- Representative from division of Surgery
- Representative from division of Medicine
- Representative from Family and Therapies Division
- Representative from Mental Health Division
- Representative from Community and Primary Care Division
- Representative from Clinical Support Services

In the absence of the chair a respective lead will be nominated to chair the meeting on that occasion

Outputs

The task and finish group will be responsible for providing the following outputs:

- Produce and communicate a programme of education around Nutrition and Hydration needs – To link with fluid balance education work
- Undertake QI project in ED to highlight nutritional need for prevention and early intervention
- Review the ward processes for providing nutrition to patients – Requires nursing and facilities collaboration

- Produce an agreed process of escalation whereby any patient that has been identified as having nutritional needs not met will have distinct actions assigned to ensure the need is fulfilled in a timely manner

Frequency of meetings:

To ensure momentum is maintained the task and finish group will meet initially on a fortnightly basis and then frequency to be agreed once the longer-term work is commenced

.

Agenda Item
5.2.2

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Corporate Governance
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 3 February 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

(Links to reports highlighted February 2025 – NHS Wales JCC QSO)

RAG Rating	Highlight
Alert / Escalate	• The Chair and Members expressed concern in relation to the risks and pace of resolution for Neonatal and Paediatric Services. Before escalating this formally to the JCC a specific update on the strategic approach and progress from the escalation process will be brought to the March 2025 QSO meeting for further discussion. Members discussed potential inequity of access and how this would be reported. It was agreed that where such inequities were identified these could be highlighted and addressed within the Director reports. This will form part of the Commissioning Approach for the JCC which will be developed over the coming months as part of the next phase of the formation work and organisational development.
Advise	• The Chair welcomed members and attendees to the first JCC QSO meeting. The Terms of Reference and Forward Work Plan were presented. Members noted the inclusion of a HB CEO as a member rather than an attendee. Further work on the forward work plan will be undertaken to ensure a comprehensive approach to reporting. The reporting of patient experience was queried and members were assured that outcomes reporting would be included within the directors' commissioning reports and the overarching incident and concerns reports. A suggestion was made to broaden the scope of the concerns report to include patient experience to meet the reporting requirements for the duty of Candor and duty of Quality. • Members discussed the reporting mechanisms into Health Boards (HBs), with the Director of Nursing suggesting the reinstatement of the Quality Newsletter to share information with HBs, as this highlighted good practice and service improvements. This would be in addition to a highlight report for inclusion on HBs' Quality and Safety Agendas and the Joint Commissioning Committee (JCC) public meeting Agenda.

RAG Rating	Highlight
	• The Director of Commissioning for Specialised Services provided updates on various specialist services, including improvements in workforce for paediatric and neonatal services, progress in plastic surgery wait times, and the status of the major trauma network data system. Members raised concerns in relation to neonatal and paediatric services as highlighted above. • The Director of Nursing presented the Director of Commissioning for Ambulance Services and 111 report and provided updates in relation to ongoing emergency ambulance pressures, including a critical incident declared by the Welsh Ambulance Service. The commissioning team has been working closely with health board colleagues to address these pressures and develop improvement plans. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. An update on ambulance measures review was provided which aims to align quality patient outcomes with ambulance performance targets. Members raised concerns over bundle compliance and it was noted that compliance for ST-elevation myocardial infarction (STEMI) was under 70%. A request was made for adding immediate release red and amber data to this report for future meetings. • The Director for Mental Health and Vulnerable Groups report was presented and members noted in relation to framework services quality ratings, that some units, including St. Andrews in Northampton, faced staffing and medication challenges, which may lead to safety concerns. Action plans have been implemented to address these issues. Staffing issues at Rampton High Secure Hospital and one patient waiting for many months for admission was highlighted as an issue within High Secure Services. The JCC Director for Mental Health will write to the Director of Specialised Commissioning in England highlighting concerns with Broadmoor Hospital not being accessible to Welsh patients. Capacity issues at Caswell were also noted. Members received an update on the review of gender assessment clinics in England and plans to open satellite clinics in Wales. An update on children and young people's gender services and the commissioning of beds in a new perinatal unit in North Wales was also provided.

RAG Rating	Highlight
Assure	• Members were informed about the Risk approach and noted that by March 2025, risks related to quality and safety will be reported to this sub-committee for review and assurance. Members requested additional information for the March 2025 meeting on the following items: • Specific update on the qualitative information regarding the review of long waiters for plastic surgery (south Wales). • An update on the resolution of the radioactive isotope production issue at Cardiff University and its impact on South Wales patients. • There were gaps in the Ambulance and 111 reporting data around percentages of patients kept at home rather than transferred to hospitals and further information was requested; and • Mental Health –a detailed update on the commissioning framework for secure services including staff training and experience to be provided. A discussion around concerns and incident reporting led to the Director of Nursing and Lay Member agreeing to meet and progress some work on this outside of the meeting.
Inform	• A presentation was shared which focused on the Microprocessor Knee (MPK) Service at Cardiff Artificial Limb and Appliance Service (ALAS). The presentation highlighted the benefits of MPKs, such as improved mobility, less pain, and increased confidence among users. The presentation included quotes from patient impact statements, emphasising the positive changes in their lives due to the MPK. • A patient story was also received, and the patient highlighted the benefits in improved mobility, reduced falls and overall quality of life along with the improved emotional and mental wellbeing. • Members received an update on incidents and concerns across the range of JCC commissioned services. A summary of the open incidents and complaints was provided and members noted that work was underway to improve reporting on complaints and concerns. • Members received an update on regulatory activity, including recent changes in representation and ongoing work with the NHS executive and Welsh Government.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Improve Equity and Population Health Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred If more than one applies please list below: Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment

Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Assurance Report
Patient Quality Safety Outcomes Committee

31 March 2025

Meeting:	Patient Quality Safety Learning & Improvement Forum
Chair:	Tracey Partridge-Wilson, Deputy Director of Nursing
Date:	11 February 2025

The Patient Quality, Safety Learning and Improvement Forum held on 11 February 2025 focused on various aspects of patient experience, safety, and quality improvement within the Aneurin Bevan University Health Board. Some highlights include:

1. Patient Experience and Learning Events

Patient Story

Presented by Tanya Strange, Head of Nursing – Patient Experience & Involvement, and Gemma Couch, Head of QPS and Learning, Natalie Skyrme Divisional Nurse, focusing on the impact of end-of-life care and the subsequent complaints process. Improvements were made as a result of a learning event held on 28 November highlighting the themes of complaints and the actions taken to address them.

Actions taken include holding listening and learning events, reviewing current PTR processes, and developing communication standards.

2. Ward Accreditation

Laura Bumpsteed, Professional Standards Senior Nurse for Accreditation explained the team accreditation process and emphasised the importance of embedding quality improvement in clinical areas The presentation outlined the criteria for achieving different levels of ward accreditation (Bronze, Silver, Gold, Platinum) based on compliance with standards. Details on the independent review process and the current status of ward accreditations.

3. Quality Improvements through PACE Training

Developed by Anthony Roach-Blackwell and Michael Rees, the PACE simulation program aims to boost staff confidence and competence in managing post-anaesthetic clinical emergencies.

The program has demonstrated positive changes in the clinical environment and increased staff confidence and competence.

4. Enhanced Care Framework

The framework has been updated to include a 7-day booklet format, evidence of care plans, and a focus on least restrictive practice.

Ongoing work within the Mental Health Division to embed the framework and develop metrics for monitoring impact.

5. Falls Strategic Oversight Panel

The panel, formerly known as the Falls Scrutiny Panel, will be re-established with a new remit and terms of reference to improve the review and management of falls incidents. Karen Hatch highlighted changes to the Falls Review Panel and the importance of timely reporting and learning from incidents.

6. Learning Repository

Leeanne Lewis demonstrated the Learning Repository and encouraged participants to share their learning and improvement activities.

7. Divisional Quality and Patient Safety Learning

Updates were provided on initiatives to improve patient and staff experience, incident reporting, and patient safety incidents.

8. Quality Improvement Strategy

The strategy outlines the Health Board's approach to embedding quality improvement into all aspects of care, focusing on building organisational capability, leadership, and a quality management system.

Emphasis on psychological safety, patient involvement, and protected time for quality improvement activities.