Patient Quality, Safety & Outcomes Committee

Wed 13 December 2023, 09:30 - 12:00

Microsoft Teams

Agenda

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declaration of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 11th October 2023

Attached *Chair*

1.4 Draft PQSOC Minutes 11th October 2023 PB Approved .pdf (9 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 Working Action Log PQSOC December 2023.pdf (4 pages)

2. ITEMS FOR APPROVAL/RATIFICATION

2.1. Putting Things Right Annual Report 2023

Attached *Director of Nursing*

2.1 PTR Annual Report 2022-23 - SBAR for PQSOC.docx2.pdf (5 pages)
2.1 PTR Annual Report 2022-23.pdf (30 pages)

3. ITEMS FOR DISCUSSION

3.1. Committee Annual Programme of Business 2023/24

Attached *Director of Corporate Governance*

3.1 PQSO_Committee Work Programme 2023-24.pdf (7 pages)

3.2. Committee Risk Report

Attached *Director Corporate Governance*

3.2 Committee Risk Report_PQSOC_Dec23.pdf (5 pages)
3.2a Appendix A Committee Risk Register PQSOC.pdf (1 pages)
3.2b Appendix B Strategic Risk Assessments PQSOC.pdf (7 pages)

3.2c Appendix C Corporate Risk Assessment RGH Robot .pdf (1 pages)

3.3. Patient Quality, Safety and Outcomes Performance Report, December 2023

Attached *Clinical Executive Director*

3.3 PQSOC Performance Report - December 2023.pdf (107 pages)

3.4. Clinical Audit Activity Report

Attached *Medical Director*

3.4 PQSOC Clinical Audit Activity Report Final Dec 2023 v2.pdf (30 pages)

3.5. Stroke Improvement Plan, Including Response to HIW National Review of Patient Flow (Stroke Pathway)

Attached *Director of Therapies & Health Science*

3.5 update version Board and Committee Report GIRFT Update.docx2.pdf (10 pages)
3.5a Appendix a. GIRFT Report.pdf (37 pages)
3.5b Appendix B Therapy Review Review of Therapies in Stroke Services.pdf (18 pages)
3.5c Appendix C 2023 HIW Patient Flow Review.pdf (89 pages)
3.5d Appendix d 2023 Updated GIRFT Tracker (002).pdf (1 pages)
3.5e Appendix e - HIW Patient Flow Review - Improvement Plan (ABUHB).pdf (19 pages)

3.6. Never Events Review: Theatres

Attached *Medical Director*

3.6 2023 Board and Committee Report Theatre Safety Programme v4.pdf (9 pages)

3.7. Birth Outcomes and Maternity Care Assurance Report, as requested by the Litigation Group

Attached *Director of Nursing*

3.7 ABUHB Birth Outcomes.pdf (14 pages)
3.7 a ABUHB PW Programme 2023-24.pdf (1 pages)
3.7 b All Wales Intrapartum Fetal Surveillance Standards.pdf (5 pages)
3.7c QPSOG MBRRRACE maternity.pdf (9 pages)
3.7d OFWP Time Table.pdf (5 pages)
3.7e1 overall Dashboard 2023.pdf (1 pages)
3.7e2 GUH Dashboard 2023.pdf (1 pages)
3.7e3 GUH BirthDashboard 2023.pdf (1 pages)
3.7e4 YYF Birth Centre Dashboard 2023.pdf (1 pages)
3.7e5 Newport Birth Centre Dashboard 2023.pdf (1 pages)
3.7e6 Abergavenny Birth Centre Dashboard 2023.pdf (1 pages)
3.7e7 YAB Dashboard 2023.pdf (1 pages)
3.7e8 Home Births Dashboard 2023.pdf (1 pages)
3.7e9 Graphs Dashboard 2023.pdf (1 pages)

3.8. Committee Annual Self-Assessment Results

Attached *Director of Corporate Governance*

3.8 PQSOC Self Assessment of Committee Effectiveness Cover Report final.pdf (8 pages)
3.8a Appendix A PQSOC Self Assessment Template.pdf (10 pages)
3.8b Appendix B Patient Quality, Safety and Outcomes Committee Self-Assessment Checklist spreadsheet.pdf (16 pages)

4. ITEMS FOR INFORMATION

4.1. WHSSC QPS Committee Report

Attached *Director of Nursing*

4.1 Quality Patient Safety Committee Chairs Report.pdf (12 pages)

4.2. Highlight Reports:

4.2.1. Safeguarding Committee Highlight Report

Attachment *Clinical Executive Directors*

4.2.1 Safeguarding Highlight Report - November 2023.pdf (2 pages)

4.2.2. Clinical Standards Effectiveness Group

Attachment *Clinical Executive Directors*

4.2.2 CSEG Minutes Sept 2023.pdf (8 pages)

5. OTHER MATTERS

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting is Wednesday 7th February 2024

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Wednesday 11th October 2023
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Louise Wright- Independent Member, Vice Chair Paul Deneen- Independent Member Helen Sweetland- Independent Member
IN ATTENDANCE	Nicola Prygodzicz, Chief Executive Jennifer Winslade, Director of Nursing Rani Dash, Director of Corporate Governance Peter Carr, Director of Therapies & Health Science James Calvert, Medical Director Michelle Jones, Head of Board Business Tracey Partridge-Wilson, Assistant Director of Nursing Karen Hatch- Assistant Director of Therapies and Health Science Craig Roberts, Assistant Director of Therapies and Health Science Leeanne Lewis, Assistant Director of Quality & Patient Safety Trish Chalk- Interim Deputy Director of Planning Moira Bevan- Head of Infection and Prevention Garvin Jones, Head of Legal Services Jayne Beasley- Head of Midwifery and Gynaecology Claire Harris, Lead Nurse Palliative Care Rhian Gard, Deputy Head of Internal Audit Nathan Couch, Audit Wales Jonathan Simms, Clinical Director of Pharmacy Emma Guscott, Committee Secretariat
APOLOGIES	None to note

PQSOC 1110/1	**Preliminary Matters**
PQSOC 1110/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 1110/1.2	**Apologies for Absence** Apologies for absence were noted.

PQSOC 1110/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
PQSOC 1110/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 20th of June 2023 were agreed as a true and accurate record.
PQSOC 1110/1.5	**Committee Action Log- October 2023** The Committee received the action log. Members were content with progress made in relation to completed actions and against any outstanding actions.
PQSOC 1110/2	**Items for Discussion**
PQSOC 1110/2.1	**Patient Quality and Safety Outcomes Performance Report, October 2023, Pillars of Quality:** • **Infection prevention Control and Safeguarding.** • **Incident Reporting and Health and Safety Scrutiny.** • **Patient and Staff feedback and Complaints and Concerns.** Clinical Executives presented the Patient Quality & Safety Outcomes Performance Report for October 2023 to the Committee. The report provided an update on the work being undertaken relating to the following quality and safety pillars: • Patient Experience and Staff feedback. • Civica implementation plan. • Patient Experience and Involvement Strategy. • Patient Experience and Staff Feedback. • PALs update and including plans for implementation in October 2023. • Incident reporting and severity of harm. • Duty of Candour, Falls, Thematic reviews, and learning. • Next steps - pressure ulcers, RAMI, and mortality. • Health, Safety and Security. • Infection Prevention and Control. • Safeguarding. • Urgent and Emergency Care. • Planned Care. • Cancer Pathways. • Complaints and concerns. • Implementation of the Pressure Ulcer Faculty 2023. • Escalated risk concerns, including the Framework for Speaking Up Safely in the NHS and COVID-19 investigations.

- Overview of the Health Inspectorate Wales (HIW) Inspection of Cedar Parc, Ysbty Tri Chwm.

Moira Bevan (MB), Head of Prevention and Infection, provided an update on Health Board completed actions and next steps for infection prevention control. CDifficle (CDiff) remained a concern, and noted that a "deep-dive" had been undertaken on toxin positive patients since April 2023. James Calvert (JC), Medical Director, requested the numbers of patients who were toxin positive/negative currently, including the number of patients admitted directly from the community and who were CDiff positive and toxin negative. MB to share numbers of toxin positive/negative in-patients and status upon admission from the community with JC outside of the meeting. **Action: Head of Prevention and Infection** Members were informed that the increase in infections was a whole system risk. MB discussed that epidemiologists had recognised links between Covid 19 and CDiff infections. Pippa Britton (PB), Committee Chair queried if the increase was a national issue and requested assurance on when numbers of hospital acquired infections were likely to drop. MB informed members that this will be monitored and included in all future reports to the Committee.

Jennifer Winslade (JW), Director of Nursing, provided a brief overview of patient centred care. There had been a focus on Dementia Care, awareness, training and education, and best practice throughout the Health Board, working alongside patients and families impacted by Dementia.

JW discussed Duty of Candor. Alongside the revised Serious Incident policy (SI), a dashboard to document SIs was in development, with the aim to include families early in the investigation process. It was noted that the Health Board was unable to report compliance with the Duty of Candor at present due to issues with the Datix system. PB noted that the Duty of Candor changes had been implemented for 6 months and queried if there was sufficient support for staff. JW informed members that the Wellbeing Service was providing additional support to staff.

The meeting was advised that Pressure Ulcers were noted as a *Never Event* theme. The Health Board had reinstated the 'Pressure Ulcer Reduction Faculty' to address actions and improve reduction. A detailed report on *Never Events* would be presented to the Committee in December 2023 for assurance. **Action: Director of Nursing**

Peter Carr (PC), Director of Therapies and Health Sciences, provided an update on inpatient falls. Members were

	assured that fall data was recorded through Datix, shared weekly throughout the Health Board, and reviewed weekly by The Executive Committee. Incident reporting triggers a multifactorial risk assessment on the ward and a review of the patients care plan. An action taken from a previous meeting was discussed; the overview of the number of falls of patients who are medically fit for discharge. PC informed members that the Health and Safety tea were reviewing Datix data to determine how to correlate that data with data informing where a patient is on their hospital journey at the time of their fall. Based upon data produced by the National Audit of Inpatient Falls, the Health Board was not an outlier in the number of inpatient falls. Louise Wright (LW), Independent Member, noted staff feedback highlighting Datix was a difficult system to use and requested an update on how the Health Board was addressing this. Members were informed that Nursing, Workforce and Health and Safety Team were working to improve the reporting arrangements for staff. Members requested that data be included to indicate how many falls per individual patient in future reports. **Action: Director of Therapies and Health Sciences** Trish Chalk (TC), Interim Deputy Director of Planning, provided an update on the proposed Quality Outcome Framework (QOF). Members noted that the Health Board was the first in Wales to launch this report into the public domain and were both impressed and assured by the information included in the report and update. Nicola Prygodzicz (NP), Chief Executive, suggested that more quality and safety data would be presented to the Board in this format. NP suggested that benchmarking data was clearly outlined in the QOF to enable the public and staff to determine clear comparisons with other Health Boards. The Committee received the reports and update for **ASSURANCE**.
PQSOC 1110/2.2	**Mental Health and Learning Disabilities (MHLD), including NHS Wales Delivery Unit Review of Mental Health Crisis & Services for Older Adults, and HIW Mental Health Discharge Review** Jennifer Winslade (JW), Director of Nursing, provided a brief overview of the reports. Recommendations arising from the All-Wales Delivery Unit Assurance Review of Crisis and Liaison Psychiatry Services for Older Adults in March 2023 were noted. Members noted the overview of current provision of mental health crisis

	and liaison services for older adults, identified actions and next steps. JW informed members that the Health Board had completed the benchmarking exercise against the Health Inspectorate Wales findings of the review of Cwm Taf Morgannwg University Health Board. The actions pertinent to the Health Board are outlined in the report and would be addressed as part of the broader MHLD improvement plan. Helen Sweetland (HS), Independent Member, noted the delay in the assessment and review of services on the Delivery Unit. JW informed members that there were some delays in receiving the updates due to Mental Health and Learning Disabilities system pressures. The Committee received the reports and **NOTED** the contents.
PQSOC 1110/2.3	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided an overview of the report, and summarised the key risks allocated to the Committee. Members noted the revised risk reporting, and the escalated Divisional risk reporting to the Executive Committee and the Board. RD highlighted the escalated risk of the Pharmacy Robot and noted that a report was included in the agenda.
PQSOC 1110/2.4	**Maternity Services Update, including -** • **Maternity Services Organisational Improvement Plans** • **Maternity and Neonatal Safety Support** • **MBBRACE** *Jayne Beasley joined the meeting.* **Maternity Services Organisational Improvement Plans** Jayne Beasley (JB), Head of Midwifery and Gynaecology, reminded members of the Health Inspectorate Wales (HIW) review of maternity services in June 2023. JB discussed HIW immediate actions and the progress of the Health Boards action plans in response. The final HIW report was published in July 2023, outlining 14 actions for the Health Board, of which 3 were outstanding. The 3 outstanding actions and progress noted as follows: - • Birthing Pool Availability: currently awaiting costings from works and estates to move an additional

	birthing pool to the Grange University Hospital (GUH). • Capacity of Post Natal beds: some bed capacity was lost upon the move to GUH. Teams were working on patient flow and temporary bed plans. • Succession Planning of Specialist Midwives: Plans were underway to support and develop Band 6 midwives to assist specialist midwives when required, noting that the Health Board had employed 24 midwives who started in post in October 2023. Members and Executives noted the praise from HIW for the excellent person-centred service provided in maternity and thanked JB and the teams for the rapid improvements in response to HIW actions. Paul Deneen (PD), Independent Member, requested assurance around recruitment and retention. JB informed members of the training, peer mentorship and support provided to midwives on appointment. The Committee received the reports for **ASSURANCE** and noted the improvements made. **Maternity and Neonatal Safety Support** Jennifer Winslade (JW), Director of Nursing, provided an overview of the report outlining the Health Boards maternity and neonatal actions, areas for consideration, resource challenges and risks in response to the discovery phase report titled 'Improving Together for Wales', released in July 2023. The Committee requested a verbal update on the progress of maternity and neonatal actions to come back to a future meeting. **Action: Director of Nursing** The committee **NOTED** the following: • the ongoing collaborative work regarding maternity and neonatal services and the response to the Maternity Neonatal Support Programme. • the actions to respond to Welsh Government regarding the events at the countess of Cheshire Hospital. • the additional actions required to respond to the recommendations. *Jayne Beasley left the meeting.*
PQSOC 1110/2.5	**Pharmacy Robot** *Jonathan Simms joined the meeting.*

	James Calvert, Medical Director, supported by Jonathan Simms (JS), Clinical Director of Pharmacy, provided an update on the progress of the business case for a new Pharmacy robot and the associated risks and mitigations, in response to a previous committee action. JC informed members that the pharmacy robot in the Royal Gwent Hospital was 10 years beyond its lifespan and has an increasing frequency of failures. The ongoing risk is included on the corporate risk register. The Executive Committee reviewed associated risks in September 2023 and the decision was made in to progress with procurement with the possibility of identifying capital in the next financial year. JS flagged that the pharmacy robot was integral to patient flow and distribution of medicines across South Gwent. Nicola Prygodzicz (NP), Chief Executive, remined members that the capital programme for the Pharmacy Robot had been signed off by the Board earlier in 2023. Members noted that the Nevil Hall Hospital pharmacy may be impacted by the RAAC issue, but at the time of the meeting the pharmacy was operating as usual. Members noted the high patient and staff risk associated with the current system and were assured that the efforts to replace the Pharmacy robot were continuing and that plans were in place in the event of failure. The Committee received the report for **ASSURANCE.**
PQSOC 1110/2.6	**Committee Self-Assessment** Rani Dash (RD), Director of Corporate Governance, provided an overview of the Health Boards statutory requirement for an annual self-evaluation of committee effectiveness. Members noted that the self-assessments would be issued in November 2023 and be presented to the Committee in December 2024. The Committee **APPROVED** the Self-Assessment Template and timescales.
PQSOC 1110/2.7	**National Incident Reporting Policy** Jennifer Winslade (JW), Director of Nursing, supported by Garvin Jones (GJ) Head of Legal Services, and Tracey

	Partridge-Wilson (TPW), Assistant Director of Nursing provided an overview of the policy to the Committee. GJ informed members that the *Health Board Patient Safety Incident Reporting & Management Policy* had been revised to align with the expectations set out in the *NHS Wales National Policy on Patient Safety Incident Reporting & Management,* published in May 2023. The following key points was discussed: - • Quality and patient safety resources would now fall under the nursing directorate. • Clear engagement with families from the start of incident investigation and management. • A learning framework would be produced to ensure learning from incidents feds into future quality and patient safety planning and process. • A family liaison officer/point of contacts support families/patients throughout investigations. • Staff support is provided throughout the investigation process. Helen Sweetland (HS), Independent Member, requested information on the recruitment of investigators for incidents. JW informed members that investigators can be clinicians or divisional managers but there was an aim to professionalise investigations of the most complex and serious incidents. Members requested that the report include the date when the policy would next be reviewed and suggested that the report specifies predicted timescales of investigations and that these are to be shared with families/patients. **Action: Assistant Director of Nursing** The Committee **APPROVED** the report for presentation to the Board.
PQSOC 1110/3	**Items for Information**
PQSOC 1110/3.1	**Highlight Reports** The Committee received the following Highlight Reports for Information: - • Clinical Effectiveness and Standards Committee Report.
PQSOC 1110/3.2	**WHSSC QPS Committee Annual Report** The report outlined the key matters discussed at the August 2023 meeting of the Quality Patient Safety Committee. The Committee received the report for **INFORMATION**.

PQSOC 1110/3.3	**Organ Donation Committee Annual Report** The report included the NHSBT Annual Report regarding Actual and Potential Deceased Organ Donation for Aneurin Bevan University Health Board between 1 April 2022 - 31 March 2023. The Committee received the report for **INFORMATION**.
PQSOC 1110/3.4	**PSOW Press Release 09/08/2023- Annual Report** The Committee received both the letter from the Ombudsman and the Health Boards response for **INFORMATION**.
PQSOC 1110/4	**Other Matters**
PQSOC 1110/4.1	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no matters arising.

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
26th July 2023	**PQSOC 2607/3.1**	**Patient Quality and Safety Outcomes Performance Report, July 2023** The End-of-Life Board report be brought to a future Committee meeting.	**Director of Nursing**	February 2024	Included in forward work programme for February 2024 meeting. Director of Nursing will provide a verbal update at December Committee
26th July 2023	**PQSOC 2607/4.2**	**Groundhog Day 2: an opportunity for cultural change in complaint handling?** Director of Nursing to provide a brief report to the Committee that the recommendations of the report have been actioned.	**Director of Nursing**	December 2023	Included on the forward work programme for December 2023 under item 3.3 **Complete**
2nd October 2023	**LG/0210/04.6**	**Action transferred from Litigation Group Meeting -** Ann Lloyd requested that assurance report of the birth outcomes and maternity care are within the expected range for the	**Medical Director**	December 2023	Included on December agenda for item 3.7 **Complete**

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		population and to include that Health Board was aware of the risks due to the staffing levels of midwifery staff to go to the Patient Safety and outcomes Committee.			
11th October 2023	**PQSOC 1110/2.1**	**Patient Quality and Safety Outcomes Performance Report, October 2023, Pillars of Quality** MB to share numbers of toxin positive/negative in-patients and status upon admission from the community with JC outside of the meeting.	**Head of Prevention and Infection**	November 2023	Head of Prevention and Infection shared the review of C diff document outside of the meeting. - **Complete.**
11th October 2023	**PQSOC 1110/2.1**	**Patient Quality and Safety Outcomes Performance Report, October 2023, Pillars of Quality** A detailed report on *Never Events* would be presented to	**Director of Nursing**	December 2023	On December agenda under item 3.6 **Complete**

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		the Committee in December 2023 for assurance.			
11th October 2023	**PQSOC 1110/2.1**	**Patient Quality and Safety Outcomes Performance Report, October 2023, Pillars of Quality** Members requested that data be included to indicate how many falls per individual patient in future reports.	**Director of Therapies and Health Sciences**	TBC	'The quality report will reference multiple falls' **Complete**
11th October 2023	**PQSOC 1110/2.4**	**Maternity Services Update** The Committee requested a verbal update on the progress of maternity and neonatal actions to come back to a future meeting.	**Director of Nursing**	TBC	Included within the PQSOC report, December agenda Item 3.3 **Complete**
11th October 2023	**PQSOC 1110/2.7**	**National Incident Reporting Policy** Members requested that the report include the date when the policy would next be reviewed and suggested that	**Director of Nursing**	TBC	**Complete** Policy updated and approved by Board on the 22nd November 2023 **Complete**

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		the report specifies predicted timescales of investigations and that these are to be shared with families/patients.			

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.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	PTR Annual Report 2022-2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jane Rowlands-Mellor - Head of Putting Things Right

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

The Putting Things Right (PTR) Annual Report has been prepared in accordance with the PTR Regulations. It will provide an overview of the 2022/2023 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed concerns, Redress cases, Claims, Patient Safety Incidents, and Public Services Ombudsman for Wales (PSOW) cases during this reporting period. It will provide information on progress, performance as well as an overview of emerging themes and trends, including lessons learnt and the subsequent vision for 2023/2024.

Cefndir / Background

The Report focuses on, and describes the successes and challenges related to 'Putting Things Right' during the reporting period. It will encompass, Complaints, Compliments, Redress, Patient Safety Incidents and PSOW cases, all of which are underpinned by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Consideration has also been given to national drivers, e.g., the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which came into force 1 April 2023.
This Report was written with input from the Legal Services Team and Divisional colleagues.

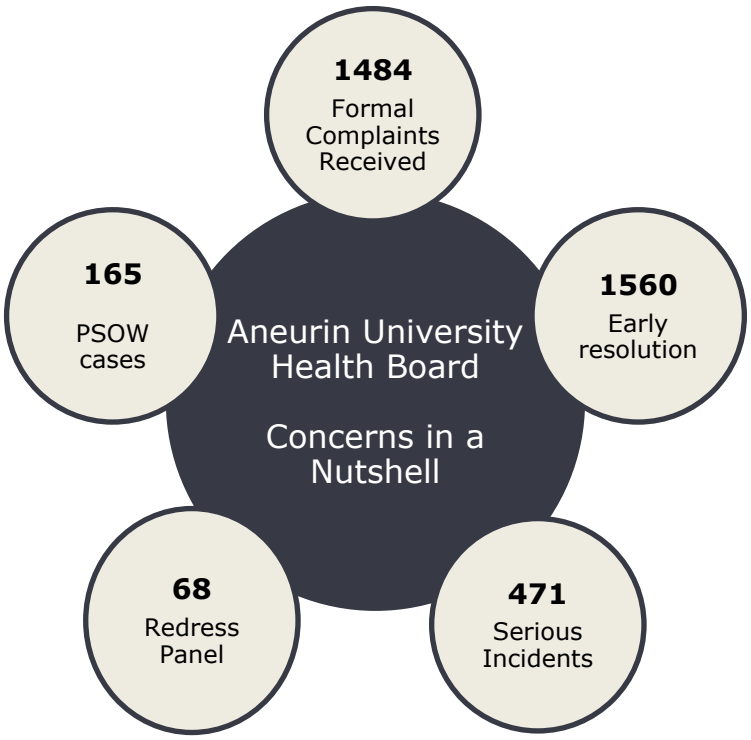
Asesiad / Assessment

2022/23 has been both exciting and challenging, with pending changes at both a local and national level, relating to the PTR agenda.

To ensure organisational preparedness, planning was commenced in readiness for the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force 1 April 2023. Alongside this, the Health Board 'Quality Strategy', was launched. This Strategy encompasses two of the 'pillars' which are fundamental to the PTR Regulations (2011), as they relate to incident reporting, complaints, concerns and compliments.

Additionally, a scoping exercise, which will be led by the Executive Director of Nursing, aims to review the structure of the Health Board's Quality Patient Safety teams. This change in model, aims to ensure improvements, in line with the evolution of the organisation and external influences.

To summarise the organisational 2022/23 position is as follows: -



Even though there have been challenges, there have also been numerous successes. These include: -

Covid-19 Investigations

Investigations are being undertaken through waves 1-4.

IO Training

From February 2023, the IO training reverted back to face to face- with over 120 Investigating Officers trained during the reporting period.

Partnership Working
Quarterly meetings continued with the Community Health Council (CHC) (Llais from 1 April 2023) and PSOW to foster open communication channels. In addition, regular weekly meetings with Welsh Ambulance Service Trust (WAST) have helped advance this important agenda and strengthen relationships. Closer links have also been formed with the '*Once for Wales'* data team who have engaged with complaints coordinator colleagues across the organisation to enhance correct use of RL Datix to record and close down concerns correctly.

Customer Management Centre (CMC) transfer into the Corporate PTR Team
In May 2022 the CMC was transferred into the Corporate PTR team. This has allowed calls to be centralised and for more in-depth monitoring of themes and trends. More importantly, it has allowed the Corporate PTR team to take early action, in the endeavour to increase the proportion of concerns that can be dealt with where possible, under 'Early Resolution'. This will ensure a better experience for the complainant.

Challenges include: -

Sickness across the Corporate and Divisional PTR/QPS Teams
There has been a significant amount of team sickness, both long-term and short-term across the organisation. This has impeded organisational capacity to progress workstreams, which has inevitably impacted upon performance. This situation has, been largely resolved towards the latter part of the year.

Covid-19 Recovery
Continued organisational pressures left over from the Covid-19 pandemic have continued to influenced concerns and incidents raised, as well as the inability to facilitate proactive events, such as Learning Events.

Use of Bank and Agency Staff
The increase in use of temporary staff impacts on performance and management of concerns and incidents due to the transient nature of the workforce and lack of knowledge regarding policies and procedures.

The Report also includes qualitative and quantitative data on complaints, claims, Redress and 'Early Resolution cases', as well as performance, themes, and learning. Interactions with the Public Services Ombudsman for Wales are highlighted, as are compliments data. Compliments are extremely valuable as they can assist in providing staff with positive recognition.

Unfortunately, overall performance has reduced for formal concerns from **57%** to **52%** however the proportion of those managed under early resolution concerns has positively increased from **41%** to **63%.** Those concerns managed through PTR (formal) tend to be representative of more complex concerns, often panning more than one division and/or organisation. The Health Board aspires to resolve **70%** of concerns as Early Resolution going forward. It is anticipated that the introduction of the PALS service, planned for 2023 will assist to ensure this target is achieved.

To summarise, the following are the four key priorities that will frame the PTR Annual Work Programme 2023/2024: -

1. Corporate PTR team to work with Divisional colleagues, ensuring the organisation is adhering to and compliant with the Health and Social Care (Quality and Engagement) (Wales) Act 2020 – (Duty of Candour), which came into force 1 April 2023.

2. Embedding teams, and processes following remodelling of QPS structure across the organisation. This work is being led by the Executive Director of Nursing.

3. Focussed, multifaceted approach to ensure Aneurin Bevan is truly a learning organisation.
4. Collaborate with Divisional colleagues to improve complaint handling, including response quality and timeliness.

Argymhelliad / Recommendation

The Committee is asked to: -

- **APPROVE** the Putting Things Right Annual Report 2022/2023
- **NOTE** the four key priorities of the PTR Annual Work Programme

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 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

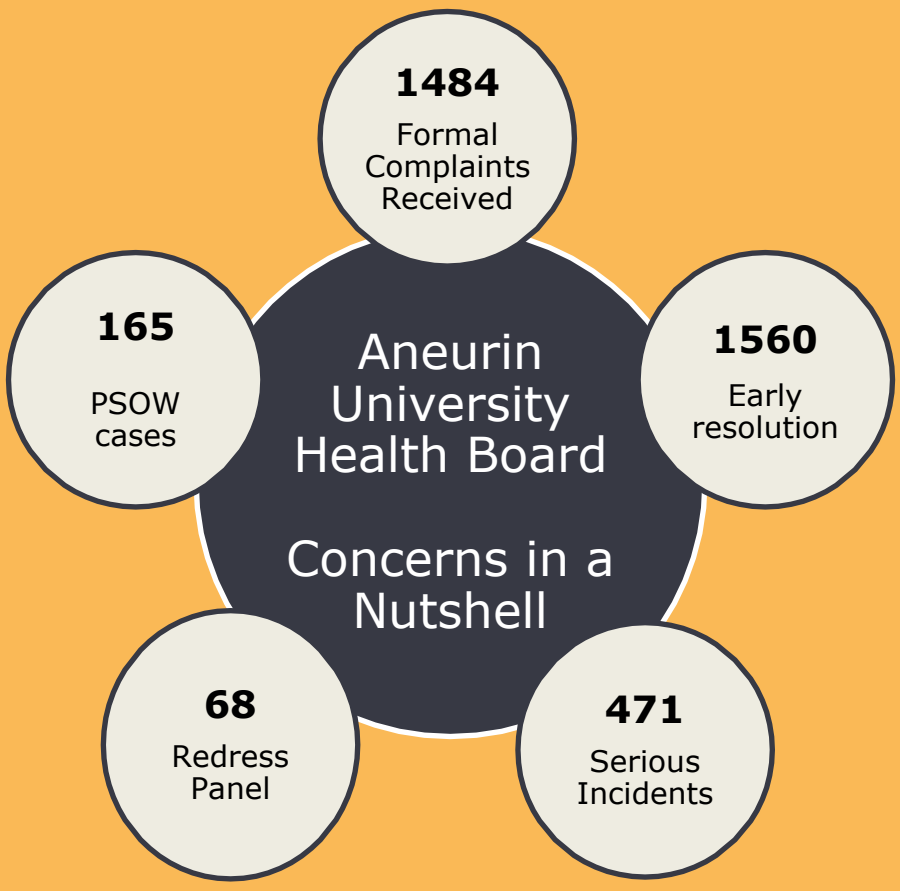
Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	NA

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

2022-2023

PUTTING THINGS RIGHT

ANNUAL REPORT



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

INTRODUCTION

Welcome to the Aneurin Bevan University Health Board's (ABUHB) Annual Putting Things Right Report. This report will cover the financial year, April 2022 to March 2023. The annual report demonstrates our ongoing commitment to the population of the Health Board, which covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to around 600,000 children, young people and adults.

The fundamental aim of "Putting Things Right" (PTR) is to be open and honest when dealing with concerns, with an emphasis on 'Learning'. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

There are several goals, including the need to make it easier for people to raise concerns and to feel engaged and supported throughout the process. Fundamentally, they must be addressed in an open and honest manner, and organisations must demonstrate learning when things go wrong.

The strategic focus of PTR has invested in the complaint experience, ensuring a 'proportionate approach' to secure, where possible, rapid handling of concerns/ complaints/ serious incidents and also importantly de-escalation.

Throughout this reporting year, the Health Board has been preparing staff and resources for the introduction of the Health and Social Care Quality and Engagement) (Wales) Act and NHS Duty of Candour (DoC) on 1 April 2023.

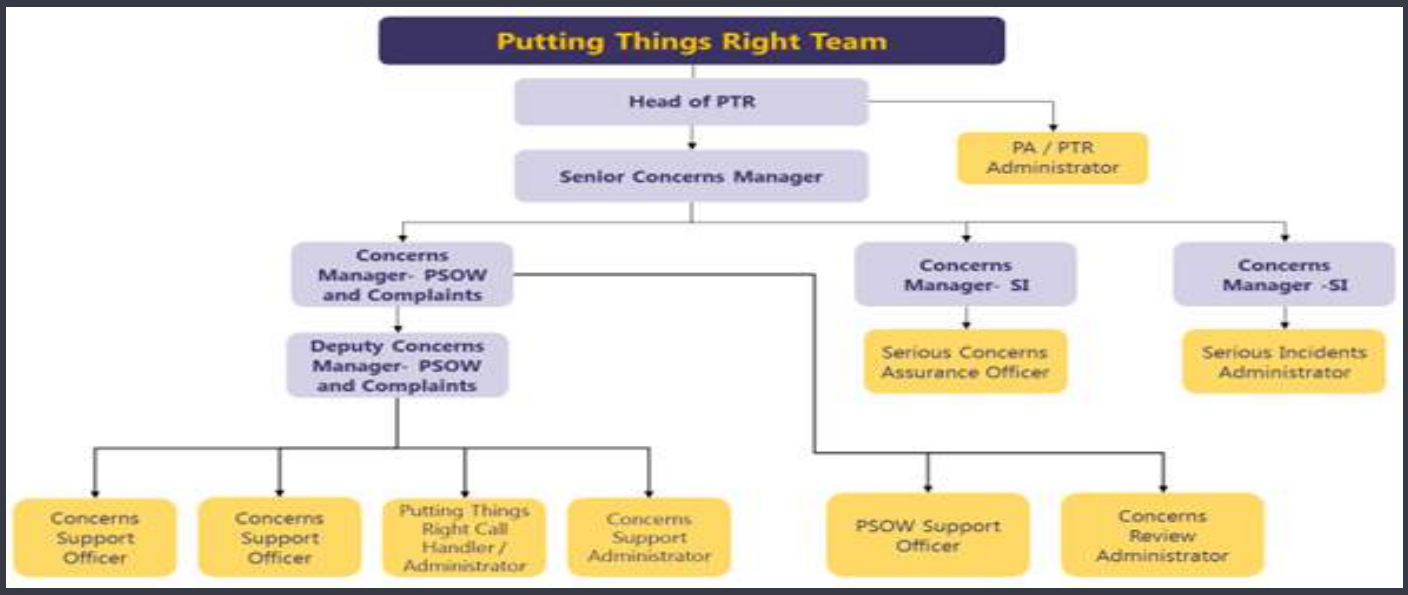
The duty of candour is triggered if **unexpected or unintended harm** that is **moderate or above** is suffered or may be suffered (referred to as adverse outcome) and the **provision of healthcare was (or may have been) a factor** in the service user suffering that adverse outcome.

The Health Board adhered to the Welsh Government mandate in preparedness for the Act go live date. An All-Wales E-learning package was rolled out for key staff to complete, in order to prepare for the introduction of DoC.

GOVERNANCE STRUCTURE

There is a robust structure underpinning PTR, with executive leadership delegated to the Executive Director of Nursing (EDoN). Assurance is provided by exception reporting to the Quality Patient Safety Operational Group, along with the Patient Quality Safety Outcomes Committee. A review is also underway on the Quality Assurance Framework, which will align with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The current Putting Things Right Team structure is illustrated below:



The above diagram illustrates the current corporate PTR structure. The Customer Management Centre's complaints component was transferred to the Corporate PTR Team in May 2022. This has centralised calls and allows for more in-depth monitoring of themes and trends. More importantly, it has allowed the Corporate PTR team to take early action, in the endeavour to increase the proportion of concerns that can be dealt with where possible, under 'early resolution'. This will ensure a better experience for the complainant.

How did we do against 2021/22 goals?

The PTR Annual Report for 2021/22 set out a series of objectives for 2022/23. The following provides a summary of the progress made against these, applying a RAG rating against achievement.

1 CARE AIMS

- In line with the ABUHB IMTP 22/25, the focus will be on **older people** as part of the life-course approach.
- For the first two years (in accordance with the IMTP review timelines), the strategic focus will align to Cancer, Dementia and End of Life Care. Each of these defined areas has dedicated Boards.
- **By April 2022, Cancer Board, End of Life Care Board and the Dementia Board will all have Care Aims as a priority focus.** This did not happen following discussion with the Executive Director of Nursing, as it was felt that a Board development day should take place first. However, this did not happen and has since been superseded by the Patient Experience and Involvement Strategy, which has Care Aims as a theme throughout.
- **The 4-day Care Aims Training will be secured for the Leads of these Boards and Team Leaders. Health Board staff have been identified to attend.** A full day workshop is to be held with the 3 Clinical Boards in June 2023.
- **Four Health Board staff have been identified to attend a Train the Trainer course in July 2022 to establish sustainability - the Educational Leads for Nursing, Medical and Therapies will develop a training strategy to support roll out and identify the resources required.** To date 14 members of ABUHB staff have been trained as 'in-house trainers'. There are two further members of staff booked to undertake the training this year. The majority of this staff group are Allied Health Professionals (AHP's), but the group does include three nurses. The in-house trainer certification enables staff to provide top-up training for new starters and to coach teams who have already undertaken the four days of Care Aims training. Two members of the group of inhouse trainers have previously worked alongside the author of Care Aims. They have indicated that with additional supervision and opportunities to practice they would approve these staff to provide the first two days of training (i.e., Module 1) to teams who are new to Care Aims. They also indicated that with further support and supervision they would approve these staff to provide the second two days (i.e., module 2). Utilising this opportunity would increase training capacity, cut costs, and support the long-term sustainability of the project.
- **In June 2023, a Care Aims Development Session for the Board will be delivered. Development Sessions for the Dementia, End of Life Care and Cancer Board will follow this.** These sessions did not go-ahead following discussions with the Executive Director of Nursing and the Director of Corporate Governance.

2 INTRODUCTION OF THE HEALTH & SOCIAL CARE (QUALITY & ENGAGEMENT) (WALES) ACT 2020

- Preparedness is underway with a public consultation on the guidance and draft regulations scheduled for Spring 2022.
- Guidance and draft regulations were finalised and laid in October 2022.
- An e-learning package, cascade training and awareness sessions were delivered by the National central team, across NHS bodies.
- They have prepared and delivered a public awareness campaign, to increase public awareness of the Duty of Candour, empowering individuals to ask questions about the care and services they receive.
- They also developed easy read information leaflets in preparation for the duty coming into force April 2023.

3 COVID-19 INVESTIGATIONS

An All-Wales approach is being taken to deal with Covid complaints and claims. In preparedness the Health Board has: -

- Recruited a programme manager to oversee the Covid-19 investigations
- Recruited a team of investigators and administration staff to support the programme.
- Comply with the national requirement to investigate nosocomial cases.

4 EMBEDDING NEW STAFF AND FURTHER DEVELOPMENT OF THE PTR TEAM

- A team development programme was introduced, strengthening teamwork and clarifying roles and responsibilities.

5 IMPROVE COMPLAINT HANDLING

- Set up regular SI and Concern 'drop-in clinics' for Divisions to allow opportunity to network and promote collaborative working to improve quality of responses and investigations at source.
- Reinstate face to face IO training to promote networking and embedding of learning.
- With closer working divisional/corporate relationships, reduce the backlog of outstanding complaints.
- Foster improved early resolution rates through centralisation of Customer Management Complaint calls to the Corporate PTR team, actioning straightforward enquiries and concerns, thus minimising escalation to the formal complaint stage.
- With the lifting of Covid restrictions, the Corporate PTR team were able to directly meet with Divisional colleagues to support and improve processes.
- Introduce improvement trajectories for all Divisions.
- A robust process of thematic analysis will be implemented for concerns.

SUCCESSES

COVID-19 INVESTIGATIONS

The Health Board Covid-19 Investigation Team is undertaking investigations through waves 1-4 of the pandemic as part of the National Nosocomial Covid-19 Programme (NNCP).

The Health Board continues to engage with the Delivery Unit (DU) to ensure a consistent all Wales approach to investigations and national strategic discussions for management of Covid-19 related concerns.

Lessons learnt from completed investigations have been shared with the DU to form part of the interim learning report to be submitted to Welsh Government (WG).

The Health Board are managing nosocomial cases and complaints associated with Covid-19 with no cases submitted to WRP at this time.

A resource plan for the on-going management of nosocomial Covid-19 cases as part of Duty of Candour is in progress.

TRAINING

The Corporate PTR Team continued to develop and facilitate Investigating Officer training via Microsoft Teams, facilitating sessions until February 2023. Following the relaxation of Covid-19 spacing rules the training was reinvigorated on a face-to-face basis.

The Health Board continued to work closely with the Public Services Ombudsman for Wales (PSOW) training department, who have delivered a number of sessions to Health Board staff. Recognizing the further need for complaint handling training, an external provider was enlisted to provide two days of bespoke training, which further equipped the PTR and Quality and Patient Safety (QPS) teams with enhanced skills.

Over the year an additional 120 Investigating Officers have been trained across the Health Board.

PARTNERSHIP WORKING

PTR have continued to collaborate with key stakeholders to improve the patient experience. This includes quarterly meetings with the Community Health Council (CHC) (to be Llais from 1 April 2023) and PSOW to foster open communication channels. In addition, regular weekly meetings with Welsh Ambulance Service Trust (WAST) have helped advance this important agenda and strengthen relationships. In addition, closer links have been formed with the Once for Wales data team who have engaged with complaints coordinator colleagues across the organisation to enhance correct use of RL Datix to record and close down concerns correctly.

CHALLENGES

Sickness across corporate & divisional PTR/QPS teams

During this reporting period, there has been a significant amount of team sickness, both long-term and short-term across the organisation. This has impeded organisational capacity to progress workstreams, which has inevitably impacted upon performance across the organisation. This situation has, towards the latter part of the year been largely resolved, and therefore much work has been undertaken by the Corporate Team training colleagues in conjunction with external partners in the endeavour to improve performance.

Covid-19 recovery

Continued organisational pressures left over from the Covid-19 pandemic have continued to influenced concerns and incidents raised, as well as the inability to facilitate proactive events, such as Learning Events.

Use of bank & agency staff

The increase in use of temporary staff impacts on performance and management of concerns and incidents due to the transient nature of the workforce and lack of knowledge regarding policies and procedures. Communication and engagement of these staff to participate in investigations sometimes proves difficult and can impede the timeliness of these.

CONCERNS

What is a concern?

A concern is when a patient or member of the public feels unhappy about any service provided by the NHS. Every concern raised deserves, and is entitled, to receive an appropriate and proportionate investigation and response.

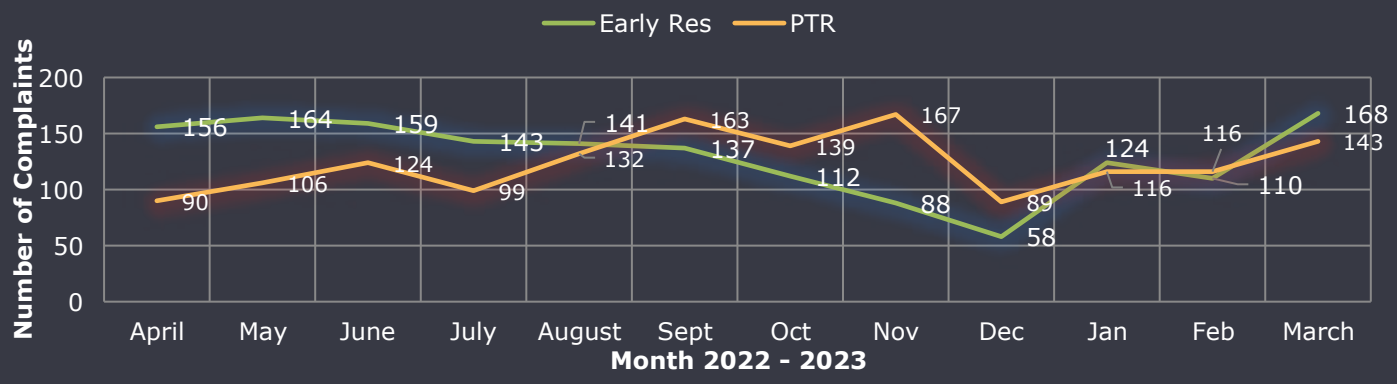
As illustrated the percentage of concerns raised in comparison with volume of patient interactions is extremely low. There is a slight decrease in the number of interactions from 1.118,795 in 2021/22, however this aligns with a decrease in interaction/complaint ratio from 0.29% in 2021/22 to 0.27% during this financial year.

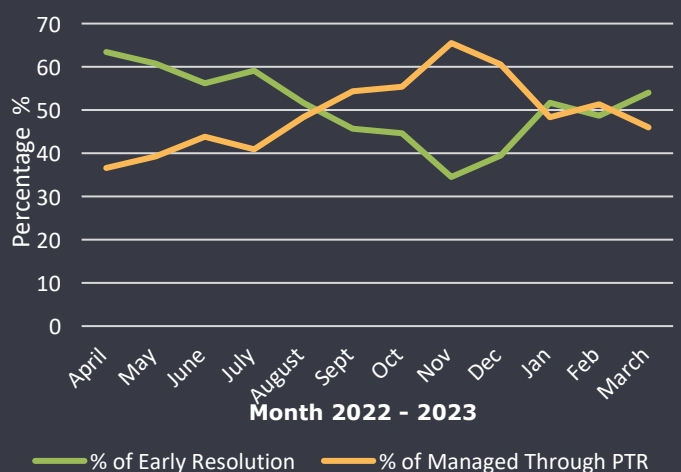
1,117,572

2022/2023 total patient interactions for 5 largest Divisions (admissions and outpatients)

Of these interactions **0.27%** resulted in the raising of a concern

Trend in Concerns managed through PTR and Early Resolution





Performance of Concerns managed through PTR and Early Resolution by Percentage

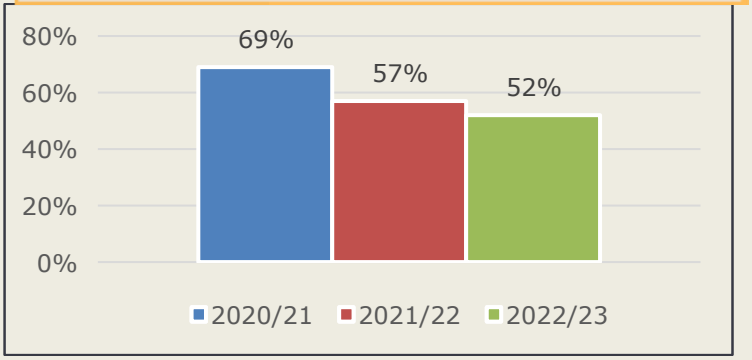
There was a steady decline from April to November 2022 in complaints managed through PTR, however conversely early resolution compliance increased over this period.

Extensive work by the Assistant Director of Nursing whose portfolio includes PTR, and the Head of Putting Things Right has taken place in conjunction with the Once for Wales data team and the Divisional leadership teams, to prioritise historic complaints and close these down. Additionally, work has taken place to ensure concerns are accurately recorded on the RLDatix (Datix Cymru) system.

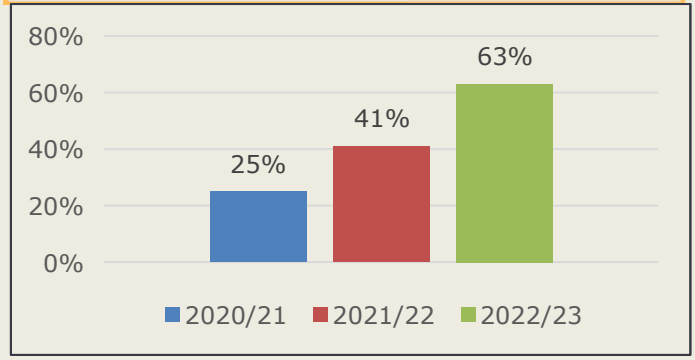
Overall Health Board Compliance

In 2022/23, the Health Board received 3044 complaints, 1560 were resolved under early resolution. The following graphs visually demonstrate the trend in overall performance for the last three years. Positively there has been a decreased trajectory in formal concerns, which supports an increase in those managed as Early Resolution. This reinforces the importance of the Corporate PTR team now managing the calls, previously received by the Customer Management Centre.

Trend in Compliance: Formal Concerns



Trend in Compliance: Early Resolution

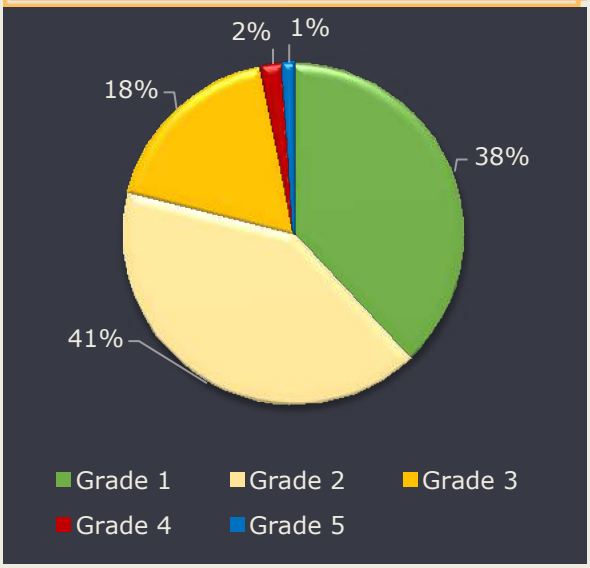


Performance has reduced for formal concerns from 57% to 52% however the proportion of those managed under early resolution concerns has positively increased from 41% to 63%. Those concerns managed through PTR (formal) tend to be representative of more complex concerns, often spanning more than one division and/or organisation. The Health Board aspires to resolve 75% of concerns as Early Resolution going forward, attaining a 75% within compliance target across Early Resolution and Managed through PTR.

When the organisation receives a complaint, it is graded accordingly. An explanation of grading is provided in the table below. Following an investigation, the majority of these are downgraded. Those graded 4 or higher are shared with the Divisional Triumvirate overseeing the area on first receipt, ensuring they are sighted early. Additionally, the Executive Team are notified of all grade 4/5 complaints via the weekly Safety Briefing.

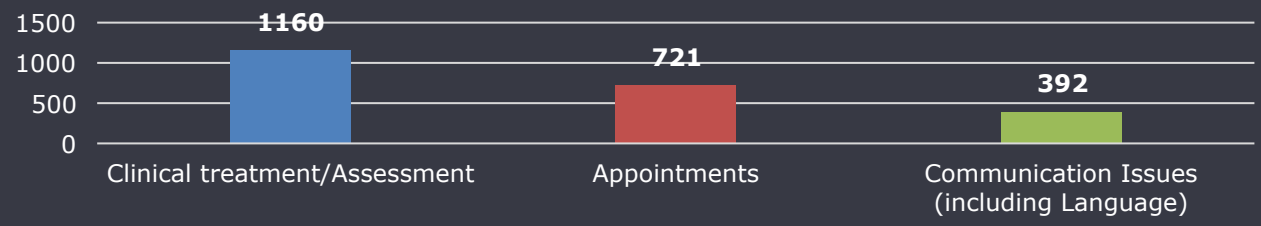
Grade 1: No Harm	No harm.
Grade 2: Low Harm	Minor implications for patient safety, patient fall requiring treatment, minor treatment.
Grade 3: Moderate Harm	Semi-permanent injury or impairment of health or damage requiring intervention, re-admission, additional interventions.
Grade 4: Severe Harm	Semi-permanent harm leading to incapacity or disability, additional interventions, increased stay >15 days.
Grade 5: Catastrophic Harm	Unexpected death, multiple harm or irreversible health effects, avoidable loss of life.

Grading of Complaints upon receipt 2022-23



A large proportion of concerns (79%) are graded as low or having caused no harm upon receipt, with moderate representing 18%, and with grades 4 and 5 accounting for 3% of the total received. The grading of complaints is dynamic and can change throughout the investigation. Going forward with the introduction of Duty of Candour (DoC) this will become even more important as there will a legal requirement to enact this once moderate or above harm has been established post management review.

Top Three Themes Raised 2022-23



The Covid-19 pandemic has intensified concerns raised about clinical treatment and assessment to delays to receiving an appointment and further delays on starting treatment plans. Throughout the reporting period, these remained consistent. Residents continue to express concern about wait times, with waiting list times emerging as a recurring theme in reporting. An example within this period that aimed to reduce numbers of enquiries from turning into concerns was a pilot programme launched within the trauma and orthopaedic department. This project generated a scheduled response letter that would be sent to waiting list patients explaining the rational for the delay to inform their position on the list and to reassure them they will receive treatment in due course. This letter included a direct contact line to division for any further concerns treating reducing the need to raise a formal concern. The evaluation process will determine its effectiveness and continuation until waiting lists are at a manageable level.

The creation of a formal Planned Care Recovery Oversight Programme aims to assist patients; it intends to include health optimisation for patients awaiting surgery and recovery. The Urgent Care Board is still concentrating on patient assessments and ambulance wait times.

Another reoccurring theme from concerns resolved through 'early resolution' revealed that communication issues unfortunately persist. This internal failure has resulted in frustrations from families that are involved in a patient's care at ward level and their subsequent discharge. There has also been a noted growing increase due to long waits in A & E with busy staff being unable to consistently update the person on their progress through their pathway on presentation to the department.

In relation to improving waiting times following the post-Covid pandemic period, there is extensive work being undertaken across a number of specialities:

Ophthalmology Unit, NHH

14-month solution for additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.

This additional capacity will provide a service for Health Board patients from Aneurin Bevan (AB), Cwm Taf Morgannwg (CTM) and Cardiff and Vale (C&V) University Health Boards.

The aims of the regional solution are:

- To enact a collaborative regional approach to recovery
- To provide additional regional capacity for cataract outpatient and inpatient stages
- To demonstrate optimal utilisation of our assets and resources across the region
- To address current waiting list backlogs
- To reduce clinical risk on an equitable basis across the region

The preferred option in the business case will deliver the following:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for C&V core capacity (1620 patients annually, funded by C&V) and 12.5 sessions for regional capacity (2700 patients annually, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 7,140 for 14 months (6,120 annual)
- Plus 9,310 additional
- Total capacity 16,450 per year (to include 14 months of core capacity)Waiting list reduction 4,832 (from 19,000 to 14,168

Endoscopy Unit, RGH

The existing Endoscopy Unit is unable to meet the capacity requirements for AB UHB as described in the Clinical Futures plan for the service. A new Joint Advisory Group on Gastrointestinal Endoscopy (JAG) compliant unit with four endoscopy procedure rooms and associated support spaces is being developed. The development of this unit currently sits within the portfolio of ABUHB Capital Team and is managed via a Project Group reporting to the Executive Team. It is planned that the new unit will open in November 2023.

Radiology – Community Diagnostic Hubs

Radiology - Community Diagnostic Hubs (CDH) is one of three projects in the SE Wales Regional Diagnostic Programme together with Pathology and Endoscopy. The key objectives of this project are:

- Increased radiology diagnostic capacity / supporting post pandemic recovery across the region
- Support the implementation of new pathways that will enhance services
- To enact a collaborative regional approach to radiology care
- To provide additional regional capacity for radiology patients
- To demonstrate optimal utilisation of our assets and resources across the region
- To address current waiting list backlogs
- To be able to accept patients from multiple Health Boards
- To provide improved services in areas of social deprivation

Following a period of consideration of options to develop increased capacity in Wales in the context of both estates and workforce constraints, the project group identified that optimal solution in the short to medium-term would be to develop a number of regional centres (between three and nine), procured from an external partner able to supply both equipment and workforce (not to be recruited from NHS Wales workforce) with these centres to be situated a strategic points across the region to ensure accessibility.

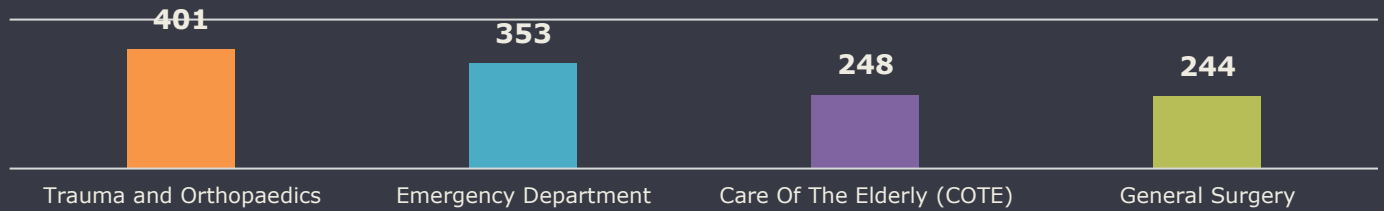
HealthPathways System

To support Primary and Secondary Care in ensuring patients are on the right pathway, the organisation is in the early stages of adopting the HealthPathways system which will standardise and communicate clearly the pathways to follow for onward patient advice and referral. This is a nationally supported system and approach, coming on the back of the system being utilised in Cardiff and Vale UHB for some time.

Orthopaedic Spinal Outpatients

Due to the large number of Orthopaedic Spine outpatients and backlog a decision has been taken to utilise a different model to ensure patients are reviewed in a timely way. Leading from recommendations from the Getting it Right First Time (GIRFT) visit last year the model will be changed to allow specialty Orthopaedic Clinicians see first outpatients. Allowing Consultant time to manage an increased throughput of patients.

Top four specialities receiving the highest number of Formal Complaints



These four specialities are consistent with reporting in 2021/22, however there has been a change in position from last year in terms of Trauma and Orthopaedics overtaking the Emergency Department.

There is a plan to introduce a Patient Advisory Liaison Service (PALS) across the Health Board. The aim that they will reduce complaints by addressing appointments and waiting list queries.

Person Centred Care Team

The Person-Centred Care Team have supported clinical teams in meeting with patients or patients' relatives who would like to share their experiences following either incidents and or complaints. The experiences are captured on video and shared by the people involved. The whole process gives them an opportunity to talk about what has happened and put structure to it in the format of a 'patient story', which can them be shared for appropriately for learning and quality improvement.

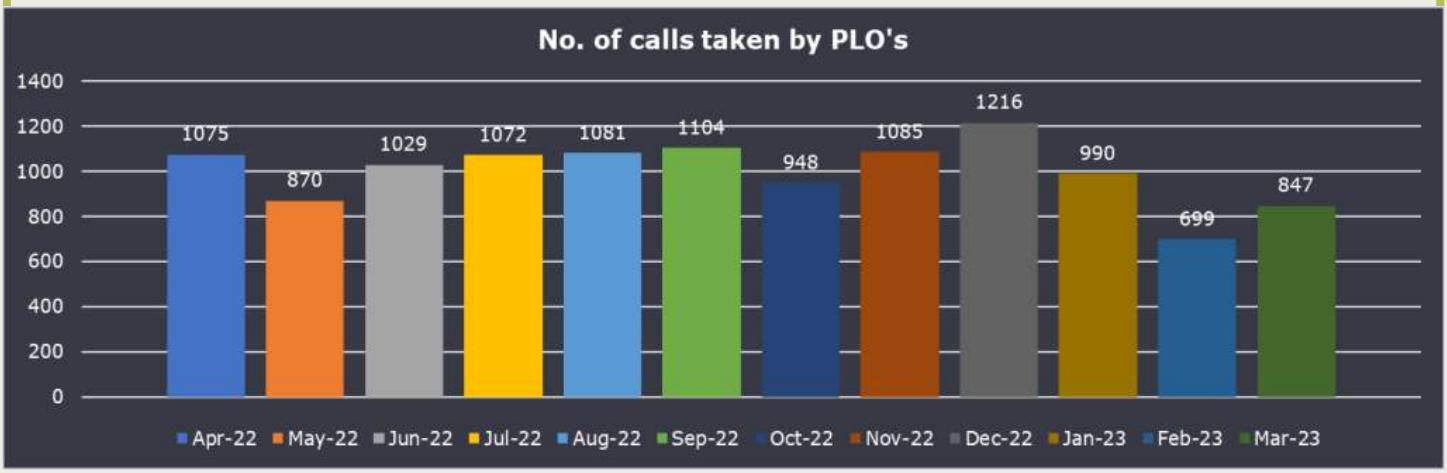
The whole process can be very emotional for those people having to relive often sad, traumatic and life changing moments, however, many of those telling their story have found the process has been helpful. They have also found the process helps by allowing them time with someone who will listen to their experiences. It also provides them opportunity to talk about their loved ones. Additionally, it has been helpful for people to know that by sharing their story, they may be helping others.

Films can be used both across the Health Board and where permission has been given, pan Wales for learning events. Collating a library and record of the stories also allows for themes to be analysed for a further level of learning.

Patient Liaison Officer Service

The Patient Liaison Officers (PLO's) work from 8am-8pm, 7 days a week at the 3 acute sites, linking in with the other hospitals. They act as a link between the relative and the wards. Relatives are encouraged to telephone the wards first and if no response to ring a dedicated telephone line.

The Health Board is proposing to implement a new service PALS service that will offer confidential advice, support and information on health-related matters. This service that will be a visual onsite presence for patients and families to access to further support to appease any urgent and pressing issues that can be resolved informally and at source.



Feedback from the PLO Service

"A caller just rang through, wanted to say how amazing the PLO staff are. The lady's husband had been brought into resus at the Grange seriously unwell and she didn't know if he would have made it through the night. She said that she couldn't thank the PLO enough for all the help she was given yesterday. On a positive note, the lady's husband made it through the night and although not out of the woods yet, they are hoping to move him to a ward."

"Hi, I wish to place on record my thanks to J, the Patient Liaison Officer at the Grange Hospital for assistance and intervention in the care of my wife today. Without her timely intervention, my wife would have discharged herself from the care of the hospital against the advice of the medical team! I would also like to thank the whole medical team for their care and assistance!"

Improving Timeliness and Quality of Complaint Responses

From April 2022 the Corporate PTR Team took over the Customer Management Centre calls This has allowed a greater overview of complaints submitted to the organisation. There remains a constant organisational focus on improving response quality and turnaround time.

The Corporate team in conjunction with the EDoN and ADoN frequently review processes to improve the timeliness of final response.

Meetings with the Complaints Co-Ordinators Network have continually virtually, as weekly meetings with Divisional QPS leads along with the Corporate PTR Team. These are critical forums for ensuring effective communication and wider learning.

Divisions continue to be supported by the temporary employment of experienced Investigating Officers to manage complaints graded 1,2 and 3. The aim to maintain traction, pace and momentum to achieve the necessary improvements and a more sustainable position moving forward.

Learning from Concerns

Mental Health and Learning Disabilities Service Referrals

A new Mental Health 111 (Option 2) service has launched in the Gwent area, offering easier access to urgent mental health and well-being advice.
The telephone service, introduced in Aneurin Bevan University Health Board this month, is a new option via the NHS 111 phone line, where callers can press 2 to speak to a local mental health advisor. The service is currently available seven days a week between 9am and midnight. By April 2023, it will become a 24-hour service.

Appropriate and Efficient Discharge Planning

New Discharge to Recover then Assess (D2RA) pathways webinars have been promoted across the Health Board to explain the rationale for the D2RA pathways and how they can improve flow in urgent care. We will focus on how the senior medical team can support discharge planning right from the moment of arrival into urgent care, with the aim of freeing up acute beds for new admissions.

Referrals into Secondary Care

Launch of The Aneurin Bevan University Health Board Flow Centre is a single point of contact to co-ordinate all urgent access to secondary care services, directing patients to the right care, in the right place, with the right service, first time.

The Flow Centre will combine two central functions, pre-hospital streaming, and the co-ordination of inter site transport (the allocation of suitable transport for admissions and transfers). From the 16th November 2022, all inter-site transfers will need to be arranged by calling the ABUHB Flow Centre on 0300 3033557 and selecting 'Inter site transfer'. Working with WAST, the Flow Centre will ensure that all patients are transported into, out of and between hospital services in the safest and most appropriate way, at the right time. It will operate 24/7, 365 days a year.

Listening and Learning from Feedback from Patients Living with Dementia

Relatives have fed back that teams don't identify what matters to the patient, staff are unable to recognise 'at a glance' when patients in hospital are living with dementia and may have additional needs, and do not receive patient-centred care.

As a result of this the Patient bedside boards have been revised across the wards.

Access to British Sign Language (BSL) Services

The 'SignLive' service for our BSL deaf community is now operational on all our hospital sites and patients can access BSL services where an interpreter is not immediately available 24/7/365. This was introduced following increasing complaints about the lack of BSL provision, delays in interpreters being available for face-to-face consultations and appointments jeopardised as a result and has been positively received by patients.

Public Service Ombudsman for Wales (PSOW)

The number of complaints referred to PSOW indicates how the Health Board has responded to the complaints received. Our goal is to always respond to complainants in a timely, fair, and robust manner, and to address all issues raised at the local level whenever possible. When complainants are dissatisfied with the response they receive, they may refer their complaint to the PSOW. On occasions, the PSOW becomes involved while the complaint is still being handled by the Health Board, because of a lengthy delay in providing a response.

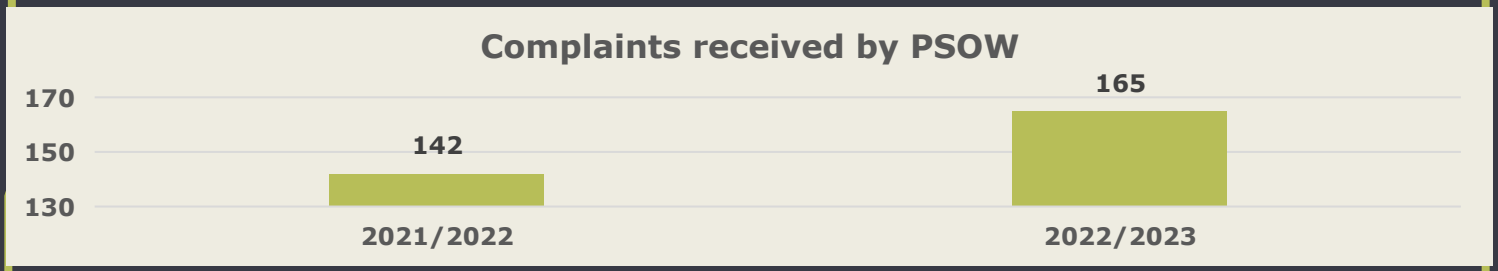
During 2022/23, quarterly meetings have been held with the PSOW Improvement Officer and Head of Complaints Standards. Therapeutic working relationships have been maintained and efficient processes are in place to ensure, where possible, deadlines are met.

Positively the Health Board has not received any Public Interest Reports during this reporting period.

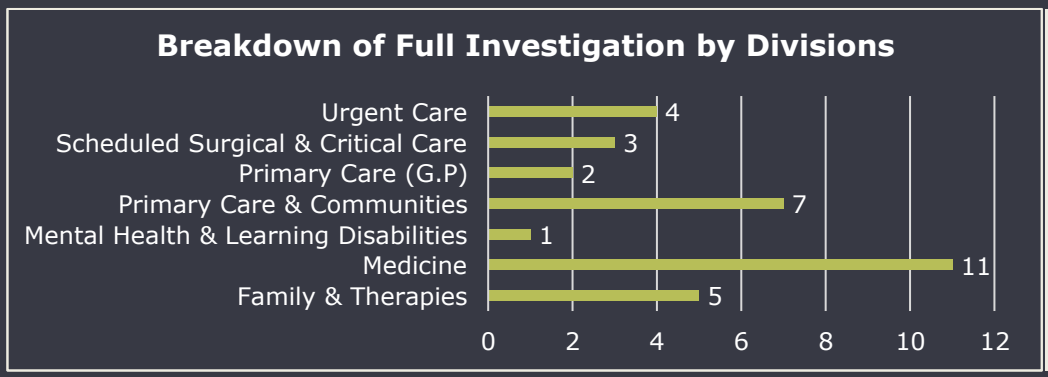
Number of Complaints Received by PSOW

During 2022/23, the PSOW received 165 referrals. Of these, 33 were taken on as full investigations for the Heath Board and 35 cases were not considered for further investigation. The remaining referrals were anonymous, requiring no action form the Health Board.

The following graph shows an increase in the number of complaints received by the PSOW for this reporting period.

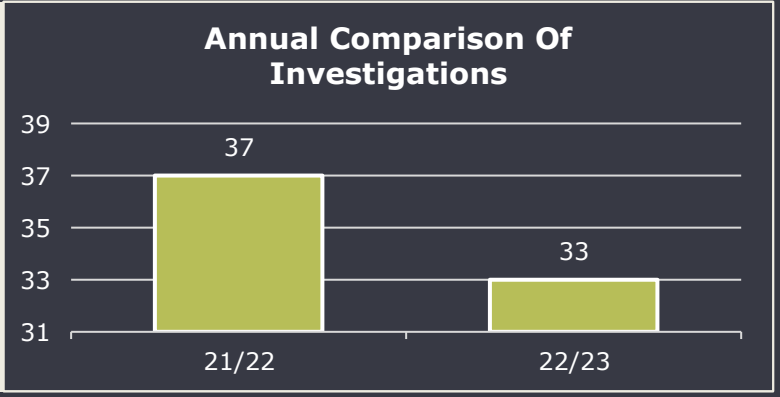


The Health Board received an additional 23 complaints in 2022/23 compared to 2021/22. This represents an increase of 16.20%. There has been an increase in number of complainants going to PSOW because they have not had their CEO response. Often these are accompanied with an early settlement recommendation of a redress amount to apologise for the delay with assurances the response will be sent as soon as possible. The Health Board is working hard to embed processes to resolve this.

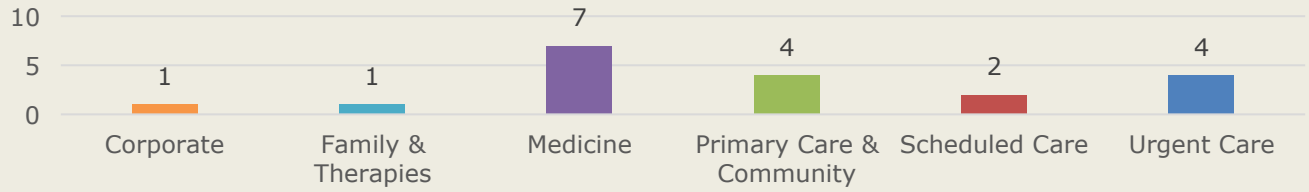


During 2021/2022, 26.06% of all referrals led to a full investigation compared to 20.00% in 2022/23. This represents a positive improvement for the Health Board as a full investigation means that the PSOW do not feel we have adequately addressed the complainants' concerns.

During 2021/22, 24.65% of concerns were not considered for investigation compared to 23.03% in 2022/23. When the PSOW Office decides not to investigate a case, it could be for a variety of reasons. A portion of these cases are deemed 'premature,' which means the Health Board has yet to complete its investigation, while others are deemed out of time or outside the Ombudsman's jurisdiction. Many of these cases are also deemed 'premature' because the PSOW believes that no further information can be gleaned and that the Health Board was thorough in their response.

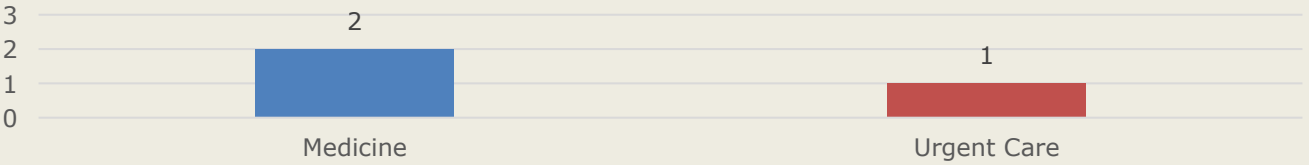


Final Upheld Reports by Division



This represents a total of 86.36% of all Final upheld reports being upheld meaning that the Health Boards' initial CEO responses were not sufficient to address the complainants' concerns.

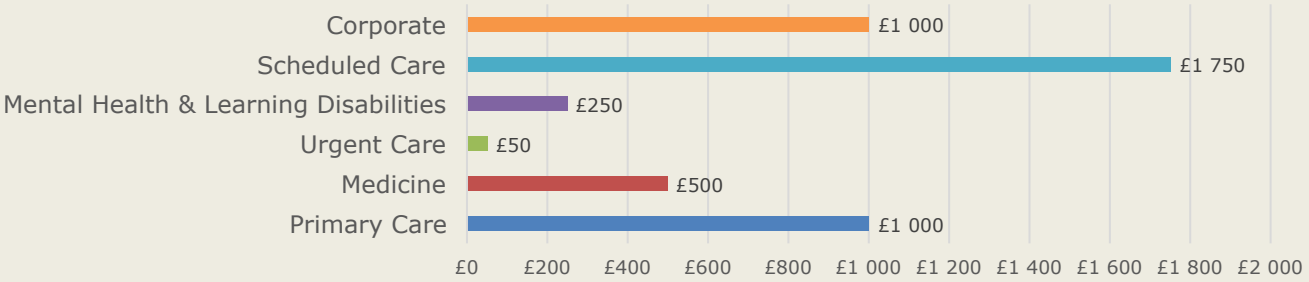
Final Not Upheld Reports by Division



Settlements are also known as 'early resolutions,' in which the Health Board agrees to respond to the complainant or complete a specific action in order to "settle" the case and avoid a full PSOW investigation.

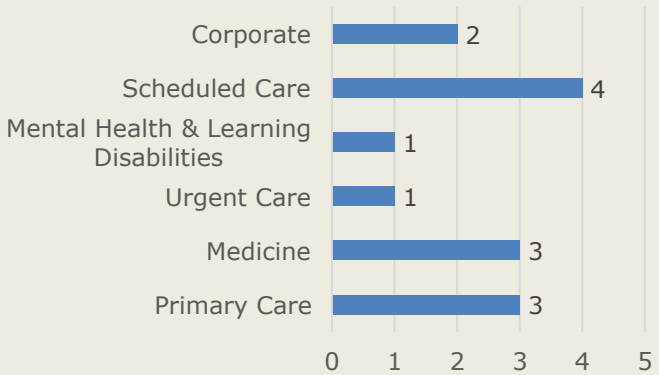
For the second consecutive year the Health Board has not been issued with any Public Interest Reports.

Financial Settlements by Division

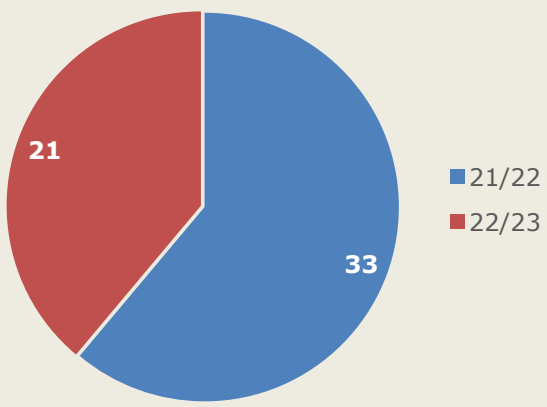


Where the PSOW believes there has been an injustice, they can recommend a financial payment. This can happen at any point, such as part of a settlement or as part of the recommendations following a thorough investigation. There has been a large reduction in financial compensation awarded for the year 2022/23, representing a positive reflection of settlements ordered. In 2022/21 it equated to £9775.00, which was approximately 50% more than 2022/23 which was £4550.00.

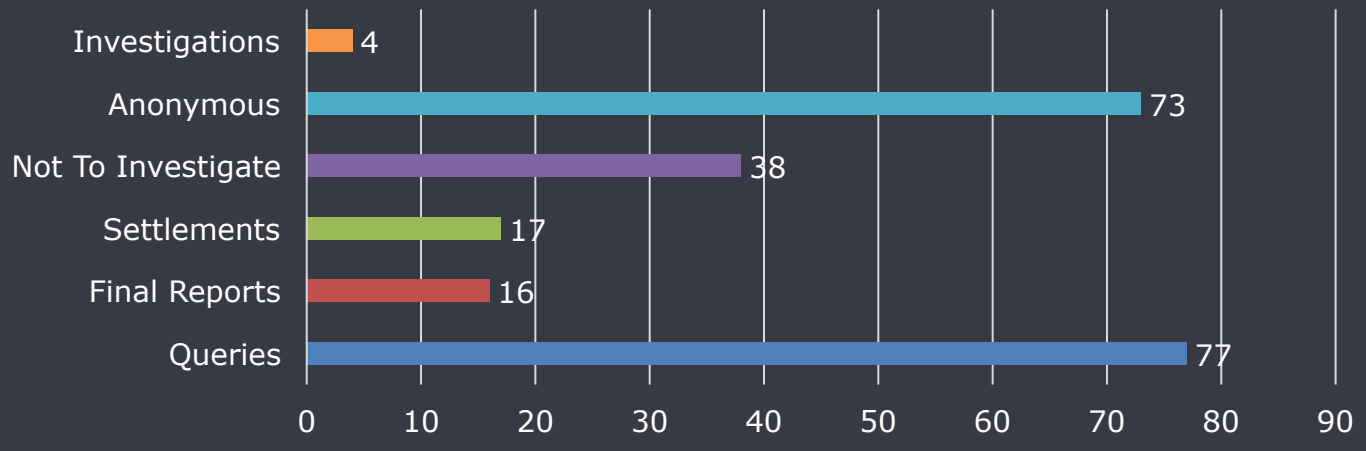
Number of Financial Settlements by Division



Annual Comparison Of Settlements



Outcome of Complaints Closed by PSOW



This graph shows at what stage the PSOW referrals were closed. This represents a total of 225.

Feedback from the Ombudsman including Learning and Actions Implemented

- Serious Incident reports to be clearer in terms of language used and a Patient Information leaflet to be designed and sent with all reports.
- In line with NICE guidelines the Health Board needs to be mindful that it is supporting the step closer to home pathway, though the placement still must be able to meet someone's needs, even though they are their family may not necessarily agree with this. The Health Board needs to embed a setting the scene approach with all patients, to include engagement with their relatives and this commences and continues across all disciplines and is reiterated by the discharge team.
- Dental loss, impacting on patient's care and the lack of interphase dentist that the Health Board can approach for assistance needs addressing.
- Complaint Handling, loss of records. An extensive action plan has been produced to ensure that the risk of losing records are minimised. A Standard Operating Procedure for Breach Reporting is now in place which includes an ICO Risk Assessment matrix, to ensure the process for reporting them is followed. A recent internal audit was completed of the IG processes and some of these findings have been used to support the action plan.
- Chest pain educational sessions run by the Cardiologist and Acute Care Physicians given to the junior doctor. Reinforce the importance of the history in the diagnosis of chest pain wherever the opportunity arises. The management of chest pain flow chart has been discussed with Cardiology and which is fit for purpose, and this will continue to be used. Continue to explore all aspects of the diagnostic pathway.
- Complaint handling and communication within Primary Care and Community Division to be improved. The Division now have a revised process approved by the Senior Leadership Team which was implemented in May 2022.

Complaint about Serious Incident Investigation Handling

The complainant raised a concern about the care of his wife following admission to Nevill Hall Hospital with a severe headache. The patient underwent a computerised tomography head scan which was clear, and a decision was taken to carry out an Epidural Blood Patch procedure. On the same day. The CT identified a bleed on the brain. The patient was then transferred to another hospital outside of the Health Board but despite surgery, sadly died.

Learning

Serious Incident reports need to be clearer in terms of language used and a Patient Information leaflet to be designed and sent with all reports. The team have now reviewed the policy and made changes to how they write reports, using clearer language and now issue a patient information leaflet.

Complaint around Fit for Discharge

The complainant approached the Ombudsman about her discharge from the eLGH, specifically that she was not fit to be discharged and that it was not appropriate to move her to a Care Home. The Ombudsman felt that the complainant had not been medically optimised for her discharge, did not do enough to satisfy itself that the Care Home was able to meet the complainant's needs, which it couldn't. In addition, the Care Home requested that the Health Board give handover to the District Nurses, this wasn't done. The PSOW felt the lady was not fit for discharge.

Learning

In line with NICE guidelines the Health Board needs to be mindful that it is supporting the step closer to home pathway, though the placement still must be able to meet someone's needs, even though their family may not necessarily agree with this. The Health Board needs to embed a setting the scene approach with all patients, to include engagement with their relatives and this commences and continues across all disciplines and is reiterated by the discharge team. This resulted in a settlement of £500.

Complaint regarding Lost Dentures

There were three separate entries on the patients notes, that the loss of their dentures had a devastating impact on the patient's eating and new dentures were requested as a priority. The PSOW response suggested that the Health Board did not recognise the amount of distress caused to the patient. Concerns also raised about lack of notes in the nursing records and staff had relied on multiple conversations rather than these being recorded. The Health Board failed to inform the family of the decision to transfer the lady on to End of Life Care.

Learning

Formal guidance has now been created for the treatment of patients who have dental issues while in hospital, including specifying whose responsibility it is to progress any dental issues and how this should be recorded. A document called 'My Mouthcare Plan' is a means of recording what the patient's needs are regarding keeping their mouth clean, what support they need to achieve this, routine mouthcare for both natural teeth and dentures. A risk assessment also needs to be completed for patients with additional mouth care needs that also considers the risk of choking and whether dentures have been broken, painful or recently lost. The policy includes a clear flow chart and address of where to send forms to and relevant contact numbers.

In response to Concerns regarding Communication with Families of End-of-Life Patients

The PSOW identified that documentation regarding communications with families was not adequate. In this case there were few recorded entries in the nursing notes about updates to the family. Concerns also raised about giving family an opportunity to say their final goodbyes when a relative is at the end of their life.

Learning

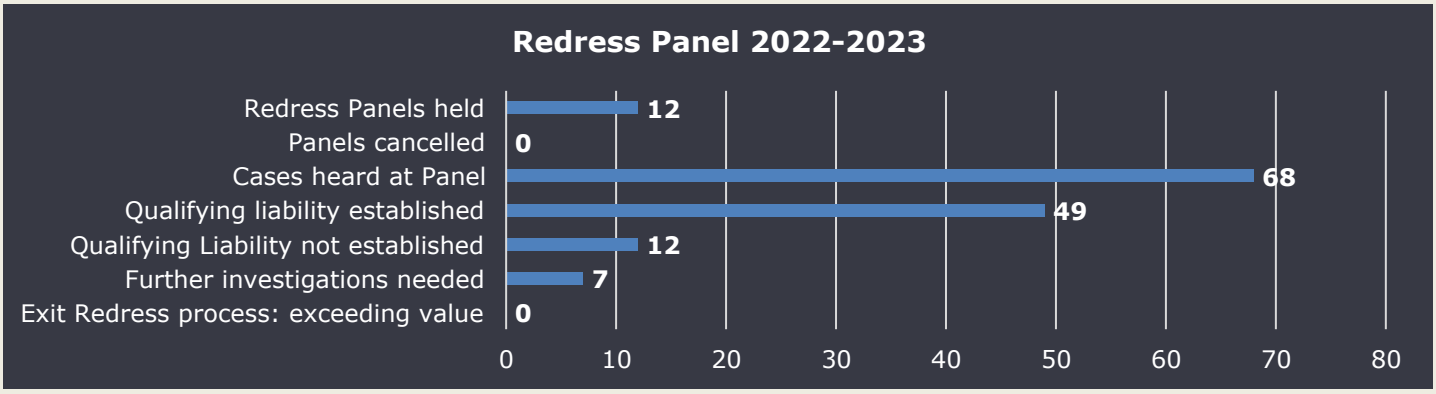
The themes for learning were discussed with both the ward staff and management teams through general meetings and focused weekly meetings. Communication documents are now on all wards to ensure communication is captured. In the absence of visitors, the nursing staff will aim to update families at least every 48 hours. Families will also be contacted if any deterioration is noted in patients. The Health Board have also distributed translation service posters in its hospitals to ensure that staff are aware of how to obtain a translator when needed. As part of bi-annual healthcare standards audit staff are challenged on the spot to provide the process to obtain translators for patients who require this service.

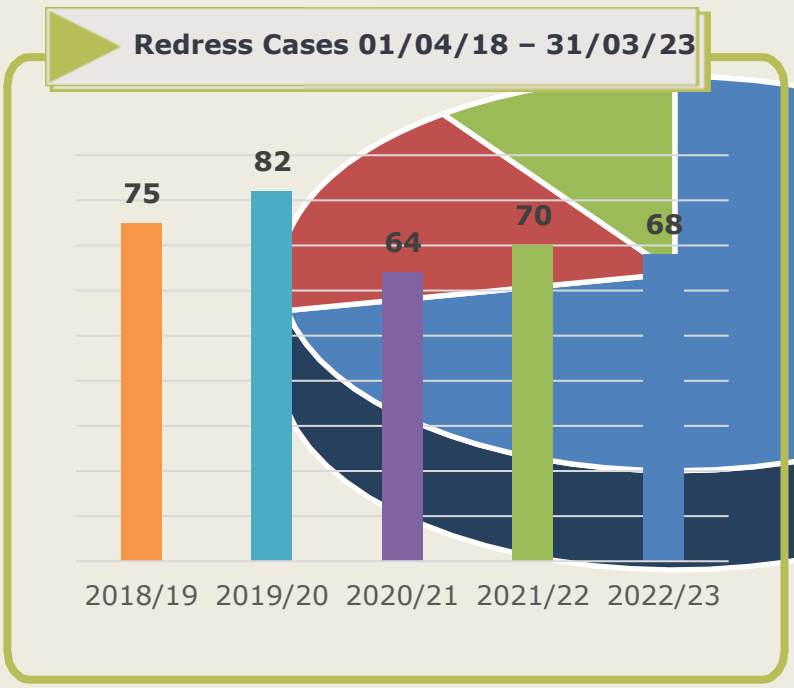
Redress

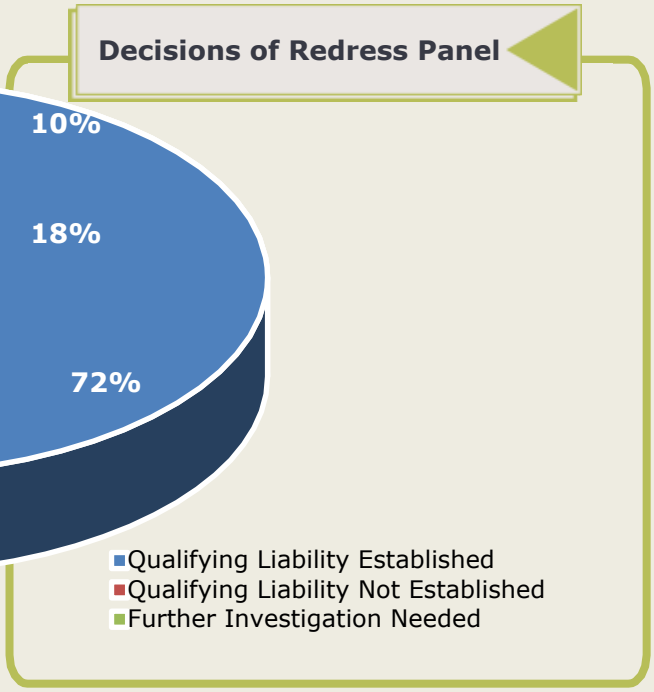
Under the PTR framework for investigating concerns, including patient safety incidents, there is an obligation on the Health Board, where harm has occurred or is alleged to have occurred, to consider whether there is a qualifying liability in tort i.e., are there failings in care which amount to a breach of duty of care and has that breach of duty led to the harm suffered or materially contributed to it.

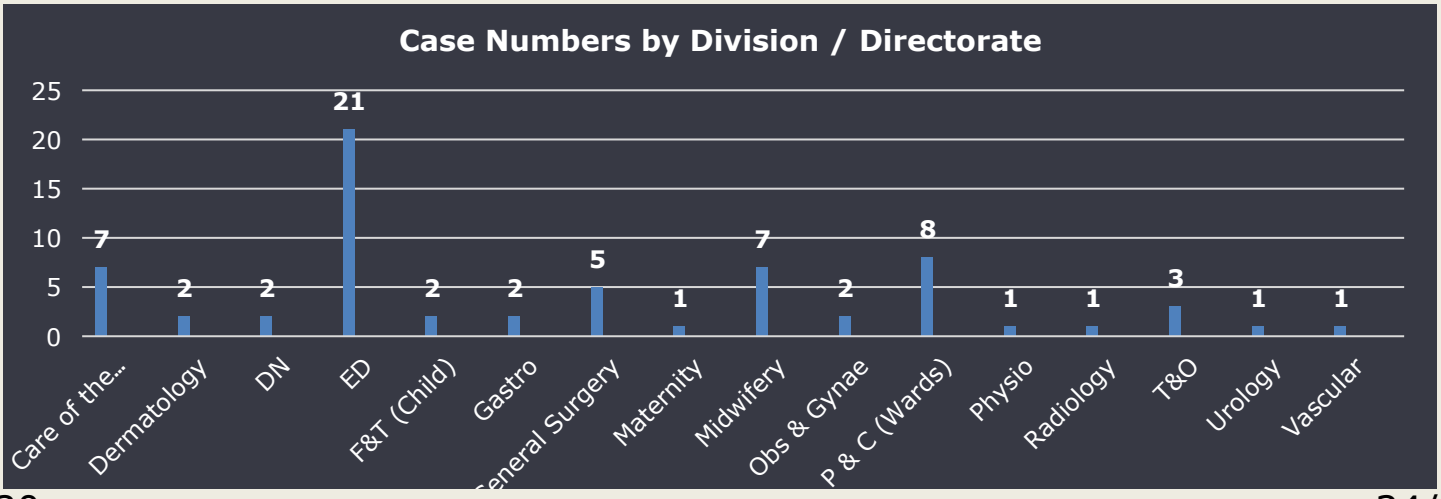
The Health Board has a well-established Redress Panel to make these determinations, meeting monthly to ensure cases heard timely. This is a high-level panel with quorate membership for Medical, Nursing and Therapies Executives or nominees, together with Chair. In addition to determinations of qualifying liability, there is a strong emphasis on ensuring that learning and actions have taken place to try to prevent future patient harm. Areas of good practice are also highlighted and shared.

It is nationally recognised that the Redress aspect of the all-Wales 'Putting Things Right Regulations' has provided a much-needed alternative to formal legal proceedings for patients and their families, achieving resolution within much shorter timeframes, and cost savings of legal proceedings.









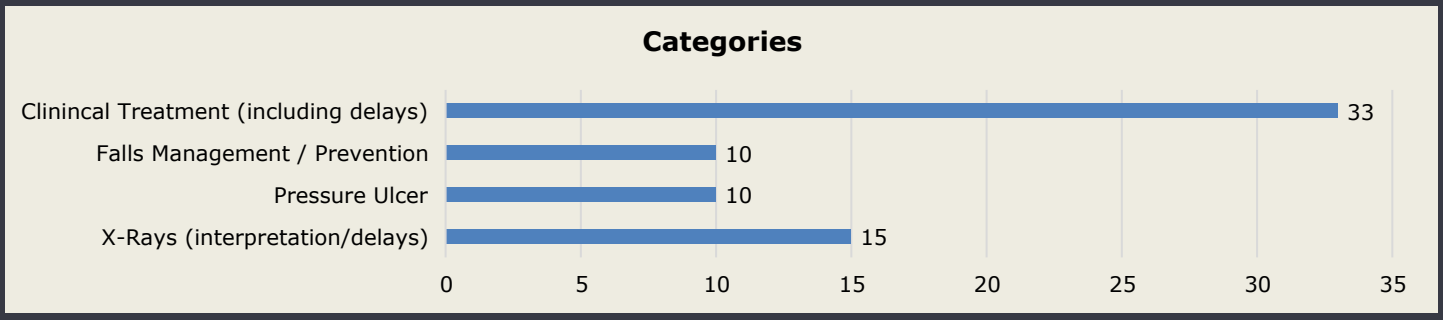
Themes of Cases taken to Redress Panel

The majority of cases heard at Redress Panel concern clinical treatment.

Whilst clinical treatment, including delays and diagnosis, were the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with no evident area of concern or outlier identified.

X-ray interpretation was the second class of cases, but again this was over multiple sites and varying degrees of expertise. All cases featuring radiology interpretation have resulted in 'Learning from Event Reports' (LFER) to ensure reflection and dissemination of learning.
Whilst cases involving falls prevention and management feature, these are down in numbers for the third year in a row. In the majority of cases there were failures to complete the Multi-Factorial Risk Assessment, failure to complete care plans or update, and issues in relation to enhanced care (failures to implement, failure to identify where this was needed). Most cases arose in the former community wards, YAB and YYF.

Pressure ulcer cases were up 50% on those heard the year before, but more Panels were held in the year. Figures overall are low at 10 cases in number.



Learning from Redress

Every case taken to panel is the subject of consideration of any immediate actions or follow up actions to prevent future patient harm or improvement in services, including the assurance of personal learning and reflections where appropriate. Much of the work undertaken is subject to regular audit to ensure that work undertaken is effective and efficacious. A Learning from Events Report (LFER) is produced for each case and is then subject to extensive scrutiny from the Welsh Risk Pool where a liability has been identified, to provide assurance on actions taken, improvements and learning.

Deteriorating Patient Improvement Cymru Initiative

ABUHB are participants in the national Safe Care Collaborative focussing on deteriorating patients. There are a number of teams involved. There are specific drivers to improve patient deterioration and potential changes that may be adopted, depending on the needs of each team involved.

Falls Management & Pressure Ulcer Prevention

We continue to see wards across the Health Board undertaking significant work around pressure ulcer and falls management prevention, actively embedding better working practices and undertaking appropriate training. PSAG boards are being utilised to capture the nutrition score, Waterlow and alerts. DECI and One Patient One Day audits to monitor and improve standards of care.

Radiology Reporting / Interpretation

Where it has been identified that an x-ray has been reported incorrectly, all cases are taken forward by the Team for review, discussion, and dissemination of learning within the Radiology Directorate Governance review meetings. The Directorate has also recently appointed a Radiology Quality and Governance lead, to help further embed and ensure these learning from incidents are captured and taken forward.

Feedback from a patient's family (Redress

"You have been fantastic dealing with my concern by telephone and discussing the process at length. Thank you."

"I would like to take this opportunity to say thank you for all your help and concern throughout the process and everyone else we met at meetings and during the process, could you please pass on to everyone. Thanks again for your attention we will not forget the help."

Claims

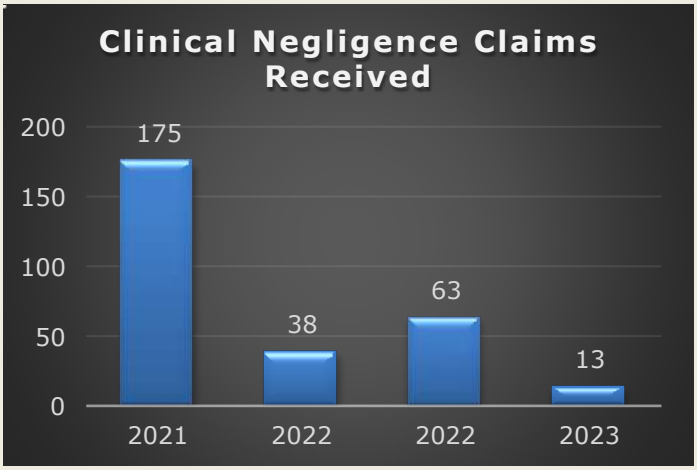
ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests.

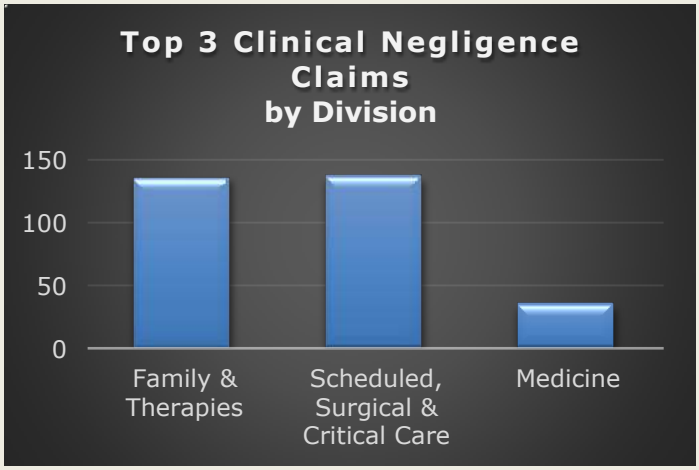
Total clinical negligence claim numbers remain steady at **(369) (60%)**. New claims are up on the year before.

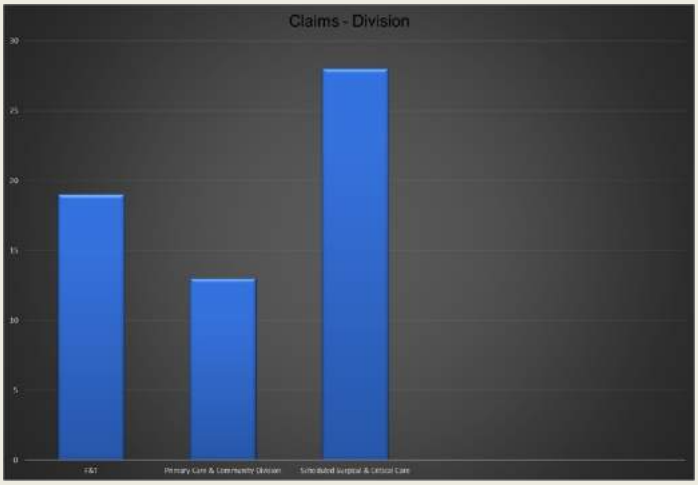
Personal injury claims continue a year-on-year reduction, currently at a **10-year low,** representing only **10%** of the claim's portfolio. This is testament to the commitment and work of multiple teams across the Health Board to mitigate and prevent personal injury incidents on our Health Board sites.

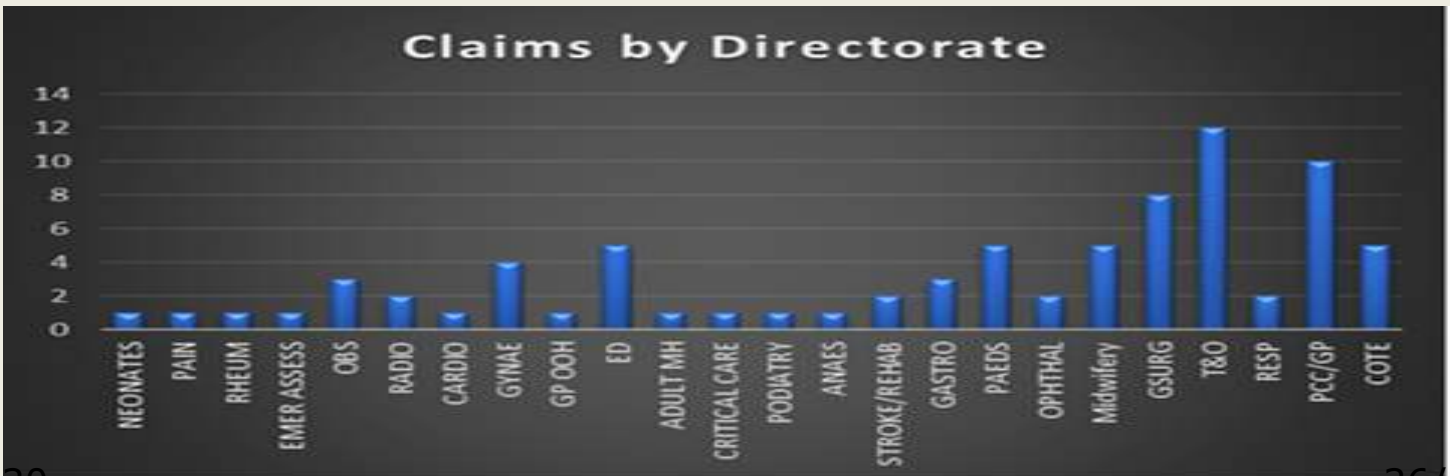
NWSSP Legal & Risk services, with whom we work closely on the management of Health Board legal claims, have reported significant improvement in timeliness and responsiveness of ABUHB Legal Services team. There were minimal delays on cases/instructions and new case referrals.

Number of Claims Received









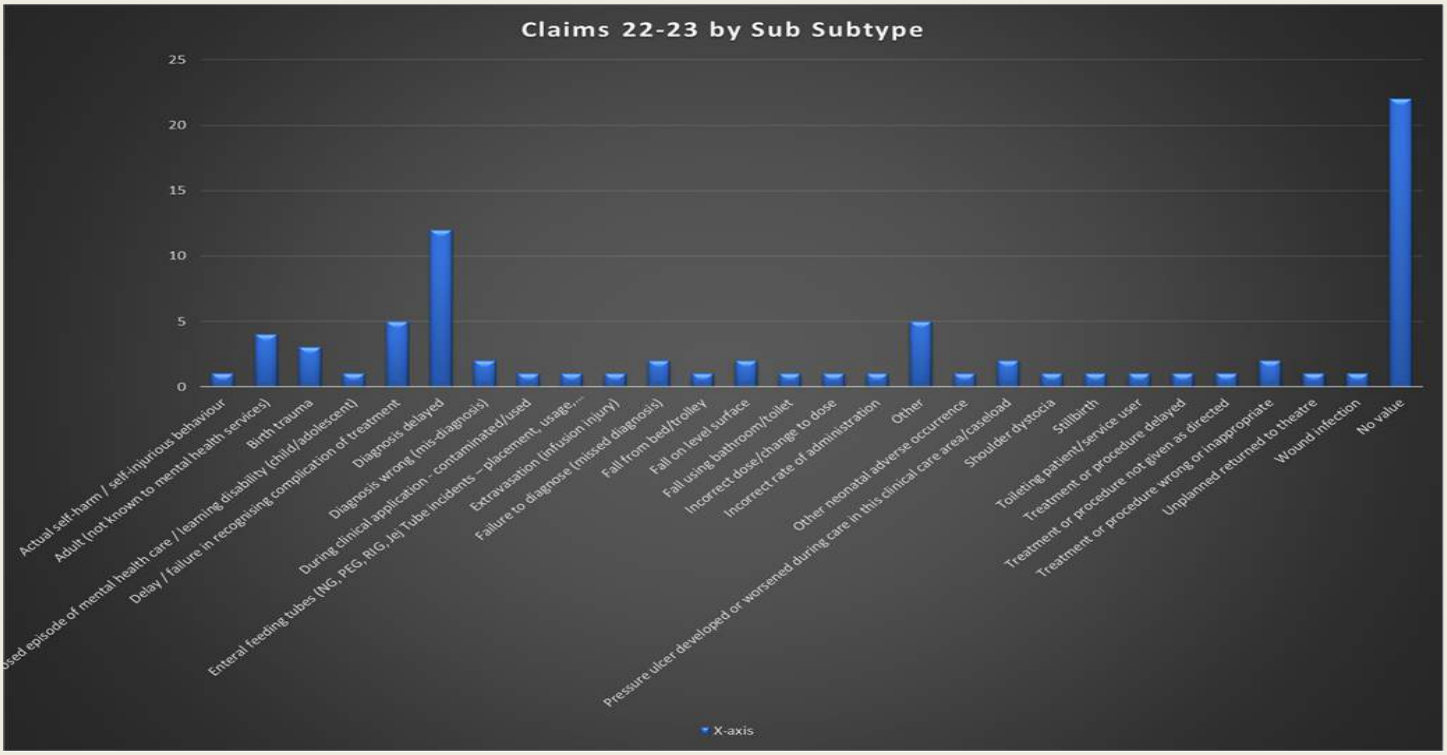
Themes raised in Claims

Claims are spread across Divisions and Directorates. Numbers are higher as expected in our higher risk areas, including surgery, T&O, Urgent Care, and Obs & Gynae. Primary Care & Community Division are in the top 3 for new claims for the first time. This is reflective that indemnity is now provided to GPs in Wales and the Health Board is the Defendant for the purpose of those claims.

The Mental Health & Learning Disabilities Division had the fewest new claims, reflective of their overall live claim numbers.

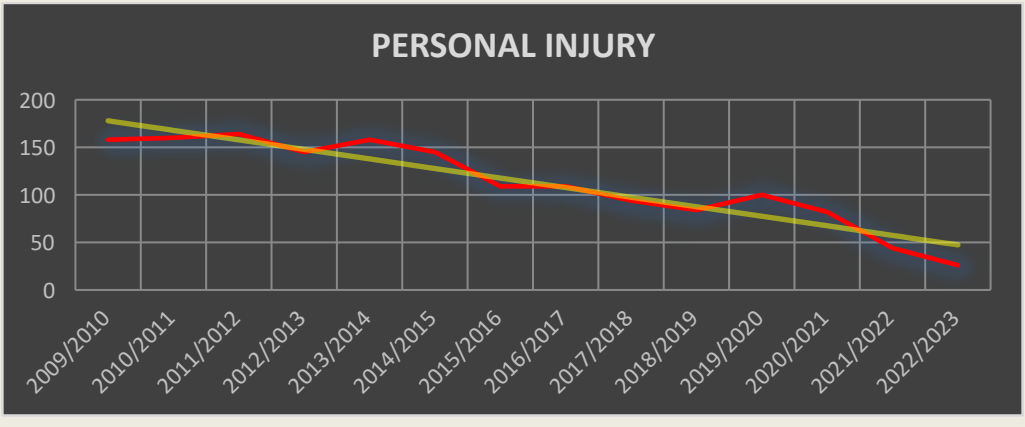
Whilst clinical treatment remains the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with key themes as illustrated:

- Delays: Diagnosis/Treatment
- Misdiagnosis
- Deteriorating patients/observations
- X-ray: reporting and interpretation
- Medication: prescribing/administering
- Procedure/technique/human error



Personal Injury

Personal injury claims continue a year-on-year reduction, currently at a **10 year low,** representing only **10%** of the claim's portfolio. This is testament to the commitment and work of multiple teams across the Health Board to mitigate and prevent personal injury incidents on our Health Board sites.



Learning from Claims and Redress

All Claims and Redress matters require submission of *'Learning from Events Reports' (*LFER) to the Welsh Risk Pool. Our learning/assurance/actions are scrutinised by a clinically led *Learning Advisory Panel.* Learning is at the heart of all claims investigated by the Health Board, with local clinical teams responsible for provision of learning, with support from the senior leadership team on the importance of responding to requests for Learning from Events Reports, action plans and updates.

CTG STAN Interpretation and Training

Birth injury claims are devastating to families and all involved. They are lengthy in nature, consuming significant time, resource and money. Incorrect CTG interpretation can lead to delay in delivery of a child, with resulting catastrophic injury. ABUHB has seen significant developments by way of STAN fetal monitoring, training programs for STAN; CTG and STAN Audits; CTG and STAN rolling training and presentations. This extensive programme of work continues to help prevent future incidents of harm occurring.

CAU Children's Assessment Unit GUH

Cases have featured care provided within CAU. CAU has now become the Childrens Emergency Assessment Unit located at the newly opened Grange University Hospital in Cwmbran. This has had the benefit of combining emergency and paediatric child services together on one site, with significantly improved staffing, skills and resources.

Obstetric & Midwifery updating of Guidelines

Where it has been identified that an x-ray has been reported incorrectly, all cases are taken forward by the Team for review, discussion, and dissemination of learning within the Radiology Directorate Governance review meetings. The Directorate has also recently appointed a Radiology Quality and Governance lead, to help further embed and ensure these learning from incidents are captured and taken forward.

Ophthalmology changes to booking after Incident

We now have waiting list officers in place who look at all clinics, look at CNA/DNA data and look more generally around the flow and booking of the clinic. We also have more trained administration staff based at Specsavers which is much better for overall cover and use of those clinics. The department hasn't seen any further incidents of this nature, which is very positive.

Feedback from Clinicians

"Thank you for the update and for your kind words. Your support has been invaluable throughout this process – thank you".

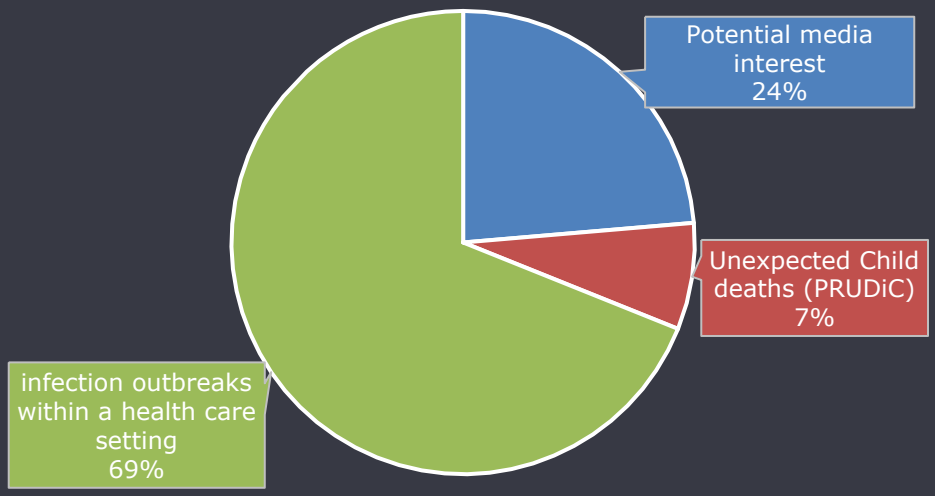
"I would like to express my gratitude and thanks to you for all the support, and for doing such a good job of preparing and manging staff's anxiety throughout this process".

All Health Boards within Wales are required to alert Welsh Government of any incidents using an Early Warning Notification (EWN) which may trigger media attention, unexpected child deaths (PRUDiC) and incidents of infection outbreaks within a health care setting (i.e. Covid-19, C Difficile).

During this reporting period a total of 148 Early Warning Notifications (EWN's) were submitted to Welsh Government. EWNs are submitted to Welsh Government when it is recognised they need to be alerted to an issue or concern or they require prior warning that an issue might relate to the following:

- Has the potential to affect a number of patients/ staff / communities etc.
- Has a significant impact on service provision
- May have an adverse impact in the media
- Might cause national or political embarrassment
- Following an Inquest which has resulted in a Regulation 28 or public interest in a Public Services Ombudsman for Wales (PSOW) report
- A positive good news story

Early Warning Notifications submitted to Welsh Government April 2022 – March 2023



Serious Incidents are reported to Welsh Government's Delivery Unit (DU) and a managed through the Serious Incident Process either as Red 1 (Corporately led) or Red 2 (Divisionally led) investigation. There are 6 reporting criteria:

1. Never Events
2. Inpatient Suicide
3. Maternal Death
4. Neonatal Death
5. Homicide
6. Any other incident of high impact (for local decision)

The new Policy allows Health Boards to determine when a proportionate investigation will be conducted. This can range between 30 and 120 days.

For the 242 additional incidents that would have previously been reportable to the DU, the Health Board is continuing to conduct a thorough internal investigation in collaboration with external partners to ensure that actions, and more importantly, learning, continue.

Serious Incidents

A Serious Incident is defined as ***"an event which has involved either an act or an omission in relation to NHS funded care which has caused an adverse outcome, resulting in severe or permanent harm or death"***.

A patient safety incident should be nationally reported within 7 working days from the occurrence or point of knowledge, if it is assessed or suspected an action of inaction in the course of a service user's treatment or care, in any healthcare setting, has or is likely to have caused or contributed to their unexpected or unavoidable death or caused or contributed to severe harm.

From 14 June 2021, The National Reporting Framework replaced the Welsh Government Serious Incident Reporting criteria. Historically, the focus of incident reporting at a national level had been to examine in detail Serious Incidents as out in NHS (Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 (the Regulations), primarily through the utilisation of Root Cause Analysis. The new National Patient Safety Incident Reporting Policy (2021) has brought about several key changes to national incident reporting.

From 1 April 2022 to 31 March 2023 a total of **22 869** (a 26% decrease from 2021-22) Datixes, reporting safety incidents across all sites of ABUHB were submitted. Of this number, 417 incidents (35% increase on 2021-22), 1.8% were deemed to meet the Serious Incident criteria whereby the incident requires investigation through either the Corporate Red 1 process or the Divisional Red 2 process. Examples of Red 2 investigations include the management of a deteriorating patient, Medication incidents with harm, missed investigation results with harm, community suicides and serious complaints with actual or potential severe harm. Corporate Red 1 examples include Coroner's cases. Inpatient suicides, sudden and unexpected death in theatre, incidents of significant media interest and Never Events (a serious incident or error that should not occur if proper safety procedures are followed).

22,869
Total number of Patient Safety Incidents

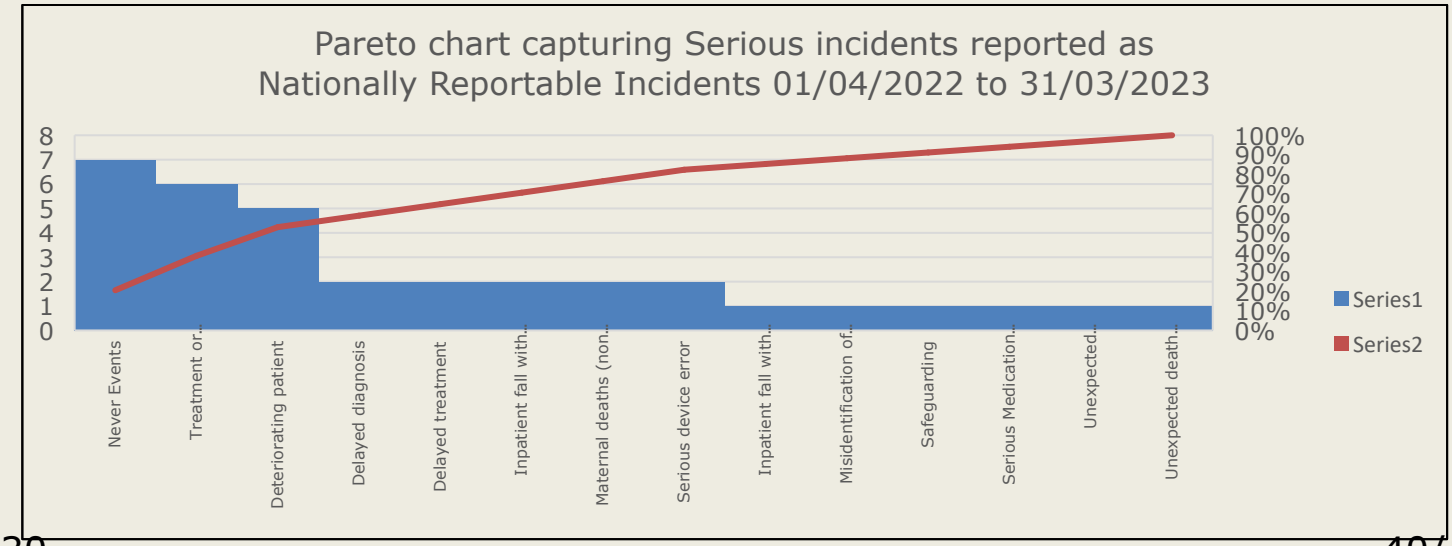
1.8%
Total number of Red 1 & Red 2 incidents

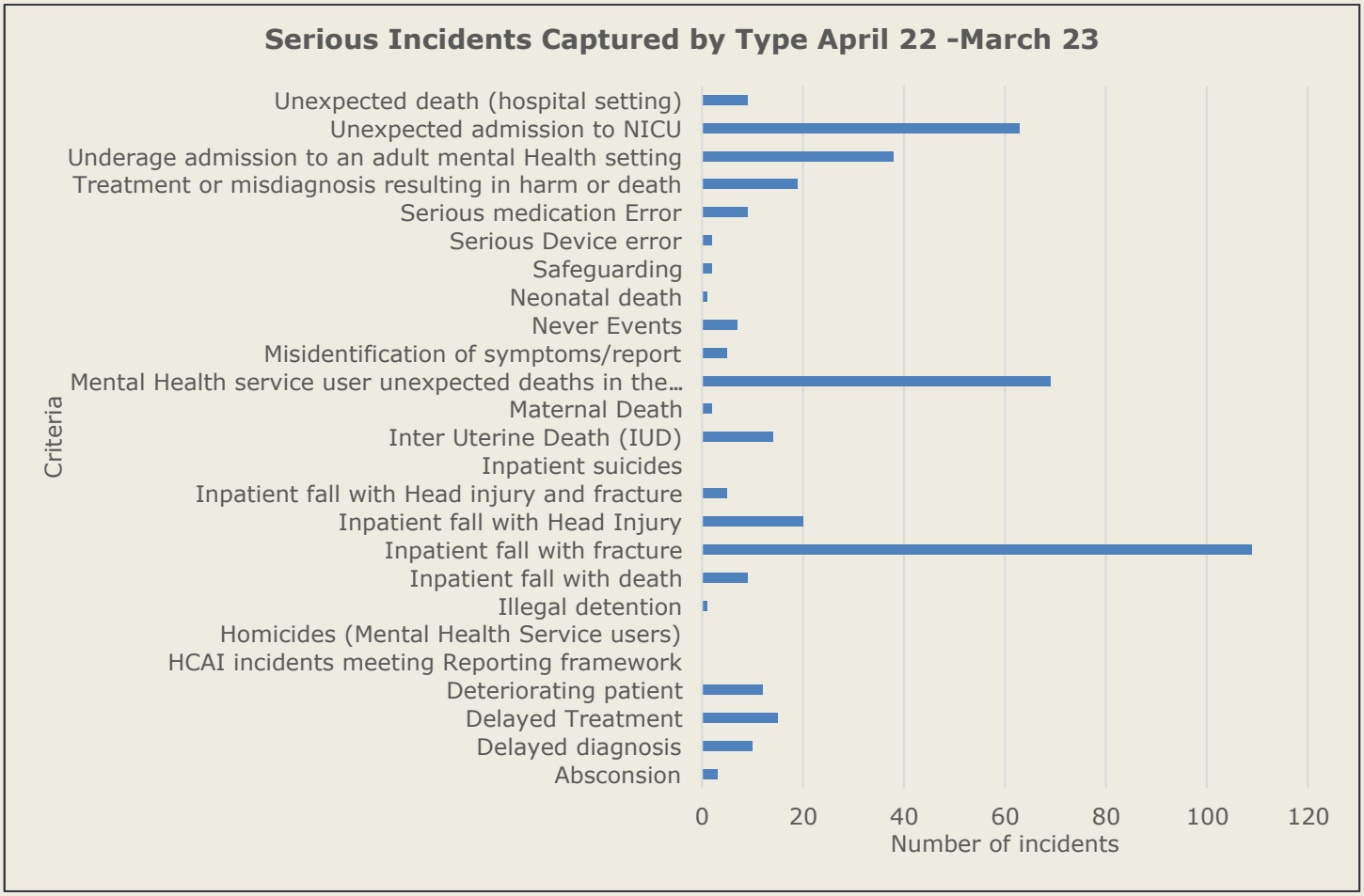
Reporting Incidents to the NHS Delivery Unit

A total of 34 (25, 2021-22) incidents from 1 April 2022 to 31 March 2023 were identified as meeting reporting criteria of the Reportable Incident framework which replaced introduced on 14 June 2021.

These 34 incidents were identified as meeting the following reporting criteria:

"A patient safety incident will be nationally reported within 7 working days from the occurrence or point of knowledge, if it is **assessed or suspected** an **action or inaction** in the course of a service user's treatment or care, in any healthcare setting**, has or is likely to have caused or contributed** to **their unexpected or unavoidable death** or **caused or contributed to severe harm**".



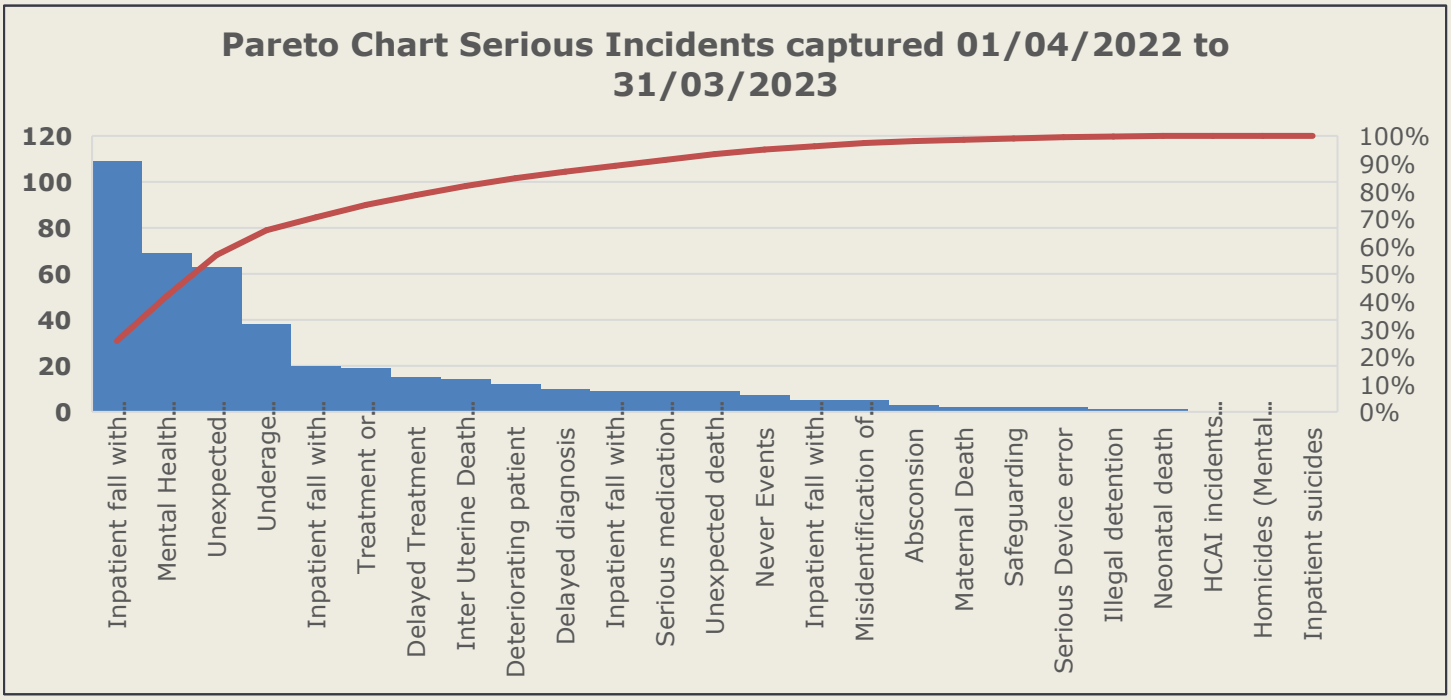


The following chart identifies the top 3 themes for SI's as: -

1) Inpatient fall with fracture – continued focused work continues through education of the Falls Policy and through learning identified by the Falls and Bone Health Steering Group.

2) Mental Health Service User unexpected death in the community – these cases are reviewed at the Mental Health and Learning Disabilities Safeguarding panel weekly and pertain to those unexpected deaths of service users open to Mental Health Services in the last 12 months.

3) Unexpected admission to NICU (This has significantly increased from 14 in 2021/22 to 63 in 2022/23). From these 63 submitted incidents, 25 are subsequently rejected from this category, since the admission of an infant born pre-37 weeks term does not represent an unexpected admission. Of the 38 incidents remaining, only 3 resulted in moderate or above harm post-investigation.



51 (21 identified 2021-22) incidents were identified as meeting the criteria for a Red 1 Corporate led investigation. 7 (a reduction from 10) of these were identified as Never Events.

Learning from Serious Incidents

Through the scrutiny of the Serious Incident Team collating themes, and communication of this through the weekly patient safety huddles with the clinical executives three categories of reported incidents have been highlighted in particular.

1) Theatre Never Events
2) Treatment or procedure
3) Deteriorating patient

As a result of these themes being identified within the reported incidents, in addition to further incidents of this nature that did not fit the reporting criteria (in terms of harm level), each of the Clinical Executives have undertaken to chair further workstreams aligned to these themes in order to establish root causes, spread organisational awareness of these incidences, and disseminate learning and action to minimise reoccurrence. Work will be ongoing throughout 23/24 to continue this work.

Theatre Never Events

There were 4 never events recorded in theatre during 22/23. The Medical Director is now leading this workstream. It has been identified that:

- There needs to be awareness and understanding of Never Event categories and reporting.
- Introduce a prompt 'stop before you block' in all clinical areas.
- Performance of the 'mock' block.
- Organise Human Factors training for all theatre staff.
- Culture audits to help create a positive, safe working environment, and increase morale.
- Review of the LocSSIPs
- An ERASE poster for each incident to support learning.

Treatment or Procedure – Missed Radiological Findings

The tasks performed by clinical teams are complex and are completed within a busy and varied system, which has been under pressure over this timeframe. It has highlighted that:

- Referring clinicians have not followed up or reviewed requested investigations appropriately or at all.
- Lack of clear process for Radiology to flag concerns to referring clinicians.
- Time between patient result and any appropriate action can be several months.
- Teams and other services have not communicated to each other the need to look out for results; teams covering multiple sites and a loss of continuity due to multiple sites working.
- There is a need for an IT system to support 'flagging' of red results.

Deteriorating Patient

- Deteriorating patient policy requires updating to reflect the opening of Grange University Hospital and the wide stream use of the Careflow system to record clinical observations and NEWS scores.
- There must be ongoing training provision for staff regarding the management of deteriorating patients and completion of observations as per Deteriorating Patient Policy.
- On-call rotas need to accurately reflect the individuals that are on call.
- Patients who are discussed with critical care/ICU as a potential airway risk should receive a formal in-person review, which should be documented in the medical notes.
- Jump call needs to be utilised more.
- Allied specialities input re referral/escalation pathways needed at doctors' induction.
- Appropriate use of temporary log in facility on Care flow
- Compliance with NEWS, neuro observations, fluid balance etc. needs to continue to be monitored at ward level.
- Registrants need to understand rules of delegation.
- The 'Impacted Fetal Head' scenario will be incorporated into
- Practical Obstetric Multi-Professional Training (PROMPT). PROMPT
- Wales have sent correspondence to PROMPT faculty at all units.

Additional Learning from Serious Incidents

Step-up transfers from GUH to e LGH's Incidents

There have been recent incidences where teams at eLGHs incorrectly called 999 for patients who have been accepted for step-up transfer to GUH.

A revised process has been devised:

1. Senior medical staff will contact the Flow Centre to trigger the process of a step-up transfer to GUH
(NB. If the conversation and acceptance to step-up a patient has been had outside of the Flow Centre, then the referring clinician needs to call the Flow Centre with all the details of the accepting consultant and the patient's condition so that the Flow Centre can appropriately respond to organise the transfer).

2. The Flow Centre will establish what crew is required following triage (including activating Transfer Practitioner / EMERTS) to complete the transfer.

3. The referring eLGH can escalate concerns or delay to the Flow Centre or to the site manager at GUH or system lead.

This established system to organise step-ups for patients who need to move from an eLGH to GUH will ensure that the step-up will happen in as timely and safe a way possible.

Radiology – Wrong patient undergoing investigations

As a result of some incorrect patients being sent to radiology and undergoing tests not ordered for them, radiology introduced an orange band system for the correct patients to wear before leaving the ward. This has been shown to be successful when an incorrect patient was sent to X-ray without an orange band, and the patient was sent back to the ward without unnecessary investigations being undertaken.

Medicines Incidents

Incidents related to medicines storage - Actions and Learning

Due to a number of recent serious RLDatix error reports, a reminder memo was issued of the required principles of good housekeeping in clinical areas:

- All cupboards, trolleys, closed storage units, automated dispensing systems, medicines storage rooms with doors and medicines refrigerators must be lockable and **locked** when not actively being used. Where keypad locks are in use, the code should not be visible to patients and visitors.
- Medication storage and preparation rooms are clean and tidy and there is adequate space to allow safe preparation of medicines.
- Medication deliveries are stored at the earliest opportunity, paying particular attention to refrigerated items. Medication which is no longer required should be **disposed** of immediately and not left accessible within treatment rooms or clinical areas.
- For areas without an Omnicell, medicines cupboards should have physical barriers to support **segregation of different formulations**, especially those considered high risk such as cytotoxic, epidural and intrathecal and potassium containing intravenous fluids.
- Ampoules of small volume injection must be stored in their **original container**. DO NOT amalgamate pack contents as these often look similar and there is a risk of mixing medication type and strength. Always double check the correct product is selected before using.
- Medication trolleys must be locked and securely stored in a locked room or **anchored to the wall/ floor** when not in use. Individual patients own drug (POD) lockers must also be locked and contain the correct patient's medication. Both trolleys and PODs lockers should not contain high risk items such as those mentioned above.
- Refrigerators must only contain medications. They should be clean, tidy and stock should not touch the sides in order to allow air to circulate. Monitoring charts should be completed daily or on each shift and maintained between 2°C – 8°C as per policy.
- Oxygen cylinders are stored securely in an allocated area and are regularly reviewed to ensure **empty cylinders** are returned to the cylinder store in a timely manner, so they are available for refill and resupply.
- No medication should be left unoccupied and accessible to patients and visitors such as in bedside drawers, table, on nursing station unless they are authorised rescue medication e.g. salbutamol inhaler, GTN pump.

Additional Learning from Serious Incidents

Medicines Incidents

Incidents related to Heparin – Actions and Learning

Following a couple of SIs that involved heparin the Assistant Director of Quality and Patient Safety and a Haematology Consultant updated the Heparin Policy and the Prescription Chart.

Part of the action plan was to make the heparin chart as a standalone chart. This has now completed this and it is available on the Health Board intranet. Once there is assurance that the chart has improved prescribing and monitoring of heparin, it will be put onto Oracle so it can be ordered as other charts (e.g., in-patient chart, warfarin and insulin).

Medication reconciliation training and education for prescribers has been expanded to include a taught session for junior doctors, a virtual summary presentation on key messages available through the junior doctor app and intranet, and incorporation of these messages into the junior doctor booklet.

The Pharmacy team collaborated with the surgical teams at GUH to identify contributing factors in prescribing incidents, which were addressed by escalating concerns to the division and providing individual support.

The Medicines Safety Group has also created a Medication Safety Strategy that places a strong emphasis on learning.

Through audits, training, internal alerts, and newsletters, pharmacy has also supported compliance with National Patient Safety Notices and Alerts.

Incidents highlighting Human Factors elements

A series of Human factors training covering Cardiology, Theatres and Obs and Gynae, in addition to the ward sites are planned for the coming year. The Human Factors Programme uses Multi professional Team based Simulations to test existing systems. Through these simulations, any issues or problems within the system or processes are identified. The programme enables Teams to generate their own solutions and promotes better team culture and staff wellbeing.

Inpatient Falls

Feedback received from HM Coroner in response to Health Board falls that have reached inquest over the past year

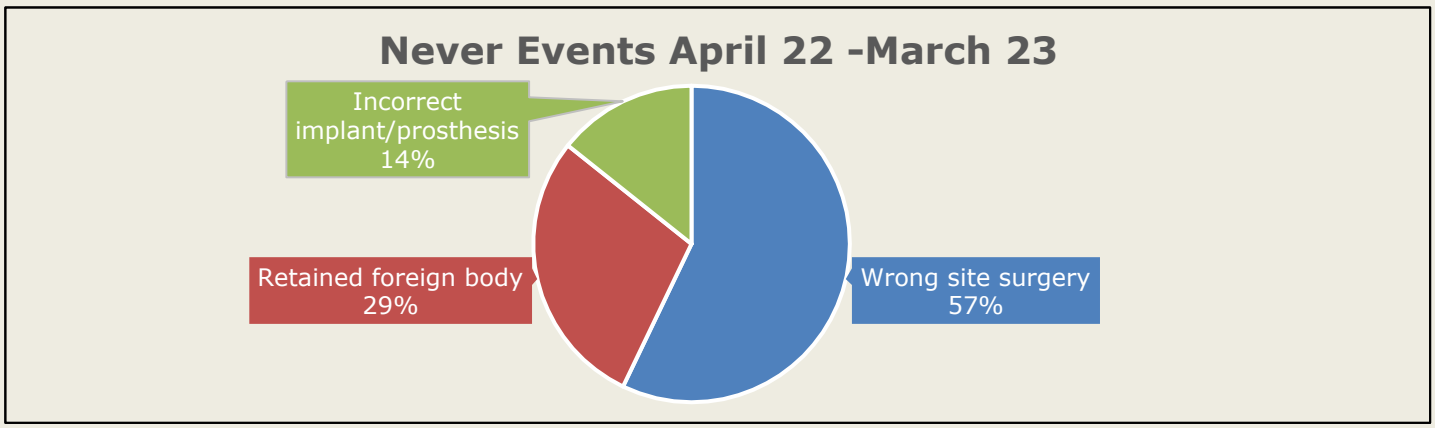
- Quality of Multi Falls Risk Assessment document – HM Coroner was critical of an assessment submitted not bearing any correlation to the patient and queried if it was the correct patient being assessed.
- There is, on occasion, inadequate handover of risks between transfers from ward to ward and hospital to hospital – for instance where patients have already been assessed as requiring enhanced care. If a patient requiring enhanced care is transferred, the receiving ward must be made aware prior to the transfer, and thereby able to meet the patient's need as soon as they arrive in terms of placing in an observable area of the ward or and where 1-1 enhanced care is needed there is a member of staff available.
- It is imperative that the IO of the Serious Incident Investigation has spoken to the nurses involved and conducted a thorough investigation drilling down to understand causes etc. and most importantly that the findings have been shared. HM Coroner will sometimes ask witnesses if they have seen the SI report prior to finalisation.
- In some cases that have not made it to Court, the main recommendation has been that there is a requirement for education and training for all staff regarding timely completion and appropriate reassessment of a patient's falls risk utilising the MFRA document. Training is also essential with regards to how and where staff access the falls policy, management of patients identified as having a high falls risk, and post fall management.

NEVER EVENTS

Never Events can be defined as ***"Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers".***

Never Events comprise 25% of the Health Boards', this is due to all Never Events being mandatorily reportable regardless of level of harm. A large amount of improvement work has gone into making processes more robust, using systems thinking lens for investigations, training IOs using Human Factors and the introduction of the Theatre Iar Safety Collaborative Group for education, sharing and learning.

A total of 7 Never Events were reported by Aneurin Bevan in 2022/23, compared with 10 in 2021/22 as shown in the below pie-chart.



LEARNING FROM NEVER EVENTS

ERASE (Educating & Recommendations After Significant Event's) posters have been developed to highlight learning from events that came from Never Events. An example of a blank poster is shown below:

Angiogram performed when patient should have had PCI

- There must be an improved process for the completion of the Angiography request forms.
- There must be development of an online request form for cardiac angiography.
- The request form should also include if the patient has been loaded on Dual Antiplatelet Therapy (DAPT).
- The generic term "Angio" should not be used when referring to the range of angiography procedures. Staff must refer to the full procedure that the patient is listed for by name.
- There must be improved MDT communication regarding patient undergoing procedures in Cardiology.
- There must be an improved processes and documentation used within Cardiac Catheter lab to ensure positive patient identification and clear communication during all Angiography Procedures to ensure safe practice.

Regional Block Never Event

Consideration to be given to dedicated regional block bays where anaesthetic blocks can be safely performed with adequate resources and support.

- Block bay has been identified in theatre recovery at GUH.
- There is a plan to identify bays across all theatre sites where regional anaesthesia will be performed.
- Appropriately trained personnel assisting anaesthetists.
- There is a Health Board wide wrong site block action plan.

The Medical Examiner Panel

The primary aim of the Medical Examiner (ME) Service for Wales is to provide independent scrutiny of all deaths that occur in Wales that are not referred directly for investigation to His Majesty's Coroner. The UK Government has now passed the required legislation for the ME Service process to be a legal requirement by April 2023.

The scrutiny of mortality cases from the ME comes in the form of referral letters, which are received at ABUHB via email. These referrals are processed by the ABUHB Mortality Review Screening Panel, the Mortality Module on the RL Datix system is used to log all of the referrals and all the requisite actions. The aim of the Panel is to investigate and respond to concerns by the referrals from the ME Service in order to generate thematic learning and improvement. The Panel has multidisciplinary representation from Medical, Surgical, Nursing, Pharmacy, Therapies, Mental Health & LD, Primary Care, WAST and PTR colleagues.

At ABUHB 268 referrals were received from the ME Service between 1st October 2022 and 1st April 2023. Over this period of time 10 ME Service referral cases progressed to SI. It is important to bear in mind that during the majority of this time period the ME Service was not scrutinising all the deaths at ABUHB. Key themes generated from the ME Referrals tend to fluctuate, but in the aforementioned time period common concerns included;

- Referrals related to nosocomial Covid-19
- Concerns about poor communication (including both with staff and with families and carers). Is often relates to inpatient transfers and difficulty in families being able to contact ward staff by telephone.
- Referrals related to pressure ulcers (both ABUHB acquired and community acquired)
- DNACPR forms not being countersigned
- Poor completion rate of discharge summaries

Key priorities for the AB UHB Mortality Review Screening Panel moving forward are to adapt to the increase in referrals we are getting as the ME Service coverage at ABUHB has recently expanded. In Spring 2023 we issued our first Newsletter which has allowed us the opportunity to share learning and awareness across the Health Board.

Further information and resources (including the Newsletter) can be found on the ABUHB Mortality Review intranet page.

Compliments

Compliments are received within a variety of ways, including letters, emails, telephone calls, thank you cards and conversations. The new RLDatix module also has a facility to log compliments. Compliments are useful for measuring and tracking feedback. They can demonstrate improvements in performance and provide a baseline for measuring patient satisfaction, generating meaningful data can help drive continuous improvement. Compliments acknowledge, reward and promote desirable behaviours and practices, also providing staff with social recognition. Positive feedback is pivotal for morale and wellbeing and reinforces what the Health Board is striving to provide. Complainants often contain a compliment within, areas are encouraged to share these with staff.

181 compliments were captured on the RL Datix system during 2022/23, with an additional 165 compliments also posted to the Wall of Thanks during this period.

APPRECIATION STATION

Compliment to MIU, NHH

"I visited Nevil Hall Minor Injury Unit tonight (23.4.22). The staff were all a credit to the NHS and I want to extend my thanks to them all. From the woman at the reception, to the lady who x-rayed my foot and all the nurses. I had managed to break my foot and my ankle but was seen and back home within 2 hours of arriving.

Thank you to Rhymney Ward, YYF

I would just like to pass on my thanks to the staff and management of Rhymney ward in Ysbyty Ystrad Fawr. I had day surgery yesterday. The whole experience was really good. The ward was absolutely spotless. The staff were informative and supportive.

Theatre staff were superb. Made me feel at ease when anxious. Above all in a vulnerable time all staff took the time to ask if I was OK. So much appreciated to all staff".

Thank you to Urology, RGH

"I would like to send a big thank you to the staff of the Urology Department at the Royal Gwent Hospital for the level of care given to my husband over this past weekend.

Compliment to CCU, GUH

As a family, we just wanted to say a huge thank you to the staff of B2 Cardiac Care Unit, at The Grange University Hospital.

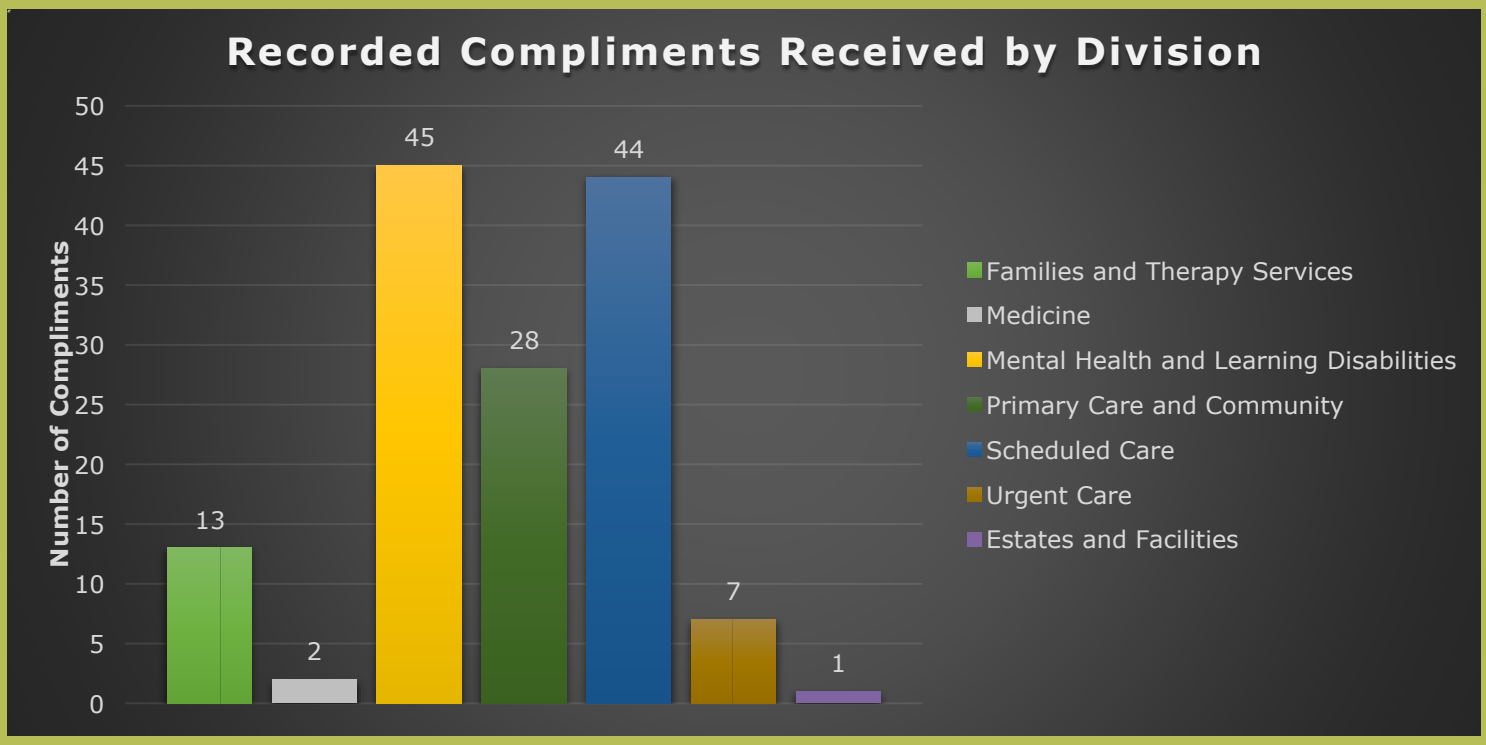
Absolutely nothing was too much trouble for any of the staff on duty.

Compliment to Bellevue Outpatients

"I just wanted to feedback that I attended Gynaecology in Belle Vue Outpatients this morning, (the staff were not aware that I was staff as I did not have my badge on). The staff were so friendly and helpful and certainly helped me to feel relaxed. I wanted to say thank you"

Compliment to Surgical Team, NHH

Once again, I would like to thank all the NHS staff. I certainly have not forgotten the sacrifices they made during the Covid pandemic and their dedication and professionalism in caring for others all the time. I truly would be grateful if you can pass on my thanks and appreciation to the Nevill Hall General Surgery team.



CONCLUSION

2022/23 has continued to represent a challenging year for the Health Board as the community it serves and beyond, endeavours to resume services following the Covid-19 pandemic.

The Health Board has continued to use a 'proportionate approach' to ensure rapid handling of concerns/complaints/serious incidents and de-escalation where possible. The changes primarily focussed on any investigations being proportionate, reinforcing the importance of honest communication with people raising concerns, but critically not raising expectations.

Despite the challenges, successes have been secured:

- **Covid investigations**
- **Restoration of Face-to-Face Investigating Officer Training**
- **Continued and strengthened Partnership Working**

A work programme has been developed for focus during 2023/24, as outlined in the following table.

Priority 1	Introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 – (Duty of Candour)	As Duty of candour becomes law on 1 April 2023, the Health Board must: ▪ Ensure Health Staff have access to and undertake the All-Wales e-learning package. ▪ Assistant Director of Nursing to chair DoC Divisional leads meeting. ▪ Identification of key DoC leads within each division. ▪ Establish DoC dashboard on RLDatix ▪ Corporate Team oversight to support Divisional colleagues.
Priority 2	Remodelling of QPS structure across the organisation	▪ Executive Director of Nursing to undertake review of QPS processes in conjunction with Divisional and Corporate colleagues.
Priority 3	Learning Framework/Quality Strategy	▪ To embed the new Quality Strategy through the Health Board which focuses on delivering 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 ▪ Develop a robust implementation plan for the quality strategy ▪ Review and alignment the QPS resources to create a resource structure to deliver the strategy and create a learning framework
Priority 4	Improve Complaint Handling	▪ Set up regular SI and Concern 'drop-in clinics' for Divisions to allow opportunity to network and promote collaborative working to improve quality of responses and investigations at source. ▪ With closer working divisional/corporate relationships, reduce the backlog of outstanding complaints. ▪ Audit of IO's trained across the organisation to evaluate effectiveness of IO training delivered through investigations undertaken. ▪ Historic complaint closure. ▪ Introduction of PALS to maximise opportunities for Early Resolution.

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

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

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board in March 2022;
- the Board's Assurance Framework (based on its Annual Objectives for 2021/22 and 2022/23);
- delivery of the Board's Experience, Quality & Safety Objectives set out within the IMTP 2022-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national and best practice requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG			✓	
Review of Committee Programme of Business	Standing Item	Chair			✓	✓
Annual Review of Committee Terms of Reference 2023/24	Annually	Chair & Director of CG				
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG				
Committee Annual Report 2023/24	Annually	Chair & Director of CG				
Pharmacy and Medicines Management Annual Report	Annually	Medical Director				
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director				
Focus on Pillars of Quality - Infection Prevention and Control and Safeguarding - Incident report and Health Safety and Security - Patient and staff feedback and Complaints and Concerns				✓	✓	✓
Mental health and learning disabilities assurance			✓	✓	✓	✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Learning from Death Report	Bi-Annually	Medical Director				
Cleaning Standards Annual Report	Annually	Director of Operations				
Nutrition and Hydration Standards and Strategy'	Annually	Director of Therapies & HS				
Falls Prevention and Management Report	Bi-Annually	Director of Therapies & HS				
Health and Safety Compliance Report	Annually	Director of Therapies & HS				
Safeguarding Annual Report	Annually	Director of Nursing				✓
Safeguarding Group Highlight Report (In Quality report)	Quarterly	Director of Nursing			✓	
Operation Jasmine Action Plan	Bi-Annually	Director of Nursing		✓		
Children's Rights & Participation Forum	Bi-Annually	Director of Nursing				✓
Infection Prevention and Control Annual Report (In Quality report)	Annually	Director of Nursing			✓	
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	✓
Blood Management Annual Report	Annually	Medical Director				
Organ Donation Annual Report	Annually	Medical Director				
Quality Assurance Framework Annual Review and Evaluation of Progress	Annually	Clinical Executives				
Commissioning Assurance Framework, Development and Implementation	Bi-Annually	Clinical Executives				
Clinical Effectiveness and Standards Committee Report	Bi-Annually	Medical Director				✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Annual Clinical Audit Plan (prior to ratification) by the Audit, Risk & Assurance Committee	Annually	Medical Director			✓	
Clinical Audit Activity Report (Local and National) Feb 23 to include Annual Clinical Audit Draft Internal Audit Report	Quarterly	Medical Director			✓	
Quality Improvement Annual Report	Annually	Director of Planning				
Research and Development Annual Report	Annually	Medical Director				
Medical Devices Annual Report	Annually	Director of Therapies & HS				
Point of Care Testing Annual Report	Annually	Director of Therapies & HS				
Quality and Safety Outcomes Report (In Quality report)	Standing Item	Clinical Executives	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓
Patient Story (In Quality report)	Standing Item	Clinical Executives	✓	✓	✓	✓
Putting Things Right Policy	Every 3-yrs (2022)	Director of Nursing				✓
Putting Things Right Reporting (complaints, compliments, and redress)	Standing Item[1]	Director of Nursing				✓

[1] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Quality & Engagement (Wales) Act, Preparedness and Implementation	Annually	Director of Nursing				✓
Patient Experience Report	Quarterly	Director of Nursing		✓		
Dementia Care Annual Report	Annually	Director of Nursing		✓		
Clinical Negligence Claims and Coroners Inquests Report	Bi-Annually	Director of Nursing				✓
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓
Covid-19 Concerns and Claims	Bi-Annually	Director of Nursing		✓		
Learning Disabilities	Annually	Director of PCCMH			✓	
Urgent and Emergency Care Demand and Impact on Outcomes	Quarterly	Director of Operations			✓	
Maternity Services: Organisational Improvement and Action Plan	Bi-Annually	Director of Nursing		✓		✓
Child and Adolescent Mental Health Crisis Hub and Safe Accommodation	Annually	Director of Nursing				
Self-Harm & Suicide - Children & Young People	Annually	Director of Nursing				
Primary Care Quality	Bi-Annually	Director of PCCMH				
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives				
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives				

[2] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓		
Internal Audit Review - Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update	Bi-Annually	Director of Primary, Community Care & Mental Health				✓
Internal Audit Review – Medical Devices – Action Plan Update	Bi-Annually	Director of Therapies & HS				✓
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓	
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing				
Inspections of the Community Health Council	Ad-hoc	Director of Nursing				
Tracking of Improvement Actions Arising from Inspections and Reviews	Quarterly	Director of Nursing		✓		✓
Healthcare Inspectorate Wales Operational Plan (In Quality report)	Annually	Director of Nursing			✓	
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing				
WRP Report and Management Response/Action Plan: National Review of Consent to examination and treatment standards in NHS Wales		Medical Director				
HIW Report/ Stroke Assurance (Requested at October A/S meeting)		Director of Therapies & HS			✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Configuration of Midwifery-led Units evaluation	Ad - Hoc	Director of Nursing				✓
Committee Self-Assessment Results		Director of Corporate Governance			✓	

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

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

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

At its meeting in July 2023, the Board approved a refreshed assessment of its strategic risks and agreed on eight high-level strategic risks with 18 sub-risks. Of the eight high-level strategic risks, the Board has delegated responsibility for focused scrutiny of three high-level strategic risks, comprising of four sub-risks to the PQSOC.

The role of the PQSOC is to ensure that the risks under its purview are effectively managed by receiving assurance of the controls in place to reduce or mitigate the level of risk to the delivery of the Health Board's strategic priorities and services.

Asesiad / Assessment

Committee Risk Register

Table 1 sets out the three high-level strategic risks compromising four sub-risks by risk level and theme.

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

Table 1

High-Level Strategic Risk	Sub Risk	Risk Level		Sub-Risk Theme
		High (8 – 12)	Extreme (15 – 25)	
SRR 003 There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.	Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care professionals.		4 X 5 = **20** Extreme	Compliance and Safey
	Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement		4 X 5 = **20** Extreme	
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.	Due to inadequate arrangements to support system-wide patient flow		3 x 4 = **12** High	Service Delivery
SRR 008 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		2 x 4 = **8** High	Transformation & Partnership Working

Following the presentation of the Health and Safety Annual Report to the Public Board on 22 November 2023, work has begun on developing risk assessments against the Health and Safety Compliance Framework to determine the level of risk being held within the Health and Safety function, as well as the impact of the potential risks on the Health Board's strategic objectives and service delivery. This will help determine whether an overarching strategic risk should be developed. This will be completed and documented as part of the next strategic oversight and assurance reporting cycle to this Committee and the Board.

Furthermore, collaboration with the Mental Health and Learning Disabilities Division is underway to review the processes in place for reporting and escalating risk through the Division. Any potential risks identified that necessitate Executive or Board intervention or oversight will be escalated and documented as part of the next strategic oversight and assurance reporting cycle to this Committee.

Corporate Risk Register

The PQSOC has been delegated responsibility for oversight of any corporate risk (significant operational risks) relevant to the agenda of the PQSOC.

Table 2 summarises the single high-level operational risk that was escalated to the Corporate Risk Register via the escalation process. Management of the risk remains where the risk is held; in the case of the risk below, Pharmacy continues to manage and update the risk, but the Executive Committee has oversight due to the potential organisational impact and the necessary investment that is required to eliminate the risk.

The full risk assessment as detailed above is attached as **Appendix C.**

Table 2

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

Work continues with risk leads to refine the controls and assurances so that the Committee can take its own assurances that all risks for which the PQSOC has delegated responsibility for are being managed effectively.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the delegated strategic risks;
- **NOTE** the delegated corporate risks; and,
- **NOTE** the ongoing work to improve risk management across the Quality and Patient Safety domain.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

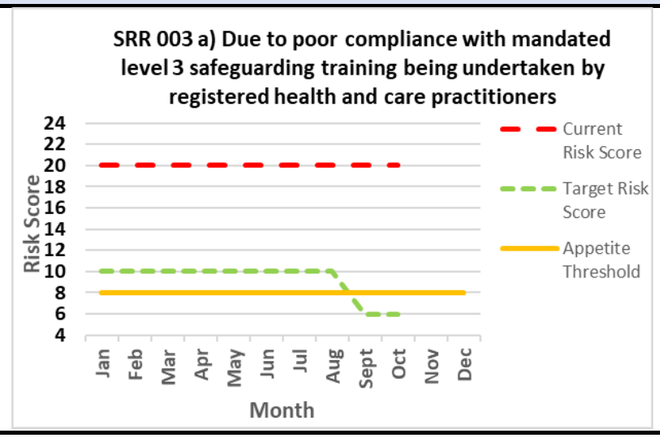
Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score		
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score
SRR 003	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Director of Nursing	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	a)Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners	•Missed safeguarding concerns, resulting in harm or death •Vulnerable individuals not identified appropriately, resulting in harm or death •Lack of staff understanding of reporting and escalation process •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Updated training packages. Training sessions booked for children and adult level three safeguarding training. Communication with practitioners, via share point intranet pages, emails to divisional nurses. Protected time to complete Level 2 and 3 training where possible. Clear mandate of level 3 training is required on ESR.	Medium	3	2	6
			Chief Operating Officer		b)Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	•Harm or injury to patients and/or staff •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.	Medium	2	2	4
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.	Medium	2	2	4

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care professionals.			
Impact	➢ Missed safeguarding concerns, resulting in harm or death. ➢ Vulnerable individuals not identified appropriately, resulting in harm or death. ➢ Lack of staff understanding of reporting and escalation process ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	15 November 2023	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*

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

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

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



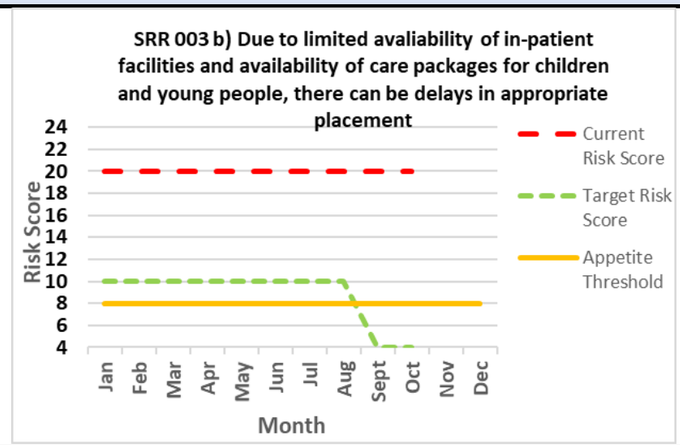
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence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

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	b) **Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.**			
Impact	➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Unlikely)*
Last Reviewed	15 November 2023	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*

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

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

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



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

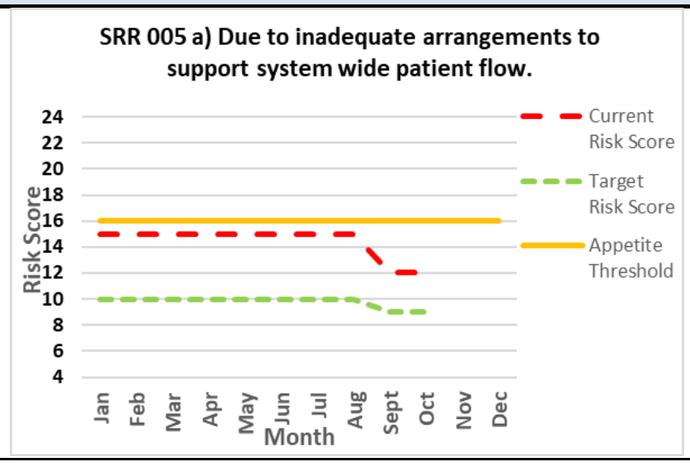
already successfully placed, supported, and transitioned several young people who may previously have required an out of county placement. • BOOST team manager in place. • Crisis Outreach Team are the designated team who manage and co-ordinate admission to the holding bed. • Standard Operational Policy in place for CAMHS teams to be able to access BOOST workers. • Agreed referral process to Windmill Farm, with a gatekeeping team comprised of CAMHS and social care colleagues who are able to advise whether or not a referral is suitable; attendance at Complex Needs panels to operationalise the gatekeeping process. • Standard operational policy and care pathway in place for admission to the holding bed. • Detailed Standard Operational Policy in place for Windmill Farm. • Regular communication meetings between CAMHS teams and the Windmill Farm team.	admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. • Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. • Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.			

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) **Due to inadequate arrangements to support system-wide patient flow**			
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3*(Minor)*
Last Reviewed	15 November 2023	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*

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

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

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. • Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: • Focus • Processing power • Capacity • Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. • Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. • Improve regional acceptance of flow processes with neighbouring Health Boards	**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 **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews**	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

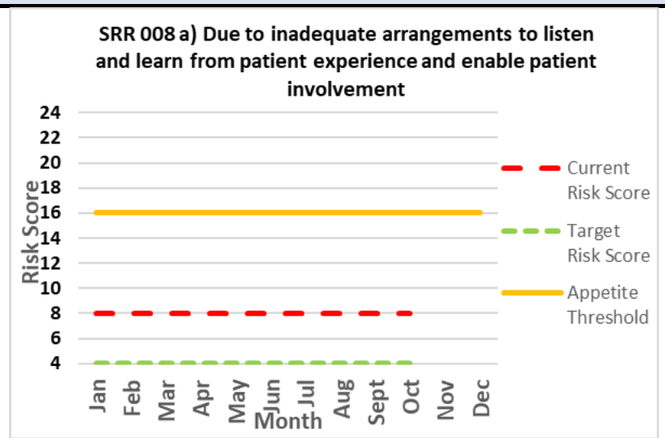
• Planned care recovery meetings with the NHS execs • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.		• Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 008)	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			
Strategic Threat	a) **Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	15 November 2023	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*

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

Risk Appetite Threshold – 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.



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

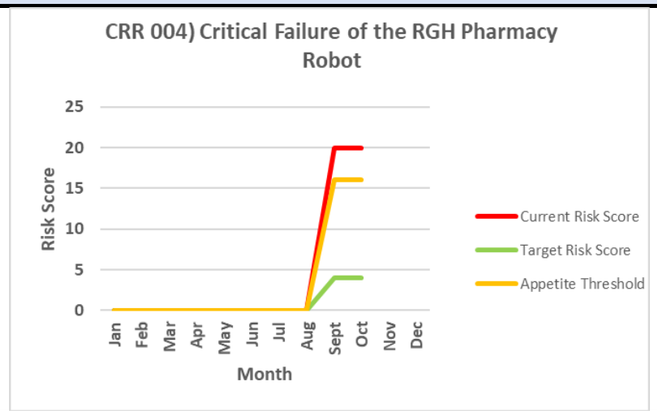
		• LLais Reports • HIW inspections	• PCC KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Implement PALS DATIX Module	

RISK THEME	Service Delivery - Critical Failure of the RGH Pharmacy Robot			
Corporate Risk (Operational) (CRR 004)	The Royal Gwent Pharmacy department is the main pharmacy hub for the Health Board's purchasing, storage, and distribution of medicines, so the site's effective operation is critical. The robot was installed in 2005 and had a 10-year estimated lifespan. This is now the UK's oldest pharmacy distribution robot still in use.			
Threat	A critical failure will result in significant disruption to the timely access of medicines across the Health Board with potential impact on patient safety and flow.			
Impact	➢ Unintended patient harm from missed doses of medicines due to the disruption in supply. ➢ Impact on patient flow through our hospitals due to the delay in supplying medicines at discharge. ➢ Reduced clinical pharmacy service at ward level to support local procurement teams at each pharmacy department, with redistribution of staff to departments with functioning robots to focus on medicines supply. A reduced clinical service will lead to a reduction in medicines reconciliation and reduction in the identification of prescribing errors leading to further patient harm. ➢ Further deterioration in staff morale leading to further vacancies.			
Lead Director	Medical Director	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	5 *(Almost Certain)* *x*	1 *(Rare)* x
Initial Date of Assessment	01 July 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	21 November 2023	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*

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

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

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



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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Patient Quality, Safety and Outcomes Committee

Performance Report

DECEMBER 2023

Overview

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

Quality and Safety Pillars

- Patient Experience and Staff Feedback, adding compliments
  - Civica implementation plan underway
  - Patient Experience and Involvement Strategy – focusing on bereavement
  - PALs team fully implemented 6.11.23
- Incident reporting and severity of harm
  - Thematic reviews and learning
  - Pressure ulcers included
  - RAMI and crude mortality updated
  - Duty of Candour update
- Complaints and concerns
  - Continue to focus on closure of historical complaints over 6-12 months
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

Urgent Care

Planned Care

Cancer

Pillars of Quality

Section 1

Good Practice and Learning from Feedback

Section 2

Medication Safety Group:

#MedSafetyWeek

- #MedSafetyWeek, is a social media campaign that takes place annually to provide a platform for Health Care Professionals to discuss and share how they can make medication safer in the areas that they work.
- Great engagement was seen across all sectors with key safety messages being shared and new Medication Safety Boards appearing across wards and clinical areas to highlight best practice.
- Themes focused on opioid use, yellow card reporting, emergency medication administration, safe storage of medication and oxygen.

Speak Up for Safety:
Rules for Reporting Medication Safety Incidents in NHS Wales

Medication safety incidents include:

- **Adverse drug reactions** – a response to a medicine that is noxious and unintended
- **Errors** - an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred

If a medication safety incident is suspected – **Speak Up for Safety**:

Raise the alarm:	**See it** – Be vigilant. **Say it** – Speak up on identifying or suspecting an incident. **Sort it** – Act immediately to aid the patient & remedy the situation. **Share it** – Report once all immediate corrective action is undertaken
Three "Cs" of reporting	**Collect** - all the information to complete the report beforehand. What happened and medication involved? Who was involved and/or informed? When? Where? Action taken? **Check** – all the required information is accessible before reporting **Complete** – incident reports using the risk management system (e.g. Datix) and/or MHRA Yellow Card Scheme for adverse drug reactions.
Write FAB reports	**Factual** **Accurate** **Brief**
SIMple reporting	**S**cenario and **S**ymptoms **I**dentifier (those involved e.g. patient, staff etc.) **M**edication details (name, form, strength, route, dose, frequency of all medicines involved)
Report to learn!	Report factors that may have contributed to the incident such as: Organisational issues – structure, policies, culture Work environment – workload, skill mix, shift pattern, equipment Team – supervision, communication (verbal and/or written) Staff – knowledge, skills, experience, health Task – design, clarity and availability of protocols Patient – clinical condition, communication and social issues

Speak up for safety.
Reporting is FAB and SIMple.
Don't delay! Report today!

FAB & SIMple Incident Report and Yellow Card

Factual Accurate Brief

Report to learn!

*Please **Describe** the incident

The patient developed a rash, facial swelling and increased difficulty breathing after a nurse administered Tazocin 4.5g intravenous infusion prescribed by a FY1 doctor for the treatment of pneumonia. The allergy section of the drug chart had not been completed. The crash team was called and the patient was treated for anaphylaxis, intubated and transferred to ITU.

The admissions unit was very busy. The patient had been admitted to hospital by ambulance after collapsing at a local shop. The unaccompanied patient was seriously unwell and acutely confused. The prescribing doctor was newly qualified and had just started working on the assessment unit. Recognising the need to urgently treat the patient's sepsis, the doctor prescribed Tazocin as per antimicrobial guidelines. Owing to the patient's acute confusion, allergy status was not confirmed prior to administering the medication by the doctor or the administering nurse.

Scenario/ Symptom Identifier Medication

REPORT OF SUSPECTED ADVERSE DRUG REACTIONS
COMMISSION ON HUMAN MEDICINES (CHM)
It's easy to report online: mhra.gov.uk/yellowcard or via the app

Yellow Card
Making medicines safer

SUSPECTED REACTIONS(S)
Please describe the reaction(s) and any treatment given:

The patient developed a rash, facial swelling and increased difficulty breathing after a nurse administered Tazocin 4.5g intravenous infusion prescribed by a FY1 doctor for the treatment of pneumonia. The allergy section of the drug chart had not been completed. The crash team was called and the patient was treated for anaphylaxis, intubated and transferred to ITU.

Produced by the All Wales Medicines Safety Network September 2019

ERASE

To be displayed in staff areas only

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

EVENT

Safety Incidents Have Occurred Where A Full Allergy History Has Not Been Documented On The Prescription Chart Or In The Initial Clerking Proformas Leading To The Prescription And Administration Of Such Medications.

OUTCOME

Failure To Prescribe Safely Can Result In The Patient Suffering An Anaphylactic Reaction And Detrimental Effects.

LEARNING

- **ALWAYS** ensure the Allergy box section on the prescription chart and in the clerking documentation is completed, signed and dated prior to administration of medicines.
- When an allergy is recorded, document as much information as possible regarding the details of allergy or reaction. Medication should not be administered if this section is not completed - refer back to the prescriber immediately to avoid doses being delayed or omitted.
- **ALWAYS** check allergy status with NOK/Carers if patient cannot / unable to confirm their allergy status.
- In exceptional circumstances, if unable to ascertain allergy status, this must be documented, signed and dated in the allergy box and the medical notes.
- Remember a medication may contain multiple active drug ingredients - **ALWAYS** check before administration.
- Remember to update the box should any new reactions occur.

Refer to: All Wales Prescription Writing Standards (nhs.wales)

Educating & Recommendations After Significant Event's

ERASE

LEARNING FROM INCIDENTS

When reviewing incidents that are recorded via Datix, or during an investigation for serious incidents, an action plan is developed. Part of the investigation also ensures themes for learning and improvements are identified.

With incidents involving heparin prescribing and administration, as part of a safety investigation the old heparin chart was reviewed and discussions were held with clinicians and practitioners. This looked at how to improve the quality of prescribing, administration and monitoring of heparin. This will support the safer prescribing of a high risk medicine.

This led to the development of the new heparin chart, which should be used to prescribe and monitor the dosing of heparin. There is additional information in the Policy, which was also updated.

The links can be found here:

Heparin Chart

Guidance for Management of Patients on Unfractionated and Low Molecular Weight Heparins.

Low Molecular Weight Heparins Chart

ERASE

To be displayed in staff areas only

Medication prescription and administration

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

EVENT

Following a recent Serious Incident and feedback from patients/relatives it has become necessary to raise awareness of the correct procedure for prescription and administration of medication within ward settings.
In particular:-

- Medication charts incorrectly filled in and accurate patient weights not recorded.
- Medication being left at the patient's bedside and therefore no observation of them taking it
- Additional assessments and reviews following any concerns around the patient's ability to swallow

OUTCOME

- Professional registration put at risk due to incomplete and inaccurate documentation.
- Patients may suffer unintentional overdose/below recommended dose due to their weight being outside of prescribed medication guidelines.
- Patient may not receive their medication which could negatively impact their illness and length of stay in hospital.
- Patient may choke on inappropriate medication if there are concerns around swallowing ability.

LEARNING

- Medication charts are all legal documents and should adhere to ABUHB policy Clinical Record Keeping.pdf
- Medication must be prescribed using an accurate patient's weight, signed, dated and timed as detailed in ABUHB Medicines Management policy. Medicines Management Policy.PDF
- When signing a medication chart for oral medication you are signing that you have observed the patient taking the medication. It is health board policy as well as NMC guidelines that the patient must be observed in taking the medication.
- Medication requiring 2 person signing MUST be dispensed and signed for by 2 relevant professionals witnessing the administration of the medication.
- If there are concerns around a patient's ability to swallow medication consider the need for a SALT assessment, discuss with the patient's doctor and also consider a pharmacy review of the patient's medications

Educating & Recommendations After Significant Event's

ERASE

April 2023

ERASE

Management of Diabetes Insipidus

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

To be displayed in staff areas only

EVENT

Desmopressin (DDAVP), a medication used to treat Diabetes Insipidus, not administered as prescribed on the Inpatient Medication Administration Record

OUTCOME

For patients requiring Desmopressin, non administration has the potential to lead to;

- **Further clinical deterioration in blood chemistry**
- **Potential admission to the Critical Care Unit**
- **Death**

LEARNING

- **All patients with a history of Diabetes Insipidus should be referred to the Endocrine Team. This includes elective admissions for procedures and those requiring surgery.**
- **NEVER withhold Desmopressin if the patient is a confirmed Diabetes Insipidus unless there is clinically significant hyponatremia. URGENTLY SEEK ENDOCRINOLOGY ADVICE**
- **Always allow free access to fluids orally or intravenously.**
- **When code 5 (unavailable) is entered onto the Inpatient Medication Administration Record, it is the responsibility of the healthcare professional to escalate to pharmacy. This is to obtain Desmopressin in working hours as a matter of urgency, to prevent a delay in administration.**
- **Medical & Nursing Teams should know how to obtain Desmopressin when required out of hours. Escalate to the site manager as Desmopressin is stored in the emergency cupboard at GUH, RGH and NHH.**
- **If Pharmacy assistance required OUT OF HOURS, this needs to be undertaken through bed management or the site practitioner.**

Further Information & Resources available at:

Policies Home Site - Reducing Harm from Omitted and Delayed Medicines in Hospital - Critical Medicines List_Issue.pdf - All Staff Documents (sharepoint.com

https://www.endocrinology.org/diabetes-insipidus

OCTOBER 2023

Educating & Recommendations After Significant Event's

ERASE

ERASE

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

EVENT

A palliative patient was prescribed midazolam at two different doses for two different indications.
The prescriptions were clearly documented:

- Midazolam 2.5mg SC for terminal agitation
- Midazolam 10mg SC for seizure management (known epileptic)

The 2.5mg prescription was crossed off in error and 10mgs of midazolam intended for seizure management was administered for terminal agitation on three occasions.

OUTCOME

The patient was benzodiazepine naïve, therefore the high doses resulted in unplanned somnolence and drowsiness.

This incident highlights the potential for severe harm when:

- Discontinuing medication with more than one indication.
- Administering medication for an indication which differs from the prescription and intended use.

LEARNING

Prescribers, Pharmacy and Nursing Teams to ensure:

- Prescriptions are legible and clearly document indication for use. Where possible prescribe them next to each other.
- Differences in dose, route and indication for prescriptions for the same drug are clearly highlighted on the medication chart e.g. with an * or highlighter and are identified to staff at ward safety briefing.
- Reason for discontinuing a medication is clearly documented in the medical notes.
- Administration of a medicine must only ever be given for the indication documented and not for any other indication.

Educating & Recommendations After Significant Event's

ERASE

How to obtain a supply of medication for your patient

Action 1

Is there a supply of patients own drug (POD) available?

Yes - assess suitability for use (as per induction training) and store in bedside locker
No - ask if own supply can be brought in

Patients often use the green medicines bag to bring their medication in to hospital. Check, with permission, in their belongings

Action 2

Has the patient's medicines been transferred from the previous bed, ward or site?

Action 3

Is the medication stock on the ward?

Omnicell ~ Omnicell Explorer ~WOREQ 2

User guides can be located on SharePoint Pharmacy > Pharmacy Services > Omnicell

Action 4

Has the pharmacy team seen the chart?

The pharmacy supply box on the medication chart will be annotated to indicate where the medication can be found. Examples:
OP - original pack ordered and dated
S - stock item
Fridge - fridge item
CD - controlled drug
POD - patients own drugs assessed, counted and dated

Please look for these items in the locker, treatment room, fridge, CD cupboard, previous bed, before you contact the pharmacy team

Drug is still not available?

Yes

URGENT
Drugs that should not be missed include antibiotics, insulin, immunosuppressants, anti-epileptics and Parkinson's medicines.

These are critical medicines.

Take immediate action for urgent supply.

Would missing a dose compromise the patients treatment?

Refer to the Critical Medicines List (1) for guidance.
Discuss with a team doctor or pharmacist if unsure.

No

NON-URGENT
Document decision in medical notes any action taken to obtain supply.

Document the reason for omission on the back of the prescription chart using relevant code e.g. 5 - medication unavailable and organise a timely supply

Contact pharmacy for supply

During pharmacy open hours

Inform ward pharmacy team during their visit or through bleep or vocera.
Pharmacy team numbers are available on the ward.
Contact pharmacy dispensary if no answer.

Out of hours

- Can the medicine be obtained from another ward or location? Check:
  - Omnicell explorer/ WOREQ 2
  - Emergency cupboard list on intranet
- Can the drug be obtained from the emergency Omnicell or emergency cupboard? Contact bed management or site practitioner who can access these.
- Medical team and on-call pharmacists can be contacted by bed management. Please provide the following information: name of drug, dose, form, indication, quantity needed, time of last dose and time next dose is due. A decision on whether or not to supply will be made.

References

1 Reducing harm from Omitted and Delayed medicines in Hospital - Critical Medicines List

Produced by Pharmacy Department ABUHB, October 2022

Have you got the right opioid?

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

#MedSafetyWeek2023

Have you checked?

- Right **DRUG**
- Right **FORMULATION**
- Right **STRENGTH**
- Right **DOSE**
- Right **ROUTE**
- Right **PATIENT**

	MORPHINE	OXYCODONE
MODIFIED RELEASE Background analgesia	MR capsules: 10mg 30mg 60mg 100mg 200mg	MR tablets: Longtec 5mg 10mg 15mg 20mg 30mg 40mg 60mg 80mg 120mg
Regular dosing	MR tablets: MST Continus 30mg — 5mg 10mg 15mg 30mg 60mg 100mg 200mg	MR tablets: OxyContin 5mg 10mg 15mg 20mg 30mg 40mg 60mg 80mg 120mg
IMMEDIATE RELEASE Breakthrough analgesia	IR tablets: Sevredol 10mg 10mg 20mg 50mg	IR capsules: Shortec 5mg 10mg 20mg
When required dosing	IR liquid: 10mg/5mL oral solution = 2mg/mL	IR liquid: 5mg/5mL oral solution = 1mg/mL

Yellow Card

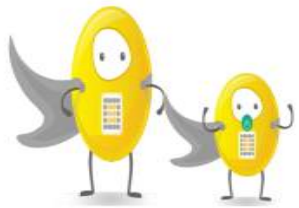
Making medicines safer

Could your patient have experienced an adverse drug reaction?
Did you know you can help make medicines safer by reporting it to the Yellow Card Scheme?

Submitting a Yellow Card is as easy as A. B. C.

Any adverse drug reaction or side effect you or your patient might have experienced?
Brief description of Medication, Reaction and Patient Identifier
Complete and submit form via the YC App

Reporting is FAB!!! (Factual – Accurate – Brief)
Don't delay and report today!!!



Hand in hand in protecting Public Health..... Making medicines safer through regular reporting

Equality, Diversity and Inclusion

ILS Internships Nevill Hall Hospital

- Supporting people with learning disabilities **additional needs** to gain work experience.
- The **Engage to Change Gwent** supported internships take place over the course of an academic year, giving students time to develop their **skills** over a longer period and prepare them for the world of work.
- Commenced in 2021, we are now in **year 3** of the Internships at Neville Hall Hospital and are in discussions to roll out to other hospitals in the future.

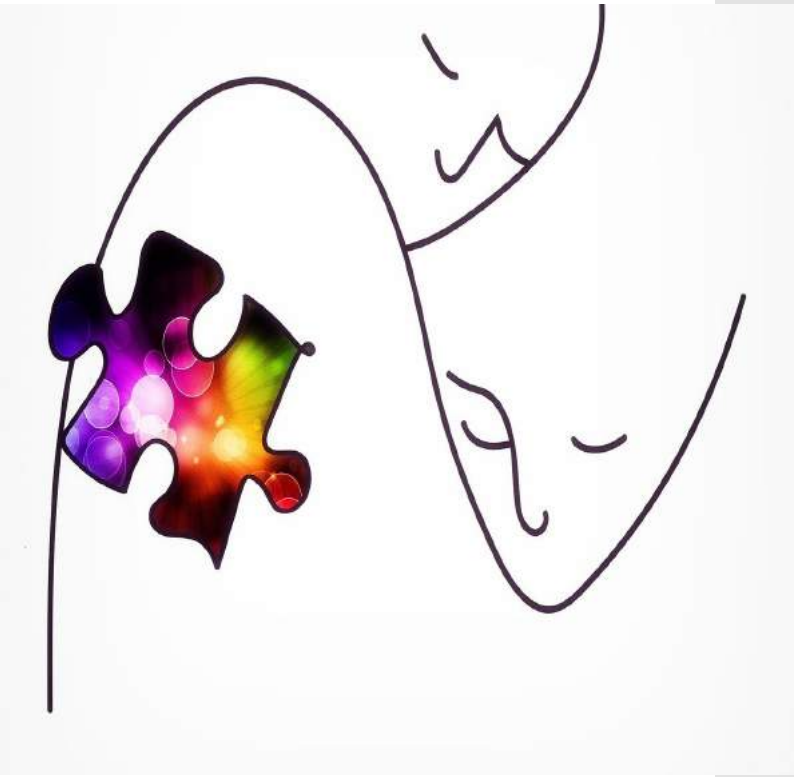
Equality, Diversity and Inclusion:

Case Study

A is a 32-year-old lady with **Asperger's.** She has gained a **Diploma** in Business Administration. She has difficulty in managing telephone discussions (her only barrier) and despite her qualification, her work coach advised that she needed to '**rethink'** her career choice as she would 'have to' use the telephone.

Her mother contacted the Patient Experience Team to ask if there was any opportunity for her to gain **work experience**.

The Project Manager met with A, assessed her sensitivities to the office environment (visual impairments), made **reasonable adjustments** and arranged a work experience placement.



Equality, Diversity and Inclusion:

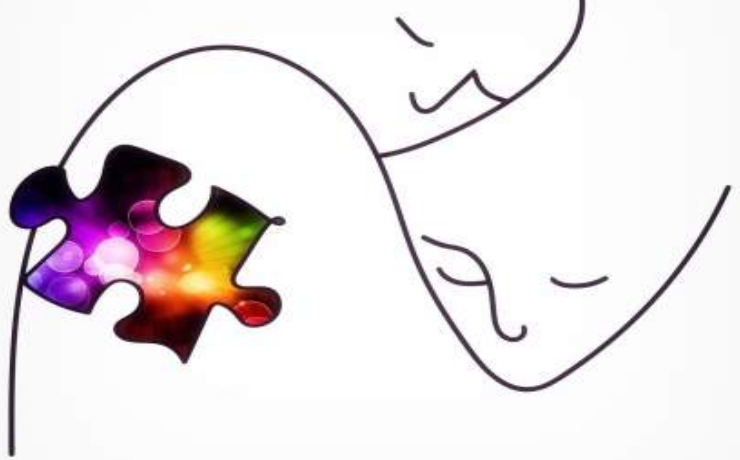
Positive Outcomes

The Project Manger met with A, assessed her needs, including potential **sensory overload** to noise, light, smell and general physical environment. **Reasonable adjustments** were made, and arrangements put in place for her to commence a work experience placement.

A started with the Team July 2023. Her duties include:

- **Data** entry
- Patient Information **Packs**
- **Volunteer** and Patient Education Packs
- Maintenance of **promotional materials**
- Supports Volunteer **rotas**

A. has managed well in the work environment with reasonable adjustments and is now being supported with completing application forms for **paid employment** in the Health Board.



Feedback from A and her Mother

Unfortunately, A. has had a recent hospital admission and is currently recovering. Her mum has messaged the Project Manager to update on A's recovery and said:

We were talking about work last night and she is missing you all VERY much! Work experience with you and your department has been such a positive experience for Axxx. She doesn't want it to end!

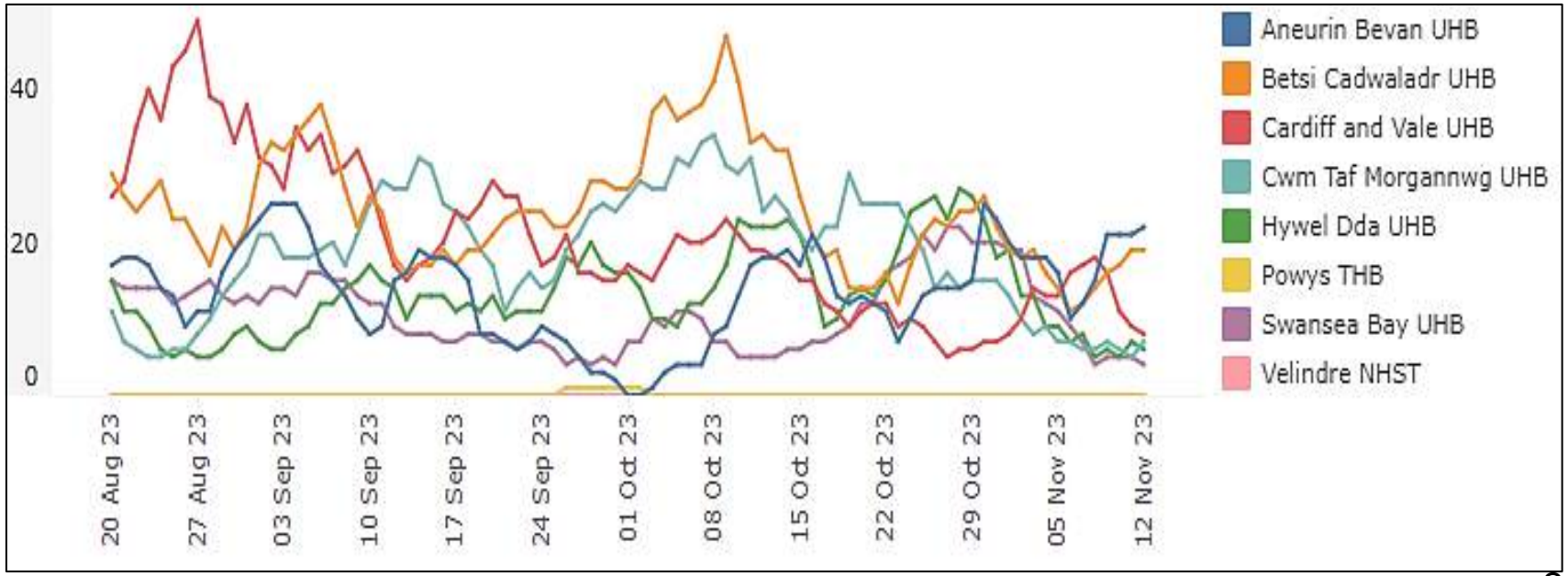
IPAC

Welsh Government targets

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

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	35.17	0.86	17.73	57.75	23.73	3.43
Betsi Cadwaladr UHB	39.63	0.97	22.13	78.05	22.37	6.32
Cardiff and Vale UHB	23.05	2.37	29.15	66.78	24.41	5.09
Cwm Taf Morgannwg UHB	30.42	1.9	31.94	90.87	26.61	4.56
Hywel Dda UHB	45.64	3.07	25.01	106.64	25.45	8.34
Powys THB	18	0	0	2.57	0	0
Swansea Bay UHB	56.87	2.62	35	69.56	24.06	6.12
Velindre NHST						
Wales	36.91	1.78	24.82	73.76	23.47	5.29

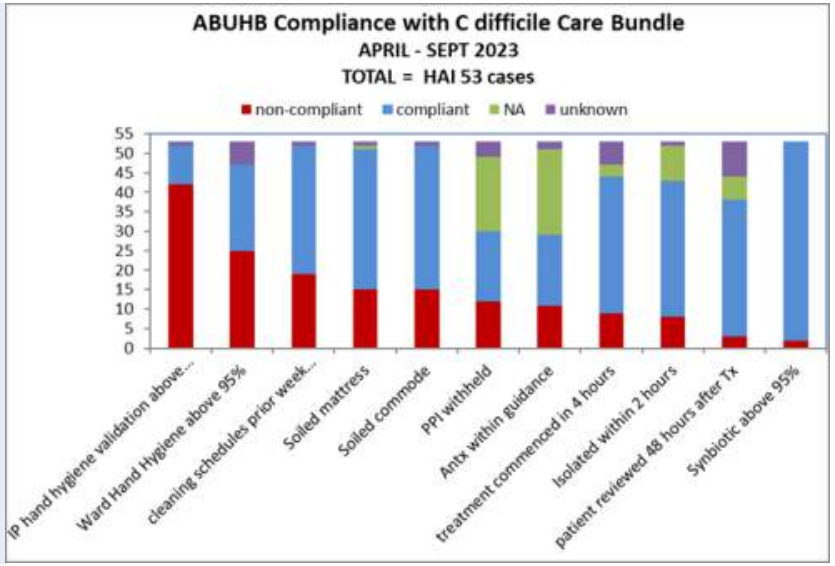
Hospital Acquired Covid



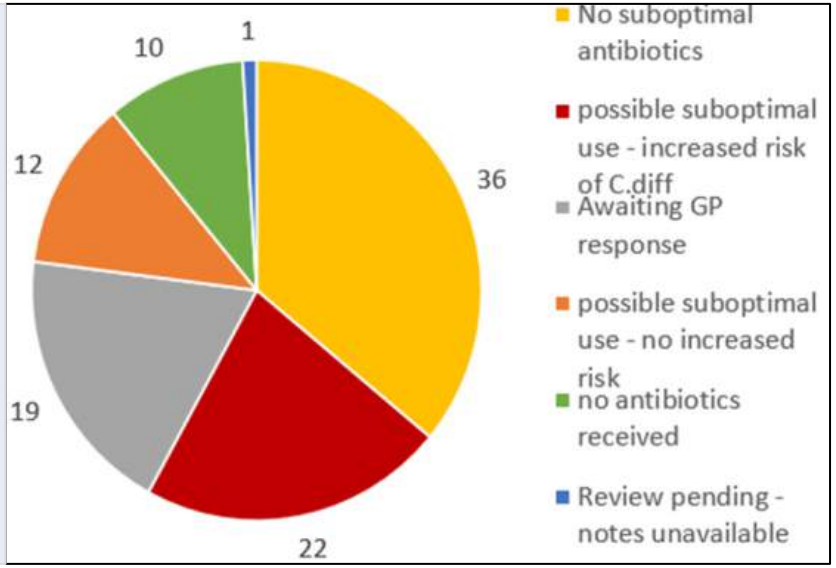
IPAC

HB rate of 35.7 per 100,000 population for C difficile

- Health Board above Welsh Government trajectory of 25 per 100,000



- Themes following RCA reviews:



IPAC

National Reportable Incidents & Significant Incidents

Issue	Cause	Remedial Action	Who	When
8 ward closures due to Covid-19 infection	Correct use of appropriate PPE Visitors attending with symptoms Shared facilities Limited isolation facilities	• Patients to wear masks whilst mobilising & using toilet. • Encouraged ventilation throughout the ward. • Cleaning with Actichlor solution 1000ppm focusing on frequently touched points • Minimised staff transfer between wards • Implemented Step down guidance for positive patients • Visiting restricted & visitors informed they were visiting an area with known Covid • Reviewed Covid safety measures	Ward Managers Senior Nurses Facilities Infection Prevention Team	Immediately
Death associated with C difficile infection	• Suboptimal antibiotic prescribing • Delay with sample processing • limited documentation relating to wound assessment despite patient having antibiotic treatment	• Timely treatment review • Improve documentation	Clinical Team and Antimicrobial pharmacist	Ongoing
Increase in Caesarean section infection	• Over reporting • High BMI	Task & Finish Group established & action plan developed Deep dive into 20% of cases reported to establish themes	Family & Therapies	Aug 2023 ongoing
TB exposure	• Failure to isolate index case	• Contacts identified, but due to minimal respiratory symptoms, no further follow up required	Medicine	Completed October 2023
General increase with C difficile infection	• Suboptimal antibiotic prescribing • Lapse with fundamental IP measures • Prompt isolation	• Antimicrobial and infection prevention education for new Drs • Promote antibiotic guidelines App • Promote SIGHT • Ward based staff education • Implemented cubicle assessment at RGH • Reviewed mattress checking	Antimicrobial pharmacist IPT Facilities	Ongoing

IPAC

Decontamination

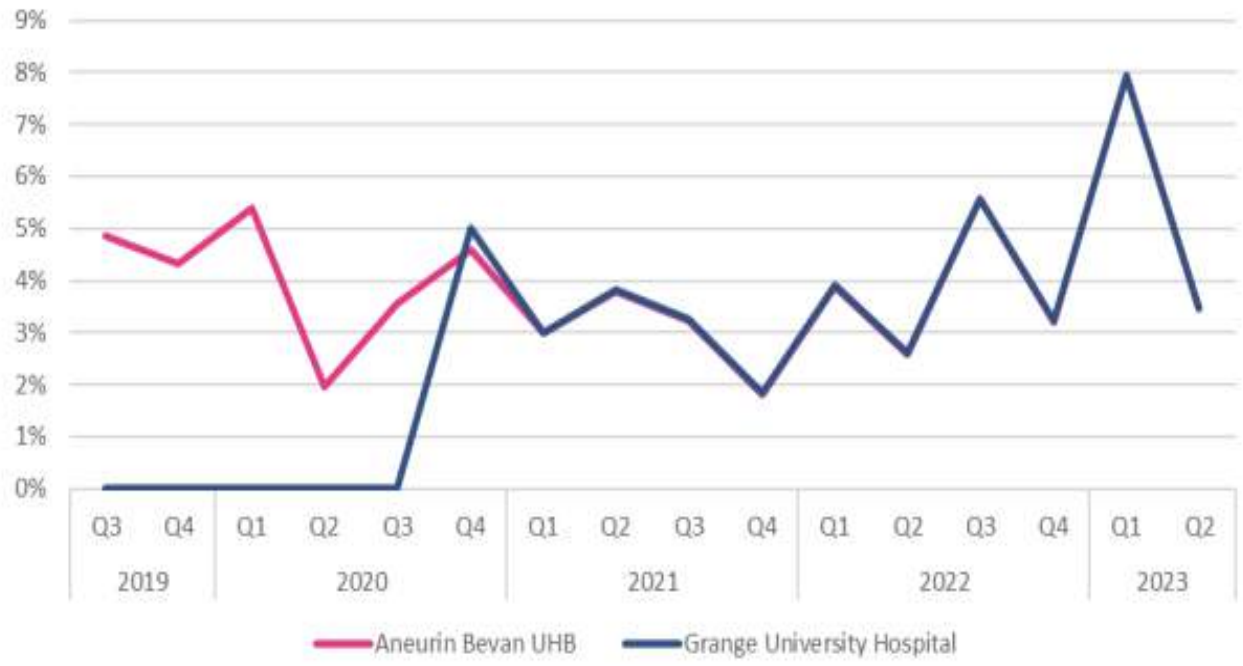
Issue	Cause	Remedial Action	Who	When
Community Dental Service washers and autoclaves have not been serviced / tested for at least 6 months	Lack of works and estates trained staff to undertake the role and their focus on other decontamination testing e.g. HSDU	Conversation with the All Wales Authorised Engineer (Decontamination) AE(D) for awareness. Undertake annual testing in December with already purchased kit.	Works and estates trained staff	December 2023
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D)	Identified issues showing little progress since previous year audits, including works and estates input, electronic track & trace (IT), report governance.	Updated action plan by Directorate stipulating responsibilities and must dos.	Directorate manager / nursing Decontamination manager Authorised Person (D) IPT	December – immediate April for financial & IT aspects
Delay in HSDU taking over the decontamination of endoscopy scopes at the Royal Gwent Hospital. Continued use of some endoscopy directorate staff as trained on the Wassenburg endoscope washers disinfectors (EWD)	Delay in receiving the interim portacabin decontamination facility from Torbay. Further delay with asbestos found in electrical board.	HSDU staff trained and undertaking manual wash but endoscopy trained staff operate the Wassenburg EWDs. Asbestos issue being addressed by works. Interim building in use New Year	HSDU Works Nov / Dec 2023	Jan 2024
AP(D) role not fully functioning from a governance aspect	Lack of AP(D)s and decontamination trained staff.	Decontamination manager continues to support AP(D)with joint report review and submission	AP(D) Decontamination manager	Ongoing Review March 2024

Maternity SSI Rates

Rates

This section contains a summary of SSI rates, including quarterly rates, overall SSI rates and infection types for the year.

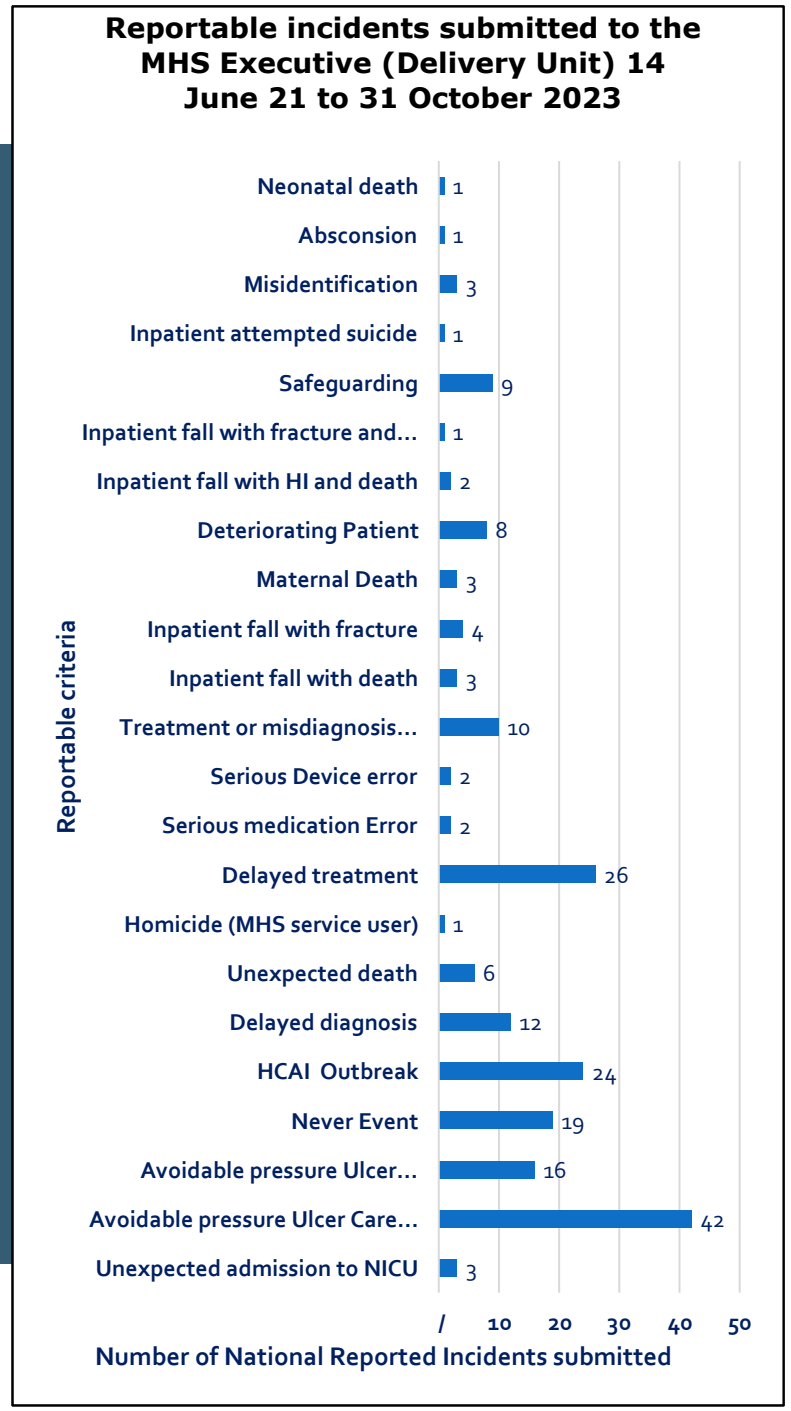
Quarterly rates



Action for Service

- Deliver SSI update and ensure mandatory training is completed.
- Patient information and education to be promoted to encourage hand hygiene in light of E.Coli being the prominent infection noted.
- Healthier together review to be undertaken.
- Data share with primary care/QPS.
- Develop a c-section SoP based on NICE guidance.
- Deep dive to be undertaken to identify potential source of increased infection rates to include a review of data and rates in line with locality.
- Theatre observation audit to be conducted to identify any poor practice.
- IPC review of Quarter 1 data has demonstrated potential over reporting of SSI's – discussion with PHW to ratify and potential retrospectively amend % data.

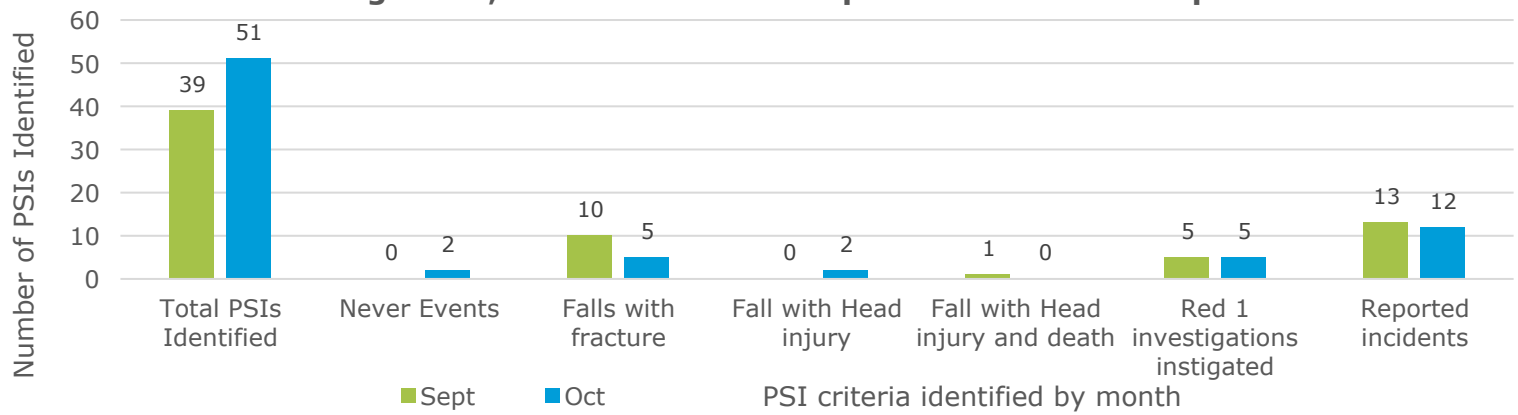
National Reportable Incidents



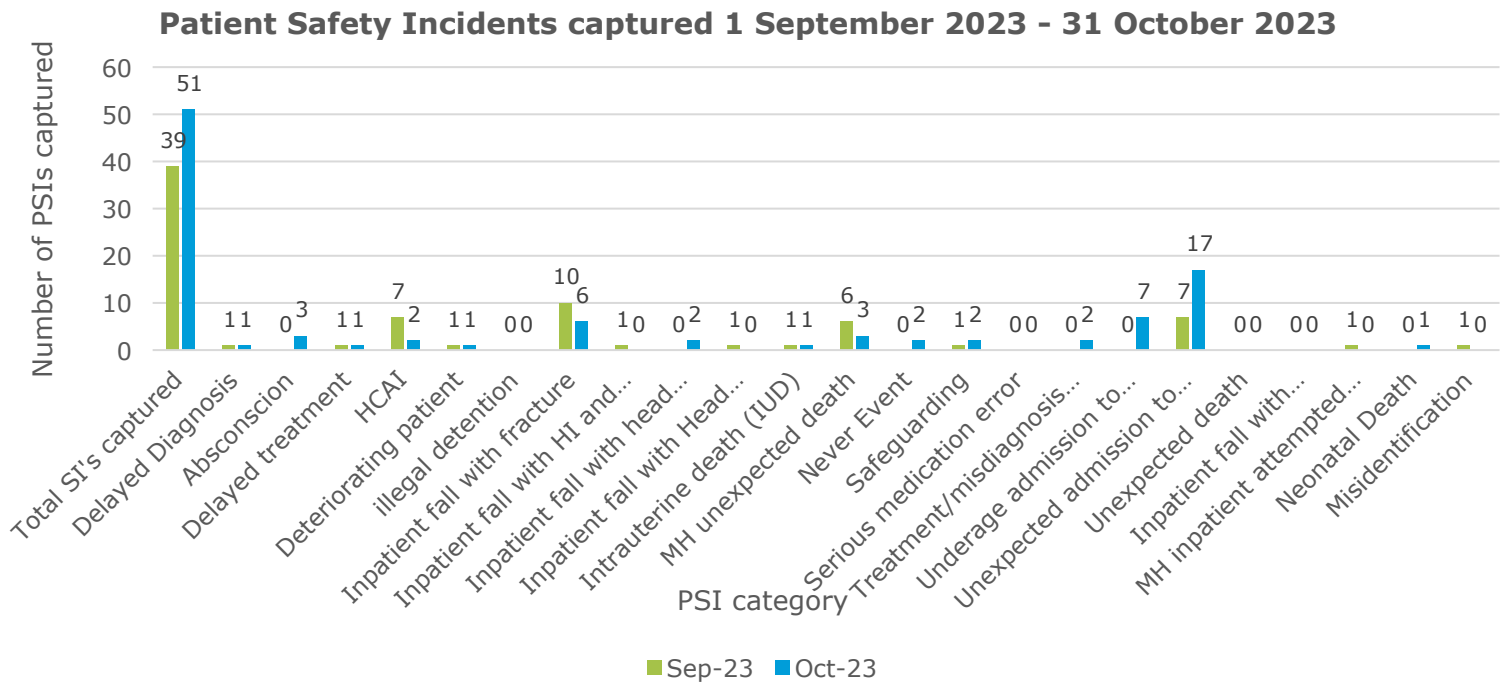
- The Health Board saw a decrease in NRI'S reported during this reporting period
- 13 incidents were reported in September, with 12 being reported during October
- There were no particular themes. However, two Never Events were reported during October. One retained foreign object in Obstetrics and one wrong site surgery within Dermatology.

Learning from NRIs	Improvement
An elderly patient was admitted to hospital with right hip pain. She was unable to weight bear and had no history of injury to her hip. An MRI scan identified a partial tear of the tendon. The patient's renal function was abnormal and was admitted under the medical team. The patient was subject to multiple site moves and became drowsy with low oxygen levels. An acute kidney injury (AKI) from dehydration secondary to vomiting and inadequate oral intake with opiate excess was identified. The patient was found by staff to be choking on their food and went into cardiac arrest but CPR was unsuccessful.	Codeine and morphine while not contraindicated in a patient with decreased kidney function, but may however accumulate when kidney function is abnormal. There can be obscured lines of responsibility and accountability in patient care when patients are under one specialty on CWS and under another on a ward. This results in the responsible team not being aware of the patients they must review. Review of watchlists to include high risk, vulnerable patients located on buddy ward. Pharmacy reviews of contraindications tightened.
There was a delay in the diagnosis of an ectopic pregnancy, and as a result, the lady required an emergency laparotomy for a ruptured ectopic pregnancy and left salpingectomy. During the first ultrasound scan there was no evidence of a gestational sac. Report suggestive of retained products of conception. It did not comment on the fallopian tubes. If an ongoing pregnancy had been diagnosed, on the balance of probability, lady would have been offered a repeat USS in 2 weeks as per ABUHB guidelines. Earlier senior input into management and care could have changed the outcome.	Development of a robust pathway for the follow up of all the patients with early pregnancy issues on conservative and medical management. The plan of management to be reviewed and updated every day by the consultant in charge of emergency gynaecology stream. Regular teaching on Emergency Pregnancy Assessment Unit (EPAU) pathways implemented. If there is a pregnancy of unknown location on ultrasound scan (USS), the clinical plan should be discussed with a consultant gynaecologist for appropriate input. Patients with a presentation of acute onset abdominal pain with a positive pregnancy test are to be admitted under the gynaecology team, unless a specific surgical diagnosis is made.

Patient Safety Incidents



A total of 90 serious incidents were identified during September and October, 39 and 51 respectivly.MH Unexpected Death, Unexpected Admission to NICU and Inpatient fall with # were the top themes.



Early Warning Notifications

There were 16 EWN reported to WG during this period, 6 in September and 10 during October. Themes were varied but predominately they related to absconsion and Safeguarding issues.

Missed Fractures

Emergency Department have undertaken a thematic review of missed fractures, the second meeting is scheduled for the 5 December 2023.

Anticoagulation Incidents

A thematic review is being undertaken relating to anticoagulation incidents. These are being overseen by the Assistant Director Quality and Patient Safety via the Medicines Safety Group.

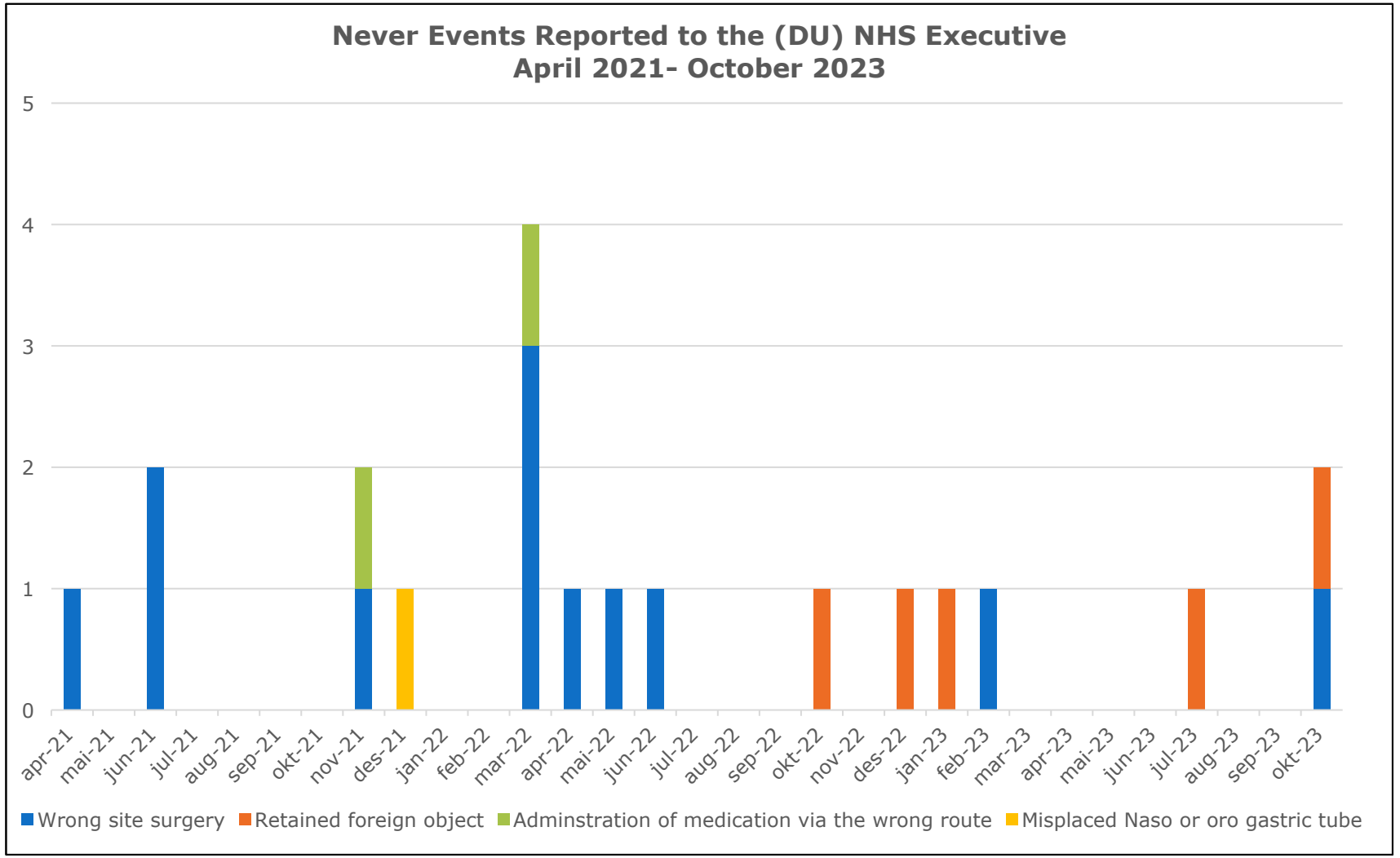
Update: Missed Cancers

A lookback involving 800 respiratory patients has been ongoing in relation to 'delay to follow up /treatment' . This has identified 2 patients where harm has occurred. Both are being investigated through the Corporate Incident process.

Review of Patient Safety Incident Process

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

Never Events



- There had only been 1 Never Event reported during Q1 and Q2– a retained swab, but unfortunately a further 2 were reported during October 2023; wrong site surgery and a retained swab.
- A report will be presented outlining the Improvement Programme for Theatres. It will encompass, a summary of incidents, themes, the Human Factors programme and a plan for the subsequent 12 months.

Duty of Candour

Overview of the Health Board performance against the requirements

Incident Affecting Patients

Since 1 April 2023 there have been **14,941** incidents affecting patients reported on the Datix Cymru system.

As at 16 November 2023 there were **1,193** incidents whereby the field '***Following the Initial/Management review, what level of adverse outcome was considered?***' has not been completed.

The table on the next slide highlights the incidents by Division/Service and incident date that have not completed the initial/management review.

Division / Service	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Total
Primary Care & Community Division	27	25	41	31	46	67	111	98	**446**
Medicine	11	15	36	38	32	32	110	73	**347**
F&T	2	0	1	0	2	30	94	52	**181**
Scheduled Surgical & Critical Care	0	1	1	9	4	12	8	34	**69**
Complex & Long Term Care	4	3	5	9	6	6	12	3	**48**
Estates & Facilities	3	0	1	2	4	5	3	6	**24**
Clinical Support Services	0	0	0	0	1	6	12	5	**24**
Nursing Director	4	1	1	3	4	5	3	1	**22**
Mental Health & Learning Disabilities	1	0	1	1	0	0	0	7	**10**
Director of Public Health	0	0	0	0	0	1	2	3	**6**
Planning, Performance & ICT	2	0	0	0	0	1	1	1	**5**
Urgent Care	0	0	0	0	0	0	1	4	**5**
Workforce & OD	0	0	1	0	1	0	0	0	**2**
Medical Director	0	0	0	0	0	1	0	1	**2**
Chief Executive / Non Executive	0	0	0	0	0	0	1	1	**2**
Total	**54**	**45**	**88**	**93**	**100**	**166**	**358**	**289**	**1193**

Duty of Candour Triggers

Since 1 April 2023 there have been **102** incidents that have triggered the Duty of Candour. *This figure is based on the initial/management review field recorded as Moderate or above.*

Division / Serivce	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Total
Primary Care & Community Division	6	4	1	3	1	3	4	1	**23**
Medicine	4	4	2	2	1	2	3	3	**21**
Scheduled Surgical & Critical Care	3	1	3	5	2	1	1	0	**16**
F&T	2	3	3	1	1	0	1	1	**12**
Mental Health & Learning Disabilities	2	1	1	0	0	3	1	1	**9**
Urgent Care	0	1	0	3	1	1	2	0	**8**
Complex & Long Term Care	1	0	1	1	1	1	0	0	**5**
Clinical Support Services	1	0	0	3	1	0	0	0	**5**
Planning, Performance & ICT	1	0	0	0	0	0	0	0	**1**
Estates & Facilities	0	0	0	0	0	1	0	0	**1**
Nursing Director	0	0	0	0	0	0	0	1	**1**
Total	**20**	**14**	**11**	**18**	**8**	**12**	**12**	**7**	**102**

- The field within Datix '**Date NHS Body first became aware that DoC was triggered**' has been populated 228 times.
  - 25 of these incidents relate to no harm and 109 relate to low harm. This highlights that users are retrospectively changing the initial/management review.
- Of the **102** incidents triggering the duty **83 (81%)** have conducted the 'in person' initial notification.
  - **11** records highlight that the date of 'in person' initial notification occurred prior to the Health Board becoming aware that DoC was triggered. **This needs validation**.
  - **69 (83%)** of the 'in person' initial notifications were carried out within 30 working days. **2 incidents** were significantly more than this target.

Duty of Candour Triggers

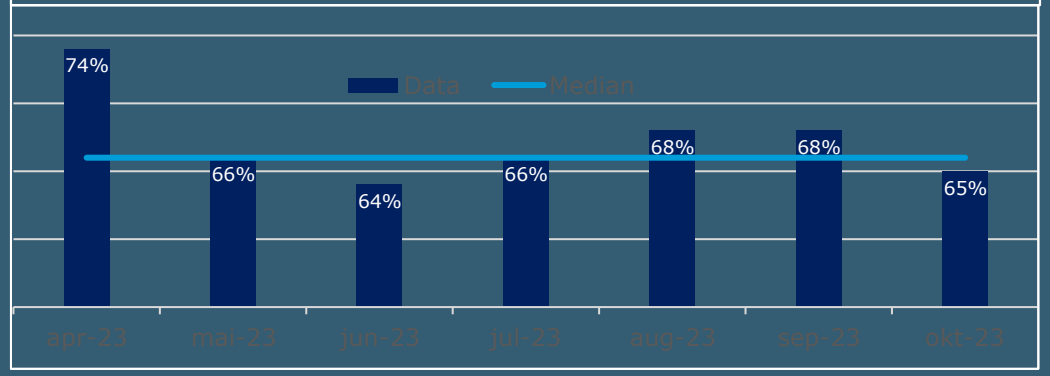
- **65 records** highlight that a date of written notification has been sent.
  - **22 (34%)** of the written notifications were sent five or more days following the 'in person' initial notification
- There are currently **84 incidents** that have not completed the final response. **54** of these are where the Health Board became aware that the DoC had triggered prior to October 2023.
- Finally, there are currently **78 incidents** where the field '*Severity of Incident Post Investigation*' has been recorded as **Moderate or above**, however, the field '*Following the Initial/Management review, what level of adverse outcome was considered?*' is recorded as no or low harm.
- These incidents will need review to identify whether the duty of candour should be triggered.

Duty of Candour Next Steps

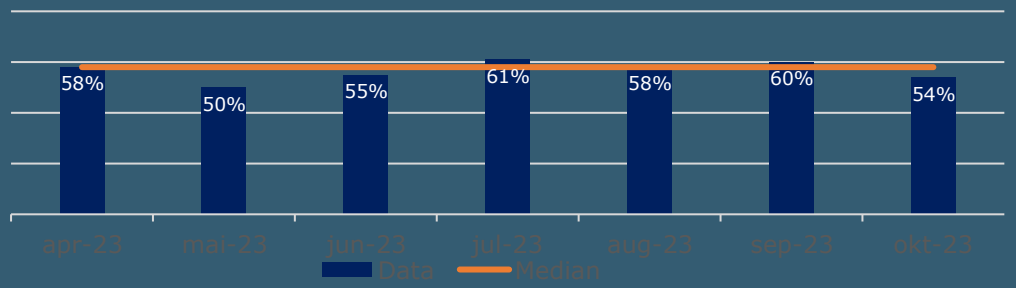
- Divisions to review the backlog of incidents where the field '*Following the Initial/ Management review, what level of adverse outcome was considered?*' has not been completed.
- Divisions to review the current position with the incidents that are triggering the duty of candour and progress as appropriate.
- Divisions to review the incidents whereby the severity of incident post investigation potentially triggers the duty of candour.

Complaints

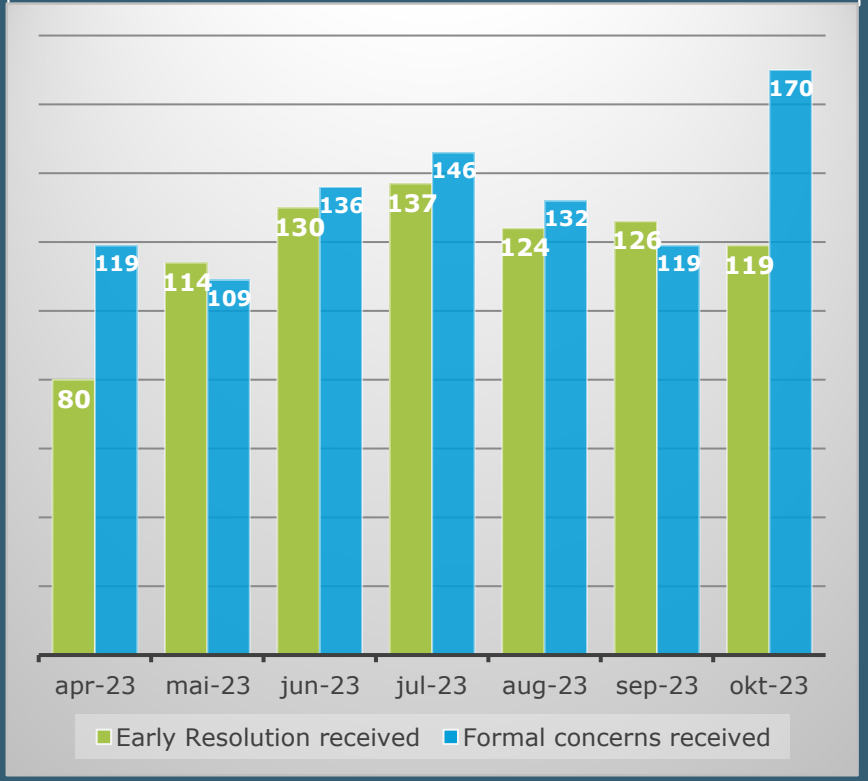
Early Resolution Performance April- October 2023



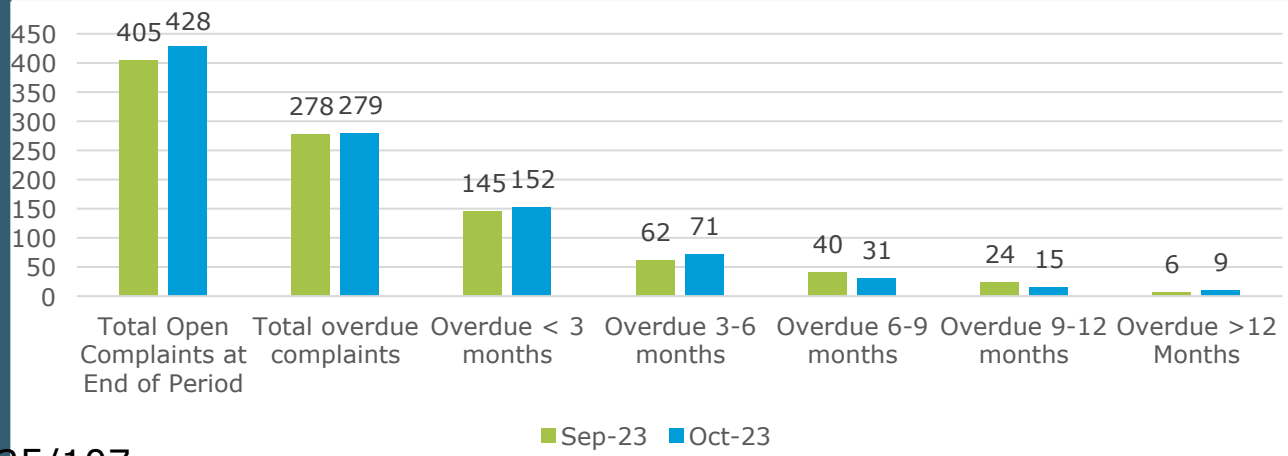
Formal Complaints Performance April –October 2023



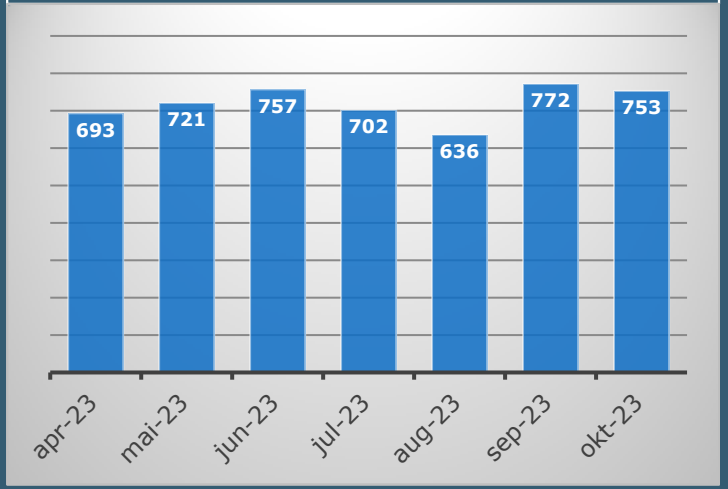
Complaints Received April- October 2023



Total Open Complaints and Overdue complaints September -October 2023



Enquiries Reordered by PLO's April-October 2023



Historic Concerns

The total overdue complaints are reducing.

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

Overdue Complaints

- Since January 2023 there has been a general downward trajectory in overdue concerns 3-6 months from, 101 to 71 in October.
- Overdue 6-12 months has reduced from 66 to 46 and >12 months has reduced from 12 to 9 as of 31 October 2023.

Compliments

A focus approach has been adopted to increase the number of compliments recorded onto RLDatix:-

- QI, 33 were recorded
- Q2, 109 were recorded – a 230% increase

It is fundamental these are documented, to celebrate success and importantly to enhance staff wellbeing.

Introduction of PALS

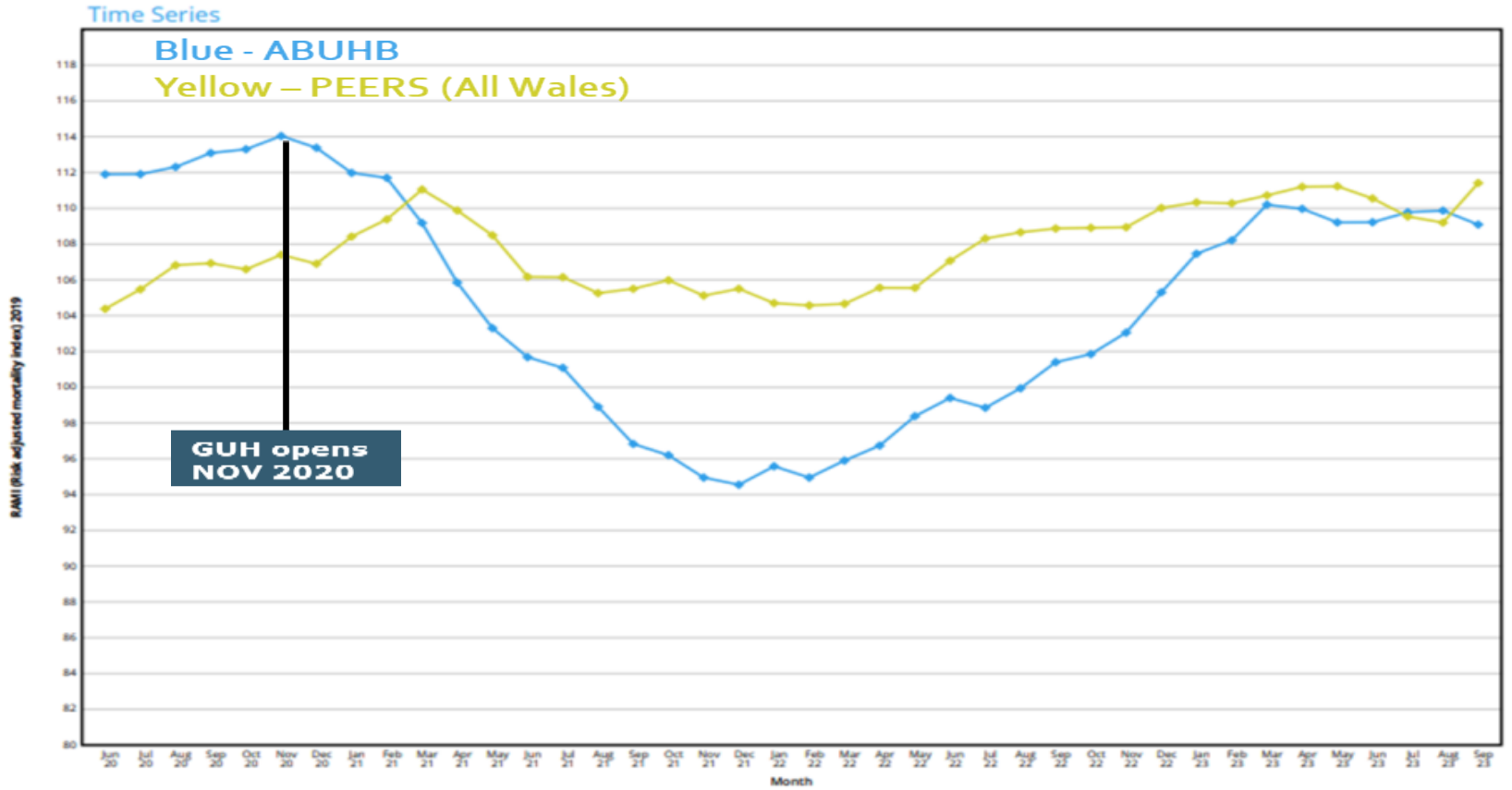
Concern received, PALS interjected and it was resolved as Early Resolution.

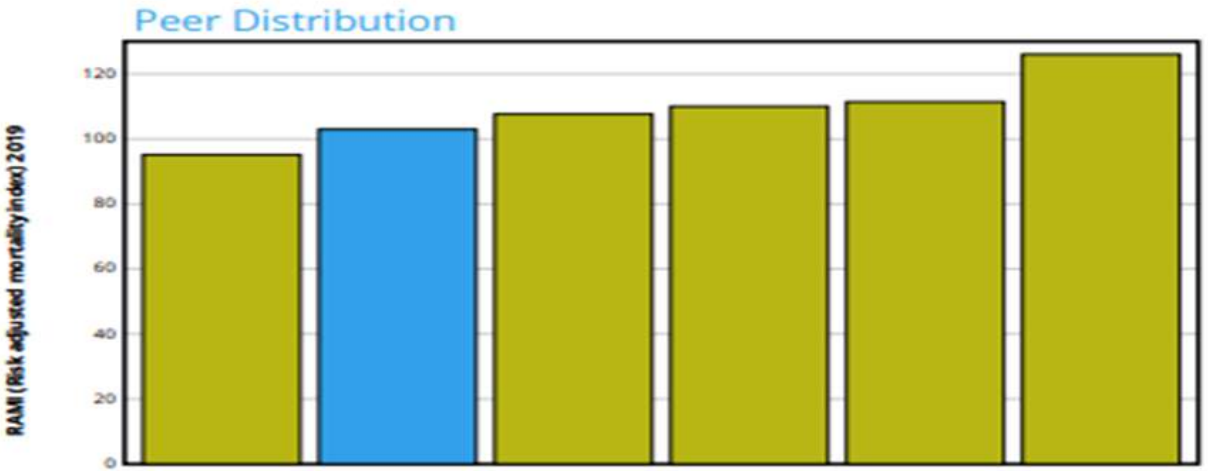
PALS contacted granddaughter, clarified complaint. PALS visited patient on ward to reassure, arranged a family meeting to discuss care plan, liaised with Ward Manager to ensure appropriate diagnostics as an inpatient. Ultimate aim, a future safe and timely discharge, that the family are in agreement with.

Learning from Complaints

Issue	Cause	Remedial Action	Who	When
The ward team failed to discharge a patient with all of their necessary ongoing therapeutic equipment	Human error	• Ward have developed a ward checklist to act as a prompt to ensure all equipment is transferred with a patient on discharge • This has been now rolled out across Ysbyty Aneurin Bevan	Medicine Division	Complete
Inaccurate information on Webpage	The Website had not been updated	• The OT webpage was redeveloped, contact details now up to date and accurate, to avoid any confusion/delays accessing an OT Practitioner. • Assurance given by Division that this will be routinely monitored to ensure compliance and raise confidence in Service User.	F&T Division	Complete
Family of patient raised concerns that staff were not trained on DOL and were not appropriately caring for patient due to lack of knowledge	Deficit in appropriately trained staff	• Staff trained to scrutinise and authorise Deprivation of Liberty Safeguard applications on behalf of the Supervisory Body; 12 more staff completed training. • This enabled a new system of scrutiny, whereby the documentation for the applications will be scrutinised using a buddy system.	MH&LD Division	Complete

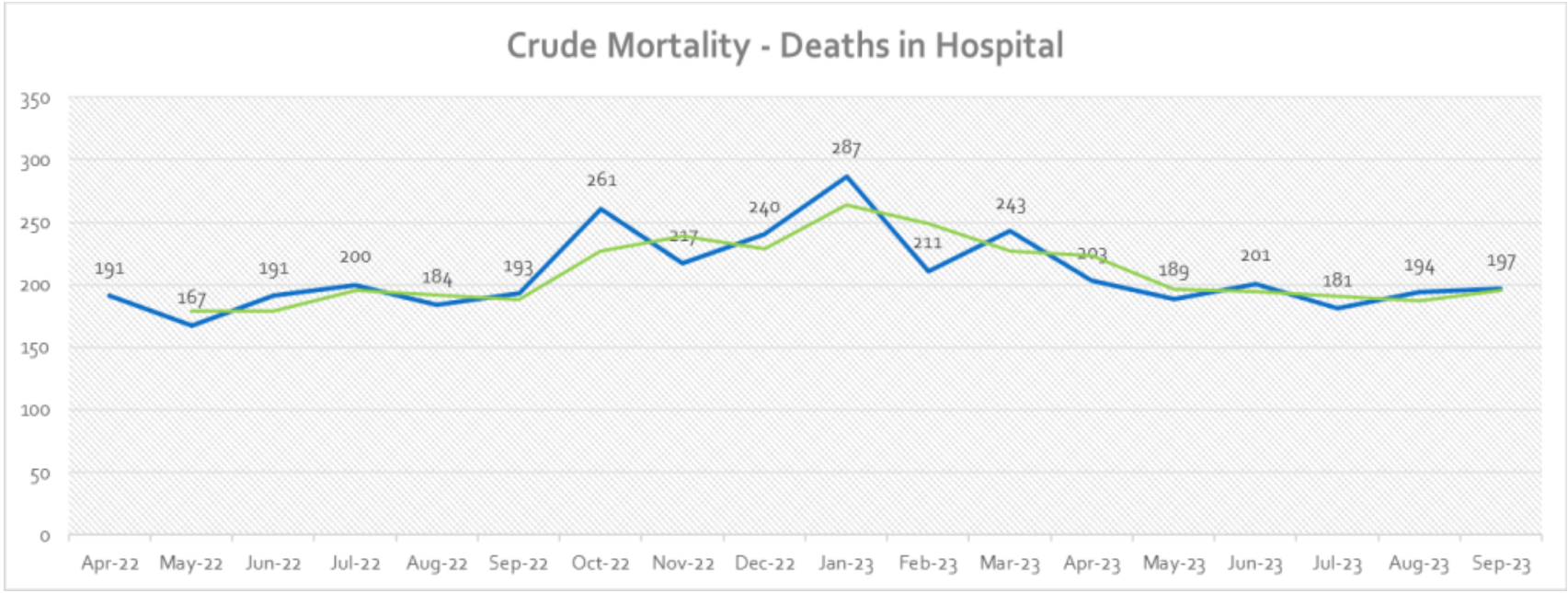
RAMI (Risk adjusted mortality index)

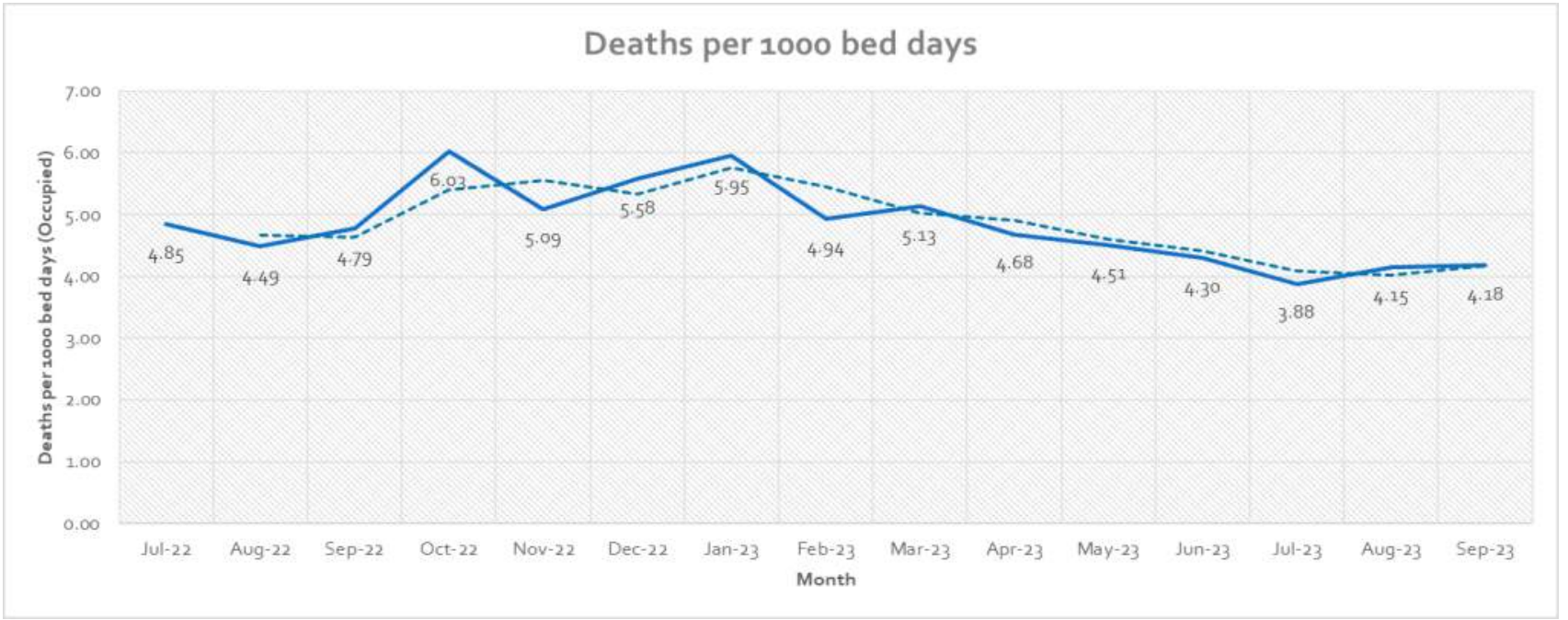




Currently performing 2nd of 6 within All Wales peer group

Crude Mortality in Hospital

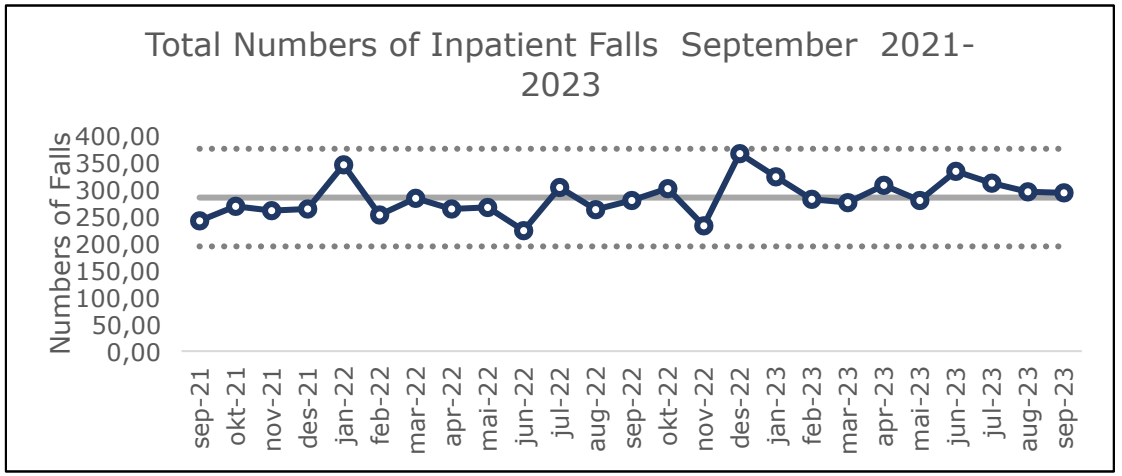




Actions

Issue	Cause	Remedial Action	Who	When
Understanding mortality data and how we implement learning from mortality	Need for understanding what is reported to PQSOC and to Board for mortality. England produce a Learning from Death framework which standardises a mortality report.	Initial work on learning from Death Framework underway and progressing to drafting stage, this will include the learning for the Medical Examiner service and the mortality review screening panel. Visit to Bristol as an Exemplar site for mortality to consider their end to end mortality process and how we can introduce similar for the Health Board. This will include processes for MHLD deaths and robust SOP for suicide.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistently of mortality reporting and data.	Producing a mortality framework that will look at crude mortality and other mortality indictors that are attributable to Divisions and Directorates, linking in with Clinicians to understand mortality outliers. All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	On-going
Mortality Data and Clinical Outcomes	Previously lack of dedicated resource to review and utilise CHKS data. Understanding, interpreting and interrogating CHKS data to formulate a clinical outcomes report. Developing governance process around mortality outliers.	Information Manager now in post and meeting regularly with CHKS Information Manager and QPS team meeting with Divisions to identify what is currently reported, to progress Clinical Outcomes around Mortality Outliers. CHKS wish list produced to request additional information. QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation. This will allow scrutiny of review for notes.	QPS Team and Information Manager	On-going
Coding lag	There is a increased time lag with coding records within ABUHB causing a delay in validated data, which affects the reliability of RAMI. Inconsistencies within the coding (sign or symptom as a primary diagnosis) this affects the accuracy of calculating RAMI.	Target of coding 95% of episodes is not being met. Currently achieving 85%, due to vacancies in coding team. External audit undertaken of clinical coding has demonstrated 97% accuracy with coding. Coding has now moved under the management of the Information Team and will be expanding the team. Medical Director initiating meetings with coding team. Liaised with CHKS – Coding data considered accurate after 3 months for ABUHB, this varies for other HB's as some do not submit data as regularly as ABUHB.	Information Team Information Manager	Complete Complete

Total Numbers of Inpatient Falls



December 2023 - Context

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

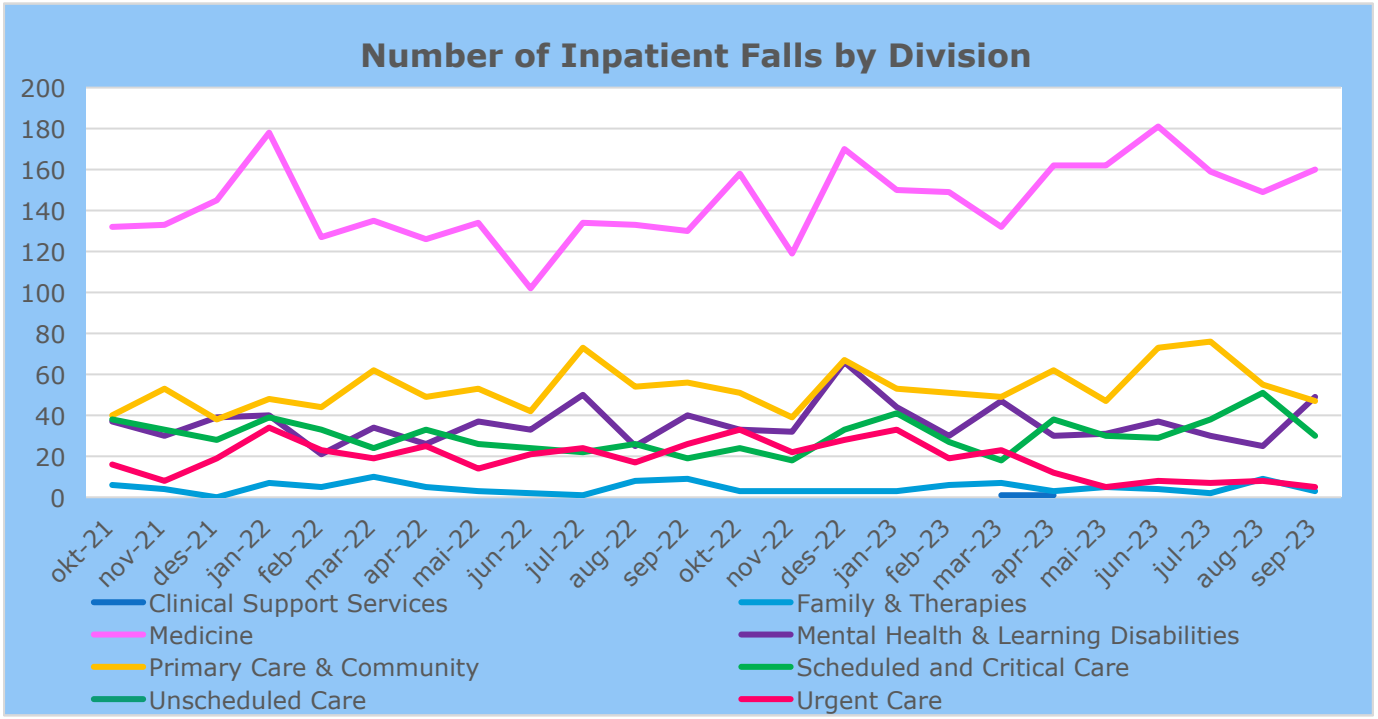
The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period September 2021-2023.

October 2023 has seen the creation of a dashboard that allows for a greater insight into instances of multiple falls for individual patients. A greater in-depth analysis will be undertaken as the detail within the dashboard is further developed.

With the information available October 2023 saw 20 patients experience two or more falls. 9 patients within this cohort experienced more than 3 falls. The numbers of incidents of falls greater that three were experienced within the Clinical Divisions of Mental Health and Medicine.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• For the year 2022-23 incident reporting numbers have demonstrated a shift with consecutive months being more closely aligned to the mean average value for the given period at 285 • Since December 2022 there have been no significant peaks in reported incidents either close to or outside of the defined control limits.	June 2023 represents the second highest value for reported incidents in the given period at 334. The period of June to September 2023 has seen a steady downwards trajectory.

Inpatient Falls Data by Division



December 2023 - Context

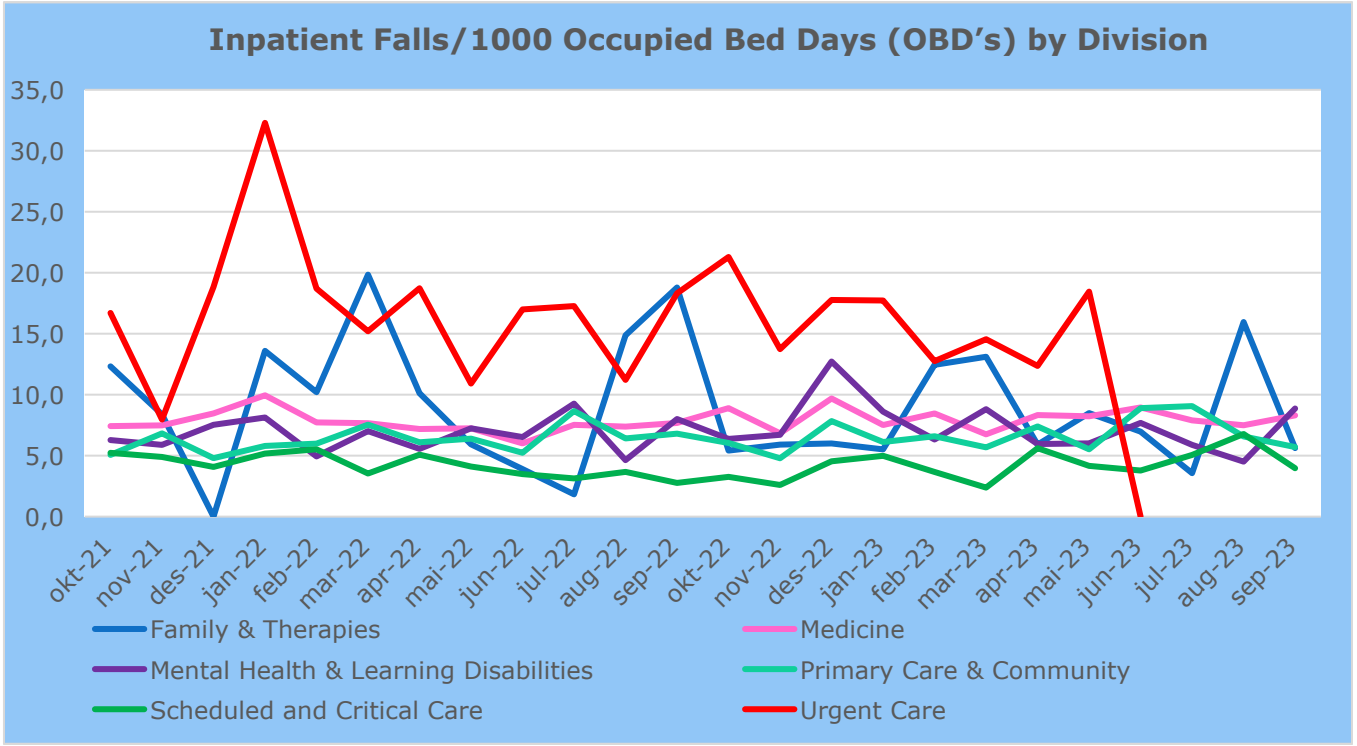
The data used in this chart has been retrieved from Datix.

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

Definitions	What the chart tells us	Key Variation Highlights for 2023
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• The information provided represents that per Division for the total numbers of inpatients falls for the period October 2021 to September 2023. • As expected, the highest numbers of falls remain linked with those ward that are populated by our frailer and older patients. • From a Divisional perspective three out of five have seen a decrease in reported incidents. Medicine and Mental Health and Learning Disabilities for September 2023 has seen an upwards trajectory as compared to the last report. • To Note the Emergency Department and Clinical Support Services do not hold a bed base.	**Primary Care and Community** • Lowest value of reported incidents for 2023. **Families and Therapies** • Return to lower reported value following a peak in August 2023. **Mental Health and Learning Disabilities** • Highest numbers of falls for 2023 with 50% being attributed to Hafen Deg ward, County Hospital.

Inpatient Falls Data

by Division



December 2023 - Context

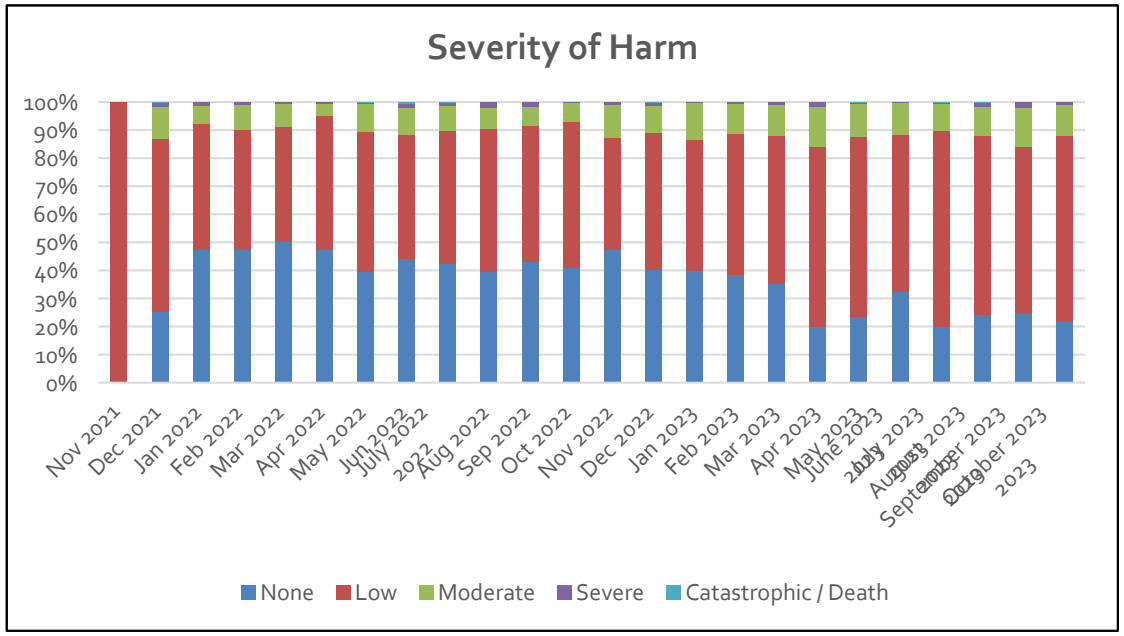
The data used in this chart has been retrieved from Datix.

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

Definitions	What the chart tells us	Key Variation Highlights
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	The information provided represents Inpatients Falls per 1000 Occupied Bed Days (OBD's) per Division for the period October 2021 to September 2023. Of the Divisions represented three out of Five Clinical Divisions saw a decrease in the value for Inpatient Falls per 1000 OBDs for September 2023 with values for the month being significantly below the National Average of 6.6 For note a value for Urgent Care is no longer calculated as this previously represented a Division which has been subject to change.	F & T OBD value represents a 65% decrease between August and September 2023 MH & LD saw a 47% increase in ODB's for the same two months

Inpatient Falls Data

Severity of Harm



December 2023 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period November 2021 to October 2023.

The severity data is reflective of the identified level of harm recorded at the time of reporting and may be subject to change following investigation.

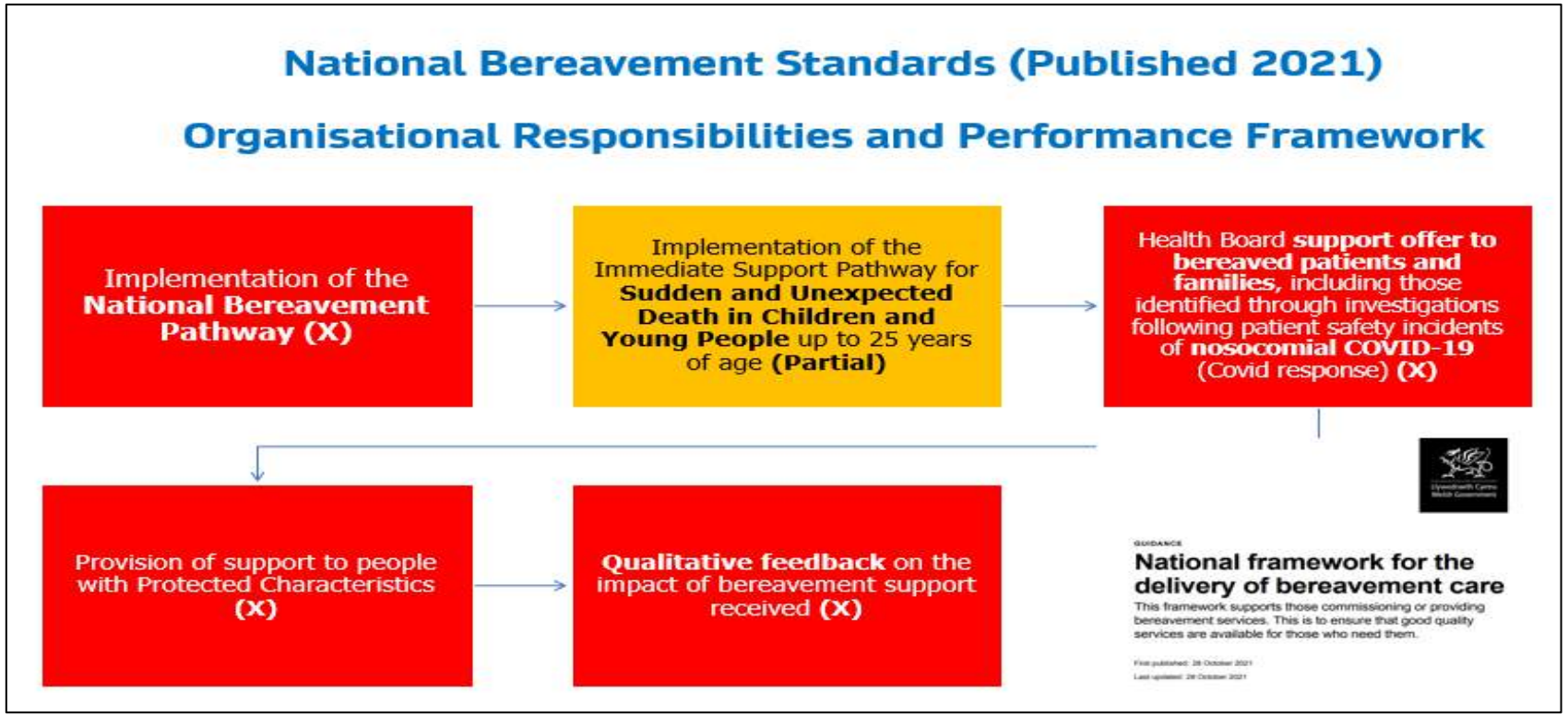
Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	Of the total numbers of falls incidents reported the severity of harm is categorised as follows for the period November 2021 to September 2023. • 36% - No harm • 54% - low harm • 9.9% - Moderate harm • 0.9 % Severe harm • 0.1 Catastrophic	No incidents were reported as catastrophic at the time of the reporting the view of harm for the months since the last report.

End of Life Care (EoLC) Board

- Board now Chaired by Executive Director of Nursing.
- Priorities of Board will align with goals 5 and 6 of urgent and emergency care.
- Opportunity to work with planning to align to goals and consider project plan for EoLC Board.
- Workstreams include advanced care planning, bereavement, outcome measures and education.
- "Quality statement for Palliative Care and End of Life for Wales" released October 2022. Need to consider how the Health Board will implement.
- Clinical leadership needed for DNACPR and National Audit for Care at End of Life (NACEL).
- Task and finish groups to be set up and to seek point of contacts from Divisions to progress actions from Audits.
- Care decisions Guidance for the last days of life updated by palliative care Wales. Implementation plan needed.
- Successes – developing a palliative care medical champion programme.

End of Life Care Board

- Focus on improving bereavement support within the Health Board
- Collecting personal experiences of bereavement. Holding drop-in sessions for listening and learning from patients, carers and staff experience and feedback. Considering:
  - Deterioration and anticipated death
  - Sudden/ unexpected death
  - Bereavement standards
  - Complicated (complex) grief



Negative Bereavement Feedback from Staff

"When are you coming back to work". My father died on a Friday, and I was asked this on Monday!

It took weeks for someone to let me know they had tried to resuscitate my husband. Weeks!

They missed my mother's brain tumour. Because she was 66, they just assumed she had dementia. By the time they took our concerns seriously, it was too late. She was 67 when she died.

As part of my job, I was asked to do a viewing in the mortuary. It was my neighbour's daughter. I was so distressed.

Two weeks after my dad died, I was made to go and assess someone on the same ward that my dad died in. I said I didn't want to; it was too raw. When I got there, the patient was in the same bed he had been in. I couldn't cope with that.

I was on duty and was bleeped to help with the resuscitation of a young girl. It was my niece. She didn't make it. My alcohol use escalated.

Negative Bereavement Feedback from Relatives and Families.

People come into hospital to get better. When someone dies of a hospital acquired infection, that's a different kind of grief!

No-one would let me speak to my husband. Why didn't you do just that little thing? He must have felt I'd abandoned him. My guilt will never go away.

You never contacted me. You wouldn't let me visit him. You robbed me of the chance to say goodbye.

They told me one day that he was ok then the day after they told me that they were withdrawing all treatment, food and drink. It was 'kinder for him'. KINDER?? I wanted him to come home to die, and they said they'd get back to me. They never did. He died alone in hospital.

He died so unexpectedly. All I wanted to know was that everything that could have been done, had been done. No-one bothered to contact me. It just says to me that his death didn't matter.

When we get it right.

When my mum was dying, my boss was great. She let me sort out my workload, work from home, flex my time. It meant I could take her for chemo and be with her when she died without feeling guilty about work. (Staff)

Being given the option to let my dad come home to die was such a relief. It's what he would have wanted.

(Relative)

We talked to the funeral director about funeral options and weren't pressured into having a religious funeral. We opted for a humanist funeral. Us 4 daughters were pall bearers and carried our dad on his final journey. It helped us grieve, knowing we could do that for him.

(Relative)

The GP practice, district nurses and palliative care team were just fab. They held MDTs in my house and asked my mam and us what we wanted to happen.
(Staff)

Progress To Date

Care after Death and **Bereavement Website** (live)- Feedback from Covid Bereaved for Justice, Cymru

'Tell us about your experience' drop-in discussions (patients, families, staff)

Bereavement **Implementation Plan**

Bereavement **Collaborative** (4th Dec 23)

PALS Service- bereavement offer

Care After Death- Administrative/Pathway Review

Clinical Lead for Bereavement (out to advert)

Bereavement Model (May 2024)

Care After Death and Bereavement - Aneurin Bevan University Health Board (nhs.wales)

Patient Safety Leadership Walkarounds

- Patient Safety Leadership Walkarounds recommenced in May 2023 across inpatient, outpatient and community patient care areas and support services through the Health Board. Since September, the walkarounds have focused on visiting mental health wards.

- Patient Safety Leadership Walk Arounds are a method for leaders to talk with front–line staff informally about culture, patient safety issues, and demonstrate their support for incident reporting, innovation and quality improvement. Walkarounds serve a dual purpose – they educate senior leaders about safety issues, whilst demonstrating to frontline workers their commitment to creating a culture of safety.

- The current process for the walkarounds is for an Executive Director to visit a clinical area, often accompanied by an Independent Member, to hear the views and concerns of front-line staff relating to patient safety. The Executive Director should agree with the staff from the area the two or three main patient safety issues and a small number of actions.

Patient Safety Visits May – November 2023

- The aim is to undertake one visit per week, with two areas seen during the visit. There would therefore usually be twelve visits, seeing twenty-four areas, in a three-month period.

Visits Scheduled	Visits Completed	Visits Cancelled
42	19	23

Patient Safety Leadership Walkarounds

Wards Visited:	
Site	**Areas**
SWH	OSU, OSU Theatre, Sycamore Ward, Dermatology Unit
GUH	MAU, SAU,SDEC, B1 Paeds, Children's EAU
NHH	Usk 3/2, 3/1 Glan Ebbw
County	Rowan, Outpatients
County MH	Hafen Deg, Talygarn
RGH	C5E, D2E
SCH	Adferiad, Pillmawr
Maindiff Court	Ty Skirrid, Lindisfarne House
GP	Aberbeeg

- At present there are no emerging themes related to patient safety, most are related to repair of estates or buildings. This may develop as the walk arounds progress over time.
- Ward staff are asked to feedback how they think the ward visit went. This is now completed via the use of MS Forms or via a QR code. It is evident that ward staff and managers value the walk arounds and the opportunity to meet with Board members. All felt positive that they were listened to, were able to raise concerns and able to discuss what mattered to them – following person centred care principles.
- As part of a Quality Improvement Project (QIP) the Patient Safety Leadership Walk Arounds are being reviewed. One of these improvements is to update the paperwork that will be used as part of the walkarounds. Going forward the '15 steps challenge – quality from a patient's perspective, following the themes of: welcoming, safe, caring and involving, well organised and calm.
- We are keen to hear from Board members who have undertaken a Patient Safety Leadership Walkaround to gain your feedback and to understand your perceived purpose of these visits This will enable us to produce a driver diagram and consider any future improvement.

Escalated risk concerns

Section 3

MH/LD Position of the 30 day plan

Risks

- The Health Board has placed the Division in Special Measures for Quality, Performance & Finance
- From the beginning of September 9 serious incidents have been reported 4 related to IPC outbreaks, 2 attempted in-patient suicides and 3 safeguarding incidents
- 6 Incidents remain under Police investigation/ Safeguarding process
- Achievement of the 30 Day Improvement Plan actions – following Independent Assessment

14 actions	Were met sufficiently
2 actions	Remain outstanding with an amber RAG rating
2 Actions	Remain outstanding with a red RAG rating

- Staff engagement, leadership and culture remain the most significant risks

Next Steps

- Improvement Director and Divisional Nurse for Improvement appointed
- Fortnightly governance and oversight meetings continue
- Structured improvement actions and safety culture plan in development to deliver improvements post the 90 day period
- High consequence thematic safety issues to be included within the safe care collaborative
- Formal letter issued to the Division to ensure clarity of expectation
- Revised target dates for achievement agreed for the 6 outstanding actions, the plan is still to complete the plan by the end of December
- Governance review commenced
- Oversight by Board and Cathy Dowling and Dave Semmens from NHS Ex

Health Inspectorate Wales Inspections

Cedar Parc, Ysbyty Tri Chwm

Health Inspectorate Wales Inspection Report & Improvement Plan *(hyperlink)*
Report Publication Date: **10 November 2023**

Inspection of Community Mental Health Team

Inspection Scheduled: **16 – 17 January 2024**

Llais Gwent Region Visits

Ysbyty Ystrad Fawr

Date of Visit: **2 August 2023**
Report Publication Date: **DRAFT reports received 2 October 2023**
Improvement Plans submitted by: **13 November 2023**

Ward	No. of Recommendations Identified by Llais	Number of Actions Identified by Service
Annwylfan Ward, YYF	7	9 (2 actions outstanding, in-date)
Oakdale Ward, YYF	4	12 (all actions complete)
Ty Cyfannol, YYF	7	9 (all actions complete)

Framework for Speaking up Safely in the NHS

- Workshop with Guest speaker Professor Aled Jones. held to generate critical reflection and discussion of a 'Speaking up Safely' programme. Looking at healthcare systems, specifically in terms of the future strategic objectives for Aneurin Bevan University Health Board, linked to the Welsh Government's recently published framework for NHS Wales.

- Past 6 months there have been 6 whistle blowing cases – 1 sexual harassment. These have led to a series of actions. Current provision includes a speaking up safely inbox and dedicated active bystander training.

- Self-assessment presented to Executive Committee 19 October 2023 and submitted to WG.

- Use the self-assessment to shape the mapping and when we get feedback, form a small working group of key stakeholders (WF&OD, Nursing, Drs, Q&S, ABCi) to develop a TOR and then a short, medium and long-term plan from which to develop an operational strategy.

Serious Incidents

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

- Continuation of a theme of deteriorating patient serious incidents (acute and chronic conditions). Collaborative event held in October and presented to Board to look at learning. Quality improvement workshop to be held in November.

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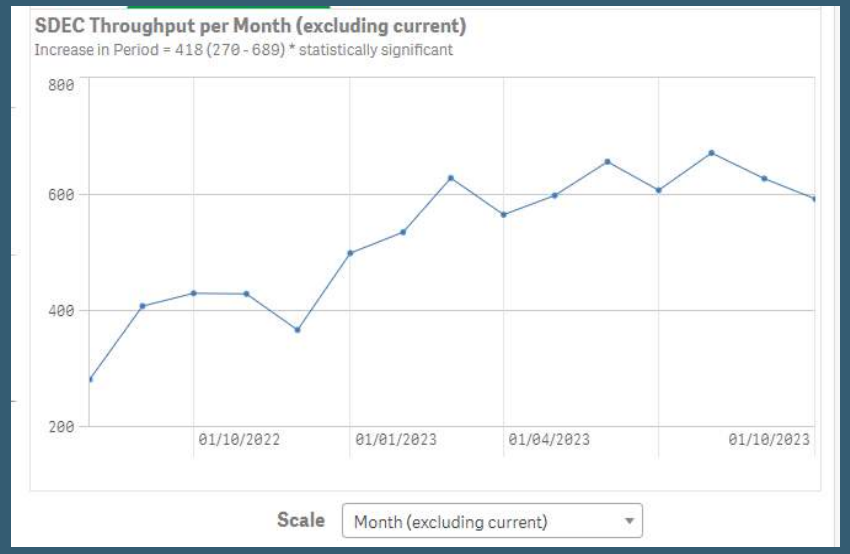
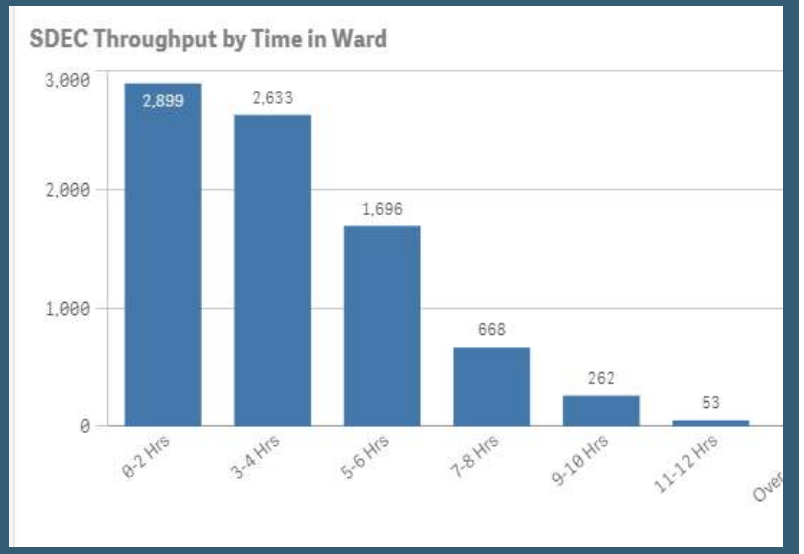
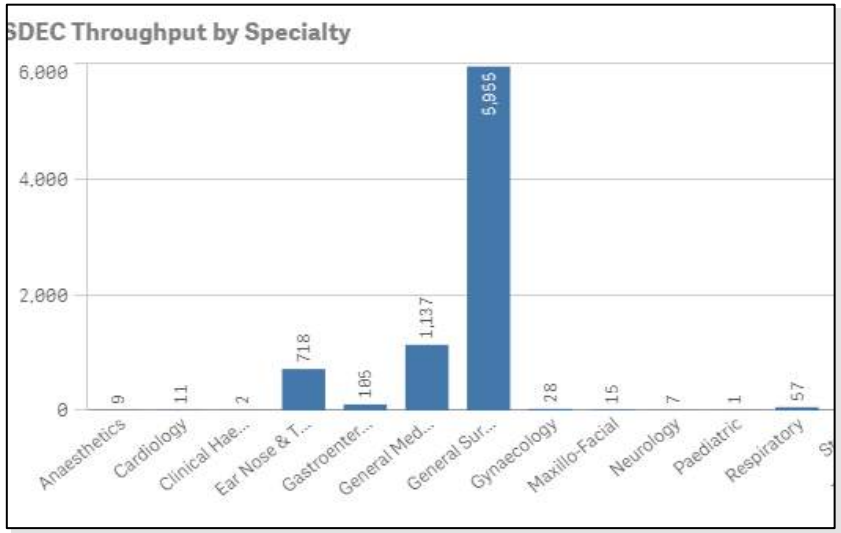
SDEC GUH at a Glance 8/8/22 – 16/11/23







8225 Patients seen

Average 37 Patients per day

621 Next day Returners

Median time 3:55 hours

6839 patients Discharged Same Day (82%)

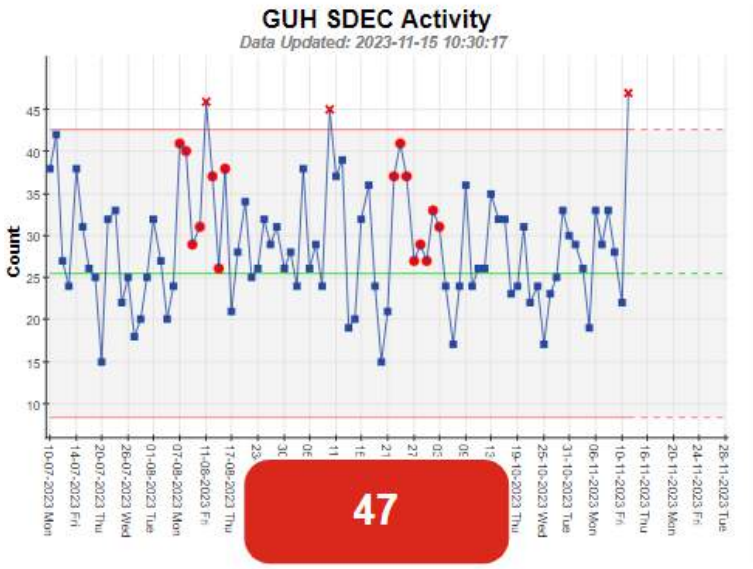
1282 Admissions

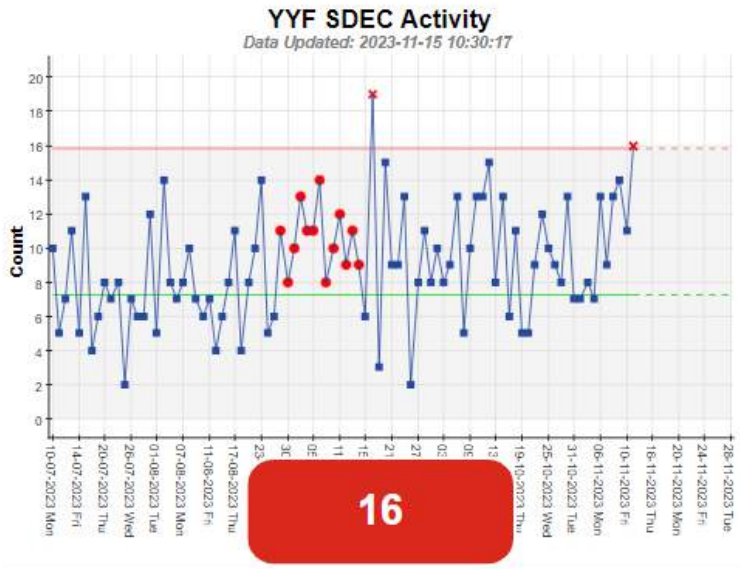
Progress Summary:

- Average daily patient throughput up from 33 to 37
- Surgical model working very well, great feedback from Primary Care
- Medical Model GP referral process now in place
- Medical referrals have increased but possible stabilising to 25 per week
- Reviewing condition specific pathways for direct referral from ED/MAU to SDEC
- Flow Centre added an SDEC advice line for Primary Care and WAST
- Consistent Positive feedback from patients and staff
- SDEC has never been used for in-patient capacity

Goal 3: Clinically safe alternatives to admissions to hospital

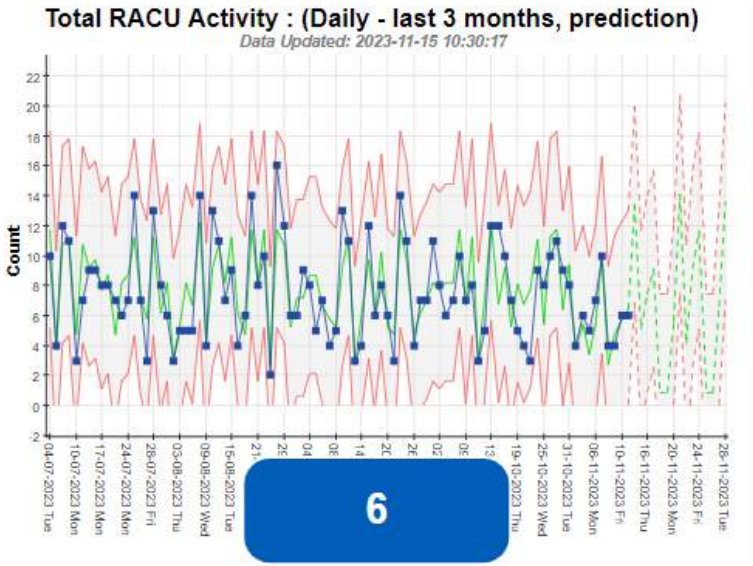
Alternatives to Admission

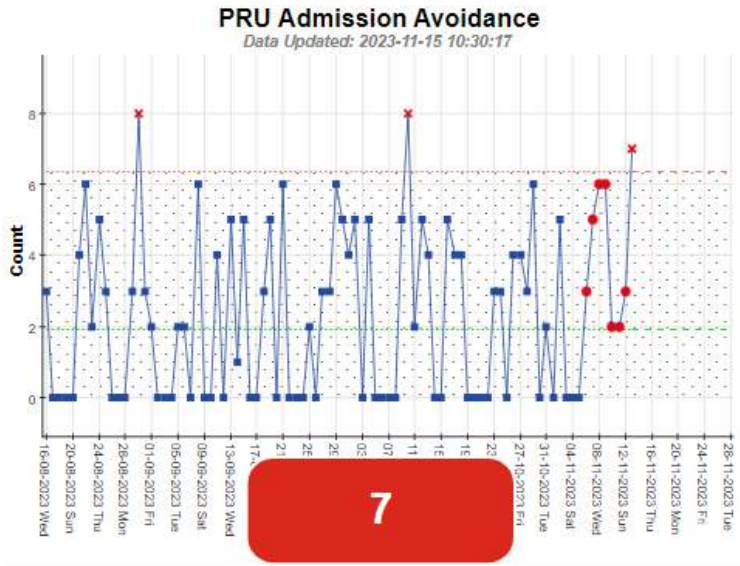




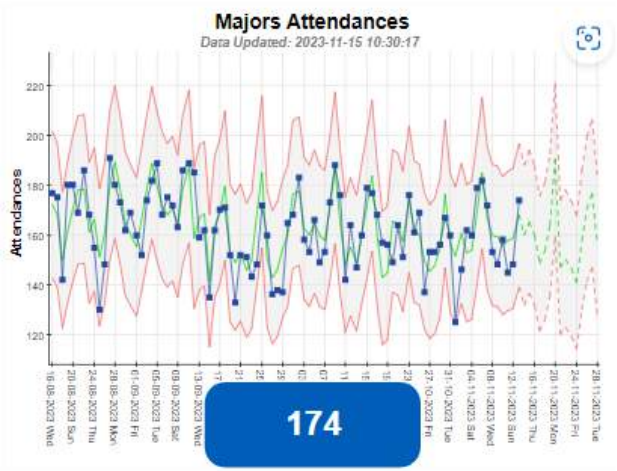
Data Updates & Forecasting:

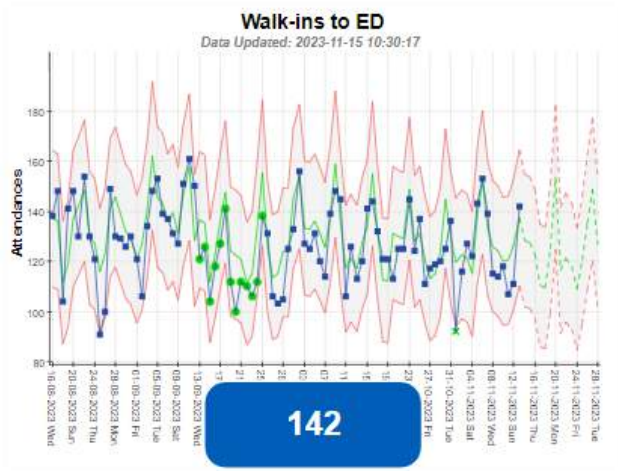
- **GUH SDEC** has been seeing around 25-45 patients/day, jumped to 47 on Monday 13th Nov.
- **YYF SDEC** increased to 16 in a day on Monday 13th Nov
- **PRU Admission Avoidance** has been more consistent at 2-7/day for the past week.

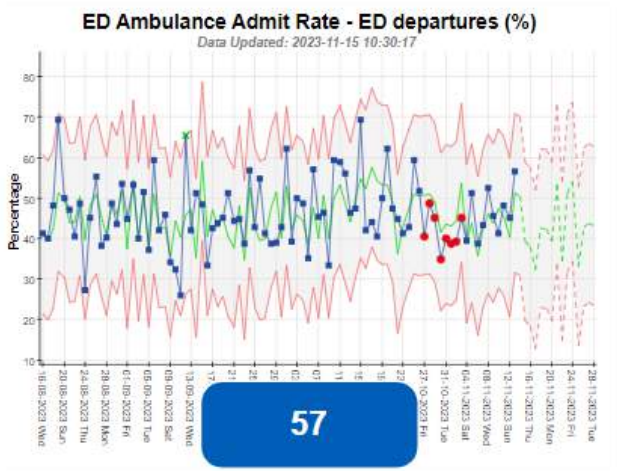


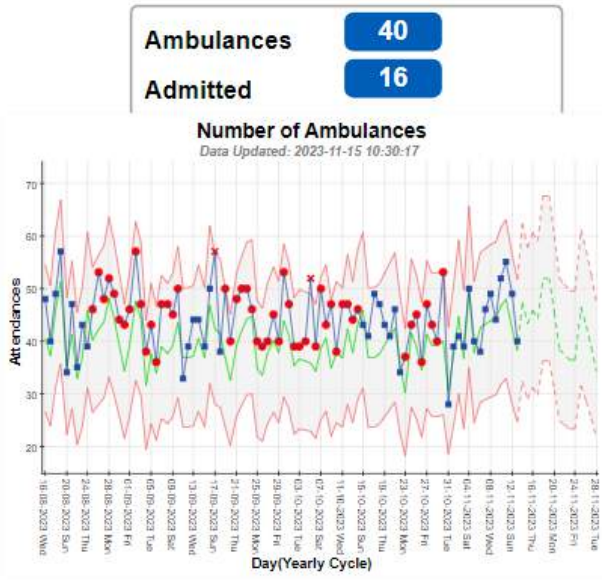


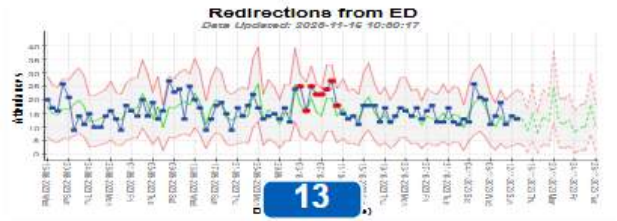
GUH ED Activity

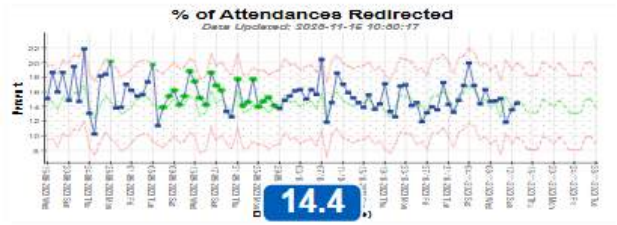


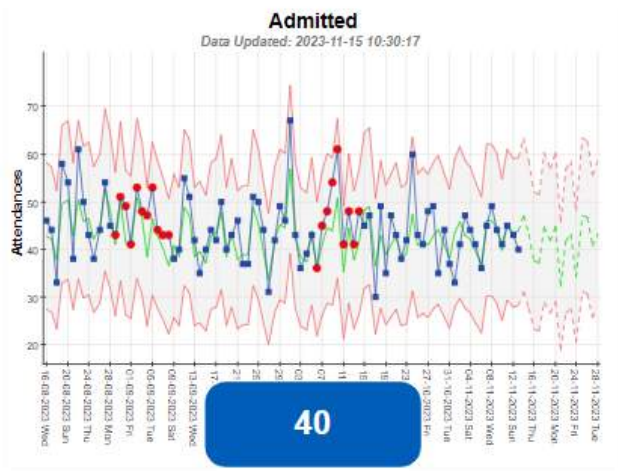


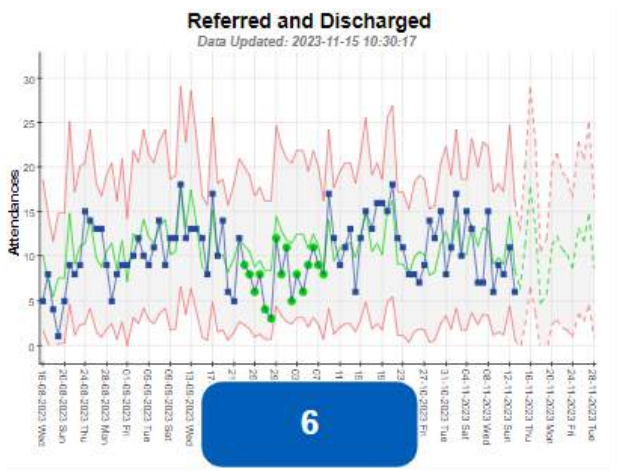


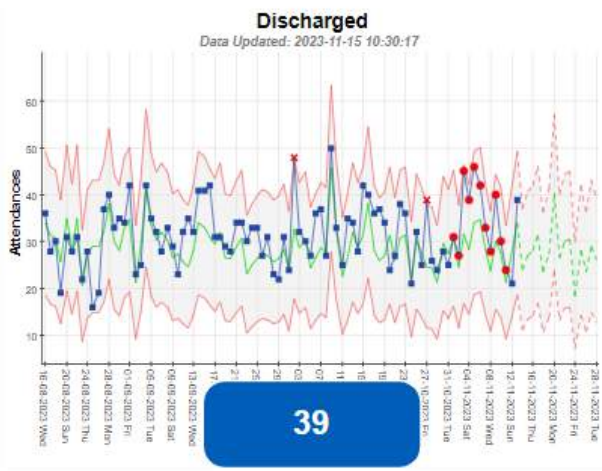




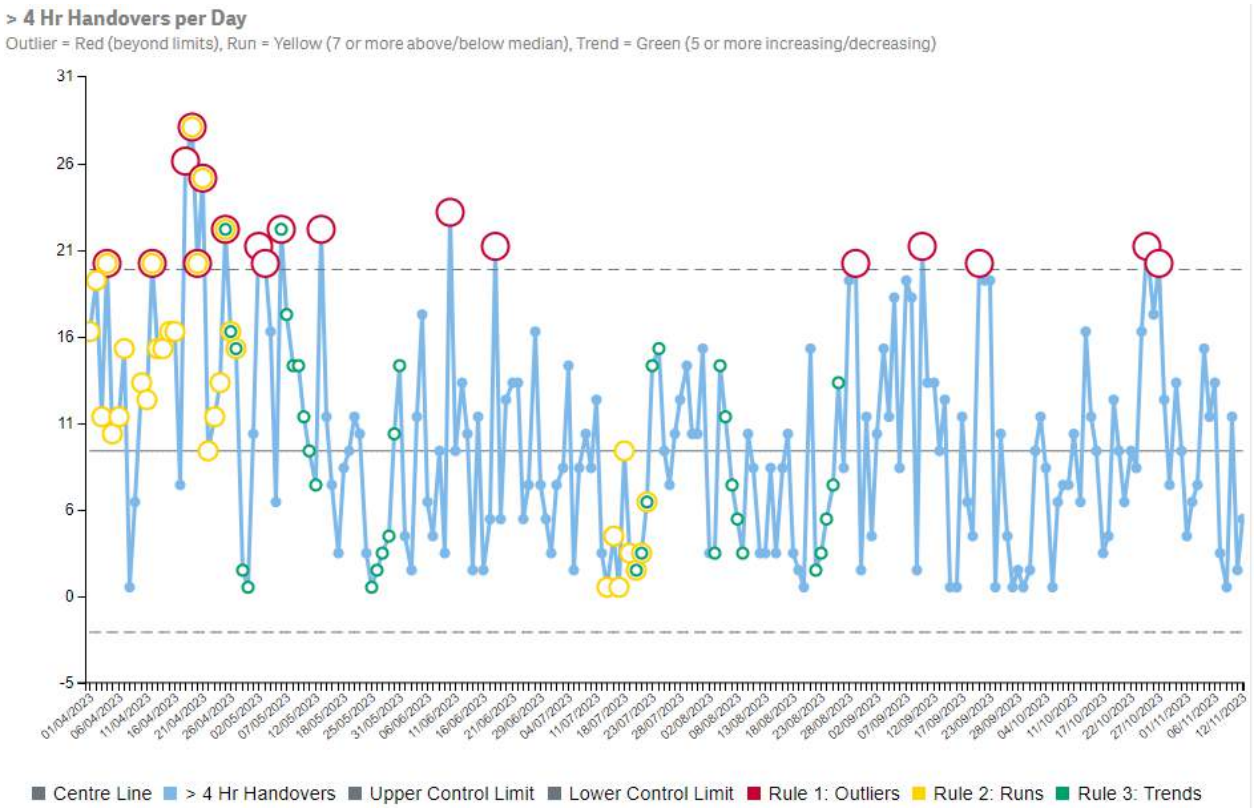


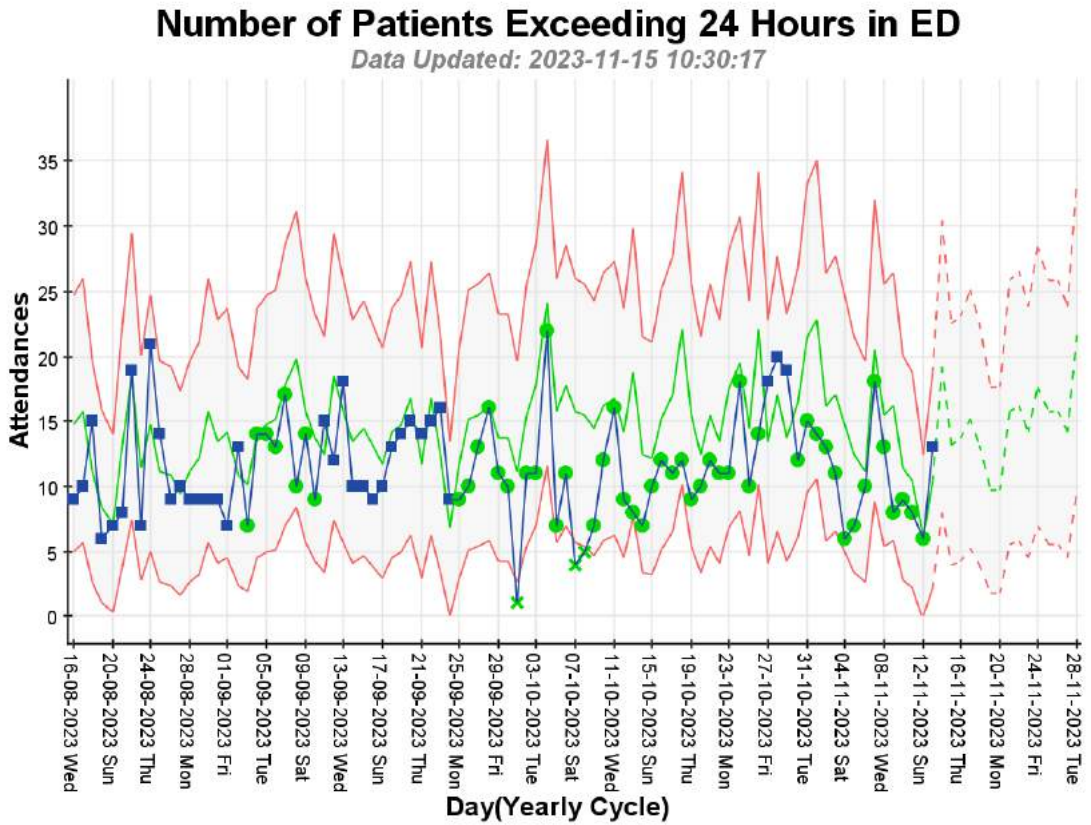






Goal 4: Rapid response in physical or mental health crisis





Data Updates & Forecasting:

- **Around 9 patients a day** waiting over 4 hours for ambulance handovers at GUH
- **Around 12 patients a day** spending over 24 hours in ED

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.		
	• Implementation of different models of care	• Explore alternative roles e.g. Physicians Assistants, ANPs etc.		
Nurse Staffing: Vacancies with increased number of patients causing additional staffing pressures and associated governance and costs.	• National shortage of registered nurses • Emergency Department Establishment was increased following the move to the GUH • Challenging place to work due to increased attendances, increased acuity, environmental challenges, inadequate flow	• Recruitments drives for Registered Nurses and HCSWs • Student streamlining • Recruitment of internationally trained nurses • Robust sickness management • Practice Educators working clinically alongside junior staffing • Senior Nurse Point of Contact (POC) • Block-booking of staff secured and robust processes in place to manage roster • 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	• Red Line (24/4) in place from 15 May 2023 to support ambulance offloads and long waits in ED (Now 24/2) • Escalation plan in place to support movement of patients • Comprehensive review of available spaces with Capital Planning colleagues at GUH (Main Wait, Sub-wait and SDEC) • Full Capacity Protocol (FCP) in place • Expansion of ED Main Wait business case approved by board and being progressed with WAG • SDEC in GUH open. Predominantly scheduled care utilising but medicine usage now increasing along with other pathways such as ED direct referrals and WAST direct access	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

For Information

Section 4

Medication Safety Group:
Gabapentinoids

- Gabapentinoid use and a fatal drug poisonings within ABUHB raised concerns over the safety of gabapentinoid prescribing, in particular pregabalin.
- ABUHB currently has the **2nd highest Gabapentinoid prescribing level** in Wales, approximately 10% above the Welsh national average, as measured by the National Prescribing Indicators and prescribing continues to increase.
- ABUHB Primary Care Medicines Management Team was tasked with **auditing high prescribing practices** which gave valuable early insight into issues. The ongoing audit is now included as part of the Practice Incentive Scheme collated via AMaT to support targeted engagement in areas that require support.
- The team also collaborated with the ABUHB Chronic Pain Group to collate and **create and evidence-based tool kit** providing education and practical resources to support clinicians in this therapeutic area.
- The Gabapentinoid Prescribing Resource Pack for pain was created and two training sessions were organised to increase awareness of the safety concerns and provide practical skills to encourage and enable best practice.
- This work has been **shared as best practice** at the AWTTC Spotlight event for chronic pain.

Medication Safety Group

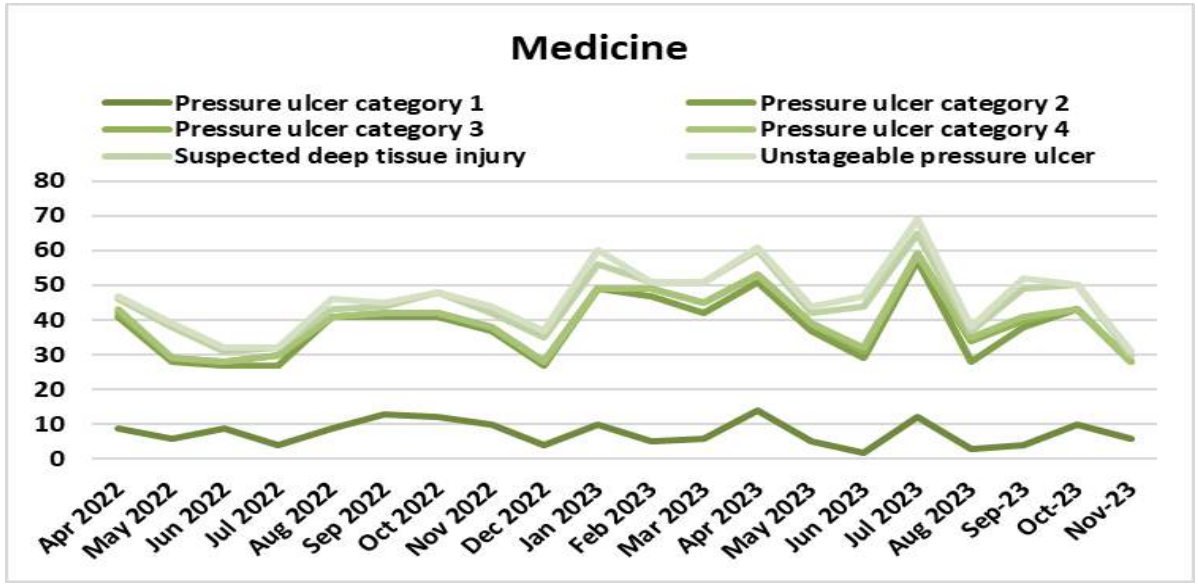
- Progress has been made on all 10 patient safety recommendations from the Time Critical Medication Campaign and an **ongoing commitment to improve access and education** on timely administration of all time critical medication has been made by the Medication Safety Group.

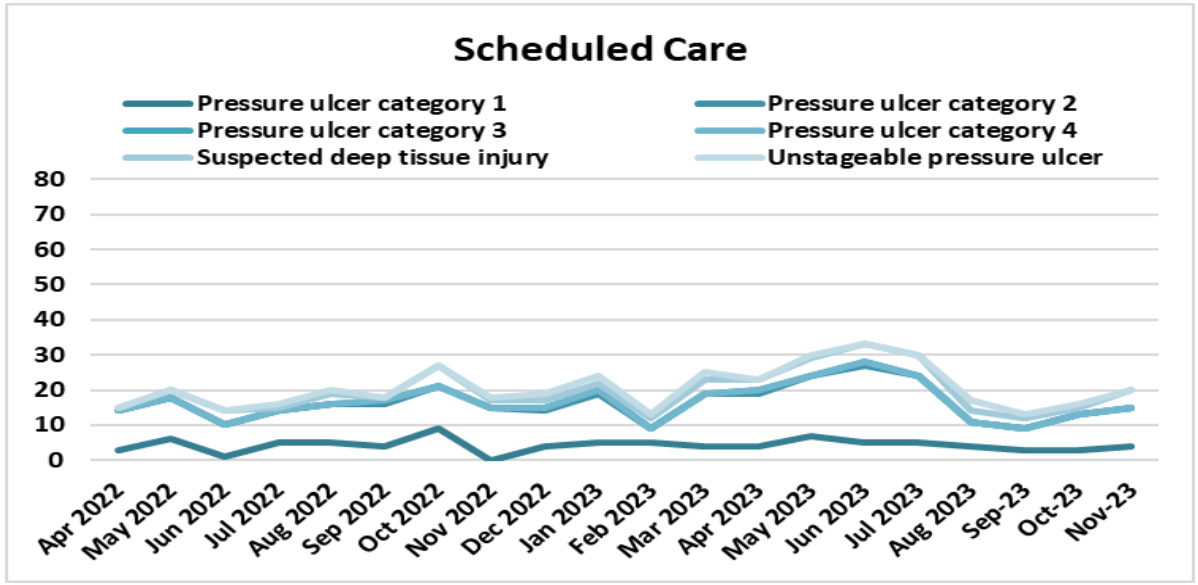
- **Current Patient Safety Notices:**
  - Potential risk of underdosing with **calcium gluconate** in severe hyperkalaemia
  - Relevant policy is being taken to Clinical Standards and Policy Group 7December 2023

- **New themes emerging:**
  - **Insulin** and **anticoagulant** safety which require a focused and thematic review by a team of multidisciplinary experts and an action plan to determine activities to impact change.
  - Data and stakeholder identified and planned work to be carried out in January.

- **Drug Safety Updates:**
  - **Sodium Valproate:** original pack dispensing to highlight risks associated with concurrent use during pregnancy.
  - **Isotretinoin:** introduction of new safety measures, including additional oversight of the initiation of treatment for patients under 18 years of age.

Healthcare Acquired Pressure Ulcer





HAPU Focus

Steering Group:

- Duplication of incidents
- Documentation around Purpose T Assessment
- Progress with the Skin Assessment on WNCR

Faculty Two update:

- Clinical teams continue to work on PDSA cycles for improvement change in PU assessment, Datix reporting, access to equipment, nutrition, staff knowledge and training and education
- Pressure Ulcer Awareness Day some resources shared
- Shared resources across the HB for improvement

Organisational progress:

- Pressure Ulcer Awareness Day – 16th November
- Shared resources across the Health Board

NRI Themes/Improvement – Primary Care & Acute

- Skin Assessment
- Nutrition Assessment
- Diabetic Management
- Wound Care

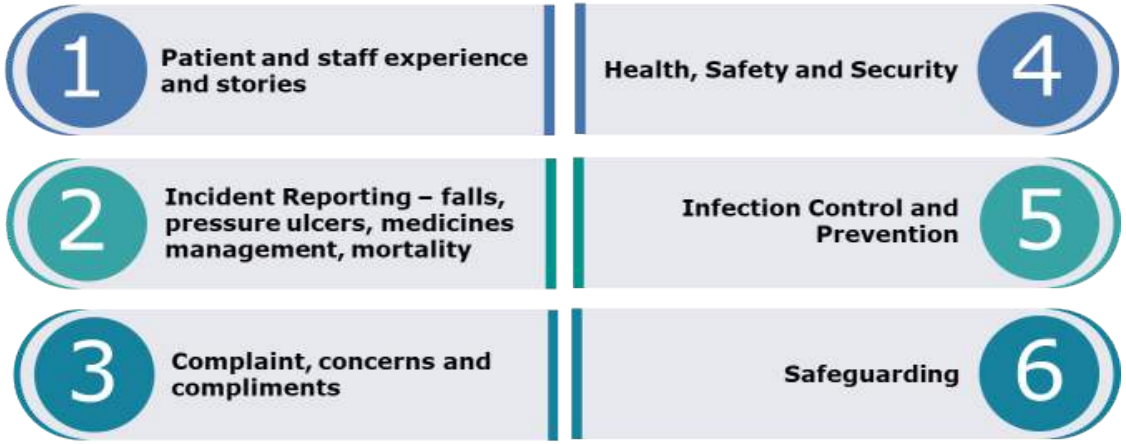
Pressure Ulcer Awareness Day

16th November 2023

Quality Strategy Implementation Plan

- Quality Strategy and Patient Experience and Involvement Strategy being fully implemented.
- QOF report with be presented quarterly, to align with IMTP dates.
- Successful two-day event with external facilitator. Following with an improvement collaborative held internally in November.
- Continue to develop Quality operating framework, implementation plan and assurance framework. To ensure triangulation of data.
- Workplan being refined, including deteriorating patients, NRIs and never events in theatres and radiology.
- Reviewing QPSOG and establishing forum for learning. Including membership and purpose of the Group (additional members to include WF & OD).
- Safe Care Collaborative ongoing and moving inhouse.

Quality pillars as defined in the Quality Strategy:



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

Quality Strategy Update

- Quality narrative report produced for In Committee Board and Public Board.
- Refining data capture to ensure narrative and learning is captured.
- Learning forum in its infancy and ToR bring updated, will align to pillars of quality and will map to Six domains of quality (STEEEP).
- QPS resource under OCP.
- Safety first - a redesigned approach to incidents, serious incident management learning and decision making.
- QI refresh – mapping of QI expertise in the organisation, identifying Quality champions. Internal improvement collaborative held on Deteriorating Patients in November, discussion on creating capacity and develop capability.
- Plan for engagement with ward-based teams and clinical areas to consider local collection of quality data.

Person Centred Care:

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Bereavement	Feedback from Covid bereaved relatives Cymru relating to minimal bereavement advice and support.	Single point of access Bi-Lingual Care After Death Bereavement Website developed. Drop in sessions will be held on all hospital sites for staff, patients and relatives to talk about their bereavement experiences Bereavement implementation plan developed. Bereavement Collaborative established.	People across the geographical area will be able to access bereavement information and support. Accessible information based on the Bereavement Standards now inclusive of those with protected characteristics.	Series of 'drop in sessions' for people to talk about their bereavement experience. Develop Bereavement Model based on the SWAN model in England.
Equality and Diversity **(Stroke Services)**	People who have experienced stroke wish to have an opportunity to volunteer.	Three volunteers have commenced this post, supporting at YYF and County Hospital. Another in recruitment.	Co-production will allow people who have experienced a stroke to gain an opportunity in volunteering.	Continue with recruitment of volunteers. Volunteers and team to meet with the Physiotherapists at YYF to discuss supporting patients as part of their role and lived experience.
Equality and Diversity **(Neuro Diversity)**	People who are neuro-diverse have shared their experience of accessing A&E.	Patient Experience Story developed and shared at QPSOG. Divisional Leads will share with clinical teams. Meeting arranged with clinical leads and equality leads to discuss actions.	People who are neuro-diverse and all people with protected characteristics will have their expressed needs understood.	To develop Patient by Experience group for people who are neuro-diverse and with Protected Characteristics.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Deteriorating Condition, Death and Bereavement	Wife whose husband died expressed concern about lack of communication and lack of bereavement support when her husband died in hospital	Meeting with wide of deceased patient Digital story developed and will be presented to Board Relative has agreed to be part of the newly formed Bereavement Collaborative Scoping for staff training has commenced	Staff will be confident to support people through their bereavement journey. People's bereavement experience will improve.	Film to be taken to Board. Draft bereavement framework based on people's feedback Film will be shared at Deteriorating Patient/Safer Care workshop November 2023- particular focus on avoidance of 'complex' grief.
Patient Experience (PALS)	Relatives have raised concerned about being unable to contact wards and lack of timely information	Introduction of PALS service – Launched November 2023 Recruitment of 3 PALS Officers Alignment of existing PLO service to PALS. Public information published DATIX PALS feedback being implemented.	Patients and relatives will be able to access a single point of access to raise enquiries. There will be a reduction in formal complaints due to better processes for Early Resolution.	PALS Officers will be provided with additional training to support bereavement offer.
Patient Experience (CIVICA)	CIVICA roll out across MH/LD division and YYF with the person-centred care survey.	All 18 mental health and learning disability wards were visited with baseline data collected from 14 of 18 wards, totalling 63 surveys, and 6 medical wards and 1 surgical ward totalling 57 surveys. Findings fed back to senior nurse and deputy heads of nursing. Findings also shared with PC&C QPS team in readiness for data to be collected for monthly QPS reports.	Training offered to all wards and CIVICA posters sent out in readiness to go live. Supported wards to have a designated area so patient feedback process is easily accessible to patients and family.	To ensure all training is completed and wards are offering surveys to patients. Data collected and actioned by ward manager. Data to be shared via QPS. PCC Survey to be included in Ward Accreditation. Safety Visits to consider asking patients the 8 core PCC survey questions.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Staff Wellbeing	Request for more information about chaplaincy services and support from community religious / faith groups. How best to access services. Patient concerns of ward failure to refer to chaplaincy following requests. Staff fatigue and weariness.	On-going work to create information resource on Health Board internet site for external usage. Updating internal intranet information and contact details. Staff visits, awareness sessions, information leaflets and a visible presence. Patient feedback to wards where referrals failed to be made. Visits and awareness sessions. Met with identified ward managers to raise concerns and awareness. Wellbeing activities arranged, both chill out and pop-up sessions.	On-going. Some of the concerns highlighted by patients depend on ward staff to follow through. Continuing to work with staff to highlight concerns and actions needed. Positive experience and excellent feedback.	Maintain regular contact with external organisation asking for information.
Access **(Reasonable Adjustments)**	Patient contacted the PALS Team concerned about his appointment times and waiting at clinic in hard seat due to chronic pain	PALS Officers contacted clinic booking centre. Arranged for patient to be given first appointment slot, minimising the time they would have to wait in the clinic.	Reasonable adjustments to clinic appointments means that this patient will not have to sit in clinic for a protracted time whilst in chronic pain.	Continue to respond to patient feedback. Equality, Diversity and Inclusion manager part of patient experience collaboratives.

Person Centred Care:

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Mental Capacity Act **(Consent)**	Feedback from patients and relatives that the process for consent and information relating to consent to care and treatment is not clearly explained and the process is not always followed.	Funding applied for and received from Welsh Government to commission an animated educational awareness video for patients and carers on the principles of consent to treatment.	Increased awareness for patients, carers (and staff) on the consent process so they know what to expect and are informed on the process.	Development team has been assembled and production company engaged. Animation planned to be completed by March 2024.
Dementia **(Meaningful Activities)**	People have stated that they are bored on hospital wards. Staff are not aware of activities that may support a person's wellbeing.	NHS Charities Together have awarded a grant to take forward the meaningful activity agenda across Health and Social Care. Meaningful Activity training in place. Linked into enhanced care review. Resources secured. Over 150 Dementia Champions across Wards. Bitesize learning in place to support Champion Learning. Champion Network established.	People using services will be better engaged in meaningful activity to maintain cognitive stimuli and relationships. Staff will be more confident to engage those they support in activities that matter to them.	Appoint Band 6 and Activity Co-ordinator. Establish Partnership Collaborative. Align work programme to safer care collaborative and Enhanced Care Programme.

Person Centred Care:

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Dementia **(Pain Assessment and Management)**	Initial feedback from the NAD suggest areas of need around pain assessment in dementia care for those who may have difficulties or lack capacity to verbalise pain. Staff requesting support to better identify pain.	Discussion meeting set up to consider actions for improvements in the area of pain assessment and management.	Collaboration will ensure better awareness, understanding and assessment of pain for staff and carers.	Training programme to raise awareness of pain, especially for people living with dementia who may be unable to verbalise this.
Patient Safety **(Bedside Boards)**	Staff and Llais have expressed the importance of recognising 'at a glance' that people may have dementia. Concern expressed from relatives who believe that staff need more information on how to care for people with dementia.	Bedside Boards on hospital wards to support individualised patient care and experience. 1st phase of impact evaluation completed , using patient, staff and visitor feedback surveys. Using ward-based visits, social media and communications team to support awareness and value of the boards.	The needs of people living with dementia and what matters to them is better understood. Improved communication and awareness of need. Improved communication with patients, relatives and staff. Relaunched Johns Campaign.	Present impact evaluation to QPSOG in 2024.
Cancer Café's & Volunteers in cancer	More support is needed for people in the community living with cancer. People report having their physical needs met but not the emotional impact	Meetings held with Cancer Project Officer to establish Cancer Cafés to support patients in the community. Volunteers recruited and supporting 3 cancer cafes across our community	People in the community diagnosed with/living with cancer will have better access to cancer support. A patient reported: ' finding out truths from others ……on how we feel about dealing with cancer on a daily weekly basis, was invaluable'	Recruiting further volunteers. Introducing volunteer support on site to support cancer patients. Ongoing discussions around peer support through the Cancer Covid Recovery Steering Group

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Volunteer to Career	People with additional learning needs and those who have not worked in the NHS need support to gain work experience.	Met with Additional Learning Needs Tutor from Coleg Gwent. Met with Workforce to update with work plan who in turn signposted personnel to discuss volunteer Wellbeing Assistant. **47 volunteers** on the Volunteer to Career pathway, of which we are working with 9 individuals to gain further experience, training and to look at employment opportunities. Roadshows at 'Fresher Weeks' held at local colleges. Roadshows and volunteer promotion in community/supermarkets Attended Coleg Gwent Jobs Fayres and School Assemblies Met with Velindre Patient Experience Team Met with members of the Gwent Regional Partnership Board In addition, we are working with Welsh School of Pharmacy and Pharmaceutical Science through which we have delivered Volunteer Core training to 75 students the first cohort of students commenced at St Woolos and RGH in September , the 2nd in November and the third are to commence in January 2024.	People with additional learning needs and those with no experience of working in the NHS will be provided with volunteer opportunities to gain experience. Shared initiative at National Bevan Commission Event, National RCN Award presentation and Helpforce Cymru Meeting. **See Case Study:**	Ongoing collaboration with WOD, colleges and job centres. Continued promotion of the Volunteer to Career Programme.

Person Centred Care: Listening and Learning from Feedback

Volunteer to Career Case Study

Earlier this year we received a referral from the Domestic Violence Team who thought volunteering may support a young lady who had been a victim of Domestic violence and give her a sense of purpose.

This volunteer commenced at YAB and thoroughly enjoyed it but wanted more. The team arranged for her to volunteer additionally in a local care home to gain further experience.

In October of this year (2023) she was successful in securing a part time job in another Care Home in her Borough but after only a few weeks of volunteering in her local care home they offered her a full-time job.

On congratulating this volunteer, we asked if she would be happy for us to share her story. Her response was:

"I would be more than happy to let you share my story. if I could even help one person it would make me so happy".

Health, Safety & Security

Health and Safety Executive Engagement

The Health and Safety Executive (HSE) have issued the Health Board with a Notification of Contravention for breaches to health and safety law.

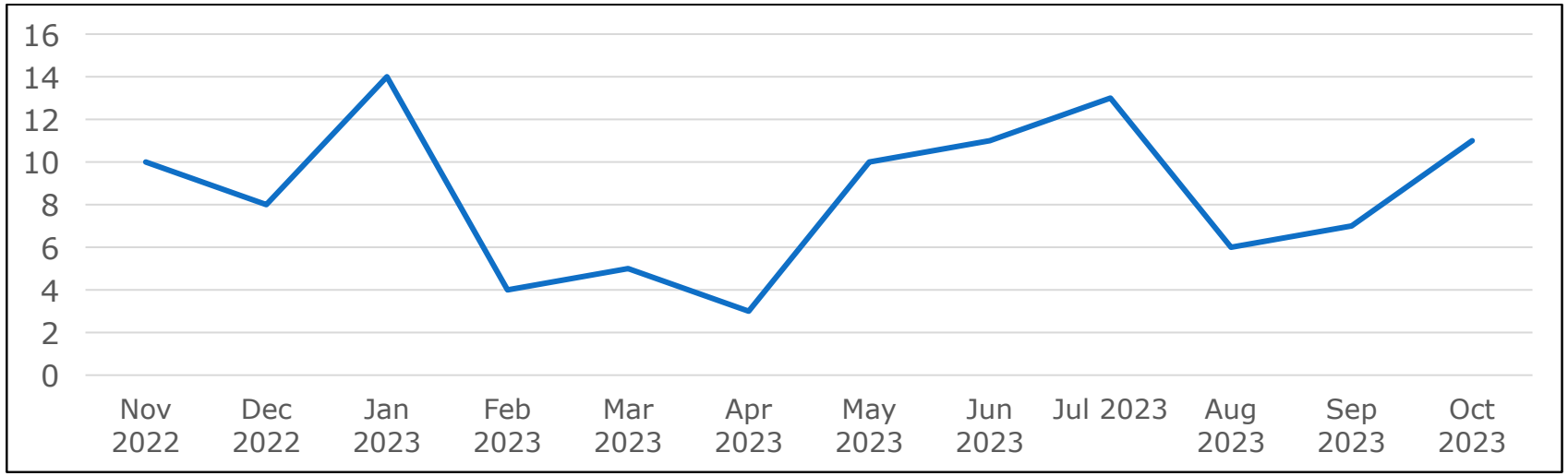
This follows the HSE investigation of a patient fall at Nevill Hall Hospital, which occurred in 2019.

The Health Board are currently preparing a response to the HSE.

Health, Safety & Security

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period November 2022 to October 2023 the Health Board have reported **102 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).



66% of these cases were reported within the legal timeframes within the legislation. This is an **increase of 6%** from the previous report.

Health, Safety & Security

Health and Safety Improvement Plan 2023/24

Seven risk areas for focus have been identified for improvement in 2023/24. These are: -

1) Manual handling training compliance
2) Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
3) Lack of proactive health and safety monitoring plan
4) The quality and standard of health and safety risk assessments
5) Compliance with the review of fire risk assessments
6) Adequacy of fire alarm systems
7) Compliance with the management of fire barriers (compartmentation)

Health, Safety & Security

Health and Safety Statutory and Mandatory Training

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

Health and Safety: 86%
Violence & Aggression: 85%
Fire Safety: 82%
Manual Handling: 55%

There has been an increase in Violence & Aggression and Fire Safety training compared with the previous report.

A review of the manual handling training strategy is being completed to ensure a sustainable programme of delivery.

Claims, Redress, Inquests, And Patient Safety Incidents

PSI Team
- Transfer to Legal Services

PSI Policy
- Updated and now approved

Time out sessions with the Team
- Back to basics
- Review of our systems and processes
- What can we improve /simplify
- Well being of Team
- More effective use of resources

Next phase
- Time out sessions to continue to build
- Focussed work with other stakeholders
  - Chairs and IO's
  - Divisional and QPS

COVID-19 Investigations

September & October 2023

	Wave 1 (27/02/2020 – 26/07/2020)	Wave 2 (27/07/2020 – 16/05/2021)	Wave 3 (17/08/2021 – 19/12/2021)	Wave 4 (20/12/2021 – 30/04/2022)**
Total Incidents	316	1152	321	10
Investigations Not Started	0	254	0	250
Under Investigation	0	34	0	37
Downgraded/ Recatergorised	31	64	177	265
Referred to Scrutiny Panel	0	294	0	131
Completed Investigations	285	506	144	356
Check +/-	0	0	0	0
Deaths	147	381	52	117

Wave 1: 100% complete

Wave 2: 75% complete

Wave 3: 100% complete

Wave 4: 72% complete

Overall: 83% complete*

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

Highlights:

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

Challenges:

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

Mitigating Actions:

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

COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Retention of FTC staff	High FTC resource & high risk of losing resource prior to 31 March 2024.	Requested 3 Month extension (to 30 June 2024) for critical resource to secure programme completion. Non-Clinical Investigator strategy tried & tested, recruited into vacancies. Early conversations with staff re: next steps and redeployment.	COVID-19 Investigation Team (CIT)	On going
Investigation resource to undertake live wave in line with Duty of Candour	Out of scope of the NNCP framework.	Actions with IP&C	IP&C	On going
General record keeping & access to information	Clinical notes sparse for COVID-19 identification & management.	N/A		
	Locating pertinent notes due to non-chronological back scans.	N/A		
	Mental Health notes in off-site storage facilities.	Liaising with Health Records colleagues. Improvement seen late June.	COVID-19 Investigation Team (CIT)	On going
Delayed start to programme & resource to complete programme on time.	High FTC resource and high risk of losing resource prior to 31 March 2024.	Requested 3 Month extension (to 30 June 2024) for critical resource to secure programme completion. Non-Clinical Investigator strategy tried & tested outcome positive. Further recruitment in progress.	COVID-19 Investigation Team (CIT)	Ongoing
Investigation resource to undertake live wave in line with Duty of Candour.	Out of scope of the NNCP framework.	Actions with IP&C	IP&C	Ongoing
Availability and time to locate clinical notes.	Mental Health notes in off-site storage facilities.	Liaising with Health Records colleagues	COVID-19 Investigation Team (CIT)	Ongoing

Safeguarding Assurance

Data Analysis and Safeguarding System Assurance

Safeguarding Maturity Matrix

The ABUHB Safeguarding Team has recently completed and submitted the Safeguarding Maturity matrix, which is an all Wales tool used to determine compliance with statutory and mandatory obligations in respect of safeguarding.

Overall compliance was good, though it was noted there were areas for improvement, for which remedial actions are underway, in relation to:

- Level 3 Adult Safeguarding Training
- Service User Feedback

Child Protection Medical National Audit

ABUHB have participated in an all England and Wales Audit, looking at standards in relation to Child Protection Medicals. Overall compliance was good, though it was noted that good practice needed to be strengthened by production of a SoP to support and standardise this practice.

Safeguarding

Current Practice Reviews

The Corporate Safeguarding Team are currently supporting Safeguarding Boards with:

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

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

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

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

Safeguarding

Training and Development

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

- Current training compliance:

Level	Adult	Children
1	84.%	77%
2	86%	85%

- Safeguarding level 3 training package commenced in April 2023. Both adults and children's training packages are currently evaluating well.

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

Safeguarding

Issue	Cause	Remedial Action	Who	When
Timeliness and Quality of Safeguarding Referrals from ABUHB Professionals	Practitioners are not always recognising the requirement to refer or prioritising the completion of the DTR forms. Some staff do not feel confident in reporting concerns, therefore await management approval/assistance to do so.	• An audit tool has been developed to assess timeliness and quality of Safeguarding Adult Referrals, which will be trailed in the Medical Division	Corporate Safeguarding Team/Medical Division	Q4 2023/24
Poor compliance/ uptake of Adult Level 3 Training	• Staff shortages impacting volume able to attend training • Understanding the value of the training for staff groups identified in the intercollegiate document • Training not mandated via ESR	• Mapping of staff groups requiring level three safeguarding training now complete • Discussion at Safeguarding Committee and request to Divisions to actively encourage engagement • Discussions with ESR to have Level Three training added to this platform ongoing	Corporate Safeguarding Team	Ongoing
Potential Failure of the Multi Agency Risk Assessment Conference (MARAC) process in Gwent	• Multi agency partners are reducing their level of support/funding to the process • The process is non statutory and therefore has no centralised funding steam	• ABUHB are looking at their current financial contribution and their in kind contribution, to ascertain if there are cost neutral solutions • ABUHB are engaged in Multi Agency Conversation to understand if the financial burden can be lessened by alternative ways of working	Corporate Safeguarding Team	January 2024

Nursing Staffing Levels Wales Act 2016 title

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 – Sept-Oct 2023	Number of closed incidents/co mplaints -Sept-Oct 2023	Total number of incidents/ complaints <u>not closed</u> and to be reported on/during the <u>next</u> reporting period -	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	3	1 of the 3	2 of the 3 (There are 2 HAPU's still open from July/Aug) (There are 4 HAPU's still open from May/June)	1	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	9	5 of the 9	4 of the 9 (There are 5 Injurious falls still open from May & June) (There are 3 injurious falls still open from July/August)	0 of the 5 closed	0
Medication errors never events	0	0	0	0	0
Any complaints about nursing care	24	6/24	18/24 (10 complaints remain open from April-September 2023)	0 of 3 closed completely Plus there are 3 closed with0ut NSLWA section completed	Not known at this time out of the 3 closed incompletely
Infiltration/ extravasation injuries	0	0	0	0	0

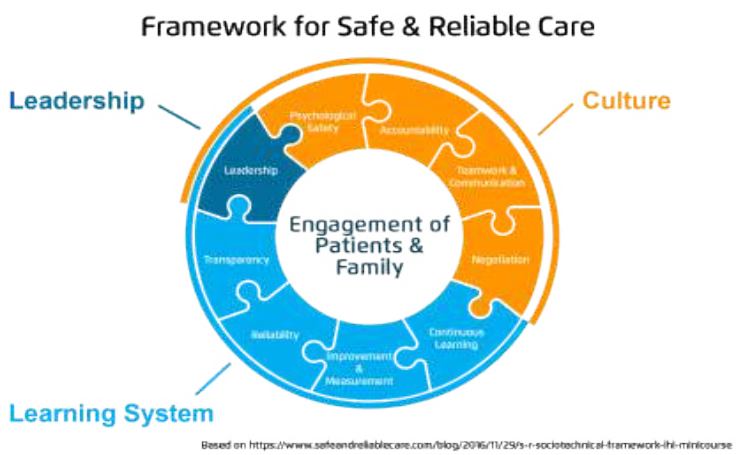
Nursing Staffing Levels Wales Act 2016 title

Issue	Cause	Remedial Actions	Who	When
Positively there is a reduction in Hapu's compared to previous 2 months (Possibly attributed to PU collaborative). However, there are historical HAPU's that still require review.	Some areas are not undertaking timely investigations of pressure ulcers	Support areas that are behind in undertaking reviews and establish the barriers to preventing timely reviews.	Divisional Nurses Nurse Staffing Programme Lead	October 2023
Fewer injurious falls than previous 2 months, however, there is a delay in closing falls datix	waiting for presentation to Falls Panel or completion of SI investigation	Staff to be reminded to close datix following presentation at Falls Panel	Divisional Nurses	October 2023
Ward managers not completing the staffing Act questions in the investigation section of Datix.	The question "Is this related to nursing care" in Datix defaults to NO in the drop-down box- resulting in the question being missed- trying to address this in the All-Wales group.	Further education and training for divisions on correct process. Nurse staffing lead reviews all reportable QI's and contacts ward managers and senior nurses to complete NSLWA questions.	Divisional Nurses Nurse Staffing Programme Lead	October 2023
The NSLWA section in complaints involving nursing care is not being completed.	Senior nurses are not prompted to update the datix by the concerns teams and sometimes the senior nurse is not assigned access to the datix	Training and education of the complaint handlers and senior nurses is necessary	Nurse Staffing Programme Lead	October 2023
Complaint handlers do not always answer yes to the question "is this to do with Nursing Care" therefore the staffing Act questions do not open on datix	Complaints often multifaceted, spanning different wards, specialities, divisions, and hospitals.	QPS teams to ensure the answer to the question is Yes- if nursing team are involved in the response.	Nurse Staffing Programme Lead	October 2023

All Wales Patient Safety Solutions:

Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
PSA008 NG Tube misplacement: continuing risk of death & severe harm Compliance deadline: 30/11/2017, updated to 29/09/2023	29-Sep-23	Work underway. Issues pending include implementing a scheme of on-going audit.	Work in-progress
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	29-Sep-23	This notice requires HBs to ensure that a plan is in place for the development of a system with a unique temporary identification of unknown patients using the system outlined in the notice. Sex, DOB + estimated age range, non-sequential unique ID number and first and last name based on an edited phonetic alphabet. This project is kindly being lead by Peggy Edwards, we have a working group at ABUHB and are meeting approximately 8 weekly.	Work in-progress
PSA016 Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	15-Dec-23	Work underway. The ABUHB policy for AKI and treatment of hyperkalaemia has been revised and is due to be presented at panel.	Work in-progress



Safe Care Collaborative - update

Organisational Update: Stage-Action Period 6

- **Learning Session 3, Sept 19-20** – Teams presented storyboards
- **ABUHB Deteriorating Patients Event – localising SCC work -** Maxine Power facilitated session in October with SCC teams and wider organisation – first session localising the work
- **Preparing for LS4 local event in November at STC**
- **Leadership programme of work** – schedule of executive Safety Walkarounds – 4 visits took place during Sept/October and are focussing on Mental Health. Board Development Session for SCC teams in October. OCP process initiated bringing together QPS & QI Teams
- **Quality Strategy** – Further work to refine Quality Outcomes Framework and initial Q1&2 report complete. Delivery Plan – work ongoing Pressure Ulcers, Theatres
- **QI Skills Development**– Dates for Improvement Cymru to run Improvement in Practice and co-produced bespoke Quality Coach Course set for December onwards. PocEd QI, PocED Measurement dates set for 2024

Team Update:

- **Storyboards -** Teams presented their work at Learning Session 3 in September, at ABUHB Deteriorating Patients day and at Board Development Session in October
- **PDSA cycles ongoing** – e.g. SBAR form use, PSAG board discussions, visual display of Careflow data, use of tablets on ward for real-time data collection
- **Measurement Strategy/data** – teams have measurement strategies in place and systems to collect data
- **Improvements** starting to be reflected in the data
- **Theatres Never Events** – Planning support for Theatres Human Factors/Never Events Programme

Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3
	Theatres – Human Factors	tbc
Ambulatory	North Monmouthshire Integrated Team	3.5
Community	Glaslyn Care Homes	1
	Mental Health OT Team	2.5
Leadership	Executives, Leaders for Safety, Faculty	3

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

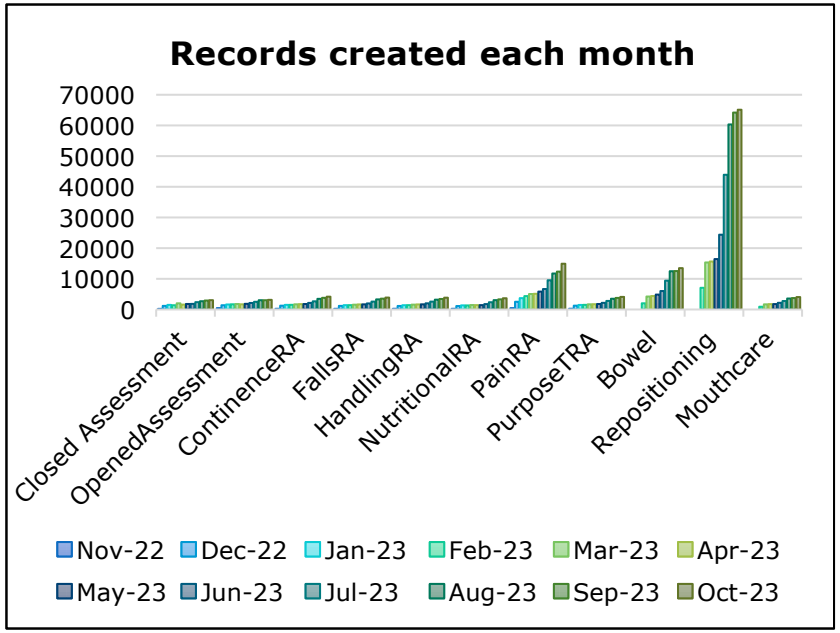
Welsh Nursing Care Record

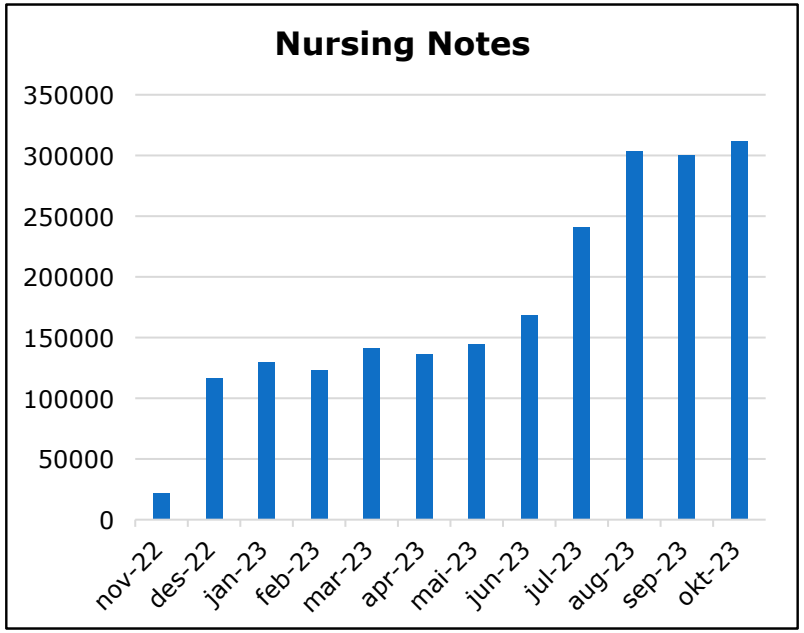
Rollout started at NHH 3 wards live (29 ward across three sites).

YYF to follow NHH implementation, plan now is in place for all in-patient setting to complete July '24.

Version 2.3 release delayed to 28th Nov 2023 with a single instance across Wales; no new form but several key changes requested e.g. falls assessment.

Funding has been provided for hardware across the health board

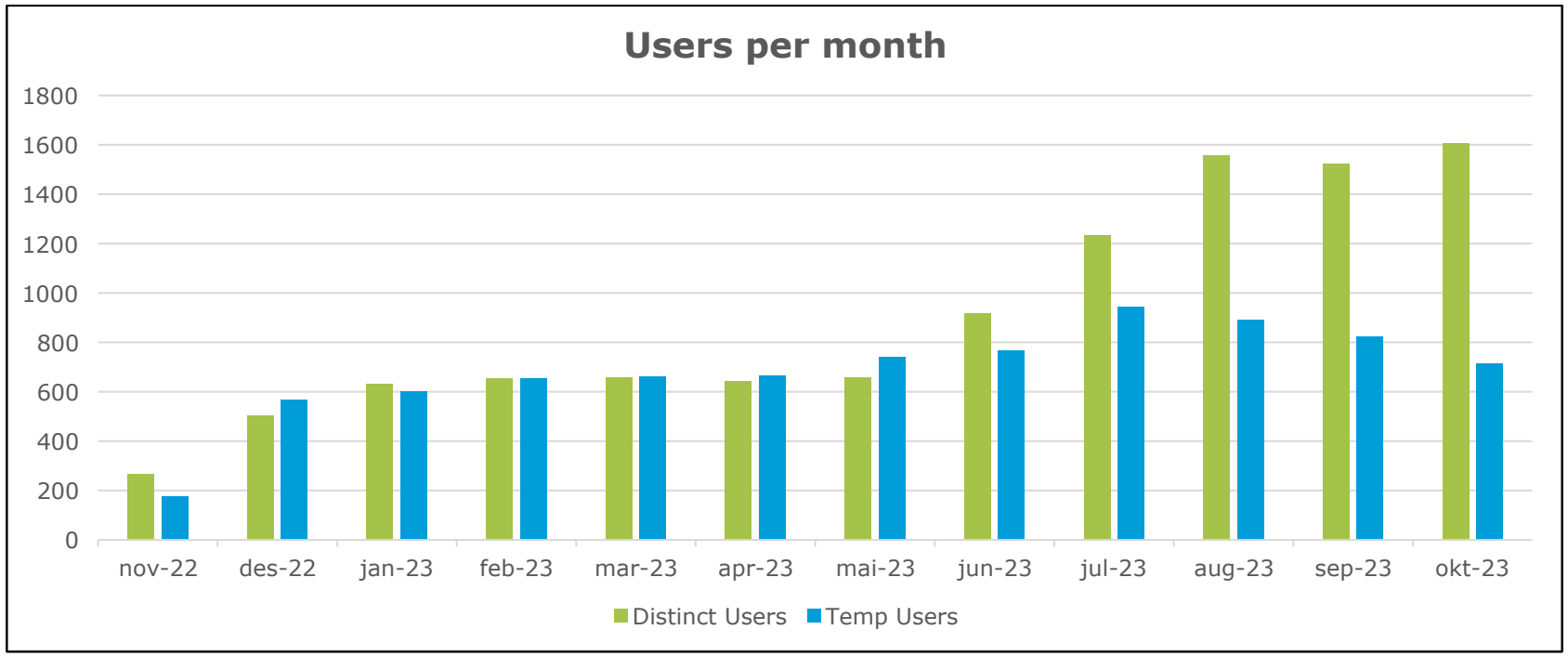




Welsh Nursing Care Record

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

However this remains a significant challenge especially with night staff who are not available during the day to engage with the access process.

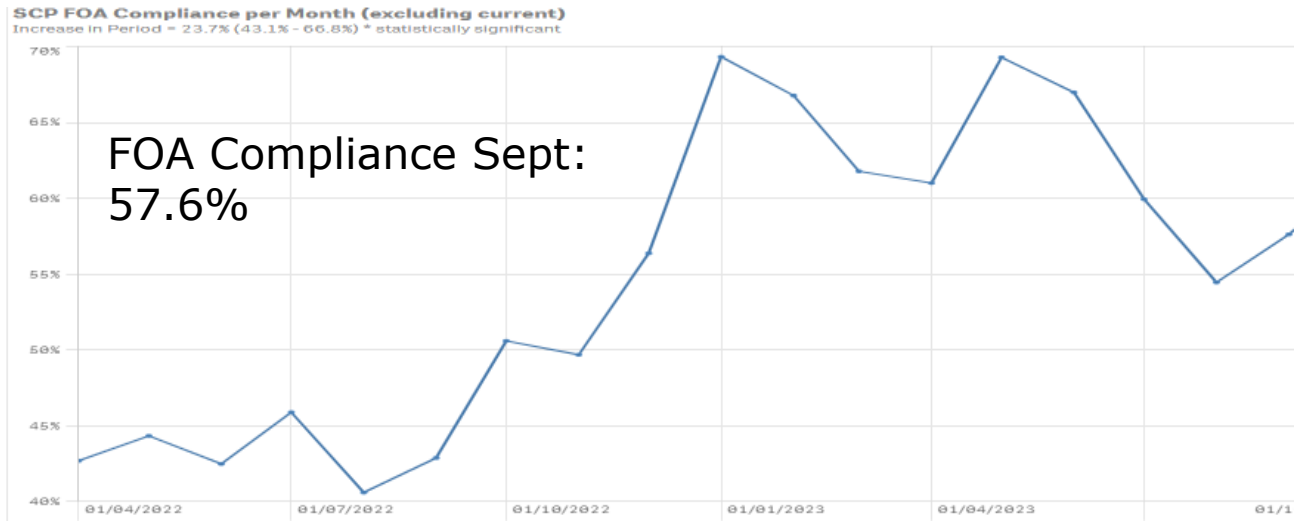


Welsh Nursing Care Record

Issue	Cause	Remedial Action	Who	When
Delay in getting a WNCR record started on one ward (one ward resolved) remains an issue	One ward have issues where the patient pathway on WPAS is not completed for semi-elective patients	Training has been provided to support WPAS pathway selection when booking patients	CNIO / Business change lead	Asap - ongoing
Dual running across the health board of paper and digital system	The digital patient assessment is only available via Welsh Clinical Portal upon step down	Digital Health and Care Wales are to provide integration with the documents data base (delayed) WCP provided for all nursing staff	DHCW	Q3
Not currently providing qualitative data to ward managers	Dashboard output from data warehouse not yet available	Requirements gathering ongoing and mechanisms to provide dashboard being explored – outline measures identified to be available in June	CNIO	Q1
Duplication of recording nursing information	Not all information requirements on WNCR. Impression all data needed on TCAB	Request for change process for WNCR Review of what data items recorded in multiple areas e.g. observations	Digitisation Nursing Documents Group	Q2
CNIO availability to support further roll out	CNIO also Clinical Safety Officer for health board	Planning and prioritisation of CSO activity	Directors of Digital	Q3
Night staff / Bank / HCSW Nadex access	Lack of use of Nadex accounts users do not have active accounts when ward areas go live	Ward managers processing accounts Engagement with Bank to ensure access Out of hours support from Service desk	Directors of Digital / Ward Managers	Ongoing

Cancer – 62 Day Performance

SCP Compliance: May 2023

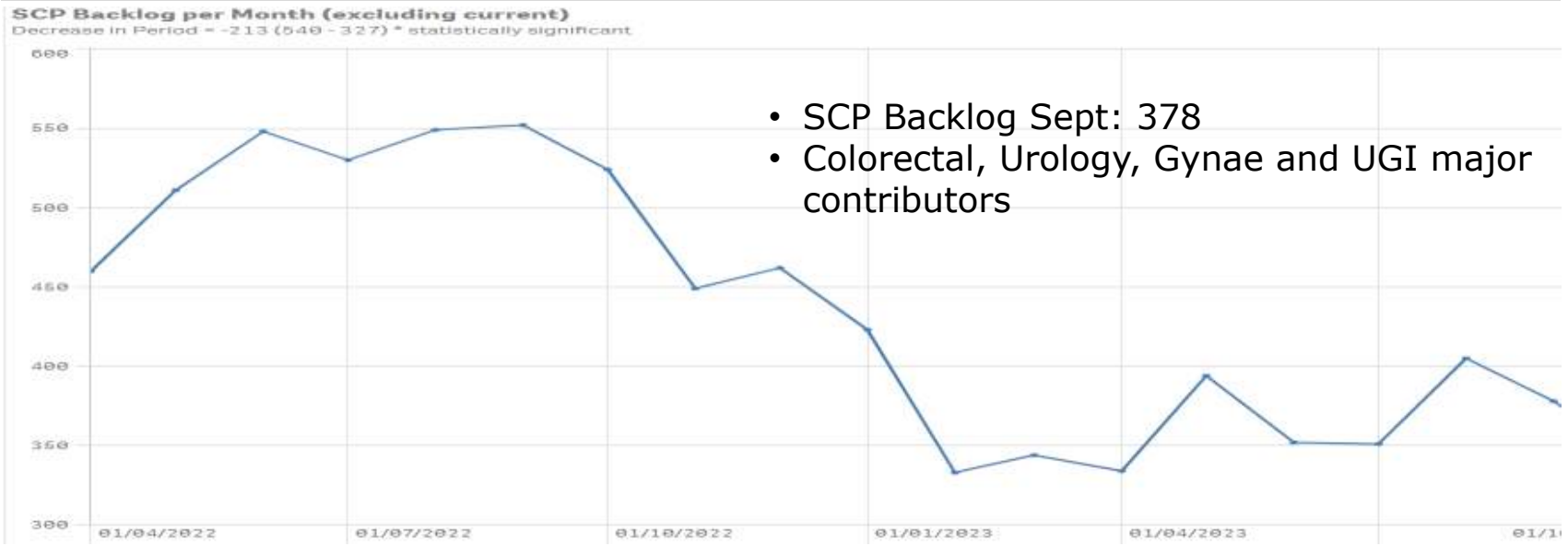


Most tumour sites saw a decrease in compliance during September due to 40% of the patients treated being in the backlog. Lower GI in particular saw a considerable decrease due to 30 breached patients being treated, 50% of which were over 104 days.

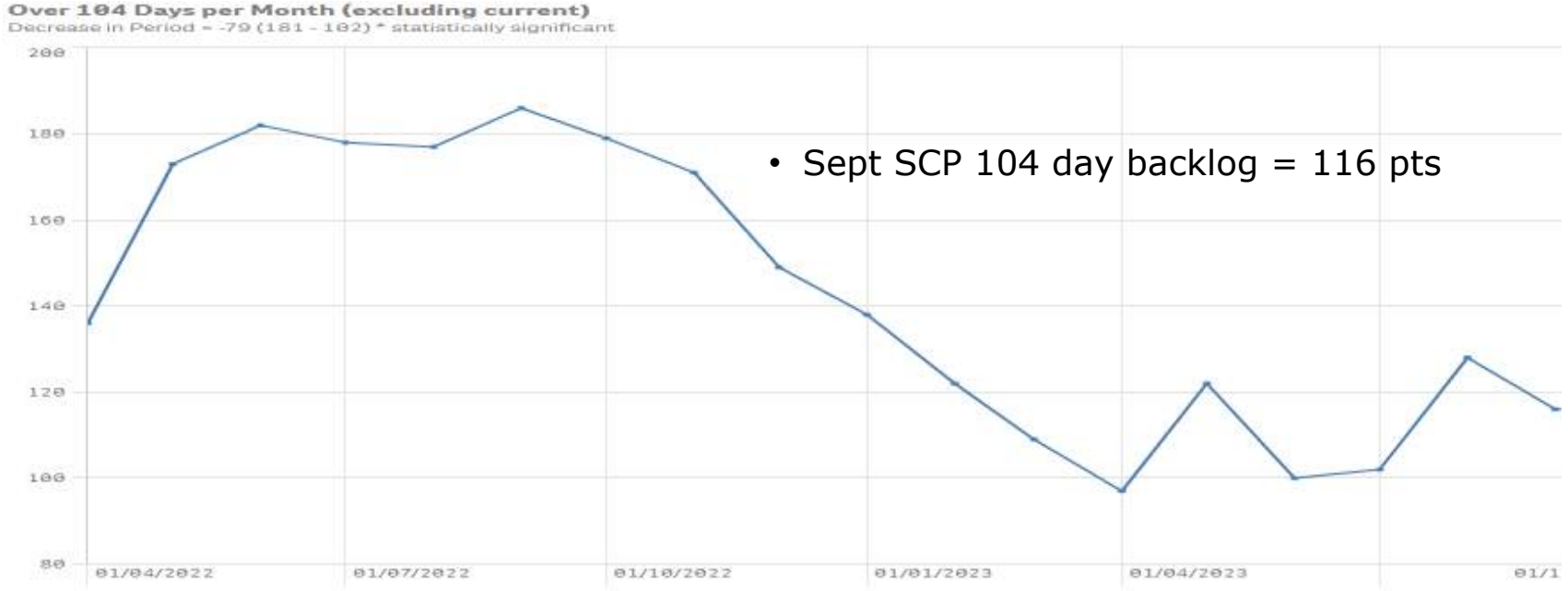
14 day compliance rose in September following the impact of the previous increased referrals and seasonal variation. In particular, Skin's FOA compliance is increasing and is expected to continue.

Cancer Backlog

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

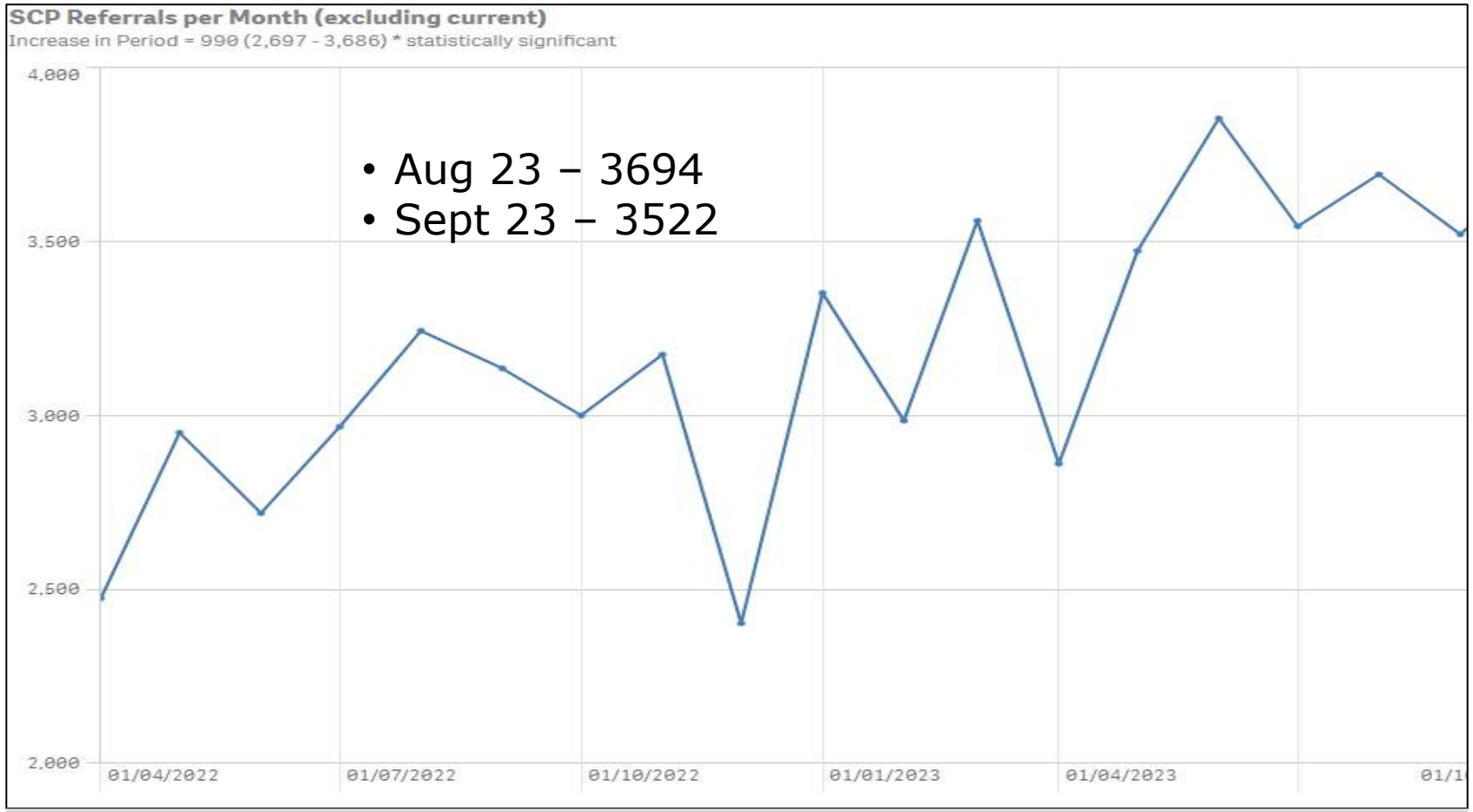


- SCP Backlog Sept: 378
- Colorectal, Urology, Gynae and UGI major contributors



- Sept SCP 104 day backlog = 116 pts

SCP Demand



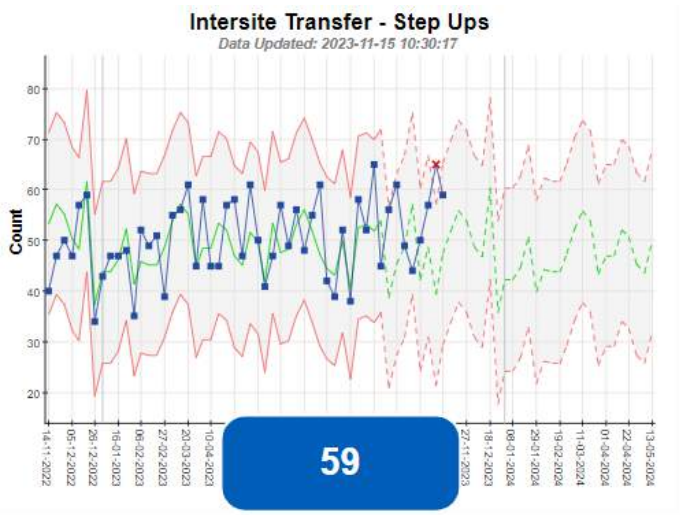
Demand continues to remain high however referrals have returned to the predicted level following the exponential increase in demand seen in June.

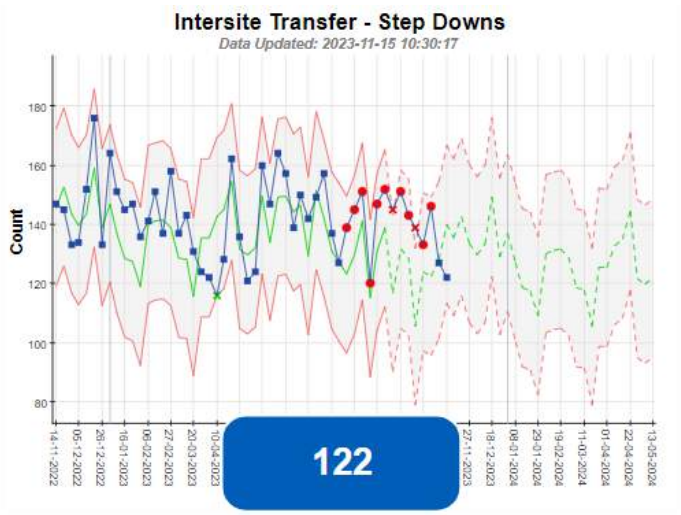
Risks

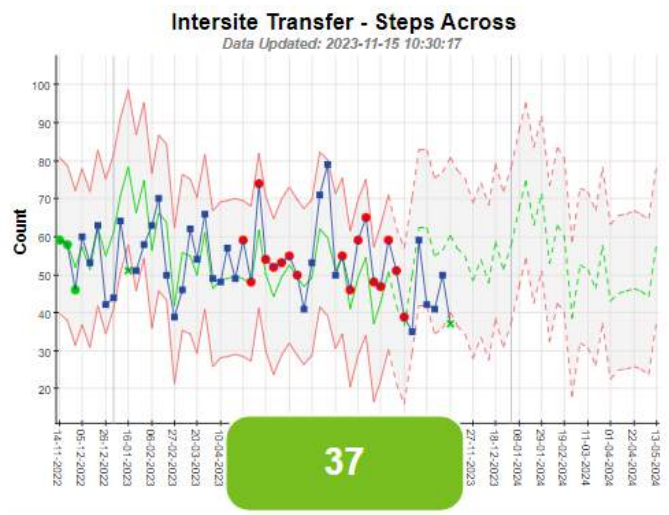
Issue	Cause	Remedial Action	Who	When
Loss of Urology clinic and surgical capacity at key holiday times, including half terms.	Overlapping and/or simultaneous annual leave taken (medical staff).	Development if local annual leave policy for implementation.	General Manager	December 2023
Long waits for endoscopy investigations	Demand outstripping capacity. Patient choice either cancelling appointment or changing to a later date after accepting first one.	New endoscopy unit opening. Additional capacity in first two weeks due to lists being prioritised for USC requests. In reach capacity remaining in place for first two weeks of new unit opening.	Assistant General Manager	November 2023
Patient choice across all elements of the pathways.	List size inflated. Negative impact on SCP performance.	Communication of SCP guidance in cases of serial CNA patients.	Cancer Services Manager	November 2023

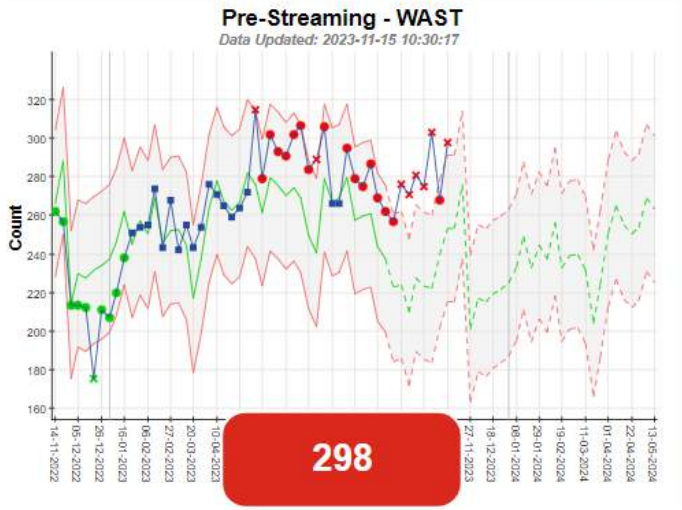
Goal 2: Signposting people with urgent care needs to the right place, first time

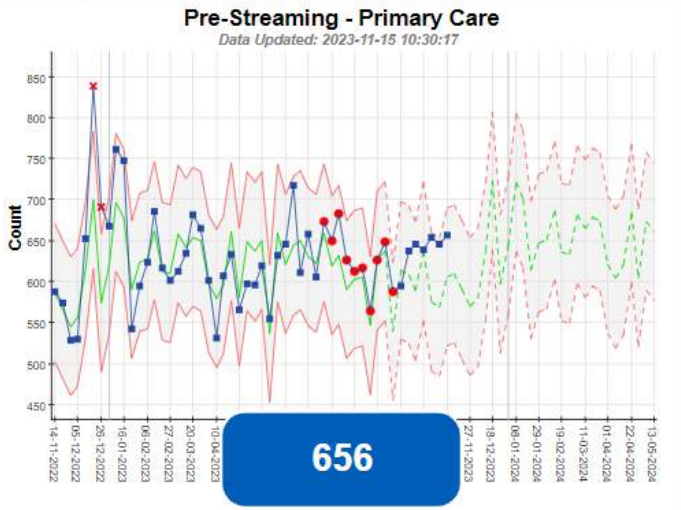
Flow Centre





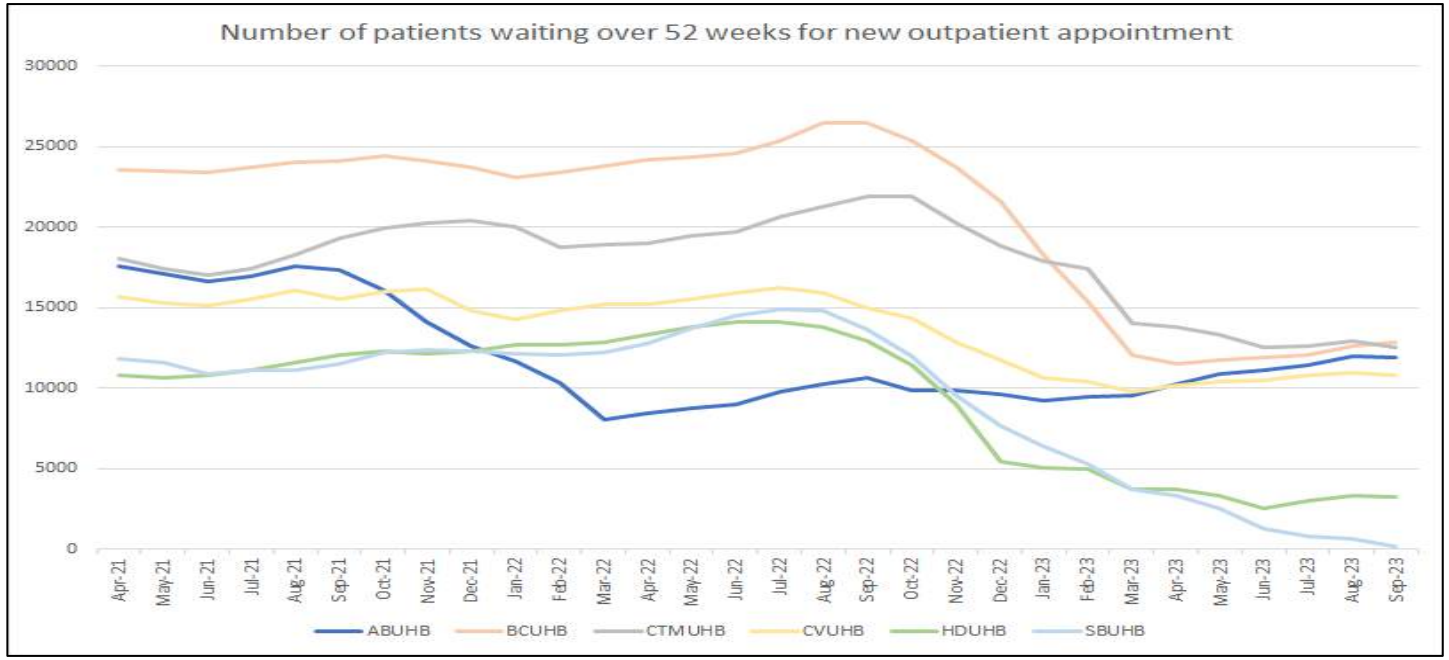


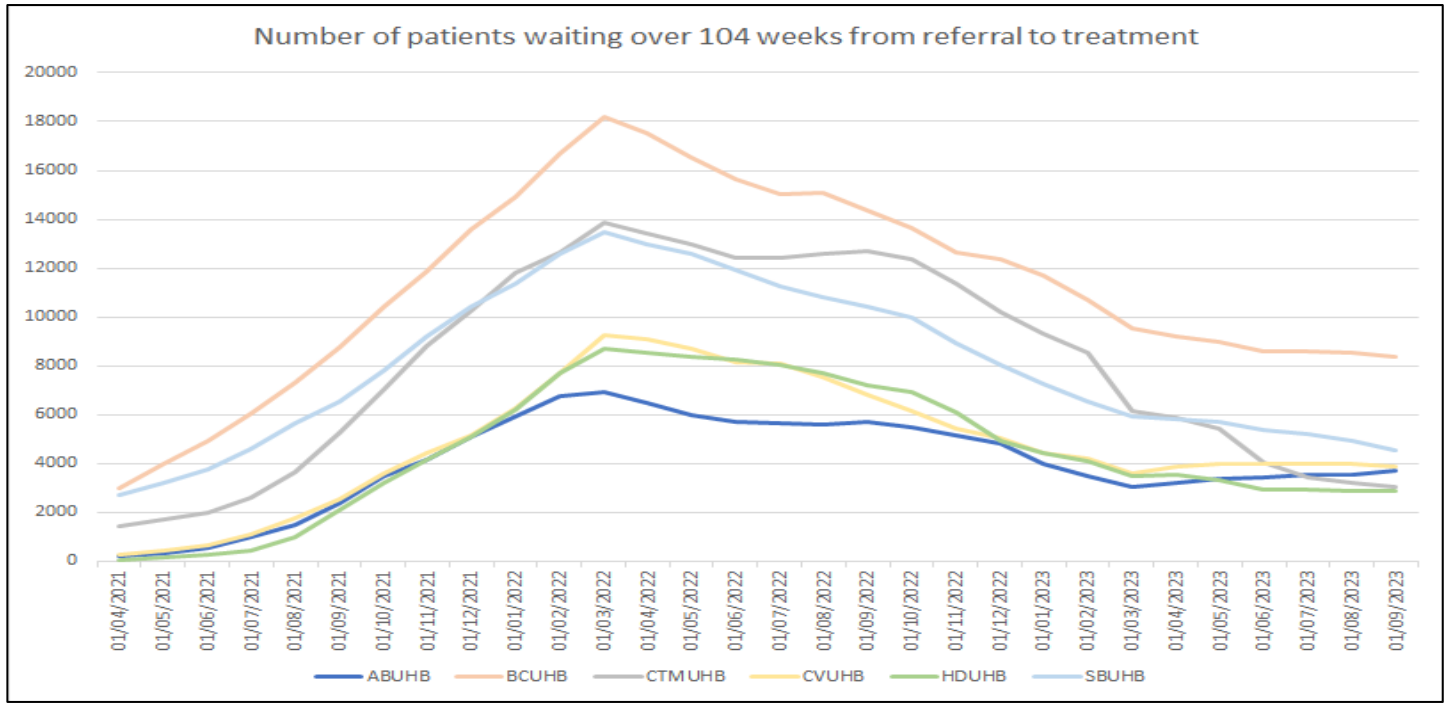




- High number of **Step Ups** recorded last week
- **Step Downs** had been higher around 140-160/week, but have reduced to usual levels
- **WAST Pre-Streaming** has been higher than usual around 250-300/week
- **PC Pre-Streaming** has reduced back to usual but showing signs of a gradual increase
- Others operating as normal

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

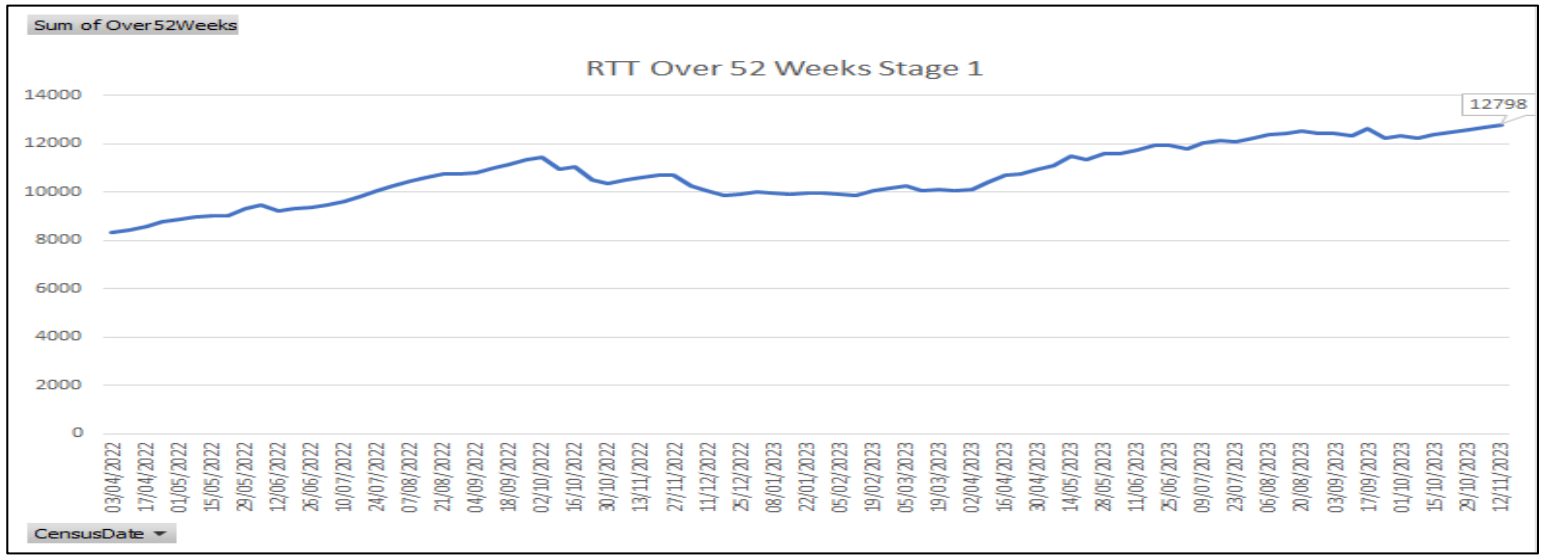




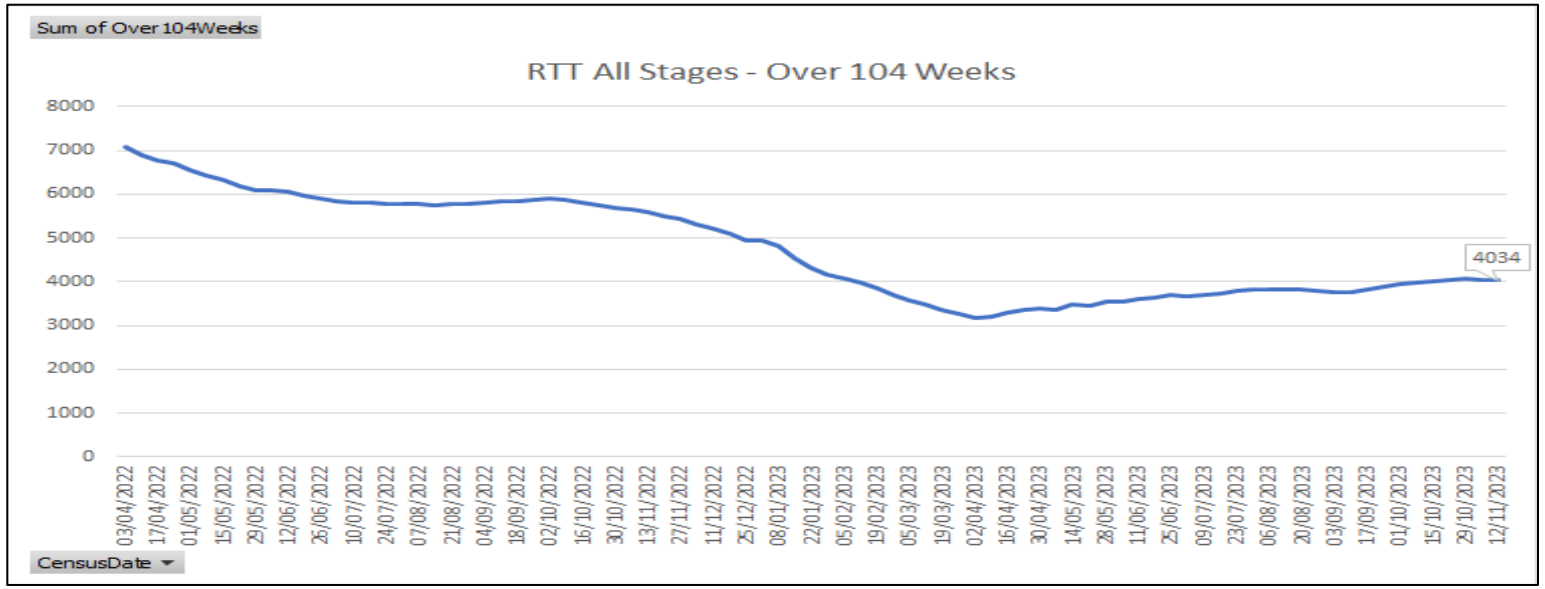
Planned Care

RTT Weekly Snapshot *(reportable activity only)*

RTT – Stage 1 (New Outpatients) Over 52 Weeks



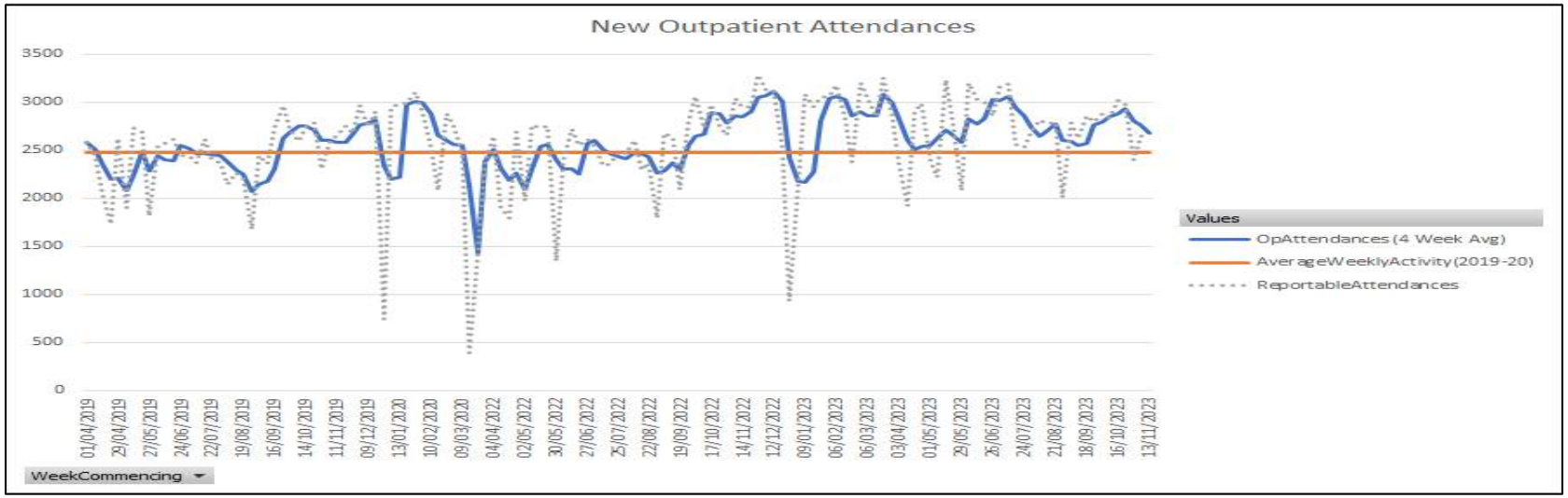
RTT – All Stages Over 104 Weeks



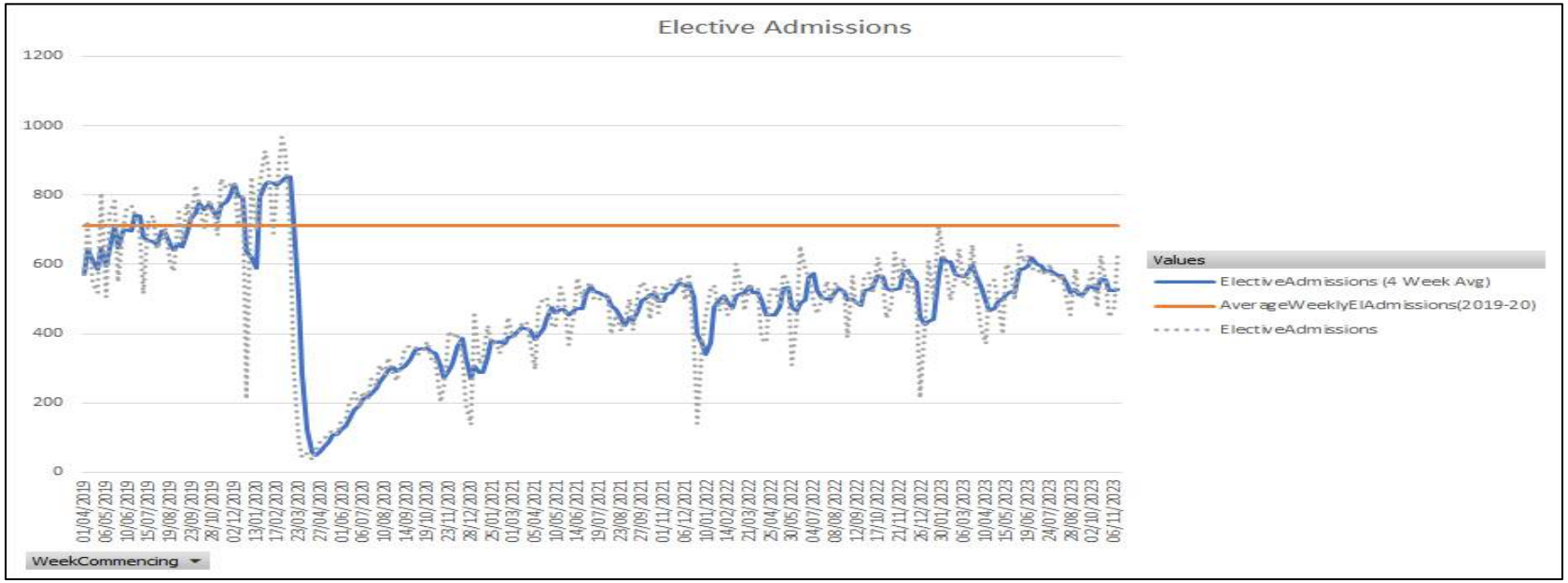
Planned Care

Activity Summary

New Outpatient Attendances (RTT Specialties Only)



Elective Admissions (Surgical Specialties Only)



Planned Care

Performance Overview – Actual (Waiting List Snapshot 20/11/23) against Model Forecast

Outpatients

Over 52 Weeks Stage1(Current Week)	Change Stage 1 Over 52 Weeks (past 5 weeks)	Model Forecast Over 52 Weeks St 1 (Current Month)
12798	570	10513
		2285

Over 104 Weeks Stage1 (Current Week)	Change Stage 1 Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks St 1 (Current Month)
1982	42	155
		1827

Division/specialty	Over 52 Weeks Stage1 (CurrentWeek)	Model Forecast Over 52 Weeks St 1 (CurrentMonth)	Variance Against Model New Over 52 Weeks	% Var Againt Model St 1 52W	% Var Againt Model St 1 52W Status	Change Stage 1 Over 52 Weeks (past 5 weeks)
⊞Clinical Support Services	3		3			1
⊞Family and Therapies	93		93			50
⊞Medicine	26		26			5
⊟Scheduled Care						
Ear Nose & Throat	3914	4187	-273	-7%		85
General Surgery	3		3			3
Maxillo-Facial	973	170	803	472%		48
Ophthalmology	4963	4501	462	10%		415
Orthodontics	76		76			22
Trauma & Orthopaedic	1699	441	1258	285%		-81
Urology	1048	1214	-166	-14%		22
Grand Total	12798	10513	2285	22%		570

Stage 4 Treatments

Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks (Current Month)
1327	-88	571
		756

Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)	Model Forecast Over 156 Weeks (Current Month)
193	-49	19
		174

Division/specialty	Over 104 Weeks All Stages (Current Week)	Model Forecast Over 104 Weeks (CurrentMonth)	Variance Against Model Over 104 Weeks	% Var Against St 4 104 Weeks Status	Change Over 104 Weeks (past 5 weeks)
⊞Medicine	1		1		0
⊟Scheduled Care					
Ear Nose & Throat	198	78	120		13
General Surgery	105		105		2
Maxillo-Facial	8	0	8		2
Ophthalmology	132	0	132		-28
Trauma & Orthopaedic	771	493	278		-54
Urology	113	0	113		-23
Grand Total	1328	571	757		-88

Planned Care Recovery Programme

Exec Lead:	Hannah Evans	SRO:	Rich Morgan Evans

Programme Objective

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

What Went Well this Period

- **Diagnostics** – Endoscopy unit at RGH opened on 6/11/23. Continuing to engage in regional diagnostic developments.
- **Theatres** – new dashboard released 9/10/23 - provides reliable and usable data on theatre productivity measures
- **Patient Access and Activation-** engaging with WG 3Ps Programme. Single Point of Contact (SPOC) service funded in principle by WG – business case to PIP on 22/11/23.
- **Health Pathways-** first pathway has been through wider review (final stage in pathway write up process). Comms plan is being implemented. Go live in Q4 23-24.
- **Outpatients** – working with DHCW to progress proof of concept and potential pilot of Automated Clinic Booking System to increase clinic efficiencies and utilisation.
- **Planned Care Academy** – 3 workstreams are progressing objectives. Finalising training packages for WPAS.

Key Milestones and Deliverables for the Next Period

- **Theatres** – embed dashboard in regular reporting alongside agreed KPIs.
- **Patient Access and Activation** – progress SPOC business case.
- **Health Pathways** – finalise first pathways. Agree on specialties for phase 2 priority pathway development.
- **Outpatients** – agree potential pilot for Automated Booking System.
- **Planned Care Academy** – agree how to deliver training and plan.

Key Risks

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

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

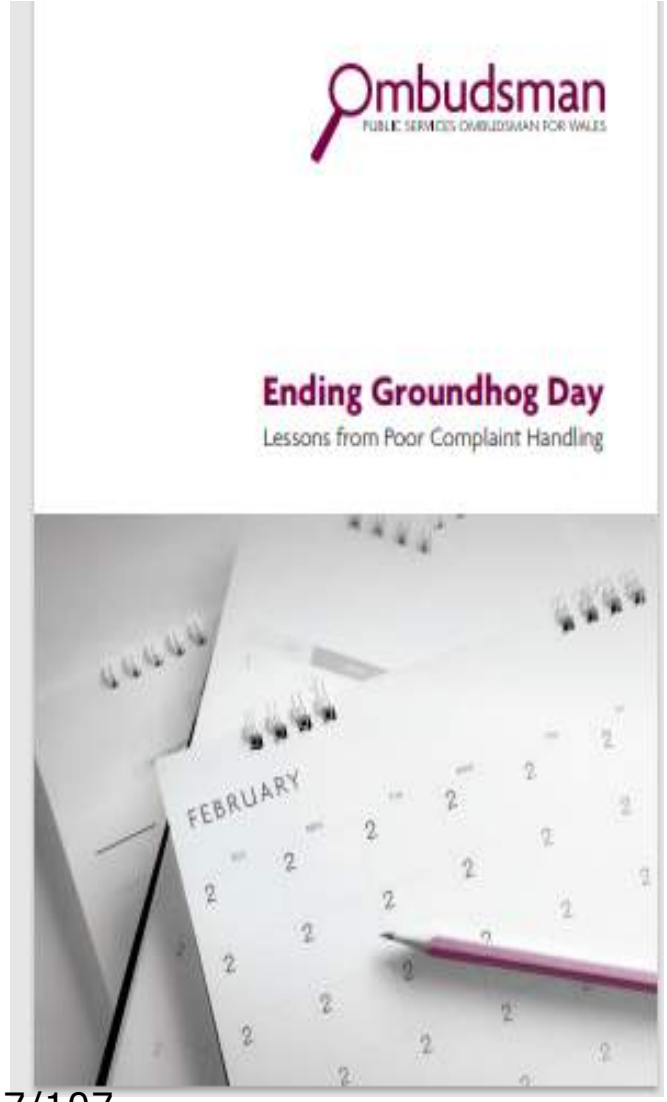
PUTTING THINGS RIGHT
GWEITHIO I WELLA

LEARNING FROM PSOW REPORT….

GROUNDHOG DAY 2:
AN OPPORTUNITY FOR CULTURAL CHANGE IN COMPLAINT HANDLING?

PQSOG November 2023

Background and Context



Published in 2018 Report highlighted;

1. inappropriate/inadequate involvement of staff complained about
2. inadequate investigation of complaints
3. delay in responding to complaints
4. incomplete/inaccurate responses to complaints
5. defensive attitude to complaints

2023 REPORT

WHAT HAS CHANGED?

A lack of openness and candour

- Clear evidence of maladministration or services failure not identified during local investigations

Importance of timeliness and good communications

- NB: Recommendation identified in recent WRP

Acting fairly and proportionately

- The need for robust investigations

A lack of objective clinical review of clinical care and treatment

LEARNING FROM WRP ASSESSMENT

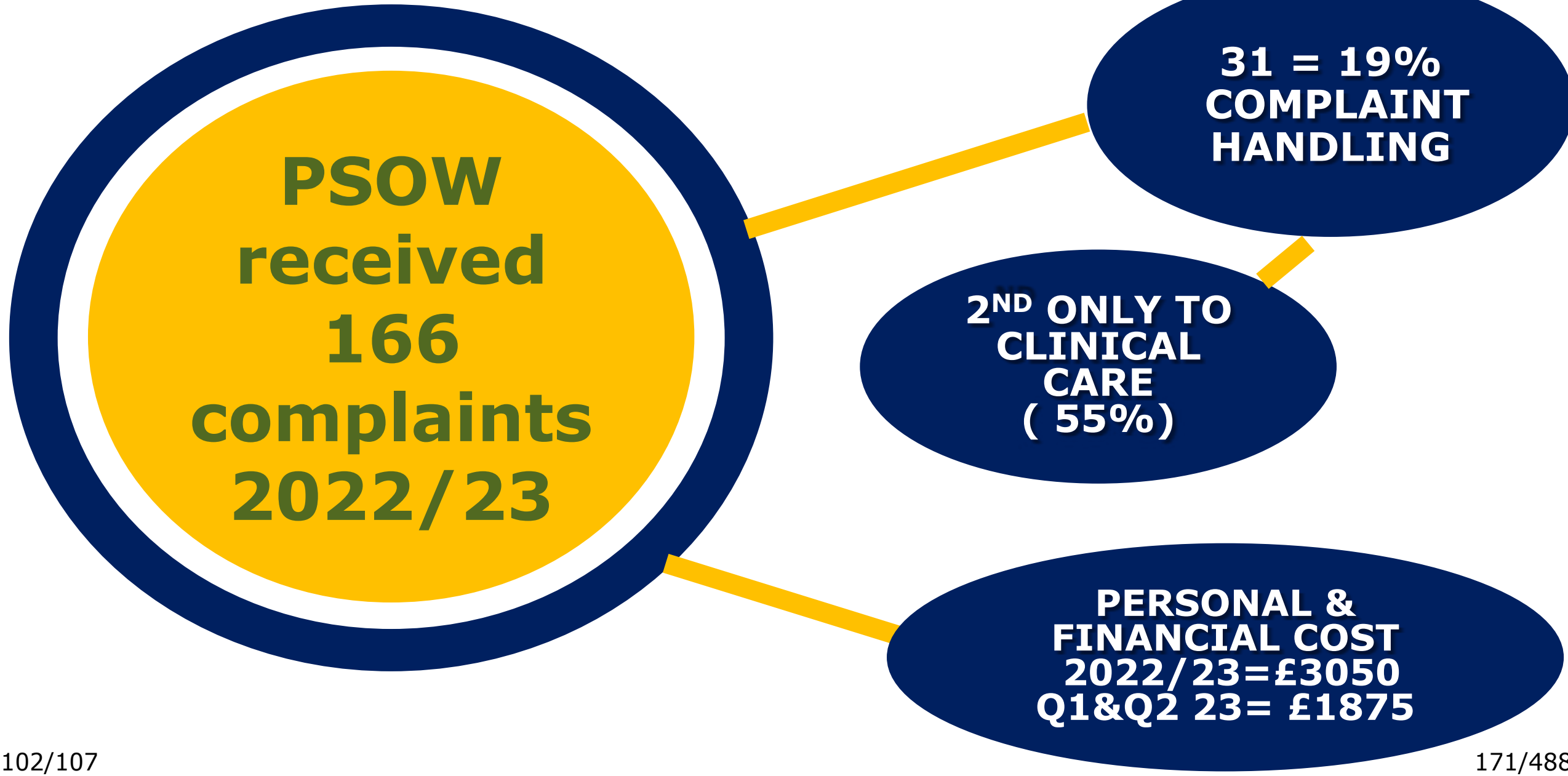
Assessment undertaken May 2023 and review June 2023:-

Recommendation:

ABUHB to ensure there is a robust process for the issuing of regular update letters and updates to patients and their families during the investigation of a complaint

LACK OF OBJECTIVE REVIEW OF CLINICAL CARE AND TREATMENT

In Mr J's case, the PSOW found that the Aneurin Bevan University Health Board had mishandled arrangements for the surgery Mr J needed. This resulted in an avoidable 5-week delay until the surgery took place (which breached the National Pathway guidelines for colorectal cancer). This had a very negative impact on Mr J. Rather than accept that it had made this mistake, the Health Board's complaint response lacked candour and openness. It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. The Health Board should have been open with Mr J about this from the start, when it responded to his complaint.


PSOW received 166 complaints 2022/23
31 = 19% COMPLAINT HANDLING
2ND ONLY TO CLINICAL CARE (55%)
PERSONAL & FINANCIAL COST 2022/23=£3050 Q1&Q2 23= £1875


Groundhog Day
2018
Groundhog Day2
2023
Work together to prevent a Trilogy

FINAL UPDATES

Quarterly meeting with PSOW this week……

PSOW are about to publish All-Wales figures for Q1 & Q2

- AB UHB receive 5.4 complaints per 1000 population - national average is 6.12
- National average for referral rate is 5% and AB UHB is aligned to that
- PSOW Concerns training to restart Feb 2024 – colleagues can self-book –

  (link will be on PTR Intranet page once available)

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

PUTTING THINGS RIGHT
GWEITHIO I WELLA

THANK YOU FOR LISTENING

GROUNDHOG-DAY-2-REPORT_PSOW_UNDER-EMBARGO.PDF (OMBUDSMAN.WALES)

PSOW

Public Service Ombudsman for Wales (PSOW) Report Groundhog Day 2: An opportunity for cultural change in complaint handling?

ABUHB Improvement Plan

Recommendation	ABUHB Action	Responsible Officer	Timescale
Review the resources available to complaints teams in their Health Board	This will be addressed through implementation of the review of the QPS Resources.	Executive Director of Nursing and Assistant Director Quality Patient Safety	December 2023
Consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case-by-case basis	Review of Putting Things Right Policies and Procedures to incorporate advice on accessing Independent Medical Advice	Senior Concerns Manager and Senior Quality and Patient Safety Manager	January 2024
	Incorporate into IO Training and reinforce during monthly face to face trainings	Senior Concerns Manager and Senior Quality and Patient Safety Manager	20 November 2023 and ongoing
Reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling	Devise and share a presentation on report theme – to be presented at PQSOG November 2023 Presentation to be uploaded onto the PTR Intranet page	Head of Putting Thing Right	16 November 2023
Ensure that lessons learned from the Public Service Ombudsman for Wales's findings and recommendations are included in the Health Board's annual report on the Duty of Candour and Quality	These will be incorporated into the inaugural Report on Duty of Candour and Quality	Head of Quality & Patient Safety	April 2024

Questions

Agenda Item: 3.4

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Effectiveness and Standards Group Clinical Audit Activity Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson – Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

CSEG also review governance arrangements for introduction of new clinical practices/procedures, not previously undertaken within the Health Board, as set out in the Policy for Implementation of New Clinical Procedures. This now includes ensuring there are sufficient governance processes around the implementation of Artificial Intelligence (AI). The Group assesses the safety and effectiveness of the proposed procedure, taking into account known benefits/ risks and proposed arrangement for training/supervision, informed consent and clinical audit.

Cefndir / Background

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

CSEG is held bi-monthly. On 21st September 2023, there was one audit report presented:

- Management of Heart Attack: analyses from the Myocardial Ischaemia National Audit Project (MINAP)

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

Asesiad / Assessment

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

The attached Appendix provides the above information for the National Clinical Audit presented in September.

- Appendix One - Myocardial Ischaemia National Audit Project (MINAP)

National Clinical Audits (NCA) are published on the HQIP webpage and form part of our annual audit plan. We are currently reviewing participation in these audits and ensuring these are discussed at CSEG. If these are discussed at other Groups or Boards (e.g., Stroke, End of Life Care Board) we will be reaching out for assurance of ongoing actions and improvement plans. We will be requesting for these to be reported on AMaT to align with the reporting of all other audits. See Appendix 2**.**

As part of our clinical audit plan and strategy we are committed to participating in the National Clinical Audit Outcome Review Plan (NCAORP). The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has several studies at various stages within the process.

- Endometriosis – This study had an extension to 30th November 2023. The Medical Director's QPS Team are currently liaising with the remaining clinicians, resending the clinical questionnaire via the NCEPOD Portal and the Divisional Director has been updated of the position. In future we will reach out to the Divisional Director sooner to escalate and ask for support.

- Juvenile Idiopathic Arthritis – Health Board data has been submitted and cases are being uploaded to the NCEPOD platform. A Clinical Lead has been identified.
- End of Life Care – Health Board data has been submitted and cases are being uploaded to the NCEPOD platform. Currently this study does not have a Clinical Lead but is being discussed at the End-of-Life Care Board.

CSEG also overseas governance behind introduction of new devices and clinical procedures. At the Sept meeting, the following Artificial Intelligence (AI) applications were discussed to ensure that the AI project had a robust governance process around its implementation.

- E-Stroke - Brainomix

E-Stroke, provided by Brainomix, is an integrated stroke imaging solution for acute stroke pathways. It includes decision support tools for the analysis of CT, CT Angiography, CT Perfusion and MRI images. It provides fast, consistent calculation of clinically relevant scores, with fast access to imaging results. The project aims to implement decision support software for interpreting CT Brain scans in acute ischaemic stroke situations via an artificial intelligence approach. This development will support the neurologist, neuroradiologists and stroke consultants in making treatment decisions rapidly.

The application was discussed by the group and approval was given based on funding being acquired.

- AI - Qure AI Chest X-ray (qXR) and CT Head (qER) 3-month free trial

The team were keen to utilise AI to assist in diagnosis and prioritise patients with pathologies. The AI assists in a speedy diagnosis and treatment in line with many pathways.
This is currently in a 3-month pilot stage and the group requested that the results are brought back to CSEG for further discussion after the pilot end date.

A new policy relating to updating pre-operative fasting was also discussed:

- Update on Pre-Operative Fasting Guidance 'Sip Til Send'

The group were provided with evidence that this updated guidance was beneficial to patients and resulted in improve outcomes for patients undergoing pre-operative fasting. Based on the evidence the group were supportive of the updated procedures. The Policy is now ready for approval at the next Clinical Standards and Policy Group.

Audit Management and Tracking (AMaT) is being widely used across the Health Board for conducting and reporting on local audits, as specified in the audit plan. The volume of audits being undertaken, and number of action plans being allocated is rising. See attached Appendix 3 for more information. The funding for AMaT is limited until February 2024. Currently this is no recurring money to fund this from NICE or Health Technology Wales. A letter is being composed to Executives to review the funding.

Argymhelliad / Recommendation

Assurance is given by all Clinical Leads presenting specialty data that Quality Improvement work is always at the forefront and to improve the quality of care for

the patients across the localities. All recommendations, successes, concerns and action plans will be added to AMaT.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and 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:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

Effaith: (rhaid cwblhau) Impact: (must be completed)

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

Appendix One

National Clinical Audit reporting template (AMaT) - MINAP

Title: **Management of Heart Attack: analyses from the Myocardial Ischaemia**

Date registered: **11/07/2023**

Category: **National (NCAORP)**

Speciality: **Cardiology**

Division: **Medicine**

Lead participant: **Nigel Brown (NB)**

Audit lead: **Lalit Bhalla**

Rationale
Quality of care is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with higher-risk ST-segment elevation myocardial infarction (STEMI) heart attacks and those with non-ST-segment elevation myocardial infarction (NSTEMI) heart attacks. The data used are drawn from the Myocardial Ischaemia National Audit Project (MINAP), which are part of the National Cardiac Audit Programme (NCAP).

Objectives
To improve the patient experience and outcomes by appropriate treatment.

Guidance	Title
QS68	Acute coronary syndromes in adults (Sept 2014)

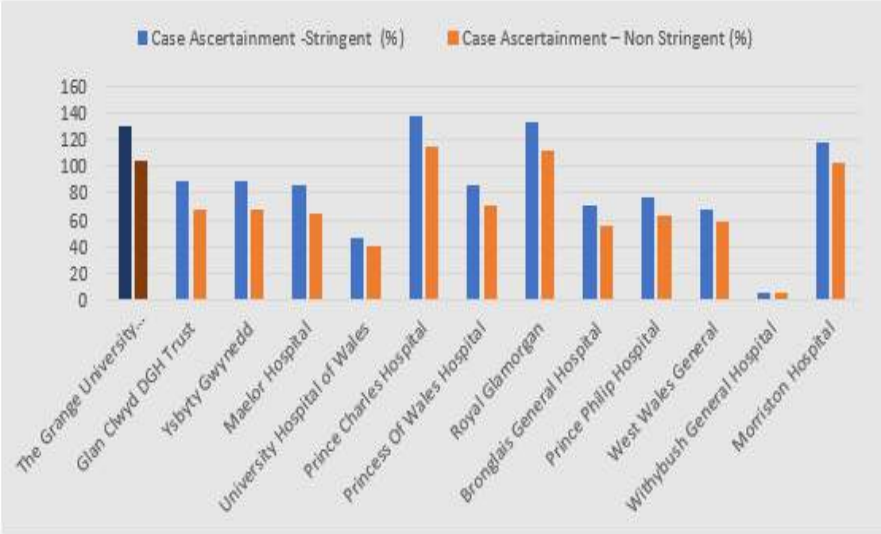
Meeting title	Date & time	Location
Clinical Standards and Effectiveness Group	21/09/2023 14:00	Teams

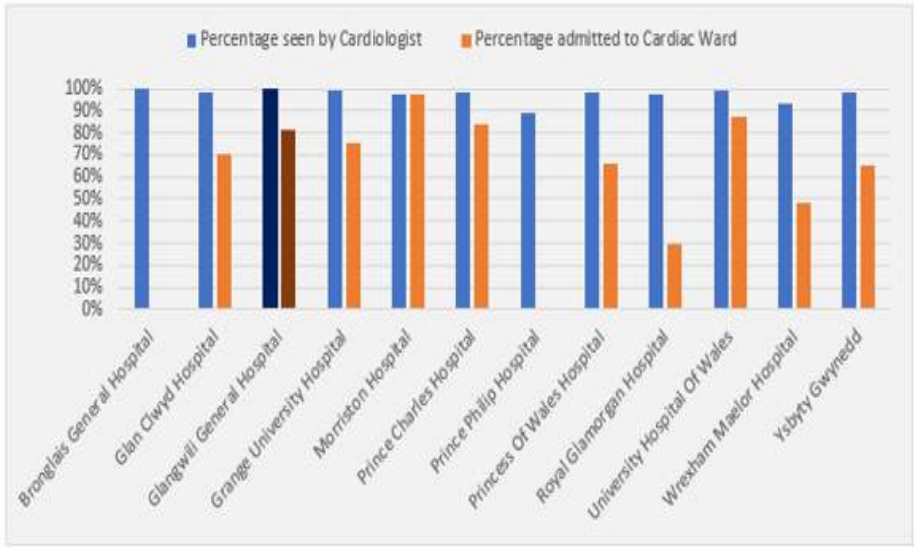
Results - Key Findings

Case ascertainment figures for MINAP	
STEMI	102
NSTEMI	439
Total	541
PEDW cases stringent	415
CA Stringent %	130.36%
PEDW cases non-stringent	521
CA non-stringent	103.84%

Nationally 97%, ABUHB 99.09% of patients were seen by a cardiologist, or their team, during the admission, a consistently high performance. Median of Welsh HB's 98.62%.

(N.B. CA Stringent % is greater than 100%. This is due to the numbers submitted to MINAP versus those on PEDW so linked to delayed or inaccurate Clinical Coding. 541 MINAP submission versus 415 PEDW. This will be looked at by the QPS audit team with cardiology.



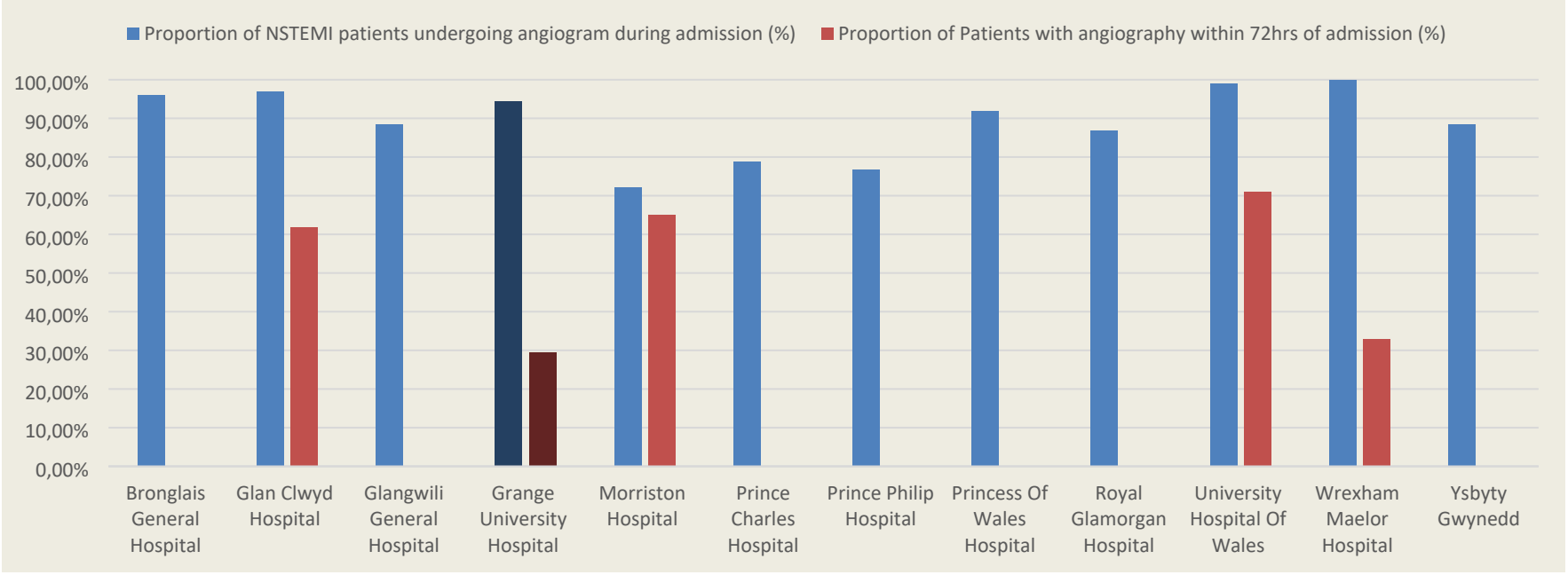


- **Proportion of Patients with angiography within 72hrs of admission (%)**

ABUHB 29.56%, 7 out of 12 Welsh hospitals performance is not reported as there are fewer than 20 eligible patients, the median between the 5 scoring HBs was 48.96% with the target set at 66%.

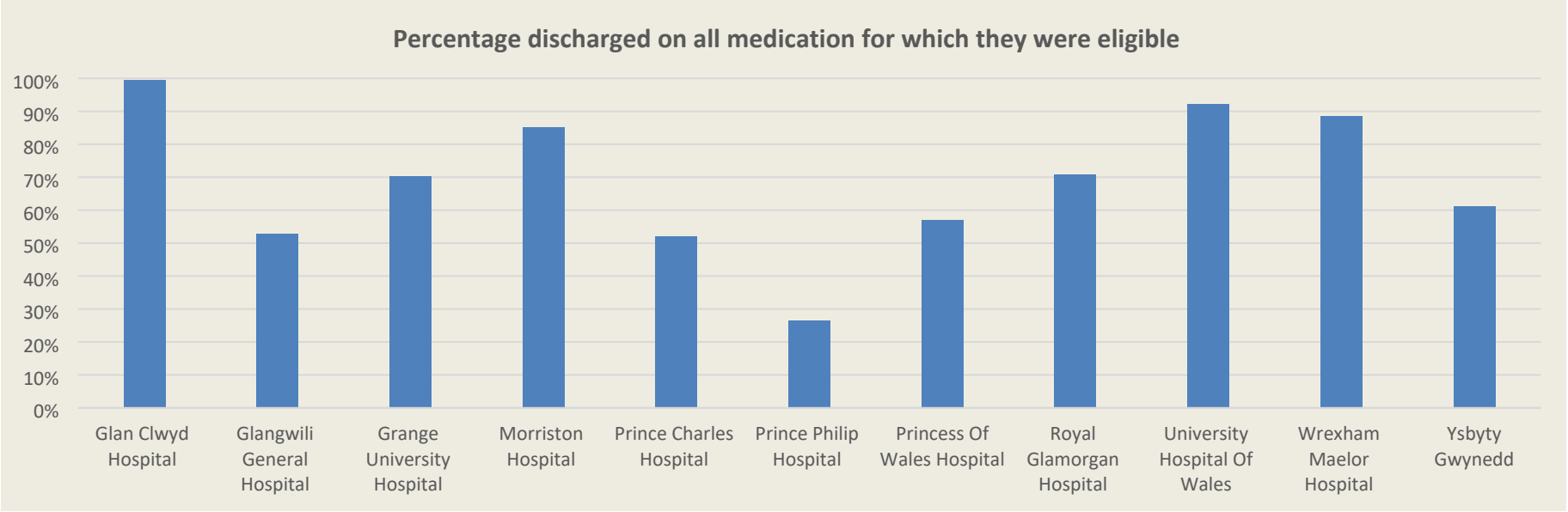
Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI.

Action - Delays to angio/PCI will be discussed at Cardiology Directorate meeting and added to the risk register. This risk will increase further if current financial constraints continue and may hamper major improvement. The Directorate will also be undertaking a more detailed look at MINAP regarding legitimate delays (not in the formal annual report) to understand the impact on waiting times.



Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI.

- Percentage discharged on all medication for which they were eligible for **ABUHB is 70.13%** compared the **Welsh Median of 70.44%. The National result is 89%.**

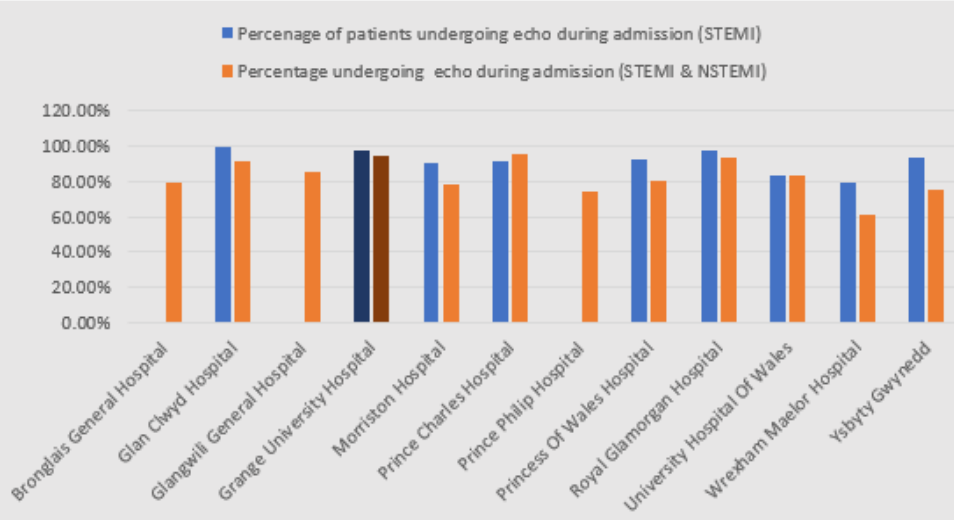


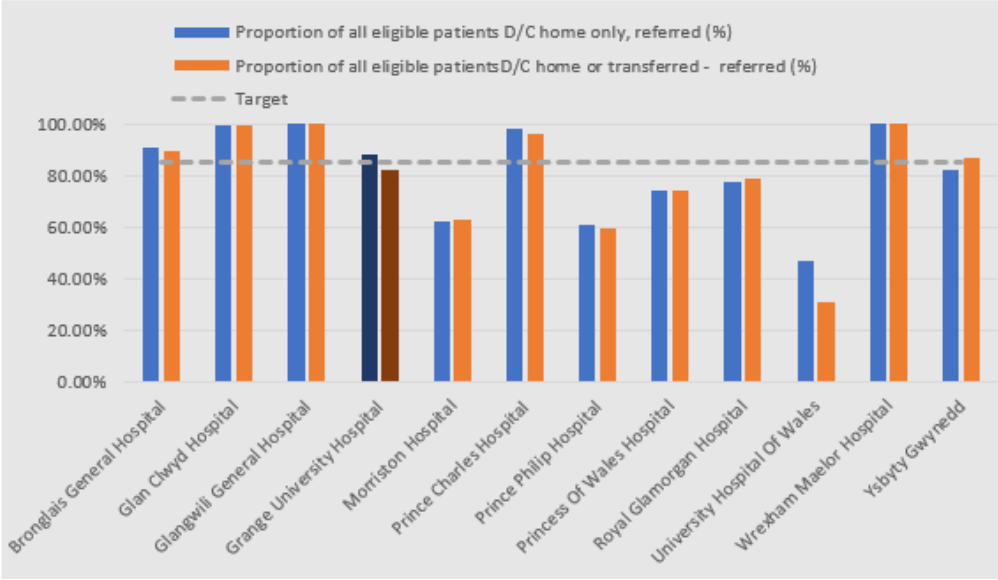
Action - We've historically done well on secondary prevention medicines at 70% equal to the Wales average this year. N.B. this may equate to only one out of 4 drugs. This may relate partly to the addition of aldosterone antagonists into a combined single data metric and/or relate to poor documentation on drug intolerance or legitimate reasons not to prescribe. We should not be complacent as a Directorate, and it requires a deeper look and perhaps a checklist for discharge meds should be considered and developed alongside our pharmacy lead.

Primary PCI

It is noted that the number of cases for ABUHB is fewer than 20 due to Grange University Hospital (GUH) not being a designated Heart Attack Centre, patients are sent to UHW, Cardiff. GUH will provide primary PCI opportunistically to a limited number of patients, which does provide data relating the Door to Balloon time (DTB) and Call To Balloon Time (CTB), both of which are significantly higher in minutes than the Heart Attack Centres.

Performance of an echocardiogram in patients with a final diagnosis of either STEMI alone, or STEMI and NSTEMI combined, during admission for **ABUHB is 97.96%** compared to the **Welsh Median of 92.59%,** this is based on 9 of the 12-hospitals providing this service. Combined STEMI and NSTEMI undergoing Echo for **ABUHB is 94.64%** compared to all **12 Welsh hospitals median of 81.84%.**





Performance of hospitals with respect to referral of patients with either STEMI or NSTEMI to cardiac rehabilitation programmes, for patient discharged home, **ABUHB is 88.37%** compared to the **Welsh Median of 85.34%**, with the inclusion of patients transferred to another hospital as well as discharged home, **ABUHB is 82.39%** where the **Welsh Median is 84.56%. The UK national result is 85%.**

National Key Messages:

Key message 1:
The overall number of cases of heart attack reported this year, 85,630. This is 16% higher than the previous year and represents a 'bounce-back' to 'pre-pandemic' levels.

Key message 2:
Proportions both of patients referred to cardiac rehabilitation programmes following heart attack and of eligible patients receiving an echocardiogram prior to discharge from hospital are at the highest recorded level. Referral to rehabilitation exceeds the aspiration that 85% of patients should being referred.

Key message 3:
Percutaneous coronary intervention (PCI) is used, appropriately, in the majority of cases despite a greater number of patients being managed this year – immediate (primary) PCI in 84% of cases of 'high-risk' STEMI heart attacks; urgent PCI in 83% of lower-risk NSTEMI heart attacks.

Key message 4:
A smaller proportion of patients receive PCI in a timely fashion. For STEMI, the proportion of patients receiving primary PCI fell to 30% within 120 minutes, and to 55% within 150 minutes, of calling for help. For NSTEMI, whereas 66% underwent angiography within 72 hours of admission to hospital in 2020/21, performance has returned to pre-pandemic levels; 56% of patients with NSTEMI received an angiogram within 72 hours in 2021/22.

Key message 5:
A larger proportion of patients make their own way to hospital, rather than arriving by ambulance. While this represents the minority (18.6%) of all cases of heart attack, there appears to be an upward trend in self-presentation during the year. For those with STEMI undergoing primary PCI, the monthly proportion who self-presented to hospital rose from 4% during April 2021 to 8% during March 2022. The proportion of patients requiring transfer between hospitals for primary PCI rose from 14% in 2020/21 to 18.7% in 2021/22. These patients are less likely to receive timely primary PCI.

Assurance

Significant – the project has mostly achieved the standards or criteria being audited against.

Risk

For overall audit –Minor risk: Minor implications for patient safety.

Moderate risk for delays to Angio/ PCI will be discussed at Cardiology Directorate meeting and added to the risk register.

Key successes & concerns

Successes

Achieving most targets, including high provision of echocardiography.
Case ascertainment has improved considerably.
High levels of assessment by a cardiologist and angiography.
High referrals rates for rehabilitation.

Concerns

Delays to angiography/intervention.
Delays in step-ups from eLGH's.
Staffing levels and catheter laboratory constraints.

Action Plan

	Recommendation(s)	Comments and Action	Lead	Date raised	Due date	Action RAG
1	Where CTB time standards are not being met in STEMI cases, emergency departments, PCI centres, neighbouring non-interventional hospitals and ambulance trusts should work together to reduce delays in the provision of primary PCI. This may include improving the hospital response to patient arrivals as well as pre-hospital Call-To-Door (CTD) times. Hospitals not able to offer primary PCI to patients with STEMI who self-present, especially if geographically remote from such services, should consider re-introducing care pathways that include immediate administration of intravenous thrombolytic drugs.	Currently the Health Board is designated a non-Heart Attack Centre, small numbers of PPCI are undertaken (mainly self-presenting patients during working hours) but the numbers are < 20 per annum and therefore not reported. Ensure harm e.g., events in patients waiting intervention captured. Retrospective review of the MINAP database to better understand detail behind delays.	Dr NB	21/09/2023	21/09/2023	Fully Complete
2	Hospitals with lower rates of echocardiogram provision, for STEMI and NSTEMI, should ensure that their data are being collected accurately and, if needed, should identify opportunities for echocardiography during the index admission.	The Health Board performs very well with 94.64% of patients undergoing echo during admission (STEMI & NSTEMI).	Dr NB	21/09/2023	21/09/2023	Fully Complete

	Use of limited 'bedside' echocardiograms should be considered if there are difficulties obtaining timely detailed tests. Patients discharged to another hospital before an echocardiogram is performed must be accompanied by a clear request for the test at the receiving hospital.	This reflects excellent work by the Physiology Team at Grange University Hospital (GUH)				
3	Hospitals not sufficiently admitting heart attack patients to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those cared for elsewhere.	The proportion of patients admitted to a cardiac ward in ABUHB is 75.4%. This compares favourably to the national average of 64%. Please note this figure represents admission *within 24hrs* so delays on the assessment unit or patients awaiting transfer from eLGH sites reflects the remainder and sits at approximately 24.6%. The cardiology team have developed a draft SOP which proposes an alternative use of additional bed capacity on B4 (currently GIM step down patients) to allow rapid transfer within 24hrs of all accepted eLGH patients.	Dr NB	21/09/2023		Ongoing
4	Hospitals reporting low rates of cardiology involvement in heart attack patient care should ensure their data are accurately reflecting practice. If they do, provision of cardiac care during	ABUHB perform exceptionally well with 99 % of patients were seen by a cardiologist (97% nationally).	Dr NB	21/09/2023	21/09/2023	Fully Complete

	admissions should be improved (e.g., by increased staffing or more flexible use of members of the cardiology team, such as nurse specialists and physician associates).					
5	Low rates of angiography in eligible NSTEMI patients require hospitals to review their systems for managing acute coronary syndromes (ACS).	ABUHB perform well with angiography during admission in 94.43% of patients (Wales median 90.1%, 83% nationally in UK)	Dr NB	21/09/2023	21/09/2023	Fully Complete
6	Where angiography for NSTEMI takes more than 72-hours, hospitals and commissioners should review pathways, referral networks and service commissioning to make quality improvements. Any lessons regarding more timely care that were learned during the pandemic should be incorporated within existing pathways. There should be an emphasis on early and reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals. This will involve weekend angiography lists for such patients.	29.6% patients underwent angiography within 72hrs compared to a median of 49% in Wales and 56% nationally. A previous notional target of 60% had been set in England (tariff based). This figure does not take account of patients with legitimate reasons for delay such as anaemia or infection and the proportion of our patients with co-morbidities/legitimate delays may be higher and will be investigated further. Preliminary review of 2022-2023 data suggests approximately 25% will have a legitimate delay. Nevertheless, several issues that contribute to delays are listed in order of importance including; a) catheter laboratory time (elective patients/lists/complex case work/CTOs compete) and staffing constraints	Dr NB	21/09/2023	21/09/2023	Fully Complete

		(medical, nursing, radiographer and physiology) b) delayed transfer from eLGH's (e.g.,1 patient taking a week in 2022) c) weekend cover is limited to Saturday am so Friday admissions will generally wait more than 72 hours unless urgent. Ensure harm e.g., events in patients waiting intervention captured. Divisional discussion re investment in uplift in catheter laboratory capacity and possibly more formal "trigger points" for review of e.g., elective activity Report to be discussed in Quality Improvement Group and at divisional level and added to the risk register.	Dr NB & director ate	Sept 2023		Ongoing
7	Hospitals not meeting the prescribing standard for all secondary prevention medication prior to discharge of both STEMI and NSTEMI patients should assess the quality of their data and, if sub-optimal performance is confirmed, pursue quality improvement. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or ACS	The percentage of patients discharged on all appropriate secondary prevention medication was 70.13%, identical to a median figure of 70.44% in Wales but lower than the UK average of 89%. This has fallen and may reflect issues with prescribing aldosterone antagonists in impaired LV function (newly added to this combined endpoint) but	Dr NB	Sept 2023		Ongoing

	nurse specialists.	inadequate documentation of intolerance/CI (e.g., due to hypotension with ACE, or hyperkalaemia in the case of aldosterone antagonist's) or a legitimate decision not to prescribe. The MINAP database will be further analysed, and we will discuss the role of an additional checklist on discharge.				
8	Hospitals with lower rates of prescribing aldosterone antagonists for patients with impaired LV function identified by echocardiography (or some other reliable assessment method) should act to ensure appropriate treatment. This could involve discharge pro-forma/checklists and the direct involvement of specialist cardiac pharmacists, ACS nurses and sonographers.	This data for aldosterone antagonist's is now included within the standard above for secondary preventative medications. Clear documentation of medication decision may be an issue and will be the focus of another discharge medication checklist to put together with our pharmacy lead.	Dr NB	21/09/2023	21/09/2023	Fully Complete
9	Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI heart attacks should ensure early identification of patients who might benefit (e.g., through routine distribution of cardiac rehabilitation information/invitation in discharge checklists and in leaflets given to all	A high proportion of 88.37% of patients were referred to cardiac rehabilitation programmes (Welsh Median 85.34%, UK almost 89%). The national UK aspirational target is 85%.	Dr NB	21/09/2023	21/09/2023	Fully Complete

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

Appendix 2

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/10/12	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report 2023 - Summary report Data collection period: 1 April 2022 – 31 March 2023	Jan-24
2023/10/12	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care State of the Nation Surveillance Report 2023 Surveillance findings from the UK Confidential Enquiries into Maternal Deaths 2019-21	Discuss with MatNeo Board
2023/10/12	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care State of the Nation Themed Report Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21	Discuss with MatNeo Board
2023/10/12	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care State of the Nation Themed Report Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth	Discuss with MatNeo Board

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/10/12	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme (NNAP) - Summary report on 2022 data	Nov-23
2023/10/12	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Overview	Nov-23
2023/10/12	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Type 1 Diabetes - Overview	Nov-23
2023/10/12	NDA - National Diabetes Audit	National Diabetes Audit National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)	Nov-23
2023/09/14	FFFAP - Falls and Fragility Fracture Audit Programme	15 Years of Quality Improvement: The 2023 National Hip Fracture Database report on 2022 (1 January 2022-31 December 2022)	Jan-24
2023/09/14	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021 - State of the Nation Report	Discuss with MatNeo Board
2023/08/10	NAD - National Audit of Dementia	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	Jan-24
2023/07/13	NPDA - National Paediatric Diabetes Audit	NPDA: Report on hospital admissions of children and young people with diabetes, 2015-2020	Jul-23
2023/07/13	NCMD - National Child Mortality Database	NCMD: Deaths of children and young people due to traumatic incidents: Vehicle Collisions, Drownings, Violence and Maltreatment and Unintentional Injuries	Discuss with Family and Therapies

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/07/13	Ep12 - National Audit of Seizures and Epilepsies	Epilepsy12 2023 combined organisational and clinical audits: Report for England and Wales Round 4, Cohort 4 (2020-22)	No – discuss with Neurology
2023/07/13	NACEL - National Audit of Care at the End of Life	NACEL: Fourth round of the audit (2022/23) report	Discussed at EoLCB
2023/07/13	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA short report: Socioeconomic differences in the impact of oesophago-gastric cancer on survival in England	NO ENGLAND ONLY
2023/07/13	Medical and Surgical Clinical Outcome Review Programme	Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease	PARTICIPATION - NO PRESENTED INTERNALLY
2023/06/08	NVR - National Vascular Registry	NVR Short Report: Impact of the COVID-19 pandemic on vascular surgery in the UK	No- discuss with vascular team
2023/06/08	Child Health & Medical and Surgical Clinical Outcome Review Programmes	NCEPOD: The Inbetweeners - A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services.	No - Discuss with Family and Therapies
2023/04/12	NLCA - National Lung Cancer Audit	NLCA: State of the Nation Report 2023	May-23
2023/03/09	FFFAP - Falls and Fragility Fracture Audit Programme	FFFAP: State of the nation Wales report 2022	Discuss with Hospital and Community Falls and Bone Health Group

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
2023/03/09	PICANet - Paediatric Intensive Care Audit	PICANet: State of the Nation Report 2022	C&VUHB
2023/03/09	NPDA - National Paediatric Diabetes Audit	NPDA: Report on Care and outcomes 2021/22	May-23
2023/03/09	CVDPREVENT- Cardiovascular Disease Prevention Audit	CVDPREVENT: Third Annual Audit Report	No – discuss with cardiology
2023/03/09	Mental Health Clinical Outcome Review Programme	NCISH: Annual Report: UK patient and general population data 2010-2020	No – discuss with mental health
2023/03/09	NACAP - National Asthma and COPD Audit Programme	NACAP: Clinical outcomes Summary report	No – discuss with respiratory
2023/02/09	NELA - National Emergency Laparotomy Audit	NELA: Eighth Patient Report of the National Emergency Laparotomy Audit	Mar-23
2023/01/12	NACAP - National Asthma and COPD Audit Programme	NACAP: Drawing breath - The state of the nation's asthma and COPD care and recommendations for improvement	Mar 2023 Partially presented (PC and Paeds)
2023/01/12	FFFAP - Falls and Fragility Fracture Audit Programme	FLS_DB Annual report: Rebuilding FLSs to meet local patient need Data from January to December 2021	May-23
2023/01/12	NPCA - National Prostate Cancer Audit	NPCA Annual Report 2022 Prostate Cancer services during the COVID-19	May-23

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
		Pandemic (published January 2023)	
2023/01/12	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA: An audit of the care received by people with oesophagogastric cancer in England and Wales	No
2023/01/12	NBoCA - National Bowel Cancer Audit	NBoCA: Annual Report 2022	May-23
2023	Myocardial Infarction Natioanl Audit Programme (MINAP)	NICOR	Sep-23
2023	Heart Failure	NICOR	Sep-23
23/11/09	NVR - National Vascular Registry	National Vascular Registry 2023 State of the Nation Report (cohort Jan-Dec 2022)	Jan-24
23/11/09	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme (SSNAP) State of the Nation Annual Report 2023 (cohort April 2022-March 2023)	Stroke Board
23/11/09	NCMD - National Child Mortality Database	National Child Mortality Database Child Death Reviews Data year ending 31/03/2023 Data only release	No – discuss with Family & Therapies
23/11/09	FFFAP - Falls & Fragility Fracture Audit	Inpatient falls and fractures - one chance to get it right: The 2023 National Audit of Inpatient Falls Report on 2022 clinical data (cohort Jan-Dec 2022)	Discuss with Hospital and Community Falls and Bone Health Group
23/11/09	NDA - National Diabetes Audit (adults)	National Diabetes Audit Q1 data only release - Core & Diabetes Prevention Programme, DPP (Non-Diabetic	No - England only

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
		Hyperglycaemia - NDH), 01/01/2023-30/06/2023; Eng only.	
23/11/09	NDA - National Diabetes Audit (adults)	National Diabetes Audit dashboard data only release: National Diabetes Footcare Audit (NDFA), 01/04/2021 – 31/03/2023, Eng & Wal.	Jan-24
23/12/14	NDA - National Diabetes Audit	National Diabetes Audit Diabetes Prevention Programme (DPP) - Non-Diabetic Hyperglycaemia (NDH) State of the Nation report (01/01/2021-31/03/2022, Eng only, Y1)	No - England only
23/12/14	NDA - National Diabetes Audit	National Diabetes Audit Young Type 2 State of the Nation report (01/01/2018-31/03/2022, Eng & Wal)	2024
23/12/14	NDA - National Diabetes Audit	National Diabetes Audit Core underlying data, 01/01/2022-31/03/2023, Eng & Wal	2024
23/12/14	NCMD - National Child Mortality Database	National Child Mortality Database Thematic report - infection	No - discuss with Family & Therapies
23/12/14	PICANet - Paediatric Intensive Care Audit	Paediatric Intensive Care Audit State of the Nation Report (Jan-Dec 2022)	C&VUHB
23/12/14	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme MNI Perinatal confidential enquiry - the care of black and white women who have experienced a stillbirth or neonatal death (01/07/2019 - 31/12/2019)	No – discuss with MatNeo Board
23/12/14	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme MNI Perinatal confidential enquiry - the care of Asian and white women who have experienced	No– discuss with MatNeo Board

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
		a stillbirth or neonatal death (01/07/2019 - 31/12/2019)	
23/12/14	Medical and Surgical Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme - Community acquired pneumonia (cohort 01/10/21-31/12/21)	No
24/01/11	NPCA - National Prostate Cancer Audit	National Prostate Cancer Audit State of the Nation report	2024
24/01/11	GICAP-NOGCA - National Gastro Intestinal Cancer Audit Prog. - National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit State of the Nation report	2024
24/01/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit data only release – Q1 to Q4 (01/01-31/12/2022 England data only) - national results spreadsheet	No - England only
24/01/11	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme quarterly data only report (Jul-Sep 2023)	Stroke Board
24/02/08	NCISH - Mental Health CORP	Mental Health Clinical Outcome Review Programme Alcohol and Drug report (cohort TBC)	No – discuss with mental health
24/02/08	NCISH - Mental Health CORP	National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2024: UK patient and general population data 2011-2021	No – discuss with mental health
24/02/08	FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLSDB) Annual Report 2024: Improved FLS identification with gaps in	2024

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
		monitoring: a call to action for national and regional planners (January-December 2022)	
24/02/08	GICAP-NBoCA - National Gastro Intestinal Cancer Audit Prog. - National Bowel Cancer Audit	National Bowel Cancer Audit State of the Nation report	2024
24/02/08	Child Health Clinical Outcome Review Programme	Child Health Clinical Outcome Review Programme - Testicular torsion report	Discuss with Family and Therapies
24/03/14	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit annual core state of the nation (01/04/2022 - 31/03/2023)	2024
24/04/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	2024
24/04/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit data only release – Q1 (01/01-31/03/2023 England data only) - national results spreadsheet	No - England only
24/04/11	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme quarterly data only report (Oct-Dec 2023)	No – discuss with stroke
24/05/09	NDA - National Diabetes Audit (adults)	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021- 31/03/2022 TBC; Eng & Wal.	2024
24/06/13	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report	2024

PUBLICATION DATE	PROJECT NAME	FULL REPORT TITLE	Health Board Participation/ CSEG Date
24/07/11	NDA - National Diabetes Audit (adults)	National Diabetes Inpatient Safety Audit (NDISA) State of the Nation report, May 2018 - Oct 2023; Eng & Wal.	2024
24/07/11	NLCA - National Lung Cancer Audit	National Lung Cancer Audit data only release – Q1 to Q2 (01/01-30/06/2023 England data only) - national results spreadsheet	No - England only
24/08/08	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Primary Care Report (cohort TBC)	2024

Appendix 3

AMAT UPDATE

This report demonstrates the current usage of AMaT since it was purchased and implementing in March 2022. Since the previous update the number of users has increased from 875 to 1,009 registered users on AMaT within the Health Board.

Clinical Area

This is the Clinical Area overview dashboard:

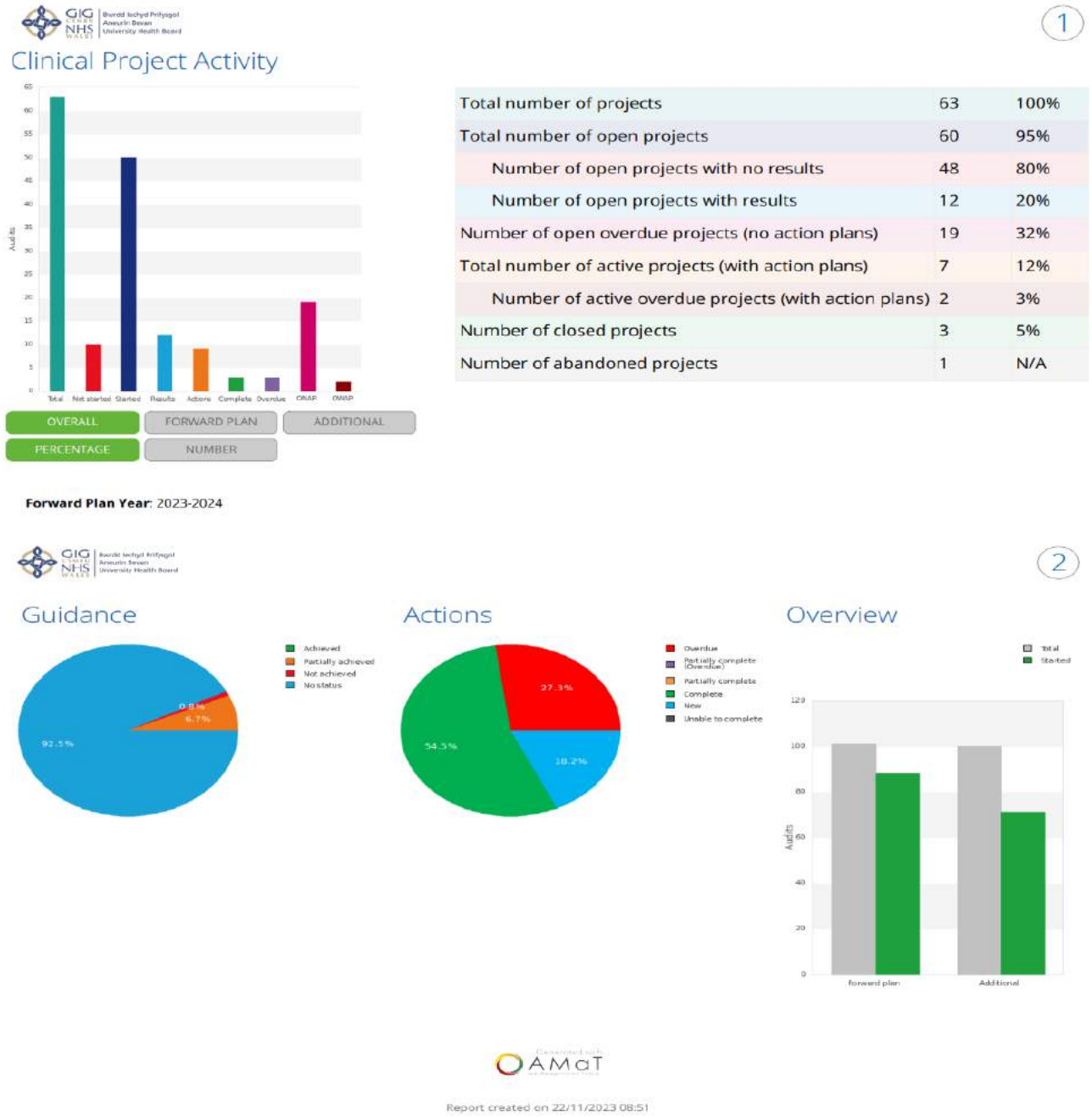


Figure 1.1 Current use of AMaT

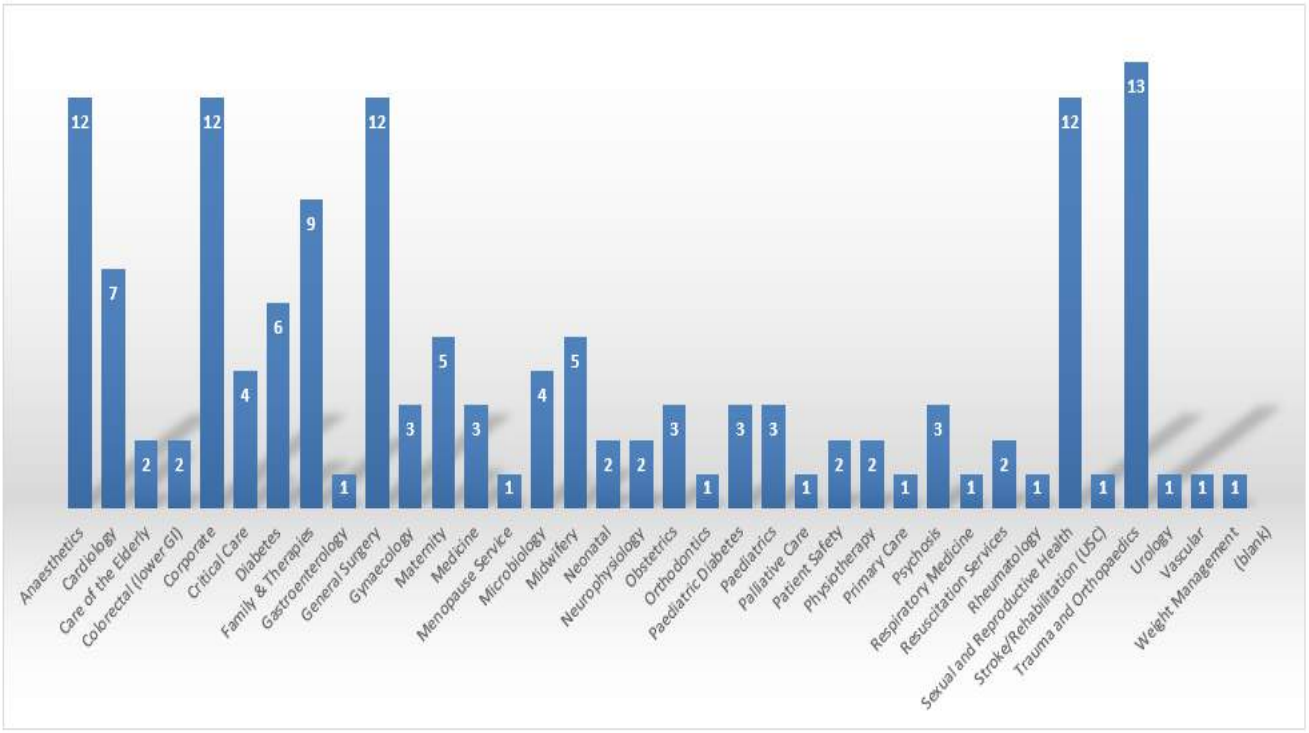


Figure 1.2 Audits in Clinical Area by Specialty

The internal audit report issued in November 2022 reported limited assurance for the local audit process within the Health Board. AMaT has helped improve the reporting of local audits. These audits have completed actions which are tracked in AMaT. The clinical audit team are reviewing the processes and governance structure in relation to users of AMaT. This will allow overdue actions to be followed up.

There are a number of action plans linked to National Clinical Audits which are part of the National Clinical Audit Outcome Review Plan (NCAORP). The management of registered audits is also being reviewed ensuring this links to the standardised registration form.

The current license for AMaT expires in February 2024. The number of clinical areas, specialities and variety of health professionals that use this system demonstrates that investment in the system has been worthwhile. It is also currently being utilised for ward accreditation audits. Given its uptake and utilisation, ongoing funding will be pursued to ensure the system can continue to be used.

Ward Area

Within the Ward Area there has been an increase from 12 registered projects containing 56 individual audits to 14 projects containing 65 audits. The audits can be registered to any number of wards or all wards.

Project overview

Project	No. audits	Current compliance	Improvement	Overdue actio
All Wales - DNACPR	1	R 72.9%	N/A	
Cardiac Arrest	1		▼	
Controlled Drugs	1	A 80.4%	▼	
Corporate	1		N/A	
DECI	3	A 82.4%	▲	0
Dietetics	4	R 44.4%	▼	
ED Nursing	1		N/A	
EFU weekly audits	6		N/A	
Haematology	1	A 87.5%	▲	
Health & Safety Monitoring	1		N/A	167
IPC Annual Audits	33	G 90.4%	▲	280
Oral Hygiene	1	A 84.8%	N/A	0
Thrombolysis Audit	1	R 71.8%	N/A	
Ward Accreditation Audits	10	A 86.2%	▼	1

As with the actions in the Clinical Area, there are trial processes underway to ensure governance relating to the overdue actions within ward area.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	GIRFT (Getting It Right First Time) Action Plan for Stroke Services Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rhys Monk

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

Er Sicrwydd/For Assurance

(N.B. Only one of the following directions should be identified for the Board/Committee):

- Decision – i.e. reaching a conclusion after the consideration of options
- Assurance – i.e. whether an assurance, or otherwise, can be taken from the report
- Discussion – i.e. examine and consider the implications of a matter
- For Information – i.e. does not require discussion and is for noting purposes only

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper is being brought to the committee to provide assurance on the progress of the Stroke Service Action Plan in response to the GIRFT (Getting It Right First Time) report commissioned in 2022. The report also references other reviews that have been undertaken since 2021, the 2021 Therapy Review and the 2023 HIW Patient Flow Review and acts as a ABUHB Stroke Improvement Plan.

Cefndir / Background

Over the past 12 months, the health board's stroke services have seen many opportunities, experienced significant challenges, and delivered substantial developments.

In 2022, the Medicine Division commissioned the GIRFT national team to undertake an assessment of its Stroke services which culminated in 20 recommendations (appendix a. GIRFT Report).

During the past year, there has been momentous change and upheaval that has highlighted the fragility of the service; a retirement of the Nevill Hall Consultant, difficulty recruiting into both Consultant and AHP (Allied Health Professional) roles, several key CNS (Clinical Nurse Specialist) taking maternity leave and well as immense pressure on an already stretched and stressed workforce.

The service is currently undergoing an urgent service change to consolidate Rehabilitation services on one site, based at YYF (Ysbyty Ystrad Fawr) to concentrate its remaining resource.
However, despite these challenges, progress has been made on the GIRFT recommendations.

In addition to the GIRFT Report, there have been other reviews and assessments of the Stroke service; The 2021 Therapy Review (appendix b.) and 2023 HIW (Healthcare Inspectorate Wales) Patient Flow Review (appendix c.). To ensure that ABUHB (Aneurin Bevan University Health Board) has a consistent improvement plan, care has been taken to integrate these three reviews into one wide ranging improvement plan.

Asesiad / Assessment

The final report from the GIRFT team was received in September 2022 and is attached as Appendix a. The report includes a total of 20 short- and medium-term recommendations, from which the key priorities are seen to be as follows:

- Provide supernumerary specialist stroke nurse presence at GUH (Grange University Hospital) on a 24/7 basis to ensure ownership and direction of the stroke patient pathway
- Enhance pre-hospital notification arrangements to ensure elimination of avoidable delays at the front door
- Increase thrombolysis rates to be consistently within agreed national norms
- Raise organisational priority for patients gaining access to the acute stroke unit within four hours
- Widen range of workforce options / competence to ensure 24/7 ability to perform swallow assessments
- Review rehabilitation / early supported discharge pathway, with emphasis on seven-day access to therapies, (this being considered likely to involve utilising fewer rehabilitation sites in the Health Board)
- Ensure robust arrangements for patient review six months post-discharge
- Support development of clinical leadership for the service

A complete update of the status of each recommendation is referenced in the attached document: (appendix d. GIRFT Action Tracker)

To summarise the contents of the referenced appendices, of the 20 recommendations, six of these have been completed and are now within specified ranges for deliverables. These are:

Action	Measurement
Action 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP (Sentinel Stroke National Audit Program) data for clinical assurance.	SSNAP Rating: A (90%+) □
Action 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB (Aneurin Bevan University Health Board) to embed the Optimal Stroke Imaging pathway. The use of first line MRI (Magnetic Resonance Imaging) for patients with mild symptoms or with diagnostic uncertainty may release bed capacity.	SSNAP Rating: A (90%+) □
Action 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.	17.00%[1]
Action 15: Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a	There is a psychology service in ABUHB which provides 3 in reach sessions per week to the Stroke Rehab Wards [1 per ward] This is

[1] Data referenced: SSNAP Quarterly Report April - Jun '23

commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.	delivered by 3 Clinical Psychologists an Assistant Psychologist and a Trainee psychologist. People are supported during their hospital stay and followed up by the psychology team once they are at home for intervention and support on a 1:1 basis or where appropriate through a range of psycho-educational group interventions. The psychology team run regular consultations with the inpatient and community therapists to support them in managing people with cognitive and emotional issues after stroke.
Action 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.	96.40%[2]
Action 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.	97.00%[3]

Further to these recommendations, there are an additional nine that are ongoing. These recommendations are noted in table a. below grouped into two categories, those actions that are improving well under current arrangements, and those that require additional support.

Table a. Ongoing implementation, improving under current arrangements

Action	Progress
Action 5: Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging should help to release bed capacity and increase access.	This metric is currently 75% compliant, and with planned developments to the rehabilitation pathway this metric is projected to increase due to the Stroke Teams having move influence over patient movement between HASU and YYF Rehabilitation wards.
Action 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.	Funding has been confirmed for 5 WTE (Whole Time Equivalent) CNS posts and posts have been filled on a substantive basis, despite challenges due to substantial amounts of maternity leave this situation is expected to improve starting from November 2023 as staff return.
Action 8: Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.	Engagement sessions have been undertaken with ED teams and training is being cascaded starting from December 2023. The metric is currently 47% compliant and expected to increase as more staff can carry out this assessment.
Action 11: Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.	The CNR Service includes a Living Well after Stroke Service which offers self-referral to all people living in ABUHB with stroke and their families. ➢ Initial Assessment ➢ Low level emotional support

[2] Data referenced: SSNAP Quarterly Report April - Jun '23
[3] Data referenced: Dashboard and Observations (sharepoint.com)

	➢ A personalised Co-produced Stroke Recovery Plan ➢ Professional referrals including communication, counselling, exercise programmes and social prescribing ➢ Advice on practical matters including navigating the social care and benefits system ➢ Advice on preventing the reoccurrence of stroke ➢ Support to carers needs such as their own health and wellbeing, access to peer support ➢ Regular informal reviews ➢ Access to a range of bespoke stroke recovery specific groups including Fatigue management, understanding my stroke, Acceptance and Commitment, Communication Groups, walking groups, Neuro@NERS gym-based exercise groups ➢ Participants are encouraged to form informal support networks and we have several examples of this becoming self-sustaining for longer term support We are supporting people to become peer mentors and have commenced in reach to the YYF Site of 2 people with lived experience of stroke
Action 12: Embed the National Stroke Service Model in ABUHB	This model will naturally be implemented as the service seeks to consolidate its rehabilitation service into one site, concentrating resources to provide a more robust service.
Action 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.	This data is being captured in the WNCR (Welsh Nursing Care Record) and is regularly monitored. A Dashboard needs to be created from this data to be provided to ward to allow the nursing teams to allow them to report by exception.

Table b. ongoing implementation, requires additional intervention

Action	Progress
Action 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.	This metric is consistently rated E by SSNAP reports and will require executive support to ringfence HASU (Hyper Acute Stroke Unit) and Stroke Rehabilitation beds to preserve patient flow through ED (Emergency Department) to HASU through to Rehabilitation wards.
Action 13: Ensure 7-day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.	The latest guidance has moved away from the 45 minutes of Therapy and now suggests 3 hours of combined motor recovery rehabilitation per day. This will not just be delivered by Therapists but will have an overall contribution from all ward staff on a ward with an enabling rehabilitation ethos.
Action 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT (Speech and Language Therapy), embracing a capability framework of competency	The current Therapies commissioned staffing for stroke across all professions is 51% below minimum National Standards. Therefore, delivery of a 5-day service is extremely challenging and without significant financial investment 7-day service provision remains

[Stroke Educational Framework https://stroke-education.org.uk/.	unachievable. A Therapies Staffing review was undertaken in 2021 but there has been no change in the commissioned stroke staffing since that review.

There are then five final recommendations that are awaiting completion of other actions before they can commence. These are:

Action	Reason that action is not started
Action 2: Commission an ESD (Early Support Discharge) pathway process flow map, it is only after full mapping of a needs based ESD (Early Support Discharge) pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.	Awaiting completion of Rehabilitation reconfiguration Nov 2023.
Action 9: ABUHB to put a cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.	Awaiting confirmation/identification of suitable and appropriate session.
Action 10: Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support	Awaiting completion of Rehabilitation reconfiguration Nov 2023. Currently CNRS (Community Neurological Rehabilitation Service) offers up to 12 weeks of specialised stroke rehab in the early Supported stroke discharge pathway to people with mild /moderate physical and communication impairment After the 12 weeks people are supported to access specialised Neurophysiotherapy outpatient services AND/OR access the Neuro@NERS exercise rehab programme which has stroke specialised support workers and a Neurophysiotherapy from CNRS (Community Neurological Rehabilitation Service) attending sessions to provide expert support and exercise modification After the 12 weeks anyone with ongoing complex communication needs is supported with integrating their communication impairment via the Living Well after stroke service The psychology service supports people in the longer term where clinically indicated
Action 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT (Multi-Disciplinary Team) goal setting in case notes. Recommendations to ensure improved access to therapy reviews are	Awaiting completion of Rehabilitation reconfiguration Nov 2023. A 5-day service provision will be unchanged without significant financial investment to be able to increase to a 7-day service which will continue to impact on the ability to achieve some of the goals around seeing patients within 72 hours.

highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5-day rota.	Ward reconfiguration and the colocation of rehabilitation services to a single site will be a priority, once complete standardising the approach for MDT (Multi-Disciplinary Team) goal setting etc will be part of ongoing pathway reconfiguration work.
Action 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.	Action has been on hold until appointment of full CNS team. Reviews are expected to begin when the team has been restructured starting from Q4 2023/24.

This summary clearly shows that work is still ongoing to implement all the GIRFT recommendations, with the upcoming reconfiguration plans playing a significant part in facilitating progress with the final six recommendations. Progress updates continue to be a standing agenda item for the Stroke Service Delivery Group, chaired by the Executive Director of Therapies and Health Science.

The attached charts (appendix e.) taken from the NHSDU Stroke Resources page which measures various KPIs (key performance indicators) and provides context across Wales show definitive improvements in many of the key metrics that indicate safe and effective Stroke care. Recognising that whilst there is still some way to go until the health board improves all metrics, considerable progress has been made.

Appendix a.
GIRFT Report.

RNOH_GIRFT_ABUH
B Stroke Report_Fin

Appendix b.
2021 Therapy Review

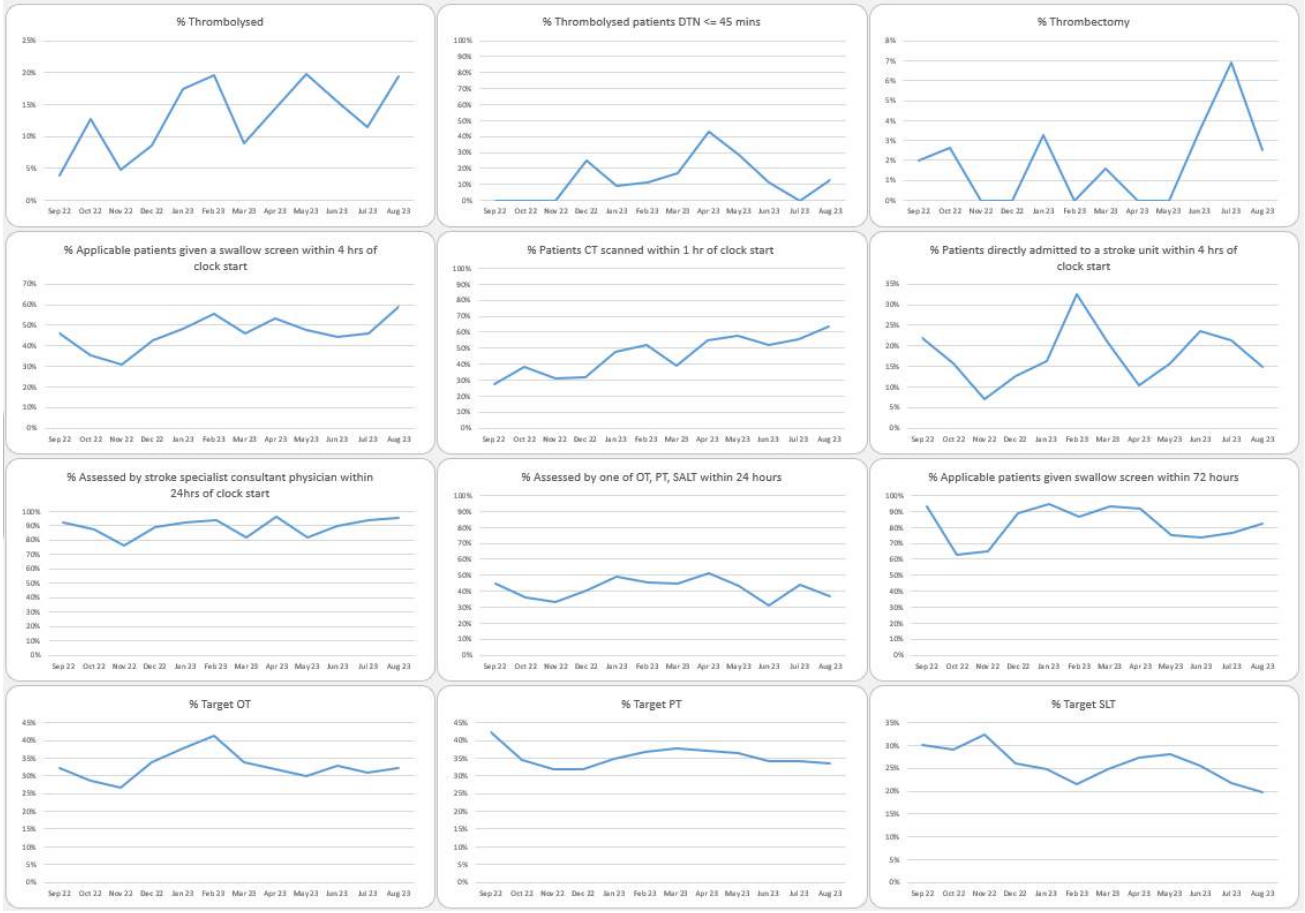
Review%20of%20Th
erapy%20Stroke%20

Appendix c.
2023 HIW Patient Flow Review

31082023 - Patient
flow - Final brandec

Appendix d.
GIRFT Action Log.

Appendix e.
NHSDU Stroke Resources Summary for ABUHB (Sept. 22 to Aug. 23).



Argymhelliad / Recommendation

The Executive Committee is asked to

- Note the assurance from this paper that progress and focus is still very much on the GIRFT recommendations, and that actions that have been taken to implement specific recommendations have shown improvements in many key performance indicators indicative of good Stroke care across the pathway.
- Note that a progress update will be presented at the Finance and Performance Committee at its December meeting

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3.1 Safe and Clinically Effective Care Choose an item. Choose an item.

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA (Equality Impact Assessment) 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	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

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

GETTING IT RIGHT FIRST TIME

Stroke Medicine Review Report

Aneurin Bevan University Health Board

September 2022

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the Wales Planned Care Board team. It aims to identify improvements in stroke services at ABUHB to help them ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

Dr David Hargroves Consultant Stroke Physician, East Kent Hospitals University Foundation Trust (EKHUFT), Clinical lead for Stroke, EKHUFT & South East (Wessex, BOB, Kent, Surrey and Sussex) for NHSE/I, National Speciality Adviser for the National Stroke Programme for NHSE, National Clinical Lead for Stroke (GIRFT) for NHSE/I and;

Dr Deb Lowe, Consultant Stroke Physician & Geriatrician Wirral University Teaching Hospital, National Clinical Director for Stroke Medicine – NHSE&I, Senior Clinical Advisor for Stroke Medicine – NHSI GIRFT Programme

Table of Contents

1. Introduction

Getting It Right First Time (GIRFT) is a national programme designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The ambition of the programme in Aneurin Bevan UHB is to identify examples of innovative, high quality and efficient service delivery as well as identifying areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. RNOH/GIRFT worked closely with the National Clinical Lead for Stroke in Wales, Dr Shakeel Ahmad, to ensure that this project is aligned with the Wales Stroke Strategy.

2. Background

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Aneurin Bevan University Health Board (ABUHB), to conduct a review of their Stroke services using the GIRFT methodology, with the aim to support the Health Board with effective delivery, structure and performance of their stroke services.

This Programme of work is split into three phrases:

1) RNOH/GIRFT delivered a summit meeting on Thursday 27th January 2022 to provide colleagues from ABUHB with an overview of the GIRFT Programme and the GIRFT stroke workstream in England and to explain the principles and approach of the stroke programme planned for ABUHB.

2) The RNOH/GIRFT team visited all four stroke units in ABUHB on 11th May 2022; Nevill Hall Hospital (NHH), Ysbyty Ystrad Fawr (YYF), Royal Gwent Hospital (RGH) and The Grange University Hospital (GUH). A deep dive review and feedback meeting was conducted at GUH with key stroke staff attending either in person or joining virtually from the other three sites that had been visited earlier in the day.

3) Once this report has been delivered and the recommended actions made clear, the GIRFT Stroke Clinical Leads will hold a series of virtual monthly implementation support meetings. The purpose of these meetings will be to support and challenge the ABUHB clinical, operational and analytical teams to implement the recommendations from this report and to leave a legacy of sustainable quality improvement.

This document captures the key findings and recommendations arising from the visit to ABUHB by Dr David Hargroves and Deb Lowe on the 11th, May 2022. We are extremely grateful to all those who attended our visit and gave such open and honest feedback.

This report is a companion document to the Health Board Provider Level SSNAP Datapack. Many of the process markers of performance used in the GIRFT stroke analysis come from The Sentinel Stroke National Audit Programme (SSNAP). This is a major national healthcare quality improvement programme based formerly at the Royal College of Physicians (RCP) in

London, now housed within the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is a single source of stroke data in England, Wales, and Northern Ireland. It measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke.

3. Aneurin Bevan University Health Board

The Aneurin Bevan University Health Board (ABUHB), which was established on the 1st October 2009, covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys and services a population of 600,000 and has approximately 850 stroke admissions per year. It employs over 14,000 staff, two thirds of whom are involved in direct patient care. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers.

ABUHB has a new specialist and critical care centre, the Grange University Hospital (GUH), which opened in November 2020, has 560 beds and features a 24-hour Acute Assessment Unit, Emergency Department and Helicopter Pad. It provides a 24/7 Emergency Service for patients that need specialist and critical care. Upon opening, GUH became the only Hyper Acute Stroke Unit in ABUHB, taking over this role from the Royal Gwent Hospital (RGH), based in Newport. RGH is one of three enhanced Local General Hospitals operating in ABUHB, the others being Nevill Hall Hospital (NHH), in Abergavenny, and Ysbyty Ystrad Fawr (YYF) in Ystrad Mynach. Each of the Local General Hospitals provides therapy and rehab services for stroke patients. Most patients are admitted via the Flow Centre to GUH for their acute phase of care. Any self-presenters at the ELGhs or patients who have had a stroke whilst on an ELGH site are assessed and depending on clinical presentation are almost always "dripped and shipped" to GUH.

There are also Community Hospitals and facilities which were not included in this review but may care for some patients once they have completed their stroke pathway and awaiting discharge as a step-down facility. These are:

1) St Woolos Hospital (Newport) 'Ruperra' ward and formally dedicated to Stroke Rehabilitation. However, when GUH opened this ward moved to the ELGH and is now a community ward.
2) County Hospital (Pontypool) this hospital receives patients who normally reside in Torfaen, from both the Royal Gwent and Neville Hall Hospitals for rehabilitation after stroke,
3) , provide some community based inpatient stroke rehabilitation services.
4) Monnow Vale, (Monmouth) provides community based inpatient rehabilitation, not specifically for stroke patients
5) Ysbyty Aneurin Bevan (Ebbw Vale) provides community based inpatient rehabilitation, not specifically for stroke patients
6) County Hospital (Pontypool) community based inpatient rehabilitation, not specifically for stroke patients

3.1. ABUHB and Its People

The strength of a National Health Service is in its people. The power of an organisation is so often in the loyalty, dedication, shared purpose and clear vison of its staff to deliver the best care they can and to always put the patient at the centre of everything they do. We were impressed by the culture and leadership at all the hospitals, which became evident within a few minutes of meeting the multi-disciplinary teams.

We also witnessed frustration and fatigue; to be expected at the end of a two-year pandemic, but this ran deeper and relates to a longer duration than the pandemic as it was clear that many felt unable to influence change within their organisation, yet still were willing and able to speak up and express their desire to drive the necessary changes forward.

We were told that the workforce challenges throughout NHS Wales are significant across medical, nursing and therapy teams, but are particularly marked in some of the ABUHB hospitals. BASP-Stroke-Medicine-Workforce-Requirements-Report and the https://www.hee.nhs.uk/our-work/hee-star are useful bench marking tools which the ABUHB stroke team may wish to use to address these workforce challenges.

There is good evidence for working within networks and we were very pleased to hear that the Welsh Stroke Strategy looks to support the development of stroke networks across Wales, to share knowledge, information, facilitate inter-organisational collaboration and learning and manage change. This will require excellent leadership, and we were impressed to see so many natural leaders across the professions whose skills need to be harnessed to support delivery of high-quality care.

4. Service Overview

The following Service Overview was provided by ABUHB prior to the meeting and discussed during the deep dive session. Additional information was gathered in the pre-visit virtual meeting and in the meetings with staff on the day.

SERVICE OVERVIEW – Aneurin Bevan University Health Board					
1	**Population served**	Total Number: 600,000 in ABUHB			
2	**Hospital beds in total in individual hospitals**	Where based and Total Number: 1217 RGH 218 NHH 212 YYF 227 GUH 560			
3	**Stroke beds**	Number of beds Stroke Rehab RGH 24 Stroke Rehab NHH 22 Stroke Rehab YYF 15 Hyper Acute Stroke GUH 12+ 3 general medicine	Base and No. of Hasu=1 HASU GUH HASU 12 beds specifically for HASU the ward is 15 bedded with the additional 3 beds used for GM patients		
4	**Stroke Consultants**	Number per site RGH- 1 Consultant NHH – 1 consultant YYF – 1 consultant GUH – 4 consultants	Number On-Cal 8 Stroke-only	Further detail: i.e. 5/7 or 7/7 service 1:8	

		Total DCC's:45,	Consultants on-call:	
5	**Stroke Nurses**	WTE Number 4	Hours of Cover 7am -5pm	Plans in discussion for 12 hour cover when vacancies filled and staff trained.
6	**Stroke Ward Staffing**	Registered Nurses: 3 day 3 night Health Care support: 3 day 3 night Nursing Bands: Band 6 x2 Band 5 Band 3 Band 2	Therapists: SLT 0.7WTE dedicated SLT for HASU 1WTE SLTA FOR HASU (No other sites have stroke specific staff. Only able to provide 4 day dysphagia cover. Occupational Therapists: GUH 0.8WTE BAND 7, 0.6 BAND 6 RGH= 1 WTE BAND 7, 1WTE BAND 6, 1WTE B5, 1WTE BAND4 1 WTE B3 NHH: 0.8 WTE BAND 6, 1WTE BAND 5, 0.8 WTE BAND 4 YYF: 1WTE BAND 6, 1WTE BAND5 1WTE BAND 3 AND 0.8 WTE BAND 8A FLOATING Physiotherapist: GUH 2 WTE YYF 2.5 WTE RGH 3.6WTE NHH 3.3 WTE	Extra Detail: 1 ward manager, supernumerary to numbers by day (M-F)
7	**Psychology**	1 WTE Psychologist for Stroke 1 WTE Assistant		Based in Community Neuro rehab service but in reach to wards and

		psychologist for Stroke 1 WTE Consultant psychologist for Stroke and Neurological conditions		provide life after stroke psychology service through 1:1 interventions and group based psychoeducational modules
8	**ESD and community stroke rehab Service**	5 days Cover 0800-1700	Speech Therapy 1.2 WTE OT 3.2 WTE Physio 2.8 WTE Dietitian 0.4 WTE Therapy Assistant Practitioner: 5.6 WTE Life after Stroke Wellbeing practitioners: 1.8 WTE	Extra detail: 1 physio is also Team Lead so has 0.3 WTE dedicated to managerial role. All patients can access the service based Niwrostiwt Neuro Recovery College which delivers education on common stroke issues and opportunities for personal recovery.
9	**6/52 and 6/12 Review Process**	6 weeks follow up consultants 6/12 is completed by CNS		
10 11.	**Stroke imaging** **Relationship with IAT Centre & Hours of Service:**	Access to CTA: hours / per day 24 hours a day Access to CTP: hours / per day 0 Hours a day Access to AI: Y/N Not available But funding been approved the Welsh Government recently **Access to MRI first line for acute stroke and TIA patients?: There are no dedicated slots for stroke and TIA but this is available daily.** **Current waiting for TIA imaging. MRI two weeks, CT one week, Carotid doppler one week.** **Inpatient CT 10 min to 1 hour, MRI 2 to 24 hours (same day 60%, next day 40 %), MRI Scans requested after 3 pm mostly done next day.** Modality used for carotid imaging? Carotid Doppler Please describe: Bristol South meads 8am to 6 Pm 7 days a week		

Most of this report focuses on the performance and data we have for ABUHB's hyper-acute stroke service, as the GIRFT methodology relies heavily on the use of data to drive improvement. This, however, is only one part of the complex pathway of stroke care within this hospital group. It was important to the visiting team to understand the flow, the facilities, and the people within the three surrounding stroke units to enable a rounded discussion at the deep dive meeting held at GUH and to support the development of strategic and quality improvement recommendations.

4.1. Nevill Hall Hospital

The NHH Rehab Team

Nevill Hall Hospital (NHH) in Abergavenny has 213 inpatient beds and a wide range of services including a 24/7 nurse led minor injuries unit and a medical assessment unit.

The stroke ward at NHH had 28 beds when we visited, 24 beds were funded and 21 of these were stroke beds; the remaining were general care of the elderly beds. The team informed us that on average, 20% of the beds were occupied by acute stroke admissions; these patients don't get entered in to SSNAP as this hospital is not classed as a routinely admitting stroke unit. The model in ABUHB is that all patients should come through the Flow Centre for admission at the GUH not ELGHs. There is access to thrombolysis 24/7 and a 'drip and ship' model is employed with some but not all patients moving to The Grange for their hyper-acute stroke care. The length of stay was reported to be 42 days. As the ward is mixed, this figure also included patients classed as "General Medicine and Care of the Elderly".

There are two medical consultants that support the unit, one substantive and one locum consultant that is going through the Certificate of Eligibility for Specialist Registration (CESR) route. The medical lead at this ward is very clearly a highly valued member of the team and there was a positive inclusive culture felt on the ward. The ward has two foundation doctors and one CMT doctor during the week. There had been two experienced Clinical Nurse Specialists supporting the ward on a pro-rata basis that had moved to the Grange when the HASU was centralised in 2021. These posts have not been backfilled on the ELGH sites. We were pleased to hear that ABUHB had recruited two new Nurse Consultants in other areas so there could be scope to develop similar roles in Stroke

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was a very high level of neuro-rehabilitation expertise within the group of senior therapists that we were able to meet. Of note there was only 0.6 WTE dysphagia trained Speech and Language Therapy provision. At the time of the review, it was reported that there was no psychology support but in theory there is usually 4 hours

per week of support for inpatients. The role of rehabilitation assistants was recognised and their ability to support 7 day working with the correct supervision was supported.

Access to Early Supported Discharge (ESD) and Community Rehabilitation Teams (CRT) was variable. There was usually at least a 1 week wait to access 'ESD' and there was no enablement/domiciliary care included within the commissioned service. The ESD responds to received referrals within 1 day of discharge Monday – Friday. Contact is via telephone triage – if same day assessment is indicated, it is available (staffing challenges may sometimes affect this). If same day assessment is not indicated, we target the right profession to complete the assessment – this approach is based on the Malcolmess Care Aims intended outcomes framework and aims to get the right person out to assess at the right time. This allows stroke survivors to settle at home and explore their new functional status so that when we assess they are able to identify hopes and goals in a more meaningful way than they can on the first day home from hospital when they are often very tired and just needing time. The pathway was commissioned for 3 months, but this could be extended based on patient need. If a patient was discharged to a nursing home, there appeared to be less access to specialist stroke rehabilitation. The ESD team works with people for up to 3 months (average 8 weeks). If ongoing support is required, this is arranged through outpatient physio/SLT services. The clinical psychology team support over a longer time frame up to and over one year.

Social work support is locality based and can be variable with significant delays for packages of care. It is not unusual to wait 4 weeks for a larger package of care and even longer delays for nursing home placements.

There had previously been a commissioned Stroke Association Family and Carer support worker service across ABUHB, but this service had been decommissioned. Following the end of the commissioned stroke association service, Life-After Stroke support is provided through 2 Life after Stroke wellbeing practitioners who are embedded in the Community Neuro Rehab Service. The recently appointed2 practitioners will support anyone who has had a stroke in the past year and provides face to face, telephone and virtual support as appropriate. The service sends a letter and leaflet contact for people to request support. The service will also in reach to the stroke units if in reach support is requested by the ward staff.

The estates at Nevill Hall were sub-optimal for delivery of effective rehabilitation. There was inadequate therapy space and no quiet space for speech and cognitive assessments. Toilet facilities were mixed sex, and you could not enable patients requiring a hoist for transfer to use the bathrooms. Some of the environmental constraints within this ward could be addressed by returning the ward to 24 funded beds and utilising the released space to address the above concerns.

4.2. Ysbyty Ystrad Fawr

The YYF Rehab Team

Ysbyty Ystrad Fawr (YYF) in Hengoed has 164 inpatient beds and has a Minor Injuries Unit, medical assessment unit included within its services. It has 30 rehabilitation beds, 15 of which are usually occupied by stroke patients. It was reported that the length of stay is approximately 42 days on this ward. At times the stroke ward may be occupied with more General Medical or Care of the Elderly patients so the length of stay will be affected by this. It was also reported that it was unusual for acute stroke patients to present to this hospital and only a handful of patients had been transferred to The Grange by 'drip and ship'. This is because all patients are managed through the flow centre and directed to the GUH. Stroke patients are referred from the HASU at GUH into this unit for rehabilitation. This makes flow management and discharge planning difficult, as the ward works with multiple locality social work teams and different commissioned community CRT services and one ESD team. There seemed to be a lack of a commissioned pathway for complex neurological rehabilitation.

There is a single-handed consultant who is job planned to deliver 6 PAs to support the service and there has been a Stroke Consultant vacancy at this site for almost 5 years. There are additional ward rounds by a Care of the Elderly Consultant but when the Stroke Consultant is away, there is usually only one ward round per week. Junior doctor support can be variable but on average there are 5 junior doctors including F2's, GPVTS and two registrars. There was an excellent culture of training and education within the unit and supported places to attend the Welsh Stroke Conference each year. There was good support from ward-based pharmacists for safe prescribing.

There was excellent nursing leadership, as with all the hospitals we visited, but there are significant nursing recruitment challenges at YYF with a 50% nursing vacancy rate despite attempts at international recruitment. Band 4 nurses had recently been appointed using band 5 funding.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1.2 WTE SLT for the entire hospital; of this, only 0.6 WTE is dysphagia trained SLT. The remaining 0.6 WTE is for communication only. At the time of the review, it was reported that there was no psychology support but in theory there is usually support for inpatients from an in-reach on referral model. There is a very limited spasticity service offered at this hospital with ad hoc support available. The senior physiotherapist was also being trained to administer Botox therapy which is to be commended.

There is good social work support and a discharge coordinator role but still major delays in accessing packages of care and nursing home places.

Follow up post discharge is delivered at 6 weeks by the Stroke Consultant, but there is no routine 6 month follow up.

The ward was made up entirely of single rooms. Whilst this has some advantages for privacy and infection control, there is evidence that stroke patients in the rehabilitation phase get a lot of benefit from the socialisation of communal bay accommodation and therapy spaces. The toilet facilities could not accommodate patients that needed to be hoisted. The rehabilitation therapy space was not based on the rehabilitation ward and was not exclusively reserved for the rehabilitation ward.

4.3. Royal Gwent Hospital

The RGH Rehab Team

Royal Gwent Hospital in Newport has approximately 370 inpatient beds and again a 24/7 Minor Injuries Unit and Medical Assessment Unit amongst its services. There are 24 stroke rehabilitation beds, and these are usually exclusively occupied by stroke patients with the occasional complex neurological rehabilitation patient. The average length of stay is

approximately 44 days. There are some self-presenting stroke patients making up around 10-15% of all admissions; these patients are rarely moved to The Grange.

The Medical Consultant cover is currently being provided by a Consultant from The Grange who carries out a twice weekly ward round. The ward is also supported with daily specialty doctor cover; this is clearly not a sustainable model and new consultant appointments were being explored to support the medical workforce. There are 4 junior doctors that support this ward, one foundation doctor and three middle grade speciality doctors.

There were significant challenges across nursing recruitment with 5 RN vacancies and 4 CSW vacancies at the time of our visit. It was clear to see that there was strong nursing leadership as this unit has previously been a nurse led rehabilitation unit, but frustration was expressed with the ongoing recruitment difficulties. There was a good working relationship between the therapy and nursing teams with key interventions to support nursing workload.

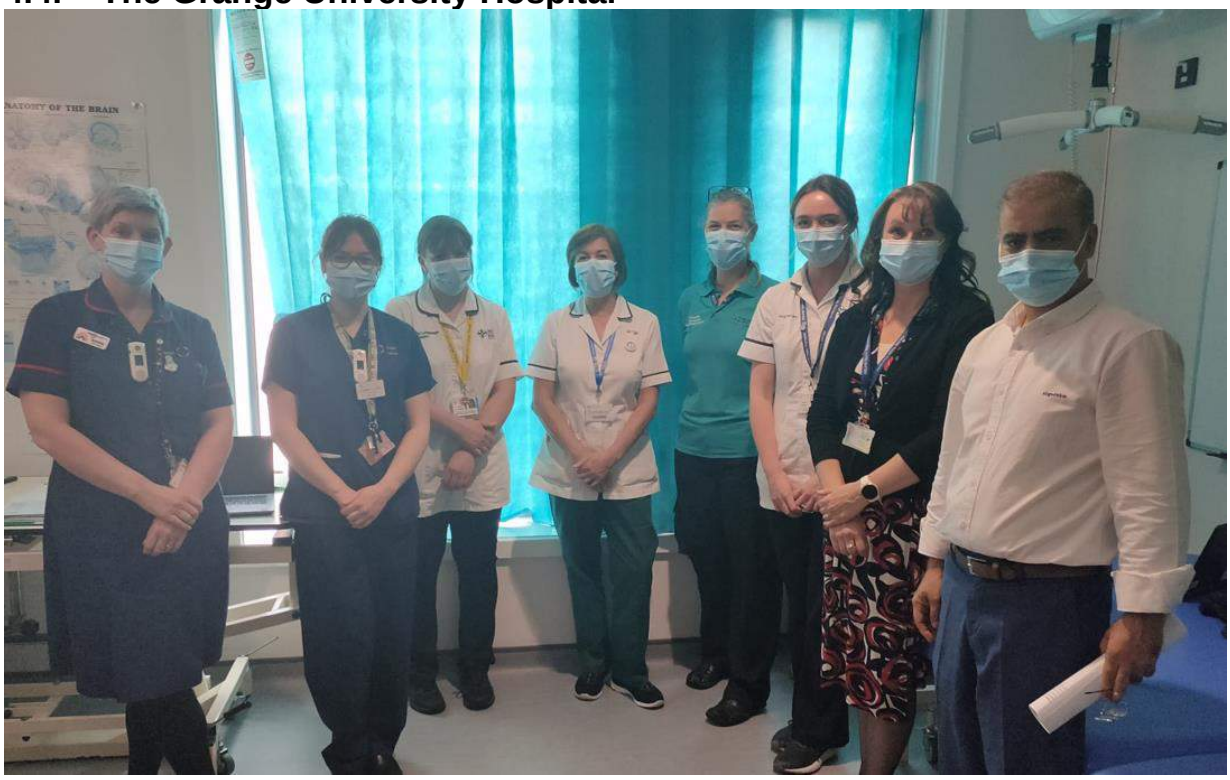
There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1 WTE band 6 SLT for the entire hospital. There was a reported delay of 3-4 weeks for PEG insertion. There is psychology support from an in-reach on referral model.

There were similar challenges to NHH and YYF with access to ESD and CRT, with a perception of a delay in availability onto ESD. NHH ESD responds to received referrals via a telephone call the day after discharge from hospital. Assessment is undertaken on the same day when required. Delays in packages of care, which sit within Social Services / Community Resource Team (CRT) is still a concern and may delay access. Only patients that were fit for transfer could be discharged for home therapy, with only one patient able to do so. Neuro-rehabilitation out-patient services were only available for Physiotherapy.

There are significant delays to access packages of care and nursing home placements. Stroke patients are moved to other ward areas to support flow due to discharge delays if they are no longer receiving active rehabilitation. It was reported that on average 15% of patients were medically optimised for discharge.

There were two large therapy areas on the ward but no quiet room for speech and cognitive assessments. There was one bathroom accessible for hoist transfer patients. Group rehabilitation was offered, and Occupational Therapists had changed working patterns recently to support morning Personal Activities of Daily Living (PADL) assessment and to support the nursing staff.

4.4. The Grange University Hospital



The GUH Rehab Team

As described earlier, this new hospital has 560 beds and provides all Specialist and Critical Care services for Gwent. It is also a major Trauma Centre for the region as well as being ABUHB's Acute Stroke Centre. It has 15 stroke beds, 12 of which are funded Hyper-Acute Stroke Unit beds, with an average length of stay of 6 days. It is difficult to meet the 4 hour target for admission as beds are not ring-fenced and frustration was expressed about the inability to manage their own beds.

There are 7 side rooms, two bays with 4 monitored beds in each and one therapy room on the ward (which at times of high demand in the hospital overnight was being used as a General Medical patient bed, although this has now been removed from the site escalation plans)

There are 4 stroke consultants that support the acute stroke pathway. There are 6 Neurologists that are employed by this Health Board and are based at the Royal Gwent Hospital, but only one works within the stroke team. A total of 8 consultants support the on-call rota from the four ABUHB hospitals. There is remote PACS radiology access to support remote review of brain scans

There were reported to be excellent nursing levels and no issues with recruitment. There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was 0.8 WTE SLT in post but 1.4WTE funded Speech and Language Therapy. There was no dietician support for the stroke unit with psychology support being offered as an in-reach service to the ELGH rehab site.

The acute care pathway was reviewed during our discussions with the team, and we had the opportunity to 'walk' the stroke pathway from A&E to radiology and up to the ward. Pre-alerts do occur directly to the stroke nurses but there is often limited information, which does not

enable pre-registration. Stroke Specialist Nurses are available Monday to Friday, 8am to 5pm and outside these times the Medical Registrar supports acute stroke assessments in A&E. An A&E sister commented during the visit, that she couldn't understand why the stroke review team would visit the resuscitation /high intensity A&E area as "stroke patients should never be assessed here". This was concerning, as acute stroke patients are some of the most acutely unstable patients in the emergency department. We accept that this may have been the opinion of an individual, but parity of esteem for stroke patients and support for the stroke team in A&E is essential to a successful stroke pathway.

Following initial review, suspected stroke patients go directly to CT +/- CT Angiogram. This pathway is less streamlined out of hours. Artificial Intelligence decision support software is not used, nor is Commuted Topography Perfusion (CTP), to support recanalization referrals and decisions. Thrombolysis is given in A&E. MRI is available 0730 to 2000 7 days a week for investigating minor strokes and stroke mimics and CT provision is available 24/7.

Thrombectomy services are delivered at Bristol South Mead Neuroscience Centre, 8am to 6pm, 7-days a week. There are good relationships between the referring hospital and the Neuroscience centre, although Thrombectomy rates remain well below a potential target of 8-10% of all stroke patients.

There are no specific TIA and Minor Stroke out-patient clinics delivered at GUH as the model for GUH does not include an outpatient footprint. These are all provided by the three other hospitals. Patients wait between 5 and 6 days to be seen and there is no provision for 'one stop assessment'. There is no access to first line MRI imaging, as per NICE guidelines, and patients often wait up to a week for brain and carotid imaging. Vascular surgery centralised in SE Wales on 18th July 2022 and is performed at the Regional Vascular Unit at the University Hospital of Wales in Cardiff. Intracerebral Haemorrhage Patients requiring Neurosurgical Intervention are also managed here.

5. SSNAP Data Performance Metrics: Findings and Recommendations

The recommendations that we have made in the report have been based upon the data accessible to us at the time of the visit to ABUHB and within the SSNAP published annual portfolio reports. It is also based on information from Trust Executives, Clinical Leads and Operations Managers on the pre-visit meeting and at the site visits. These are not exhaustive but are key areas that if focused on will reduce unwarranted variation and improve delivery of services along the stroke pathway.

During the deep dive visit on 11th May 2022, RNOH/GIRFT presented performance data for SSNAP registered routinely admitting stroke services in Wales, benchmarked against all stroke units in Wales and against the English national average. GUH is represented as the single routinely admitting stroke service in ABUHB; however, it is recognised that there are patients directly admitted to ELGHs and may not transfer to GUH (and therefore not included in SSNAP data). This included data from the most recent published SSNAP data available for the period October 2021-December 2021. Although this represents only a short period in time, having reviewed annual data in preparation for this visit, the Clinical Leads are confident that this quarterly data is representative of the performance out with this timeframe, and that recommendations are all relevant for future quality improvement.

5.1 Stroke Activity and Performance

Figure1

Routinely Admitting Team	Admissions (Oct 21 - Dec 21)	SSNAP level	SSNAP score	*Case ascertainment band*	*Audit compliance band*	Combined Total Key Indicator level
Grange University Hospital	186	D	48.4	A	B	D
Glan Clwyd District General Hospital	95	D	59	A	A	D
Maelor Hospital	92	D	42.5	C	A	D
Ysbyty Gwynedd	88	D	44	A	A	D
University Hospital of Wales	178	C	64	A	A	C
Prince Charles Hospital	135	C	65	A	A	C
Princess Of Wales Hospital	70	D	45.6	B	A	D
Bronglais Hospital	28	B	71.7	A	A	B
Prince Philip Hospital	40	B	72	A	A	B
West Wales General	44	C	63.2	B	B	B
Withybush General Hospital	45	A	81.7	A	B	A
Morriston Hospital	153	D	59	A	A	D

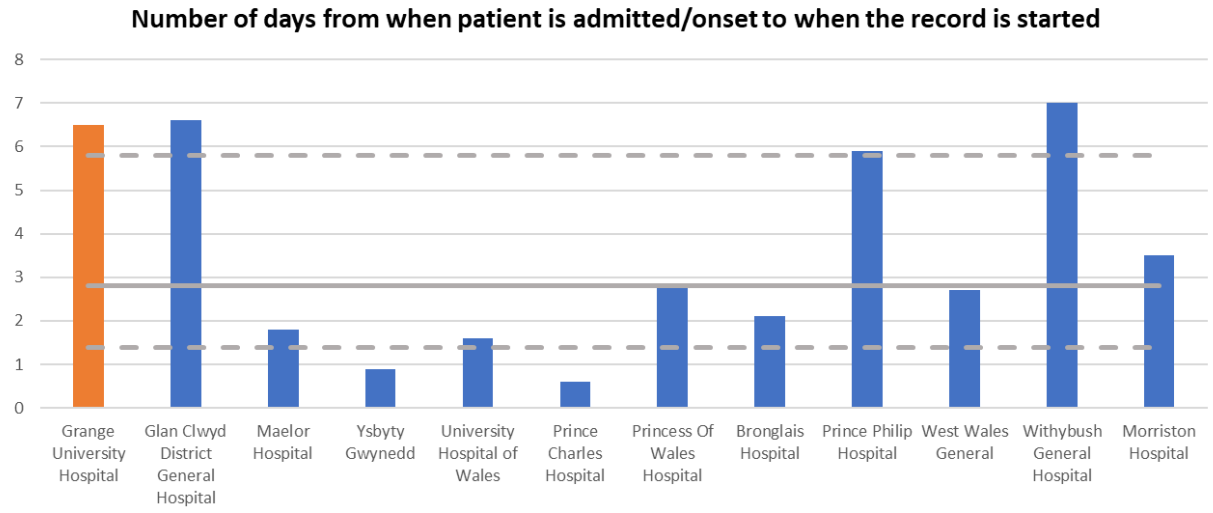
5.2 SSNAP Patient-Centred Data (routinely admitting teams)

Figure2

	Patient Centred Data										
Routinely admitting teams	Scan	SU	Throm	Spec Asst	OT	PT	SALT	MDT	Std Disch	Disch Proc	PC KI
Grange University Hospital	A	E	D	D	B	B	D	E	D	C	D
Glan Clwyd District General Hospital	B	E	D	D	C	C	B	C	A	C	C
Maelor Hospital	B	E	B	D	D	D	D	B	C	D	D
Ysbyty Gwynedd	C	E	E	D	E	D	D	C	A	D	D
University Hospital of Wales	B	E	E	E	B	A	C	B	B	A	C
Prince Charles Hospital	A	E	C	E	A	B	C	D	B	B	C
Princess Of Wales Hospital	B	E	C	E	C	D	E	E	A	C	D
Bronglais Hospital	A	C	B	B	C	B	C	C	A	E	B
Prince Philip Hospital	A	D	E	A	C	B	B	B	A	C	B
West Wales General	A	E	C	B	C	B	C	B	A	C	B
Withybush General Hospital	A	B	B	A	B	A	C	B	B	A	A
Morriston Hospital	C	E	D	B	C	B	C	D	B	C	D

5.3 Admission to record start

Figure3



Grey lines show the median and interquartile range of sites in England

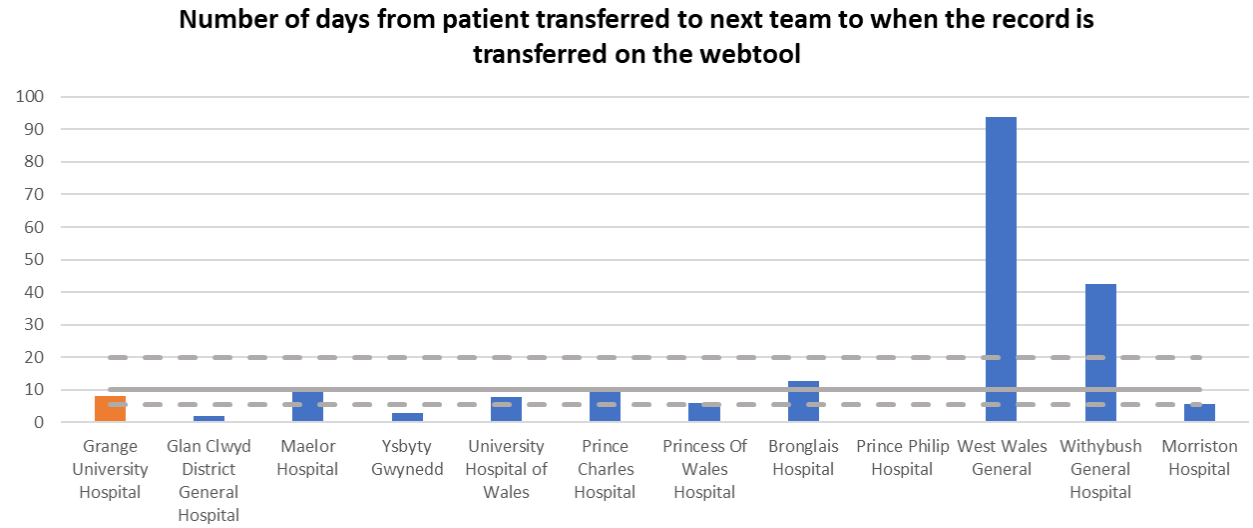
Team-centred results at team level for Audit Compliance measure C5.1

Source: SSNAP Oct 2021-Dec 2021

Number of days from when patient is admitted/onset to when the record is started – 6.5 days

5.4 Delay (days) between clock start and date of starting electronic SSNAP record

Figure 4



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Audit Compliance measure C4.4

Source: SSNAP Oct 2021-Dec 2021

Number of days from patient transferred to next team to when the record is transferred on the webtool – 7.9 days

Analysis from the most recent SSNAP process markers (fig 1 and 2) at the time of this review demonstrated:

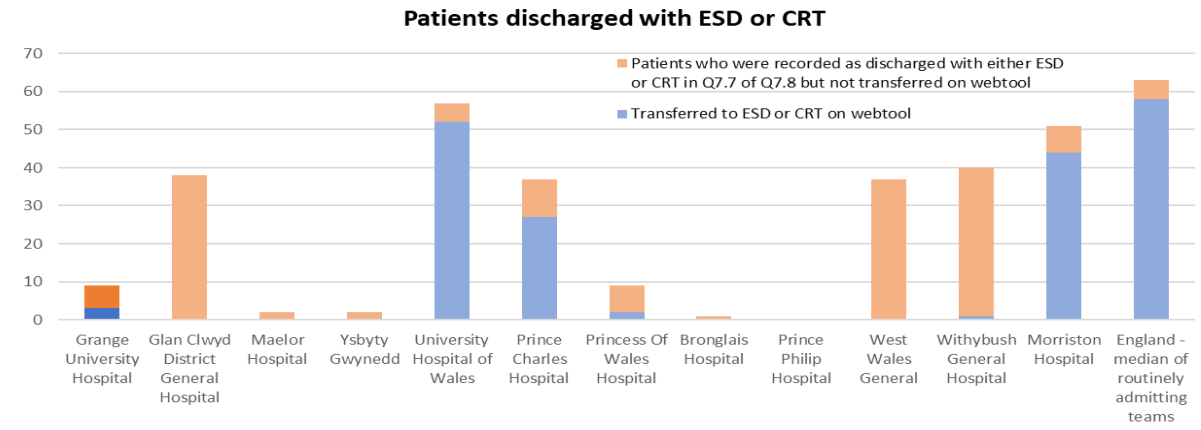
- A good level of case ascertainment band
- Excellent data submission for time to first scan
- There is significant opportunity for improvement in the timely access to the stroke beds at GUH with specialist assessments (particularly SLT) and access to mechanical thrombectomy
- Improvement is required in audit compliance, with significant delays of 6.5 days from admission to records starting respectively (fig 3)
- MDT working and discharge processes are lacking in the SSNAP record

SSNAP collects data on the whole care pathway from initial arrival at hospital, through all inpatient settings, across ESD and community rehabilitation and up to a six-month follow-up appointment. Use of SSNAP is an imperative to drive quality improvement. Recognising that the overall aim of SSNAP (fig 4) is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients is vitally important. SSNAP operates through manual provider level data entry. Acknowledging that SSNAP is only as good as the data submitted is paramount; all efforts should be made to ensure data is entered as accurately possible

Recommendation 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.

5.5 Patents discharged with ESD or CRT

Figure 5



Team-centred results at team level for Audit Compliance measure C4.6
Source: SSNAP Oct 2021-Dec 2021

Total number of patients discharged with ESD or CRT: 9x patients

- ***Transferred to ESD or CRT on webtool – 3x patients***
- ***Patients who were recorded as discharged with either ESD or CRT in Q7.7 of Q7.8 but not transferred on webtool – 6x patients***

Local intelligence suggests the number of patients supported with ESD during this timeframe was 31 referrals accepted from GUH during Q3 of 2021 (total number of referrals received from all sites including Cardiff and England was 85).

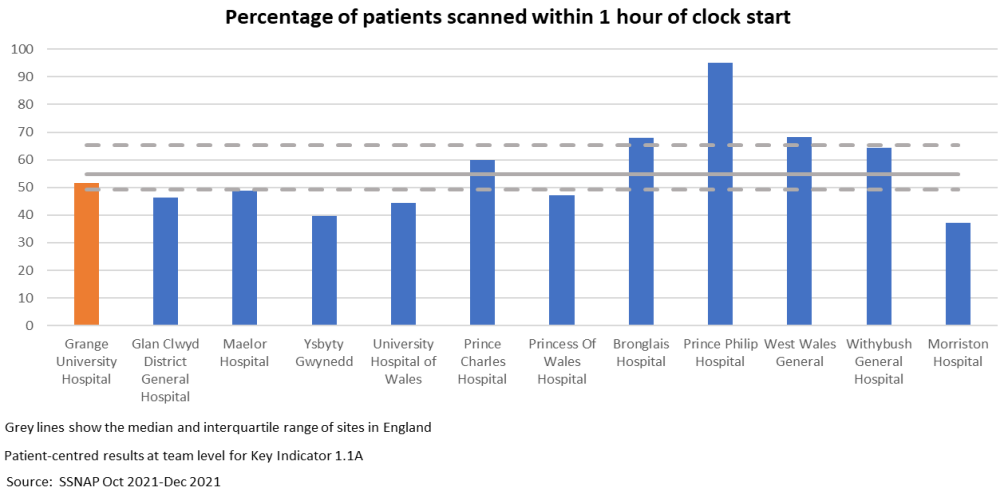
There was wide variation in the access to ESD as recorded on SSNAP. At GUH, the rate of patients discharged with ESD or CRT is significantly lower than the England median. Continued rehab may be delivered at ELGH sites.

Recommendation 2: Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)**) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.**

6. Hyper-Acute Stroke Pathway SSNAP Performance Metrics

6.1 Percentage of patients scanned within 1 hour of clock start

Figure 6



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 1.1A

Source: SSNAP Oct 2021-Dec 2021

Percentage of patients scanned within 1 hour of clock start – 51.6%

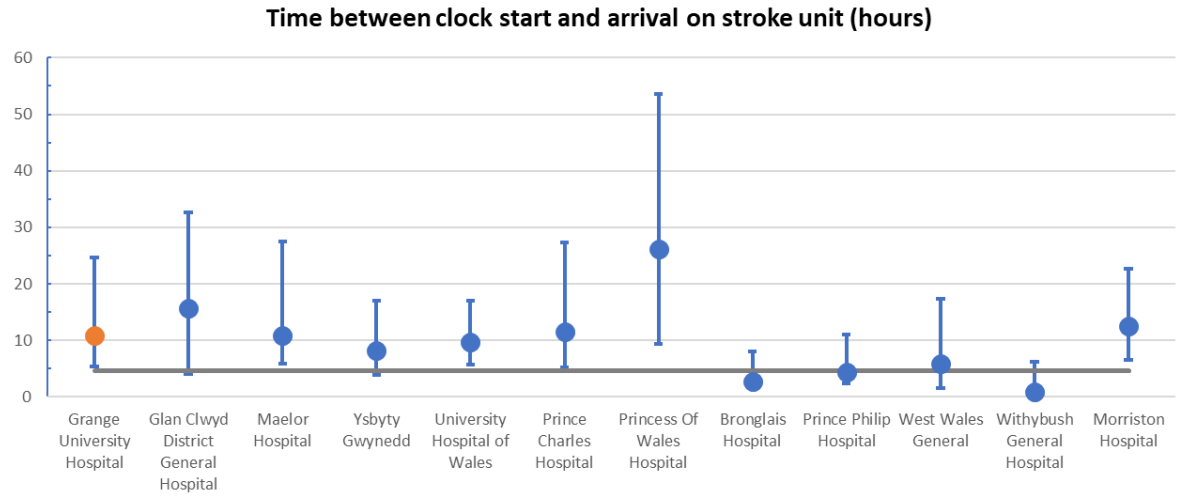
GUH's percentage of patients scanned within 1 hour of clock start was slightly lower than the national average.

Pre-hospital identification of suspected stroke patients could reduce delays to scanning and delivery of emergency treatment and stroke unit admission.

Recommendation 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 National-stroke-service-model-integrated-stroke-delivery-networks**.**

6.2 Clock start to stroke time

Figure 7



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient centred results at team level for Key Indicator 2.2A

Source: SSNAP Oct 2021-Dec 2021

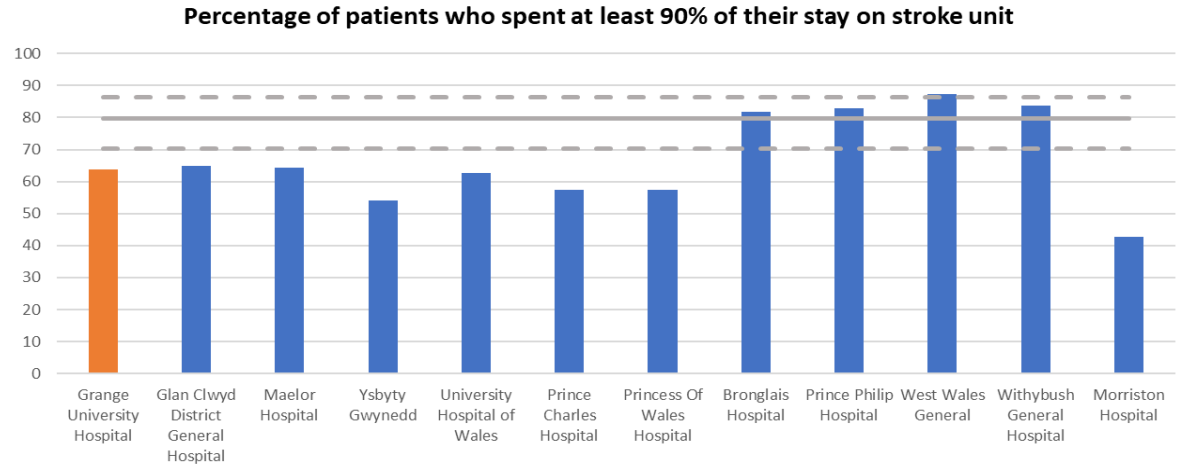
Time between clock start and arrival on stroke unit (hours) – 10.85

Timely admission to a Stroke Unit is considered a vital aspect of hyper acute care. GUH rates are on a par with the Welsh average, but are however, below the England average rates. There is inadequate bed capacity at GUH to enable all stroke patients to have an admission within 4 hours of presentation to hospital and enable equitable access to evidence-based stroke unit care for all.

Recommendation 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.

6.3 Stay on stroke unit

Figure 8



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 2.3A

Source: SSNAP Oct 2021-Dec 2021

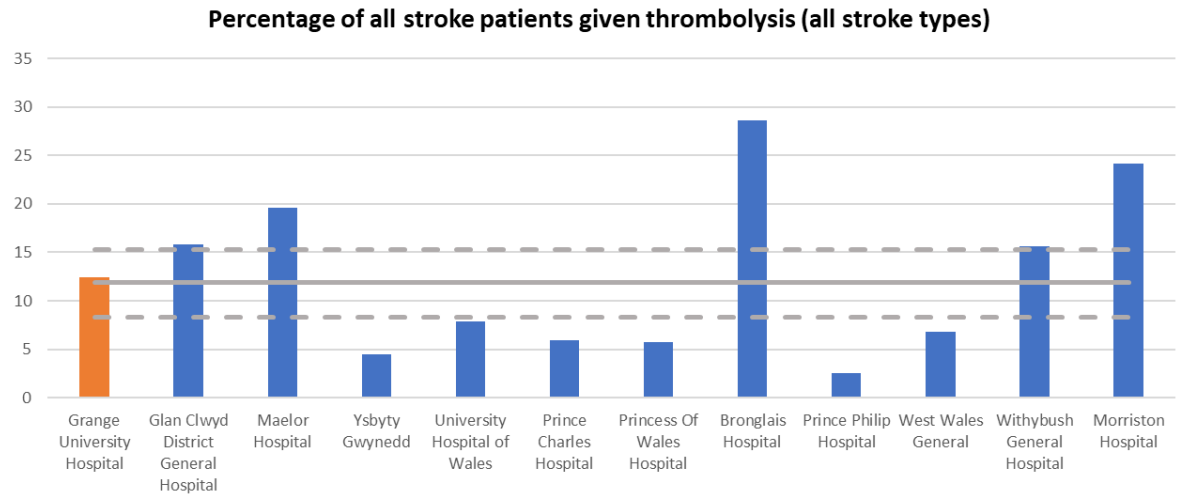
Percentage of patients who spent at least 90% of their stay on stroke unit – 63.9%

The GUH rates for accommodating patients for 90% of their in-patient stay on a stroke unit is lower than the England median. Patients that spend greater than 90% of their time on a stroke unit have fewer severe complications compared to those spending less than 90% of their inpatient stay on stroke units. The RGH reported moving stroke patients to other wards when they were medically optimised, to release beds. This will also have a positive impact on the 90% stay target.

Recommendation 5: Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging (see fig 7 and 8) should help to release bed capacity and increase access.

6.4 Thrombolysis rate (all stroke)

Figure 9



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 3.1A

Source: SSNAP Oct 2021-Dec 2021

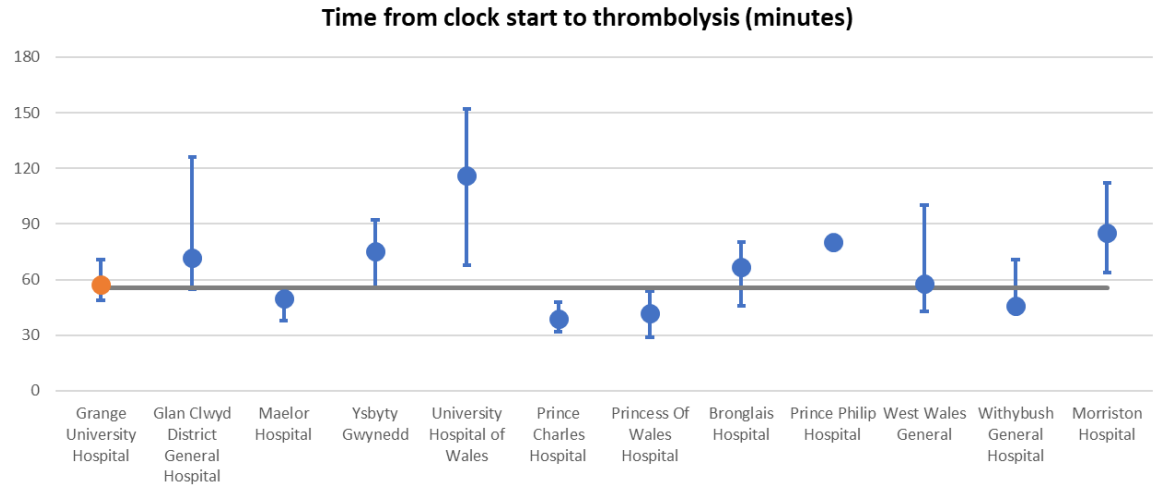
Thrombolysis rate – 12.4%

The thrombolysis rates are slightly above the England national average of 12%.

Recommendation 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.

6.5 Clock start to thrombolysis

Figure10



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 3.5A

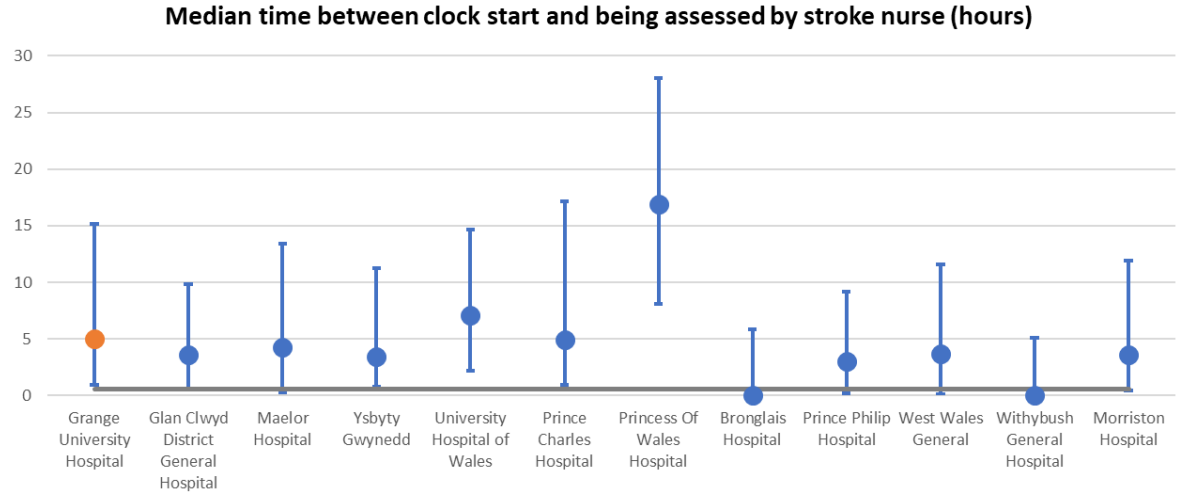
Source: SSNAP Oct 2021-Dec 2021

Time from clock start to thrombolysis (minutes) – 57mins

The GUH is providing timely access to thrombolysis from admission. Rates are in line with the median of sites in England. Aiming for a target closer to 30 minutes is gold standard and is being achieved in many highly performing stroke units in England, aided mostly by pre-registration of patients, immediate review by the stroke team and going straight to CT scanning.

6.6 Median time between clock start and being assessed by stroke nurse

Figure 11



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.4A

Source: SSNAP Oct 2021-Dec 2021

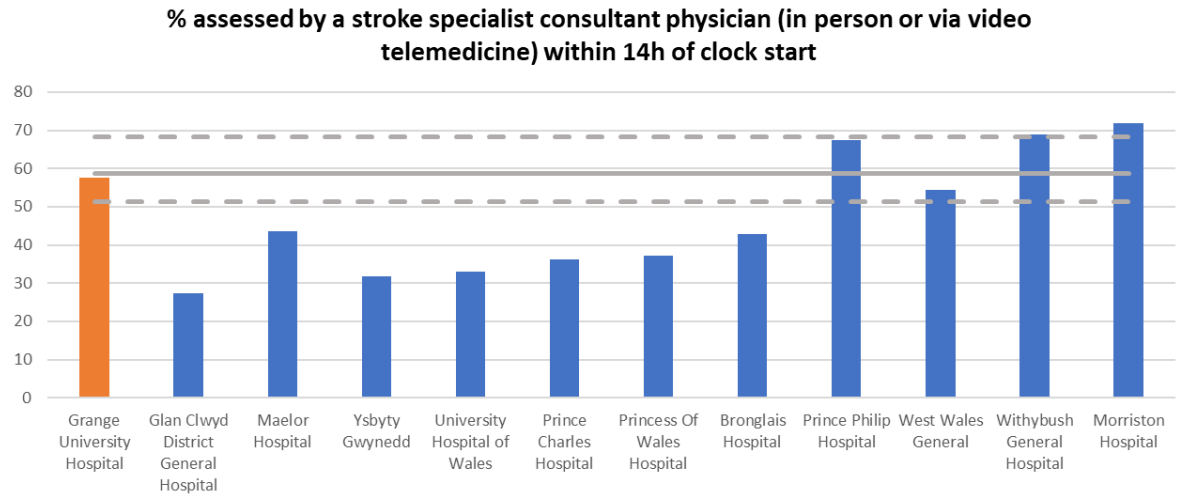
Median time between clock start and being assessed by stroke nurse – 4.95hr

GUH's median time between clock start and being assessed by a stroke nurse is 4.95 hours. There is variation due to GUH's inability to deliver a Stroke Specialist Nurse Assessment out-of-hours (outside of Monday-Friday 8am to-5pm).

Recommendation 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.

6.7 Specialist consultant assessment - % assessed by stroke consultant within 14hrs

Figure 12



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Item Reference G9.19

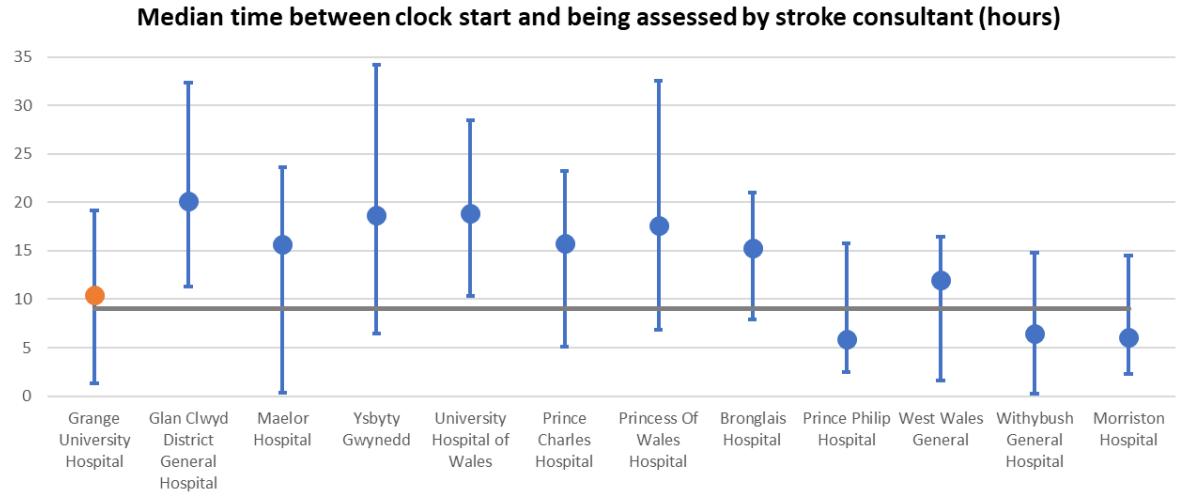
Source: SSNAP Oct 2021-Dec 2021

% assessed by a stroke specialist consultant physician (in person or via video telemedicine) within 14h of clock start – 57.5%

Good practice identified: The percentage of patients assessed by a stroke specialist consultant physician within 14hrs of clock start is in line with the English national average.

6.8 Specialist consultant assessment – Time between clock start and being assessed

Figure 13



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.2A

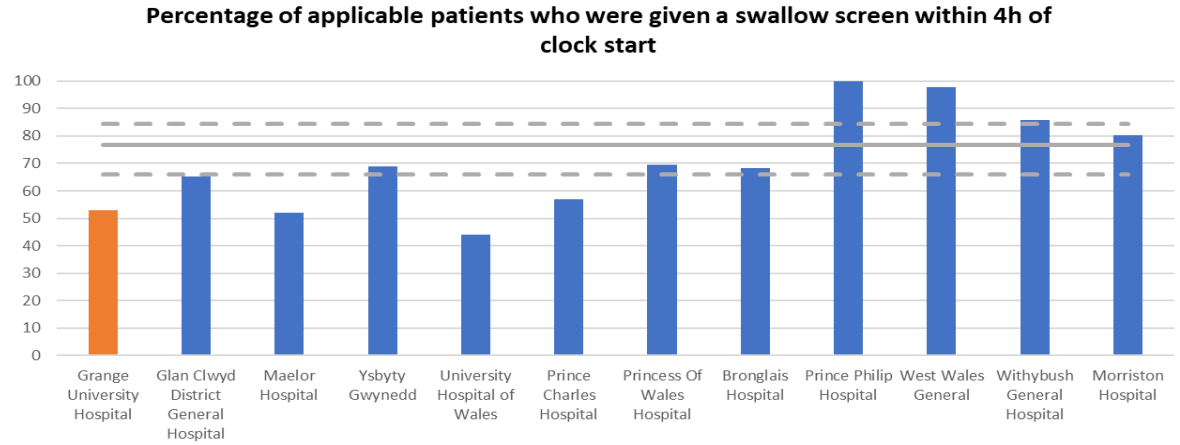
Source: SSNAP Oct 2021-Dec 2021

Median time between clock start and being assessed by stroke consultant (hours) – 10.37hrs

GUH are in line with the national average for the median time taken for first consultant review.

6.9 Swallow screen within 4 hours

Figure14



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.5A

Source: SSNAP Oct 2021-Dec 2021

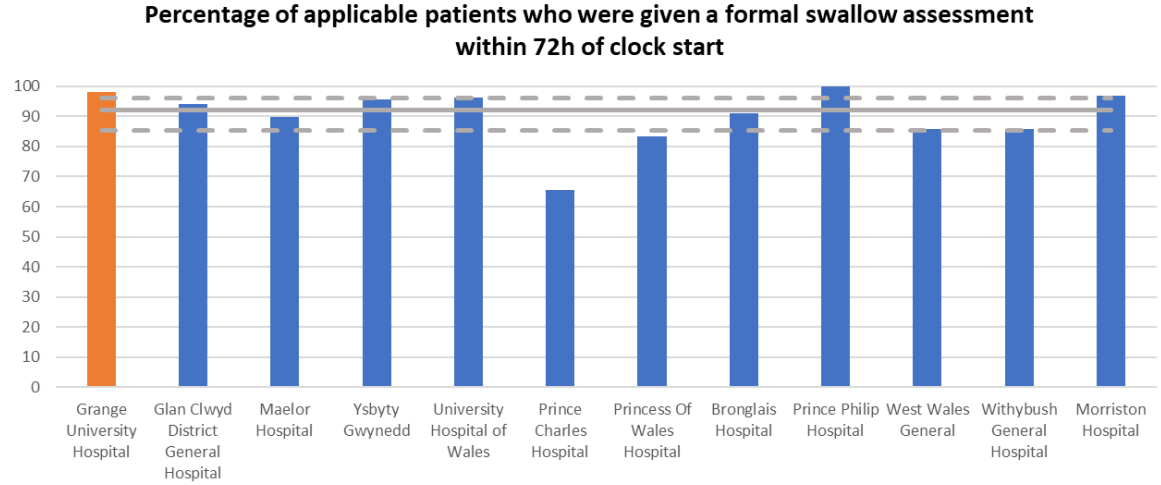
Percentage of applicable patients who were given a swallow screen within 4hrs of clock start – 52.8%

Only 52.8% of patients accessed a swallow screen within 4 hours, this is significantly lower than the national average.

Recommendation 8: Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.

6.10 Swallow Screen within 72hrs of clock start

Figure15



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.6A

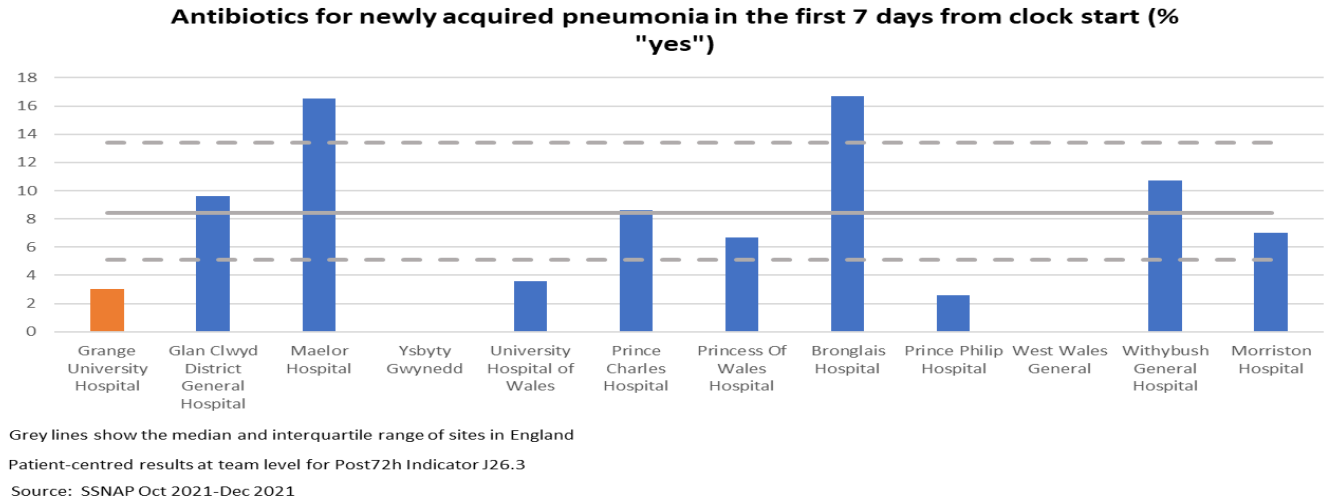
Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start - 98.2%

Good practice identified: 98.2% of GUH's patients accessed a formal swallow assessment by a Speech and Language Therapist within 72 hours of clock start. This is in the top quartile when compared with NHS Trusts in England.

6.11 Antibiotics for newly acquired pneumonia

Figure16



Antibiotics for newly acquired pneumonia in the first 7 days from clock start – 3 cases

Good practice identified: The data shows a low use of antibiotics for presumed pneumonia within the first 7 days of admission. This may be due to good processes being in place regarding swallow screening.

6. MDT Working

There is good evidence of early supported discharge and the delivery of therapy in people's homes.

There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

There is significant room for improvement in discharge processes and services i.e. social, packages of care and availability of care homes. Offering a stepdown for these patients to encourage flow across GUH and the rehab sites should be a priority. A goal should be to maximise support for patients who are most impaired and dependant following discharge.

ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3rd sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

Recommendation 9: ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.

The community discharge pathway demonstrated a time based model, the current commissioned pathway is for 3 months. The Stroke Association carers support pathway has not been fully embeded in all units, with significant gaps in two thirds of the units. Currently,

patients in a residential or nursing home in this region do not have access to rehabilitation, other than ESD to people who meet the ESD criteria. People with more significant impairment requiring additional staffing to undertake effective rehab do not fit the criteria. The ESD rehab programme is time limited but there is a Neuro recovery college model which provides a range of educational modules covering fatigue management, living well with stroke, GRASP upper limb rehab, rebuilding your life after stroke, community exercise. These modules are open for people to attend and provide support for much longer than 3 months for ESD. The Life After Stroke wellbeing practitioners also support on a longer term basis as do the clinical psychology team. We also informed that there is also a pathway to which works in partnership with the DWP to support people back into employment and or voluntary roles.

The psychology team routinely provide life after stroke support. The Acquired Brain Injury (ABI) team have also stepped in to provide longer term rehab on a number of occasions. Both the ABI and psychology resources are small and we have worked hard to prioritise people who are most in need of ongoing support. The basis of our prioritisation is risk to wellbeing and ability of people who are already proximal to manage this risk.

The Niwrostiwt Recovery College was developed by the ABI and psychology teams to support us in our commitment to doing the most good for the most people, whilst minimising harm and maximising autonomy. Whilst led by the ABI team the Niworstiwt is a collaboration between CNRS ABI & Stroke teams, people with lived experience of stroke and brain injury, Headway and the Stroke Association. The latter organisations contribute to the Stiwt's steering group.

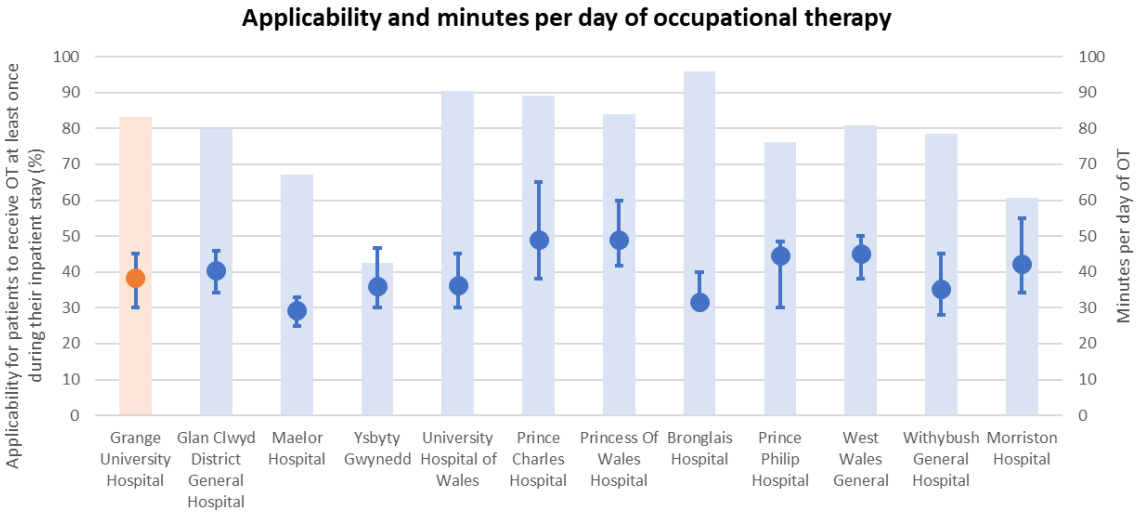
Recommendation 10: Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).

Recommendation 11: Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.

Recommendation: 12: Embed the National Stroke Service Model in ABUHB
https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf

7.1 Applicability and minutes of OT

Figure17



Bars show the % of patients applicable to receive physiotherapy at least once during their inpatient stay (England median is 87%). Dots show the median minutes receiverd per day (and interquartile range)

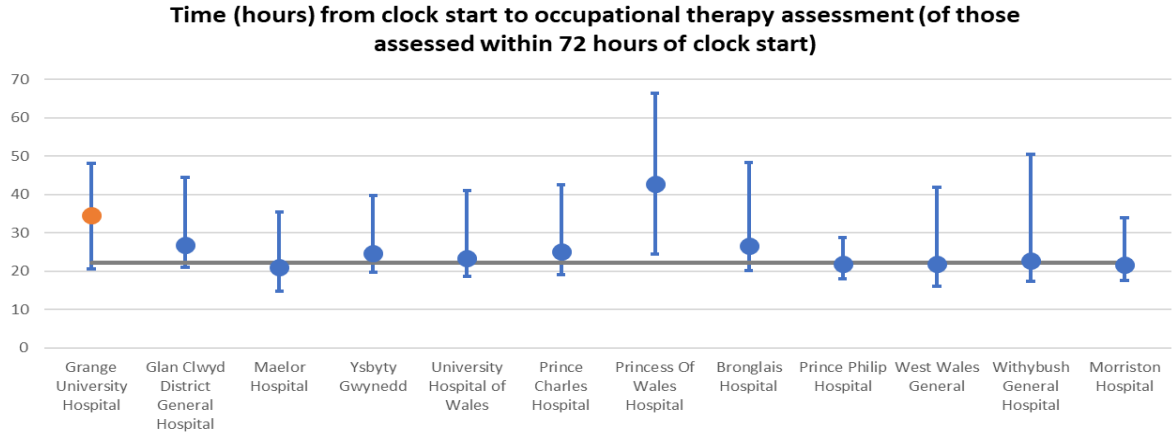
Patient -centred results at team level for Key Indicators 5.1A and 5.2A

Source: SSNAP Oct 2021-Dec 2021

Applicability and minutes per day of OT – 38.38%, in line with Wales's average

7.2 Clock start to OT assessment time

Figure18



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

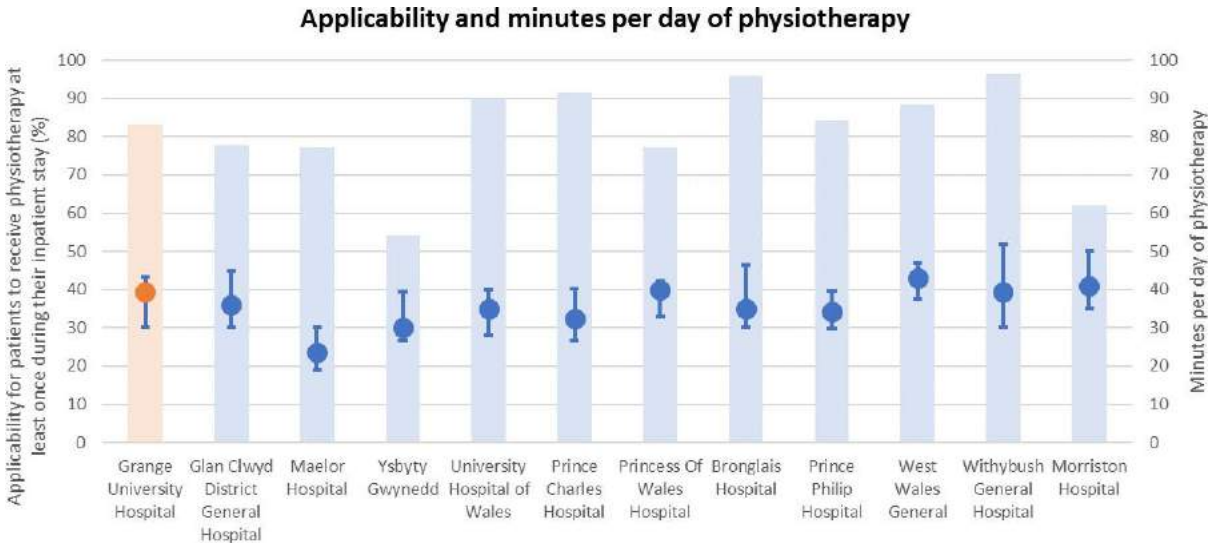
Patient-centred results at team level for Key Indicator 8.2A

Source: SSNAP Oct 2021-Dec 2021

Time from clock start to occupational therapy assessment – 34.35 hours

7.3 Applicability and minutes of physiotherapy

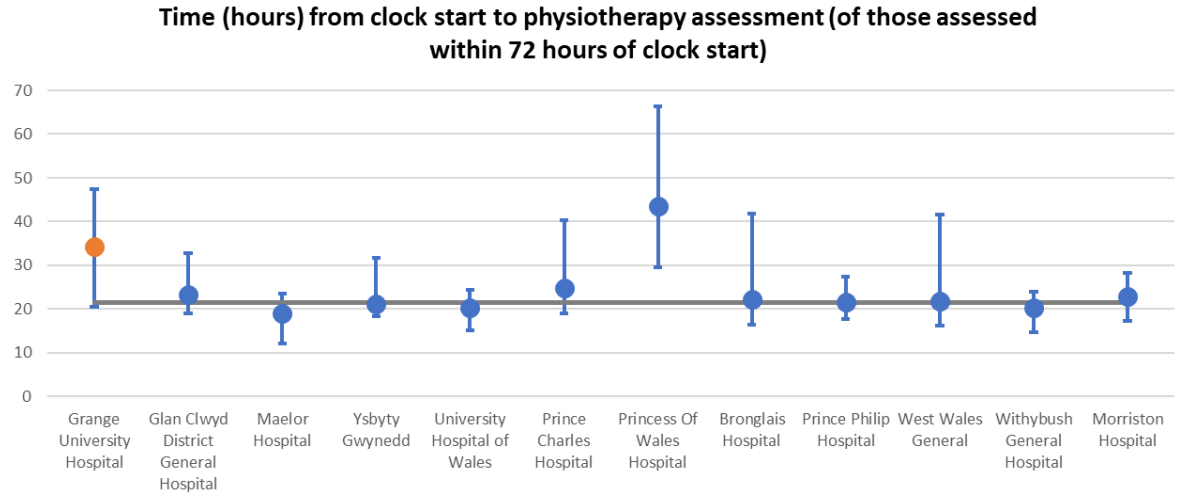
Figure 19



Applicability and minutes per day of physiotherapy – 39.2% in line with Wales's average

7.4 Clock start to physiotherapy assessment time

Figure20



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.4A

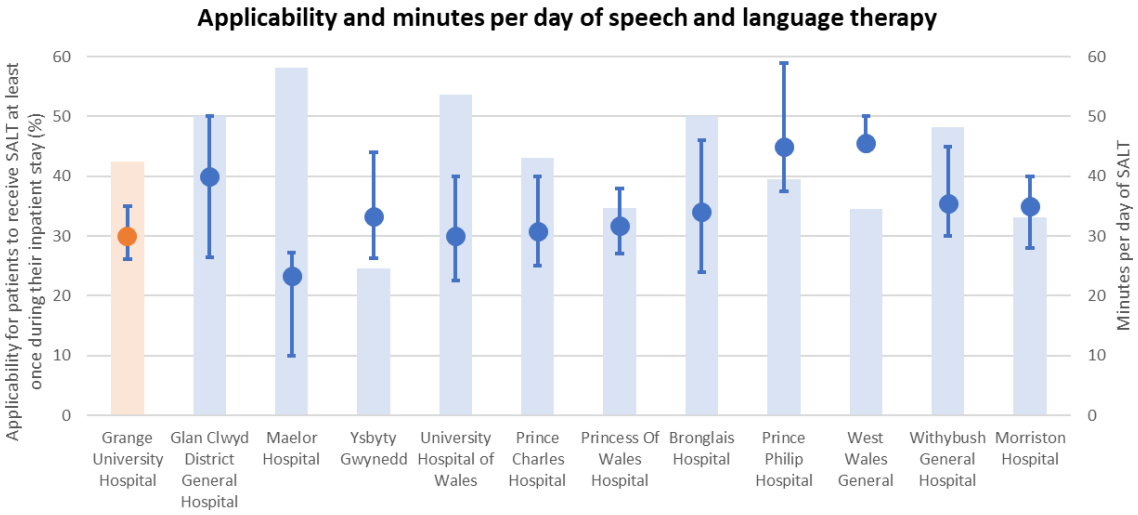
Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start) – 34.17%

Recommendation 13: Ensure 7 day access to physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients

7.5 Applicability and minutes of SALT

Figure21



Bars show the % of patients applicable to receive speech and language therapy at least once during their inpatient stay (England median is 54.4%). Dots show the median minutes receiverd per day (and interquartile range)

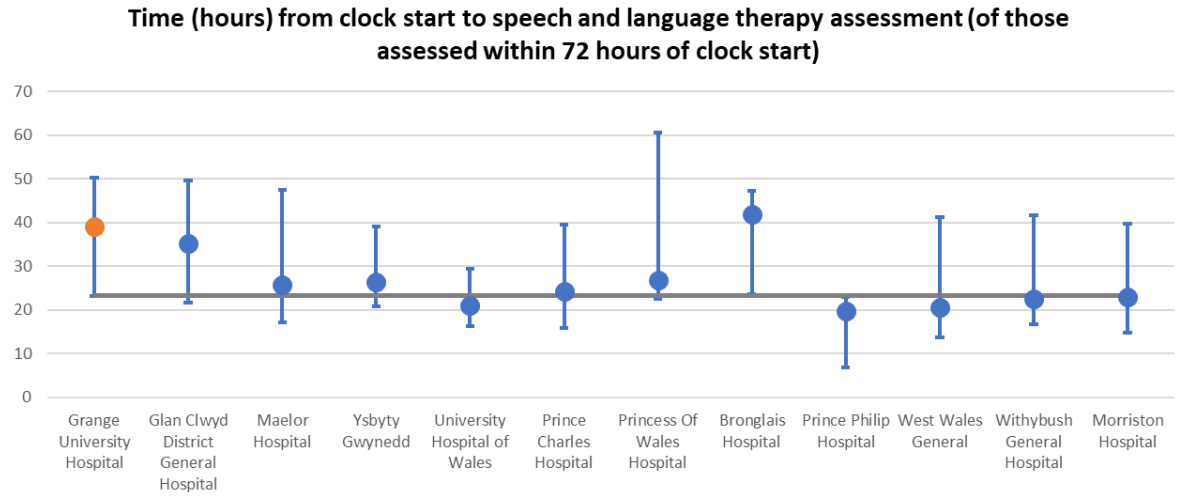
Patient -centred results at team level for Key Indicators 7.1A and 7.2A

Source: SSNAP Oct 2021-Dec 2021

Number of minutes per day on which SALT is actually received – 30%, below Wales's average.

7.6 Clock start to SALT assessment time

Figure22



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.6A

Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to speech and language therapy (SLT) assessment (of those assessed within 72 hours of clock start) – 39.05hrs

There is variation in the timely access to speech and language therapy services (see fig 21 and 22), as well as to physiotherapy and occupational therapy. The HASU currently provides a 5-day service for speech and language therapy. There are significant challenges in this pathway. The SSNAP standard is that sites should have at least two of the therapies shown available seven days a week. In most units, this is physiotherapy and occupational therapy.

Recommendation 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.

Currently not meeting the SSNAP 5 day standards for intensity of therapy, so it is clear that a review of rehabilitation staffing is required to meet 5 days before expansion to days can be considered. Expanded use of rehabilitation assistants and group therapy sessions to be considered. It may be worth exploring a virtual liaison tele-swallow service given the extreme staffing pressure within speech and language therapy.

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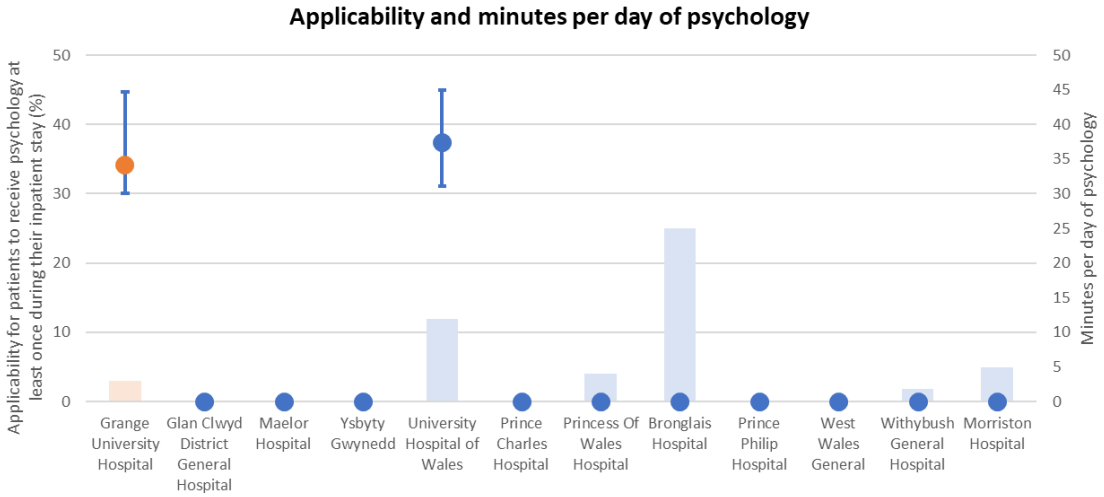
7.7 Applicability and minutes per day of psychology

Figure23



Bars show the % of patients applicable to receive psychology at least once during their inpatient stay (England median is 3.2%). Dots show the median minutes receiverd per day (and interquartile range)

Patient-centred results at team level for Item Reference J7.3-J7.7

Source: SSNAP Oct 2021-Dec 2021

% of the patient's days at in hospital (out of period patient requires psychology across all teams) on which it is received by the patient – 34.2%

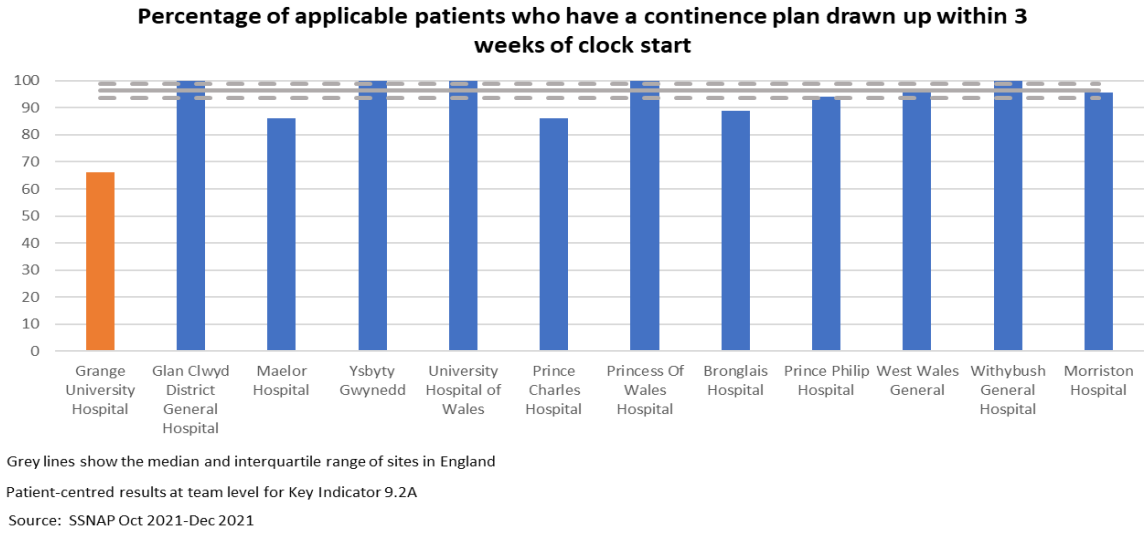
Assess to neuropsychology is variable across the region. A high proportion of patients (1 in 3) may require psychological support post-event. The current psychology model is 1 session of in reach per week for each ELGH based stroke unit. However, at the time of the GIRFT visit the psychology resource was significantly depleted by absences. We are told this has improved now, although there have not been any applicants to cover fixed term appointments, through secondments or agency staff. The psychology service provides support across the whole pathway and takes referrals from medics, primary care and healthcare professionals.

The ABUHB CNRS psychology team work across the width and along the full length of the stroke pathway. In practical terms this involves responding to requests for assistance from the HASU, the three sub-acute rehabilitation wards, the three Early Supported Discharge Teams, the ABUHB Living Well-After Stroke Service, and colleagues working in community services supporting stroke survivors. The CNRS psychology team have also been instrumental in the establishment of the Neurological Conditions Recovery College.

Recommendation 15: Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.

7.7 Continence plans

Figure 24



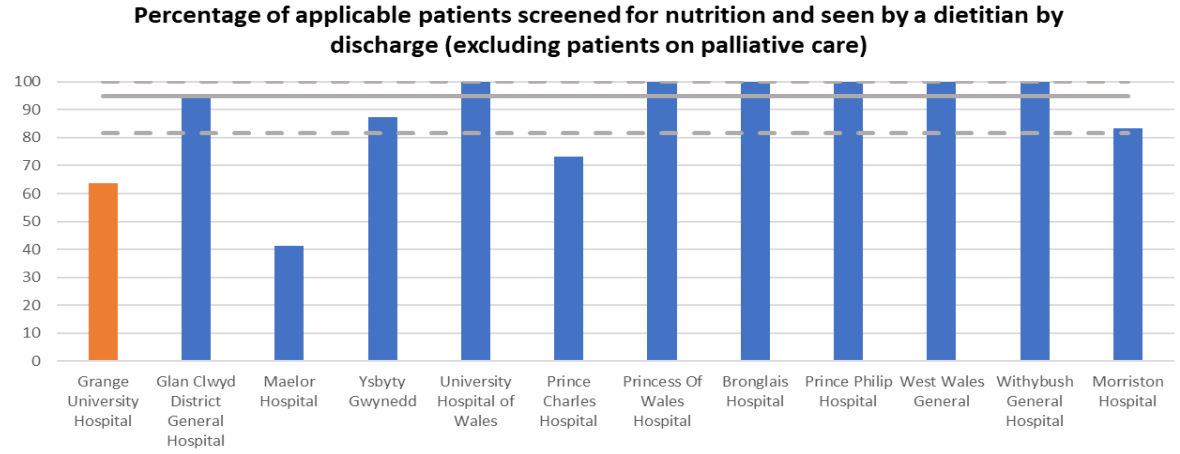
Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start – 66.1%

The data showing the percentage of patients who have continence planning within 3 weeks of admission is low in comparison to the national average. This is likely to be an issue with documentation in medical notes and hence data reporting.

Recommendation 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.

7.8 Nutrition screening and seen by dietician at discharge

Figure25



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key indicator 9.1A

Source: SSNAP Oct 2021-Dec 2021

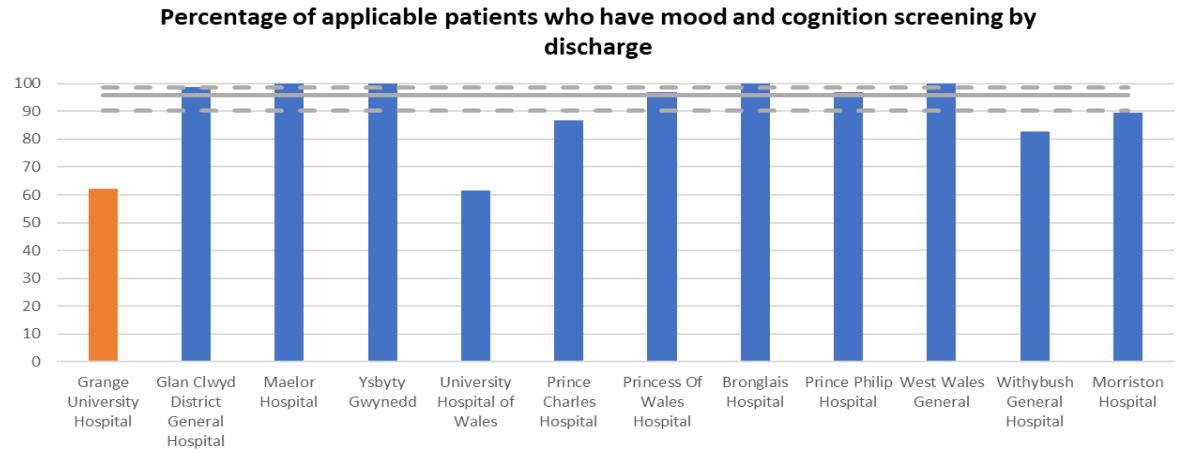
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (excluding patients on palliative care) – 63.6%, below Wales average

The data showing the percentage of patients who have been screened for nutrition and been seen by a dietitian by discharge is low in comparison to both the English and Welsh national averages. This is likely to be due to an issue with documentation and hence data reporting. We were informed that all patients assessed by ESD teams have a nutritional screen completed.

Recommendation 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.

7.9 Mood and cognition screening by discharge

Figure26



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.3A

Source: SSNAP Oct 2021-Dec 2021

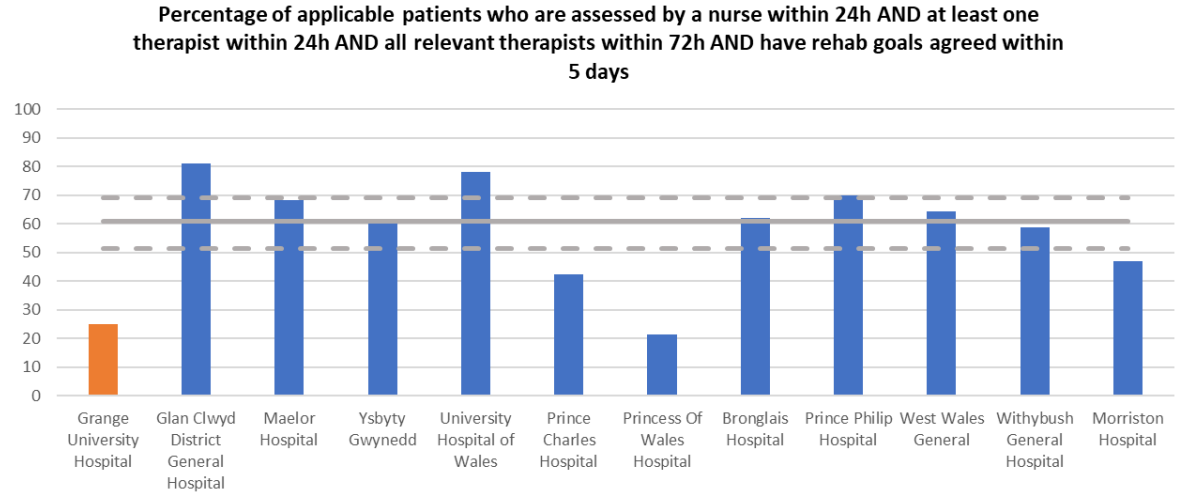
Percentage of applicable patients who have mood and cognition screening by discharge – 62.1% which is below the Wales average.

It was evident there is focus on mood and cognition assessment. The data showing the percentage of patients who have mood and cognition screening by discharge is low in comparison to the national average. This is likely to be an issue with documentation and hence data reporting.

Recommendation 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.

7.10 Nursing therapy and rehab goals

Figure27



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 8.8A

Source: SSNAP Oct 2021-Dec 2021

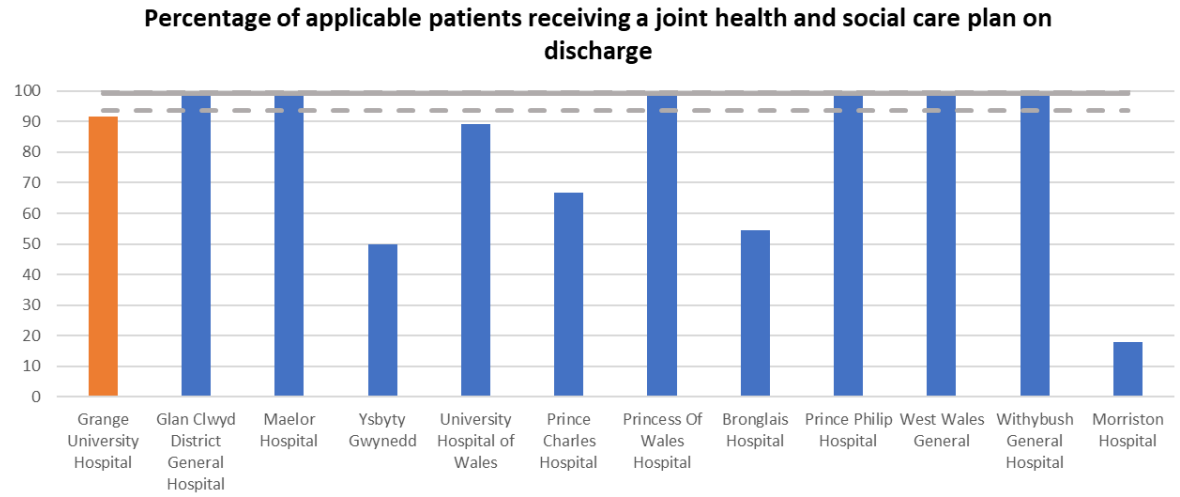
Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days – 25%

This performance measure (see fig 27) may be related to poor documentation, which makes it difficult for a data clerk to record that this target has been met. Although goals are often set, this may not be clearly documented following MDT discussions.

Recommendation 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.

7.11 Joint health and social care plan by discharge

Figure28



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.1A

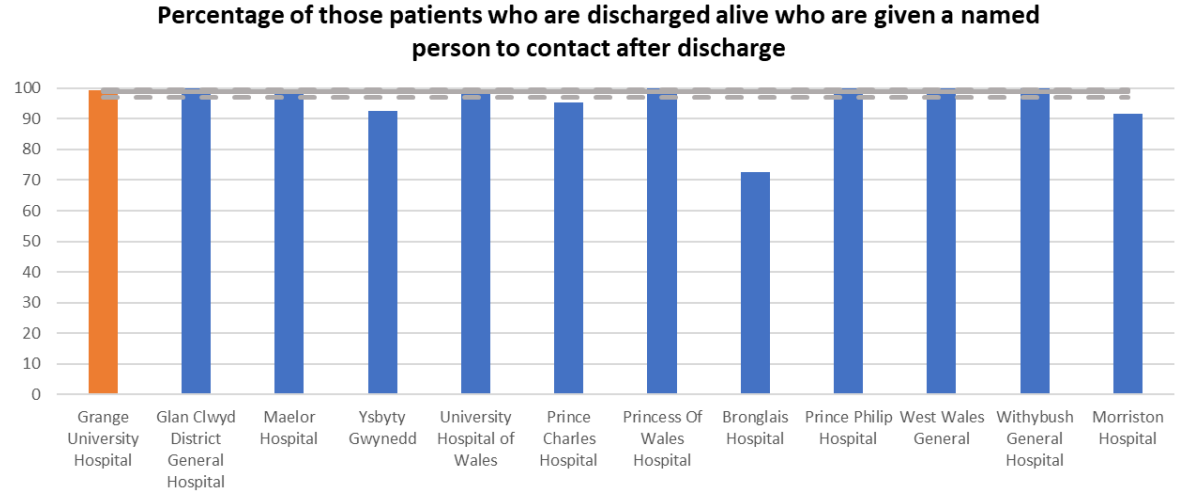
Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients receiving a joint health and social care plan on discharge – 91.7%

Joint health and social care planning by discharge is delivered and documented in over 90% of patients, this is below the English national average.

7.12 Discharged with a named contact

Figure29



Grey lines show the median and interquartile range of sites in England

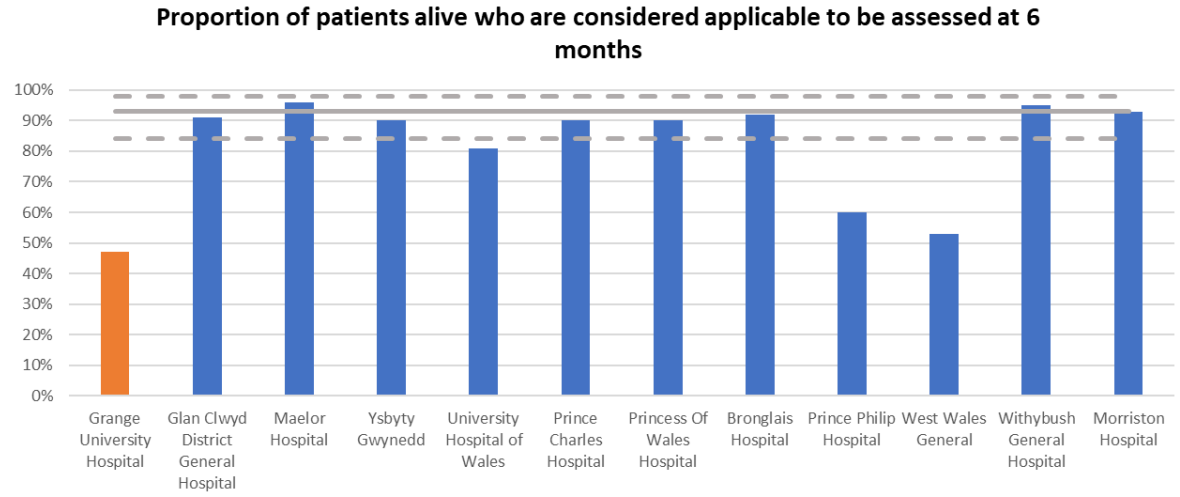
Patient-centred results at team level for Key Indicator 10.4A

Source: SSNAP Oct 2021-Dec 2021

Percentage of those patients who are discharged alive who are given a named person to contact after discharge – 99.3%

7.13 Patients applicable for a 6-month assessment

Figure 30



Grey lines show the median and interquartile range of sites in England

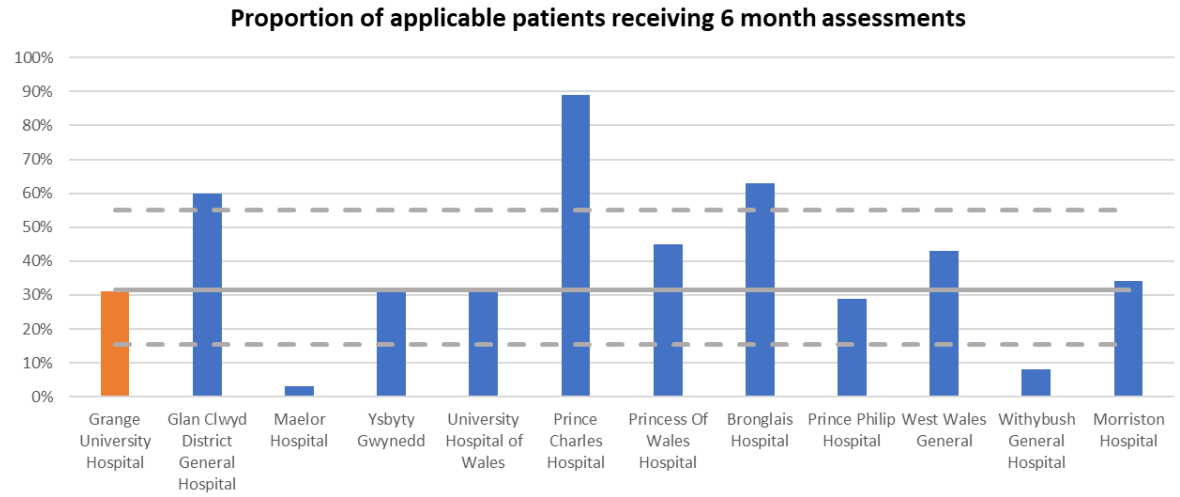
Team-centred results at team level for Item Reference B12.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of patients alive who are considered applicable to be assessed at 6 months – 47%, below Wales's average.

7.14 Applicable patients receiving 6-month assessments

Figure31



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B13.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of applicable patients receiving 6-month assessments – 60%

There is unwarranted variation in the proportion of patients who receive a 6-month assessment.

Delivering an adequate review post discharge is essential to ensure that patients have completed all the necessary investigations to identify the aetiology of stroke, have had access to appropriate post discharge rehabilitation, are taking appropriate secondary prevention and are having their risk factors for recurrent stroke adequately managed. This

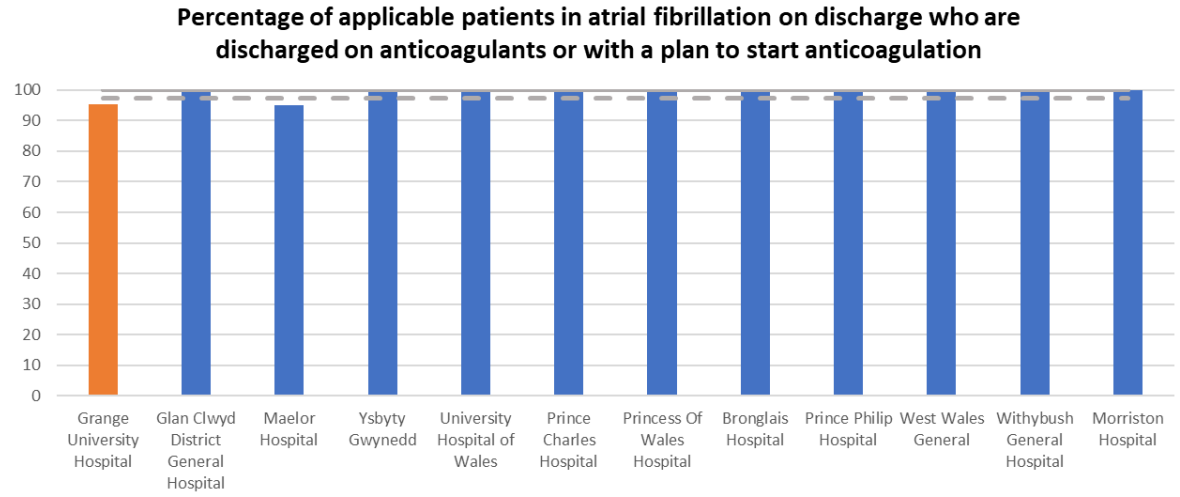
does not need to be delivered by a secondary care stroke physician and is often more effectively delivered by community stroke nurses who deliver a more holistic approach

Recommendation 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.

8 Secondary prevention

8.1 If in atrial fibrillation, discharged on anticoagulants

Figure32



Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation – 95.2%

9 Summary of Recommendations

The table below summarises the recommendations made in the body of this report and is intended to serve as a useful tool for action planning.

Table of Recommendations

#	Recommendation
1	Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.
2	Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.
3	Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf.
4	ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.
5	Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for

	imaging should help to release bed capacity and increase access.
6	Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.
7	Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.
8	Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.
9	ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.
10	Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).
11	Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.
12	Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf
13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.
14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.
15	Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.
16	ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.
17	Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.
18	Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.
19	Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.
20	Standardise post discharge reviews using the GM-SAT six-month post stroke review tool:https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/07/gm-sat-proforma.pdf

Review of Therapies in Stroke Services

Aneurin Bevan University Health Board (July 2021)

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Background

In February 2017, Welsh Government published its Stroke Delivery Plan 2017-2020 (Welsh Government, 2017) to continue to improve stroke services in Wales. It provided a framework for action by Heath Boards setting out expectations of stroke care which included workforce. Allied Health Professionals form an integral and part of this critical workforce in giving patients 'an excellent chance of surviving and returning to independence as quickly as possible'.

All Health Boards in Wales participate in the Sentinel Stroke National Audit programme (SSNAP) (Kings College London, 2021) which includes regular review of performance against set standards.

In a recent review by the NHS Wales Delivery Unit (Appendix A), stroke services at ABUHB were reported for targets associated with therapies as B, C, C and D to St. Woolos, Royal Gwent (RGH), Neville Hall (NHH) Hospitals and Ysbyty Ystrad Fawr (YYF) respectively. This report was against October to December 2019 performance. The report also stated there continues to be minimal change in performance overall. Several observations and subsequent recommendations were made. Many improvements have already been scoped and some initiated to date by the stroke therapy team with plans to implement others over time. This in itself will result in some efficiencies.

Whilst treatment of stroke patients remained a priority service during 2020, it was undoubtedly affected by the urgent need to address the impact of COVID19. From discussions with the therapy team staff worked flexibly over this period to support stroke patients and wider priority patients during the pandemic.

A significant impact for ABUHB was the opening of the Grange University Hospital (GUH) ahead of schedule to increase bed capacity during the pandemic. Originally, plans proposed to move HASU stroke beds to GUH. This was completed without immediate closure of stroke beds on other sites and therefore without additional stroke specialist therapy workforce. The current specialist workforce stretched to cover these additional beds.

Purpose

The aim of this report is to analyse the current status of specialist therapy workforce for stroke services in ABUHB against recommended standards. This includes services to patients in commissioned stroke beds as well as those receiving specialist care from the Early Supported Discharge (ESD) community service which in Aneurin Bevan University Health Board is via the Community Neuro-rehabilitation Service (CNRS).

*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

The purpose is to identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent.

The report objectives are set out as follows:

1. Mapping of existing therapy workforce for hyper-acute stay unit (HASU), acute & rehabilitation beds
2. Mapping of existing therapy workforce for ESD
3. Comparison of therapy workforce levels against clinically recommended levels in each setting
4. Identification of gaps in therapy workforce for stroke services in ABUHB
5. Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services

Criteria

Professions included in this analysis include;

- Physiotherapists
- Occupational therapists
- Speech & Language therapists
- Dietitians

The therapy workforce that is included are those who are classed as stroke specialist. This includes those that are deemed competent in the clinical area of stroke through training, achievement of professional competencies or through experience. Some therapy staff at band 5 level are included that may not be classed as stroke specialist however work under the direct supervision of a senior stroke specialist therapist and has dedicated time to commissioned stroke beds.

Senior staff time to operationally lead teams or strategically develop stroke services have been omitted from the workforce numbers. Generalist therapy staff who provide ad hoc cover are not included in the workforce analysis.

All therapy workforce included in this report have a mix of WTE from defined stroke financial resources and some dedicated from core professional services budget. Therapy Service Managers have prioritised WTE from core service budgets to stroke services in combination with dedicated stroke financial investment as services developed.

Stroke services within ABUHB covered within this report:

- Grange University Hospital (GUH) – 15 beds;12 hyper-acute, 3 GM/TIA
- Ysbyty Ystrad Fawr (YYF) – 17 beds; 3 acute, 14 rehabilitation
- Royal Gwent Hospital (RGH) – 24 beds; 6 acute,18 rehabilitation
- Neville Hall Hospital (NHH) – 21 beds; 5 acute, 16 rehabilitation
- Early Supported Discharge (ESD) via CNRS* – average 348 patients per year

Data was provided by therapy services on current workforce. Skill mix of workforce and split over multiple units was obtained. General subjective assessment of working within settings was also discussed with the senior staff within each of the therapy professions.

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The therapy workforce has recommended standards of staffing levels per beds or number of beds from several sources. For this report, clinical recommended standards for therapy workforce were used as follows:

- Hyper-acute and acute services
    - RCP National Clinical Guideline for Stroke (Royal College of Physicians, 2016)
- Rehabilitation in-patient services
    - Specialised Neuro-rehabilitation Service Standards (updated May 2019) (British Society of Rehabilitation Medicine, 2019)
    - As mid-point level 2a to 2b (pp. 5)
- CNRS (ESD) Services
    - 'A Consensus on Stroke: Early Supported Discharge' (Fisher et al, 2011)

Within the standards for ESD services there were no recommended workforce levels for dietitians. These standards are now in effect 10 years old and although reference need for access to dietetics, several articles state dietitians must be part of the multi-disciplinary team. As a result this report was unable to determine recommended dietetic workforce needs in the ESD service.

All workforce figures are based on services for 5 days a week for both stroke beds and CNRS service. Where Saturday services have been trialled, this did not include additional workforce but stretched the working week.

Findings – Commissioned Stroke beds

Total workforce for each of the therapy professions for all HB commissioned beds can be seen in table below 'Therapy Workforce Analysis in total; 77 stroke beds in ABUHB'. All professions have a gap in workforce against the relevant recommended standards for bed type (i.e. hyper-acute, acute or rehabilitation). The percentage gap can be seen for each profession ranging from 36 to 51% over all sites.

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Therapy Workforce Analysis for total; 77 (29 acute, 48 rehabilitation), Stroke bed in ABUHB				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	17.7	11.4	-6.4	-36
Occupational Therapy	17.5	8.8	-8.7	-50
Speech & Language Therapy	6.9	3.4	-3.5	-51
Dietetics	2.7	1.6	-1.1	-40

As the commissioned stroke beds are split across 4 hospital sites within the Health Board. The next table 'Therapy Workforce Analysis per site' shows the breakdown of each professions workforce at each site. Against each of the professions relevant standards per bed type (i.e. hyper-acute, acute or rehabilitation) some sites are better staffed than others. Only 1 site, GUH has the sufficient staffing levels for only 1 profession, occupational therapy, but this is not consistent with the other professions. Generally physiotherapy appears to be the most adequately staffed over all sites but is still in all areas below recommendations.

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Therapy Workforce Analysis per site																	
Site	Bed numbers	Profession	Required workforce against standards	Actual workforce	Gap in workforce	Profession	Required workforce against standards	Actual workforce	Gap in workforce	Profession	Required workforce against standards	Actual workforce	Gap in workforce	Profession	Required workforce against standards	Actual workforce	Gap in workforce
		PHYSIOTHERAPY	WTE			OCCUPATIONAL THERAPY	WTE			SPEECH & LANGUAGE THERAPY	WTE			DIETETICS	WTE		
GUH	15		2.2	2.0	-0.2		2.0	2.0	0.0		1.0	0.7	-0.3		0.5	0.2	-0.3
YYF	17		4.4	2.5	-1.9		4.3	2.0	-2.3		1.6	0.9	-0.7		0.6	0.0	-0.6
RGH	24		6.0	3.6	-2.4		5.9	2.8	-3.1		2.3	0.8	-1.5		0.8	1.0	0.2
NHH	21		5.2	3.3	-1.9		5.2	2.0	-3.2		2.0	1.0	-1.0		0.8	0.4	-0.4

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The following 4 tables below show the breakdown of therapy staffing per site including percentage gap of each profession. The best staffed site from a therapy perspective is GUH (as seen in table 'GUH Therapy Workforce Analysis'). Although the gap varies greatly between each profession, for example, with no gap if staffing for occupational therapy to 60% staffing gap in Dietetics.

GUH Therapy Workforce Analysis (15 acute beds)				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	2.2	2.0	-0.2	-9
Occupational Therapy	2.0	2.0	0.0	0
Speech & Language Therapy	1.0	0.7	-0.3	-30
Dietetics	0.5	0.2	-0.3	-60

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YYF Therapy Workforce Analysis (17 beds; 3 acute, 14 rehab)				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	4.4	2.5	-1.9	-43
Occupational Therapy	4.3	2.0	-2.3	-53
Speech & Language Therapy	1.6	0.9	-0.7	-44
Dietetics	0.6	0.0	-0.6	-100

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RGH Therapy Workforce Analysis (24 beds; 6 acute, 18 beds)				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	6.0	3.6	-2.4	-40
Occupational Therapy	5.9	2.8	-3.1	-53
Speech & Language Therapy	2.3	0.8	-1.5	-65
Dietetics	0.8	1.0	0.2	25

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NHH Therapy Workforce Analysis (21 beds; 5 acute, 16 rehab)				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	5.2	3.3	-1.9	-37
Occupational Therapy	5.2	2.0	-3.2	-62
Speech & Language Therapy	2.0	1.0	-1.0	-50
Dietetics	0.8	0.4	-0.4	-50

YYF, RGH and NHH were similar in their inadequacy of staffing. YYF featured a slightly worse in the gap average over the professions. This site had no specialist stroke dietetic cover so a 100% gap in the specialist dietetic profession recommended workforce. Interestingly, YYF was the site with the poorest SSNAP scores overall (score D). Other than GUH all other sites were at 50% gap in therapy workforce on average or higher.

Summary of Findings - Commissioned stroke beds:

- There is insufficient specialist therapy workforce to commissioned stroke beds
- Gaps in therapy workforce vary between professions and between sites
- GUH is the best staffed site overall but still carries significant gaps in therapy workforce
- 1 site has no specialist stroke dietetic workforce
- Only 1 site, GUH overall has sufficient staffing for only 1 profession, OT
- Site will lowest gap in therapy staffing performed better in SNNAP targets (see table below)

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Percentage gap in therapy staffing mapped to stroke target score for each stroke site		
Stroke Site	**Therapy staffing gap**	**SSNAP score**
St. Woolos (beds transferred to GUH)	14%	B
YYF	50%	D
RGH	45%	C
NHH	49%	C

To safely staff commissioned stroke beds without enhancement in the existing therapy workforce then the current bed capacity would need to be reduced. This is not a recommendation of this report as this should be set according to population needs for stroke incidents. The table below theoretically represents the beds numbers each profession in therapies could safely staff in line with recommended workforce levels. Current bed numbers total 77 across the health board. The number of sites would also impact on the ability to logistically work well. The geographical area would also dictate this in reality. Whilst collocating could bring efficiencies in current staffing levels it still would not solve the deficient in therapy workforce staffing. Efficiencies are possibly use of better skill mix of workforce, cover during leave and reduction in travel of staff who cover multiple sites

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Number of stroke beds safely staffed from existing therapy workforce		
Profession	Existing Workforce (WTE)	Beds safely staffed from existing workforce*
Physiotherapy	11.4	49
Occupational Therapy	8.8	39
Speech & Language Therapy	3.4	38
Dietetics	1.6	46

*assuming the current hyper-acute, acute, rehabilitation bed type ratio is the same

Findings – CNRS Service

Analysis of workforce against recommended clinical standards in the CNRS can be seen in the table below. Overall, physiotherapy, occupational therapy and speech and language therapy workforce are insufficiently staffed to patient's numbers. As discussed earlier there are no recommendations for dietetic workforce. The Therapy assistant practitioner workforce appears to be staffed above recommended standards.

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Therapy Workforce Analysis for ESD Service in ABUHB; based on average 385 patients per year				
Profession	Required workforce from clinical standards	Actual workforce	Gap in workforce	% Gap
Physiotherapy	3.9	2.5	-1.4	-36
Occupational Therapy	3.9	3.0	-0.9	-23
Speech & Language Therapy	1.5	1.2	-0.3	20
Dietetics	no std	0.4	no std	no std
Unregistered	1.0	5.4	4.4	440

The patients per year data was based on an average of the last 2 years. However, the patient numbers have grown year on year and so the workforce is likely to be increasingly insufficient as the year's progress and the gaps underestimated with current year to date.

CNRS Service:

- All qualified therapy staff, where standards of workforce exist, are insufficient
- Gaps in workforce per patient numbers per year are likely to be underestimated and as demand grows this gap will worsen and impact on service capacity

With current workforce levels the table below shows per profession how many patients can be safely managed in the CNRS. On average this equates to 283 patients per year which is

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much lower than the current average of 385 which has already been suggested as below current year forecast of 409.

Number of ESD patients per year safely staffed from existing therapy workforce		
Profession	Existing Workforce (WTE)	Patient numbers/year safely staffed from existing workforce
Physiotherapy	2.5	250
Occupational Therapy	3.0	300
Speech & Language Therapy	1.2	300
Dietetics	0.4	unknown

Discussion

Commissioned beds

Overall, all sites where there are commissioned stroke beds are understaffed for therapy workforce.

Only 1 site met only 1 professions standards and that was Occupational Therapy services at GUH. Without an MDT there is limitations in each profession to support patients to achieve their overall expected outcomes of recovery from stroke and prolonged hospital stay.

With multiple sites to staff across the therapy professions, this adds its own inefficiencies. Any potential efficiencies identified may not be possible even if staffed appropriately and further detrimental with staff levels low due to the multiple site model. The multiple sites, whilst also

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needing to be suitable for the population needs and accessibility adds further concerns to the ability to treat patients following a stroke for several reasons suggested below:

- With staff covering more than 1 site, daily targets for therapy are not met as the majority of therapy professions do not have the staffing requirements to cover all sites 5 days a week. This was identified in delivery unit review 2019 (Appendix A).
- Not all professions able to attend MDT depending on day they visit site. Recommendation in SSNAP (2021).
- Travel between sites is inevitable and therefore a loss of clinical time. Mostly staff coordinate their week to minimise travel during the day, adhering to one site per day however this means patient referrals, assessments or follow-ups will have to wait until the therapist next visits. Alternatively telephone support or more generalist staff support can be sought but is not in line with standards of clinical treatment in stroke for therapies and can impact of patient's stroke recovery and potential outcomes.

Where hyper-acute, acute and rehabilitation are not delivered in the same site, therein results in the need to transfer patients. This again can result in inefficiencies in therapy staffing provision. Concern was also raised by the therapy staff for a need to improve the patient pathway for stroke. Points were raised and discussed by staff as follows:

- With no rehabilitation beds at the site of the HASU this means transfer to other site impacting on services for transfer and therefore flow within site rather than between sites for stroke patients.
- Frequently prior to COVID stroke patients were not on the designated stroke beds but on other wards (outliers).
- Stroke patients, cared for in non-stroke beds were not in the most appropriate environment to enable stroke specialist care due to space, equipment available causing restrictions to rehabilitation that could be achieved.
- Stroke beds often would have general medical patients (particularly in NHH and YYF) and so therapy team would pick up non stroke work as well as seeing outliers in non-stroke beds.
- Often OT stroke staff would keep patients requiring complex discharge planning support in stroke beds and covered by these staff. It aids reducing 'hand-offs' and minimising length of stay but is not accounted for in staffing requirements for stroke services.
- Self-presenting patients were not always transferred to the correct site for the stroke pathway treatment needed

The staffing figures in this report are based on the 5 days service only for both stroke beds and CNRS service. The SSNAP target recommend 7 day services to improve patient outcomes. Where the therapy services are already under staffed across 5 days, to stretch to a 7 day service to meet SSNAP targets would dilute the week day service without extra investment therefore further impacting patient outcomes.

Whilst work has been trialled to deliver a 6 day service, which included Saturdays, this showed the Occupational therapy, Physiotherapy and Speech and language therapy staff spread thinly as no additional resource was added to support the increase in cover. Therefore this diminished the therapy services overall. The Therapy Stroke team also, over a period of 12 weeks, monitored a period of no weekend working, which showed limited impact on stroke patients overall compared to the 6 day/week pilot.

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All of the four therapy professions provide band 5 rotation programmes through the specialist stroke service. This is accepted as staffing resource in the standards reviewed given they are supervised by a stroke specialist. Whilst this has benefit training staff and increasing recruitment of specialists in future it also adds an extra pressure into the need for specialist stroke therapists to train. The rotations can vary in length but are generally 12 month in duration. The re-training of staff takes significant time and likely to impact on the time to deliver clinical care. This impact is significant in Speech and language therapy were it takes a minimum of 6 months to achieve specialist level dysphagia competencies, a key skillset for stroke intervention.

Most of the therapy professionals have part of their senior specialist work as team/strategic lead in addition to their highly skilled clinical work. Whilst this is imperative to service improvements, ensuring staff are appropriately trained and supported and evaluating excellent care to patient it does take up time from multiple staff. DU suggested a multi-professional lead similar to ESD. This would have more benefits to replicating team leads across each therapy and therefore diluting remaining time in work for clinical. It may also show efficiencies for inter-disciplinary working as basic as structuring the day, hand overs, replicating paperwork and QIM reporting.

Whilst there are no specialist stroke recommendations for therapy support worker staff, they remain a vital part of the specialist stroke therapy workforce. Most professions utilise therapy support worker hours either solely for the clinical area or as part of a wider generic caseload. Whilst in the stroke units, supervision by specialist therapists would be in place. By utilising support workers in addition to the qualified therapy workforce this provides an effective workforce skill mix but support workers should not replace only compliment qualified therapists.

Other discussion points raised for the teams DU report in 2019 includes use of clinical staff for clerical tasks. Many of the qualified therapist carry out clinical administrative tasks but also considerable amount of non-clinical administrative tasks. This was identified in the DU report and a regular frustration of staff. To quantify efficiencies with adequate administrative support is difficult to determine. However, currently utilising qualified staff for admin duties diminishes clinical time and will continue to do so if not addressed.

Lastly for commissioned stroke beds, the DU report also noted that focus should be made on increasing the intensity of therapy not simply the quantity. With a staffing level below recommended this will difficult to achieve with the deficit in demand already.

CNRS

Within the CNRS there is a deficit across all professions in comparison to the Fisher 2011 consensus, although Dietetics cannot be mapped to this. The current service is above the recommendations for unregistered staff, with these staff likely to be supporting some but not all of the gaps in qualified therapists. Psychology has not been included in the review although is recommended with the ESD standards.

The original service was set up using the staffing establishment suggested by Fisher 2011. This consensus statement is limited in that it is ten years old and so may not take into account relevant recent research into ESD services and neither does it include all relevant professions i.e. Dietetics. However, there is not a more recent consensus in the evidence base to use. SSNAP also reference access to dietetics as a recommendation. It is thought that further

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research and publication will include dietetics as a recommended need of the ESD MDT with many NHS services already including a dietitian as part of their local ESD teams. CNRS within ABUHB does have dedicated dietetic supported within the team. It is be determined locally if this is effective and sufficient for the population needs.

For the purposes of this staffing review the average number of accepted referrals into the service over the last 2 years was included. It should be noted that the service is growing year on year with a predicted 14% increase between 2019-2020 and the projection for 2020-2021. For 2020-2021 only the first 9 months was included and so the year total was estimated based on a forecast from the first 9 months. This does not take into account any capacity needed around those referrals not accepted i.e. with triage and in reach.

During the pandemic in-reach services have been replaced with a trusted assessor model. On review by the team, there has been no significant impact of using this change in model and may be able to be continued longer-term to improve team efficiencies.

The CNRS has increased its scope to accepting more severe strokes in to the service. On discussion with staff, when they have reviewed this, they found little improvement in patient outcomes for this cohort. Accepting these patients impacts the service for the mild to moderate patients due to the greater demands on therapy time from the more server strokes.

Similar recommendations were made by the DU (2019) report releasing more time for clinical task by considering better reporting systems to streamline therapists work. Introducing nursing establishment as per the ESD service standard recommendations may also release therapist's time for therapy interventions.

All of the above posts with the exception of 2.0 WTE band 4 Therapy Assistant Practitioner and the Clinical Psychologist have been funded via the ICF route ending in 2022. Although this staffing resource has been appointed to permanently this is now a financial risk for the organisation.

As in commissioned stroke bed discussion. The staffing resource of CNRS is based on a 5 day service. Whilst there are recommendations for this is work as a 7 day service this too would require additional investment so not to dilute the week day service.

Conclusion

The report objectives were set out as follows:

1. Mapping of existing therapy workforce for hyper-acute stay unit (HASU), acute & rehabilitation beds
2. Mapping of existing therapy workforce for CNRS
3. Comparison of therapy workforce levels against clinically recommended levels in each setting
4. Identification of gaps in therapy workforce for stroke services in ABUHB
5. Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services

Objectives 1- 4 have been addressed as part of the findings of this report. The current therapy workforce is significantly below the recommended standards for hyper-acute, acute,

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rehabilitation and CNRS overall. In addition to the low workforce provision a number of factors compound the limited resources available including multiple sites providing specialist stroke care, need for a clear stroke pathway for patients, rotational therapy staff, need for 7 day services as per recommendations and clinical time used for non-clinical administrative tasks.

Whilst investment appears to be needed to improve the Therapy workforce to meet standards there are several other opportunities to improve the efficiency of the therapy workforce and would be remiss to not further explore whether these are feasible to improve care for stroke patients.

Recommendations

The purpose of this report is to identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent.

The last objective; Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services, is addressed in the recommendations below. Ultimately, investment of Therapy resources is the most urgent and clear need but there are also opportunities to improve efficiencies. This would improve efficiencies in, not only the current workforce clinical time, but also even if further invested, enabling a more effective therapy workforce:

Commissioned beds

- Investment into increasing therapy staff levels to recommendations as set out in this report per commissioned stroke bed
- Explore the current need for administrative support for the 4 sites to release clinical time
- Review of stroke bed sites available both from the case of multiple sites but also multi stroke treatment need (i.e. hyper-acute, acute, rehabilitation) thus reducing transfer of patient between sites
- A clear stroke pathway for stroke patient's i.e. ring-fencing beds for stroke care so not used by general medical and reducing outliers of stroke patients on other wards.
- Consideration of increasing therapy workforce above recommendations were rotational staff form a large percentage of the allocated specialist workforce including identification of most effective skill mix to enable continuity of patient care and training of staff to increase future workforce.
- With time deducted from several professions for 'team lead' or service development needs consideration of multi-professional leads similar to CNRS. Explore the benefits from inter-disciplinary working not only for staff efficiencies but better patient experience and outcomes.
- Consideration of inter-disciplinary therapy assessments to enable regular therapy monitoring or intervention and efficiencies for blended therapy approach and supervision particularly around reporting to MDT's if not all qualified staff available daily

CNRS

- Investment into increasing therapy staff levels to recommendations as set out in this report as per service demand.

*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

- Permanent financial investment in CNRS with scope to increase based on service demand to reduce impact on hospital beds, delays to discharge and potential readmissions
- Mapping of local population need to dietetic services for CNRS. To internally identify the current need and whether provision meets this. To identify any gaps in demand and capacity with CNRS for dietetic support.
- Maintain the 'trusted assessor' model rather than physical in reach into services. This has been implemented during COVID with positive feedback from staff and no reported negative impact on flow.
- Consideration of the introduction of nurse provision into CNRS establishment to release therapist time
- Review of reporting systems and ability to streamline and release therapy time back to clinical
- Review the current practice of accepting more severe stroke patients. Currently accepting patients with higher needs with no obvious improvement for those patients and causing a reduction in intensity of therapy for the rest of the caseload.

These recommendations outlined not only would improve therapy provision but likely to have a positive impact on other professions ensuring no impact on ability to meet patient outcomes for stroke survival.

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National Review of Patient Flow

a journey through the stroke pathway

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Content

Page

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:

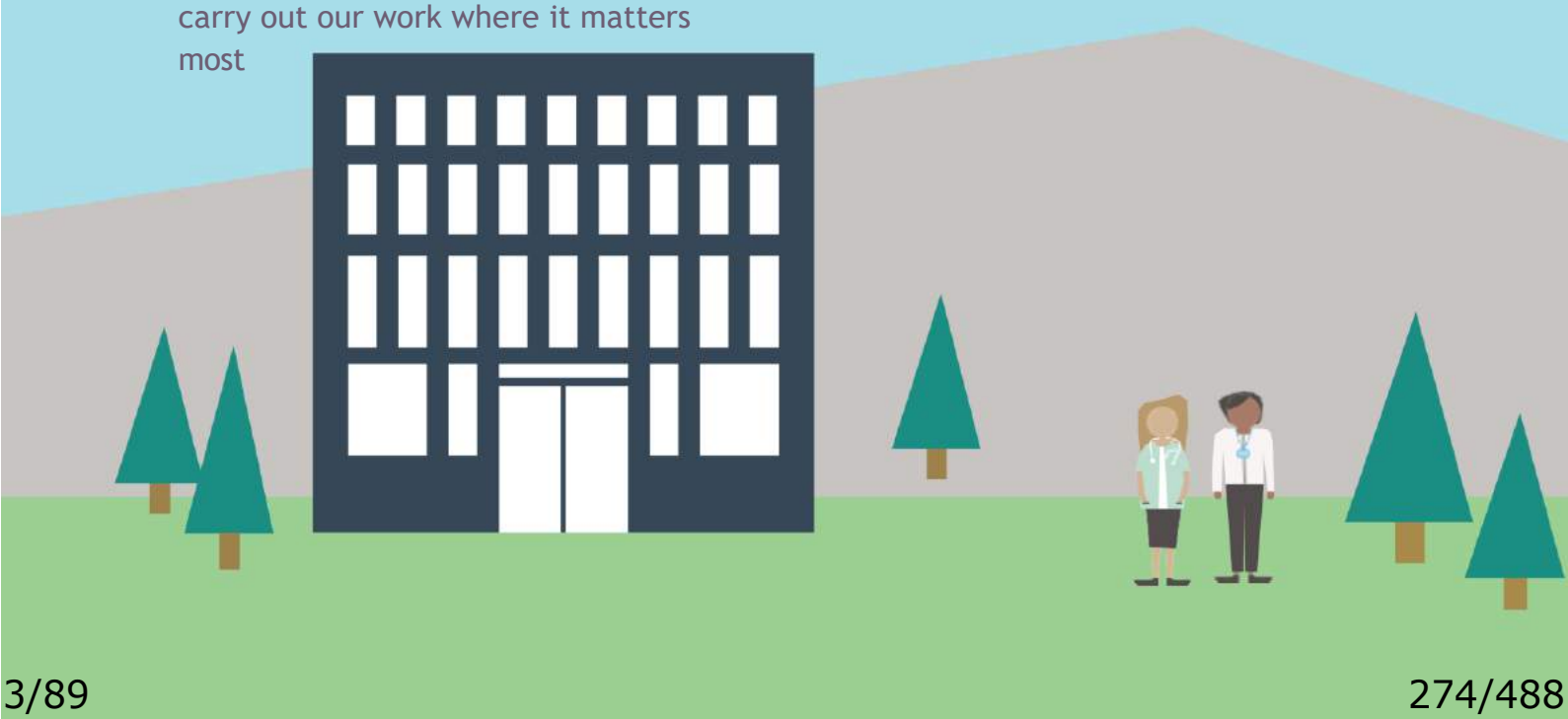
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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.



Foreword

I am pleased to be publishing this report which presents the findings from our National Review of Patient Flow: a journey through the stroke pathway. The focus of this work was to understand the risks and challenges associated with inefficient patient flow, and what impact this has on patients.

We know from our programme of assurance work that poor patient flow can have a hugely negative impact on the quality of services being provided. This has been a common factor in our inspections of Emergency Departments, and our previous review looking at ambulance handover delays to hospitals.[1] Poor flow can have a detrimental impact on the ability of staff to deliver safe and consistent standards of care and affects the experience and outcomes for patients.

It is fair to say that examples of poor patient flow are well known, and not just cited in the work of HIW. Every one of us is likely to know someone who works in a healthcare service; has been a patient who has encountered this during a hospital stay; or indeed, works in a service area where patient flow is a daily challenge.

What our review has done, however, is to highlight what these challenges mean in reality, to patients and to staff at various points on a journey from hospital admission through to discharge.

The impact of poor patient flow is ultimately felt by patients, who are not always receiving the care and treatment they need in the most timely manner. Delays in treatment can substantially impact the likelihood of developing further complications. This was particularly evident in stroke patients whom we considered as our case study. What is crucial now, is that all aspects of the health and social care system work together as effectively as possible to address poor flow and achieve better outcomes for patients in Wales.

As healthcare services continue to face unprecedented demands, and staff work tirelessly to provide safe and effective care to patients, it is clear that renewed efforts are required from the health and social care sectors, alongside Welsh Government, to tackle the issue of poor patient flow.

[1] Review of patient safety, privacy, dignity and experience whist waiting in ambulances during delayed handover

I am pleased that our work has enabled us to identify areas for improvement, and to highlight areas of good practice. Not just in relation to the stroke pathway, but also for all patients.

I want to take this opportunity to thank staff working within both health and social care sectors who endeavour to provide safe and effective care to people on a daily basis. Their dedication and commitment provide a strong and positive basis upon which to improve.

Alun Jones
Chief Executive

Healthcare Inspectorate Wales

Summary

This report sets out the findings from our National Review of Patient Flow: a journey through the stroke pathway.

The review explored the experiences of people accessing care and treatment for stroke at each stage, from calling an ambulance, transfer to hospital, assessment, inpatient treatment, through to discharge.

Patient flow is the movement of patients through a healthcare system, from the point of admission to the point of discharge. When patient flow is impeded or is inefficient, it has significant repercussions on the quality and safety of patient care.

Our review has highlighted that across Wales, there are significant challenges which are having a negative impact on the efficiency of patient flow, and this means patients are not always receiving the care they need in a timely and appropriate manner. These challenges are wide ranging; the high demand for inpatient hospital beds combined with the complexities with discharging medically fit patients from hospital, leads to the inpatient healthcare system across Wales operating under extreme pressure. This impacts on the delivery of safe and timely care.

Whilst we found a range of initiatives, different models of care, and approaches being taken within health and social care to tackle the problems arising from poor patient flow, these have not sufficiently tackled the problem. Although there is no single solution, our review identifies opportunities for the health and social care systems to make improvements across each stage of the patient pathway, which may help lessen the impact of poor patient flow. The positive initiatives and approaches identified by our review, should be considered across Wales as services attempt to tackle their challenges with poor patient flow.

We specifically examined the journey of patients through the stroke pathway. This was to understand what is being done to mitigate any harm to those awaiting care, as well as to understand how the quality and safety of care is being maintained throughout the stroke pathway.

Demand is exceeding supply in relation to the healthcare system, and during our fieldwork almost all hospitals we visited were under level four ‘extreme pressure’, as highlighted in the National Emergency Pressures Escalation and De-escalation Action Plan[2]. The demand was having a knock-on impact on Welsh Ambulance Services NHS Trust (WAST) and its timely response to emergency calls.

[2] National Emergency Pressures Escalation and De-escalation Action Plan

Despite hospital patient flow teams across Wales working tirelessly 24 hours a day seeking to manage patient flow, we found that patient flow issues were negatively impacting on every stage of stroke care. This was from the point of needing to access healthcare at home, through to discharge from hospital.

A key area requiring improvement identified by our work, relates to the need for healthcare services to engage with people, to better understand the barriers to them accessing or choosing from the range of healthcare services available in Wales. The range of healthcare services includes pharmacies, Minor Injury Units, mental health helplines, online NHS consultations, and the NHS 111 Wales service. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

There were prolonged patient handover delays from ambulances to ED at all hospital sites we visited. These delays were significantly impacting on the ability of WAST to respond to emergency calls in the community and increase the risk to patients requiring emergency treatment and transportation into hospital.

It was positive to find that patients suspected as having had a stroke, were prioritised for ambulance handover, and transferred into ED promptly in line with the stroke pathway. However, we found that achievement of the Welsh Government 15-minute target for handover of stroke patients was challenging. This target aims to ensure that time critical investigations and treatment are undertaken promptly to ensure the best outcome for patients.

Challenges with the demand on EDs meant that some patients waited longer than expected for triage and ongoing assessment or treatment. This is a particular risk for those patients who self-present at an ED and have not had any clinical input prior to their arrival.

We found that the recognition of stroke and its prevention is a key area that needs attention across Wales. More needs to be done by NHS healthcare providers and Public Health Wales (PHW) to educate people about this debilitating condition, to help minimise their risk of developing a stroke, and to seek immediate help if symptoms arise. This is of relevance to certain population groups who are at a greater risk of having a stroke, such as those who smoke, have high blood pressure, high cholesterol, diabetes, are obese, or who excessively consume alcohol[3].

Evidence also suggest that Black and Asian people are at a higher risk of developing a stroke. Health boards and PHW should therefore work closely with these communities to understand the specific issues they face and ensure ongoing engagement with them, in support of better health outcomes.

It was disappointing to find that in 2022, the performance of most acute hospitals in Wales which provide stroke services had deteriorated since 2019.

[3] Causes of Stroke

As highlighted within the UK's Sentinel Stroke National Audit Programme (SSNAP) data, there was an increase from three, to 11 out of 14 acute hospitals who were performing poorly and were categorised as either a D or an E grade (lowest).

However, it is important to note that this period coincided with the global Covid-19 pandemic, and there was an unprecedented demand on hospital beds nationally, which was significantly impacting on patient flow in general, and throughout the stroke pathway.

As highlighted earlier, during our fieldwork almost all hospitals were under level four 'extreme pressure'. To help manage the pressure and patient flow through hospital systems, patient flow meetings were held regularly in all hospitals. They were well attended by the key staff responsible for a patient's journey through hospital. In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the handover delays and plans for longest wait patient handovers. We found this to have a positive impact in managing the issues associated with delayed patient handovers from ambulance crew to ED staff.

Overall, we found that patient flow teams appeared to manage meetings well, and we concluded that they had a strong understanding about which patients needed beds or moves to other wards. This included the oversight of patient specialty outliers in other service groups, such as medical patients cared for in surgical beds and vice versa.

Due to pressure on bed availability, hospitals were not always able to admit patients to the right bed or ward for their treatment. These patient outliers, as they are known, were a consistent finding across Wales. This meant that it was not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment. It was concerning to find that because of poor patient flow, patients are regularly being treated on a ward that would not usually care for that condition.

Patients who are not allocated to the right bed or ward, can at times experience an increased length of stay. This may lead to other complications, creating additional challenges for care teams and adding to the issue of poor flow. A stroke patient who has been admitted to hospital is likely to have a much better outcome if they are treated on a stroke ward.

During our work, it was positive to find that Improvement Cymru[4], was undertaking a pilot within three acute hospitals supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity methodology to focus on the flow process. This focuses on discharge and improving flow in small increments.

[4] Improvement Cymru website

Whilst it does not assist with the existing flow issues which relate to social care, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. We noted that this pilot was making a positive difference to the flow process and overall management of beds, and it is an approach that should be considered nationally.

We found that in all cases, staff endeavour to achieve a brain scan for a symptomatic stroke patient within an hour of arrival at hospital. However, although infrequent, it was concerning to find in our clinical records review, that some patients were not receiving a brain scan within the one-hour target. In addition, the SSNAP data we reviewed for the period of April to June during 2019, 2021 and 2022, showed that performance had reduced in nine out of 12 sites, with an increased number of patients suspected as having a stroke waiting more than one hour for a brain scan.

Following assessment and a subsequent stroke diagnosis, it was positive to find that overall, the treatment (called thrombolysis) to help dissolve the clot in the brain, was commenced promptly in ED if there were no beds available to administer this on the acute stroke ward. Thrombolysis is used for certain categories of ischaemic stroke diagnosis and must usually be undertaken within 4.5 hours of the known onset times of stroke symptoms. However, within the updated *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*[5], this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion imaging[6]. Therefore, it is important that WAST works with health boards and Welsh Government to consider the protocol when sending an ambulance to stroke patients, and the increased treatment window.

An alternative procedure to thrombolysis therapy, is surgery to remove a blood clot which is known as a thrombectomy. Thrombectomy can be effective up to 24 hours from onset time of stroke symptoms and can significantly reduce the severity of disability a stroke can cause. This can result in better patient outcomes than those treated with thrombolysis. The only health board in Wales which provides a thrombectomy service is Cardiff and Vale University Health Board. This service operates Monday to Friday from 9am to 5pm, when expert interventional neuroradiology staff and radiology facilities are available to undertake this treatment.

All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust, where the service is available to patients from Wales daily between 8am and midnight, or to the Walton Centre NHS Foundation Trust in Liverpool, which offers a 24/7 service. Given the geographical challenges and the availability of ambulances across Wales due to handover delays, this can have a negative effect on the timely provision of a thrombectomy and is of particular concern when thrombolysis is not clinically appropriate.

[5] National Clinical Guideline for Stroke for UK and Ireland
[6] CT Perfusion – The Walton Centre NHS Foundation Trust

Treating stroke patients with thrombectomy can have better long-term outcomes for people. According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763[7].

It is concerning to find that in Wales, only 13 patients received a thrombectomy at the University Hospital of Wales, just 16 patients from other health boards received treatment in North Bristol and only four at the Walton Centre. More needs to be done to provide equitable access to thrombectomy treatment across Wales.

To give a patient the best possible chance of recovery, specialised stroke unit care must be initiated as soon as possible after the onset of stroke symptoms. Due to the range of specialist treatment they provide, acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs. It was, therefore, disappointing to find several delayed admissions to acute stroke wards from ED. This was often due to a lack of available beds owing to delayed transfers to rehabilitation wards, or delayed discharges out of hospital impacted by the inability of social care providers to deliver timely social care.

To help mitigate this issue and maintain flow for stroke patients, most stroke wards aim to ring-fence a stroke beds. However, we found these beds are repeatedly used for non-stroke patients across Wales, due to the persistent issues with the demands on ED services. This is a concern since some stroke patients may not receive the most appropriate and timely care for their condition, including timely ongoing treatment needed to help with their recovery.

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh. We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS ‘Gwaith Iaith’ badge.

Across Wales, we found inconsistencies with the provision of rehabilitation to people following their stroke. Overall, we found that the health boards with stroke rehabilitation wards provided an environment that facilitated specific multidisciplinary stroke rehabilitation care, although in some hospitals both acute and rehabilitation care were undertaken in the same environment. We also found inconsistencies across Wales in the provision of the 45-minute daily target for physiotherapy, occupational therapy and speech and language therapy. This was attributed to the challenge with recruiting staff into key therapies posts, and the ability to provide timely services on wards that manage both acute and rehabilitation care to stroke patients.

HIW found good collaborative working between the stroke multidisciplinary teams

[7] Annual thrombectomy April 2020 to March 2021

in relation to patient discharge preparation.

However, a key issue which significantly impacts on patient flow and overall patient progress, is the delayed transfer of care and discharge for patients who are medically fit to leave acute care. This can be due to the availability of care home beds or social care and rehabilitation therapies provided within the home.

Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections, deconditioning or deterioration whilst awaiting discharge, all of which further impact on flow. The bottleneck at the point of discharge has a knock-on impact on EDs, WAST response times, inpatient care, primary care, planned admissions and overall staff wellbeing.

It is therefore essential that Welsh Government, health boards and social care providers redouble their efforts and work collaboratively to help improve the persistent issues with discharging people from hospital.

To support us with the social care aspects of our review, we utilised the help of Care Inspectorate Wales (CIW)[8]. Through collaboration with CIW and its peer reviewer, we found several factors aligned to social care which also contributed to discharge delays. One issue was frequent delays with social worker allocation causing unnecessary discharge delays for patients who are medically fit to go home. This was identified as an issue in most health boards. Another challenge impacting timely discharge is the ability to provide timely or appropriate domiciliary care packages to people in the community, or the availability of beds in care homes. We found the most significant issue was the recruitment and retention of domiciliary carers, who are needed to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. This in turn, increases the flow bottleneck at the hospital 'back door'.

Adding to the complexity of organising packages of care, some hospitals discharge patients to numerous local authorities within their own health board boundary, to local authorities within the boundaries of another health board, or even across the border to England. Sometimes the process in each can be different, adding to the existing challenges, which may include different referral processes or different IT systems. This makes the processes difficult to navigate and more challenging, therefore causing further unnecessary discharge delays and impacting on patient care.

It is evident that staff working within patient flow and stroke services are dedicated to helping patients move through hospital systems. However, our review indicates that health and social care services are not operating as efficiently as they could be. This inefficiency increases the risk of complications arising from delayed discharge and has a significant impact on the overall health and care system in Wales.

In our report, we have identified various areas that require improvement, and have

[8] Care Inspectorate Wales website

made recommendations for action to address these issues. We firmly believe that more can and should be done to tackle the problems highlighted by our review.

Context

In our Operational Plan for 2021-22, we committed to a programme of national reviews which considered the risks and challenges facing health services as they continue their response to, and recovery from, the pandemic.

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. This is caused by severe congestion within our hospital systems. There are ongoing pressures on the ability of healthcare systems to manage patients effectively and with minimal delays, as they move through each stage of care through to discharge or moved onto an appropriate care pathway.

Poor patient flow leads to congestion and overcrowding within our EDs, with patients waiting for admission into bed on the wards. Consequently, this also impacts on delays with patient handover from ambulances into EDs. This is consistent within several findings during previous HIW inspections of EDs across Wales, including Ysbyty Glan Clwyd[9], University Hospital of Wales[10] and Glangwili General Hospital[11] which were undertaken during 2022. In addition, patients in the community must often wait unacceptable lengths of time for an emergency response from WAST and transportation into hospital. This results in increased risks to those patients, as they have not yet been clinically assessed. Poor patient flow frequently impacts negatively on the whole of a patient's journey through the healthcare system.

Our most recent WAST review[12] highlighted how patient handover delays are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care systems. The impact of inadequate bed/trolley availability in EDs is that there are occasions where multiple ambulances are waiting together outside EDs for prolonged periods of time to handover their patients.

[9] HIW Hospital Inspection Report - (Unannounced) - ED, Ysbyty Glan Clwyd - Betsi Cadwaladr University Health - 03, 04 & 05 May 2022
[10] HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff, and Vale University Health Board - Inspection date: 20, 21 and 22 June 2022
[11] HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff and Vale University Health Board, Inspection date: 20, 21 and 22 June 2022
[12] HIW WAST review: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances

The consequences of poor patient flow are well known nationally and can include:

- Delayed ambulance response times to calls
- Delayed ambulance handover
- Overcrowding in EDs
- Patients admitted as 'outliers' to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes
- Ambulatory care services, clinical decision units, even catheter labs and recovery units may be used with patients waiting for ward admission
- Inpatients are also often moved between different wards to accommodate new patients
- Staff are overstretched, and routine activities slow down dramatically
- Clinical outcomes can be measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds.

We recognise there are pressures through the stroke pathway to deliver effective person-centred stroke care, which relate to:

- Timely access to effective care, including transfer to hospital, assessment, key diagnostic interventions, thrombolysis[13] and/or thrombectomy
- Timely admission to an acute stroke ward/unit[14] (or other relevant ward), and other acute care requirements
- Timely therapeutic assessments and treatment
- Stroke rehabilitation and preparation for life after stroke
- Discharge with social care pressures, access to required therapies and ensuring the right support.

As a result of these issues, and our intelligence and other data sources, media reports, and the issues identified through our previous ED inspections, and within both our WAST reviews in 2019-20[15] and in 2020-21[16], we decided to undertake a review of patient flow with a focus on the stroke pathway. This is because stroke is a complex condition, and timely assessment, treatment, rehabilitation, and

[13] Thrombolysis is a procedure to disperse a blood clot and return the blood supply to the brain. Some people with ischaemic stroke are eligible for thrombolysis which, for most people, needs to be given within 4 ½ hours of stroke symptoms starting.
[14] An acute stroke ward/unit is an area in the hospital that is staffed by a specialist stroke. multidisciplinary team.
[15] HIW local review report of WAST - Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centres
[16] HIW review report of Welsh Ambulance Services Trust - Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during delayed handovers

recovery for patients affected by a stroke, requires support from a range of health and social care professionals, with specialist knowledge and skill.

What We Did

Focus of Review

The focus of our patient flow review was to consider the patient journey through the stroke pathway from the point of requesting an ambulance or people self-presenting at ED, through to discharge from hospital or transfer of care to other services.

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, our retrospective review of clinical records considered the time-period from March 2020, through to the time of our fieldwork between March and August 2022.

Throughout our review we explored the experiences of people accessing care and treatment for stroke at each stage of care, from calling for an ambulance, to assessment, inpatient treatment, and through to discharge.

Throughout, we considered the following key questions:

- How are healthcare services ensuring that timely access and treatment is provided to patients on the stroke pathway?
- What steps healthcare services are taking to ensure that safe and effective quality care is provided at each stage of care, minimising the impact of delays?
- What measures are healthcare services taking to ensure that patients are able to be discharged effectively, and safely from hospital services?

When planning our review, we were aware work was (and still is) ongoing to tackle the issue of patient flow, with various approaches and initiatives in progress at a national level.

Scope and methodology

To review the areas detailed above, we requested relevant documents and key information from health boards in Wales and WAST. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the processes in place for patient flow on the quality and safety of stroke patients awaiting assessment and treatment. It also helped us to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

We also considered local and national performance data and statistics. The Sentinel Stroke National Audit Programme[17] (SSNAP) aims to improve the quality of

[17] The Sentinel Stroke National Audit Programme

stroke care by measuring both the structure and processes of stroke care against evidence-based standards. The SSNAP targets are informed by the *National Clinical Guideline for Stroke for the United Kingdom and Ireland*, and national and local benchmarks. The SSNAP clinical audit collects a minimum dataset for stroke patients in England, Wales, and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of six-month assessment. All patients with a stroke admitted to hospital in Wales are included on the SSNAP database, which is used to monitor and audit stroke treatment and outcomes.

Over the course of our review, we undertook interviews with a variety of health board staff across Wales. We developed and shared several staff surveys and a survey of stroke patients, or their family members or carers.

We also completed fieldwork focusing on retrospective case studies and current cases of people travelling through the stroke pathway, which included the period of the Covid-19 pandemic.

Professional staff surveys

We developed and launched a staff questionnaire to obtain views from health board staff involved throughout the stroke pathway and their patient flow within the pathway.

In addition, we designed and distributed a questionnaire to obtain views from staff at WAST to gain their opinion of the flow of stroke patients to and from hospitals.

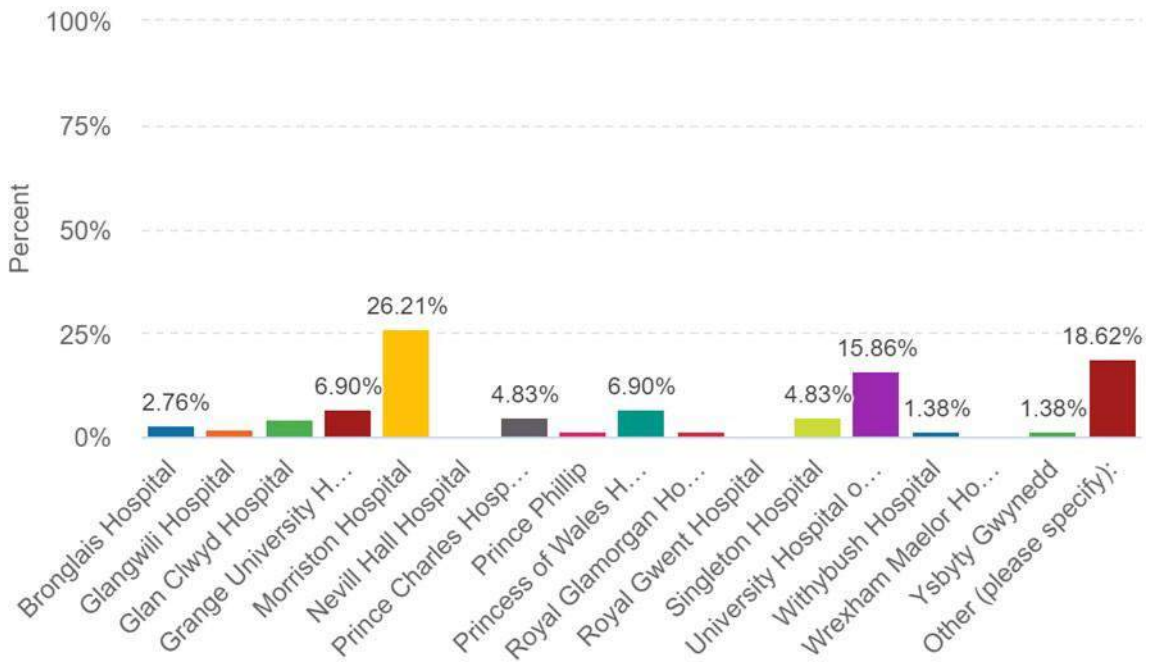
In conjunction with the Care Inspectorate Wales (CIW) we also developed and distributed two additional questionnaires. These were to obtain the views of staff working in social care and local authority staff on their opinion of the challenges faced in effective discharge of patients from hospital.

Health board staff survey

We had a total of 146 respondents who fully completed the health board staff survey.

Our survey found 75 respondents worked directly within stroke services, 20 worked within Patient Flow, 32 worked for emergency departments, 13 were senior management, 16 were site/bed management, 6 were discharge staff and the remainder were made up of various other roles.

The respondents worked within the hospitals highlighted in the chart below:



Social Care providers and Local Authority staff surveys

Both Social Services staff and Local Authority staff surveys were emailed to staff for completion in May to July 2022.

We had 26 staff respond to our social care provider survey from 16 of the 22 local authorities in Wales, which includes:

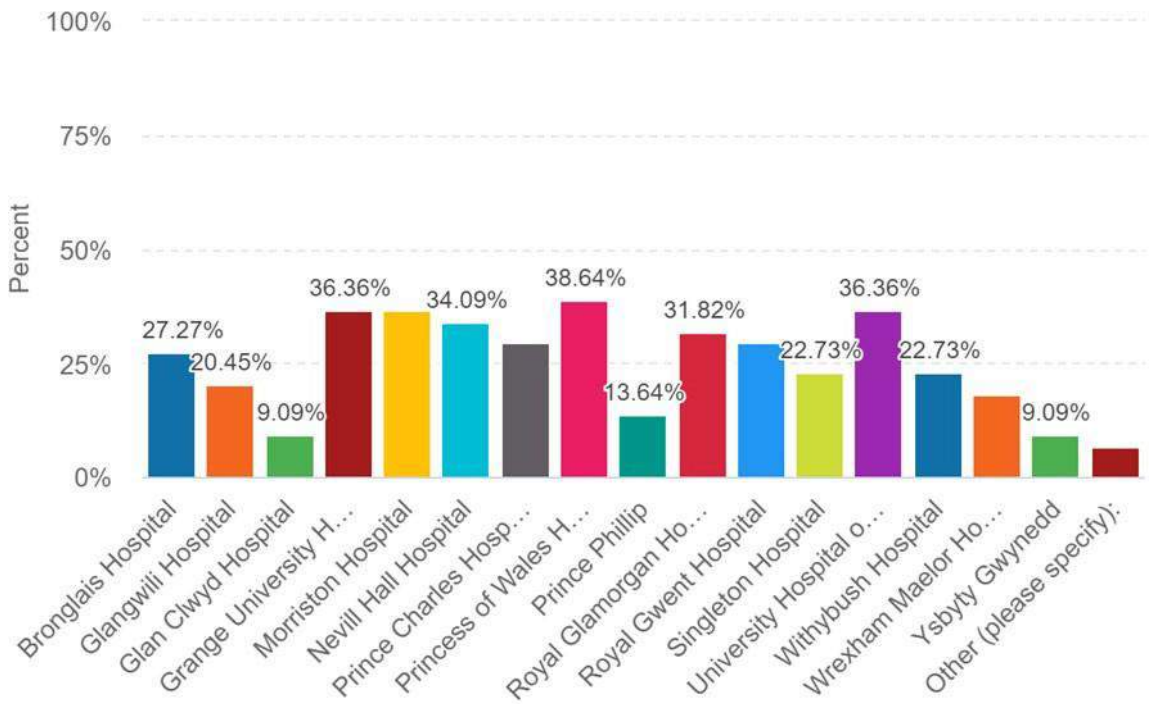
- 7 Registered Managers
- 7 Service Managers
- 6 Care Home Managers
- 3 Responsible Individuals
- 3 Other

Due to the limited number of responses, we have not undertaken a quantitative analysis, however, where applicable, we have considered comments from our qualitative analysis within the report.

WAST staff survey

The survey was emailed to staff for completion in May to October 2022.

We had 44 staff respond to our survey who worked with the following hospitals:



Public survey

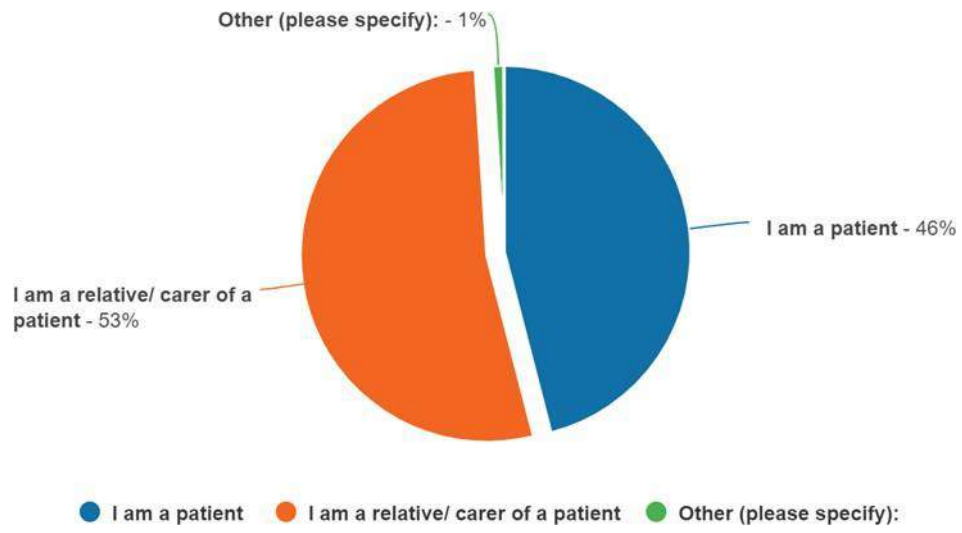
We conducted a survey to capture the views of stroke patients who had used healthcare services, or the views of their family members or carers. The patient questionnaire was designed and distributed by HIW, with the input of the Stroke Association, to obtain views from patients on the quality and safety of care throughout the stroke pathway.

The survey was promoted for completion from May to September 2022.

We received a total of 106 responses to our survey. Some partially completed or skipped some questions, but all 106 responses have been considered as part of this analysis. When asked of their gender identity, 52.5% said they identified as female, 42.5% as male and the remaining preferred not to say.

Only 81 respondents answered our multiple-choice question relating to ethnicity. 61 answered ‘white’, 29 answered ‘Welsh/English/Scottish/Northern Irish/British’, and one person answered ‘Irish’. There were zero responses to all other available options, for example, black, Asian, mixed ethnicity, gypsy/Irish travellers, or other ethnic groups.

The 106 responses were received from patients, carers or relatives, or other:



The ‘other’ response was a friend of a stroke patient. All respondents were asked to respond to questions on behalf of the patient. There was a good distribution of responses across Wales.

Fieldwork

Currently 12 hospitals across six of the seven health boards provides emergency services for stroke patients. Powys Teaching health board does not provide acute stroke services but accesses services from NHS England and Welsh health boards. All 12 sites listed below provide acute stroke services including thrombolysis treatment for patients with an acute, ischaemic stroke.

- The Grange University Hospital, Cwmbran
- Prince Charles Hospital, Merthyr
- University Hospital of Wales, Cardiff
- Princess of Wales Hospital, Bridgend
- Morriston Hospital, Swansea
- Prince Philip Hospital, Llanelli
- Withybush Hospital, Haverfordwest
- Glangwili Hospital, Carmarthen
- Bronglais Hospital, Aberystwyth
- Ysbyty Gwynedd, Bangor
- Glan Clwyd Hospital, Rhyl
- Wrexham Maelor Hospital, Wrexham

As highlighted above, we attended one acute site within every health board area during the period from March to August 2022. Most of our onsite visits were conducted over three days. Our approach to the fieldwork conducted within Powys Teaching Health Board was reduced to a two-day visit to a rehabilitation ward, given the absence of an acute stroke ward.

Our fieldwork included face to face interviews with ED staff, stroke services staff and patient flow/discharge managers. We were unable to visit all the acute sites providing stroke services within Wales; however, to understand the challenges faced with patient flow through the stroke pathway at every site, interviews were held via Microsoft Teams. We held in the region of 250 interviews with health board staff across Wales.

During our onsite visits, we also attended board rounds, multidisciplinary team meetings (MDT) or equivalent for stroke patients, bed or site management meetings and patient discharge meetings. Where we were unable to attend in person, and for sites we did not carry out fieldwork, these meetings were attended via Microsoft Teams.

Our focus during our fieldwork was on reviewing patient records and key documents within each health board, both on a retrospective review of patient clinical records from 2020 onwards, and the records of patients in hospital travelling through the stroke pathway at the time of our site visits.

The inspection team for each onsite visit consisted of:

- HIW Senior Healthcare Inspector (review lead)
- HIW Healthcare inspector (review support)
- Up to three clinical peer reviewers
- CIW peer reviewer (to interview key staff involved with the discharge of stroke patients from hospitals across Wales).

It was positive to note that during our onsite fieldwork site visits we did not identify any areas of immediate concern for patient safety, and we therefore did not need to implement our immediate assurance process.

In November 2022, we wrote to all health board Chief Executives with a summary of the initial key general findings to date. We did not require any specific action to be taken in response to these findings at that time.

Relevant guidance for patient flow and the stroke pathway

In considering the effectiveness of patient discharge, we looked at whether hospital wards follow the Welsh Government principles of ‘SAFER Patient Flow

Guidance'[18]. This guidance provides good practice to promote safe and timely discharge, improve patient flow and prevent unnecessary waiting for patients.

Throughout this report, we often refer to the NICE guideline *'Stroke and transient ischaemic attack in over 16s: diagnosis and initial management' (NG128)*[19]. In addition, the *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*[20]. We also refer to the NICE *Stroke Rehabilitation in Adults* clinical guideline (CG162)[21]. This relates to stroke rehabilitation for adults and young people aged 16 and over who have had a stroke with continuing impairment, activity limitation or participation restriction.

Welsh language 'active offer'

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh.

We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS 'Gwaith Iaith' badge.

Within our staff survey, 22 people said their first language was Welsh, although every questionnaire was completed in English, despite the choice available to complete this in Welsh. Our patient survey identified that eight people speak Welsh, with just one who said they were offered the opportunity to speak Welsh.

In most cases during our clinical records review, we found no evidence or reference to a patient's language choice. However, in one hospital, it was recorded that patients were English speaking only within the records reviewed. We also saw in one patient record, that a patient was asked for their preferred language, as part of the Occupational Therapy cognition test.

What We Found

Patient flow: a journey through the stroke pathway

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. It is caused by severe congestion within our hospitals, and there are ongoing pressures within health and social care services to manage patient journeys effectively. The challenge within both systems can impact on timely hospital discharges, and often, people do not always receive the right care, at the right time, in the right place, which may impact on their safety.

To explore the complexities of patient flow through the healthcare system, we focussed on a patient journey through the stroke pathway. It is therefore important to highlight the significance of stroke and its prevention first.

[18] Welsh Government SAFER patient flow Guidance
[19] NICE guidance stroke-and-transient-ischaemic-attack-in-over-16s
[20] National Clinical Guideline for Stroke for the UK and Ireland
[21] NICE Stroke rehabilitation in adult's Clinical guideline

What is a stroke?

Stroke is the fourth leading cause of death in Wales and can have a significant long-term impact on survivors. The Stroke Association[22] suggests that currently, there are around 69,000 stroke survivors living in Wales, and NICE[23] suggest around 8,000 people in Wales experience a stroke each year.

As highlighted above, NICE highlights that stroke is a leading cause of death and disability, causing around 38,000 deaths each year in the UK, and in addition, in the UK there are approximately 1.3 million stroke survivors. The number of hospital admissions per year due to stroke is approximately:

- 126,000 in England
- 9900 in Scotland
- 8000 in Wales
- 5000 in Northern Ireland.

There are three different types of strokes, these include:

- **Ischaemic stroke** - caused by a blockage, such as a blood clot, cutting off the blood supply to a part of the brain
- **Haemorrhagic stroke** - caused by bleeding in or around the brain
- **Transient Ischaemic Attack (TIA)** - also known as a mini-stroke – brief blockage in supply of blood to parts of the brain.

It is critical that people know how to spot the signs and symptoms of stroke, and they should call 999 immediately, due to the time critical nature for the treatment.

The signs of stroke are highlighted below and are represented as the acronym **'FAST'**:

Face	Has their face fallen on one side? Can they smile?
Arms	Can they raise both their arms and keep them there?
Speech	Is their speech slurred?
Time	Time to call 999!

Stroke prevention

In its 2018 report, *A Healthier Wales: our Plan for Health and Social Care*[24], Welsh Government set out a long-term future vision of a 'whole system approach to health and social care'. It places a greater emphasis on preventing illness, by supporting people to manage their own health and wellbeing, and to enable people

[22] Stroke Association
[23] NICE - What is the prevalence of stroke and TIA in the UK?
[24] A Healthier Wales (gov.wales)

to live independently for as long as possible, supported by new technologies and by integrated health and social care services.

As part of our review, we considered what information is available to advise the people of Wales on the risks associated with having a stroke, and its prevention. The Royal College of Physicians[25] estimate that up to 70% of all strokes could be avoided if the risk factors were treated and people adopted healthier lifestyles.

The role of Public Health Wales in stroke awareness and prevention

Public Health Wales NHS Trust (PHW)[26] is the national public health agency in Wales. Through its work, the aim is to protect and improve the health and wellbeing of people and reduce health inequalities across Wales. As highlighted earlier, our review considered patient flow through the stroke pathway. It is, therefore, important to understand what PHW is doing to help prevent people in Wales having a stroke.

We considered how PHW were engaging with people to raise their awareness of the risk factors associated with a stroke, and their understanding of stroke symptoms. Additionally, what the Trust is doing locally or nationally to target certain groups of people who may be at the highest risk of sustaining a stroke. This may include Black and Asian people, and those living with high blood pressure, high cholesterol, diabetes, excessive alcohol intake, smokers, and those with Atrial Fibrillation (AF).

AF is a heart rhythm problem and increases the risk of a stroke due to a risk of blood clots forming in the vascular system (blood stream), which may travel to the brain causing a stroke. The Stroke Association[27] highlights that AF can happen to anyone, including people who are otherwise fit and well. It usually affects adults, and the risk increases with age, but also for people with conditions, such as heart disease, diabetes, obesity, high blood pressure, and in smokers.

In our survey, when we asked respondents about their ethnicity, there were zero responses indicating people were from Black, Asian, or other ethnic groups.

According to the Stroke Association and Different Strokes organisation[28], strokes may happen more often in people who are black or from Asian families. In addition, it is suggested that within these groups, people may need to get checked at an earlier age for diabetes, particularly if they have any risk factors, such as being overweight[29].

In 2021, Different Strokes Organisation launched a national outreach program, to raise awareness of stroke risk amongst Black and Asian communities, and to develop a longer-term plan, to break down barriers preventing Black and Asian stroke survivors from accessing its support services. Through the outreach programme, the organisation found there was lack of awareness of the risk of

[25] The Royal College of Physicians
[26] Home - Public Health Wales (nhs.wales)
[27] Stroke Association - Atrial Fibrillation
[28] Different Strokes
[29] Stroke Association - What is stroke, are you at risk of stroke

stroke at all ages, and Black and Asian people were not aware of their increased risk of stroke. They also found limited information available regarding stroke for people from Black or Asian communities, or for people whose first language is not English. Additionally, they found in UK-wide NHS campaigns, there was a limited representation for these communities, such as a lack of images of Black and Asian people, meaning that when they were looking at stroke campaigns, they would not see themselves in the images or the stories shared.

The Different Strokes Organisation has developed an engagement strategy to tackle the issues highlighted above, which plans to support and raise awareness of younger stroke amongst Black and Asian communities in the UK. The equality and diversity statics in Wales for 2018-2020 indicate that 95% of the population described their ethnic group as White, and 5% described themselves as Asian, Black, or as being from mixed or multiple ethnic groups or from another ethnic group[30]. The Different Strokes Organisation alone cannot raise the profile of stroke in Black, Asian and ethnic communities, therefore, health boards, Welsh Government and PHW must make a concerted effort with reaching out to people within these communities through stroke awareness education and campaigns.

Stroke and health inequality

Socio-economic factors also impact on the risk of stroke. Health inequalities disproportionately affect certain communities and socio-economic deprivation is linked to worse health outcomes[31]. Strokes occur more commonly in areas of deprivation, therefore, highlights the inequalities in people's health status[31]. It is therefore important that when engaging with the public on stroke awareness and stroke prevention, health boards, Welsh Government and PHW should ensure they reaches out to people affected negatively by socio-economic factors.

[30] https://www.gov.wales/review-evidence-socio-economic-disadvantage-and-inequalities-outcome-summary-html
[31] https://phw.nhs.wales/services-and-teams/local-public-health1/cwm-taf-morgannwg-public-health-team/cwm-taf-morgannwg-public-health-documents/cwm-taf-annual-report-of-the-director-of-public-health-2018-a-public-health-approach-pdf/

Recommendation 1:

Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning between themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.

Recommendation 2:

Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.

Recommendation 3:

Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.

Stroke management performance in NHS Wales

To demonstrate their performance in managing stroke services, hospital sites in Wales (and the UK), are graded in line with SSNAP data. Each hospital which manages stroke patients is required to regularly submit their performance data to SSNAP. The grade for performance is categorised from A (highest) to E (lowest).

In 2019, just three out of 16 hospitals in Wales who manage stroke patients, received a D or E grade. In 2022, the data reflects an increase to 11 of 14 hospitals who received a D or E score. This is concerning, not only as each hospital is graded in the lower categories, but it also highlights hospital performance has declined significantly across Wales in the past three years. However, it is important to note that this period did coincide with the COVID-19 pandemic.

The extreme and unprecedented demand for hospital beds during the pandemic had a significant impact on flow through healthcare systems, to the extent that field hospitals were implemented to cope with the overwhelming demand for beds. Health and care staff across all roles and services showed huge resilience in the face of unprecedented demands and pressures and adapted quickly with different ways of working to keep themselves and people safe. Staff worked in extremely difficult circumstances to care for people not only with COVID-19, but for others with other healthcare needs.

Despite their best efforts to protect people, tragically, many of those they cared

for died, and some staff also had to deal with the loss of colleagues.

What is Patient Flow?

Patient flow is the movement of patients through a healthcare system. It involves the clinical care, physical resources, and the internal processes and systems needed to move patients from the point of admission to the point of discharge.

Within its *Programme for Government 2021-2026*[32], Welsh Government committed to the provision of urgent and emergency care services in the right place, first time. It developed the *Six Goals for Urgent and Emergency Care*[33], which supports the health and social care system in the delivery of the programme for government commitments.

Improvement Cymru[34] is the improvement service for NHS Wales. Its aim is to support the establishment of the best quality health and care system for Wales, so that everyone has access to safe, effective, and efficient care in the right place and at the right time. During our onsite fieldwork, we found that Improvement Cymru was undertaking a pilot in three hospital sites and was supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity (RTDC) methodology to focus on the process, using improvement methodology. This will be highlighted further, later in the report.

Managing people through the stroke pathway

In 2021, Welsh Government published its 5-year plan[35] to improve the quality of stroke services and outcomes. The new quality statement for stroke, sets out the future vision for stroke services in Wales and was developed with Wales' Stroke Implementation Group.

The Stroke Implementation Group provides guidance to the government and advice to key stakeholders and is developing a delivery plan[36] which is overseen by the National Clinical Lead for stroke in Wales. The plan will outline how services must improve the quality of stroke care and reduce variations in care across Wales. The group will also be supporting health boards to develop a network of comprehensive regional stroke centres, supported by regional operational delivery networks that work across boundaries to improve care, from acute treatment to rehabilitation.

However, to successfully achieve the above, effectively managing patient flow is pivotal.

The Senedd Health and Social Care Committee, undertook an inquiry into hospital discharge and its impact on patient flow through hospitals.

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[32] Welsh Government Programme for government: update | GOV.WALES
[33] Welsh Government - Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026
[34] Improvement Cymru website
[35] New plan for Stroke care announced for Wales | GOV.WALES
[36] This a Service Specification which is being developed by a sub-group of the Stroke Implementation Group, led by the Clinical Lead for Stroke in Wales and comprises clinical, third sector and academic partners

The report[37] was published in June 2022, and highlights several challenges facing the health and social care sectors. The inquiry identified the need to take radical steps to reform health and social care systems and made 22 recommendations for improvement to Welsh Government.

We found that several of the recommendations align with the improvements needed identified as part of our review. Our review highlights that whilst work is ongoing nationally to tackle patient flow, it is not clear how effective these work streams have been to date since the complex issues with patient flow remain unchanged.

How do health boards manage patient flow?

To manage the demand for beds across Welsh hospitals, designated teams within each health board hold regular meetings to address the issues with hospital admissions and discharges.

These meetings are held several times a day, 365 days a year. They are commonly referred to as patient flow, bed management or site management meetings. In addition to these, further regular meetings take place internally with members of the executive team such as the Chief Operating Officer, to consider the movement of patients across hospital sites within health boards. In addition, external meetings are held with other health boards and WAST. These consider the wider impact on flow across health board boundaries and the impact this may have on WAST providing services to people in the community. This will be highlighted later in the report.

For ease, throughout this report, we will refer to the meetings above as 'patient flow' meetings.

Patient flow meetings

During our fieldwork, we attended several patient flow meetings across Wales, and considered how effective they were in managing flow to provide timely, safe, and effective care to patients.

Patient flow meetings were held regularly, at least three times each day across the sites visited as part of our review. They were well attended by the key staff responsible for a patient's journey through hospital, such as patient flow managers, department managers, different MDT members, senior managers, and discharge co-ordinators. The meetings enable everyone to have a collective understanding and a joint ownership of patient risk and safety across the whole hospital site.

In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the ambulance handover delays and plans for longest wait patient handovers.

Actions and plans were also discussed on how to off-load certain patients into ED,

[37] Welsh Parliament Health and Social Care Committee, into hospital discharge and its impact on patient flow through hospitals

to release an ambulance from the hospital. In the absence of a HALO, this input was provided by staff from ED.

Ambulance Immediate Release Protocol

To help manage the constant issue found across Wales with ambulance handover delays, in June 2022, WAST in conjunction with NHS Wales, developed its first draft of the *All-Wales Immediate Release Protocol*[38].

When a person calls 999, there is a triage process which is completed by a call handler who enters data into the Medical Priority Dispatch System (MPDS)[39]. The response provided by the caller and data entered in the MPDS, generates a WAST priority code to determine the clinical response required for the patient. The system prioritises the most urgent patients, who are categorised as Red, Amber (1 and 2), and Green. Details of call categories are highlighted on the WAST website[40].

The immediate release protocol outlines the principles and processes for managing the immediate release of ambulances when new calls are categorised as 'Red or Amber 1'. This aims to minimise safety risk for people awaiting an ambulance response in the communities. This is usually invoked when ambulance capacity is reduced, when the time for patient handover at EDs is prolonged. The handover standard is 15 minutes and is considered extended beyond 30 minutes.

Data provided by WAST for the period 1 July 2022 to 5 September 2022, reflects a high volume of Immediate Release Directions (IRDs) being made. The data reflects the pressures that EDs across Wales are experiencing, which results in patient handover delays and patients in the community experiencing long waits for an ambulance response. During this period, a total of 1,900 IRDs were made. Around 30% of these related to 'Red' priority calls and 70% for 'Amber 1'. Whilst a high percentage of IRDs relating to immediately life-threatening incidents were accepted, only 35.5% of the directions between April 2021 to June 2022, received this decision within the 8-minute response target for 'Red' calls. In addition, there remains a high percentage (62%) of declined directions for Amber 1 IRDs, despite the new protocol stating that they must not occur.

Recommendation 4:

Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.

Patient flow dashboard

[38] NHS Wales Immediate Release Protocol
[39] MPDS is a unified system used to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.
[40] How WAST Responds to Emergency 999 Calls

Each acute hospital site had a patient flow dashboard (commonly known as the 'SitRep' (Situation Report)) displayed within the patient flow meeting rooms. It presents all key details for patient flow throughout the hospital, which was reviewed systematically and was referred to appropriately throughout the meetings. They were used to visualise the key areas requiring discussion, and to help plan timely management of all patients from ambulance handover, the ED and through to the wards (and operating theatres), to patient discharge.

During the patient flow meetings, we found the Chair would consider all aspects of flow systematically through the SitRep. This was from the ED ('the front door'), to discharge or transfer from hospital ('the back door'). In addition, consideration was given to the workforce requirements, such as staffing on the wards or in ED. The escalation status of the hospital was determined within the flow meetings, based on the availability of the beds available, ambulance waits, ED capacity and ability to admit people for key treatment or surgery.

Hospital escalation Status

To establish a hospital escalation status consistently across Wales, Welsh Government, health boards and WAST, jointly approved a National Emergency Pressures Escalation and De-escalation Action Plan[41]. The action plan defines the four main escalation status levels for health boards and WAST. These levels and the triggers are used to determine the appropriate response to escalating and de-escalating emergency pressures, and the actions necessary to protect core services. This is to help provide the best possible level of service with the resources available.

Levels of Escalation

The table below defines the four main escalation status levels for health boards and WAST.

Level 1 **Level 2** **Level 3**	**Steady State** **Moderate Pressure** **Severe Pressure**	Ensure all standard operating processes are functioning as efficiently as possible to maintain flow. Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow. Initiate contingencies. Escalate when applicable. Prioritise available capacity to meet immediate pressures.

[41] National Emergency Pressures Escalation and De-escalation Action Plan

		Put contingencies into action to bring pressures back within organisational control. De-escalate when applicable.
Level 4	**Extreme Pressure**	Ensure all contingencies are fully operational to recover the situation. Executive command and control of the situation. De-escalate when applicable.

Throughout our onsite fieldwork, almost all hospitals were at a level four escalation at some point during our visit, which represents extreme pressure on the hospital system overall.

Focus of flow across departments

Overall, we found that patient flow teams appeared to manage meetings well. We witnessed discussions about each ward systematically, which included bed capacity and staffing of each ward and specialty of patients within the ward beds. Concerns were highlighted and discussed appropriately during all meetings we attended, with effective communication regarding the challenges with flow through the hospital system.

Updates were given from each area which includes the following examples:

- Patient handover delays from ambulances including the longest wait and number of ambulances waiting outside ED, and plans for the handover
- Demands and risk within ED, including the number of patients awaiting admission to a ward bed
- Numbers of patients on each ward, such as medical, surgery, paediatric, critical care
- Situation on ringfenced beds, including stroke
- Department staffing and resources
- Infection prevention and control issues
- Number of patients requiring surgery that day
- Total number of patients awaiting discharge or repatriation
- Action required on patients awaiting discharge and repatriation.

Overall, we saw that patient flow teams had a good understanding of which patients needed beds or needed moves to other wards. In addition, they had knowledge of the patients requiring transfer or repatriation to other hospitals or

community settings, and discussions took place on transport requirements. This included stroke patients who were deemed appropriate for transfer from acute settings to community rehabilitation wards. It is positive to note that 87% of stroke services staff who responded to our survey said, patient flow staff were involved with the stroke patient's journey throughout their care.

Patient outliers on different specialty wards

We found adequate oversight of patient specialty outliers in other service groups or hospital areas, such as medical patients being cared for in surgical beds and vice versa. Patient outliers was a consistent finding across Wales, due to pressure on the system and the high demand for beds. It was also an issue prior to our review and is frequently evident through HIWs annual inspection process.

It was clearly not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment due to bed availability. Whilst this is a common occurrence across Wales, it is concerning since patients are regularly being treated on a ward that would not usually care for that specialty. Whilst it was not always possible to place people on the correct ward, staff and flow teams risk assessed the most suitable patient to place to a different specialty ward. Effective management at patient flow meetings can help to ensure this happens effectively.

When considering the stroke pathway, some healthcare staff explained issues with demand and capacity in stroke services, as there were more acute stroke beds available than rehabilitation beds. Consequently, this can have a negative impact on patient flow through stroke services because patients were waiting in acute beds longer than necessary, before being moved to a rehabilitation ward.

We also found in some health boards, wards cared for both acute stroke patients and those in their rehabilitation stage on the same ward. Within one health board, we found patients were placed in an area of a ward which was previously a rehabilitation gym. Whilst this enabled stroke care in the right ward, losing the gym area was impacting on the prompt rehabilitation of all patients. Like this finding, a staff member commented in our survey as below:

'Currently even with good MDT working and effective discharge planning, there is no step-down from acute to help flow. Patients that are no longer having active treatment then increases bed pressures in other areas of the hospital and often these patients still require input from a discharge planning point of view and reduce time spent with acute / rehab patients receiving active treatment. This then means there is increased pressures on staff and reduced available time to meet stroke guidelines and directly having a knock-on effect to patient progression and the time it takes to reach a safe level of discharge with increase length of stay and inhibits flow.'

Bed capacity pressure

We interviewed patient flow staff across Wales, who told us that pressures on the hospital patient flow system had been exacerbated by the pandemic, and the pressure continues to rise. We were told that 'winter pressures' have become an

all-year-round issue, with hospitals finding it difficult to recover during the spring and summer months due to demands on the ED and ward beds.

During the winter period, many health conditions, including respiratory diseases such as asthma, can be caused or worsened by cold weather. Those issues along with higher incidences of so-called 'seasonal illnesses, such as flu and norovirus, can mean the NHS often faces much greater pressure during winter, due to demand on healthcare services. This not only impact on hospitals, but also within community services, such as GPs, community nursing teams and pharmacy services.

During our staff interviews, we found other reasons which can affect ED capacity, therefore impacting on patient flow. This includes:

- Difficulties in people accessing primary health care, such as GP appointments, means more people are self-presenting to EDs when they do not require emergency care
- An increased demand on ED services from people needing mental health support, as adequate community support is not available when needed.

Our interviews with patient flow staff, also found consistent problems with the timely discharge of patients. This was an issue across Wales, from both acute and rehabilitation wards, and was negatively impacting on patient flow and overcrowding in ED. This includes:

- Difficulties in admitting patients to a Ward from ED, due to a lack of available ward beds, as wards cannot discharge medically fit people due to social care capacity
- Insufficient capacity for patients who require rehabilitation or intermediate care after their acute phase.

Patient flow - discharge discussions

During the patient flow meetings, the number of patients medically fit for discharge were discussed in all hospitals we visited. Staff told us that on average, approximately one third of patients on a hospital site were fit for discharge.

However, they either had no social worker allocation, set plan or date for a social care package to commence at home, or there was a lack of beds available within nursing or residential homes, if they were unable to return to their previous residence.

We found in some but not all hospitals, that when a patient was likely to be discharged on a given day, an action plan would be developed and discussed at the patient flow meetings with a view to ensure the discharge is fulfilled as planned.

This may include completing timely blood tests, ensuring take home medication was prepared in advance of discharge, and hospital non-emergency patient transport was arranged in a timely manner.

These actions would sometimes be followed up at the next meeting and addressed in subsequent meetings if incomplete. We found examples where such actions were expedited effectively and saw progress had been made by the next meeting, or the patient had been discharged or placed within the hospital's discharge lounge awaiting transport. However, there were some occasions when actions had not been delegated appropriately, which impacted on the timely discharge process.

Recommendation 5:

Health boards must communicate with each other to establish the good practices taking place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.

Further details relating to the challenges faced for effective discharge of patients, are highlighted later in the report.

Improving flow with Improvement Cymru

As highlighted earlier, during our onsite fieldwork we noted that an Improvement Cymru team was undertaking a pilot to support three acute hospital sites to help manage their patient flow. This was done using a Real Time Demand Capacity (RTDC) methodology. We engaged with the Improvement Cymru team, to gain an understanding of their work and any progress made since the onset of the pilot.

The goal of the RTDC tool is to improve patient flow processes by developing a situational awareness amongst staff teams within hospitals. This is to ensure staff fully understand the demand and capacity, and to establish an appropriate awareness and understanding of the bottlenecks and constraints impacting on flow. This would help structure the planning process to improve flow and to pre-empt or predict demand and capacity, and to manage flow more effectively.

The RTDC methodology focuses on discharge and improving flow in small increments, particularly in the earlier part of the day. Whilst this does not assist with the existing flow issues which relate to social care challenges impacting on discharge, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. This can result in earlier availability of ward beds, which allows for a timelier transfer of patients from ED to the wards or minimise delays with theatre list start times. This in turn, impacts positively on the timeliness of patient handovers from ambulances to ED, hence releasing ambulance crews to attend emergency calls within the community, or to repatriate or transfer patients home from hospital when applicable.

The Improvement Cymru team highlighted to us some themes found which contribute to delays in patient discharge. This included transport delays and the timely management of take-home medication. They found that often, take-home medication was not being prescribed and sent to pharmacy until the same morning that the patient is due to be discharged, which adds to unnecessary delays. This is consistent with our findings in our review of *Patient Discharge from Hospital to*

General Practice[42].

During the first week of the RTDC project at one hospital, the Improvement Cymru team found significant delays in the undertaking of blood tests and obtaining the results for these in a timely manner. An immediate action to improve this was for the health board to allocate ten priority slots with phlebotomy services to ensure patient blood tests were completed early in a timely manner, for those being discharged that day. This had a positive impact on preventing some delays with discharge.

Recommendation 6:

Health boards must review and consider processes for prescribing take home medication so that these can be obtained from pharmacy more promptly in order to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).

Recommendation 7:

Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timely discharge.

We spoke with several staff from the three pilot sites about their engagement with the Improvement Cymru team. This was to establish what impact the RTDC methodology was having on their patient flow processes. One person said that one of the challenges they identified was the Ward Manager engagement with the RTDC process, and for them to understand how this would benefit their ward flow.

We were told by several patient flow managers that the flow processes currently in place in their hospitals had remained the same for many years, and to help change the process was a significant challenge. This would require strong leadership at both department and flow team level. The flow teams told us that to support the process, templates were developed to capture key information, and they would attend the wards in person to engage with ward managers, to support them in identifying solutions themselves, to help resolve delays in flow issues at a local level.

It was also explained to us that the RTDC methodology allows all departments across hospital sites to take ownership of the safety and risk associated with patient flow, and staff are now more engaged to share resources to help mitigate and balance the risk and safety of flow barriers across the whole hospital site.

As a result of the RTDC pilots, we also observed some positive processes implemented for improving flow discussions and the overall management of beds,

[42] HIW - Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018.

which included analysis of bottlenecks and challenges with patient discharge. We heard from staff in one hospital that work was in progress to analyse data of the key flow issues. This was to support predicted planning arrangements to improve the overall flow processes. An example of this includes data analysis of ambulance attendances at the ED, both daily and weekly, to understand and predict potential patterns for demand on the service with the aim to help reduce capacity issues.

We found some disparities across Wales with directorate clinical oversight of patient flow at more senior levels, such as Senior Nurses or Lead Nurses. In some hospitals, senior nurses would be placed on a daily directorate rota for effective senior clinical oversight of patient flow for their directorate, such as one for medicine and one for surgery. They would attend the daily flow meetings, and visit the relevant wards across their directorate frequently, to ensure staff teams were making timely progress to discharge patients, consult with senior nurses from other directorates (rostered to manage flow), challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding patient needs. They would also establish a plan for proposed discharges for the following or subsequent days. However, in some hospitals there was no daily senior nurse/ clinical oversight. We found that where a senior nurse oversight for flow was part of the daily process, the daily ward discharge process and planning for subsequent days was more effective. Any actions and discharges appeared to progress timelier, than hospitals without clinical flow oversight.

Recommendation 8:

Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timely patient flow.

Recommendation 9:

Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

Recommendation 10:

Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. This could also support early planning for patient discharge.

Non-emergency clinical care in the community

To help understand how people can access the most appropriate clinical support, if they have urgent, but not emergency healthcare needs, we considered what supportive measures were in place within the community.

Reducing the burden on GPs and EDs

Signposting people to other resources can help improve patient flow by reducing the burden and pressure on GPs or local EDs. Using other community services where appropriate, may reduce the overcrowding that occurs in EDs, and ensure people are getting the right care, in the right place, first time.

Welsh Government is currently promoting the '*Help Us to Help You*' campaign. This highlights to people that better health starts with them, and educates people on how to access relevant advice, support, or care for their health concern, with any new or existing condition.

The campaign and information on the *'Better Health Starts with You'* webpage[43], highlights the many ways to access healthcare in Wales. This includes using pharmacies, Minor Injury Units (MIUs) and mental health helplines, or using other online NHS consultations, to reduce the need for people to attend their GP surgery, or attending ED when their health concern is not an emergency.

Key messages relating to this campaign include advice on using the *NHS 111 Wales service*[44], which starts as a symptom checker and advises people of what steps to take prior to attending the GP or ED. There is also guidance available on accessing other local services and MIUs, and signposts support for mental health needs. We were told by Welsh Government that the reach and impact of this campaign is being measured at regular intervals; however, no data was provided to us to support this.

WAST also launched its campaign around awareness for the NHS 111 Wales service on their website[45]. It supports the *Help us to Help You* campaign by highlighting the 111-symptom checker. If a person feels their health concern is urgent, they can call 111 and speak with highly trained call handlers who will provide advice over the telephone and can arrange a call back from a clinician if needed. Using NHS 111 Wales first, can reduce pressure on the emergency 999 service and EDs.

The NHS 111 Wales service has now implemented further support for people needing help with their mental health, where they call the usual 111 number and press OPTION 2[46]. The service is available for everyone, 24 hours a day, 7 days a week to ensure those in need of mental health support can access it quickly when they need it most. The number is free to call from a landline or mobile, even to those with no credit on their phone.

When considering the *Help Us to Help You* measures in place across Wales, we explored whether it was having a positive impact on WAST and its ability to manage emergency calls in a more timely and effective way. We interviewed a senior manager within WAST who informed us that despite the promotion of the NHS 111 campaigns in Wales, the Trust continues to have multiple 999 calls for non-life-threatening emergencies. We were also told that the winter of 2022/2023

[43] Better Health Starts with You
[44] NHS 111 Wales
[45] NHS 111 Wales: Healthcare advice you can trust - Welsh Ambulance Services NHS Trust
[46] https://www.gov.wales/nhs-111-press-2

had been particularly challenging for the service, with a high number of calls, and particularly from patients with respiratory issues. WAST regularly manages the data relating to calls and categories of need.

A key area requiring improvement is for healthcare services to engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

Recommendation 11:

Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.

Recommendation 12:

Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.

Impact of flow on WAST

WAST patient pathway

We considered the stroke patient's journey through WAST services as the primary frontline service for emergency transport into hospitals across Wales.

In 2015, WAST introduced a framework which replaced the time-based targets for measuring response times of ambulances. The framework is a five step Ambulance Care Pathway, which focuses on the patient journey and is more aligned to the patient outcomes and experiences.

Using the Ambulance Care Pathway framework, we sought to understand how a potential stroke patient is managed from the time of calling 999 for an ambulance, the outcomes they might expect, and the impact of poor flow on WAST's ability to respond to emergency calls.

These include:

Help me to choose

We have already discussed the benefits of people in choosing the most appropriate service for their health concern through NHS 111 Wales. This is to help prevent the need to use the resource of the GP or attend ED. However, when a stroke patient

feels it necessary to call 999 for an ambulance, the data available from Stats Wales[47] shows on average, around 1400 stroke related calls can be received by WAST each month.

Answer my call

As highlighted earlier, when a person calls 999, a call handler completes a triage process and enters data into the MPDS. This allows the MPDS to generate a priority code to determine the clinical response required for the patient, as either Red, Amber, or Green.

If a caller is suggesting symptoms of a stroke, the MPDS will prompt the call handler to undertake the 'Act FAST' test. If the patient is conscious and breathing with positive stroke symptoms, and the onset of symptoms are known to be less than five hours, the call is prioritised as 'Amber 1'. If the symptom onset time is over five hours, the call will be prioritised as an 'Amber 2'. This is because the time to treat a clot in the brain must commence within four hours of known onset of symptoms, and to be considered for thrombectomy for symptoms in less than six hours.

Results from our staff survey reflected seven views on call categorisation, and a feeling that stroke callers should be categorised as 'Red' and not 'Amber', if they are to meet the therapeutic timescales for treatment. This is to help ensure a better patient outcome. One comment included:

'From a WAST perspective, strokes are categorised as an Amber 2, when they should be a red, as the quicker we can attend and recognise, the sooner we can get them to hospital'.

In HIWs previous review of WAST[48], the findings recommended that work was required to consider stroke patients as an emergency who need a 'Red' response. This is due to the time critical nature for treatment. WAST, as a commissioned service cannot make this decision to change alone; it is dependent on guidance from NHS Wales, commissioners, and Welsh Government. Discussions and votes at Senedd Cymru on 26 October 2022[49],[50] , confirmed that stroke patients will remain within the 'Amber' category.

When a patient is waiting for an ambulance, there is a process in place to monitor a patient's clinical status if necessary. If a call handler has concerns for a patient's well-being, they would 'flag' the call on the MPDS to notify the WAST clinical team that a telephone review is required. Whilst this process is in place, it was concerning to find that over the Christmas period in 2022, there were occasions when over 200 callers awaiting a WAST vehicle response, who needed clinical team's intervention.

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[47] StatsWales is the Welsh Government's free-to-use online repository for detailed statistical data for Wales.
[48] Local Review of the Patient Management Arrangements within the Welsh Ambulance Service Trust
[49] Y Senedd - Votes and Proceedings Plenary - 26 October 2022
[50] Y Senedd TV - Plenary 26 October 2022

Come to see me

The ability of WAST to send a response to a caller is dependent on the resources available at the time. This is often impacted by the number of ambulances waiting outside EDs to handover their patients. We found this was a consistent issue across Wales because of poor flow within hospital sites. WAST call handlers or the clinical team are usually aware of prolonged waits for an ambulance to attend callers in the community. Therefore, guidance with a script is available which staff use to recommend the caller makes their own way to hospital, if it is safe to do so, as opposed to losing time whilst waiting for an ambulance to arrive.

Give me treatment

When WAST staff attend a patient suffering with a stroke, they will undertake a further assessment at the scene, which follows the *Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines*[51]. The guidelines identify stroke as a 'time critical' medical emergency and references the time dependency for thrombolysis (clot dissolving treatment). The guidance also states that patients must be transferred to an appropriate hospital as quickly as possible, to commence treatment once the stroke diagnosis is suspected.

Take me to hospital

There are arrangements in place for ambulance crews across Wales to provide pre-alert calls to ED. WAST has guidance in place for clinicians to follow when a stroke has been confirmed during assessment. We were informed that it is the decision of the clinician at the scene of the incident to determine which is the most appropriate hospital to transport a patient, according to their condition (including stroke). On occasion, this may be a hospital across the border, such as for patients living within Powys.

We considered how patients in rural areas would access timely treatment for stroke. We were told that there are challenges with this, and during our fieldwork, we found that work was ongoing in some areas of North Wales and Powys to try to improve transfer arrangements. WAST has been working with healthcare services across the border in England to ensure that arrangements are in place to review and treat stroke patients promptly when required.

Within our staff survey, it was positive to find a good response from WAST staff who felt well equipped to undertake their role with managing a stroke patient.

Almost 85% of staff told us in the survey they had received training to support and manage stroke patients, however, only 77% of respondents said they understood the WAST stroke pathway. In addition, we found that only 49% of WAST respondents said they always allocate or take a stroke patient to a specialist stroke unit.

We recognise the challenges faced by WAST in its ability to deliver a timely response to life-threatening emergencies. This is due to increased pressures on the

[51] JRCALC Clinical Practice Guidelines - aace.org.uk

healthcare system overall, with prolonged ambulance handover delays to EDs all over Wales. It is, however, a concern that patients in the community have prolonged waits for ambulance resource, which places them at increased risk of deterioration and harm. This was also found in our two previous WAST reviews.

The impact of this is significant for stroke patients, due to the time critical nature of the investigations and treatment which are required to manage a stroke patient. Any delays to treatment will likely have life-long consequences for people.

We were told of a pilot project which is due to take place within one health board to evaluate a Pre-hospital Video Triage (PVT), which has been successful in several Trusts in England. A structured pre-hospital assessment will take place with WAST and the health board's stroke team while the patient is at home. If it is assessed that the patient is likely to have had a stroke, they will be immediately transferred to hospital and taken directly for a CT scan on arrival, bypassing the ED. In addition, when there is a pre-alert call from WAST to the ED, patients will be pre-registered within the department, which will reduce delays to thrombolysis and thrombectomy. This pilot is due to commence in August 2023.

Recommendation 13:

WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.

WAST initiatives to manage patients in the community instead of hospital

During our WAST interviews, we found that the Trust is exploring a new process with the aim of reducing the number of ambulances being sent to patients by 50%. This, however, will require increased establishments of staff within the clinical desk, advanced paramedic practitioner teams, ambulance paramedics, nurses, midwives, and mental health practitioners.

The response to calls via the clinical desks will be a Multidisciplinary Team (MDT) approach, which will determine how best to respond to patients instead of inappropriately sending an ambulance. The proposed timescales to fully implement this model is three years which will need additional Welsh Government funding.

However, we were informed that funding had not yet been approved for this.

Evidence has been collated which reflects the benefits of having people treated at home via advanced paramedic practitioners.

We were provided with data which outlines the number of patients who have been managed at home or referred to other services, as well as those who are taken to hospital. It reflects that on the occasions where advanced paramedic practitioners have been sent to see patients, as opposed to ambulance paramedics, in the region of 65-70% have been treated at home without the need to go to hospital. Advanced Paramedic Practitioners can administer a greater range of medication than an ambulance paramedic, which means that more patients can be treated at home, and can be referred to ongoing services, such as their GP practice, physiotherapy

services, or healthcare clinics, such as for TIA where appropriate.

We were told that the service will need to develop and implement different types of resource to operate, such as an increased number of Advanced Paramedic Practitioners. To implement this type of service, staff need to be supported to develop their skills and knowledge, to enable them to work in these roles.

Early implementation of the new WAST model should have a positive impact on the pressures on our hospital system across Wales by reducing the number of patients being transported to EDs by ambulance. A reduction in the first bottleneck of patient flow at 'the front door' of Welsh hospitals, could lead to a reduction in pressure across the whole hospital system and an improvement in patient flow.

Recommendation 14:

Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.

Patient transfer to hospital

We explored the ways in which a patient can arrive at the ED seeking treatment, and this is highlighted below.

Patient arrival at ED

Patients can arrive at EDs in several ways, such as by ambulance, by GP or clinicians through the 111 service, or by referral from other healthcare practitioners, such as district nurses, or by people self-presenting. In our interviews with ED staff across Wales, we were told that people frequently attend ED who do not require emergency care.

There are many occasions where ED staff could redirect patients to alternative care pathways following initial clinical assessment, which would lessen the burden on ED, but also reduce waiting times at ED. The examples provided to us highlighted that people are often turned away from ED to use the services of their MIU, GP, community services, dentistry, and paediatric assessment units. However, some staff said that at times, there is a reluctance by ED staff to re-direct patients elsewhere and away from EDs, as they are risk averse and are not always confident to do so.

Stroke pre-alert calls

The stroke pre-alert call is used to notify ED staff of inbound patients that require immediate attention and is a key component in the stroke care pathway. The call enables the receiving hospital to have the specialist staff available upon the patient's arrival and aims to improve the timeliness of the treatment a patient receives.

We were informed by WAST that they have developed, in partnership with the

relevant stroke units across Wales, a standardised pathway to enable the conveyance of a patient to the appropriate hospital first time. The WAST clinician, upon suspecting a diagnosis of stroke, will pre-alert the ED of a hospital with a stroke unit capable of undertaking a scan, and when appropriate undertake thrombolysis treatment.

WAST staff told us that despite the effectiveness of the pre-alert call, issues can arise when hospital services are under extreme pressures due to poor patient flow. This can result in patients being assessed on the ambulance, then receiving their initial investigations and brain scan, and then returned to the ambulance due to pressures on ED services. This was supported by results from our WAST staff survey, which confirmed that a stroke patient is normally pre-alerted to the hospital, but often EDs are full and are unable to accept patients into the department.

During our onsite fieldwork, we found that some patients who were pre alerted or not, still showed signs of being FAST positive on arrival to ED. Some ambulance crew had documented on arrival at ED, that these patients were then a query Transient ischaemic attack (TIA)[52] as opposed to stroke, however, not all symptoms had resolved.

To support the stroke assessment process, NICE guidance for stroke, states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER (Recognition of Stroke in the Emergency Room). The aim of the ROSIER assessment tool is to enable medical and nursing staff to differentiate patients with stroke and stroke mimics, such as TIA.

Since the use of ROSIER is a recommended tool within NICE guidelines to differentiate Stroke from TIAs, it may be beneficial for WAST to train its paramedic staff in the use of the ROSIER assessment tool, alongside the FAST assessment.

The ROSIER assessment tool is discussed later in the report.

Recommendation 15:

WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.

It is positive to note that 94% of ED staff who responded to our survey said they were informed by a pre-alert call from ambulance services if it was a FAST positive patient. This was also supported by our interviews with ED and stroke services staff across Wales.

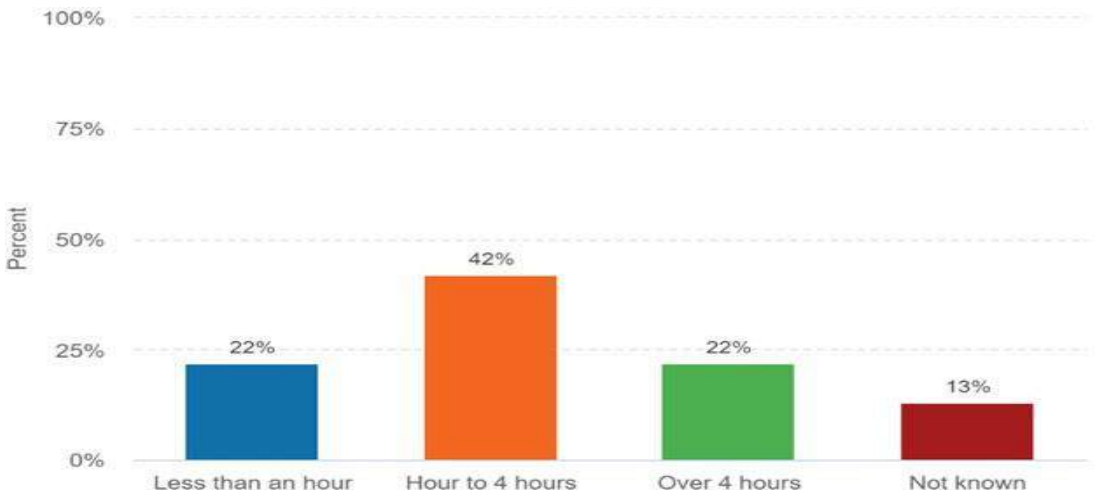
As highlighted above, we established that stroke patients arrive at EDs in different

[52] A TIA is a warning sign that you're at increased risk of having a full stroke in the near future. See: Transient ischaemic attack (TIA) - Treatment - NHS (www.nhs.uk)

ways, such as by ambulance, GP referral, or patients who self-present at EDs.

Therefore, there is a risk to some patients of missing their therapeutic window for thrombolysis treatment if there are delays in transfer or receiving timely assessments.

We asked people in our survey how long before arriving at hospital did their stroke symptoms start. The chart below highlights the times reported to us:



The above chart reflects that 64% of patients arrived at hospital within the time critical thrombolysis window.

People self-presenting at hospital

We were told by some patients and staff that due to the timely availability of an ambulance, some people self-present to ED. We were told that this can present risks to a patient if they did not clearly raise their stroke symptoms to the receptionist on arrival to ED, which consequently may impact on their triage and assessment time.

In addition, if a patient self-presents at a hospital that does not treat stroke patients, such as a MIU instead of ED, this may also present a risk for timely treatment.

This is because they may need to be transferred to a hospital that can appropriately scan and treat patients with a stroke. This in turn, may delay the time they have in the therapeutic treatment window of four and a half hours.

We considered the training provided to reception staff to help identify red flag

Recommendation 16:

Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation processes are in place if a receptionist is or is not sure a patient may be suffering with a stroke.

symptoms[53] of stroke, and to prioritise and escalate triage for patients if symptoms are present. We found that in general, most (but not all) reception staff had received training for this. Despite being non-clinical, they still have a vital role to play in the potential identification of stroke patients.

Impact of delayed ambulance handovers for stroke patients

We considered whether ambulance handover delays were having a negative impact on patients along the stroke pathway. In our staff survey, most ED staff said they were familiar with the hospital's handover policy to stroke services, and that the policy was easy to follow and was achievable. Whilst this finding is positive, delays in the ability of ambulance crews to hand over patients to ED staff are frequent and common.

Throughout our onsite fieldwork, we saw ambulances waiting outside EDs across Wales, waiting to handover and offload patients to the departments. Despite this, it was positive to find that patients suspected of having a stroke (and others with life threatening conditions), were prioritised and transferred into the ED promptly in line with the stroke pathway.

Timely assessment and treatment in ED for stroke patients

We observed stroke patients being assessed, investigations were undertaken, and treatment was commenced in a timely manner. We saw staff consider the risks and appropriately mobilise other lower acuity patients throughout the department, to accommodate those confirmed as stroke positive. This was to ensure timely assessment and treatment promptly.

Through our discussions with ED staff, we were told that in the event of no trolley space being available in ED to offload a stroke patient, assessment would take place onboard the ambulance if the appropriate ED staff suspected stroke.

We were told that whilst stroke patients would always be prioritised for transfer into the departments, there are occasions when this was not possible. In such instances, staff explained that investigations, such as blood tests and a CT scan would still be undertaken, although the patient may return to the ambulance until a decision on commencing treatment is made. This was to help maintain a timely response to the patient's needs. In response to our staff survey, one person said:

'At some hospitals there may be delays with handover, but assessment, and interventions are completed despite trolley or bed availability.'

In contrast to this, it was concerning to find that most respondents to our WAST survey said that ambulance offload delays are negatively impacting stroke patients. Several comments were received which included concerns with delayed

[53] Red flag symptoms of stroke may include complete paralysis of 1 side of the body, sudden loss or blurring of vision, being or feeling sick, dizziness, confusion, difficulty understanding what others are saying, problems with balance and co-ordination, difficulty swallowing (dysphagia), a sudden and very severe headache resulting in a blinding pain unlike anything experienced before, loss of consciousness.

response to those waiting in the community, timely offloading of patients to ED, and delayed patient assessment due to the bottlenecks within ED. One comment included:

'There doesn't appear to be any urgency when we pre alert a still FAST+ patient into ED. Or we are asked to take patient back onto vehicle. Not really appropriate when symptoms of a stroke have a good chance of being reversed if treatment is given promptly'.

The findings in our clinical records review were overall positive. Most FAST positive patients were taken into ED within the 15-minute Welsh Government handover target time. However, we did find instances of delays in handover and no investigations had been instigated by ED staff. This is a concern, particularly when stroke treatment is time critical, and delays may have life-long consequences.

Recommendation 17:

WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.

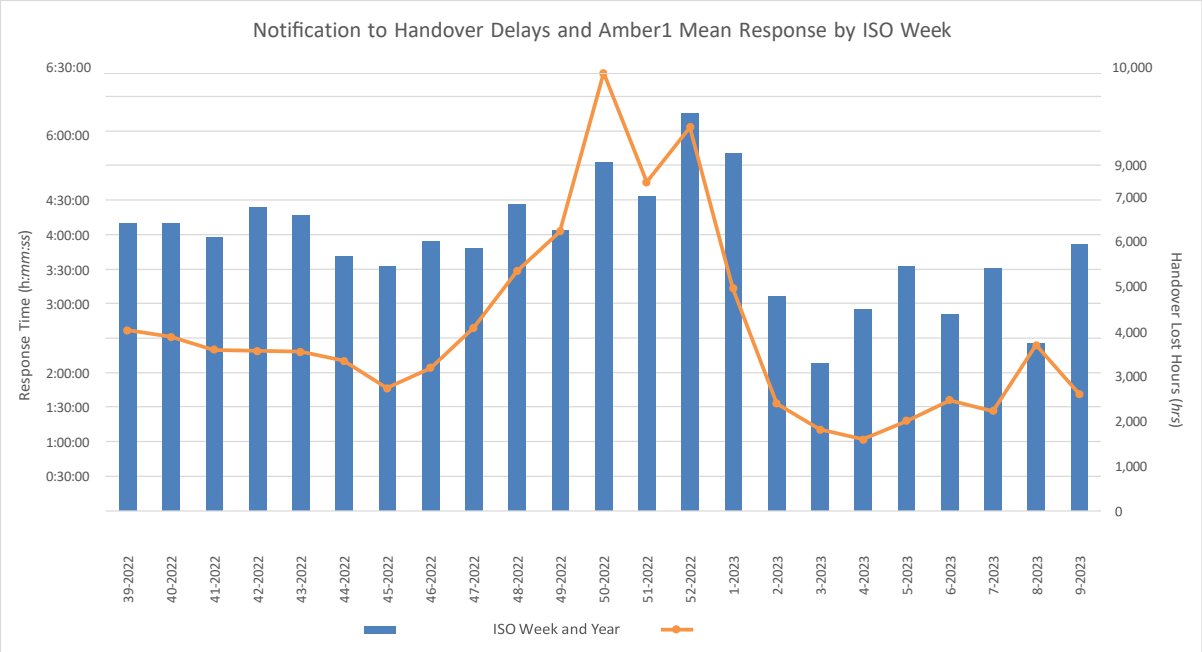
During our staff interviews, we were consistently told about the unprecedented increase in emergency care demand, impacting further on the ability to offload and handover patients from ambulances. Handover delays have been a challenge for WAST for a prolonged period, because of poor flow in hospitals. This has led to the service to re-evaluate its service delivery model, to help improve services, as highlighted earlier in the report, relating to the use of advanced paramedics in the community.

In our report, *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover,* it is highlighted that in December 2020, 11,542 hours of ambulance crew resource was lost due to delays experienced with hospital handover.

We also found the data for this in September 2022 was significantly worse, with around 25,166 lost hours due to handover delays.

This increase is concerning and is attributed to poor patient flow. The flow is impacted further by the ability of hospitals to discharge patients in a timely manner, because of the delays with social worker allocation, availability of social care packages or placements available in care homes.

Data provided by WAST in the chart below, highlights a clear correlation between lost hours due to handover delays, and the Amber 1 response times over a six-month period.



The chart reflects that in week 52 of 2022, 8,835 hours were lost due to handover delays, and the mean time of an Amber 1 category call response (which includes most stroke calls), for that week was 5.33 hours. Given the time critical nature of potential treatment for stroke patients, the delays in the ability of WAST resources to attend patients in the community is of particular concern.

We are aware of the ongoing work nationally to improve handover delays; however, despite this, our review has found that the challenges remain. To address these issues, is not something WAST or a health board can do alone, and collaborative work is required between Welsh Government and key stakeholders in health and social care systems, to analyse the issues in order to make improvements.

Recommendation 18:

Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving

Impact of flow on stroke assessment and admission to hospital

Stroke pathways

We considered whether health boards had a clear process in place for managing patients in ED with a stroke in line with NICE guidance. Overall, we found there are clear stroke pathways in place across Wales which focus on timely assessment, investigation, and ongoing treatment. All health boards follow a similar but not

identical pathway when stroke patients are admitted through ED. In general, the pathways include assessment, diagnosis, and treatment for thrombotic or haemorrhagic stroke, and for those where treatment is not a viable option, due to the extent of their stroke.

Timely assessment on arrival at hospital

We highlighted earlier that the incidences of people self-presenting at EDs with a suspected stroke is increasing. This is due to delays with the availability of ambulance resources in the community. This can prove challenging, since EDs are not pre-alerted to the arrival people self-presenting, which may present a risk in the timely assessment or diagnosis of stroke for some people.

During our onsite fieldwork, we found the challenges with the demand on ED, impacted by poor hospital flow, meant that some patients waited longer than expected for triage and ongoing assessment or treatment. Whilst this may not have impacted on FAST positive stroke patients, such delays may pose a risk to self-presenting patients who do not display easily identifiable stroke symptoms.

Stroke team assessment

When FAST positive patients are pre-alerted and arrive at hospital (and within the thrombolysis or thrombectomy treatment window), the relevant stroke team is alerted by an emergency stroke bleep of the imminent arrival of a patient. We found that all acute sites who provide stroke services have the stroke bleep system in place.

We considered the effectiveness of the relevant team response to the emergency stroke bleep. Our staff interviews found that the response to the bleep varied across Wales, according to the time and day, and who is on-call to respond.

Through the health board self-assessment responses and our interviews with staff, we found that when there is a Clinical Nurse Specialist (CNS) or Advanced Nurse Practitioner (ANP) for stroke available in acute sites across Wales, and their response is generally rapid. They will also facilitate prompt investigations and diagnosis, and the required treatment and plans for patients within the stroke pathway.

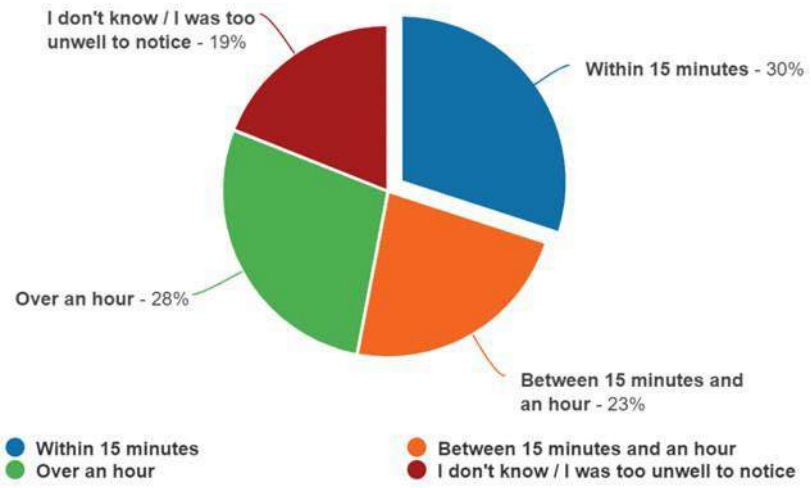
We found that during out of hours periods (such as nights or weekends), or in the absence of a Stroke CNS, ED staff and medical teams are alerted by the stroke bleep and arrange investigations and treatment for stroke patients. The medical team responders would also have access to an on-call stroke consultant.

We considered the process for those who self-present at hospital, and we found that the process was the same.

Through our clinical records review, we found positive responses from a designated on-site stroke team for attending ED. However, the timeliness of the bleep response was not always adequate. Some clinical records highlighted that triage and assessments were not always conducted in a timely manner, which may negatively impact on the ability to promptly assess and treat patients. Whilst we could not always identify the reason for this inconsistency, often the medical

teams were dealing with other in-hospital medical urgencies and emergencies on the wards.

We asked patients in our public survey how soon they were reviewed by a nurse or doctor following arrival at hospital. It was disappointing to find that over half the patients were not seen within 15 minutes, and 28% of those waited over one hour for assessment. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode. Our survey findings are highlighted in the chart below:



Within our staff survey, we also found that just 28% of ED staff felt patients were assessed within 15 minutes, 60% said sometimes, and 12% said patients are not assessed in a timely manner. This again is a concern due to the time critical window for stroke patients receiving treatment.

Recommendation 19:

Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.

Recommendation 20:

Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a tertiary referral centre is relatively close to the ED.

The CNS and ANP for stroke care

It is evident that prompt stroke care is essential for better patient outcomes, and the role of the CNS and ANP is beneficial in facilitating prompt progress through the stroke pathway.

We explored the CNS and ANP role further and found that it not only includes rapid assessment of patients for possible thrombolysis, but CNSs and ANPs also coordinate post-thrombolysis monitoring and acute stroke care. Their role was found to be significant in liaising between ED staff and acute stroke wards to facilitate prompt flow of stroke patients to an appropriate bed on a stroke ward, in line with national targets.

During our interviews, ED staff highlighted the benefits of the Stroke CNS and ANP to attend patients in ED. Staff reported that their presence assisted greatly in providing a prompt expert clinical opinion, and with ensuring stroke patients moved efficiently through the stroke pathway to the acute stroke ward. This also took pressure off the ED nurses and allowed them to focus on other patients requiring urgent clinical attention.

Across Wales, we interviewed staff within EDs and stroke services, and found consistently, that a key barrier to effective and timely stroke care, is the absence of a CNS or ANP for stroke service 24/7. Whilst medical teams have the appropriate knowledge and skills to manage stroke patients, there are occasions when their attendance at ED is delayed whilst they deal with other emergencies across the hospital. Such instances may negatively impact on stroke patients and their ability to be reviewed and treated in a timely manner.

Our interviews found that all hospitals aspire to have a 24/7 CNS for stroke services. However, we found inconsistencies across Wales in the provision of the CNS/ ANP service. The absence of a CNS/ ANP out of hours, such as nights and weekends, may impact negatively on patients due to the commitment of medical teams dealing with issues elsewhere across the hospital.

We found that issues with funding for the posts, or challenges in the recruitment for these key roles did not always enable a 24/7 service. Through our communication with the National Allied Health Professionals Lead for Stroke in Wales, it was highlighted that CNS or ANP for Stroke should be resourced to cover as much of the peak periods of stroke presentations to EDs as is possible, particularly during thrombectomy referral and the service availability time periods. It is therefore important that health boards regularly audit their stroke presentation and demand times on the service.

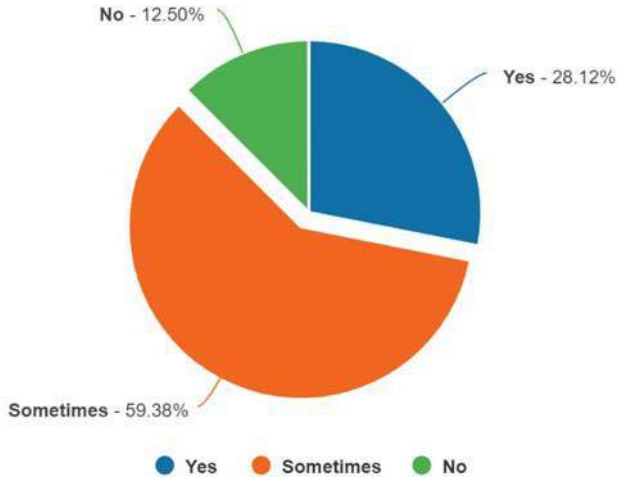
In the absence of a CNS/ ANP, we considered whether stroke patients were reviewed promptly by other stroke team members or medical teams. In our clinical records review, we found that most stroke patients arriving at EDs by ambulance were prioritised appropriately. We also saw evidence of patients who had self-presented at EDs receiving timely and appropriate assessments and investigations. However, we found that patients were not always assessed as promptly and did not

progress through the stroke pathway as effectively, in the absence of a Stroke CNS.

Recommendation 21:

Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.

In our survey, we asked staff whether they could assess stroke patients in a timely manner. Their response is highlighted in the chart below:



It is concerning that only 28% said they were able to assess people in a timely manner, and whilst 12.5% said no, the majority (60%) said they sometimes could.

The reasons highlighted to us as barriers to achieving a timely assessment include:

- Staffing issues or staff capacity
- High volume of patients to assess
- Lack of space or trolley bays in ED
- Increase of patients self-presenting at hospital

In response to our staff survey, we received the following comment which highlights the risk with people self-presenting with a stroke:

'Accident and Emergency unit staff need to be trained to pinpoint stroke pathway. Sometimes when patients have been admitted to hospital, they are not able to access the stroke pathway as efficiently as a patient attending the hospital in an Ambulance, this issue needs to be addressed. If all staff received training, it would benefit patients.'

Recommendation 22:

Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.

Stroke assessment tools

As highlighted earlier, to support the stroke assessment process, NICE guidance for stroke states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER. This will ensure the prompt diagnosis prior to scan of a potential stroke or TIA.

A key example of the benefits for using the ROSIER tool is; if the stroke call is put out by ED staff to alert the medical team of an imminent arrival, and a triage and ROSIER assessment is undertaken by the ED staff promptly, then a CT scan can be booked by the medical team and the patient can be taken directly to the scanner. This is to help ensure no time is lost in diagnosis, particularly when the ED is full, and ambulances are waiting outside to offload patients. Patients could then be moved directly into a space in ED to receive treatment, or placed back on board the ambulance if thrombolysis or thrombectomy is not indicated, to await the next available space in ED, if admission is needed.

The example above further questions if there is a need for WAST paramedics to be trained in ROSIER assessment as highlighted earlier in the report. This assessment could be undertaken at the scene in the community when a patient is displaying stroke symptoms, which may help with the timeliness of assessment, imaging, diagnosis, and treatment at the receiving hospital.

We found that stroke assessments and interventions were being undertaken by clinicians with appropriate expertise in neurological disability, and nursing and medical staff had the appropriate knowledge, skills, and experience to recognise and manage stroke patients. However, we considered whether an assessment tool, such as ROSIER tool was being used in EDs in all health boards.

Whilst the ROSIER tool was in use across Wales, during our fieldwork, this was not always consistent. Our clinical records review and our staff interviews found inconsistencies in the tools used across Wales. Overall, we found good examples of assessment and the use of appropriate tools, however, in some records we did not find evidence that a tool had been used to support diagnosis or treatment plan.

Recommendation 23:

Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.

Recommendation 24:

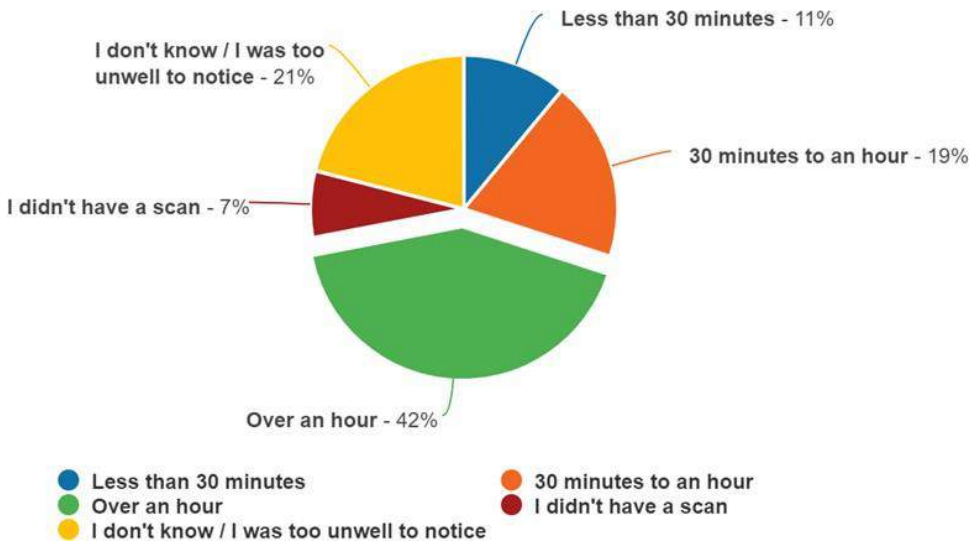
Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.

Timely imaging

We considered whether patient flow issues through departments impact on timely brain scans. The NICE guidelines for stroke state that specific categories of suspected stroke need to receive a CT scan immediately. That is defined in the guidelines as, ideally the next slot and definitely within 1 hour of arrival at hospital, whichever is sooner. The CT scan will diagnose whether the stroke is due to a clot or a bleed on in the brain and will help determine the required treatment promptly.

In our public survey, we asked peoplehow long they waited before receiving a brain scan after they arrived at hospital. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode.

Our survey findings are highlighted in the chart below:



On analysis of the survey results, it is concerning to find that 42% of patients felt that they waited over an hour for a scan after they arrived at hospital, which is beyond the recommendations within NICE guidance.

We explored this further through our interviews with staff. We found that staff

endeavour to achieve a brain scan for a patient within an hour. We found good working relationships existed between ED and stroke or medical staff and the radiology teams, which supported timely imaging for stroke diagnosis. We also found that scans are reviewed and reported on promptly by relevant radiology staff. In some health board areas, an after-hours radiology service[54] is utilised to provide interpretations of scans and ensure specialist expertise and round-the-clock support. This means that scans are sent electronically to a radiologist to obtain a rapid report of the scan.

We found a positive initiative within one acute site, where the stroke pathway facilitates symptomatic FAST positive patients (identified by ambulance paramedics), by-passing the ED, and being transported directly to the CT scanning department. This is to help mitigate against any delays with handover at ED and enables prompt diagnosis and subsequent treatment as appropriate.

We were told that the advance imaging can be supported by Artificial Intelligence (AI) for stroke imaging. The all-Wales procurement of AI stroke imaging was completed in Dec 21, and it is now in the implementation phase. This will have a positive impact on the prompt identification of patients for thrombectomy and thrombolysis through stroke imaging. Therefore, patients can access the treatment they need in a timely manner.

Recommendation 25:

All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.

As highlighted earlier, to support the diagnosis of stroke, consideration should be given to WAST paramedics training in the use of the ROSIER assessment tool for stroke patients. Health boards across Wales in conjunction with WAST, may wish to explore the benefits of direct admission by paramedic to CT scan for FAST positive stroke patients where appropriate.

Through our clinical records review, it was concerning to find that some patients were not consistently receiving a CT scan within the one-hour target. Whilst reasonable explanations were documented in the records for some patients, such as patients not presenting with typical stroke symptoms, other records provided no explanation for the delay.

We also considered SSNAP data of patients scanned within one hour of arrival at hospital. The data reviewed considered the period of April to June 2019, 2021 and 2022. Of the 12 acute sites who now deliver stroke services within Wales, the performance of nine sites dropped between 2019 and 2022 signifying that an increased number of patients waited more than one hour for a brain scan. As highlighted earlier in the report, consideration to the timing of the pandemic must be given when reviewing this data.

[54] Everlight Radiology provide immediate access to radiologists 24/7 and are often replied upon for out of hours service.

Recommendation 26:

Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.

Swallow assessment

In line with NICE guidelines, patients with acute stroke should have their swallow screened by an appropriately trained healthcare professional, such as a speech and language therapist or other competently trained healthcare professional on admission or within four hours. If the screen shows signs of difficulty, the swallow should be assessed within 24-72 hours and before the person is given any oral food, fluid, or medication. We considered whether patients received a swallow screen and/or assessment within the timeframe, particularly in the event of a delay in them being transferred from ED to the stroke ward.

During our interviews with ED staff, we were told that rosters aim to ensure there are sufficient staff on duty to complete timely swallow screen and/or assessments within ED, however, this was not always possible due to high turnover of staff at some acute sites, and a high number of bank or agency staff on duty.

Staff in one health board told us that training had recently been completed for ED staff, to help further identify stroke patients and the importance of swallow assessments, which is in line with within the NICE guidance. They told us that this positive action had benefitted patients with timely assessments and demonstrated improvements in their SSNAP data.

Through our clinical records review, it was positive to find that in general, most patients had received a swallow assessment within the four-hour target as recommended by NICE. This included patients who remained in ED awaiting an inpatient bed, and for those who had been transferred to an acute stroke ward.

Impact of flow on prompt stroke treatment

Thrombolysis

People who are diagnosed with an ischaemic stroke and who are eligible for thrombolysis, should usually receive treatment within 4.5 hours of the known onset time of stroke symptoms. However, within the new *National Clinical Guideline for Stroke,* this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion[55]. Therefore, in line with national guidance, treatment can be started between 4.5 and nine hours of known onset of symptoms, or within nine hours of the midpoint of sleep, when they have woken with symptoms[56].

We considered whether issues with flow prevented patients receiving thrombolysis

[55] Perfusion CT is an X ray examination that looks at blood flow and the amount of blood within the brain.
[56] National Clinical Guideline for Stroke for the United Kingdom and Ireland

treatment in a timely manner. Our clinical records review found that decision for thrombolysis was done on an individual patient basis, and is influenced by factors, such as pre-existing conditions and the timing of the onset of symptoms. We found the rationale for decisions were recorded in all relevant notes we reviewed, and treatment commenced in an appropriate time.

We found in some records that thrombolysis was not clinically appropriate, and the rationale for this was documented appropriately. However, it was concerning to find that some reasons for this included a delay in obtaining a CT scan, and delays in patients seeking medical assistance following onset of symptoms. Evidence in one of the records reviewed reflected that one patient who lived in a rural area had been significantly disadvantaged due to their travel time to hospital, which resulted in them missing the four-hour thrombolysis window.

We also considered which staff were trained in thrombolysis administration outside of the stroke or medical teams. Across Wales several appropriately trained ED nurses can administer thrombolysis where required, this therefore meant delays for thrombolysis treatment was minimised.

When staff were asked whether they felt they have had appropriate training to undertake their role, the majority (72%), agreed they had. For those who disagreed, the following reasons were provided:

'I have had no additional stroke training since starting my role, I have learnt on the job.'

'I have been given the opportunity to take part in training however, due to operational pressures I often do the work in my own time.'

'This is very much caseload dependent and staffing dependent. We have significant staffing issues currently therefore our priorities are mainly clinical.'

When reviewing SSNAP data, we found inconsistencies across Wales in the timeliness of thrombolysis treatment. This is not conducive to equitable treatment to people across Wales.

Recommendation 27:

Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.

Recommendation 28:

Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.

Recommendation 29:

Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.

Thrombectomy

An alternative procedure to thrombolysis therapy is surgery to remove a blood clot, which is known as a thrombectomy. In the Stroke Association's publication, *What we think about: Thrombectomy*[57], it highlights evidence demonstrating that thrombectomy treatment can significantly reduce the severity of disability a stroke can cause, therefore can result in better patient outcomes.

When clinically appropriate, the NICE guidance states that a thrombectomy should be offered for people with acute ischaemic stroke as soon as possible, and within six hours of symptom onset.

We considered the provision of thrombectomy treatment across Wales. Only Cardiff and Vale University Health Board provides a thrombectomy service.

The service is available Monday to Friday from 09:00am to 5:00pm, and only when expert interventional neuroradiology staff, and the appropriate radiology facilities are available. The service is provided mainly to people who live within the health board boundary. All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust where the service is available to patients in Wales daily 8am-midnight, or to the Walton Centre NHS Foundation Trust which offers a 24/7 thrombectomy service. Given the geographical challenges and the impact of ambulance delays across Wales due to handover delays, this impacts negatively on the ability of some people receiving thrombectomy in a timely manner, particularly when thrombolysis may not be clinically appropriate for them.

According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763[58].

[57] https://www.stroke.org.uk/sites/default/files/new_pdfs_2019/our_policy_position/psp_-_thrombectomy.pdf
[58] Annual thrombectomy April 2020 to March 2021

It is concerning to find that in Wales, just 13 patients received a thrombectomy at the University Hospital of Wales (for those living in the locality), just 16 patients received treatment in North Bristol and only four patients at the Walton Centre.

This does not appear to be conducive to equitable access to thrombectomy treatment across Wales, and those living within the Cardiff and Vale locality are at an advantage of receiving this type of treatment for stroke to those living in other health boards across Wales.

Our clinical records review found that where appropriate, stroke teams considered thrombectomy treatment for patients, although just one patient was deemed appropriate for the procedure. Whilst it was noted clearly in some records that the patients were not considered suitable for thrombectomy treatment, in several other records there was no evidence to suggest this had even been considered when it is part of the decision-making process for treatment.

Our interviews with stroke clinicians found that there was often consideration of patients who are suitable for thrombectomy, and where referrals have been accepted, there were often challenges with timely ambulance transfers to meet the treatment window target time. This was particularly challenging for cross border transfers, despite inter-hospital transfers for thrombectomy categorised as a 'Red' response by WAST. This may be due to the geographical location of a person, or the availability of an ambulance to transfer the patient in a timely manner.

We recognise that one of the aims within the quality statement for stroke services in Wales as highlighted earlier, is to improve opportunities for patients in Wales to receive thrombectomy treatment and to develop Comprehensive Stroke Centres within a network delivering thrombectomy locally. This is a significant challenge in Wales due to resources across the country and the number of suitably trained people to undertake the procedure. Work to consider this is currently ongoing nationally.

Recommendation 30:

Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.

Recommendation 31:

Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.

Recommendation 32:

WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.

Patient flow to acute stroke wards

During our review, we considered whether people are admitted to an acute stroke ward in a timely manner. NICE Guidance (NG 128)[59] states that hospitals should admit everyone with suspected stroke directly to a specialist acute stroke unit after initial assessment, from either the community, the ED, or outpatient

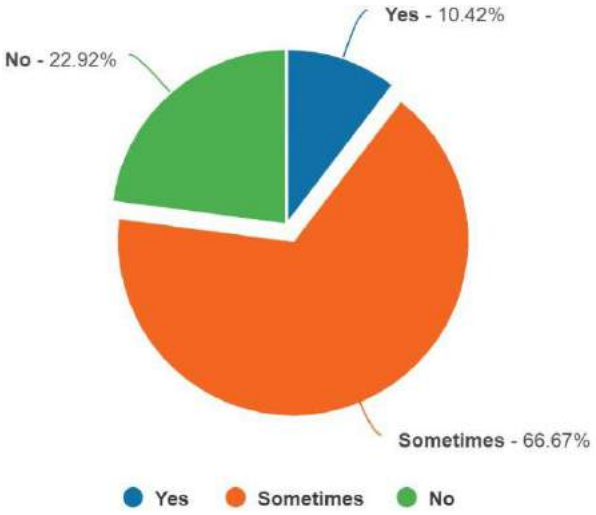
clinics. Acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs due to the range of specialist treatments they provide. They are staffed by a specialist stroke multidisciplinary team and should have access to equipment for monitoring and rehabilitating stroke patients.

Acute specialist stroke units are associated with improved patient outcomes. Admission targets to these units should be within four hours of arrival at ED, so specialist treatment can begin as quickly as possible, in line with NICE guidance (NG 128). We found in all stroke pathways across Wales, that admission to a specialist stroke ward/unit, must be within four hours of arrival at ED.

We considered whether issues with poor hospital flow, impacted on the timely admission of people to acute stroke unit in line with NICE guidance. It is concerning to find that just 10% of those who responded to our staff survey said it was possible to transfer patients to a stroke ward when needed, and 23% said no.

This is highlighted in the chart below:

[59] NICE guideline [NG128] Published: 01 May 2019 Last updated: 13 April 2022



This finding was consistent with responses in our staff interviews across Wales, who suggested that poor patient flow within their hospitals prevent patients being transferred to an acute stroke ward in a timely manner.

Our interviews with ED and stroke service staff found, that every effort is made to transfer patients to the acute stroke ward within the four-hour timeframe.

However, they are consistently faced with several challenges in achieving this, which were attributed to patient flow issues.

During our fieldwork, every acute stroke ward across Wales was at full capacity. This resulted in stroke patients either remaining in ED to receive treatment and post treatment care, until a bed became available, or they were being placed as an outlier in another ward.

In our public survey, people told us of delays in their transfer to an acute stroke ward. Comments included:

'Day and a half in A&E before being admitted to ward.'

'Admission to stroke ward not possible, still waiting 13 days after admission when writing this'.

We attended patient flow meetings across Wales and witnessed discussions on how teams tried to accommodate stroke patients on the acute stroke ward. However, due to the system wide flow issues, this was not always possible. We also found in some wards that staff were proactively attempting to receive stroke patients from ED at the earliest opportunity when they had a bed available.

We explored the reason for delays entering the acute stroke ward. Several reasons were provided to us in the staff survey.

These included a lack of bed availability with delayed discharges due to social care issues and outliers of other specialties placed in stroke beds, due to flow issues

elsewhere in the hospital. We were also informed that stroke patients who required transfer to a stroke rehabilitation ward cannot be transferred due to capacity there.

Some comments in our survey from staff included:

'Often due to poor discharge flow from patients awaiting care packages and placements beds are not always readily available when a stroke patient has been identified for the pathway.'

'Bed availability on acute and rehab ward becoming an increasing problem due to the inability to step down patients from the ward and into the community. Bed availability is also taken up on stroke units by non-stroke (medical) patients/admissions.'

'Unfortunately, stroke patients are not always prioritised according to the stroke pathway, and when beds are available the decision on who fills stroke beds is not made by the stroke team.'

In our staff survey, we also asked people to comment on how the NHS could improve the service it provides to stroke patients, one respondent commented:

'Immediate availability of access to stroke ward and the specialist patient care this would provide.'

When beds were not available on the acute stroke wards, we considered whether patients were managed safely and effectively in ED. In our clinical records review, we did not find any evidence to suggest delays in transfer to a stroke ward negatively impacted on the safe and effective care to patients.

Ring-fenced stroke beds

We found that each acute site we visited had a policy to 'ring-fence[60]' stroke beds. Whilst policies are in place to ring-fence beds, this is frequently breached due to the high escalation status of the hospital site and due to overall lack of bed availability in other areas.

Staff within stroke services told us they always aim to ring-fence a stroke bed, but it is frequently not possible due to patient flow issues within the whole system, and they are made to use the bed for a different specialty patient. This frequently results in medical outliers (non-stroke patients), being placed in the ringfenced stroke bed, and stroke patients frequently being placed as outliers on other wards.

This is concerning since this may result in stroke patients not receiving the most appropriate and timely treatment for their condition, and likewise for other

[60] A ring fence bed is a method of protecting an acute bed on a stroke ward from use by patients who are not stroke patients.

specialty patients.

Our staff interviews found that ring-fencing a stroke bed was essential to maintain flow in the stroke pathway. In addition, we asked staff in our survey if they had comments on what could be improved with the flow of patients along the stroke pathway. The most common theme in the feedback related to the need to ring-fence stroke beds for stroke patients. We received 22 comments suggesting the need to maintain a ring-fenced bed.

One comment included:

'We had a ring-fenced bed for a while, but hospital pressures have meant that this is rarely available and so patients need to be moved about to get an appropriate bed on the stroke ward, that can cause delay.'

Delays in accessing stroke beds

We explored the issues around outlying patients on different wards in relation to stroke. The aim was always to transfer patients to a stroke ward as soon as a bed was available. We also found examples that at times, patients may be swapped from other wards to allow for stroke patients to be in the best environment to manage their needs.

Our clinical records review found that patients remained in ED for prolonged periods of time. Some records found overnight delays and instances where patients had remained in ED over 24 hours, prior to their admission to the stroke ward.

Whilst this is not acceptable in the appropriate management of a person within the stroke pathway, it is positive to note that evidence demonstrated that patients received the required care from other specialties, such as therapies staff, in a timely manner.

Despite the continual issues with patient flow to the stroke wards, we found some positive patient experiences for timely transfer. Several clinical records showed that patients had been transferred to the acute stroke ward within the four-hour timeframe. One record highlighted that a patient remained in ED until their condition had stabilised and were transferred to the acute stroke ward within the four-hour timeframe. Other records demonstrated that a bed on the stroke ward was ring fenced for a patient and was not used whilst they received urgent care in ED. Whilst overall, the clinical records were clear and legible, in some records it was not always clear to establish times and dates of transfer of some to the stroke ward.

It is evident from exploring the timely transfer of patient flow to the stroke wards, that there is significant pressure on the whole of the system. Patient flow is a problem across all specialties, and for stroke patients, they are not always placed in right bed in the right place at the right time, due to the high demand on beds.

Recommendation 33:

Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.

Recommendation 34:

Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.

Impact of flow on stroke rehabilitation

NICE guidance (NG128), states that stroke rehabilitation is essential for better patient outcomes. Ideally, this should be provided within a dedicated stroke inpatient unit, and by a specialist stroke team within the community if required.

Across Wales, we found clear inconsistencies for the provision of rehabilitation to people following their stroke. Some hospitals provide rehabilitation within the acute stroke ward since there is no separate ward available to provide this elsewhere. Other health boards have a dedicated rehabilitation ward within the same hospital site, or stroke rehabilitation may be provided within a different hospital site, such as community hospitals.

Early Supported Discharge

Early Supported Discharge (ESD) is an intervention for adults following a stroke which allows their care to be transferred from an inpatient to a community setting[61]. ESD enables people to continue their rehabilitation therapy at home, with the same intensity that they would receive in hospital. However, this may not always be suitable for everyone following a stroke, or in all circumstances, and the decision to offer ESD is made by the stroke MDT, after discussion with the person and their family or carer if applicable.

The stroke MDT will assess whether ESD is suitable for adults who have had a stroke.

The assessment will consider the person's functional, cognitive, and social circumstances, such as the person's ability to transfer from bed to chair independently or with assistance, and whether a safe and secure environment can be provided at home.

When considering the provision of ESD for people following a stroke, we found inconsistencies with the service available across Wales. Not all health boards provide this service and for those that do, there is no standardised format in the

[61] Early Supported Discharge - NICE

provision of ESD. Access to the service across Wales is varied and there is a lot of variation in the service provided in terms of frequency of home visits and intensity of rehabilitation provision).

Our interviews with ESD staff highlighted the significant benefits and positive outcomes for patients who have received ESD. The risks associated with remaining in hospital are minimised, and the psychological impact on patients improves with the ability to be discharged from hospital. We also found that where the service was available, staff reported improvement in patient flow due to savings on patient bed days.

Despite the benefits of ESD, it was disappointing to find inconsistencies across Wales with its provision. When speaking with staff about this, it appears there is a lack of resource or funding available to provide ESD services in some health board areas. This therefore highlights the inconsistencies with equitable access to ESD for people who may benefit from this.

Recommendation 35:

Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to hospitals, with earlier discharge improving flow through the stroke pathway.

Stroke rehabilitation wards

Overall, we found that hospitals with stroke rehabilitation wards provide an environment which facilitates multidisciplinary stroke care, such as nursing, medical and therapies treatment. For hospitals that do not have separate rehabilitation wards, our staff survey highlighted several comments which suggested the need for a step down or rehabilitation ward for treatment to assist with the flow of patients from acute stroke wards. One member of staff commented:

'a dedicated rehabilitation area that would allow for proper dignified assessment and rehabilitation to progress people.'

In one health board, the process was ongoing to separate the stroke ward into acute and rehabilitation wards, and it was also introducing the provision of ESD.

The rehabilitation ward was re-located to community hospital sites which were also in the process of introducing ESD for all three sites. The aim is to facilitate the provision of a seven-day therapies service on the rehabilitation ward, with plans to progress to a seven-day therapies provision at the acute site. The purpose is to improve flow for stroke patients from the acute setting to the rehabilitation ward, and to facilitate earlier discharge to the community with the support of ESD.

Another health board was providing a full therapies service over seven days. Whilst this was positive in enabling earlier discharge of patients, staff told us it was having a negative impact on the weekday provision of care, due to the thin spread

of stroke speciality staff to cover seven days. Our interviews with Senior Managers found that they were considering the options of increasing the staff establishment; however, recruitment to the site was a challenge, due to complexity with discharge planning. Therefore, a high reliance on regular agency and bank staff was necessary.

We received several comments from therapies staff in our survey in relation to this issue, which included:

'Occupational therapy are involved with patients they are able to assist patients to improve ability with increased level of rehabilitation for each patient however this service is very limited. Services need to be seven-day services.'

Physiotherapy stroke service

We held discussions with staff across Wales regarding the provision of physiotherapy services. It was highlighted that it was not always possible to provide the NICE recommendation for 45-minute daily treatment, which was subsequently highlighted in SSNAP data we reviewed. This was due to the high volume of stroke patients and insufficient capacity within physiotherapy teams.

Our clinical records review found inconsistencies in the provision of the 45-minute daily physiotherapy and occupational therapy across Wales. Our staff interviews found this was attributed to the challenge with recruiting staff and several sites we visited were carrying vacancies within their therapy establishments.

We considered the physiotherapy needs of patients during our clinical records review. In some records, we found evidence of patients being assessed in a timely manner and receiving regular physiotherapy as appropriate. However, in some records the physiotherapy notes were not filed within the clinical records and were kept elsewhere. This prevented us from making a judgement on the provision of the service provided to some patients. When considering other records, some demonstrated delays in referral for physiotherapy assessment, or no evidence of physiotherapy intervention despite referral. We also found examples of stroke patients placed as outliers on other wards with no physiotherapy assessments documented. This highlights the importance of stroke patients being placed on the appropriate stroke wards to prevent any issues with not receiving the required treatment.

We received some comments in our public survey relating to physiotherapy services, which support our records review findings, these included:

'The hospital was short of physiotherapists would have liked physiotherapy on a daily basis but this was not possible. The nurses on the ward were not even allowed to help with simple arm and leg exercises.'

'No physio available cos it was a weekend.'

'Treatment/physio was not frequent enough in hospital which had an effect on recovery as the first few weeks/months are critical. No physio sessions on weekends very frustrating.'

'I was prepared to attend physio gym every day but sadly, the facilities were unavailable on weekends, which makes for a very long day with no activity.'

Occupational therapy for stroke services

When considering the records for occupational therapy input, we found similar issues to that within physiotherapy. We found inconsistencies in the patient records, with some areas demonstrating positive evidence of timely treatment, whilst several records had no documentation completed at all.

Issues were also found at times following discharge, for example, when patients were repatriated to other health boards. Patients are sometimes repatriated from acute care, and the receiving health board has not been informed of the need for referral to other services, such as occupational therapy or physiotherapy.

Therefore, delays in the provision of care are inevitable. This is clearly not appropriate for patients who are reliant on additional timely therapies services.

The issue of insufficient provision of therapies for patients was also reflected by respondents to our patient survey when asked what the NHS could do to improve the service it provides for stroke patients. One comment included:

'More physio and speech and language help [is needed] and for a much longer period.'

Speech and Language Therapy (SALT)

As highlighted earlier, a swallow screen must be completed within four hours of admission to hospital for strike patients. If the assessment identifies that a patient has problems with swallowing safely, they should receive a specialist swallow assessment. This should be undertaken within 24 hours of admission, but no longer that 72 hours, as highlighted within NICE guidelines.

Our review of clinical records reflected that most patients had passed the initial swallow screen. Where patients required a referral to SALT, this had been done within the 72 hours. In addition, there was evidence to support that a plan of care had been prescribed to support the SALT assessment.

We also considered whether patients who were unable to take oral nutrition, fluids or medication received other means of nutrition, such as tube feeding with a nasogastric tube (a small tube inserted through the nostril to the stomach), within 24 hours of admission, unless contraindicated following thrombolysis, in line with NICE guidelines.

It was positive to find that for those who may be compromised nutritionally, relevant patients had been referred to Dietetics and Nutrition teams for a nutritional assessment and were prescribed individualised feeding regimes. In addition, oral medication was reviewed to amend either the formulation or the route of administration.

When reviewing SSNAP data we considered the therapy services across Wales and found variances in the provision of therapies within stroke services for patients. Inadequate therapy services have a negative impact on patient recovery from stroke and also impact on discharge planning and patient flow within stroke services. Therefore, health boards must ensure all therapy services for stroke patients are reviewed to consider how each is meeting the needs of patients in line with national guidelines.

Recommendation 36:

Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.

Psychology support in stroke services

Patients with stroke may suffer psychologically because of their stroke due to the significant impact it may have on their mental and physical well-being. This may include anger, frustration, depression, and anxiety. In addition, to maintain psychological wellbeing, patients should be able to speak in the language of their choice. It is important that health and social care providers maintain the Welsh language active offer for people in Wales, as highlighted earlier in the report. In addition, providers must maintain the ability to provide a translation service for people in other languages, such as Spanish, Polish, Urdu or Chinese. We found that access to a translation service was available in all health boards.

In line with NICE guidance (NG128), people who have had a stroke should have access to a clinical psychologist with expertise in stroke rehabilitation, and who is part of the core multidisciplinary stroke rehabilitation team.

Soon after a stroke, and where appropriate, patients should receive a psychological assessment to assess whether they are experiencing any early emotional problems which may have a lasting impact.

Their psychological needs may fluctuate along the stroke pathway as they recover from the acute stroke, and the reality of any disabilities may become overwhelming. The psychological support alongside physical rehabilitation, can increase a patient's opportunities to engage with rehabilitation and help maximise the outcomes.

We considered the psychological support provided to stroke survivors across Wales and found this to be inconsistent, as not all health boards provide support in this area. Our review of clinical records highlighted the lack of psychological support to patients within several health boards. This was also highlighted through our interviews with staff. We found that one health board within Wales had recently appointed three psychologists. One for each of its rehabilitation sites, along with three assistants. In addition, the staff discussed the positive work in progress, which offers education and training around the psychological needs of the patient, to all MDT members involved with the patients journey through the stroke

pathway.

We interviewed a GP who undertakes weekly ward rounds on a stroke rehabilitation ward in one health board area, which is attended by the MDT members to discuss the progress and needs of stroke patients. They supported the need for psychology input and suggested this service would be beneficial for patients. They highlighted that for stroke patients there may be a need to prescribe anti-depressants to help with their mental well-being, and that complemented by psychology support could improve the rehabilitation process for patients. In addition, having a family member with a stroke can be challenging for families or carers to deal with, and participation in the psychologically and support could also be beneficial for them.

Recommendation 37:

Health boards must consider the need for psychological support for people with stroke, and ensure that adequately trained staff are providing this support to help effectively manage patient recovery.

Overall, we found that therapy services play a key role in the patient's journey through the stroke pathway, and when preparing people for discharge. We found good collaborative working between therapy teams and others within the stroke MDT, however, as highlighted above, further investment may be required in some therapy teams for patient progress, recovery, and overall wellbeing.

In line with the inconsistencies found across Wales, not all stroke services can provide the required timely therapy services to patients. This was for several reasons, such as staff vacancies, the impact of patient flow resulting in different specialty outliers using stroke beds and vice versa and demand exceeding capacity. In addition, the overall environment to conduct therapies on the wards was problematic, relating to facilities and space for timely rehabilitation services.

A holistic approach to therapies is required across Wales, to provide patients with both physical and mental support. This approach would also benefit flow within our hospital system by enabling patients to be discharged timelier and over seven days a week.

Recommendation 38:

Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.

Recommendation 39:

Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.

The impact of delayed discharge on patient flow

Discharge delays for medically fit patients

As highlighted earlier, in June 2022, the Senedd Health and Social Care Committee published its *Hospital discharge and its impact on patient flow through hospitals inquiry* report[62]. The report highlights that in February 2022, there were 1,081 patients who remained in hospital who were medically fit for discharge.

During our fieldwork, staff told us that around a third of all patients in their health board area were medically fit for discharge. Some patients had remained in hospital for months until an appropriate placement or package of care was available to facilitate a safe discharge. Health boards regularly provide up-to-date numbers to Welsh Government of the medically fit people waiting in hospital beds, for a package of care, to enable them to go home, or a care home placement.

Impact of delayed discharge or Delayed Transfer of Care (DTOC) flow

To support our review in relation to patient discharge, our team included a peer reviewer from Care Inspectorate Wales (CIW), who supported our work through interviewing key staff relating to social care and those involved in the discharge planning process. This assisted our team to gain a sound understanding of the challenges related to the provision of social care.

Our report has already highlighted the challenges with the bottlenecks at the 'back door' of the healthcare system with delayed discharge, which impacts on patient flow throughout a hospital. This is felt at the 'front door' where EDs are unable to admit patients from ambulances in a timely manner.

The conclusion to the Senedd's Health and Social Care Committee's inquiry highlights the lack of social care capacity is the biggest contributor to delayed discharges and restricted patient flow through hospitals.

Unnecessary stays in hospital due to delayed discharge of care (or DTOC), can place patients at risk of hospital acquired infections and deconditioning, which can lead to further ongoing care needs following discharge. The bottleneck at the point of discharge can affect Eds, WAST, inpatient care, primary care, planned admissions and staff wellbeing.

To help support the more complex discharges, across Wales, we found teams of staff in post, who had the responsibility for the discharge of patients with complex needs and who, therefore, need detailed planning to implement ongoing support following discharge. This includes patients following a stroke. We will discuss the complexities throughout this section of the report.

Discharging stroke patients

Our review found that most stroke patients have a range of complex needs both

[62] Hospital discharge and its impact on patient flow through hospitals

physical and cognitive. This may include paralysis of limbs affecting mobility, issues with speech or swallow and cognitive impairment. Therefore, they are more likely to need ongoing packages of care at home, which are often complex to arrange. The resource is not always readily available, which may further delay a patient's discharge.

Our interviews with staff consistently found reports that discharge delays and DTOC can lead to worsening outcomes for patients and can also mean that some revert into an acute bed, and also impacts on their long-term care needs. Our staff survey also found similar, and one comment relating to this included:

'It is not good for patients' wellbeing for them to remain in hospital when they are ready to leave.'

Planning for discharge

We considered how the MDTs across Wales planned and prepared for patient discharges from hospital.

Board rounds

We attended stroke board rounds where discharge planning was central to the discussions that took place. They were led by a dedicated member of staff, and had an MDT approach, highlighting key information about each stroke patient, including diagnosis, admission date, care management plan and expected date of discharge. These meetings were consistent across Wales.

We found in most instances, a summary was made at the end of each patient discussion with the aim to highlight any daily tasks required, and the delegated person and task completion date to help ensure patient progress their journey through the stroke pathway to discharge. This also allowed for the opportunity to discuss any patients who were delayed in their discharge or DTOC.

Overall, we found board rounds were dynamic, constructive, and led to clear actions. However, some lacked effective leadership, direction, and decision-making, which in turn increased a risk to timely flow through the pathway, and out of hospital.

Recommendation 40:

Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.

SAFER patient flow guidance[63].

The *SAFER Patient Flow Guidance* was published by Welsh Government, and acts as a key enabler for an overarching good practice guide to improving patient flow.

[63] SAFER patient flow guidance

The guide identifies ten areas of focus to support flow across the unscheduled care patient pathway, and *SAFER* fits into one of these ten areas, relating to transfers of care.

SAFER consists of five elements of best practice which are summarised as:

- **S** – **Senior review** of all patients before midday, informed by a multidisciplinary assessment
- **A** – **All patients** and their families involved in the setting of an Expected Discharge Date (EDD)
- **F** – **Flow of patients** at the earliest opportunity from assessment units to inpatient wards
- **E** – **Early discharge** with at least a third of patients discharged from inpatient wards by midday on their day of discharge
- **R** – **Review** of patients involving MDT, the patients, and their families for those with extended lengths of stay.

We considered whether the sites we visited used any tools to help manage flow at a ward level. During our staff interviews, we were told that wards use the principles of *SAFER Patient Flow,* however, our findings from clinical records did not fully support this. We found inconsistencies in the recording of an EDD, or the rationale of why a date had not been considered, and there were also inconsistencies in the evidence recorded relating to the use of 'Red' and 'Green' days[64]. Our attendance at stroke board rounds also found that the use of the *SAFER principles* was not consistent across Wales.

It is evident that treating patients promptly with the appropriate care in the right place at the right time, can enable a person to be supported back to their own home in a timely manner. It is pivotal that all staff work together to manage the issues that may arise through a patient's journey, to be effective. Early planning for discharge is essential, and the individual, their family, and healthcare and social care professionals must work together, to achieve a smooth and timely discharge. This, in turn will help facilitate better patient flow through healthcare systems.

Recommendation 41:

Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.

Multidisciplinary meetings

We considered how well teams work together to support the discharge process for

[64] The Red and Green Days approach is an example of using simple rules to help reduce delays for patients by making 'non-value' adding days (from a patient perspective) visible, and a daily topic of conversation for clinical and managerial staff. It works particularly well when it is used across inpatient wards where patients often experience significant periods of time waiting for things to happen in their plan of care.

patients. During our fieldwork, we attended several MDT meetings to observe the discharge planning process within the relevant teams. We found the discharge teams help manage the support required for stroke patients, such as arranging and referring patients to appropriate post-discharge services. The teams also consult with services to manage their discharge home from hospital, including packages of social care or transfer of care to other services.

To plan for the discharge of stroke patients from hospital, we found an MDT approach for the continuity of patient care is taken by all health boards. A patient discharge plan is developed on an individualised basis, and includes all patients' needs for their continued rehabilitation and care at home, any community services required to support them, and any equipment or other aids they will need to maintain their care and safety following discharge.

We saw effective communication through all therapy disciplines to manage the flow of a patient through to discharge. In our staff survey, 81% said that there was an effective working relationship between all Allied Health Professions. We found good examples of early planning for discharge, and for ongoing care to facilitate rehabilitation and discharge from hospital. However, there were several prolonged delays in the allocation of social workers to patients, social care packages, and delays in obtaining nursing or residential home placements. This was consistent across Wales.

In line with NICE guidelines, we observed the core multidisciplinary stroke rehabilitation teams discussing individual patients to set and follow-up on goals. The rehabilitation teams consisted of:

- Consultant physicians
- Nurses
- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Rehabilitation assistants
- Pharmacy.

At some MDT meetings clinical psychologists and social workers were also in attendance, however, this varied across Wales. Through discussions with staff, we identified that prior to the COVID-19 pandemic, social workers were present at most MDT meetings to discuss and arrange the social care requirements for stroke patients who were close to the end of their rehabilitation phase and would soon be ready for discharge. Their involvement was described to us as a positive step in enabling a timely discharge. However, during our fieldwork, at most MDT meetings we attended, social workers were not present which added to the challenges of timely discharges.

Within our staff survey, all stroke services healthcare staff who responded, said

there are often delays in the discharge process, and 78% said the delays were frequent. We also received comments in our survey from local authority staff, which included:

'Poor communication between ward staff and social care staff appears to be one of the main reason for inadequate /ineffective discharge planning.

'Social Care is often inappropriately blamed as being the cause of delays when in actual fact the delays are frequently as a result of an internal issue on the ward.'

'One of the fundamental things that would see a marked improvement in discharge planning and make it a positive discharge for the patient would be evidence that a person centred/strengths based/outcome focused conversation has actually taken place with the patients themselves and health and social care staff are clear what matters to that individual. This would then help inform discharge planning and make sure we get it right.'

Communication with social care providers

When considering the perspective of staff who work within the social care system, their response to our survey highlighted issues with the communication with hospital teams. This included inaccurate or insufficient information being provided in the referral process. Only five of 17 respondents said they were given the right information about the patient to assist with discharge. Some comments included:

'Very little information provided, inaccurate most of the time.'

'Not always given correct information in terms of functional ability and rehabilitation / recovery plans.'

'We rarely get any information unless we go looking for it. We spend hours trying to contact the hospital wards and then are told different information depending on who you speak to. Its patchy and unreliable.

The staff nurses are unaware of their own discharge policy as the LA which health forms they need to complete. They ask the SW to take the lead in most meetings as they are just unsure of the process.'

'Agency nurses used to complete referrals are a massive setback as they do not know the patients well enough.'

The findings in our survey clearly highlight issues with communication between healthcare and social care teams. We also found that the view of local authority and social care staff were generally quite negative in relation to the health board's discharge policy. Just over half the respondents said that the health board had not shared their discharge policy with their teams. Ten of the 16 respondents said the health board policy was not easy to understand, and almost all said the policy wasn't followed in practice. In addition, very few said they had sight of the health board policy.

Social care providers also made comments regarding poor discharge documentation, along with the communication for patient discharge plans. These included:

'Hospital discharges are sent out without paperwork and guidelines.'

'Communication between the hospital staff and the home has been lacking at times and the information received from discharge has been wrong.'

'More effective communications between hospital and us on discharge as at times it's very difficult to get the information required until after they are home.'

In addition, nine of the 17 respondents to our local authority survey said it was not clear what was required from them, to meet the needs on discharge. The comments included:

'As information is often limited, we can only work with the information we are given. When information is missing, we do not see the full scope of needs on discharge. Following admission, we often see a higher level of need, and these are addressed when they are realised.'

These comments were supported by information received as part of our social services provider survey, with one staff member commenting:

'Better information and planning for discharge and more communication both verbal and written, from the ward.'

Our staff survey also found that health board staff reflected similar opinions, with around 50% agreeing that patients are discharged with a written and detailed discharge plan, but with insufficient information available to inform the social care teams to support the discharge process. Staff also suggested that the most common reasons for discharge delays, were challenges from family or carers and community support. Supporting the later comment, in our patient survey, only 55% said they had been included in the discharge planning process.

One respondent told us:

'There were obviously insufficient staff, my mother was left on her own feeling very confused with no one to ask about her treatment. As her next of kin, I was given no information about her post discharge care.'

The findings above, in addition to others throughout this report, highlight the need for collaborative work between health and social care services, to improve working relationships and develop a clear understanding across service teams, as to what each sector is doing to progress a discharge and improve outcomes for patients.

Recommendation 42:

Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.

Allocation of social workers

When patients are medically fit for discharge but have ongoing complex needs, they are referred by healthcare staff to Social Services for social worker allocation. Social workers are required for numerous patients, and their role in discharge is to assess individuals to determine the social needs, and to help achieve a safe discharge plan that is considered the best outcome for the patient. They take into consideration patient views and wishes, and often need to balance complex family dynamics.

When exploring the access to social workers, our interviews with healthcare staff highlighted frequent delays with patient social worker allocation and the required assessments. We were told that social worker vacancies across Wales are negatively impacting on timely allocation to patients. Supporting their reflections, nearly all local authority staff who responded to our survey said they were unable to meet the demands on their time at work, and there aren't enough staff to do their job properly.

To help mitigate against staffing issues, some social care teams use agency staff to bolster the service, particularly in areas where recruitment of social workers is a challenge. However, we were told that the use of social worker agency staff can result in some inconsistencies in the service provided. One local authority staff commented:

'Agency [social worker] staff have no understanding of geography or rurality.'

Through our interview process, some healthcare staff shared their frustrations around the delays in the discharge process. They explained that in some localities, the allocation of a social worker was taking up to three weeks. Once a social worker is allocated, further delays are common with their ability to attend the

hospital to undertake patient assessments.

In addition, once the assessments have been completed, and care plans developed there are challenges in obtaining the social care package in a timely manner. This prolonged process is causing unnecessary discharge delays for several patients and is consistent across most health boards.

Other examples provided to us during interviews noted that once referred to social worker teams, staff would not come to assess the patient until a full referral had been completed. The nursing staff often notify the ward or hospital based social worker that a patient will need some assistance on discharge. However, the nurses were often informed that until the referral is received by fax, they would not commence the process of allocating a social worker.

It is evident through our work, that nursing staff do not always have time to sit and complete a full referral when a patient is ready for assessment, since they have several other patients to care for during their shift, as well as arrange discharges and admissions from ED. Sometimes, the referral cannot be completed until the end of a 12-hour shift, and if this were a Friday, then it would be several days before the social worker team would receive the fax and commence the process

from their department. This would unnecessarily prolong the potential discharge of a patient.

In our staff survey, healthcare staff highlighted the challenges they face with the allocation of social workers and eight people made comments in relation to this. One included:

'Long waits for social services and packages of care and inadequate rehabilitation staffing means we can't optimise patients for their best recovery.'

We did, however, find a positive example of good engagement and cross team working with social work teams in one health board area. This was because of excellent relationships between health and social care workers. This enables timely allocation, and assessment of patients to be carried out in some localities, minimising delays with the discharge process for patients.

As highlighted earlier, delayed discharges for patients who are medically fit to leave hospital can impact on some patient's well-being. If they acquire an infection or become deconditioned whilst they are waiting to leave hospital, they may need new or additional treatment. If this does occur, we found that the process for social worker allocation and assessment is stopped if the patient is no longer medically fit for discharge. Consequently, once the patient recovers, the process of allocation and assessment must re-commence, delaying discharge further.

Recommendation 43:

Health Boards and social worker teams must work together to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.

Recommendation 44:

Welsh Government must consider the process in place for social worker teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.

Patient Best Interest Meetings

For patients with more complex needs, and who require a Best Interest Meeting[65] in line with the Mental Capacity Act[66], we considered whether there were delays in arranging these meetings. Consistently across Wales, we found delays in holding a timely meeting on several occasions. This was due to coordinating attendance for all required attendees, which could include MDT members, family members or

[65] Best Interest Meetings take place where a patient lacks mental capacity to make significant decisions for themselves and need others to make those decisions on their behalf.
[66] The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

carers and social work or care home managers. This was also highlighted in our staff interviews, and within our staff survey. One person commented:

'If a patient requires a Best Interest Meeting once clinically optimised, there are delays and difficulties in arranging the meetings to ensure all relevant stakeholders are in attendance.'

Recommendation 45:

Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.

Whole system approach to health and social care

We considered how healthcare and social care teams are working to achieve Welsh Government's long-term future vision of a 'whole system approach to health and social care', as published in its updated plan, *A Healthier Wales: Our plan for health and social care*[67]. The vision outlines a shift over time from the reliance on traditional hospital services providing care to people, to a seamless approach of integrated care, which includes health, local authority and third sector services.

Through our staff interviews across Wales, it is positive to find that several key areas of work are effective in progressing the process of safe patient discharges, which includes stroke patients. As part of this work, some healthcare, social care and third sector teams have been developing new partnerships and implementing new models of 'Home First' and 'Hospital to Home' services in Wales, which is highlighted in the *Home First: The Discharge to Recover then Assess Model (Wales)*[68].

The model highlights the care and support offered to patients, to leave hospital and to receive ongoing assessment and recovery at home, and to limit unnecessary time in hospital settings. Since 2018 the development of Home First and Hospital to Home services and its implementation has been supported by the NHS Wales Delivery Unit, now known as NHS Wales Executive[69].

We found that Home First teams are dedicated in promoting faster discharge from hospital and provide ongoing support to people and can arrange the required packages of care for people who are medically fit for discharge. Welsh Government's long-term objective is for health and social care providers to implement and scale services from a local and regional level to a national level.

Overall, it was positive to hear from staff where the Home First model is effective, and patient discharge can happen more quickly, which in turn assists with the flow of patients through hospital. Our review has identified the benefits of Home First

[67] A Healthier Wales: Our plan for health and social care
[68] Home First: The Discharge to Recover then Assess model (Wales)
[69] NHS Wales Executive

teams, which are making the required difference in line with the set ambition of *A Healthier Wales*. It is therefore important that health and social care teams develop this service to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

Recommendation 46:

Health boards must develop and strengthen Home First services across Wales to benefit the people who need this, and to help manage the issues with patient flow through health and social care systems.

Domiciliary care

During our interviews with discharge teams, across Wales we were told that domiciliary care-packages are difficult to obtain in most health board areas. The most significant issue highlighted, was the recruitment and retention of care workers to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. Therefore, increasing the size of the hospital's 'back door' bottleneck.

We found that social care providers have ongoing pressures heightened since the pandemic which includes, staff sickness, low morale, and exhaustion, which impacts on recruitment and retention. It also important to highlight that the complexity of some individuals who are very frail and need higher levels of social care support, often with two carers, has placed additional pressures on social care agencies in their ability to provide care to new patients leaving hospital.

We found that healthcare staff are fully aware of the demands for domiciliary care agencies and their ability to meet demand and are always in frequent contact with them. We were told that in some health board areas, some families are encouraged to seek private domiciliary care where local authority care provision is not yet available. However, this is not always affordable to some, therefore people remain in hospital unnecessarily, which is contributing to the issues with patient flow.

Within our staff survey, most social care staff said that there were challenges of people accessing services to enable appropriate discharge. The comments included:

'Lack of care providers to meet assessed care and support needs. Lack of carers.'

'Care sector is under huge pressures for staff capacity and poor discharges are a growing issue.'

'Lack of stroke rehab services locally both in patient and community.'

Recommendation 47:

Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.

Care home placements

Many patients who have sustained a stroke and others who need ongoing long-term care may need to move in to a nursing or residential home following their discharge from hospital.

Our staff interviews found that some health board staff are required to have difficult conversations with patients and their carers or families, around their care home choices. This can also include their finances and potentially paying for long term care placements. We also heard examples where due to the unavailability of domiciliary care services, patients have no choice but to move into a care home for interim periods.

We were told by healthcare staff that patients are often reluctant to enter care homes, as they want to go to their usual residence and often decline a bed when offered.

Many also decline admission to an interim bed placement for reablement, as they are worried of deteriorating and not being able to go home, or they may be faced with the need to pay high charges when their funded placement ends. In addition, for patients who require long term care home placement, many homes are long distances from their usual home and their family, and they often do not wish to move to these homes. We were told that having these conversations is challenging and can be quite upsetting at times, and most do not have experience or training for managing these difficult conversations.

We found that when people need admission to a care home in Wales, the funding process can be complex. In most cases, the person is financially means tested, and in many instances people in Wales are required to self-fund their bed if they haven more £50,000 in capital and assets. If capital and assets are less than this, then a person will likely be eligible for local authority funding. In addition, when some individuals are assessed as having long-term health needs, they may be eligible for NHS continuing healthcare funding. However, if a person does not qualify for this funding, sometimes they may be eligible for NHS funded nursing care, where the NHS will partially fund the placement, for the nursing element of the fees[70].

In our staff survey, people working within social care or local authorities shared comments with us around care home placements, with one comment including:

We have a long waiting list for both domiciliary care and residential and nursing

[70] Care Home Funding in Wales 2023.

placements.'

Reablement services

As part of its Deliver Home First[71] model, Welsh Government suggests that the process of discharge from hospital is a key factor for rehabilitation, and that the lack of support an individual receives leading up to discharge and post-discharge will impact the likelihood of them requiring care in the future.

Reablement services provided support to help people regain their independence after illness or disability, and it is usually provided for a relatively short time, such as weeks rather than months. This may include some stroke patients.

We found that the Continuing NHS Healthcare (CHC)[72] teams and complex care teams work well in their aim is to return people home quickly, however, we were told that where reablement care is needed, there have been waits for this service in some health board localities.

Variations in reablement services

There are variations to reablement services across Wales. Some health boards reported having Home First services available from all their sites.

We heard examples from staff, who said the availability of Home First for 10 days rehabilitation had a positive impact on discharging patients home promptly, and the health board approved funding to allow an extension of the daily working hours.

In other health board areas, we found waiting lists for patients to be discharged through the Hospital to Home schemes[73]; however, transition beds are available for up to six weeks, with funding agreed for up to three times a day.

We found that interim placements in care homes were available in some health boards, and patients were encouraged to utilise these when they were fit for discharge, until their home care was ready to start. These beds are funded by the health boards and at no cost to the patient but had a maximum stay of up to six weeks. Patients or their family/ carers were sometimes reluctant to utilise these beds, as they felt it would hinder their ability to return home, and if it they were not able to leave the home after the set period, they would need to pay for them after that time.

During our interviews, staff told us that the provision of interim or reablement beds in the community is often difficult to obtain. Whilst health boards can fund these beds for up to six weeks, they are associated with very high costs. During one interview, we were told that all care home beds were full within their health board and increased significant pressure on the wards to manage patient flow.

Overall, the provision of early supported discharge is inconsistent across Wales

[71] Delivering Home First. Hospital to Home Community of practice: key learning and practice examples
[72] Any adult who has complex needs and as a result might be eligible for Continuing NHS Healthcare. Continuing NHS Healthcare information booklet for individuals, families, and carers | GOV.WALES
[73] Delivering Home First - Hospital to Home Community of Practice: key learning and practice examples

with peaks and troughs being reported in these services.

Patient home equipment needs

When patients need equipment or small adjustments made at home to support their discharge, we were informed by staff across Wales that this service generally works well. This was a consistent finding across Wales. These teams, based in the community, aim to provide and install home equipment or make minor adjustments quickly to support patient discharges. Overall, we were told the waiting times for equipment assessments, delivery and/or installation was quite low. However, longer waits were reported for home adaptation which required more complex structural alterations.

Whilst health board staff were positive with this in our interviews, several comments within our staff survey of social care providers were not so positive. These included:

'Users are sent home without the necessary equipment in place and the responsibility and stress then falls on the provider to source this and ensure the safety of the users.'

'The industry is under a lot of pressure but when people are discharged unsafely without equipment, and they end up going back to hospital.'

'People are discharged without assessing the environment they are returning to. This means that in some instances people return to hospital as they are unable to live independently as they do not have access to the right equipment and services.'

It is concerning to hear the disparities in staff opinions regarding the availability of equipment. Particularly if healthcare staff suggest the service is working well, yet when social care staff attend people's homes, the required equipment is allegedly not in place. We did not visit people's homes as part of our review; therefore, we cannot establish whether the appropriate equipment was provided in line with assessment pre-discharge and whether the needs changed after a patient was home.

Positive aspects in preparing for discharge

Despite the challenges faced by health board staff across Wales for the safe and effective discharge of patients, our staff interviews highlighted several positive findings. These included the following:

- Occupational therapists and physiotherapists are available at all acute sites and as part of community reablement teams. This means that rehabilitation happens quickly and continues at home or in the community, where possible
- Where discharge coordinator posts exist in hospitals, complex discharges are managed effectively
- Partnership working at all levels is particularly good. Senior managers in both health and social care services are well informed of the issues and challenges with discharge and patient flow. Meetings occur daily and weekly

which focus on delayed discharges

- Where there is agreement for trusted assessors, assessments and care plans are carried out quickly but there is still a delay in obtaining the necessary service provision
- One health board reported operating an effective Discharge to Recover then Assess model with the aim to assess people in their own environments
- Specialist stroke rehabilitation units, with sufficient beds, and appropriate clinical support, allows people to be discharged from acute settings where appropriate
- Step-down beds are available throughout the county at the 10 Community Hospitals
- Integrated teams work well together with all professionals and the third sector playing a key part. The intermediate care teams in the community aim to keep people at home alleviating the pressure on admissions. The health board has invested in intermediate care to support people to remain at home, virtual wards, use of community hospitals for rehabilitation and GP's operate systems of case management
- There is a strong social work team in some parts of the health board, supported by students and agency staff are used where necessary
- Allocation and assessment of cases is therefore carried out speedily in those areas
- The health board has invested in Discharge Liaison Nurses who are part of the multi-disciplinary team.

Overall, we found that when patients were deemed medically fit for discharge, there were frequent lengthy delays in obtaining packages of care for patients across Wales as a whole, with minimal knowledge in some cases of when these packages could commence.

Where a patient was awaiting a placement in a nursing or residential home, we found dates were often set for transfer out, or plans were in place to cover the interim period elsewhere in reablement beds, before the placement was available, however, this was not consistent across Wales due to bed availability.

Discharge or repatriation to several localities

An additional challenge faced by several health boards is the need to discharge to several local authority areas, and the requirements in each can be different.

Whilst overall, relationships with different local authorities were described as good, we were told there are different referral routes, processes, and IT systems in place, which can make the processes difficult to navigate and more complex at times, delaying the discharge process unnecessarily. We were also informed some local authorities receive people to their homes from NHS Trusts in England, or from other health boards, where discharge processes may be different again from the usual discharging health board. This often makes discharge communication more

complex and challenging.

The day of discharge

To help facilitate daily discharges, we considered whether the hospitals we visited had a discharge lounge. A discharge lounge can help improve flow on a daily basis, as patients who are due to be discharged that day can be moved to the lounge to await transport home, or to await medication from pharmacy to take home. This can free up ward beds earlier in the day, which will help with flow across the hospital.

We found that most sites had a discharge lounge. Some lounges had flexible spaces which could be adapted according to demand and patient requirements, such as for a chair or bed. Access to the discharge lounge also varied across Wales, with some open from 8am to 6pm or 8pm, Monday to Friday with no weekend provision.

Our clinical record review found that some discharges took place late afternoon or in the evening. However, in some records reviewed, it was not clear what time of day the patient left the ward, or whether they went to a discharge lounge or other means. Therefore, it was not clear whether the wards had formally completed the timing of discharge process on the electronic patient system, therefore making them appear that they were still in the ward bed. This would make it difficult for patient flow managers to know when the bed is available (or not), which is important particularly when EDs are full, and beds are needed.

We recognise that use of the discharge lounge and accelerated discharge processes may not be clinically appropriate for all stroke patients, particularly those with complex needs, such as physical or cognitive impairments. Staff told us that some stroke wards use their day room for patients to wait for their discharge to help improve the flow through stroke services.

Recommendation 48:

Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.

Recommendation 49:

Health boards must identify the hospital sites that do not have a discharge lounge service and consider the positive benefits on patient flow of implementing this service.

Recommendation 50:

Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.

Conclusion

It is clear from our findings that the healthcare system across Wales is frequently operating under extreme pressure, with hospitals regularly operating at the highest level of escalation. Poor patient flow is a fundamental issue causing this pressure, and our review has brought to the surface the negative impact this can, and is, having on all patients, not just those on the stroke pathway.

Whilst we have reflected in our review an intention and ambition to tackle this problem, as well as examples of good practice that have made a positive impact in alleviating flow problems, more needs to be done. It is clear that no single solution exists to solve poor flow, rather a range of approaches are required in combination to release the pressures on the health and social care system.

These solutions range from doing more to help inform and educate the public about the choices they make when accessing healthcare services, spreading the positive learning that exists from flow management initiatives within acute hospital settings, and strengthening collaboration and processes around discharge from hospitals between the health and social care sector in particular.

This review used stroke to understand the impact and dynamic nature of flow, and overall, our view is that the stroke pathway is operating effectively to some extent. People receive timely assessment, imaging, and thrombolysis treatment where appropriate. However, access to thrombectomy and the ability to progress people through their recovery and rehabilitation phase, following their stroke, is inconsistent across Wales and needs attention.

Poor patient flow is undoubtedly having a detrimental impact on aspects of the stroke pathway. We have seen the lack of timely packages of domiciliary care, and the availability of community hospital beds or care home beds, resulting in patients remaining in hospital much longer than is necessary. This can lead to patients become deconditioned with a risk that they are no longer medically fit for discharge and require further treatment.

Blockages in the discharge process can cause challenges and pressures across hospital beds, and lead to overcrowded EDs, causing significant issues in the ability of WAST to respond to patients who need emergency care in the community in a timely manner.

It is clear there is an unprecedented pressure across the whole of the health and social care systems in Wales, which has been intensified by the Covid-19 pandemic, however, this pressure is continuing to prevail. Staff are working tirelessly to help manage the flow through hospitals and out to the community. However, despite their best efforts, for a variety of reasons outlined in this report, including demand and system weaknesses this is not leading to a significant improvement in the overall position. Tackling the issue of flow is a multi-faceted challenge that needs the health and social care system, along with Welsh Government, to come together and ensure all is being done to address the issues highlighted by our review.

What Next?

We expect the health boards, Welsh Government, WAST, PHW and Local Authorities to carefully consider the findings from this review and act upon the 48 recommendations set out within the report and listed within Appendix A.

We hope this review will be used to help health boards to improve flow, by encouraging health board teams to collaborate with each other in relation to good practice and innovative practice. In addition, that this work can be a catalyst for improved relationships between health and social care teams.

All relevant stakeholders highlighted within this report are required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

The findings highlighted in our report, and the responses that we receive, will support HIW in considering whether to undertake further, local or national work.

Appendix A

Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

	Recommendations
1	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.
2	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.
3	Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.
4	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.
5	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.
6	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).
7	Health boards should consider the benefits of dedicated ‘discharge phlebotomy slots’ for managing the necessary blood tests, to assist with effective and timelier discharge.
8	Health boards must consider the benefits of Improvement Cymru’s Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.
9	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

10	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.
11	Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.
12	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.
13	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.
14	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.
15	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.
16	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.
17	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.
18	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.
19	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.
20	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.

21	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.
22	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.
23	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.
24	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.
25	All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.
26	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.
27	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.
28	Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.
29	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.
30	Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.
31	Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.
32	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms
33	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.
34	Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards

	must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.
35	Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.
36	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.
37	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.
38	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.
39	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.
40	Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.
41	Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.
42	Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.
43	Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.
44	Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.
45	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.
46	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

47	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.
48	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.
49	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.
50	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.

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This document is also available in Welsh.

WG47778

Digital ISBN 978-1-83504-616-6

Action	GIRFT Reccomendation	Progress	Responsibility	RAG Rating	Current Metric (if applicable)	Further notes
1	Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.	Complete	**Stroke Directorate**		SSNAP Rating : A (90%+)	Data referenced: SSNAP Quarterly Report April - Jun '23
3	Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf.	Complete	**Stroke Directorate** **Radiology**		SSNAP Rating : A (90%+)	Data referenced: SSNAP Quarterly Report April - Jun '23
6	Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.	Complete	**Stroke Directorate**		17.00%	Data referenced: SSNAP Quarterly Report April - Jun '23
17	Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.	Complete	**Therapies**		96.40%	Data referenced: SSNAP Quarterly Report April - Jun '23
18	Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.	Complete	**Therapies** **Psychology**		97.00%	No weekly meeting planned, report on exception basis if rate is <95%
4	**ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.**	**In Progress (Need Sup**	**Stroke Directorate** **Patient Flow**		**SSNAP Rating : E**	
5	Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging should help to release bed capacity and increase access.	In Progress	**Stroke Directorate** **Patient Flow**		75.00%	Data referenced: SSNAP Quarterly Report April - Jun '23
7	Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.	In Progress	**Stroke Directorate**		5/5 Recruited to cover 12 Hour service (note next steps challenges)	Recruitment & retention challenges. All posts substantively appointed into (5) however four currently on/due to start Maternity leave. Currently exploring ability to backfill with alt. role e.g. PA/JCF
8	Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.	In Progress	**Emergency Department** **Therapies**		47.00%	Engagement with ED ongoing | Training to be provided early Oct 2023
11	Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.	In Progress	**Therapies** **CNRS**			Requires completion of rehabilitation reconfiguration then contact Naheed Ashraf
12	Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf	In Progress	**Stroke Directorate**			Action will be completed as part of the Rehabilitation Reconfiguration
13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.	In Progress	**Therapies** **CNRS**		33.60%	The latest guidance has moved away from the 45 minutes of Therapy and now suggests 3 hours of combined motor recovery rehabilitation per day.
14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.	In Progress	**Therapies**			The current Therapies commissioned staffing for stroke across all professions is 51% below minimum National Standards.
15	Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach .	In Progress	**Therapies** **CNRS** **Psychology**			Initial plans being worked up
16	ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.	In Progress	**Stroke Directorate**		Provisional 100% compliance (require data corroboration)	Update Sept. 2023: Requested datasource from Peggy Edwards Nursing metric and datasource requested
2	Commission an ESD pathway process flow map, it is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.	Not Started	**Therapies**			Requires completion of rehabilitation reconfiguration: Nov 2023
9	ABUHB to put a cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.	Not Started	**ABUHB Corporate**			Seeking clarification about which course to enrol on.
10	Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).	Not Started	**Therapies** **CNRS**			
19	Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.	Not Started	**Therapies**		Link to Metrics	Requires completion of rehabilitation reconfiguration & then more resource/funding. Therapies to take this forward
20	Standardise post discharge reviews using the GM-SAT six-month post stroke review tool .	Not Started	**Stroke Directorate**			Update Sept 2023: Start from November 2023 when B7 CNS in post Unable to start until CNS workforce is stabilised. Est. Dec 2023

Improvement plan

HIW - National Review of Patient Flow - a journey through the stroke pathway

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

Recommendation 1		
Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.		
Health Board Measures/Evidence	Responsible Officer	Timescale
There are extensive ongoing discussions between stroke services and programme managers / planners, both through formal governance arrangements such as the national network and through a range of informal channels and collaborations. **Actions** Engagement with the Stroke Network Appointment of Programme Manager	 Peter Carr / Rhys Monk Rhys Monk	 Ongoing 3 Months
Recommendation 2		
Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.		

Health Board Action(s)	Responsible Officer	Timescale
Action for Public Health Wales		

Recommendation 3
Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.

Health Board Action(s)	Responsible Officer	Timescale
To be addressed as part of the IMTP / annual plan development process		

Recommendation 4
Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.

Health Board Action(s)	Responsible Officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	**Flow & Ops Team**	

Recommendation 5

Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.		
Health Board Action(s)	Responsible Officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	**Flow & Ops Team**	
Recommendation 6		
Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).		
Health Board Action(s)	**Responsible officer**	**Timescale**
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	**Pharmacy**	
Recommendation 7		
Health boards should consider the benefits of dedicated ‘discharge phlebotomy slots’ for managing the necessary blood tests, to assist with effective and timelier discharge.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Pharmacy	
Recommendation 8		

Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team	
Recommendation 9		
Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team	
Recommendation 10		
Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team	

Recommendation 11		
Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.		
Health Board Action(s)	Responsible officer	Timescale
Action for Welsh Government		
Recommendation 12		
Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.		
Health Board Action(s)	Responsible officer	Timescale
To be addressed as part of the IMTP / annual plan development process		
Recommendation 13		
WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.		
Health Board Action(s)	Responsible officer	Timescale
Action for WAST		
Recommendation 14		

Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.		
Health Board Action(s)	Responsible officer	Timescale
Action for Welsh Government		
Recommendation 15		
WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.		
Health Board Action(s)	Responsible officer	Timescale
Action for WAST		
Recommendation 16		
Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	ED Team	
Recommendation 17		

WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Stroke, ED & Flow/Ops Team	
Recommendation 18		
Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas		
Recommendation 19		
Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.		
Health Board Action(s)	Responsible officer	Timescale

This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	ED Team	

Recommendation 20		
Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.		
Health Board Action(s)	Responsible officer	Timescale
ABUHB have updated the Stroke Thrombolysis/Thrombectomy pathway in Sept. 2023 and adjusted processes in relation to image transfer to facilitate 08:00 – 22:00 referral for Thrombectomy to Southmead Hospital.	Yaqoob Bhat	Ongoing

Recommendation 21		
Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.		
Health Board Action(s)	Responsible officer	Timescale
Recruitment working towards 24/7 CNS service as per GIRFT recommendation. Some challenges with significant amount of maternity leave but workforce should stabilise in Q3 2024/25	Rhys Monk & Lynsey Hook	12 Months

Recommendation 22
Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.

Health Board Action(s)	Responsible officer	Timescale
This is a core function of the clinical nurse specialist role referenced in 21 above	ED Team/Stroke directorate	12 months

Recommendation 23
Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.

Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	ED Team	

Recommendation 24
Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.

Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	ED Team	

Recommendation 25
All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.

Health Board Action(s)	Responsible officer	Timescale
Preparatory works complete (AI assurance/networking etc.) awaiting funding decision	Rhys Monk	3 Months

Recommendation 26		
Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.		
Health Board Action(s)	Responsible officer	Timescale
Regular review of SSNAP data to identify trends/exceptions in weekly SSNAP meetings	Rhys Monk	3 Months

Recommendation 27		
Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Workforce/Training/Practice educators?	

Recommendation 28		
Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.		
Health Board Action(s)	Responsible officer	Timescale
This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review	ED Team	
Recommendation 29		
Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.		
Health Board Action(s)	Responsible officer	Timescale
Refresh of Stroke/ED pathway and recruitment of additional CNS to move to a 24/7 front-end service model. Note Thrombolysis rate improvements over the past 12 months and increase in SSNAP rating to C	Yaqoob Bhat & Rhys Monk	Ongoing
Recommendation 30		
Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.		
Health Board Action(s)	Responsible officer	Timescale

Action for Welsh Government		

Recommendation 31		
Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.		
Health Board Action(s)	Responsible officer	Timescale
Currently under discussion within the service	Yaqoob Bhat (Clinical Director)	Ongoing

Recommendation 32		
WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.		
Health Board Action(s)	Responsible officer	Timescale
Action for WAST		

Recommendation 33		
Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.		
Health Board Action(s)	Responsible officer	Timescale

This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review	Flow/Ops team Stroke service	

Recommendation 34		
Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.		
Health Board Action(s)	Responsible officer	Timescale
This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review	Flow/Ops team	

Recommendation 35		
Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.		
Health Board Action(s)	Responsible officer	Timescale
This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review ESD rates in ABUHB are currently approx. 60% compliant, representing a significant Improvement since Oct 2022 when rates were 20%	Adele Griffiths	12 Months

Recommendation 36

Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.		
Health Board Action(s)	Responsible officer	Timescale
This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review, but represents a major challenge in the current financial climate	Therapies	
Recommendation 37		
Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.		
Health Board Action(s)	Responsible officer	Timescale
This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review, but represents a major challenge in the current financial climate	Therapies	
Recommendation 38		
Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.		
Health Board Action(s)	Responsible officer	Timescale

This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review. It is proposed to centralise stroke rehabilitation services, but represents a major challenge in the current in line with GIRFT recommendations, subject to operational deliverability and full public engagement	Medicine Division Therapies Directorate	12 months
Recommendation 39		
Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.		
Health Board Action(s)	Responsible officer	Timescale
Stroke reconfiguration to centralise resources (as above) Rehabilitation bays agreed to be protected from breaches in all cases	Therapies Flow & Ops Team	
Recommendation 40		
Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.		
Health Board Action(s)	Responsible officer	Timescale
This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review Review of Ward Round Processes to be taken forward	Rhys Monk	6 Months
Recommendation 41		

Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team	
Recommendation 42		
Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team Discharge Co-ordinators	
Recommendation 43		
Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.		
Health Board Action(s)	Responsible officer	Timescale

This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team Discharge Co-ordinators	

Recommendation 44
Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.

Health Board Action(s)	Responsible officer	Timescale
Action for Welsh Government		

Recommendation 45
Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.

Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team Discharge Co-ordinators	

Recommendation 46
Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team Discharge Co-ordinators	

Recommendation 47
Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.

Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team Discharge Co-ordinators	

Recommendation 48
Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.

Health Board Action(s)	Responsible officer	Timescale
Review of appropriateness of discharge lounge against SSNAP metric of % time spent in Stroke pathway: Currently under active discussion in the service	Rhys Monk	12 Months

Recommendation 49
Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.

Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Flow & Ops Team	

Recommendation 50		
Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.		
Health Board Action(s)	Responsible officer	Timescale
This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas	Stroke Nursing	

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): Peter Carr

Job role: Executive Director of Therapies & Health Science

Date: 12th October 2023

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on improvement work being undertaken to prevent Never Event incidents in Theatres
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk Assistant Director ABCi Marcus Silcocks – Theatres Directorate Lead Rachel Trask – Improvement Lead Anna March – Patient Safety Incidents Manager

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

Choose an item.

- Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

'Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.' (NHS Improvement, 2018)

The purpose of this paper is to update the Patient, Quality, Safety & Outcomes Committee on improvement work being undertaken to prevent Never Event incidents in Theatres across Aneurin Bevan University Health Board and to provide details of the Theatre Safety Programme led by the Clinical Teams working with ABCi.

Investigation into these incidents has identified lack of reliability in delivery of basic processes in theatres (for example completion of WHO Safety Checklists and swab counts following completion of surgical procedures). Other human factor issues have been identified including staff being unclear of responsibilities and key

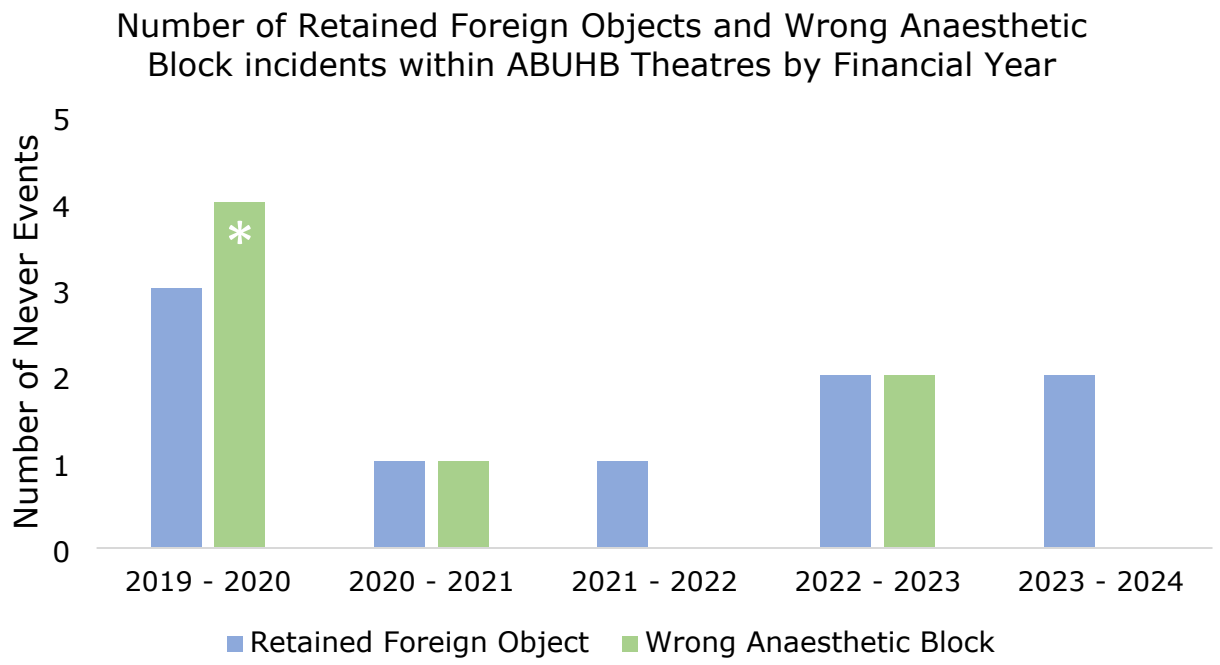
staff being distracted at decision points in procedures. Deviations or 'workarounds' from our expected processes have also been highlighted.

The Scheduled Care Division and Theatres Directorate have an ongoing Theatres Safety Programme which aims to implement the National Safety Standards for Invasive Procedures (NatSSIPS 2) - 5 steps to safer surgery (2023) and to embed Human Factors methodology and skills in theatre staff. They have engaged with ABCi and OD to teach these skills and a work programme to address emergent safety issues is being implemented to create a long-term learning environment which is focused on continual improvement.

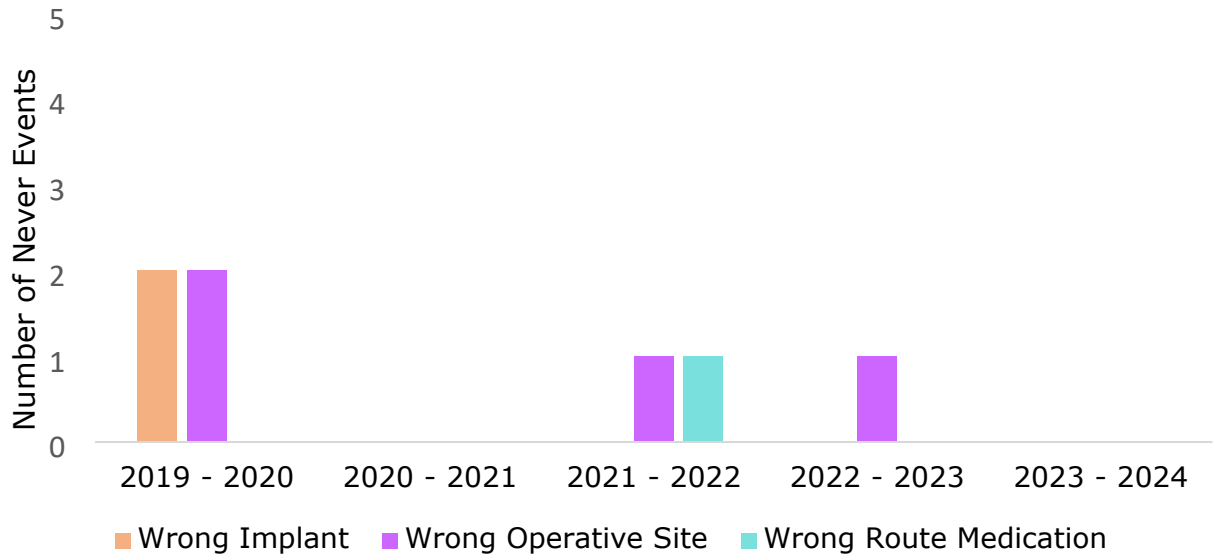
Cefndir / Background

As part of delivering the ABUHB Quality Strategy, key safety themes have been identified. Reducing Never Events in Theatres has been prioritised as a key area of improvement focus. Recent data illustrates that the most common type of Never Event which has occurred within ABUHB theatres over the past 5 years is 'Retained Foreign Objects' (these included retained swabs) and 'Wrong Site Surgery' (in particular, wrong sided Anaesthetic blocks).

Please note that the data below includes Never Events in General and Obstetric Theatres only. Wrong sided Anaesthetic blocks are undertaken in other clinical areas of the Health Board, (such as Radiology and the Emergency Department), where there have been 2 Wrong sided Anaesthetic block incidents recorded in each of 2021-2022 and 2023-2024.



*NB: 3 historical Wrong Anaesthetic blocks were identified during a look-back review and reported in 2019-2020.



A number of existing resources and programmes of work are already in place to ensure that the highest standards are maintained.
These include:

- A Theatre Safety Team and programme of work
- A team of Theatre Practice Educators to foster continuous learning and high standards of care
- A Human Factors training programme led by one of the Anaesthetics Team which commenced as a test of change, with the potential to identify and support the programme of improvement required, and expand as needed

In 2023, the existing Theatre Safety Programme was reviewed alongside the ABUHB Quality and Patient Safety work programme and its priorities expanded to include:

- Reducing Never Event incidents within Theatres
- Building Quality Improvement capability within Theatres
- Embedding Human Factors within the Theatres Safety Culture Programme
- Involvement in the Safe Care Collaborative – Acute Workstream
- Theatre Safety workstream within Theatre Maximisation Programme
- National Safety Standards for Invasive Procedures (NatSSIPS 2)

National Safety Standards for Invasive Procedures 2 (NatSSIPS 2)

Welsh Health Boards received a circular from Welsh Government in August 2023 advising that they will be expected to act on NatSSIPs 2 and ensure that the actions specified in the Patient Safety Notice (PSN034, September 2016) are applied accordingly.

NatSSIPS 2 places less emphasis on 'tick boxes' or rare 'Never Events' and now include cautions, priorities and a clear concept of proportionate checks based on risk. It recognises that 'teams' may change, or may be newly formed on the day of a procedure, and therefore require clear processes to be in place. NatSSIPs 2 will form the basis of improvement work, inspections and curricula, including clear guidance as part of the 'NatSSIPS 8' sequential steps which support work to reduce Never Events incidents within Theatres (as shown in the above diagram).

Key principles of NatSSIPS 2:

a) To help achieve triple goals of; *improved patient safety, better team-working and enhanced efficiency*
b) NatSIPPS2 categorises invasive procedures into 'major' or 'minor' procedures, each requiring checks which are proportionate to the risk of patient harm
c) NatSIPPS2 promotes 'Standardisation, Harmonisation, and Education'
d) To consider human factors with systems thinking, culture, psychological safety and team-work to underpin NatSSIPS 2 implementation
e) Includes three more steps to the existing 'WHO Five steps to safer surgery' to include 'Consent and Procedural verification', 'Safe use of implants' and 'Reconciliation of items' (to prevent retained foreign objects) in addition to the existing 'Team Brief, Sign In, Time Out, Sign Out and Handover/ Debrief' steps
f) That checks performed by an engaged team enable communication and save misunderstandings, reduce risk, provide clarity and set expectation
g) Considers the central role of the patient as a participant in safety checks
h) The need for a learning safety system supported by insight, involvement and improvement
i) A structure of 'People, Processes and Performance' within the organisational standards
j) The requirement for adequately resourced organisational leadership and support for safety

ABUHB is currently implementing NatSSIPS 2 within ABUHB, which consists of two interrelated sets of standards:

I. The organisational standards are clear expectations of what Trusts and external bodies should do to support teams to deliver safe invasive care

II. The sequential standards are the procedural steps that should be taken where appropriate by individuals and teams, for every patient undergoing an invasive procedure

The standards will cover *all* invasive procedures in *all* settings, including Outpatient areas and Primary Care, and introduces the concept of checks for both major and minor procedures. Within Theatres, there is a lead practitioner and the implementation is being embedded into the education and programme of improvement work.

Human Factors Safety Culture Programme

The established Human Factors Programme examines the complex system that our Health Board staff work within, considering environmental, organisational, team, and communication factors, including individual characteristics which may influence behaviour at work and impact upon patient safety outcomes. The programme uses systems methodology to establish a stronger safety culture, through embedding the principles of psychological safety and teamworking through simulation sessions based on identified risk issues in Theatres. These are further supported by Debriefing sessions with clinical teams, to learn, reflect and agree onward steps to reduce safety risks in practice and will support the new NatSSIPS 2 standards.

The Human Factors Programme has been running in Theatres since the opening of Grange University Hospital. This was initially commenced in CEPOD Theatres but has since extended to Trauma and Catheter Lab Theatres with a view to spreading across other Theatre areas and Theatre intake wards. Greater focus is being given to expanding this programme of work and more specifically, to apply Quality Improvement/QI methodology to support improvements in practice based on emergent learning from fortnightly simulation sessions.

Asesiad / Assessment

The ABUHB Theatre Directorate strives to maintain continuous learning and improvement so that they can ensure the safest operating theatres through development of exceptional safety awareness and healthy departmental cultures in an often high-pressured and fast-paced environment.

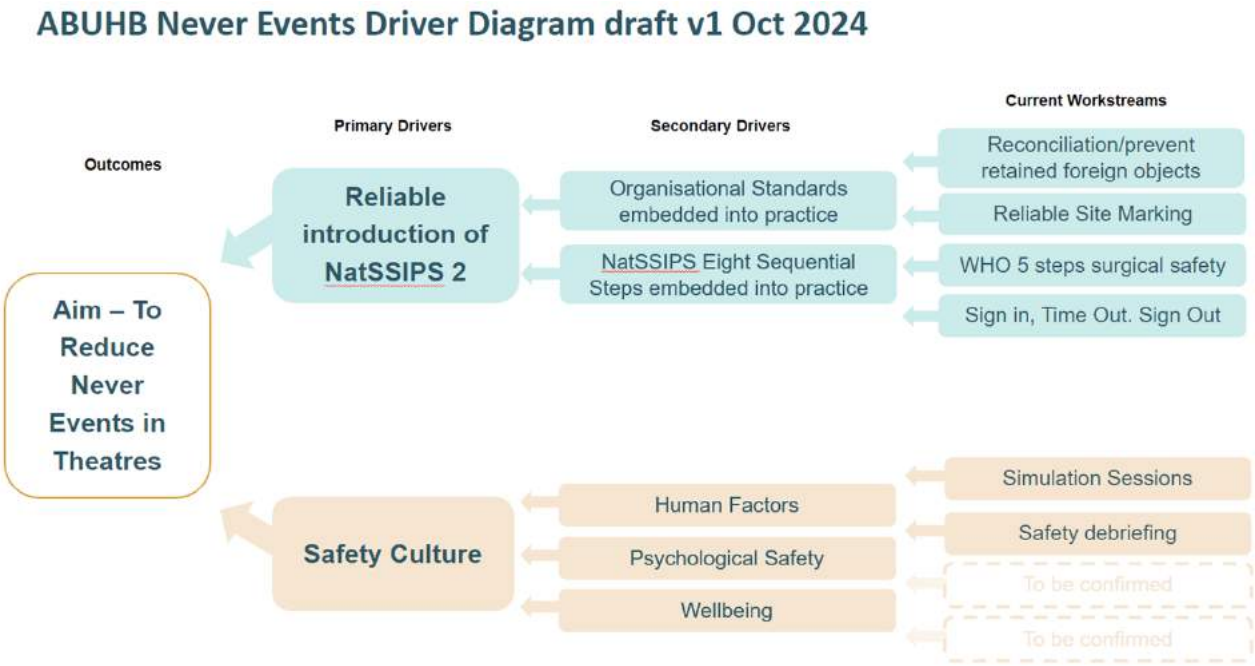
The Aneurin Bevan University Health Board Quality Strategy and work programme has set out a clear programme of work to improve safety in Theatres (as per driver diagram below). This includes the establishment of a dedicated Theatre Improvement Advisor who will support;

- Human Factors and improvement work
- Learning programmes supporting the teams
- Identification of key projects to focus and improve safety

Additional to the programme of work, building integrated quality improvement capability within every day practice forms part of the ABUHB Quality Strategy. As part of the ABCi team structure, a fixed term clinical secondment will ensure that the Improvement Advisor and associated clinical teams have the knowledge, skills, and time to undertake quality improvement in their practice.

In response to the Never Event incidents, the current programme of work has been reviewed and the Directorate are working in partnership to increase the capacity and focus on addressing these and establishing the learning programme.

Key themes and objectives have been agreed, which include a focus on resources, knowledge, and improving practice.



The work programme for the next 12 months builds on existing work and includes:

Resources

- The appointment of a Theatres Improvement Advisor post, jointly managed between ABCi and the Theatres Directorate, who will work with multidisciplinary teams across Theatres and wider (as appropriate) to deliver the programme of work. Interviews for this post are taking place at the end of November 2023
- Objectives of the Assistant Medical Director (AMD) for Quality Improvement include supporting and leading the improvement arm of the Theatre Safety Programme. The AMD is working with the clinical leadership in theatres to agree the priority order of work, embed Human Factors and establish clear improvements to process and practice, coach and teach as appropriate
- The Quality & Patient Safety (QPS) and Theatre Practice Education teams to lead on priorities as appropriate to improve learning and practice as part of the programme of work
- Consultant Clinical Leads within Theatres to provide leadership and expertise around the reduction of theatre Never Events

- Patient Safety Incidents Team to support ongoing Never Event investigation using a systems approach and methodology (fishbone diagrams) to ensure high quality reviews. They will continue to support data collection and thematic learning from Never Event incident investigations in Theatres
- ABCi team to support the development of QI coaches across ABUHB and to provide coaching support and training for the Theatres Improvement Advisor and teams as required. A Senior Theatre Practitioner is currently being coached as part of the Scottish Improvement Leaders Programme
- Human Factors Programme Lead to support work around safety culture

Knowledge and Improving Practice

- Embedding Human Factors in Theatres should embed a safety culture and approach to learning which will drive improved outcomes for patient safety and staff wellbeing within Theatres. This programme is being led by Dr Francis Subash in collaboration with Theatre Practice Educators. The next step is to incorporate QI principles into its structure, enabling changes to be tested and spread as part of a wider learning system. In order to provide additional support for the Human Factors in Theatres programme, it has been agreed that it will form one of seven teams taking part in the All-Wales Safe Care Collaborative
- The Improvement Advisor will coordinate, scale up and spread the Human Factors in Theatres programme, act as a Safety Coach for the Theatres work as part of the Safe Care Collaborative
- Increase in ABCi delivery and coaching to develop, and monitor the programme progress, this includes training in QI, Human Factors, safety coaching and Measurement for Improvement
- 'Back to Basics Tea Trolley Training', is being prepared during December, with a view to rolling this out in January 2024. Focusing on key topics, this will initially address 'areas pertaining to swab counts' and then targeting key issues identified within Theatres for future training, which will be supported by the Practice Educator and QPS nursing team
- Trials of 'Pause for the Gauze' are commencing within elective Obstetric Theatres from the end of November 2023

Argymhelliad / Recommendation

The Committee is asked to receive this report and to comment on the programme of work and steps being undertaken to update and enhance the programme of work.

It is recommended alongside the existing updates provided at Committee meetings through the normal performance reporting, that a formal progress report is prepared by the Directorate and the Division and is presented every 6 months to review the progress of implementation and the impact of the improvement work and dedicated resources.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.3 Quality Improvement, Research and Innovation Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the wellbeing and engagement of our staff 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	**No does not meet requirements**

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	PQSOC
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	ABUHB Birth Outcomes
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jayne Beasley

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

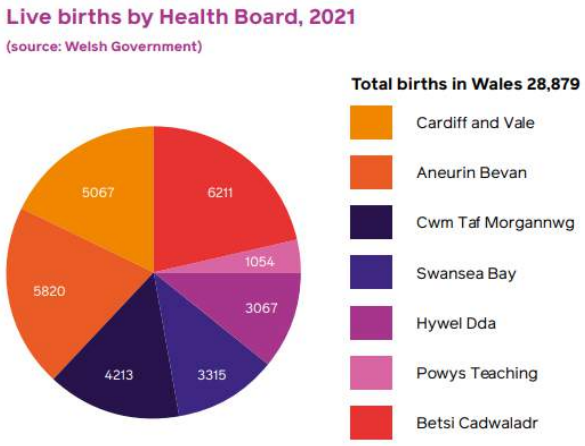
Sefyllfa / Situation

Litigation in NHS Wales sees the highest value of claims related to maternity care. Whilst in general claims should be sought within 3 years of the clinical incident, for children this is extended to 3 years past their 18th birthday and in some cases such as brain injury there may be no time limit. Poor birth outcomes and litigation claims have significant financial implications to the NHS but also represent devastating disability for the baby and child or indeed the mother, and as such will have a long term impact on families. This paper will serve to highlight any issues that may impact on service delivery and will provide assurance that: -

- Obstetric and maternity services have birth outcomes within the expected range.
- The Maternity service is meeting the relevant standards of care and ongoing work to ensure safe services is being delivered.

Cefndir / Background

Aneurin Bevan University Health Board has the second highest number of births across Wales.



In keeping with NICE guidance all four choices for birth are offered to include: home, freestanding birth unit, alongside midwife led unit and birth in an obstetric unit. Outcomes for women with healthy pregnancies who chose midwife led births have fewer interventions with no difference to outcome.

As such midwife led births offer an excellent option for a positive birth experience with good outcomes. Despite a Welsh Government directive and an aim that 45% of women are at low risk of complications and can birth in any setting, Midwife led births have reduced. Notably, ABUHB has the highest number of actual births in a midwife led setting across Wales.

Midwife Led Birth across Wales (2021/2022 data) by number and percentage						
ABUHB	Betsi	Singleton	C&V	CT	HD	Powys
1063	562	560	821	587	190	266
18%	10.8%	16.8%	15.1%	12.6%	6.3%	100%

The reduction in Midwife led birth's is likely to be multifaceted and linked to health disparities such as increased body mass index, diabetes, and more complex pregnancies in the general population.

Population

Aneurin Bevan University Board serves a diverse population with high levels of socio-economic deprivation across a wide geographical area. Maternal deprivation is linked to disparities in health and an increased risk of adverse maternal and perinatal outcomes. With increased deprivation comes increased maternal and perinatal death rates, increased morbidity with increased pre-existing medical conditions, increases in perinatal mental illness, pre term birth, growth restricted babies and subsequent increases in neonatal unit admissions.

29.5% of Aneurin Bevan births are from the most deprived areas compared to a UK average of 20%. In addition, ABUHB has the highest number of births before 34 weeks in comparison to Health Boards across Wales. Pre term births are linked to increased mortality and morbidity and worse health outcomes in childhood and into adulthood.

Preterm Birth per HB 2023					
ABUHB	Betsi	Singleton	UHW	CT	HD
126	110	108	109	49	13

The additional risks of deprivation and links to smoking, obesity and rising rates of diabetes places additional risk of adverse pregnancy outcomes and increased rates of caesarean section (2022- Caesarean Section 35.5%).

The service is actively working with public health in relation to smoking cessation and obesity rates. The smoking cessation pathway is well embedded into the service and the health weight in pregnancy pathway has received funding for care provision.

Public Health Data ABUHB 2022			
Smoking	Body Mass index > 35	Alcohol substance misuse	Mental Health- referral for PNMH
16.6%	14.4%	0.6%	4.5%

The ABUHB maternity service sees increased levels of complex pregnancies, public health concerns and increased risk factors for pre term birth with subsequent admissions to the neonatal unit. This poses a challenge for the service with potential increased adverse maternal and perinatal outcomes.

Therefore, it is essential that the service seeks to improve outcomes for women and babies, through participation in local and national audit, targeted intervention, policy development, support for healthy behaviours - mecc training (make every contact count, CTG and PROMPT training as well as robust governance, learning and monitoring.

Asesiad / Assessment

Governance

All booking and birth data, mode of delivery and outcomes is collated monthly from the current maternity data system, named the CSC maternity clinical solution. In addition, monthly data is collated via the DATIX system. This enables a visual month by month review of birth and outcome data. The service is moving to a digitised format for clinical records which will enable real time evaluation of care received, and accurate data recording.

PROMPT clinical outcome measures were added to the maternity local clinical dashboard from 2021, and an evaluation from July 2019 – July 2021 identified that ABUHB had: -

Births	**11,619**	**Average UK rates**
5-minute apgar <7 – Term birth	1.4%	1.3%
5-minute apgar < 7 – pre term birth	0.64%	-
Post-partum haemorrhage 1500	3.33%	3.3%
Post-partum haemorrhage 2500	0.73%	1.3%
Maternity admission to level 3 care	1.54%	2.24-2.57/1000

Midwifery and Obstetrics are committed to continuous improvement in the quality of care, reducing harm and adverse incidents, risk management and safe services.

As such the directorate and division has an extremely robust governance structure to ensure review, escalation and learning from all clinical incidents, this includes: -

- Maternity dashboard to monitor clinical performance and outcomes.
- High engagement and reporting of clinical incidents – Use of Trigger list, updated 3 yearly and monitored via dashboard.
- Weekly MDT risk meeting and monthly transfer meetings with MDT case review, assessment, learning and feedback.
- Allocated session for Consultant Anaesthetist, Obstetrician, Neonatologist, Senior Midwife, Governance lead Midwife,
  Clinical Supervisor for Midwives (CSfM) All staff welcome.
- Themes and learning shared widely, locally and via national forums.
- Monthly clinical governance meeting for feedback, learning and audit.
- Monitoring via Divisional QPS, DoC meetings, closing the loop, Directorate and Empowering Lead Midwife meeting.
- Monthly Head of Midwifery/CSfM meeting.
- Monthly Labour ward forum
- Quarterly Mat/Neo Board
- Escalation through PTR for NRI, investigations and Never Events.
- Early warning report to legal leam in cases of Hypoxic Ischemic Encephalopathy/potential litigation cases.
- Direct feedback to risk register and guideline group
- Monthly Clinical effectiveness group to update guidelines and practice evidence-based medicine and midwifery care. Review of current NICE guidelines and RCOG updates. Participation in national guideline groups. and adoption of All Wales Guidelines.
- Monitor action - Perinatal Mortality Review Tool.
- Monthly perinatal mortality morbidity meetings.
- Risk management forms part of maternity mandated training.
- Participation in National and local audit, UKOSS and MBRRACE.

Neonatal Outcomes

Adverse neonatal outcomes represent a significant causative factor in litigation claims to the NHS. High value claims specifically relate to long term disability and therefore more often relate to unexpected admission to Neonatal Intensive Care Unit due to hypoxic ischemic encephalopathy, shoulder dystocia and brachial plexus injury. With less high value claims for still birth and neonatal death.

Hypoxic Ischaemic Encephalopathy (HIE)

Term admissions to the neonatal unit may reflect poor adaptation to birth, respiratory distress, infection, hypoglycaemia and jaundice. These are not always reflective of poor long-term outcomes and ABUHB admission rates have remained within green rag rating for 2022 (N=240 = 4.4% < 4.5% goal)

Hypoxic Ischaemic Encephalopathy (HIE) is a serious birth complication affecting full term infants. It results from impaired blood flow and oxygen to the brain, and accounts for neonatal deaths and disability, therefore any increases in HIE cases may result in litigation claims to the NHS. Rates of HIE vary and are approximately 1/1000- 3.5/1000 births. With rates of up to 2.1/1000 across the UK. Within ABUHB

any full-term infant requiring ongoing resuscitation, with low cord gases and apgar scores undergo therapeutic cooling which has been shown to improve long term outcomes. HIE is usually recorded as HIE 1 – mild, HIE 2 moderate, HIE 3 severe. HIE 3 would be the most significant for life long disabilities.

ABUHB cases 2020-2023			
2020	**2021**	**2022**	**2023**
6	7	15	4
1.1/1000	1.3/1000	2.7/1000	1.04/1000

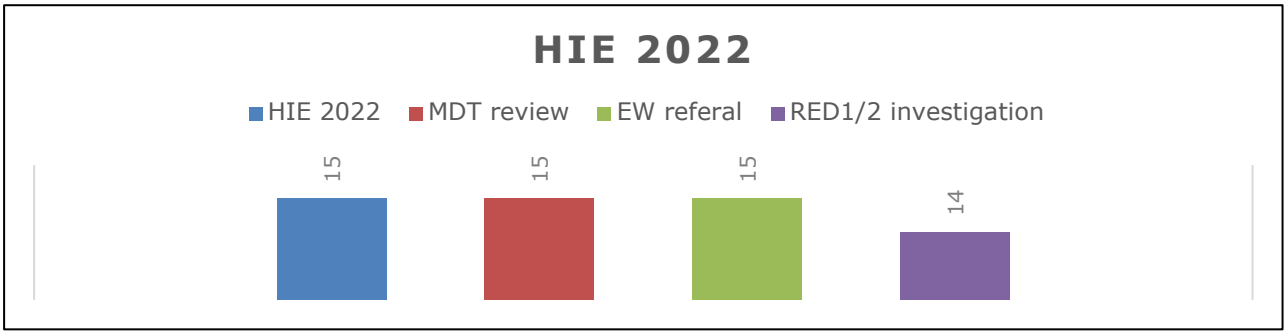
ABUHB HIE rate has been within the expected number of HIE cases, for years 2020, 2021 and 2023. All cases of HIE are scrutinised as part of MDT risk management review and or escalation to divisional led or executive led review.

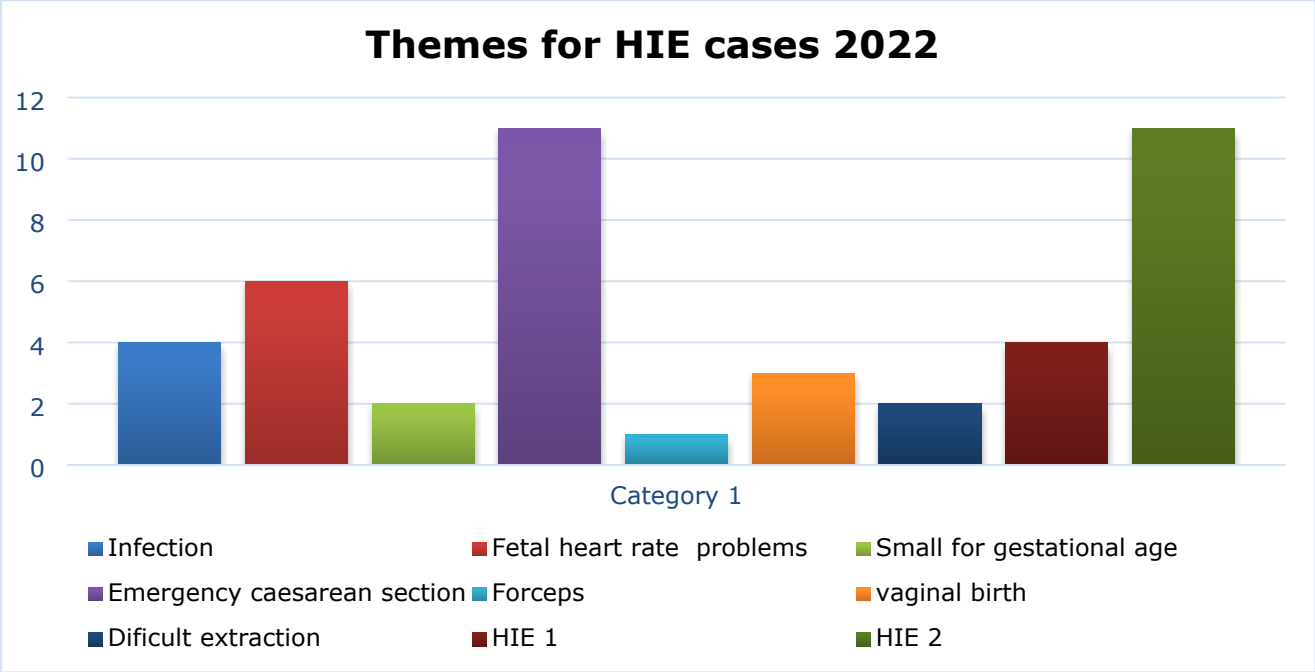
In 2022 there was a noted increase in cases. A total of 18 babies were treated with cooling for suspected HIE, 1 case was out born (born in another health board) and has been excluded from the numbers. In 2 cases cooling was ceased after a few hours as they did not meet the criteria. This gave an overall number of 15 or 2.7/1000 which demonstrates an increase.

A further 2 babies not included in the figures were cooled in 2022, both less than 37/40 weeks gestation:

- 1x abruption (placental separation) HIE 2 possible genetic – resulted in a neonatal death
- 1x presented full dilatation Spontaneous Vaginal Delivery (SVD) - HIE 2

All HIE cases from 2022 were subject to MDT review. Furthermore 14 cases had an additional formal investigation with 1 case (abruption no delay in identification and care) not subject to a formal investigation. No development delays noted on initial follow up.





Other cases presented as: -

- 1x abruption – birth within 19 mins of presentation – HIE 2
- Waterbirth cord entanglement HIE 1
- Presentation to Day assessment unit with reduced fetal movement – transfer to GUH Emergency Caesarean section (EMCS) HIE 2

Whilst the overall rate for 2022 saw an increase this has not sustained for 2023 whereupon the rates are more within expected levels.

Sepsis and CTG /Intermittent auscultation (IIA) of fetal heart rate and abnormalities were a contributory factor in just over half the cases. Infection is a major contributor in cerebral palsy and training in the identification and management of CTG are essential in the prevention of cases of HIE.

Action from HIE cases 2020-2023

- Datix reported
- Early Warning report to legal
- Investigation of cases via local risk meeting and or red1/red2
- Local and national learning (Morbidity review)
- Introduction of Intrapartum Fetal Surveillance (IFS) post
- Review of hours (IFS) midwife
- Embed IFS standards
- Review training compliance CTG and PROMPT
- Impaction of fetal head included in PROMPT syllabus
- Guideline update – Review SFGA, IIA and CTG, Induction on Labour pathway, Jump call policy
- Igel insertion training
- Individual learning
- Monitoring of numbers via dashboard- triangulated with NICU data

Brachial Plexus Injury & Shoulder Dystocia

Brachial plexus injury (BPI) can result in debilitating and long-term disability with weakness of the involved arm, thus a risk factor for litigation claims. Rates of 0.4-4/1000 births are generally reported. Usually BPI is associated with macrosomia (b-wght >4.5kgs in diabetic mothers or 5kg in non-diabetic mothers) and/or shoulder dystocia, though it can occur in its absence. All cases of shoulder dystocia irrespective of severity are reported via Datix, receive an MDT case review and are monitored via the monthly dashboard. Rates noted to be within expected levels:

	2020	2021	2022
Shoulder Dystocia	1.3%	0.8%	0.8%
BPI	1	0	0

Routine screening for macrosomia cannot correctly identify those who will have shoulder dystocia or BPI. Though those identified as Large for Dates will receive counselling re shoulder dystocia, the most important aspect of care will be in prevention of adverse outcomes through training, and inclusion as part of PROMPT MDT training.

Stillbirth and Neonatal Death

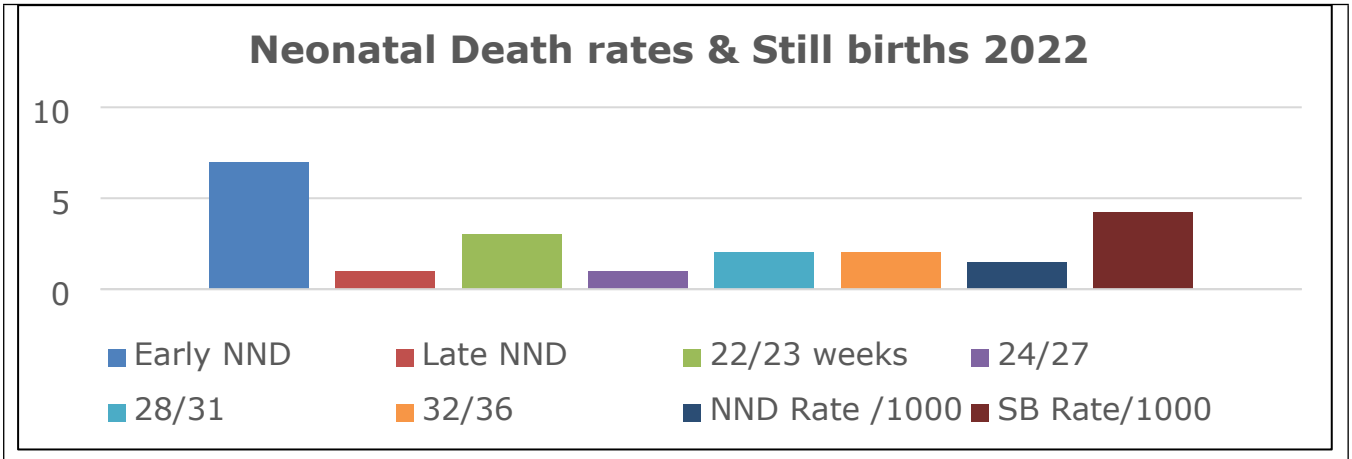
The majority of stillbirths (SB) are classified as no known cause however care issues can result in stillbirths and result in claims against the health board. Following publication of the MBRRACE report in 2023, (reporting 2021 data), it was noted that in 2020 the HB had lower rates of SB than similar Trusts or Health Boards, yet in 2021 the stillbirth data revealed higher deaths than similar Health Boards. A comparison for 2022 is yet to be made available, however initial crude data would suggest a lower rate of 4.1/1000.

	2020	2021	2022
Total all births	5337	5348	5359
Rate/1000	3.52/1000	4.17/1000	4.1/1000
Number	15	24	22
Redress	0	1	2

Neonatal Death (NND) rates have been consistently lower than similar health boards or trusts for the preceding 3 years.

- 2021 1.66/1000
- 2020 1.58/1000
- 2019 1.48/1000

In 2022 8 (1.49/1000) Neonatal Deaths were recorded – these were all pre term babies born before 36 weeks gestation.



Still birth and neonatal death are reviewed as part of: -

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

Growth restriction (SFGA) is a known risk factor for stillbirth. Identification and management of SFGA is an element of care to reduce stillbirths. In part this includes an initial risk assessment but in cases whereby a risk assessment does not highlight concerns the plotting of fetal growth is paramount.

Over the preceding 2 years 3 cases were noted where there had been inaccurate plotting of the fetal growth or insufficient action when it was felt that growth issues had been identified. Of these 3 cases 2 were accepted to redress though causation could not be confirmed.

To improve identification of poor fetal growth in the antenatal period additional training has been mandated re Gap and Grow from September 2023. A review of the sonography service has determined that increased scanning capacity of some 3000 scans per year is required to ensure identification of growth restricted babies.

This equates to an additional 2.2 WTE midwife sonographers.

2.2 WTE band 7 @ Tier point 2	**£129,404**
2.2 WTE band 7 @ Tier point 3	**£141,071**

2 midwives are undergoing sonography training in 2023/24 and a further 3 midwives are undertaking training 2024/25. This should ensure adequate scan provision for 2025. `

Maternal Outcomes

Whilst higher value claims relate more often to HIE cases, maternal adverse outcomes still occur resulting in long term harm and distress.

Obstetric Anal Sphincter Injury - OASI/ Continence Issues

Obstetric Anal Sphincter injury (OASI)– a third-, or fourth-degree tear complication in 3/100 vaginal births. This is approximately 6% in primigravida women and 2% in multiparous women. Whilst OASI is a known complication following vaginal birth, long term problems can and do occur. All cases of 3b and above OASI are reviewed via MDT risk meetings and rates are monitored and shared via the monthly dashboard. In 2022 the overall rate for OASI 3b and above was 0.5% of all vaginal births. The rates are relatively low, the HB was part of the OASI trial in 2018 and has followed its' care bundle since this date. This includes: -

1) Antenatal information
2) Manual perineal protection
3) Medio lateral episiotomy
4) Recognition and diagnosis of tears.

Via this care bundle the service has maintained low rates of OASI and assured good outcomes for women.

Training

Education and training within maternity and obstetrics is pivotal to improving maternal and neonatal outcomes. All new preceptor midwives have a 2-week induction at the outset of joining the health board. This incorporates mandated training, neonatal life support, gap and grow and IFS. Obstetric trainees receive an induction programme as part of their introduction to the Health Board.

PROMPT Wales is a maternity safety programme funded by Welsh Risk Pool and was introduced in 2018 as a means to reduce harm to mothers and babies through evidence based multi professional training and research. Since 2022 quality assurance visits have been undertaken to ensure high standards of PROMPT training is maintained. In June 2022 ABUHB received the following recommendations in relation to PROMPT training

- There should be plans for full onsite training to commence from September 2022.
- There should be scope to improve briefing and prepare scenarios, use of aide memoire to facilitate.
- Reinforce Human factors throughout course – use of presentations for same.
- Use of emergency boxes trolleys to be used.
- Mannequins should be fit for purpose
- A Midwife and an obstetrician should facilitate shoulder dystocia and breech scenarios

Except for full onsite training all actions have been achieved. Due to room capacity at GUH 2 training scenarios only could be accommodated within the clinical setting and there would be a requirement to retain 4 scenarios within the education centre. A plan to return to full clinical based scenario is underway for 2024.

2021/22 Compliance		
Consultant/SAS **Obstetric** Anaesthetists	18	**90%**
1st on call Obstetric Anaesthetic trainees	10	**67%**
2nd on call (second tier/SR tier) Obstetric Anaesthetic trainees	8	**45%**
Consultant Obstetricians	22	**96%**
Obs - 2nd on call (ST3 - 7, AS, speciality doctors/staff grade)	20	**100.00%**
Obs - 1st on call (FY2, ST1 ST2, Junior Clinical Fellow, GPVTS)	18	**100.00%**
Midwives - PW	103	**63%**
Midwives - CPW	80	**83%**
Total number for mandated staff	**279**	
Percentage of mandated staff attended (of total number provided for Standard One)		**75%**

2022/23 Compliance			
Consultant/SAS **Obstetric** Anaesthetists	38	17	44.7%
1st on call Obstetric Anaesthetic trainees	30	19	63.3%
2nd on call (second tier/SR tier) Obstetric Anaesthetic trainees	28	10	35.7%
Obstetricians - Consultants, AS, speciality doctors/staff grade	23	22	95.7%
Trainee Obstetricians - ST3 - 7	22	7	31.8%
FY2, ST1 ST2, Junior Clinical Fellow, GPVTS - in obstetrics	21	14	66.7%
Midwives who participated in hospital-based PW training	152	153	99.3%
Midwives who participated in Community PW training	101	93	92.0%
Total number	**415**	**335**	**81%**

This is a 6% increase on 2021 compliance data though to note the target is 95%.

In order to further increase compliance, the following actions will be undertaken: -

- A new Consultant obstetrician lead for PROMPT was appointed in 2023.
- Ensure calculation of staff to attend is accurate for example removal of staff not able to attend due to maternity leave etc
- Explore option for ESR addition
- Ensure sufficient course are run throughout year- all dates set for 2023/24
- Additional staff attended faculty Training 2023.
- Prioritise staff who have not attended in the preceding year.

CTG training

Misinterpretation of CTG is implicated in poor outcomes for babies. To ensure improvement in outcomes it is essential that all maternity staff receive education in CTG interpretation and Intelligent Auscultation of the Fetal Heart (IIA)

For ABUHB 2022/2023 data reporting 90% compliance with CTG training was achieved.

IFS standards were updated in 2023 to promote standardisation of fetal surveillance training across Wales. This includes a requirement for a full day of CTG training for all obstetric and midwives and a review of 6 cases.

To achieve the IFS standards ABUHB are incorporating the following into the training: -

- Human factors
- Intelligent Intermittent Auscultation (IIA)
- Meconium-stained liquor
- Chorioamnionitis
- Fetal physiology
- Case reviews.

It is anticipated that the programme will be developed and implemented by March 2024. The service has a Lead Midwife for IFS in post, hours will be increased to full time to support development of IFS training. The Lead Obstetrician for IFS is supporting the programme. Weekly CTG sessions are well established and well attended in GUH.

Staffing

To provide safe care it is essential that appropriate staffing levels are maintained across the Health Board. An additional Consultant Obstetrician with an interest in High-risk pregnancy to support SFGA pregnancies and Twin pregnancies has been appointed. Maternity services utilise Birth rate plus to calculate workforce as this is currently the only recognised staffing tool accepted by Welsh Government and The Royal College of Midwives. The total funded establishment is 268.96 WTE. The most recent Birth rate plus assessment identified that the service required: -

- **0.51 WTE** additional Midwife in line with BR+ standard assessment.

  Cost: £28,941 per annum recurrent. Currently the service has 94/6% split of midwives to band 3 maternity support workers. A 90/10 % split is suggested within Birth rate plus and this could be considered as a cost-effective alternative.
- However, a second calculation within BR Plus suggested an additional **7.36 WTE** midwifery staff to support additional workforce requirements
- Women birthing outside of guidance as a birth choice
- Increased time for antenatal care
- Increased midwifery student numbers and standards for student supervision and assessment.
- Increased complexity of care
- Increased training requirements.

Total cost for 7.87 WTE midwives = £426,014 per annum recurrent.

Whilst the funding has been considered at DMT and Executive committee this has not yet been agreed.

Recent recruitment has seen an increase in staffing and the current vacancy numbers are: -

Band 7 - 2.2 WTE
Band 5/6 - 2 WTE

Improved staffing has enabled midwives to move into community to support continuity of care which affords women and Midwives to build trusting relationships and has been demonstrated to improve maternal outcomes.

Work has been ongoing to improve outcomes for women and babies, to address inequalities this includes: -

- Research and development – i.e. OASI, Giant Panda, Chapter, Craft obs.
- Digitised records
- Healthy weight pathway for pregnant women, initial data suggests improved breastfeeding rates, reduced induction, rates of post-partum haemorrhage, still birth and low birth weight babies.
- Public Health Lead Midwife – developing contraception, improvements to vaccination and care of women who misuse substances.
- Service user engagement group BABI
- Volunteer project
- Healthier together website
- Perinatal Mental Health service
- After birth clinics.
- YOGA Aqua-natal, parent education working in collaboration with health visiting services.
- Created Diabetic Lead Midwife post
- Smoking cessation leads
- Early Years transformation programme
- Physiological birth
- Cultural competencies
- Positive birth experience
- Induction of labour preparation workshop.
- IPAD- video link to neonates

Argymhelliad / Recommendation

The Executive Team is asked to: -

- Receive this report and acknowledge the review of the current work and the steps being undertaken to enhance the quality and safety of the services delivered.

- Take assurance from the report

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 7. Staff and Resources 5.1 Timely Access
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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:	maternity-care-in-wales-a-five-year-vision-for-the-future-2019-2024.pdf (gov.wales) QPSOG MBRRRACE mat... OFWP Time Table.pdf All Wales Intrapartum Fetal Su Dashboard 2022.xlsx ABUHB PW Prog 2023-24 APPROVED.
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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

ABUHB PROMPT Wales programme 2023-2024

Time	Topic		Lead
08:30 – 08:45	Registration (candidates) Faculty Huddle Faculty introductions		All faculty
09:00 – 09:30	PROMPT Wales – What is PROMPT? Human factors presentation		All
09:30 – 10:15	DKA presentation & MEOWS		All
10:15 – 10:30	Ice Breaker		All
10:30 – 10:45	Break/move to scenarios		All
	Group 1	Group 2	Group 3
10:45 – 11:25	PPH B3/BC	Breech EC	DKA LW/HDU
11:30 – 12:10	DKA LW/HDU	PPH B3/BC	Breech EC
12:15 – 12:55	Breech EC	DKA LW/HDU	PPH B3/BC
13:00 – 13:30	Lunch		
13:35 -14:00	Chris Turner: 'When rudeness in teams turns deadly'		
14:00 – 14:40	Eclampsia B3/LW	Shoulder Dystocia Workstation EC	IFH LW/ TH2
14:45 – 15:15	IFH LW/TH2	Eclampsia B3/LW	Shoulder Dystocia Workstation EC
15:20 – 16:00	Shoulder Dystocia Workstation EC	IFH LW/TH2	Eclampsia B3/LW
16:05 – 16:20	Evaluations and debrief		
16:20 – 16:45	Faculty debrief huddle and pack away		

Rhwydwaith Mamolaeth a Newyddenedigol Cymru
Wales Maternity and Neonatal Network

All Wales Intrapartum Fetal Surveillance Standards

Authors:

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Version: 2.0

First Published: *September 2018*

Updated: *July 2023*

Review date: *July 2025*

Introduction

Effective fetal monitoring in labour and prompt intervention when needed is essential in reducing the number of stillbirths in Wales. There is also a need to reduce avoidable fetal harm such as hypoxic ischemic encephalopathy, as well as minimise unnecessary intervention. In order to achieve improved outcomes for babies and their families, there is a need for all staff involved in intrapartum care to undertake regular, high quality training.

In 2016, a recommendation from an all-Wales expert reference group was that the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCM/RCOG) online electronic package did not satisfy the training requirements for midwives and obstetricians within Wales.
In response, in 2018, the Wales Maternity Network together with an all-Wales expert reference group developed standards for electronic fetal monitoring (EFM) and intermittent auscultation (IA), within the context of intrapartum fetal surveillance.

The Standards have been mandated since 2018, yet there remains variation in practice throughout NHS Wales. These Standards have been updated by the Wales Maternity & Neonatal Guideline Group in order to support a standardised approach to practice and high quality training and have considered the views of colleagues across NHS Wales maternity services.

These Intrapartum Fetal Surveillance Standards represent a consensus which were updated and ratified during July 2023.

1	Intermittent Auscultation (IA) should be offered to all women who meet the criteria following an appropriate risk assessment, regardless of birth setting.[1]
2	CTG interpretation throughout NHS Wales should be based on robust understanding of physiology of mother and baby in labour and any of the standard interpretation guidelines for example NICE[2], FIGO[3], or Physiological could be adopted as per preference of the Health Board.
3	Training in IA, CTG (or ST analysis [STAN] where used) should be equitable for all midwives and obstetric clinicians practicing within NHS Wales.
4	All midwives and obstetric doctors should attend a full day of multidisciplinary fetal monitoring training annually[4]. The study day should incorporate: • Fetal physiology in labour • IA • CTG interpretation (and STAN where used) • Maternal co-morbidities • Existing and evolving maternal and fetal risk factors for example, prematurity, meconium, pyrexia, infection, duration of membrane rupture and fetal growth restriction • A standardised approach to documentation of the hourly holistic review and the 'fresh eyes' review • Use of the All Wales Clinical Pathway for Normal Labour when using IA • The impact of human factors including situational awareness, teamworking, communication and escalation All midwives who use IA should complete an additional e-learning training package on IA. An example of a package which may be considered is the eLearning for Healthcare (e-lfh) Intelligent Intermittent Auscultation in Labour.[5] The IA e-learning package can be undertaken in lieu of one local reflection/teaching session (as per standard 5). ***Please note**: These Standards do not recommend one IA counting technique over another.*
5	All midwives and doctors should participate in the review of 6 cases via local education sessions on fetal surveillance (including CTG and IA) annually. This should be made up of local Health Board multidisciplinary reflection/teaching sessions.[4] Where appropriate antenatal CTGs may be included. These sessions should follow a standardised format to ensure a quality learning experience with a focus on multi-professional reflection and discussion. Good practice would be that all obstetric units should aim to provide these sessions weekly. Reflective discussion in the clinical area is regarded as good practice and should be encouraged.
6	The midwife caring for a woman in labour using CTG should perform and document a full holistic risk assessment at least hourly with 'fresh eyes' performed ideally within 1 hour or a maximum of 2 hours (or sooner if any concerns). The assessment must include documentation on: Reason for CTG Maternal: Evolving risk factors, contractions, pulse, progress in labour Fetal: Evolving risk factors, gestation, liquor, baseline FHR, variability, accelerations, decelerations, and presence of cycling. The baseline should be appropriate for gestation and compared to a previous CTG to appreciate any rise in baseline (antenatal if available, or onset of labour) Decision: Classification of CTG and action taken Review: Date and time of review, signature, and status of both reviewers. It should specify if reviewers agree with provision of escalation or the seeking of a senior review in the case of disagreement or uncertainty Women receiving IA should have an hourly holistic assessment (or sooner if clinical situation evolves) as per the All Wales Clinical Pathway for Normal Labour, and this should be clearly documented.

Using a tool to record a CTG review

Training in obstetric emergencies within the PROMPT programme highlights that when a team who are responding to an emergency or unexpected situation use an algorithm or checklist, this improves collective decision making and enhances compliance with guidelines.

The use of a tool to document the findings of a CTG holistic review is a commonly used system across the healthcare sector. An interpretation and decision making tool which guides midwives and obstetricians through the analysis of observations and findings, supports decision making and meets the requirements of Standard 6 should be used.

References

1. Royal College of Midwives. *Evidence Based Guidelines for Midwifery–Led Care in Labour, Intermittent Auscultation*. 2012. evidence-based-guidelines-intermittent-auscultation.pdf (rcm.org.uk)

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MBRRACE-UK

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

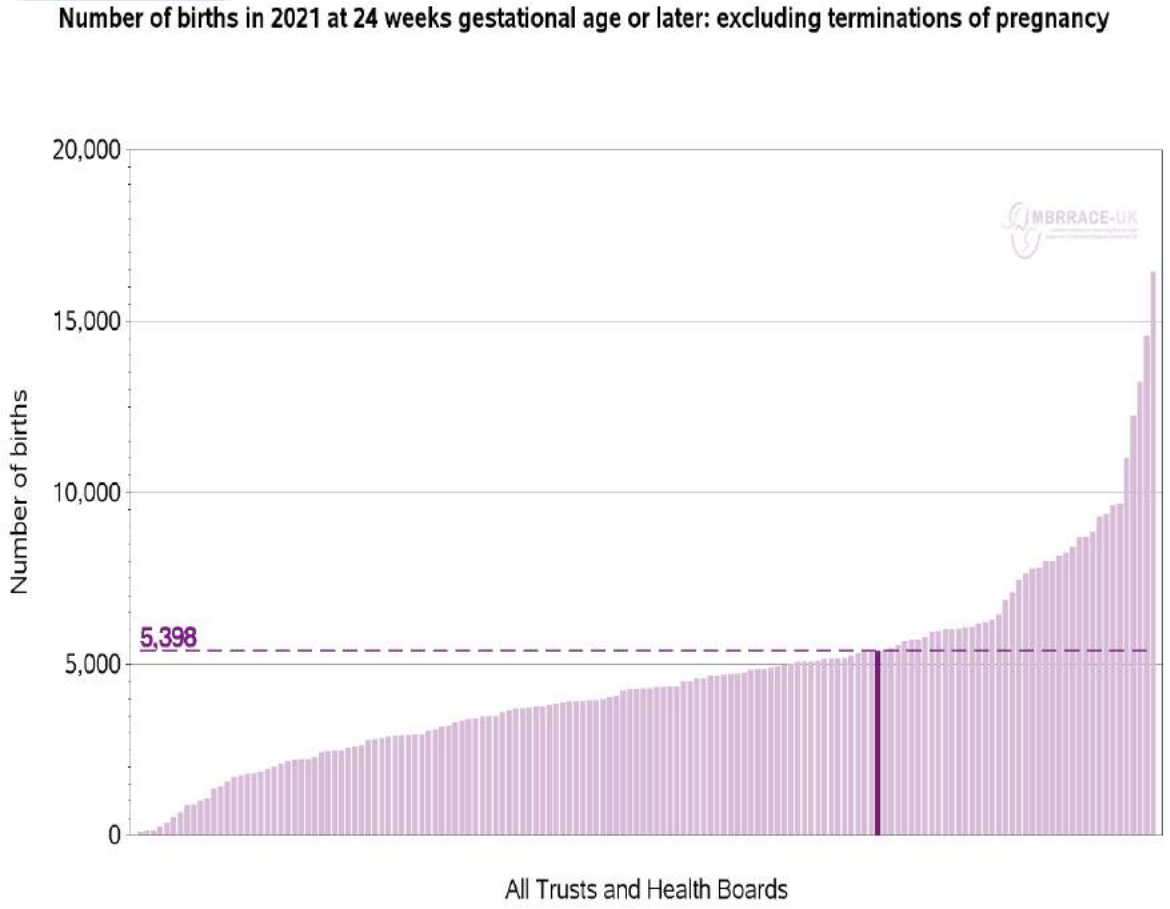
Aneurin Bevan Health Board

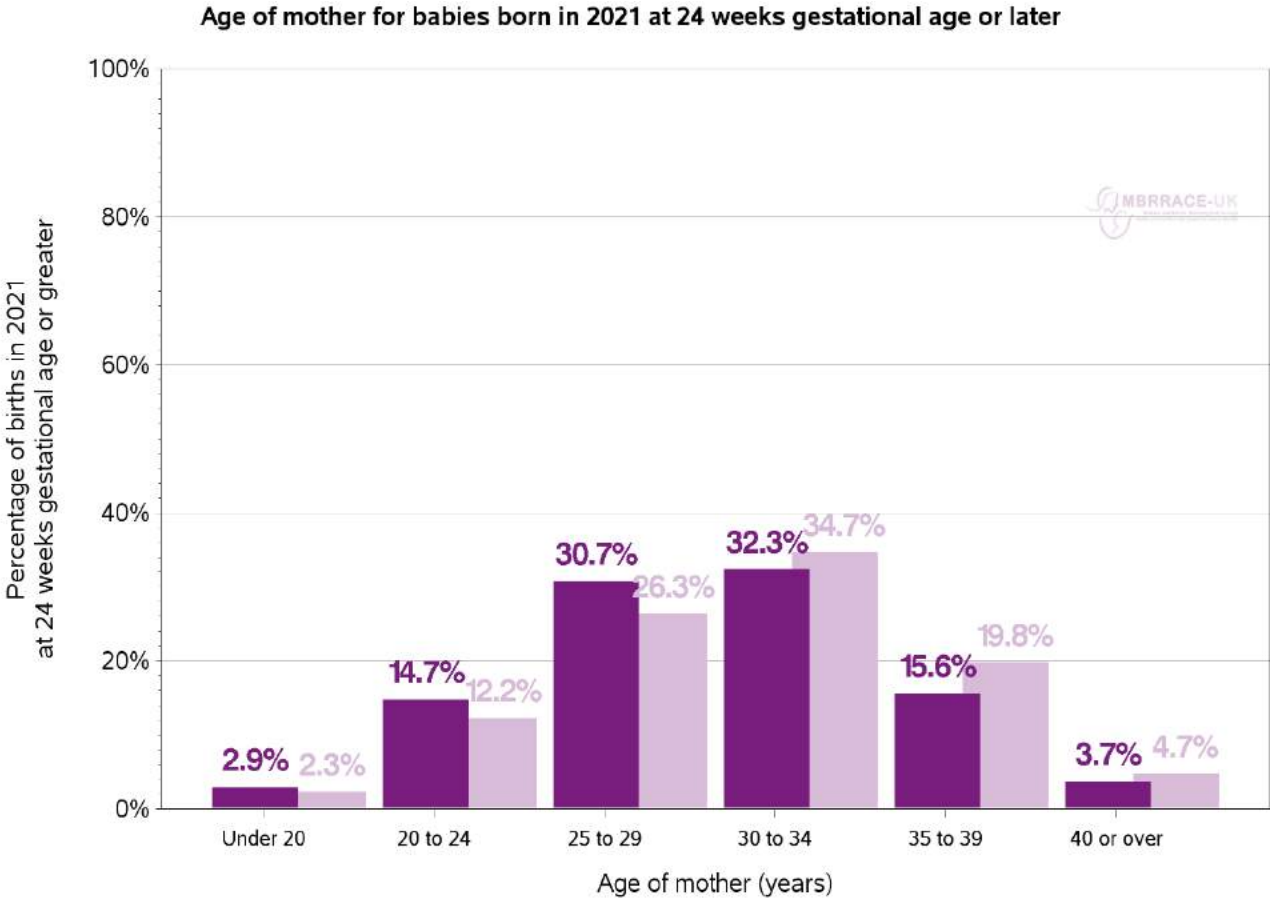
Perinatal mortality report: 2021 births

- ABUHB reports all still birth and neonatal deaths to MBRRACE-UK

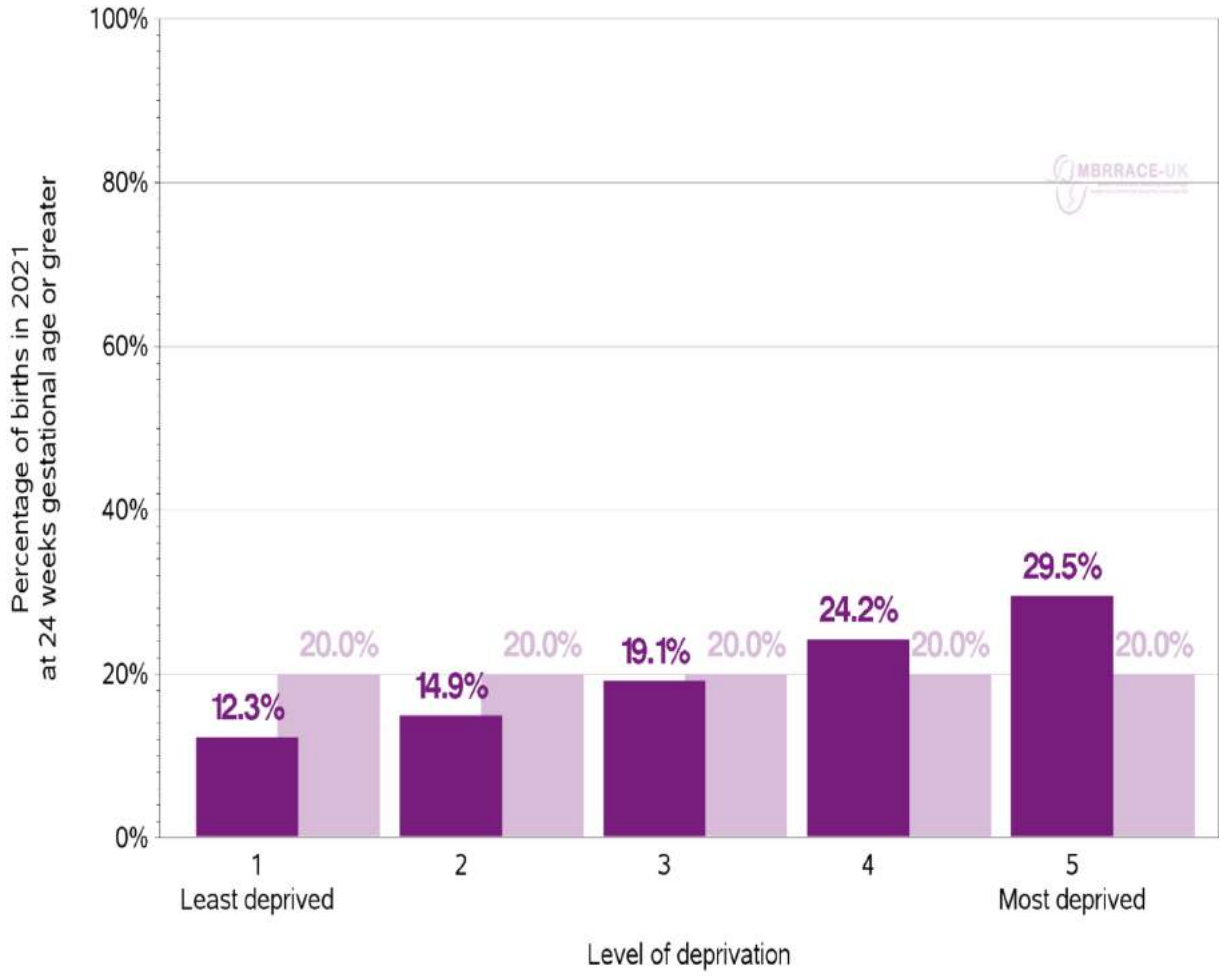
- **Stillbirths**: A baby born after 24 weeks gestation showing no signs of life.
- **Neonatal deaths**: A live born baby who died up to 28 completed days after birth.
- **Extended perinatal deaths**: Includes stillbirths and neonatal deaths.

ABUHB Perinatal Mortality 2021 Demographics

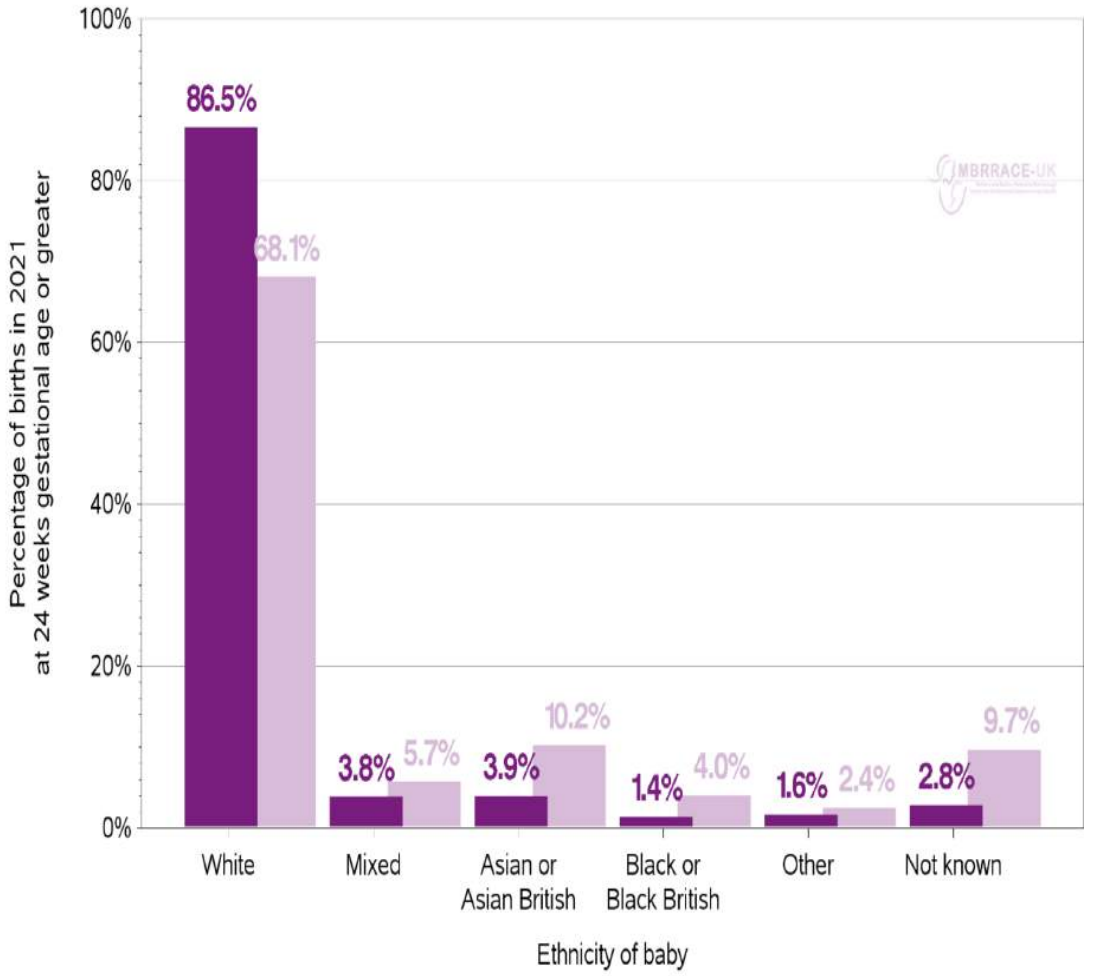




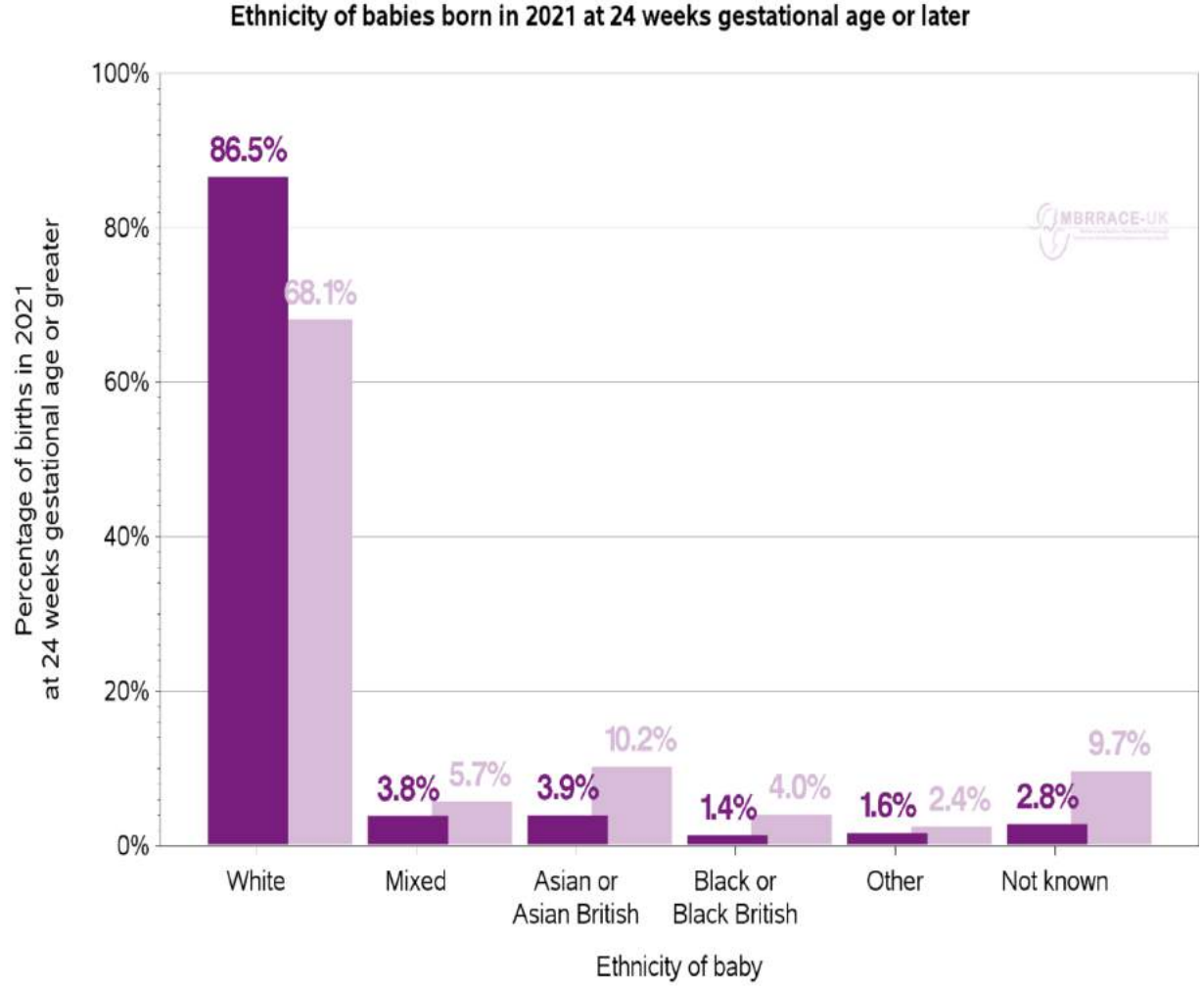
Distribution of births by level of deprivation, based on the postcode of the mothers' residence

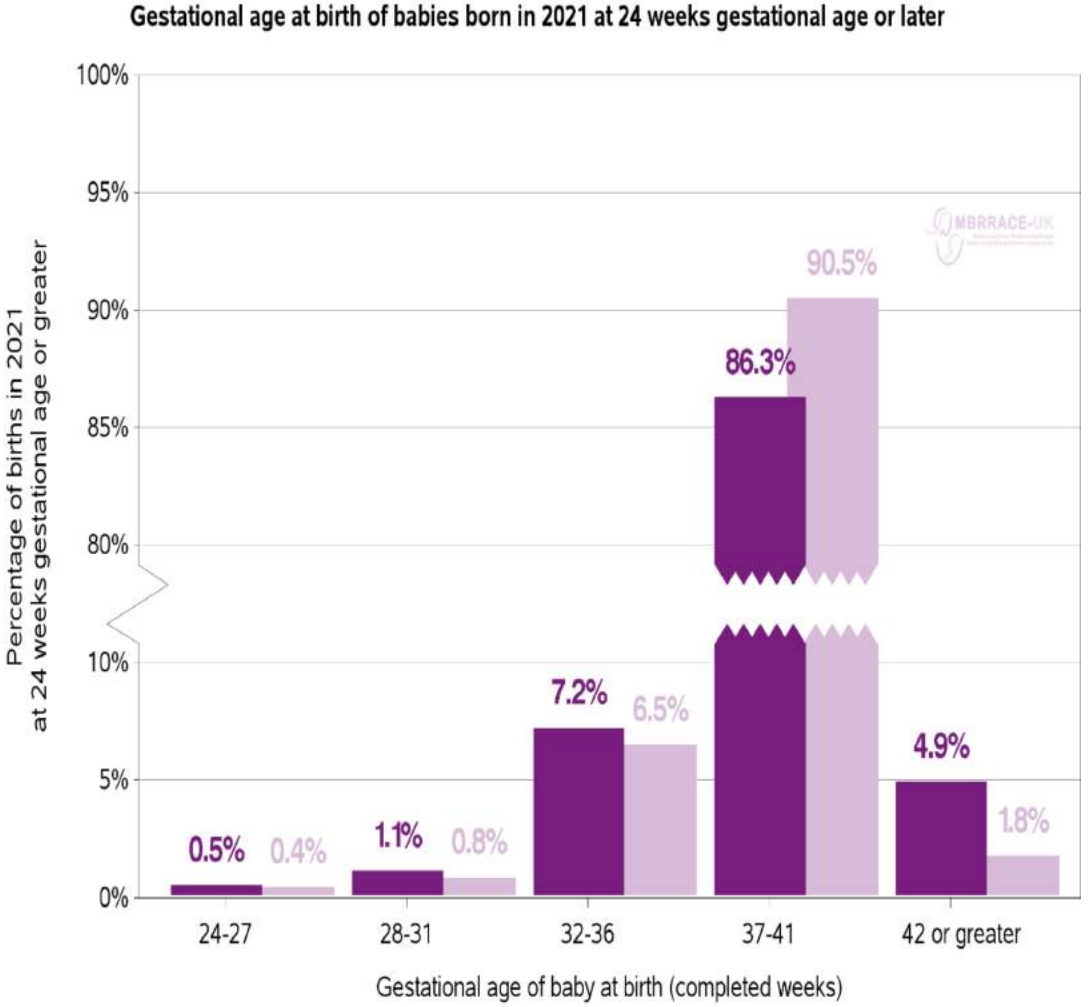


Ethnicity of babies born in 2021 at 24 weeks gestational age or later

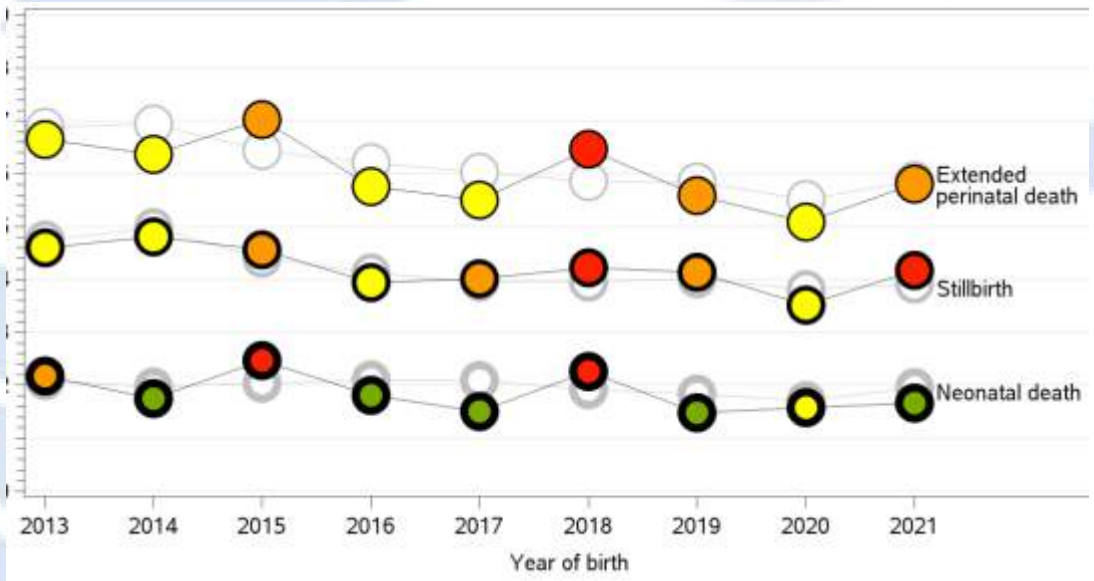


Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board


Ethnicity of babies born in 2021 at 24 weeks gestational age or later
Percentage of births in 2021 at 24 weeks gestational age or greater
100%
80%
60%
40%
20%
0%
86.5%
68.1%
3.8%
5.7%
3.9%
10.2%
1.4%
4.0%
1.6%
2.4%
2.8%
9.7%
White
Mixed
Asian or Asian British
Black or Black British
Other
Not known
Ethnicity of baby
MBRRACE-UK


Gestational age at birth of babies born in 2021 at 24 weeks gestational age or later
Percentage of births in 2021 at 24 weeks gestational age or greater
100%
95%
90%
85%
80%
10%
5%
0%
0.5%
0.4%
1.1%
0.8%
7.2%
6.5%
86.3%
90.5%
4.9%
1.8%
24-27
28-31
32-36
37-41
42 or greater
Gestational age of baby at birth (completed weeks)
MBRRACE-UK

Perinatal mortality 2013-2021



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

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

Stillbirth		Neonatal Mortality		Extended Mortality	
Stabilised and Adjusted Stillbirth rate	**4.17/1000**	**Stabilised and Adjusted Neonatal Mortality rate**	**1.66/1000**	**Stabilised and Adjusted Perinatal Mortality rate**	**5.81/1000**
Excluding anomalies	3.73/1000	Excluding anomalies	1.4/1000	Excluding anomalies	5.12/1000
5% higher than similar Trusts and Health Boards		15% lower than similar trusts and Health boards.		Similar to other trusts and health boards	

Themes Identified

Growth restriction factor (7 cases – 35%)	• **Aspirin to be administered to women with previous SFGA and stillbirth.** • **Third trimester scan to identify late growth restriction.** • **Review of SFGA guideline to consider symphysis fundal height measurement from 24/40 and serial growth scans from 24/40.**
Scanning not always detecting SFGA	• Audit to measure detection rates. • All SFGA DATIX • Develop role for Governance Lead for obstetrics and Gynaecology scanning.
Inaccuracies in plotting Symphysis Fundal Height on customised growth chart	• Mandated Gap and Grow online training. • Monitoring via Senior management team at monthly meetings. • Face to face gap and grow training.

Smoking	• **Public Health Midwife in post** • **Healthier together website Smoking in pregnancy :: Healthier Together (cymru.nhs.uk)** • **Referral to help me quit during AN** • **MECC training to commence** • **Reintroduction of Co2 monitoring** • **Increase public health messages via social media site.** • **Consideration for band 4 to support the PH agenda**
Prematurity greatest factor for neonatal death	• Midwife and Neonatal lead in place for PeriPrem.
Majority of cases no cause identified (62%)	• Increase PM Uptake • Bereavement lead midwife post. • Post-mortem consent training update. • Timely completion of Perinatal Mortality review tool, letters and follow up to families. • Audit of stillbirth cases for 2022
Timely referral to MBRRACE	• Bereavement lead midwife post reporting responsibility handed to maternity

Key Messages .....

- SB rate 4.17/1000 – 5% higher
- NN mortality 1.66/1000 15% lower
- ABUHB has associated risk for perinatal mortality
- 91.6% of stillbirths occurred during the antenatal period.
- Most deaths occurred during the third trimester.
- 0 deaths occurred after 42 weeks gestation.
- For most deaths the cause is unknown (62.5% stillbirth and 60% neonatal deaths)
- Post mortem is offered in 100% cases where there has been a stillbirth and in 50% cases when there has been a neonatal death.
- Good rates of compliance with data (98% key data received)
- Notification of deaths within 7 days to MBRRACE-UK is 22% for stillbirths and 10% for neonatal deaths. An improvement on 2020 (0%)
- SB rate 2022 4.1/1000

Monday 9th October

GUH Education Centre Room 8 (4th Floor)

0900 to 9.30	Registration with coffee	
9.30 to 10.00	Meet the Senior Management Team	Confirmed invite sent
10.00 to 10.30	Meet Lead Midwives from Community and Birth Centre	Confirmed invite sent
10.30 to 11.00	Meet Lead Midwives from Obstetric Led Care	Confirmed invite sent
11.00 to 11.15	Coffee	
11.15 to 12.30	Health Roster and Allocation	Confirmed invite sent
12.30 to 13.00	Lunch	
13.00 to 14.00	Birth Choices	Confirmed invite sent
14.00 to 15.30	X-Tag and Videos	Hannah
15.30 to 16.30	Previous Preceptors	Email Sent

Tuesday 10th October

Mamhilad Brecon House Small Meeting Rooms 1 and 2

	Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
09:30 to 10:30	CWS Training	OFWP Folders		BD Package	
10:30 to 11:30	OFWP Folders	CWS Training	OFWP Folders	BD Package	BD Package
11:30 to 12:30	BD Package	BD Package	CWS Training	OFWP Folders	BD Package
12:30 to 13:00	Lunch	Lunch	Lunch	Lunch	Lunch
13:00 to 14:00	BD Package	BD Package	BD Package	CWS	OFWP Folders
14:00 to 15:00			BD Package		CWS

Wednesday 11th October

Working at Home

IIA Training Package	Via EFHL Website
Gap and Grow Training	Via EFHL Website
ANTT	Via ESR

Thursday 12th October

GUH Education Centre Room 8 (4th Floor)

08:30 to 09:30	Communication	Emma Mills
	Equality and Diversity	
09:30 to 10:30	Medicines Management	Wendy Scrim
10:30 to 10:45	**Coffee**	
10:45 to 11:45	Supervision	Wendy Scrim
11:45 to 12:15	Clinical Governance and Risk	Pauline Summers
12:15 to 13:00	Perinatal Mental Health	Cris Grand
13:00 to 13:30	**Lunch**	
13:30 to 14:30	Safeguarding	Jo Plaster
13:45 to 14:15	Infection Control	Anna Jackson
14:15 to 15:15	Putting Things Right	Adele Baker
15:15 to 16:00	Diabetes Mangement	Adele Baker

Friday 13th October

GUH Education Centre

08:45 to 09:00	Registration		
	Group 1	Group 2	Group 3
09:00 to 10:30	Manual Handling	BLS	NLS
10:30 to 10:45	Coffee		
10:45 to 12:15	BLS	NLS	Manual Handling
12:15 to 12:45	Lunch		
12:45 to 14:15	NLS	Manual Handling	BLS
14:15 to 15:45	i-Gel insertion	i-Gel insertion	i-Gel insertion

Monday 16th October

GUH Education Centre

08:30 to 09:00	Antenatal Screening	Julie Crane
09:00 to 09:30	Students Supervision and Assessment	Lesley Ann Bushell
09:30 to 10:30	Bereavement	Louise Howells
10:30 to 10:45	**Coffee**	
10:45 to 11:30	Mat/Neo Project	Bec Clements/Louise Howells
11:30 to 12:30	Physiological Birth	Emma Mills/Lauren Kearney
12:30 to 13:00	**Lunch**	
13:00 to 14:00	Infant Feeding	Bethan Thorn
14:15 to 14:45	Gap and Grow	Cath Barwise/Sophie Wong
14:45 to 15:45	MECC Training/Public health	Claire Haymond
15:45 to 16:30	Badgernet Update	Ellie / Cath /Lauren

Tuesday 17th October

GUH Education Centre

08:30 to 09:00	Registration		
	Group 1	**Group 2**	**Group 3**
09:00 to 11:00	Cannulation	Supervision	Suturing
11:00 to 11:15	**Coffee**	**Coffee**	**Coffee**
11:15 to 13:15	Supervision	Suturing	Cannulation
13:15 to 14:15	**Lunch**	**Lunch**	**Lunch**
14:15 to 16:15	Suturing	Cannulation	Supervision

Wednesday 18th October

GUH Education Centre

08:30 to 09:30	Registration	
09:30 to 11:00	Fetal Surveillance	
11:00 to 11:15	**Coffee**	
11:15 to 13:00		
13:00 to 13:30	**Lunch**	
13:30 to 16:30		

Thursday 19th October

GUH Education Centre

08:30 to 09:00	Registration	
09:30 to 10:00	Continence	Emily Bird (confirmed)
10:00 to 10:30	Epidurals	Chris Whitfield (confirmed)
10:30 to 11:00	Care of the Critical Woman	Chris Whitfield (confirmed)
11:00 to 11:15	Coffee	
11:15 to 12:00	Theatre Care	Louise Heiriene (confirmed)
12:00 to 12:30	Still Birth	Louise Howells (confirmed)
12:30 to 13:00	Lunch	
13:00 to 14:30	Blood Gas Training	Tony Barker (confirmed)
14:30 to 15:30	Blood Transfusion	Susan Puttock (confirmed)
15:30 to 16:30	New Early Years	Stacey Price (confirmed)

Aneurin Bevan University Health Board

Maternity Dashboard : 2023

Clinical Performance and Governance Score Card

ABUHB 2023			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC		2022 Totals	2021 Total	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	414	404	449	409	386	452	430	444	444	460	510			5359	5348	5337	5718	500	>525-550	10161
	Home Births		10	9	13	15	12	13	7	16	10	14	20			140	193	155	123			
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	630	411	477	520	431	494	446	441	430	487	538			6243	6538	6477	6069	6600	≥630	Tolerance 15%
		Midwifery	249	173	165	177	150	166	154	162	137	178	165			2166	2380	2446	2327			
		Joint care	381	238	312	333	281	328	292	279	293	309	373			4077	4158	4031	3723			
		Transfer rate (average)																		12%	12-17%	
	Ventouse & Forceps	% Inst Vag D/Birth	10.00%	8.00%	9.30%	7.00%	7.70%	5.50%	6.00%	7.40%	6.98%	9.78%	9.21%			7.91%	8.00%	9.30%	9.02%	10-15%	<5%or >20%	
		No Ins Vag D/Birth	42	33	42	29	30	25	26	33	31	45	47			425	432	500	492			
INDUCTION OF LABOUR		%UK data	26.00%	27.00%	22.00%	23.00%	26.00%	28.00%	24.00%	27.00%	24.00%	25.00%	24.00%			24.2%	22.3%	23.3%	26.2%	20-22%	26%	Average % Total
		No. UK Data	108	113	101	96	100	125	104	120	105	114	120			1298	1195	1246	1465			
C-SECTION	Total rate (planned & unscheduled)	C Section %	38.00%	38.00%	40.00%	33.00%	40.00%	39.00%	38.00%	38.00%	42.00%	38.00%	37.00%			35.58%	33.20%	29.00%	26.30%	≤23% -25	≥26%	Average % Total
		C Section Emergency	83	70	91	63	69	86	81	87	109	99	99			925	836	715	657			
		C Section Elective	74	85	88	73	86	91	84	82	79	77	88			986	945	845	847			
		No. C section	157	155	179	136	155	177	165	169	188	176	187			1911	1780	1557	1504			
VBAC	Number of VBAC's attemped		2	7	9	3	4	9	9	7	15	4	3			58	15		69			
	Number of successful VBAC's		2	5	4	1	2	6	6	4	11	2	1			43	12		42			
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	1	0	0	0	1	0	0	0			3	5	1	2	<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	1	0	0	1	0	0	1	0	0	0	4			6	10	1	8			
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	1	0	1	0	0	0	4			2	4	0	2			
	Post partum hysterectomies	No. of patients	1	0	0	0	0	0	0	0	0	0	3			1	2	0	0			
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0	0	0	0			5	16	2	3			
	Number of cases of hypoxic encephalopathy (Grades 2&3)	-	0	0	0	0	0	1	0	0	0	2	2			13	5	3	9			
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0	0	0	0			90	0	0	0			
	NICU Status - Number of Episodes	Black														50	56					
		Red														29	49					
		Amber														65	113					
	NICU admission >36 weeks	%	1.9%	2.7%	1.3%	1.7%	2.0%	3.3%	2.6%	2.9%	2.7%	6.3%	3.3%			4%	3%	5%	4%	4.50%	5.50%	AWNN Network
		No	8	11	6	7	8	15	11	13	12	29	17			158	168	288	245			
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	1	3	0	0	2	1	1	2	1	1	1			22	25	15	26	5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	1.0%	0.2%	0.4%	0.7%	0.0%	1.3%	0.9%	1.1%	2.0%	0.4%	0.2%			0.7%	0.7%		0.5%	<1%	>3%	
		no Ins Del/birth	4	1	2	3	0	6	4	5	9	2	1			48	42	37	29			
	Massive PPH 2.5L		4	1	2	3	0	2	4	3	3	4	6			19	26	27	23	<12/ month	15	
	Shoulder dystocia		5	1	2	5	3	3	3	1	2	4	7			31	31	52	49	< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3b degree tear	%	0.5%	0.5%	0.9%	0.7%	0.7%	0.2%	0.5%	1.1%	0.5%	1.1%	0.0%			0.4%	0.4%	0.7%	0.6%	<5% month	>5%month	RCOG
		No of 3b degree tear	2	2	4	3	3	1	2	5	2	5	0			20	26	38	35			
CLINICAL GOVERNANCE	Number of Datix's submitted		101	85	97	95	87	137	110	124	115	129	139			979	1151	980	884			
	Datix: Exception reporting (Harm/ staff behaviour)															0			0			
	Number for redress		0	0	0											6	3	0	4			
	Number of formal complaints		1	3	4											41		50	51	<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)		0	0	3	0	0	1	3							20	7	7	5			
	Closure of total maternity service		0	0	0	0	0	0	0	0	0	0	0					0	0	<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE		259	259	259	259	242	242	242	242	242	242	242									
	Midwifery funded establishment WTE		259	259	259	259	242	242	242	242	242	242	242									
	Current midwifery staffing WTE																					
	1 : 1 midwifery care in labour %	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%									
	Weekly hours of consultant presence on Labour Ward %	GUH	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%	76%									
	Sickness Medical %	%	3.93%	0.88%	2.15%	3.85%	3.02%	2.92%	4.97%	5.62%	2.78%											
	Sickness Midwifery %	%	8.30%	6.60%	6.49%	5.38%	5.92%	6.37%	6.86%	6.90%	6.62%	5.98%										
	Hours of midwifery bank usage (Total hours)																					
	Hours of locum use (Total Hours)																					
TRAINING COMPLIANCE	CTG	Number of Midwives attended																				
	GAP/Grow	Number of Midwives attended																				
	PROMPT	Number of Midwives attended																				
	CTG	Number of Doctors attended																				
	GAP/Grow	Number of Doctors attended																				
	PROMPT	Number of Doctors attended																				
	PADR	% Midwifery	75.79%	74.21%	69.39%	71.00%	68.59%	70.16%	71.88%	72.00%	70.87%	65.87%	66.31%									
	Medical Appraisal	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%									

	PROMPT WALES CLINICAL OUTCOME MEASURES																				
5 minute APGAR <7 (Term)	The proportion of all live babies >=37 weeks with an Apgar score of less than 7 at 5 minutes. Excludes babies where Apgar score is not known	1%	0.99%	1.55%	1.71%	0.51%	1.99%	0.93%	1.57%	0.74%	0.65%	0.98%									
5 minute APGAR <7 (Preterm) births	<37 weeks with an Apgaar Score of less than 7 at 5. Excludes babies where Apgar score is not known	0.72%	0.24%	1.11%	0.73%	1%	0.88%	0.69%	0.67%	0.77%	1.00%	0.58%									
Hypoxic Ischaemic Encephalopathy Grade 2 & 3	Rate of HIE per 10,000 deliveries	0.00%	0.00%	0%	0.00%	0.00%	0%	0%	0%	0.00%	0.00%	0%									
Shoulder dystocia	The incidence of Shoulder Dystocia per 10,000 babies (as the denominator for BPI)	1.20%	0.49%	0.04%	1.20%	0.77%	0.66%	0.69%	0.22%	0.45%	0.86%	1.37%									
Brachial Plexus injury at birth	1. Injury to the brachial plexus per 10,000 births identified in first 28 days of birth. 2. Percentage of shoulder dystocia resulting in BPI																				
Brachial Plexus Injury at 12 months	1. Injury to the brachial plexus per 10,000 births persisting at 12 months of age. 2. Percentage of shoulder dystocia resulting in BPI																				
1500ml PPH (Primary)	The proportion of all women who gave birth who had a weighed blood loss at birth of 1500ml-2499mls within 24 hours of birth. Note exact blood loss required	2.60%	2.90%	2.00%	1.95%	3.80%	2.43%	2.79%	2.47%	1.89%	2.39%	3.13%									
2500ml PPH (Primary)	The proportion of all women who gave birth who had a weighed blood loss at birth of 2500ml or more within 24 hours of birth. Note exact blood loss required	0.90%	0.24%	0.44%	0.73%	0%	0.44%	0.93%	0.67%	0.31%	0.21%	0.78%									
Maternity admissions to level 3 care	The total number of women who were admitted from maternity to level 3 care antenatally or postnatally	0.24%	0%	0.00%	0%	0.00%	0%	1%	0%	0.00%	0%	0.78%									
3a tear		3	4	7	1	1	3	0	2	4	8	2									

Aneurin Bevan University Health Board

GUH Maternity Dashboard : 2023

Clinical Performance and Governance Score Card

GUH 2023			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	328	322	359	314	294	350	344	349	351	374	400					500	>525-550	
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	413	315	394	442	355	404	338	354	340							6600	≥630	Tolerance 15%
		Midwifery	134	122	119	148	111	121	105	118	98									
		Joint care	279	193	275	294	244	283	233	236	242									
		Transfer rate																12%	12-17%	
INSTRAMENTAL VAGINAL DEL	Ventouse & Forceps	% Inst Vag D/Birth	13.00%	10.00%	12.00%	9.20%	10.00%	7.00%	7.55%	9.45%	8.83%	12.00%	11.75%					10-15%	<5%or >20%	
		No Ins Vag D/Birth	42	33	42	29	30	25	26	33	31	45	47							
INDUCTION OF LABOUR		%UK data	33.00%	35.00%	28.00%	31.00%	34.00%	36.00%	30.00%	34.00%	30.00%	30.00%	30.00%					20-22%	26%	Average % Total
		No. UK Data	108	113	101	96	100	125	104	120	105	114	120							
C-SECTION	Total rate (planned & unscheduled)	C Section %	48.00%	48.00%	50.00%	43.00%	53.00%	51.00%	48.00%	48.00%	53.00%	47.00%	47.00%					≤23% -25	≥26%	Average % Total
		C Section Emergency	83	70	91	63	69	86	81	87	109	99	99							
		C Section Elective	74	85	88	73	86	91	84	82	79	77	88							
		No. C section	157	155	179	136	155	177	165	169	188	176	187							
VBAC	Number of VBAC's attemped		2	7	9	3	4	9	9	7	15	4	3							
	Number of successful VBAC's		2	5	4	1	2	6	6	4	11	2	1							
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	1	0	0	0	1	0	0	0					<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	1	0	0	0	0	0	1	0	0	0	4							
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	1	0	1	0	0	0	4							
	Post partum hysterectomies	No. of patients	1	0	0	0	0	0	0	0	0	0	3							
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0	0	0	0							
	Number of cases of hypoxic encephalopathy (Grades 2&3)	-	0	0	0	0	0	1	0	0	0	2	2							
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0	0	0	0							
	NICU Status	Black																		
		Red																		
		Amber																		
	NICU admission >36 weeks	%	2.4%	3.4%	1.7%	2.2%	2.7%	4.3%	3.2%	3.7%	3.4%	5.0%	4.3%					4.50%	5.50%	AWNN Network
		No	8	11	6	7	8	15	11	13	12	29	17							
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	1	3	0	3	3	1	1	2	1	1	1					5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	1.2%	0.3%	0.6%	1.0%	0.0%	1.7%	1.2%	1.4%	2.6%	0.5%	0.3%					<1%	>3%	
		no Ins Del/birth	4	1	2	3	0	6	4	5	9	2	1							
	Massive PPH 2.5L		4	1	2	3	0	2	4	3	3	4	6					<12/ month	15	
	Shoulder dystocia		5	2	2	5	3	2	0	1	2	4	7					< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3rd degree tear	%	0.6%	0.0%	1.1%	1.0%	1.0%	0.3%	0.0%	0.9%	0.7%	0.3%	6.0%					<5% month	>5%month	RCOG
		No of 3rd degree tear	2	0	4	3	3	1	0	3	3	1	24							
CLINICAL GOVERNANCE	Number of Datix's submitted		101	85	97	95	87	137	110	124	115	129	139							
	Datix: Exception reporting (Harm/ staff behaviour)																			
	Number for redress		0	0	0															
	Number of formal complaints		1	3	4													<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)		0	0	1	0	0	1												
	Closure of total maternity service		0	0	0	0	0	0	0	0	0	0	0					<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE													4						
	Midwifery funded establishment WTE																			
	Current midwifery staffing WTE																			
	1 : 1 midwifery care in labour %	%																		
	Weekly hours of consultant presence on Labour Ward %	GUH																		
	Sickness Medical %	%																		
	Sickness Midwifery %	%																		
	Hours of midwifery bank usage (Total hours)																			
	Hours of locum use (Total Hours)																			
TRAINING COMPLIANCE	CTG	% Midwives																		
	GAP/Grow	% Midwives																		
	PROMPT	% Midwives																		
	CTG	% Doctors																		
	GAP/Grow	% Doctors																		
	PROMPT	% Doctors																		
	PADR	% Midwifery																		
	Medical Appraisal	%																		

Aneurin Bevan University Health Board

GUH Maternity Dashboard : 2023

Clinical Performance and Governance Score Card

GUH 2023			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	328	322	359	314	294	350	344	349	351	374	400					500	>525-550	
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	413	315	394	442	355	404	338	354	340							6600	≥630	Tolerance 15%
		Midwifery	134	122	119	148	111	121	105	118	98									
		Joint care	279	193	275	294	244	283	233	236	242									
		Transfer rate																12%	12-17%	
INSTRAMENTAL VAGINAL DEL	Ventouse & Forceps	% Inst Vag D/Birth	13.00%	10.00%	12.00%	9.20%	10.00%	7.00%	7.55%	9.45%	8.83%	12.00%	11.75%					10-15%	<5%or >20%	
		No Ins Vag D/Birth	42	33	42	29	30	25	26	33	31	45	47							
INDUCTION OF LABOUR		%UK data	33.00%	35.00%	28.00%	31.00%	34.00%	36.00%	30.00%	34.00%	30.00%	30.00%	30.00%					20-22%	26%	Average % Total
		No. UK Data	108	113	101	96	100	125	104	120	105	114	120							
C-SECTION	Total rate (planned & unscheduled)	C Section %	48.00%	48.00%	50.00%	43.00%	53.00%	51.00%	48.00%	48.00%	53.00%	47.00%	47.00%					≤23% -25	≥26%	Average % Total
		C Section Emergency	83	70	91	63	69	86	81	87	109	99	99							
		C Section Elective	74	85	88	73	86	91	84	82	79	77	88							
		No. C section	157	155	179	136	155	177	165	169	188	176	187							
VBAC	Number of VBAC's attemped		2	7	9	3	4	9	9	7	15	4	3							
	Number of successful VBAC's		2	5	4	1	2	6	6	4	11	2	1							
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	1	0	0	0	1	0	0	0					<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	1	0	0	0	0	0	1	0	0	0	4							
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	1	0	1	0	0	0	4							
	Post partum hysterectomies	No. of patients	1	0	0	0	0	0	0	0	0	0	3							
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0	0	0	0							
	Number of cases of hypoxic encephalopathy (Grades 2&3)	-	0	0	0	0	0	1	0	0	0	2	2							
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0	0	0	0							
	NICU Status	Black																		
		Red																		
		Amber																		
	NICU admission >36 weeks	%	2.4%	3.4%	1.7%	2.2%	2.7%	4.3%	3.2%	3.7%	3.4%	5.0%	4.3%					4.50%	5.50%	AWNN Network
		No	8	11	6	7	8	15	11	13	12	29	17							
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	1	3	0	3	3	1	1	2	1	1	1					5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	1.2%	0.3%	0.6%	1.0%	0.0%	1.7%	1.2%	1.4%	2.6%	0.5%	0.3%					<1%	>3%	
		no Ins Del/birth	4	1	2	3	0	6	4	5	9	2	1							
	Massive PPH 2.5L		4	1	2	3	0	2	4	3	3	4	6					<12/ month	15	
	Shoulder dystocia		5	2	2	5	3	2	0	1	2	4	7					< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3rd degree tear	%	0.6%	0.0%	1.1%	1.0%	1.0%	0.3%	0.0%	0.9%	0.7%	0.3%	6.0%					<5% month	>5%month	RCOG
		No of 3rd degree tear	2	0	4	3	3	1	0	3	3	1	24							
CLINICAL GOVERNANCE	Number of Datix's submitted		101	85	97	95	87	137	110	124	115	129	139							
	Datix: Exception reporting (Harm/ staff behaviour)																			
	Number for redress		0	0	0															
	Number of formal complaints		1	3	4													<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)		0	0	1	0	0	1												
	Closure of total maternity service		0	0	0	0	0	0	0	0	0	0	0					<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE													4						
	Midwifery funded establishment WTE																			
	Current midwifery staffing WTE																			
	1 : 1 midwifery care in labour %	%																		
	Weekly hours of consultant presence on Labour Ward %	GUH																		
	Sickness Medical %	%																		
	Sickness Midwifery %	%																		
	Hours of midwifery bank usage (Total hours)																			
	Hours of locum use (Total Hours)																			
TRAINING COMPLIANCE	CTG	% Midwives																		
	GAP/Grow	% Midwives																		
	PROMPT	% Midwives																		
	CTG	% Doctors																		
	GAP/Grow	% Doctors																		
	PROMPT	% Doctors																		
	PADR	% Midwifery																		
	Medical Appraisal	%																		

Aneurin Bevan University Health Board

YYF Birth Centre Maternity Dashboard :2022

Clinical Performance and Governance Score Card

YYF Birth Centre 2022			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	7	2	8	6	2	1	3	5	9	3	7					500	>525-550	
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	95	86	70	71	57	72	67	61	78	94						6600	≥630	Tolerance 15%
		Midwifery	61	44	39	33	33	40	31	25	34									
		Joint care	34	42	31	38	24	32	36	36	44									
		Transfer rate																12%	12-17%	
INSTRAMENTAL VAGINAL DEL	Ventouse & Forceps	% Inst Vag D/Birth	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					10-15%	<5%or >20%	
		No Ins Vag D/Birth	0	0	0	0	0	0	0	0	0	0	0							
INDUCTION OF LABOUR		%UK data	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					20-22%	26%	Average % Total
		No. UK Data	0	0	0	0	0	0	0	0	0	0	0							
C-SECTION	Total rate (planned & unscheduled)	C Section %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%					≤23% -25	≥26%	Average % Total
		C Section Emergency	0	0	0	0	0	0	0	0	0	0	0							
		C Section Elective	0	0	0	0	0	0	0	0	0	0	0							
		No. C section	0	0	0	0	0	0	0	0	0	0	0							
VBAC	Number of VBAC's attemped		0	0	0	0	0	0	0	0	0	0	0							
	Number of successful VBAC's		0	0	0	0	0	0	0	0	0	0	0							
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	0	0	0	0	0	0	0	0					<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	0	0	0	0	0	0	0	0	0	0	0							
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	0	0	0	0	0	0	0							
	Post partum hysterectomies	No. of patients	0	0	0	0	0	0	0	0	0	0	0							
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0	0	0	0							
	Number of cases of hypoxic	-	0	0	0	0	0	0	0	0	0	0	0							
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0	0	0	0							
	NICU admission >36 weeks	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0	0					4.50%	5.50%	AWNN Network
		No	0	0	0	0	0	0	0	0	0	0	0							
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	0	0	0	0	0	0	0	0	0	0	0					5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0	0					<1%	>3%	
		no Ins Del/birth	0	0	0	0	0	0	0	0	0	0	0							
	Massive PPH 2.5L		0	0	0	0	0	0	0	0	0	0	0					<12/ month	15	
	Shoulder dystocia		0	0	0	0	0	0	0	0	0	0	0					< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3rd degree tear	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0	0					<5% month	>5%month	RCOG
		No of 3rd degree tear	0	0	0	0	0	0	0	0	0	0	0							
CLINICAL GOVERNANCE	Number of Datix's submitted																			
	Datix: Exception reporting (Harm/ staff behaviour)																			
	Number for redress																			
	Number of formal complaints																	<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)																			
	Closure of total maternity service																	<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE																			
	Midwifery funded establishment WTE																			
	Current midwifery staffing WTE																			
	1 : 1 midwifery care in labour %	%																		
	Weekly hours of consultant presence on Labour Ward %	GUH																		
	Sickness Medical %	%																		
	Sickness Midwifery %	%																		
	Hours of midwifery bank usage (Total hours)																			
	Hours of locum use (Total Hours)																			
TRAINING COMPLIANCE	CTG	% Midwives																		
	GAP/Grow	% Midwives																		
	PROMPT	% Midwives																		
	CTG	% Doctors																		
	GAP/Grow	% Doctors																		
	PROMPT	% Doctors																		
	PADR	% Midwifery																		
	Medical Appraisal	%																		

Aneurin Bevan University Health Board

Newport Birth Centre Maternity Dashboard 2023

Clinical Performance and Governance Score Card

Newport Birth Centre 2023			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	0	0	0	1	0	0	0	0	0	Closed	Closed					500	>525-550	
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	4	5	7	18	14	10	24	18	9							6600	≥630	Tolerance 15%
		Midwifery	4	3	5	11	4	2	11	13	3									
		Joint care	0	2	2	7	10	8	13	5	6									
		Transfer rate	0%	0%	0%	0%	0%	0%	0%	0%								12%	12-17%	
INSTRAMENTAL VAGINAL DEL	Ventouse & Forceps	% Inst Vag D/Birth	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%								10-15%	<5%or >20%	
		No Ins Vag D/Birth	0	0	0	0	0	0	0	0										
INDUCTION OF LABOUR		%UK data	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%								20-22%	26%	Average % Total
		No. UK Data	0	0	0	0	0	0	0	0										
C-SECTION	Total rate (planned & unscheduled)	C Section %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%								≤23% -25	≥26%	Average % Total
		C Section Emergency	0	0	0	0	0	0	0	0										
		C Section Elective	0	0	0	0	0	0	0	0										
		No. C section	0	0	0	0	0	0	0	0										
VBAC	Number of VBAC's attemped		0	0	0	0	0	0	0	0										
	Number of successful VBAC's		0	0	0	0	0	0	0	0										
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	0	0	0	0	0								<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	0	0	0	0	0	0	0	0										
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	0	0	0	0										
	Post partum hysterectomies	No. of patients	0	0	0	0	0	0	0	0										
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0										
	Number of cases of hypoxic encephalopathy (Grades 2&3)	-	0	0	0	0	0	0	0	0										
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0										
	NICU admission >36 weeks	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								4.50%	5.50%	AWNN Network
		No	0	0	0	0	0	0	0	0										
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	0	0	0	0	0	0	0	0								5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								<1%	>3%	
		no Ins Del/birth	0	0	0	0	0	0	0	0										
	Massive PPH 2.5L		0	0	0	0	0	0	0	0								<12/ month	15	
	Shoulder dystocia		0	0	0	0	0	0	0	0								< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3rd degree tear	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								<5% month	>5%month	RCOG
		No of 3rd degree tear	0	0	0	0	0	0	0	0										
CLINICAL GOVERNANCE	Number of Datix's submitted		0	0	0	0	0	0	0	0										
	Datix: Exception reporting (Harm/ staff behaviour)		0	0	0	0	0	0	0	0										
	Number for redress		0	0	0	0	0	0	0	0										
	Number of formal complaints		0	0	0	0	0	0	0	0								<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)		0	0	0	0	0	0	0	0										
	Closure of total maternity service		0	0	0	0	0	0	0	0								<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE																			
	Midwifery funded establishment WTE																			
	Current midwifery staffing WTE																			
	1 : 1 midwifery care in labour %	%																		
	Weekly hours of consultant presence on Labour Ward %	GUH																		
	Sickness Medical %	%																		
	Sickness Midwifery %	%																		
	Hours of midwifery bank usage (Total hours)																			
	Hours of locum use (Total Hours)																			
TRAINING COMPLIANCE	CTG	% Midwives																		
	GAP/Grow	% Midwives																		
	PROMPT	% Midwives																		
	CTG	% Doctors																		
	GAP/Grow	% Doctors																		
	PROMPT	% Doctors																		
	PADR	% Midwifery																		
	Medical Appraisal	%																		

Aneurin Bevan University Health Board

Abergavenny Birth Centre Maternity Dashboard 2023

Clinical Performance and Governance Score Card

Abergavenny Birth Centre 2023			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	0	0	0	0	0	0	0	0	0	Closed	Closed					500	>525-550	
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	6	5	4	7	4	7	16	7	2							6600	≥630	Tolerance 15%
		Midwifery	2	4	1	4	1	2	7	5	1									
		Joint care	4	1	3	3	3	5	9	2	1									
		Transfer rate	0%	0%	0%	0%	0	0	0%	0%								12%	12-17%	
INSTRAMENTAL VAGINAL DEL	Ventouse & Forceps	% Inst Vag D/Birth	0.00%	0.00%	0.00%	0.00%	0	0	0.00%	0.00%								10-15%	<5%or >20%	
		No Ins Vag D/Birth	0	0	0	0	0	0	0	0										
INDUCTION OF LABOUR		%UK data	0.00%	0.00%	0.00%	0.00%	0	0	0.00%	0.00%								20-22%	26%	Average % Total
		No. UK Data	0	0	0	0	0	0	0	0										
C-SECTION	Total rate (planned & unscheduled)	C Section %	0%0	0.00%	0.00%	0.00%	0	0	0.00%	0.00%								≤23% -25	≥26%	Average % Total
		C Section Emergency	0	0	0	0	0	0	0	0										
		C Section Elective	0	0	0	0	0	0	0	0										
		No. C section	0	0	0	0	0	0	0	0										
VBAC	Number of VBAC's attemped		0	0	0	0	0	0	0	0										
	Number of successful VBAC's		0	0	0	0	0	0	0	0										
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	0	0.0%	0.0%	0	0								<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	0	0	0	0	0	0	0	0										
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	0	0	0	0										
	Post partum hysterectomies	No. of patients	0	0	0	0	0.0%	0.0%	0	0										
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0										
	Number of cases of hypoxic encephalopathy (Grades 2&3)	-	0	0	0	0	0	0	0	0										
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0										
	NICU admission >36 weeks	%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								4.50%	5.50%	AWNN Network
		No	0	0	0	0	0	0	0	0										
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	0	0	0	0	0	0	0	0								5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	0.0%	0.0%	0.0%	0.0%	0	0	0.0%	0.0%								<1%	>3%	
		no Ins Del/birth	0	0	0	0	0	0	0	0										
	Massive PPH 2.5L		0	0	0	0	0	0	0	0								<12/ month	15	
	Shoulder dystocia		0	0	0	0	0	0	0	0								< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3rd degree tear	%	0.0%	0.0%	0.0%	0.0%	0	0	0.0%	0.0%								<5% month	>5%month	RCOG
		No of 3rd degree tear	0	0	0	0	0	0	0	0										
CLINICAL GOVERNANCE	Number of Datix's submitted		0	0	0	0	0	0	0	0										
	Datix: Exception reporting (Harm/ staff behaviour)		0	0	0	0	0	0	0	0										
	Number for redress		0	0	0	0	0	0	0	0										
	Number of formal complaints		0	0	0	0	0	0	0	0								<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)		0	0	0	0	0	0	0	0										
	Closure of total maternity service		0	0	0	0	0	0	0	0								<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE																			
	Midwifery funded establishment WTE																			
	Current midwifery staffing WTE																			
	1 : 1 midwifery care in labour %	%																		
	Weekly hours of consultant presence on Labour Ward %	GUH																		
	Sickness Medical %	%																		
	Sickness Midwifery %	%																		
	Hours of midwifery bank usage (Total hours)																			
	Hours of locum use (Total Hours)																			
TRAINING COMPLIANCE	CTG	% Midwives																		
	GAP/Grow	% Midwives																		
	PROMPT	% Midwives																		
	CTG	% Doctors																		
	GAP/Grow	% Doctors																		
	PROMPT	% Doctors																		
	PADR	% Midwifery																		
	Medical Appraisal	%																		

Aneurin Bevan University Health Board

YAB Maternity Dashboard : 2023

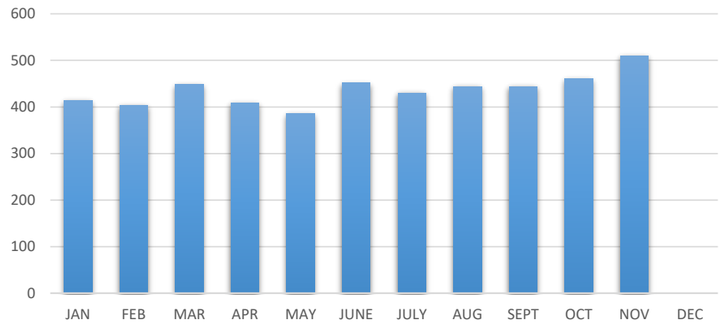
Clinical Performance and Governance Score Card

YAB 2023			JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	2020 Total	2019 Total	Goal	Red Flag	Comment
BIRTHS	Benchmarked to 6000 per annum	Births	2	0	1	1	1	0	1	0	0	0	0					500	>525-550	
SCHEDULED BOOKINGS	Scheduled Bookings by intended hospital	Total (1st visit)	1	0	2	2	1	1	1	1	1							6600	≥630	Tolerance 15%
		Midwifery	1	0	1	1	1	1	0	1	1									
		Joint care	0	0	1	1	0	0	1	0	0									
		Transfer rate	0%	0%	0%	0%	0	0	0%	0%								12%	12-17%	
INSTRAMENTAL VAGINAL DEL	Ventouse & Forceps	% Inst Vag D/Birth	0.00%	0.00%	0.00%	0.00%	0	0	0.00%	0.00%								10-15%	<5%or >20%	
		No Ins Vag D/Birth	0	0	0	0	0	0	0	0										
INDUCTION OF LABOUR		%UK data	0.00%	0.00%	0.00%	0.00%	0	0	0.00%	0.00%								20-22%	26%	Average % Total
		No. UK Data	0	0	0	0	0	0	0	0										
C-SECTION	Total rate (planned & unscheduled)	C Section %	0.00%	0.00%	0.00%	0.00%	0	0	0.00%	0.00%								≤23% -25	≥26%	Average % Total
		C Section Emergency	0	0	0	0	0	0	0	0										
		C Section Elective	0	0	0	0	0	0	0	0										
		No. C section	0	0	0	0	0	0	0	0										
VBAC	Number of VBAC's attemped		0	0	0	0	0	0	0	0										
	Number of successful VBAC's		0	0	0	0	0	0	0	0										
CLINICAL INDICATOR	Eclampsia	No. of patients	0	0	0	0	0.0%	0.0%	0	0								<4 in any 2 month period	>4cases in any 2 month period	
	ICU admissions in Obstetrics	No. of patients	0	0	0	0	0	0	0	0										
	Blood Transfusions (4 units of blood)	No. of patients	0	0	0	0	0	0	0	0										
	Post partum hysterectomies	No. of patients	0	0	0	0	0.0%	0.0%	0	0										
NEONATAL MORBIDITY	Number of cases of meconium aspiration	No. of patients	0	0	0	0	0	0	0	0										
	Number of cases of hypoxic encephalopathy (Grades 2&3)	-	0	0	0	0	0	0	0	0										
NNU STATUS	Total Closure of Neonatal Units		0	0	0	0	0	0	0	0										
	NICU admission >36 weeks	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								4.50%	5.50%	AWNN Network
		No	0	0	0	0	0	0	0	0										
RISK MANAGEMENT	Number of SBs / IUDs	per 1000 registered births	0	0	0	0	0	0	0	0								5.4	7	AWPM national statistic
	Failed Instrumental numbers	% Ins Del/Birth	0.0%	0.0%	0.0%	0.0%	0	0	0.0%	0.0%								<1%	>3%	
		no Ins Del/birth	0	0	0	0	0	0	0	0										
	Massive PPH 2.5L		0	0	0	0	0	0	0	0								<12/ month	15	
	Shoulder dystocia		0	0	0	0	0	0	0	0								< 4 / month	> 7/ month	0.5-1.5 % of Deliveries rcog
	3rd degree tear	%	0.0%	0.0%	0.0%	0.0%	0	0	0.0%	0.0%								<5% month	>5%month	RCOG
		No of 3rd degree tear	0	0	0	0	0	0	0	0										
CLINICAL GOVERNANCE	Number of Datix's submitted		0	0	0	0	0	0	0	0										
	Datix: Exception reporting (Harm/ staff behaviour)		0	0	0	0	0	0	0	0										
	Number for redress		0	0	0	0	0	0	0	0										
	Number of formal complaints		0	0	0	0	0	0	0	0								<1 per month	>10	threshhold for review
CLINICAL OUTCOMES	Number of SUI's triggered (number and category)		0	0	0	0	0	0	0	0										
	Closure of total maternity service		0	0	0	0	0	0	0	0								<1 per month	>3 times per month	
WORKFORCE	Birth rate plus required establishment WTE																			
	Midwifery funded establishment WTE																			
	Current midwifery staffing WTE																			
	1 : 1 midwifery care in labour %	%																		
	Weekly hours of consultant presence on Labour Ward %	GUH																		
	Sickness Medical %	%																		
	Sickness Midwifery %	%																		
	Hours of midwifery bank usage (Total hours)																			
	Hours of locum use (Total Hours)																			
TRAINING COMPLIANCE	CTG	% Midwives																		
	GAP/Grow	% Midwives																		
	PROMPT	% Midwives																		
	CTG	% Doctors																		
	GAP/Grow	% Doctors																		
	PROMPT	% Doctors																		
	PADR	% Midwifery																		
	Medical Appraisal	%																		

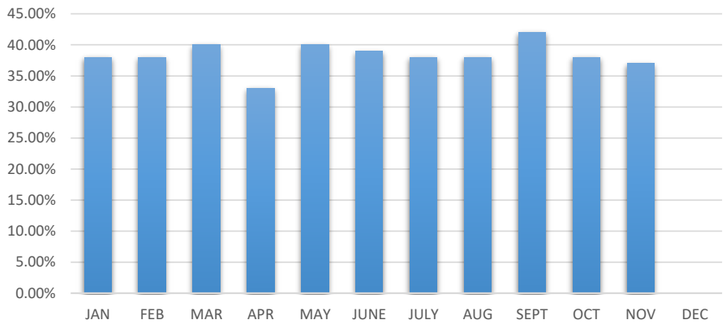
Aneurin Bevan University Health Board
HOME BIRTH Dashboard : 2023
Clinical Performance and Governance Score Card

Homebirths	Measure	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	Goal	Red Flag	Comment
		10	9	13	15	12	13	7	16	10	14	20					

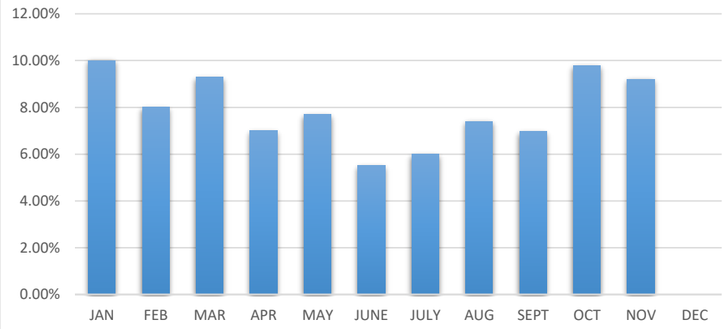
Total number of births



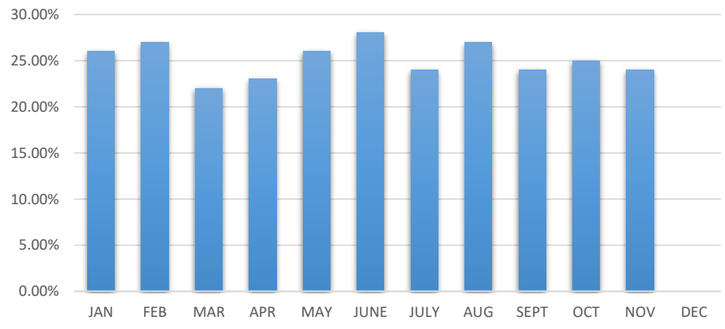
C-Section %



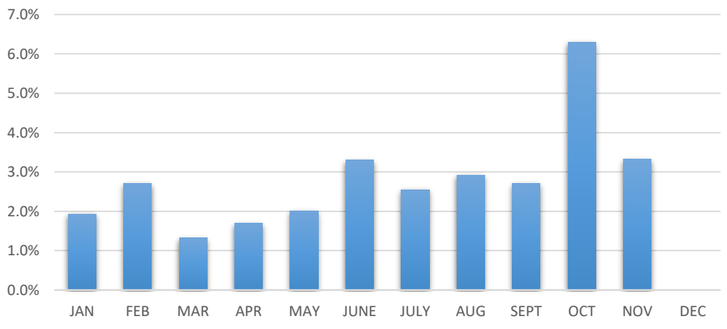
Instrumental birth %



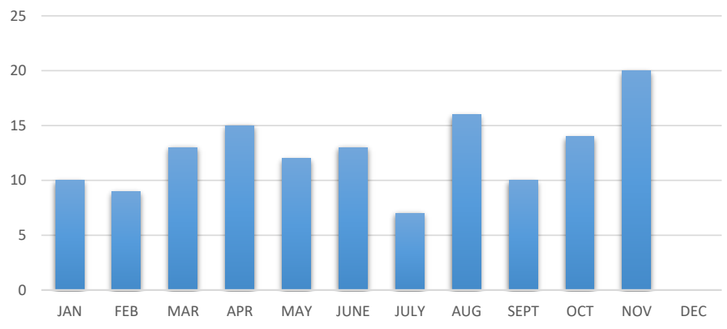
Induction %



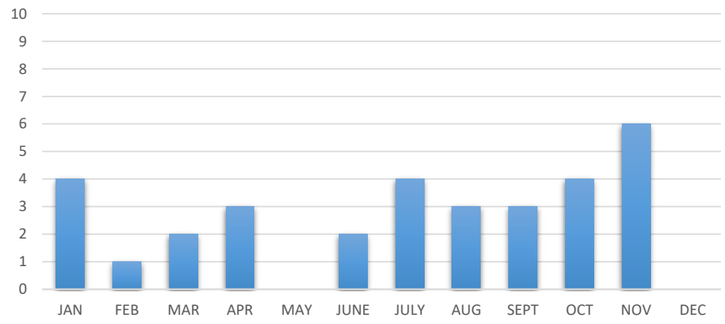
Admissions to NICU >36 weeks



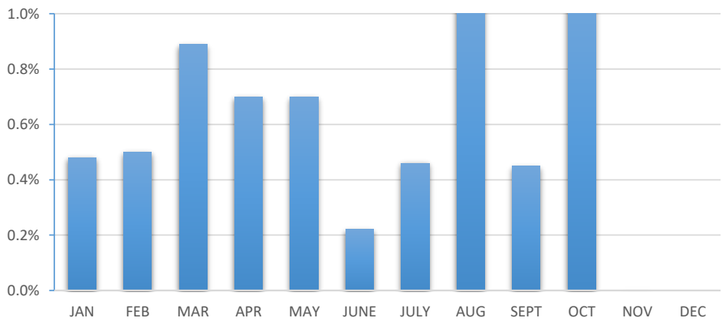
Number of home births



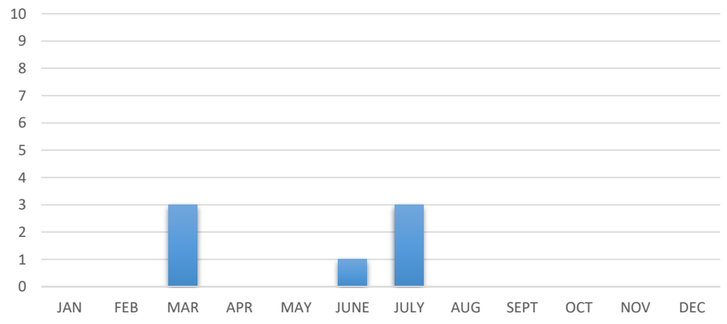
Postpartum hemorrhage



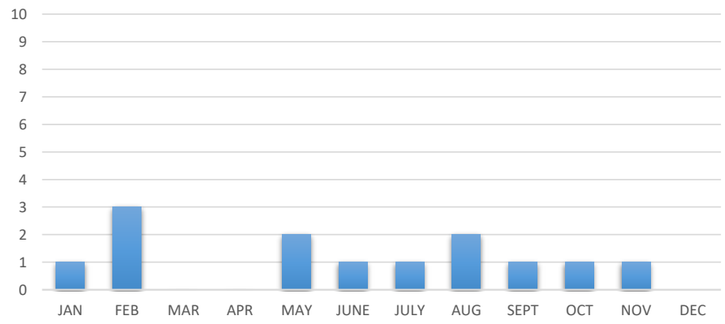
Third degree tear %



Number of SUI's



Number of still births



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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 December 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Self-Assessment 2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Board Business

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to discuss the findings from the annual self-assessment process in respect of the Patient Quality Safety and Outcomes Committee.

Cefndir / Background

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

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, well as any development of a comprehensive Board Business Improvement Plan.

At the meeting held on 11th October 2023 the Committee agreed to undertake the self- assessment.

Asesiad / Assessment

The self-assessment for the Patient Quality, Safety and Outcomes Committee was completed throughout November 2023 by both Committee members and those individuals who regularly support the work of the Committee. The self-assessment template is included in Appendix A, and the completed response are in included in Appendix B

Following completion of the self-assessments, the sections were analysed to provide a summary of the response and recommendation for improvements for each section. The suggestion will help the development of a comprehensive Board Improvement Plan.

The questionnaire was distributed to both committee members and those who regularly support the work of this committee. Five responses were received to the questionnaire.

Summary of Individual Sections

Section 1 Committee Processes: Composition, Establishment, and Ways of Working

The majority of respondents agreed that committee processes are well executed, and that the overall co-ordination and management of the meeting is consistent and well managed to allow the Committee to conduct its responsibilities.

There were some opportunities for strengthening in particular these included:

- The Committee to hold additional meetings and also have flexibly in length of meetings to enable the Committee to perform effectively.
- Not all Independent Members had received induction training.
- A greater understanding of the assurance mapping processes.
- The structure of the report template to be reviewed to enable Committee Members to better understand the key areas for discussion.
- Inclusion of standard agenda item to facilitate Committee Member reflections of the meeting held.

Section 2 - Clinical Quality Governance

From the responses received there was a general agreement that the Clinical Quality Governance arrangements are well implemented, with appropriate arrangements to cover the 6 clinical pillars being reported.

The following opportunity for strengthening was identified:

- Inclusion of regular updates to ensure good progress against patient's experience.

Section 3 - Patient Experience and Involvement

Most respondents reported that there was limited coverage of the patient experience but acknowledged that this was improving.

The following opportunity for strengthening was identified :

- Progress of key areas of work such as patient experience could be improved.

Section 4 - High Quality, Safe and Effective Healthcare

The majority of respondents confirmed that the Committee receives regular updates on clinical audit activity in inline with the local and national priorities that includes action plans with clear timescales.

The following opportunity for strengthening was identified :

- The inclusion of the Joint Committee reports e.g WHSCC and EASC to discuss key issues and to obtain assurance of the commissioning arrangements in place.

Section 5 - Research and Development and Improvement and Innovation

The majority of respondents agreed that there was work to be undertaken to improve this area of primarily through the inclusion of a forward work plan that better focuses on this . The following suggestions were made:-

There were some opportunities for strengthening in particular:

- The assurance of research and development activities to be included in the forward work plan.
- Regular report updates to be provided on those projects that focus on securing improvements and innovation for quality and safety of the services.

Section 6 - Compliance with Health and Safety Regulations and Fire Safety Standards

The majority of respondents confirmed that they were assured through the updates provided to the Committee in respect of Health & Safety regulations and Fire Safety standards.

There were some opportunities for strengthening in particular:

- The regular report from health & safety could be strengthened with the inclusion of a priority and risk focus.

<u>Specific Responses for Patient Quality, Safety and Outcomes Committee Improvement</u>

The table below details the specific areas where suggestions for improving the Committee's effectiveness were made.

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**How & by When**	**Action Holder**
1 Committee Processes: Composition, Establishment, and Ways of Working	• Report template to be reviewed and training on report writing to be delivered • A programme of training for independent members to be developed • Agendas to include an item on reflection upon meeting	All actions to inform the development of an overarching Board Business Improvement Plan – January 2024 for Board approval	Director of Corporate Governance with Head of Board Business
2 - Clinical Quality Governance 3 - Patient Experience and Involvement	• Explore ways of ensuring greater assurance and opportunities for committee members to be better appraised of patient experience matters	To be strengthened within Committee Workplan 2024/25 – April 2024	Head of Board Business with Director of Nursing
4 - High Quality, Safe and Effective Healthcare	• Strengthened focus on reporting of Joint Committee activity to this Committee	To be considered within the development of the Commissioning for Quality Framework	Director of Corporate Governance with Director of Nursing
5 - Research and Development and Improvement and Innovation	• Secure a greater understanding of those improvement projects through better reporting to the Committee and to capture this on the fwp for the Committee	To be strengthened within Committee Workplan 2024/25 – April 2024	Head of Board Business with Medical Director and Director of Nursing
6 - Compliance with Health and Safety Regulations and Fire Safety Standards	• Health and Safety Assurance reporting to be strengthened to include a focus on risk and assurance gaps.	In future reporting arrangements, in-line with the Committee's workplan.	Director of Therapies and Health Science with support of Head of Risk and Assurance

Overall Assessment of Effectiveness

To determine the overall effectiveness of the Committee, a standardised scoring matrix has been used to assess each Committee; this is in accordance with the Well-Led Framework for Leadership and Governance Developmental Reviews and is shown below.

Overall Assessment		
Score	**Definition**	**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.

Two of the Five respondents provided a statement in respect of the overall assessment of the Committee's effectiveness, as shown below.

Return ID	Assurance Rating	Comments
1	**Meeting standards**	The Patient Quality Stafey and Outcomes Committee is performing fairly well. The papers had improved, the agenda are at full capacity which makes it difficult to do everything in the time. I don't think more meetings is the answer to this, but possibly making sure that we have longer or shorter meetings depending on time of year and competing priorities could be an option.
2	**Meeting standards**	The committee works hard and there has been considerable progress over the last year to improve format and the information is discussed. It has a very complex and crucial agenda to address so very full meetings. Quality now appears to have a higher profile than it may have had before. Plenty of work to do.

Overall Assurance Rating

The table below provides a breakdown of the responses to each section, as well as an overall assurance rating against the committee's effectiveness.

Section	No of Questions	Number of Possible Responses	Number of responses 'Yes'	Number of responses 'No'	Number that 'Didn't Answer'	Overall Assurance Rating
1	26	130	117	9	4	
2	5	25	18	1	6	

3	3	15	11	4	0	
4	6	30	25	4	1	
5	2	10	6	2	2	
6	1	5	4	1	0	
Total	**43**	**215**	**181**	**21**	**13**	

In conclusion, the results of the individual self-assessment, combined with the analysis of the five self-assessments with an add 84% response rate of 'Yes,' determined that the Committee is effective and meeting the standards.

Rating	Definition	Evidence
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.

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25. 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.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the performance information contained within the report,
- **CONSIDER** the proposed actions to address those areas as requiring further improvement, and;
- **NOTE** the proposed improvement actions to be taken forward within the Committee Forward Plan for 2024/25 or the wider Board Business Improvement Plan.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The self-assessment of committee effectiveness ensures risk is appropriately monitored and managed.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well-Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

Patient Quality, Safety and Outcomes Committee Self-Assessment Checklist

Introduction

The self-assessment tool is a way for our Patient Quality, Safety and Outcomes Committee (PQSOC) to develop its effectiveness. The Board and its sub-Committees should aim to assess their effectiveness against these questions on an annual basis.

To gain an overall view of PPC effectiveness, it is important that the individual views of all members are considered as a whole, therefore, each area of the effectiveness tool allows space for comments. This provides an important opportunity to expand on any considerations relating to that section of the effectiveness tool and to highlight any concerns about the Committee's performance.

At the end of the self-assessment there is an opportunity for you to provide an overall score on the Committee's effectiveness using the scoring scale below.

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

The completed self-assessments will enable the Corporate Governance Team to: -

1. generate an overall view of PQSOC effectiveness; and
2. drill down and analyse specific areas of strength or improvement on a section, sub-section, and individual question level.

The results of which will be reported to the Committee in December 2023 and used to inform the Committee Annual Report, Annual Accountability Report and Governance Statement.

Section 1 - Committee Processes: Composition, Establishment, and Ways of Working				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
1	Does the Committee have written terms of reference and have they been approved by the Board?			
2	Are the terms of reference reviewed annually?			
3	The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?			
4	Has the Committee been quorate for each meeting this year?			
5	In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?			
6	Members who have recently joined the PQSOC have been provided with induction training to help them understand their role and the organisation?			
7	The Committee is clear about its role in relationship to other Committees that play a role in relations to patient quality and safety matters?			
8	Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?			
9	The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor?			
10	The Committee has an established a plan of matters to be dealt with across the year?			

11	Does the Committee consider issues at the right time and in the right level of detail?			
12	The Committee ensures that the relevant executive director(s) attends meetings to enable it to understand the reports and information it receives?			
13	Are the Committee's papers distributed in sufficient time for members to give them due consideration?			
14	The quality of the Committee's papers received allows Committee members to perform their roles effectively?			
15	Committee meetings are chaired effectively?			
16	The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?			
17	The Committee environment enables people to express their views, doubts, and opinions?			
18	The Committee challenges management and other assurance providers to gain a clear understanding of their findings?			
19	Members hold their assurance providers (management) to account for late or missing assurance?			
20	Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored?			

21	At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc?			
22	Decisions and actions are implemented in line with the timescale agreed?			
23	Are the outcomes of each meeting and any issues of concern reported to the next Board meeting?			
24	Does the Committee prepare an annual report on its work and performance for the Board?			
25	The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.			
26	The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?			

Section 2 – Clinical Quality Governance				
	Question	**Response Yes/No**	**Comments**	**Suggested Improvement Actions**
27	Is the Committee satisfied that there is a credible process for assessing, measuring and reporting on Clinical Quality Governance			
28	Is the Committee assured that the Health Board's Clinical Quality Governance Arrangements remain appropriate and aligned to the National Quality Framework			
29	Is the Committee assured that Clinical Quality Governance is embedded in practice?			
30	Does the Committee receive sufficient assurance that the systems, processes and plans to measure, monitor and enhance the quality of our healthcare services are fit for purpose			
31	Does the committee effectively scrutinise the quality performance issues and key performance indicators (6 pillars):			

	1. Person Centred			
	2. Safe			
	3. Timely			
	4. Effective			
	5. Efficient			
	6. Equitable			

Section 3 – Patient Experience and Involvement				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
32.	Does the Committee receive assurance that the arrangements for capturing the experience of patients, citizens and carers are sufficient, effective and robust?			
33.	Does the Committee review progress against the Patient Experience and Involvement Strategy			
34.	Does the Committee receive and consider sufficient information on compliance with Putting Things Right Regulations, including trends and ensuring lessons are learned?			

Section 4 – High Quality, Safe and Effective Healthcare				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
35	Does the Committee receive assurance that commissioning arrangements are in place to ensure the efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on behalf of ABUHB?			

36	Is the Committee satisfied that arrangements are in place to undertake, review and act on clinical audit activity which responds to local and national priorities?			
37	Does the Committee consider recommendations made by internal and external review bodies and ensure that action is taken in response?			
38	Does the Committee received sufficient assurance that arrangements are in place to ensure that there are robust infection prevention and control measures in place in all settings?			
39	Does the Committee contribute to the development of the Health Board's Annual Quality Priorities?			
40	Does the Committee consider performance against key quality outcomes focussed indicators and metrics?			

Section 5 – Research and Development and Improvement and Innovation				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
41	Does the Committee receive assurance in respect of the research and development activity within the organisation?			
42	Does the Committee receive assurance in respect of improvement and innovation projects to improve the quality and safety of services?			

Section 6 – Compliance with Health and Safety Regulations and Fire Safety Standards				
	Question	**Response Yes / No**	**Comments**	**Suggested Improvement Actions**
43	Does the Committee receive assurance in respect of arrangements in place for compliance with Health and Safety Regulations and Fire Safety Standards, including operating practices in respect of: • Staff Health and Safety • Stress at Work • Patient Health and Safety (ie falls, patient manual handling violence and aggression) • Fire Safety • Risk Assessment processes • Safe handling of loads • Hazardous substances			

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

ID	Start time	Completion time	Email	Name	Last modified time	1. Does the Committee	1a. Comments	1b. Suggested Improveme
1	10/26/23 14:57:03	10/26/23 15:11:12	anonymous			Yes		We are engaged in an iterative process with meeting attendees to balance the burden of reporting on teams against the information needed by PQSOC to discharge its oversight role
2	10/30/23 13:21:06	10/30/23 13:33:48	anonymous			Yes	Much improved over the past 2 years with consistency across committees	
3	11/6/23 17:25:29	11/6/23 18:59:21	anonymous			Yes		
4	11/14/23 11:40:18	11/14/23 13:53:52	anonymous			Yes	Easily access via the Internet	None
5	11/20/23 9:50:05	11/20/23 9:57:59	anonymous			Yes		
Presentage						100% yes		
Yes						5		
No								
No response								
Overall rating								

2. Are the terms of refe	2a. Comments	2b. Suggested Improver	3. The number of meeti	3a. Comments	3b. Suggested Improver	4. Has the Committee b	4a. Comments	4b. Suggested Improver
Yes			Yes			Yes		
Yes			Yes	We have had to change the format of the meeting to make this improvement and are still refining it	Items of significant focus for each meeting could be highlighted to the committee beforehand. Committee meeting length could flex to suit agenda (e.g. sometimes 3 hours, sometimes 3.5)	Yes		
Yes			Yes	Meeting every 2 months seems appropriate but sometimes the agenda is difficult to fit into 3 hours so may be helpful to have a slightly longer time set aside and if it is not needed then that is good news. Should also have the option for additional meetings or in-cttee meeting if needed to discuss a significant urgent matter that needs prompt action.		Yes		
Yes	Noted within the ToR	None	Yes	None	None	Yes	None	None
Yes			Yes			Yes		
100% yes			100% yes			100% Yes		
5			5			5		

5. In terms of numbers,	5a. Comments	5b. Suggested Improver	6. Members who have r	6a. Comments	6b. Suggested Improver	7. The Committee is cle	7a. Comments	7b. Suggested Improver
Yes			No			Yes		
Yes				We have no new members	Chair of committee could be notified when induction has taken place for assurance	Yes	Think this is an area of strength.	
Yes				Don't know if recent IMs have had any specific induction, but I didn't have any when I joined PQSO Cttee. It would have been helpful.		Yes	With patient safety and experience at the heart of this committee it doesn't seem to overlap with other committees.	
Yes	None	None	Yes	None	None	Yes	None	None
Yes				I am not sure however any staff are briefed prior to attending		Yes	There are occasions where particularly with Audit committee this can result in debate however the committee has sound corporate governance advice	
100% yes			50% Yes 50% No			100% yes		
5			1			5		
			1					
			3					

8. Committee members	8a. Comments	8b. Suggested Improver	9. The Committee uses	9a. Comments	9b. Suggested Improver	10. The Committee has	10a. Comments	10b. Suggested Improve
Yes			Yes	This is a work in progress and the assurance gaps are being identified and addressed as part of developing the forward work plan for the group		Yes	This list is refined at each meeting	
Yes			Yes		Room for improvement in highlighting this to committee	Yes	Again – improved area with consistency across committees & flexibility is accepted	
Yes			No	Not aware of this specific terminology - 'assurance mapping'. Is this something that should be included in agenda ?		Yes	Very detailed plan with lots of areas to be covered.	
Yes	It is a standard agenda item	None	Yes	None	None	Yes	None	None
Yes			No	This has not been completed formally historically however the review of the effectiveness of the Quality Strategy will meet this requirement		Yes		
100% Yes			60% yes 40% No			100% yes		
5			3			5		
			2					

11. Does the Committee	11a. Comments	11b. Suggested Improve	12. The Committee ensu	12a. Comments	12b. Suggested Improve	13. Are the Committee's	13a. Comments	13b. Suggested Improve
Yes			Yes			Yes		
Yes	Although timing can be an issue – hence note above about length of meetings		Yes	Although this is executive led (as it should be)		Yes	Also, very happy that we get reminders to access them	
Yes	It sometimes seems that some things are covered at most meetings and other areas are only covered once a year and sometimes rushed as a busy agenda. There is however, the option to have in-cttee sections if urgent confidential matter.		Yes	The main executives and members of their team with specific responsibility for an area usually attend meetings as required, so they can be asked questions.		Yes		
Yes	None	None	Yes	Have observed this	None	Yes	None	None
Yes	In most part the debate can sometimes become operational in nature however when challenged the response is appropriate		Yes			Yes		
100% yes			100% yes			100% yes		
5			5			5		

14. The quality of the C	14a. Comments	14b. Suggested Improve	15. Committee meeting	15a. Comments	15b. Suggested Improve	16. The Committee chai	16a. Comments
Yes			Yes			Yes	
Yes	Definitely a big area of improvement for this committee		Yes			Yes	I believe so
Yes	In general the papers are very detailed and sometimes there are lots of additional appendices too, which can be a bit repetitive. It is important that the covering paper is clear and highlights the decisions that need to be made as sometimes that can be unclear if a document is very long. The performance report which starts each meeting is very long so it would be helpful to know before hand which areas are going to be discussed in detail at each meeting.		Yes			Yes	Everyone who wants to comment or ask questions is able to in a fair way.
Yes	None	None	Yes	Chaired effectively	None	Yes	Chair does not intervene unnecessarily.
Yes			Yes			Yes	
100% yes			100% yes			100% yes	
5			5			5	

16b. Suggested Improve	17. The Committee envi	17a. Comments	17b. Suggested Improve	18. The Committee chal	18a. Comments	18b. Suggested Improve	19. Members hold their	19a. Comments
	Yes			Yes			Yes	
	Yes	There is a good level of trust and transparency		Yes			Yes	But we could be stronger in this area
	Yes	The committee has met online for last few years and that seems to work well as everyone can see and hear any presentations and comment in an appropriate way. Online seems to work effectively.		Yes			Yes	
None	Yes	There is good debate.	None.	Yes	None	None	Yes	Have observed challenge around late or missing assurance.
	Yes			Yes			Yes	
	100% yes			100% yes			100% yes	
	5			5			5	

19b. Suggested Improve	20. Each agenda item is	20a. Comments	20b. Suggested Improve	21. At the end of each n	21a. Comments	21b. Suggested Improve	22. Decisions and actior	22a. Comments
	Yes			No	There is an element of this. I would say that this question is asked at the right frequency - but not at the end of every meeting		Yes	In line with operational pressures
	Yes	Action log is a useful tool here.	Perhaps the could be clearer in the minutes about how/who things would be followed up or otherwise have a 'monitoring list' like the action log?	No	We don't always do this	We could add a section to the agenda to do this.	Yes	Usually
	Yes	Items seem to be closed off appropriately and added to action plans if necessary.		No	Don't think we do this in a formal way and it would probably be a good idea to do this as a specific agenda item so that cttee is reminded of decisions made.		Yes	Action log is reviewed at each meeting and there is a time scale.
None	Yes	None	None	Yes	None	None	Yes	None
	Yes			No	The committee does not always have time to do this	Making time for a final agenda item of 'what went well' & 'even better if' Could resolve this simply	Yes	
	100% yes			20% yes 80% No			100% yes	
	5			1			5	
				4				

22b. Suggested Improve	23. Are the outcomes of	23a. Comments	23b. Suggested Improve	24. Does the Committee	24a. Comments	24b. Suggested Improve	25. The results of the ar	25a. Comments
	Yes			No			No	This is the first self assessment done during my membership
	Yes			Yes			Yes	It is difficult to plan succession planning within the committee, but the Chair speaks to the Chair of the health board when considering this.
	Yes			Yes				Hopefully this review and self assessment will be discussed by the committee to improve overall work of cttee.
None	Yes	None	None	Yes	None	None	Yes	None
	Yes			Yes			Yes	
	100% yes			80% yes 20% no			60% yes 40% No	
	5			4			3	
				1			1	
							1	

25b. Suggested Improve	26. The self-assessment	26a. Comments	26b. Suggested Improve	27. Is the Committee sa	27a. Comments	27b. Suggested Improve	28. Is the Committee as	28a. Comments
	Yes			Yes			Yes	
	Yes			Yes			Yes	
	Yes			Yes	There has been a lot of work in this area over the last 9 months and it is clear that there is now a plan to collate lots of information - data and feedback and present it regularly so that the trends are clear and appropriate actions can be taken to address areas of concern.		Yes	There have been significant developments regarding a National Quality Framework and aligning the Health Board's Quality Governance arrangements - this is an ongoing work in progress.
None	Yes	None	None	Yes	None	None	Yes	None
	Yes			Yes	The Quality Strategy and Quality Reporting supports this		Yes	
	100% yes			100% yes			100% yes	
	5			5			5	

28b. Suggested Improve	29. Is the Committee as	29a. Comments	29b. Suggested Improve	30. Does the Committee	30a. Comments	30b. Suggested Improve	31. Does the committee
	Yes			Yes			Person Centred;Safe;Timely;Effective;Efficient;Equitable;
	Yes	Normally		Yes	This is another area that is definitely improving		Person Centred;Safe;Timely;Effective;Efficient;Equitable;
		Over the last 12 mths there seems to have been progress to embed Clinical quality Governance as there were apparently gaps regarding areas such as audit in divisions and within the HB. It is difficult for the cttee to know exactly what is going on in all Divisions as the committee only gets an overview but the profile of Clinical QG seems to have become more important across the UHB and this should continue as a priority.		No	Think this is an area for ongoing improvement now that systems and processes are being developed to record quantitative data and qualitative data such as patient experience feedback and information from complaints etc. There are some areas where collation of information such as from Datix or via feedback has started but that only covers a small part of UHB, This is quite labour intensive and does require appropriate people to have time and the skills to respond to feedback and investigate complaints etc so this will probably be an ongoing issue with financial constraints.		Person Centred;Safe;Timely;Effective;Efficient;Equitable;
None	Yes	None	None	Yes	None	None	
	Yes			Yes			Person Centred;Safe;Timely;Effective;Equitable;Efficient;
	80% yes 20%no			80% yes 20% no			
	4			4			
	0			1			5
	1						

31a. Comments	31b. Suggested Improve	32. Does the Committee	32a. Comments	32b. Suggested Improve	33. Does the Committee	33a. Comments	33b. Suggested Improve	34. Does the Committee
Becoming increasingly effective at this as the Quality Framework is clarified		No	Will improve as Civica and the learning framework evolve		No	Not to date on a regular basis		Yes
Key area of interest that is regularly discussed	If time allows we could have more patient stories	Yes	Both at Board and at the committee Llais are considered fully		No	yes/no - I'm not sure there is consistency of approach	We could have regular reviews set up	Yes
This is the structure that is being used but difficult to know whether we are covering each of these areas across the whole of ABUHB.		No	The systems for capturing feedback have only rolled out to a small number of areas within the UHB, so a lot of work to be done to broaden the collection of experience feedback for patients and carers etc		Yes	Patient experience reported on several times a year but unsure whether that is linked to Patient Experience and involvement strategy - but I may have forgotten.		Yes
None	None	Yes			Yes			Yes
		Yes	The committee receive an engagement story at each meeting to evidence how the voice of patient, citizens and carers is embedded within Health Board services		Yes	As above		Yes
		60% yes 40% no			60% yes 40% no			100% yes
		3			3			5
		2			2			

34a. Comments	34b. Suggested Improve	35. Does the Committee	35a. Comments	35b. Suggested Improve	36. Is the Committee sa	36a. Comments	36b. Suggested Improve	37. Does the Committee
Partly and improving		No	Im not sure this sits with PQSOC		Yes			Yes
A good area of discussion and assurance		Yes		Clearly indicating which services are commissioned and who oversees them along with any cost could be included	Yes	We also get regular updates from this team		Yes
This seems to be covered well - information on complaints , incidents, deaths etc and lessons learned.		No	Cttee receives the papers for WHSCC but received for information and perhaps cttee should discuss some of the issues raised and cttee chair feedback to WHSCC cttee		No	12 months ago this was not the case but it seems that a lot of work is now being done to address the issues of clinical audit to ensure that national audits are complied with and that local audits are done and completed so lessons can be learnt.		Yes
		Yes			Yes			Yes
		No	There is further work required within the Health Board on quality assurance within commissioned services	A commissioning for quality framework is in draft and will be shared for approval in due course	Yes			Yes
		40% yes 60% no			80% yes 20% no			100% yes
		2			4			5
		3			1			

37a. Comments	37b. Suggested Improve	38. Does the Committee	38a. Comments	38b. Suggested Improve	39. Does the Committee	39a. Comments	39b. Suggested Improve	40. Does the Committee
		Yes			Yes			Yes
		Yes				I'm not sure we had discussed development as a separate item		Yes
Good discussion on external inspections / reviews and actions plans with timescales developed and followed up.		Yes	Discussed frequently / regularly.		Yes			Yes
		Yes			Yes			Yes
		Yes			Yes	Through the setting of the Quality Strategy, a review will be planned when the strategy has been implemented for 12 months		Yes
		100% yes			80% yes 20% no			100% yes
		5			4			5
					0			
					1			

Section 5 | Section 6

40a. Comments	40b. Suggested Improve	41. Does the Committe	41b. Comments	41b. Suggested Improve	42. Does the Committe	42a. Comments	42b. Suggested Improve	43. Does the Committee
		No	This has not been on the forward work plan but will be in the future		Yes			No
			We have done but I'm not sure it is regular reporting		Yes		Possibly these are areas that could be brought to our attention more often?	Yes
		No	The cttee received a research strategy a year ago but an annual report is awaited for this year. Research activity should also be included somewhere in the risk register and I don't think it is currently.			This could probably be more obvious and receive more regular information on projects - some excellent projects presented to the Board, rather than PQSO Cttee last week - good session.		Yes
		Yes			Yes			Yes
		Yes			Yes	Quality improvement and the safe care collaborative report through the committee		Yes
		40% yes 60% no			80% yes 20%no			80% yes 20%no
		2			4			4
		2			0			1
		1			1			

43a. Comments	43b. Suggested Improve	Score	Comments
I think this would sit with other committees		Meeting standards - The PQSOC is performing to the required standard in this area. There may be room for improvement, but the PQSOC can be seen to be discharging its responsibilities effectively.	
There have been some delays with late papers in this area but I believe we are back on track		Room for improvement - The PQSOC is falling short of requirements and should consider how it can work towards becoming more effective in this area	The PQSOC is performing fairly well. The papers are much better but there is always a lot on the agenda which makes it difficult to do everything in the time. I don't think more meetings is the answer to this, but possibly making sure that we have longer or shorter meetings depending on time of year and competing priorities could be an option.
Think this is covered by Healthy and Safety reports.		Meeting standards - The PQSOC is performing to the required standard in this area. There may be room for improvement, but the PQSOC can be seen to be discharging its responsibilities effectively.	The committee works hard and there has been considerable progress over the last year to improve format and the information is discussed . It has a very complex and crucial agenda to address so very full meetings. Quality now appears to have a higher profile than it may have had before. Plenty of work to do.
There is a regular report from H&S to PQSOC this needs to be strengthened to ensure a priority and risk focus	The H&S priorities based on risk are being reset, this will strengthen reporting at PQSOC	Meeting standards - The PQSOC is performing to the required standard in this area. There may be room for improvement, but the PQSOC can be seen to be discharging its responsibilities effectively.	Room for improvement - The PQSOC is falling short of requirements and should consider how it can work towards becoming more effective in this area Meeting standards - The PQSOC is performing to the required standard in this area. There may be room for improvement, but the PQSOC can be seen to be discharging its responsibilities effectively. Excelling - This is an area where the PQSOC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Carolyn Donoghue**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**23rd October 2023**

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

As the morning had been taken up with the Quality Patient Safety Development Day there was no presentation or Patient Story at this meeting. The Chair welcomed two new members to the committee representing Cardiff & Vale University Health Board and the Deputy Regional Director for Llais.

1.0 COMMISSIONING TEAM AND NETWORK UPDATES

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

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

- **Cancer & Blood**

It was noted that no new risks for the portfolio had been added to the Risk Register since the last report.

- Members noted the improved traction on the performance issues within the All Wales Lymphoma Panel (AWLP) service and following the submission of a final report by the service, it is likely a recommendation will be made to reduce the level of escalation level by the next meeting.
- The Harm Review being undertaken on the North Wales (NW) plastics service remains outstanding. No timescales for completion were presented to the committee and members asked for further clarity.
- Whilst the Burns South Wales (SW) remains in Escalation Level 3 the capital case has been approved by Welsh Government and it is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- A Neuro Endocrine Tumour Stakeholder meeting was organised by Cardiff & Vale University health Board on the 17th October 2023.

- **Neurosciences**

Members noted that one new risk scoring above 15, relating to staffing levels within Neuro-rehabilitation at CVUHB, had been added since the last report was received. The committee was informed that due to quality issues with current provider commencement of Designated Provider process for the South Wales Deep Brain Simulation (DBS) service has been initiated. A letter has been sent to Llais informing them of the position.

- **Cardiac**

No new risks for the Cardiac portfolio had been added to the Risk Register since the last report. Members noted the updates against the two services, which currently remained in escalation at level 2.

- **Women & Children**

Members were concerned that there were five service areas with risks scoring 15 and above and that two new risks scoring above 15, both relating to Neonatal at CVUHB, had been added since the last report was received.

There are five service areas with high risks and in Escalation Level 3 are noted as follows and further detail and actions can be found in the summary of services in escalation, which is attached to the report.

  - Paediatric Intensive Care (CVUHB)
  - Paediatric Surgery (CVUHB)
  - Neonatal Intensive Care (CVUHB)
  - Paediatric Cardiac Surgery (UHBNHSFT)
  - Wales Fertility Institute (WFI) (SBUHB)

The committee were informed that an extraordinary Exec to Exec meeting with CVUHB was due to take place later that day to consider the areas of concern and agree a way forward. It has been proposed that all three will be brought into a single Escalation process with joint Exec Leads to provide additional support. It was also noted that Paediatric Surgery is not meeting contract volumes but ministerial measures are being met. A recommendation will be considered at the November Joint Committee for the escalation objectives to remain that Paediatric Surgery achieves contract volumes.

It was noted that the SBUHB assurance report was not submitted to HFEA on time. A further WHSSC escalation meeting is scheduled for the 27th October 2023, and the worst case scenario will be to source a new provider.

- **Mental Health & Vulnerable Groups**

One new risk has been added to the risk register regarding the magna security locks in the North Wales CAMHS unit. Assurance was received that this was being closely monitored and a meeting with the provider had identified the need for a capital bid to fund the necessary remedial works. A number of incidents had

been reported to WHSSC following that meeting and it was agreed that these would be further escalated to the BCUHB DoN for urgent consideration.

Members received an update regarding progress on the development of a Children and Young People's Gender Identity Service led through the NHS England transformation programme.

Members noted that there are a number of safeguarding concerns at an NHSE Eating Disorder provider and these have been escalated to NHSE for discussion and investigation. The relevant safeguarding teams are aware and the care coordinators from the Health Boards have been asked to review the individual patients. A more detailed report was to be received at the next meeting.

The new Eating Disorder unit in Tŷ Glyn Ebwy Hospital, Hillside, Ebbw Vale is due to be opened by the Deputy Minister for Health on the 9th November 2023. This will allow for repatriation of out of area placements and reduce the risk identified with one of the current independent providers.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members received an update of the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register since the last report.

2.0 OTHER REPORTS RECEIVED

Members received reports on the following:

- **Services in Escalation Summary**

A copy of each of the services in escalation is attached to the report at ***Appendix 1***

- **CRAF Risk Assurance Framework**
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
- **Incident and Concerns Report**
- **Report from the WHSSC Policy Group**.

3.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee September 2023
- Welsh Health Circular: Speaking up Safely Framework
- QPSC Distribution List; and
- QPSC Forward Work Plan.

4.0 ANY OTHER BUSINESS

It was noted that there had been a Development Day for QPS members and Quality Leads from the Health Boards that morning. The theme of the session

was to consider the impact of the Duty of Quality Act in terms of future reporting and monitoring of commissioned services. It had been well attended and a report will be presented at the next meeting.	
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above. Members expressed concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.	
Summary of services in Escalation • Attached (***Appendix 1***)	
Matters requiring Committee level consideration and/or approval • None	
Matters referred to other Committees As above.	
Confirmed minutes for the meeting are available upon request	
Date of Next Scheduled Meeting	5 December 2023

Appendix 1

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

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

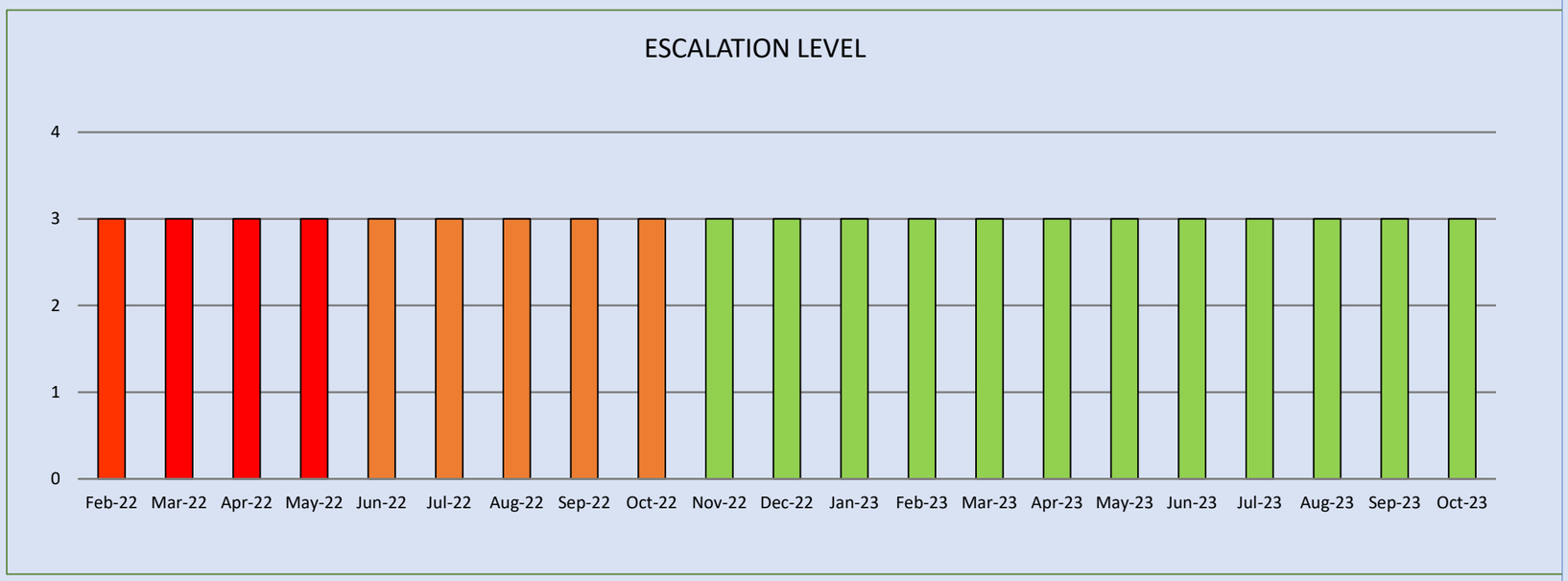
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case may be delayed to the initial intended timeline as the case goes through the scrutiny process.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed

SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	Completed
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	Completed
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	Completed
The capital case has now been approved by Welsh Government. The level of escalation will therefore be reviewed further to the next escalation meeting which is scheduled for November. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet.**
- **October 2023: the capital case has been approved by Welsh Government. Timeline tbc.**

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23 & 10/10/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

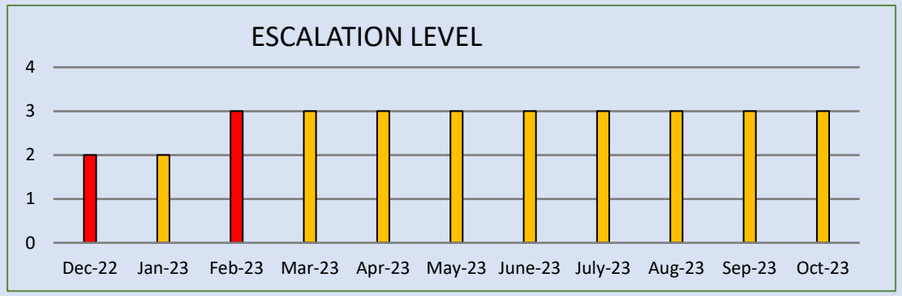
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

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

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan did not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The current financial pressures and savings plans requested by WG have resulted in the Health Board re-profiling the trajectories and unlikely to meet contract volumes for the remainder of the financial year.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

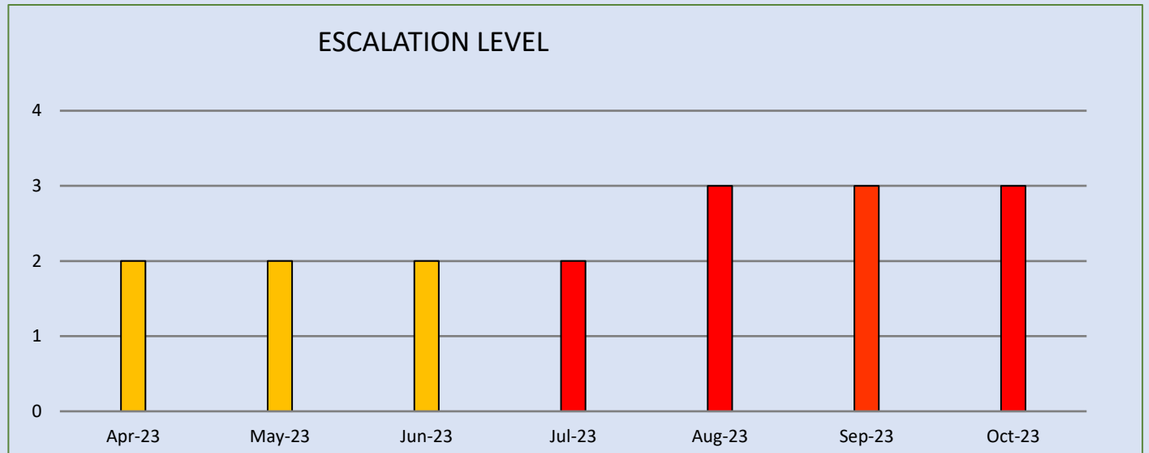
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

Date	Escalation Level

Rationale for Escalation Status :
Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	31 October 2023	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	31 October 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

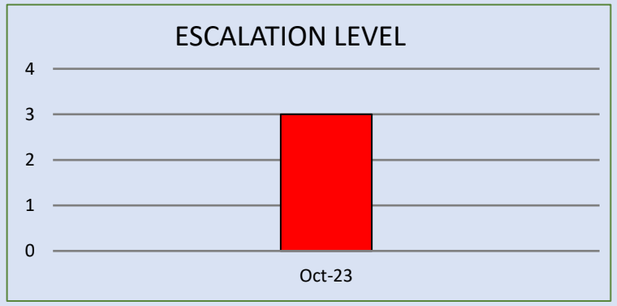
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:

The service were only notified of escalation in late September therefore at the time of writing the report the objectives have not yet been set.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

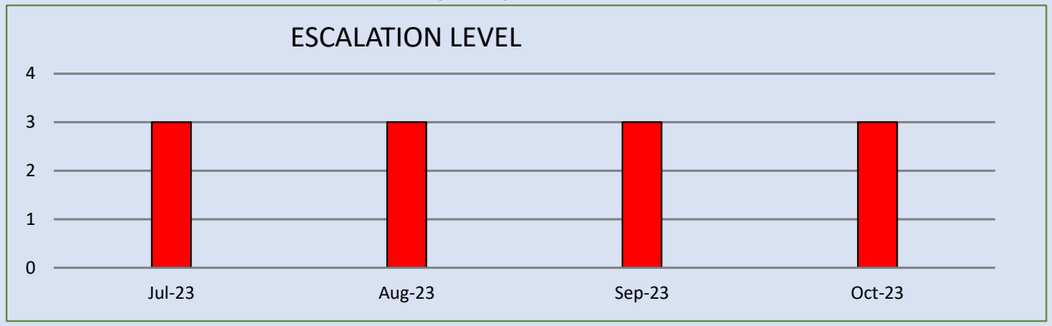
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

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

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:

Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.
The service are due to submit a progress report to the HFEA by the 18th October. HFEA re-inspection is due to take place in January 2024.

Actions:

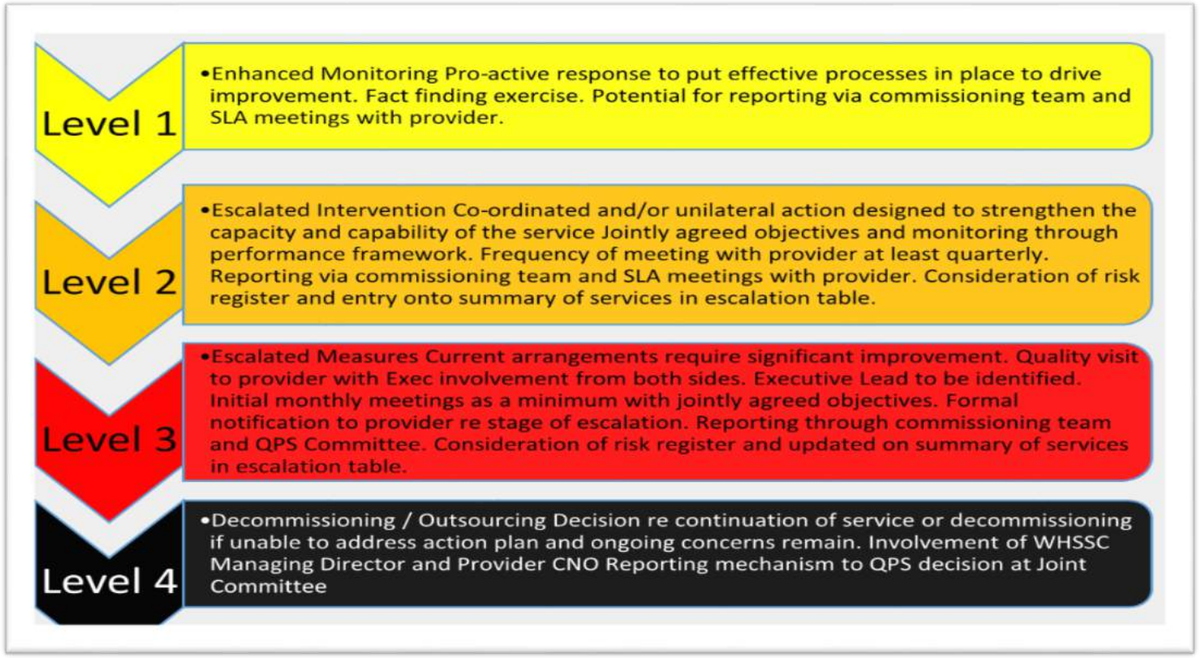
Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7th August 2023	7th August 2023
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit	Assistant Specialised Planner	14th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	7th August 2023
SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 2023

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

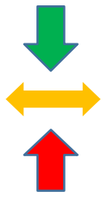
Appendix 1

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.
Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.

Appendix 1



SERVICES IN ESCALATION



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Highlight Report

Group Name:	**ABUHB Safeguarding Committee**		
Group Aim:	The Safeguarding Committee has delegated authority to establish and implement the strategic direction of safeguarding activity across the Health Board, providing assurance that legal requirements and national guidance are incorporated into policy.		
Date Completed:	30 November 2023	**Date of last meeting:**	8 November 2023
Completed By:	Howard Stanley – Head of Safeguarding		
Distribution:	PQSOC		
Summary:	This highlight report contains a brief summary of discussions at the ABUHB Safeguarding Committee.		

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

The high level of DoLS activity was discussed and the pressures this is putting on the system. Still no updates regarding LPS, which is on hold, but will release some of the pressures. Risk to be updated on risk register.

Divisional Reporting

The Divisional representatives presented templates in relation to safeguarding themes and challenged. Whilst training was a theme, it was also agreed that some form of measurement of performance would be useful. The Medical Division have agreed to work with Corporate Safeguarding in develop and testing of an audit tool.

Section 5/Practitioner Concerns

Work is underway within ABUHB, to look at how to restructure the Practitioner Concerns process. It was agreed that there should be representation from senior members of workforce. Therapies, Nursing and Medicine to ensure the new process dovetails with professional reporting expectations and fitness to practice.

Multi Agency Risk Assessment Conference (MARAC)

Concerns were discussed regarding the sustainability of MARAC across the Gwent footprint and the risks associated with other agencies aiming to reduce their current level of funding, placing pressures on the Health Board to provide further resourcing. It was agreed that we would actively contribute to the Multi Agency review of the process and consider any requests for funding once this work is completed.

Safeguarding Training

Divisions presented their current training compliance and, whilst gaps are evident in Level 1 and Level 2, were able to offer reassurance that this is not amongst patient facing staff. Uptake of level 3 training is improving, but work remains to be done via ESR to ascertain compliance levels, as there is currently no formal record of training.

Aneurin Bevan University Health Board

Clinical Standards Effectiveness Group

Minutes of the Meeting of the Clinical Standards Effectiveness Group held on Thursday, 20th July 2023 at 14:00-16:00, via Microsoft Teams

Dr Leo Pinto (LP)	Asst Med. Dir. for Clinical Effectiveness & Consultant Physician (Chair)
Leeanne Lewis (LL)	Asst. Dir. of Quality & Patient Safety (Vice Chair)
Dr Stephen Edwards (SE)	Consultant Anaesthetist, & Deputy Med. Director
Pam Price (PP)	Quality & Patient Safety Administrator (notes)
Pip Ellaway (PE)	Quality & Patient Safety Administrator (observer)
Sarah Cadman (SC)	Head of Quality & Improvement, MH&LD
Caroline Rowlands (CR)	Deputy Head of Nursing, QPS and Nurse Education
Dr Tom Morgan-Jones (TMJ)	Consultant Anaesthetist & Scheduled Care Div. Dir.
Susan Dinsdale (SD)	Assistant Divisional Nurse, Family and Therapies
Dr Clifford Jones (CJ)	Primary Care Clinical Director Division
Craig Roberts (CR)	Asst Dir. of Therapies and Health Science, Corporate Services
Daniel Jones (DJ)	Radiographer
Rhys Monk (RM)	Directorate Manager for Stroke, CoTE, Neurology & Nephrology

Guests in attendance:

Nigel Brown (NB)	Consultant Cardiologist
Linda Edmunds (LE)	Consultant Nurse, Cardiac Rehabilitation
Heather Rodgers (HR)	Consultant Anaesthetist
Aled Rees (AR)	CT2 Anaesthetics

CSEG 21/09/01 Welcome and Introductions

Dr Pinto (Chair) welcomed all attendees to the meeting and requested a round of introductions.

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

Apologies for Absence

No apologies received.

Declarations of Interest

There were no declarations made of potential conflicts of interest by those attending the meeting.

Draft Minutes of the Meeting held on 20th July 2023

Agreed by the group as an accurate representation of discussions, presentations and action plans.

CSEG 21/09/02 – Management of Heart Attack: analyses from the **Myocardial Ischaemia National Audit Project (MINAP) data from 2021/2022**

Clinical Lead - Dr Nigel Brown, Consultant Cardiologist

The Clinical Lead (CL) stated that MINAP reports one year in arrears and currently data for 2022/2023 is being completed and validated. The data relates to metrics for and ST segment elevation myocardial infarction (STEMI) and Non-ST segment elevation myocardial infarction (NSTEMI). Lasts years data (2020-2021) was incomplete due to staffing issues as MINAP requires a full time and experienced clinical member of staff. Previous case ascertainment (CA) was approx. 60% affecting the data quality. The total number of cases for 2020-2021 was 541, with 130% Stringent CA and 103% non-stringent CA, the difference between the two is the position on the clinical coding data.

One metric looks at the proportion of patients reviewed by a cardiologist; the National Average 97% and the median across Welsh Health Boards is 98% with Aneurin Bevan University Health Board at 99%. Patients admitted direct to a Cardiac ward within 24 hours relates to patients with NSTEMI as patients with STEMI go direct to Cath Lab and then direct to a cardiac ward. The national picture is 64%, low risk NSTEMI admitted to a cardiac ward, median for Wales is 72% the Health Board at 75.4%. Bed availability, and delayed transfer from Local General Hospitals (eLHG's) plays a role here.

The metric relating to NSTEMI patients undergoing angiography during the index admission shows a very high ABUHB figure of 94%, cf Wales median 90% and nationally 83%. Disappointingly, there has been a fall in the proportion of patients undergoing angiography within 72 hours of admission. The Health Board compliance sits at 29.5% with the median rate across Wales of 48.9%. The notional UK target is 60%. This is the most concerning area of this report for the Health Board. SE asked if there was data relating to the harm level of these delays, the CL stated that this type of data was not currently quantifiable but patients are prioritised and escalated on the basis of risk so some patients will have immediate or < 24 hr intervention if their clinical condition merits this. A Saturday morning angiography/PCI session is carried out for lower risk patients.

Secondary prevention medication at time of discharge of a patient with either NSTEMI or STEMI, NA 89%, Wales 70% and the Health Board 70%. This figure now includes aldosterone antagonists in the setting of LVSD with an EF < 30% and requires review. Patients may have contraindications or legitimate reasons for non-prescription and an additional pharmacy checklist to include prescription of aldosterone antagonist's will be developed.

Primary PCI data has not been reported as numbers for the Health Board are low due to not being a designated Heart Attack Centre, Primary PCI is only undertaken in the Health Board if the patient has Myocardial Infarction (MI) whilst admitted for another reason or self-presents and there is capacity within the Cath Lab. The expectation for the data currently being validated (2022/2023) is that the Health Board has

exceeded the minimum limit of 20 for reporting, with more self-presenters and improved staffing levels in the Cath Lab creating flexibility to take on more cases.
98% of the Health Board patients compared to the Welsh median of 92% underwent in-patient echocardiography. This is in line with good practice to determine left ventricular function before discharge and whether they require follow up with heart function nursing team.
The CL noted that this result is a credit to the Physiology Team at Grange University Hospital (GUH) providing an excellent service in challenging circumstances.
Cardiac Rehabilitation referral performance is good at 88%, higher than the Welsh NA of 85%. The Health Board performance has steadily improved on this measure due with virtual appointments offered for patients who previously would struggle to attend.

Report: National Recommendations:

1. Where CTB time standards are not being met in STEMI cases, emergency departments, PCI centres, neighbouring non-interventional hospitals and ambulance trusts should work together to reduce delays in the provision of primary PCI. This may include improving the hospital response to patient arrivals (Door-To-Balloon (DTB) times) as well as pre-hospital Call-To-Door (CTD) times.
   Hospitals not able to offer primary PCI to patients with STEMI who self-present, especially if geographically remote from such services, should consider re-introducing care pathways that include immediate administration of intravenous thrombolytic drugs.
   Currently the Health Board is designated a non-Heart Attack Centre, small numbers of PPCI are undertaken (mainly self-presenting patients during working hours) but the numbers are < 20 per annum and therefore not reported.

2. Hospitals with lower rates of echocardiogram provision, for STEMI and NSTEMI, should ensure that their data are being collected accurately and, if needed, should identify opportunities for echocardiography during the index admission.
   The Health Board performs very well with 94.64% of patients undergoing echo during admission (STEMI & NSTEMI).
   Use of limited 'bedside' targeted-assessment echocardiograms should be considered if there are difficulties obtaining timely detailed tests.
   Patients discharged to another hospital before an echocardiogram is performed must be accompanied by a clear request for the test at the receiving hospital.
   This reflects excellent work by the Physiology Team at Grange University Hospital (GUH)

3. Hospitals not sufficiently admitting heart attack patients to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those cared for elsewhere. **The proportion of patients admitted to a cardiac ward in ABUHB is 75.4%. This compares favourably to the national average of 64%. Please note this figure represents admission *within 24hrs* so delays on the assessment unit or patients awaiting transfer from eLGH sites reflects the remainder and sits at approximately 24.6%. The cardiology team**

have developed a draft SOP which proposes an alternative use of additional bed capacity on B4 (currently GIM step down patients) to allow rapid transfer within 24hrs of all accepted eLGH patients.

4. Hospitals reporting low rates of cardiology involvement in heart attack patient care should ensure their data are accurately reflecting practice. If they do, provision of cardiac care during admissions should be improved (for example by increased staffing or more flexible use of members of the cardiology team, such as nurse specialists and physician associates). **ABUHB perform exceptionally well with 99 % of patients were seen by a cardiologist (97% nationally).**
5. Low rates of angiography in eligible NSTEMI patients require hospitals to review their systems for managing acute coronary syndromes (ACS). **ABUHB perform well with angiography during admission in 94.43% of patients (Wales median 90.1%, 83% nationally in UK)**
6. Where angiography for NSTEMI takes more than 72 hours, hospitals and commissioners should review pathways, referral networks and service commissioning to make quality improvements. Any lessons regarding more timely care that were learned during the pandemic should be incorporated within existing pathways.
   There should be an emphasis on early and reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals. This will involve weekend angiography lists for such patients.
   29.6% patients underwent angiography within 72hrs compared to a median of 49% in Wales and 56% nationally. A previous notional target of 60% had been set in England (tariff based). This figure does not take account of patients with legitimate reasons for delay such as anaemia or infection and the proportion of our patients with co-morbidities/legitimate delays may be higher and will be investigated further. Preliminary review of 2022-2023 data suggests approximately 25% will have a legitimate delay. Nevertheless, several issues that contribute to delays are listed in order of importance including;
   a) catheter laboratory time (elective patients/lists/complex case work/CTO's compete) and staffing constraints (medical, nursing, radiographer and physiology)
   b) delayed transfer from eLGH's (e.g.1 patient taking a week in 2022)
   c) weekend cover is limited to Saturday am so Friday admissions will generally wait more than 72 hours unless urgent.
7. Hospitals not meeting the prescribing standard for all secondary prevention medication prior to discharge of both STEMI and NSTEMI patients should assess the quality of their data and, if sub-optimal performance is confirmed, pursue quality improvement. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or ACS nurse specialists. **The percentage of patients discharged on all appropriate secondary prevention medication was 70.13%, identical to a median figure of 70.44% in Wales but lower than the UK average of 89%. This has fallen and may reflect issues with prescribing aldosterone antagonists in impaired LV function (newly added to this combined endpoint) but inadequate documentation of intolerance/CI (e.g., due to hypotension with ACE, or hyperkalaemia in the case of**

aldosterone antagonist's) or a legitimate decision not to prescribe. The MINAP database will be further analysed and we will discuss the role of an additional checklist on discharge.

8. Hospitals with lower rates of prescribing aldosterone antagonists for patients with impaired LV function identified by echocardiography (or some other reliable assessment method) should act to ensure appropriate treatment. This could involve discharge pro-forma/checklists and the direct involvement of specialist cardiac pharmacists, ACS nurses and sonographers. **This data for aldosterone antagonist's is now included within the standard above for secondary preventative medications. Clear documentation of medication decision may be an issue and will be the focus of another discharge medication checklist to put together with our pharmacy lead.**
9. Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI heart attacks should ensure early identification of patients who might benefit (for example through routine distribution of cardiac rehabilitation information/invitation in discharge checklists and in leaflets given to all patients). All hospitals should ensure equitable access to cardiac rehabilitation. Rehabilitation staff who were redeployed to ward-based duties during the pandemic should return to their original practices. **A high proportion of 88.37% of patients were referred to cardiac rehabilitation programmes (Welsh Median 85.34%, UK almost 89%). The national UK aspirational target is 85%.**

Successes:

1. Case ascertainment has improved considerably.
2. Achieving most targets, including high provision of echocardiography.
3. High levels of assessment by a cardiologist and angiography.
4. High referrals rates for rehabilitation.

Concerns:

1. Delays to angiography/intervention
2. Delays in step-ups from eLGH's
3. Staffing levels and catheter laboratory constraints

Actions: ***(Specific, Measurable, Achievable, Relevant, Timely)***

- Retrospective review of the MINAP database to better understand detail behind delays
- Ensure harm e.g. events in patients waiting intervention captured
- Additional pharmacy checklist
- Divisional discussion re investment in uplift in catheter laboratory capacity and possibly more formal "trigger points" for review of e.g., elective activity
- Report to be discussed in Quality Improvement Group and at divisional level

CSEG 21/09/03 – Update on Pre-Operative Fasting Guidance 'Sip Til Send'

Aled Rees, CT2 Anaesthetics provided an explanation as to why patients are fasted pre-operatively for context to understand the update to the guidance. National Audit Project (NAP 4) managed by the Royal College of Anaesthetics and the Difficult Airway Society is the largest UK study of its kind and recorded 36 cases of aspiration in 115,000 general anaesthetics, risk of less than one in 3000. There is often confusion around the guidance of when a patient should be fasted from before anaesthetic.

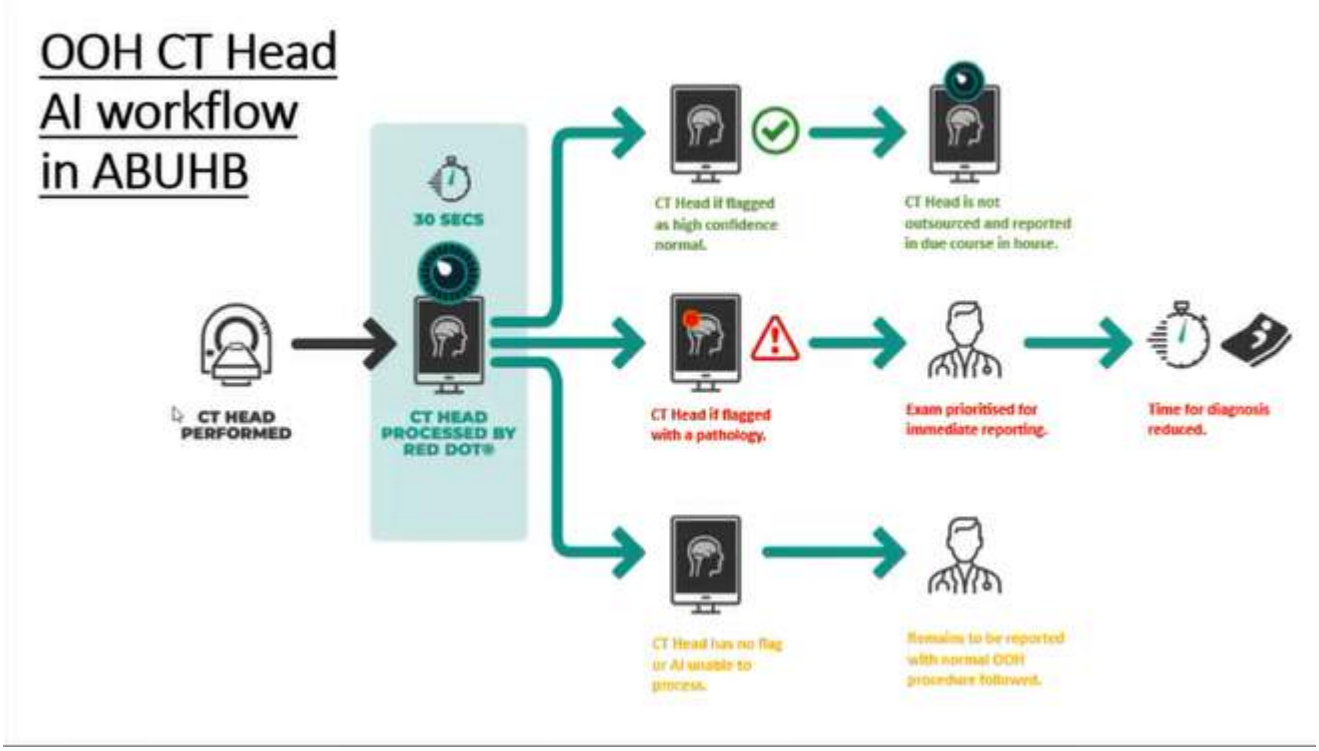
Currently the Health Board follow guidelines from 2011 and paediatrics from guidance in 2018. Often fasting times are longer than needed and effects are that patient are discomfort and anxiety, de-hydrated, Post -Operative Nausea and vomiting, and increased gastric volume and there is uncertainty about medicines management. Gastric emptying risks have changed and can have an adverse effect. Organisations across the UK have introduced alternative pre-fasting guidance termed 'Sip Til Send' policies, which encourage patients to drink clear fluids up to the point of sending for surgery.

A review in October 2022 found that 21 Trusts in England had introduced these new fasting policies with 15 removing time limits all together with no risks recorded and ESA guidance is currently under review. 'Sip Til Send' can also be used in many emergency cases as well as elective. Identification of higher risk patients should be completed on a case-by-case basis with both surgical and anaesthetic review. AR presented the new Health Board guidance based on the 'Sip Til Send' guidance for both adults and paediatric cases grouped by age and emergency guidance with exceptions where the new guidelines would not be used.

It was identified that this process was cost neutral, safe and reduces fasting times and harm associated with excessive pre-operative fluid fasting. The Health Board is currently running an education programme for staff and information supplied to surgical ward and staff, update patient information leaflets and protocol on DATIX for any issues. HR also provided the group with the confirmation of the confidence of this guidance and requesting approval from this group.
LL confirmed that this guidance had been signed off by anaesthetics and surgical colleagues and how this links to the hydration and nutrition group and effects of improved discharge when reducing de-hydration risks. HR brought in Charlotte Thomas to the call to confirm agreement by surgical colleagues and to emphasis the benefits of the new guidance.
TMJ fully supported the new guidance. CR asked if he could invite AR to the Nutrition and Hydration Group for information.
LL confirmed that there is adequate representation within the group and the evidence is clear to sign off this new guidance and follow up signed documentation.

CSEG 21/09/05 - Artificial Intelligence -CT Head

Daniel Jones, Radiographer previously came to the group to discuss the CT chest pilot using Artificial Intelligence (AI), and now wants to discuss the use of AI for Head Reporting would remain the same however the use of AI would trigger emails to prioritise cases, using smart worklists. The benefits would be quicker pathways for patients, which is being seen with eh chest CT AI. There would also be a significant cost saving. Last financial year over £30,000 was spent on outsourcing CT heads scans. Data to evidence the benefits will be taken through the governance channels. Normal scans will be recommended as inhouse reporting and urgent results outsourced, which is expected to save money even after paying the AI license fee.
This will have benefits to the workflow and patient outcomes. AI for the chest scans has picked up GP cases of primary lung cancers in 3 days compared to the previous 37 days. With increasing workloads and without AI the teams could not sustain the current workload. DJ shared the workflow diagram:



Dr Pinto requested clarification on whether a radiologist has oversight, which was confirmed that reporting is carried out in the normal way, reported by the usual radiology staff. It was noted that the pilot is for 3 months, with no significant costs to the Health Board. If this was to be continued, then there would be integration costs, which has been discussed with the radiology department. LL would like the pilot to be presented back to the group with the results. Dr Pinto queried the paperwork being approved by NICE especially in terms of the CT as there is a briefing on chest x-rays but not specific to CT. DJ will look at this and feedback to the group. Action was to ensure the paperwork for approval reflected the discussion at CSEG and to include projected costs and that the pilot needed to be evaluated.
CR asked if a compendium of AI is being developed in the Health Board, LL stated that this would sit with the informatics team and will request if this can be shared. DJ was asked to update the application for the group and clarified that the group approval is for the trial period only.

CSEG 21/09/06 - Artificial Intelligence -Brainomix

Rhys Monk, Directorate Manager for Stroke, informed that the Brainomix is an AI system used to diagnose and identify patient with varying symptoms because of Stroke. It has been procured on an All-Wales basis and implementation is being led by a project team form NHS Wales Health Collaborative and has gone through governance and processes with Digital Health Care Wales and now approval is required from within the Health Board. Other Health Boards are in the process or due to implement this within their services.
Thrombectomy rates in Wales are low, at 1% with the Health Board slightly higher at 1.9% the belief is that with proper support and procedures in place that can be increased up to about 10%, which will have excellent improvements in patient outcomes from length of stay, reducing disability after a stroke and a reduction in mortality rates as well, which all naturally translate into cost savings. Dr Bhatt, Clinical Director for Stroke is backing this application and supported by the Medicine Divisions SMTP. Funding issues remains ongoing, Dr Pinto stated that with the funding needs to be

provided in the application. LL stated that whilst this was to be led as an initiative by Welsh Government, they had not provided funding. Other Health Boards have maintained the funding; however, this would be an issue for the Health Board to fund recurring funding. RM stated that it is difficult to evidence the savings on bed days and outcomes with regards to freeing up financial resources. These processes can be in place upfront of funding to enable the Health Board to move on as soon as funding is allocated.
Dr Pinto confirmed that the group are happy to fund in principle based on the funding being acquired.

Next meeting Thursday 30th November 2023 @ 14:00 – 16:00