# Patient, Quality, Safety & Outcomes Committee

*Tue 30 April 2024, 09:30 - 12:30*

**Microsoft Teams**

# Agenda

## 1. PRELIMINARY MATTERS

### 1.1. Welcome and Introductions

*Oral* *Chair*

### 1.2. Apologies for Absence

*Oral* *Chair*

### 1.3. Declarations of Interest

*Oral* *Chair*

### 1.4. Draft Minutes of the last Meeting held on 23rd February 2024

*Attached* *Chair*

### 1.5. Committee Action Log

*Attached* *Chair*

## 2. ITEMS FOR APPROVAL/RATIFICATION

### 2.1. Quality Report (Interim)

*Attached* *Clinical Executives*

- **Local Authority Safeguarding Update**

### 2.2. Listening and Learning Framework

*Attached* *Director of Nursing*

### 2.3. Development of Committee Annual Programme of Business 2024/25

*Attached* *Director of Corporate Governance*

### 2.4. Committee Annual Report 2023/24

*Attached* *Director of Corporate Governance*

## 3. ITEMS FOR DISCUSSION

### 3.1. Committee Risk Report

*Attached* *Director of Corporate Governance*

### 3.2. Overview of Audit Recommendation Tracking

*Attached* *Director of Corporate Governance*

### 3.3. Learning from Death Report to include an update on the Learning from Death Framework

*Attached* *Medical Director*

### 3.4. Update on the Management of Higher Risk Surgical Patients in the Royal Gwent Hospital POCU

*Attached* *Medical Director*

### 3.5. 3-year Welsh Government Assurance Report on Compliance with the NSLWA 2021-2024

*Attached* *Director of Nursing*

## 4. FOR INFORMATION

### 4.1. Clinical Audit Annual Plan and Clinical Audit Annual Activity Report

*Attached* *Medical Director*

### 4.2. Healthcare Inspectorate Wales Annual Report

*Attached* *Director of Nursing*

### 4.3. WHSSC QPSC Chairs report presented to the JCC meeting on 23 April 2024

*Attached* *Director of Corporate Governance*

## 5. OTHER MATTERS

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

*Oral* *Chair*

### 5.2. Any Other Business

*Oral* *Chair*

### 5.3. Committee Reflections

*Oral* *Chair*

### 5.4. Date of the Next Meeting

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

# MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

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| DATE OF MEETING | Friday 23rd February 2024 9:00-11:00 |
| VENUE | Microsoft Teams |

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| PRESENT | Pippa Britton, Independent Member, Committee Chair<br>Paul Deneen- Independent Member<br>Helen Sweetland- Independent Member |
| IN ATTENDANCE | Nicola Prygodzicz, Chief Executive<br>Jennifer Winslade, Director of Nursing<br>Rani Dash, Director of Corporate Governance<br>Peter Carr, Director of Therapies & Health Science<br>James Calvert, Medical Director<br>Michelle Jones, Head of Board Business<br>Leeanne Lewis, Assistant Director of Quality & Patient Safety<br>Rhian Gard, Deputy Head of Internal Audit<br>Heledd Thomas, External Audit<br>Tracey PartridgeWilson, Deputy Director of Nursing<br>Ian Jenkins, Head of Systems Planning<br>Howard Stanley, Head of Safeguarding<br>Fern Cook, Committee Secretariat |
| APOLOGIES | Louise Wright- Independent Member, Vice Chair |

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| PQSOC 2302/1 | Preliminary Matters |
| PQSOC 2302/1.1 | Welcome and Introductions<br><br>The Chair welcomed everyone to the meeting. |
| PQSOC 2302/1.2 | Apologies for Absence<br><br>Apologies for absence were noted. |
| PQSOC 2302/1.3 | Declarations of Interest<br><br>There were no declarations of interest raised to record. |
| PQSOC 2302/1.4 | Minutes of the previous meeting<br><br>The minutes of the Patient Quality Safety and Outcomes Committee held on 13th of December 2023 were agreed as a true and accurate record. |

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| PQSOC 2302/1.5 | Committee Action Log<br><br>The Committee received the action log, and was content with progress made in relation to completed actions and against any outstanding actions. |
| PQSOC 2302/2 | **Items for Approval/Ratification** |
| PQSOC 2302/2.1 | Safeguarding Annual Report<br>*Howard Stanley joined the meeting*<br><br>Howard Stanley (HS), Head of Safeguarding, provided an overview of the Safeguarding Annual report.<br><br>The following key points were highlighted to the Committee: -<br>A learning Group had been set up to monitor the progress of the recommendations.<br>There were challenges around the national requirements for level 3 children and adults learning.<br>These challenges related to the large cohort of people that would need to undertake this training.<br>The Committee was assured that advice had been sought from the ESR team as to how this could be included on the relevant system.<br>Increase in numbers of children being harmed, that had resulted in additional strategy meetings being held.<br>Increase in adult safeguarding concerns with a Datix submitted for incident reported, were monitoring the Datix system regularly.<br>Support was being provided to one local authority, as a result of their additional requirements. The Committee requested that in the next annual report a section outlining the support to staff members be included. Action: Jennifer Winslade, Director of Nursing<br><br>Paul Deneen (PD), Independent Member, questioned why there was an issue with one local authority. HS advised that this Local Authority had capacity issues and noted that the Health Board was meeting with their Executive team to address this matter, but noted that the Health Board would continue to follow their process in reporting concerns. The Committee requested a further updated on this matter at the next Committee meeting in April 2024. Action: Jennifer Winslade, Director of Nursing & Howard Stanley, Head of Safeguarding.<br><br>*The Committee APPROVED the Annual Safeguarding report.*<br>*Howard Stanley left the meeting.* |

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| PQSOC 2302/3 | Items for Discussion |
| PQSOC 2302/3.1 | Committee Risk Report<br><br>Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of the current strategic risks that have been delegated to the Committee for monitoring, highlighting that the pharmacy robot risk had been included from the Corporate Risk Register.<br><br>The Committee noted that the following risks were highlighted in the report at a risk level of Extreme (20) :-<br>There was 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.<br>There was a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.<br>There was a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.<br><br>*The Committee NOTED the following:-*<br>*delegated strategic risks*<br>*delegated corporate risks*<br>*the work being undertaken to reduce the risks to within the risk appetite level, and,*<br>*the ongoing work to improve risk management across the quality and patient safety domain.* |
| PQSOC 2302/3.2 | Overview of Audit Recommendations<br><br>Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the internal and external recommendations resulting from planned audit reviews that fall under the remit of the Committee.<br><br>The Committee noted that there were 32 outstanding actions in relation to this committee that were covered across the following audit reports:-<br>Health & Safety<br>Medical Equipment and Devices<br>Medicines Management<br>Monitoring Action Plan<br>Discharge Planning<br>Dementia Service<br>Structure Assessment<br>Putting thing right: Advisory Review |

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| | Helen Sweetland (HS), Independent Member, sought assurance that an action plan was in place for those actions that had been outstanding for a period of time. RD advised that there were action plans in place that covered all the recommendations highlighted and advised the Committee that the progress of these recommendations was monitored by the Audit, Risk, Assurance Committee.<br><br>*The Committee NOTED the report and in doing so, the position of the 32 audit recommendations.* |
| PQSOC 2302/3.3 | Focus on the Pillars of Quality<br><br>*Ian Jenkins joined the meeting*.<br><br>Jennifer Winslade (JW), Director of Nursing, supported by Leeanne Lewis (LW) Assistant Director of Quality & Patient Safety, Ian Jenkins (IJ), Head of Systems Planning, Tracey PartridgeWilson (TPW), Deputy Director of Nursing, Peter Carr(PC), Director of Therapies & Health Science, provided the Committee with an overview of the patient quality safety outcomes performance report for February. priorities.<br><br>The Committee was appraised of the report content noting that it also covered the relevant Ministerial priorities. The Committee noted that the report included the following areas: duty of candour, HEIW, bereavement, Medication Safety Group, Complaints, Health and Safety, Planned care and the noted the following key points -<br><br>o The Annual Duty of Candour performance report was due to be completed in April 2024.<br>o Since 1 April 2023 there have been 20,807 incidents affecting patients reported on the Datix Cymru system.<br>o Progress had been made with responding to complaints within 30 days, and that there was still work required to ensure compliance.<br>o A new Head of Complaints had now been appointed and this role would over the next 6 months focus on the compliance.<br>o A notification of Contravention for breaches to health and safety law, from the HSE had been received in relation to a fall at Nevil Hall hospital in 2019<br>o During the period, 94 incidents were reported to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.<br>o Manual handling training compliance required improvement from the 54% compliance level recorded. The Committee was advised that an external provider was supporting the provision of additional courses |

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| | o 7 risk areas had been identified as a focus for improvement in 2024, and that these would be progressed through the implementation of an action plan.<br>o HEIW had inspected Talygarn Unit at County Hospital earlier this year and the Health Board had responded to the improvement notice that had been received in respect of this inspection.<br>o In terms of planned care, it was noted that:<br>  o although improvements had been made, the Health Board had not achieved the targets for the year, and a review was underway to identify learning opportunities to aid improvements in performance<br>  o Endoscopy unit at the Royal Gwent hospital opened in November 2023<br>o At each Clinical Effectiveness meeting the Clinical leads action plan was being considered, to address the recommendations identified within the service area.<br>o AMAT system funding had been approved by the Executive Team.<br><br>Paul Deneen (PD), Independent Member, questioned how the Health Board's incidents compared to other Health Boards. TPW advised that following the implementation of the duty of candour there had been an increase in the reporting of incidents, even if a patient did not suffer any harm. JW agreed that the themes of the incidents would be included in the next performance report. Action: Jennifer Winslade, Director of Nursing<br><br>PC assured the Committee that an improvement plan was in place to support each risk with regular review and updates being collated.<br><br>Pippa Britton (PB), Committee Chair, questioned how often the Planned Care outpatients waiting list data was reviewed to determine if there was a need to refocus the actions required. The Committee was advised that from a programme perspective the data is reviewed on a monthly basis with the data shared annually with Welsh Government.<br><br>*The Committee NOTED the information within the report.*<br><br>*Ian Jenkins left the meeting.* |
| PQSOC 2302/3.4 | Q3 Quality Outcomes Framework (QOF) |

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| | Jennifer Winslade (JW),Director of Nursing, provided the Committee with an overview of the Quarter 3 Quality Outcomes Framework, and noted that the framework would be prestented to Board in March 2024.<br><br>The Committee noted that the QOF was updated quarterly and included the data available at that time. The Committee was advised that the 2023/24 the Quality Outcomes Framework was reviewed and, where appropriate, aligned with the 6 Domains of Quality.<br><br>Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, advised the Committee of an exception as at this time not all data was available for inclusion but confirmed that this would be included when submitted to Board.<br><br>*The Committee NOTED the information provided regarding the Quality Outcome Framework* |
| PQSOC 2302/3.5a<br><br>PQSOC 2302/3.5b | Maternity Services<br><br>Jennifer Winslade (JW),Director of Nursing, provided the Committee with an overview of the Maternity Services improvement plan. The Committee noted that the plan covered the following areas that included:<br>how the maternity service would achieve high-quality maternity care<br>the approach to providing individualised care, and reductions in health inequalities<br><br>The Committee was advised that the duration of the improvement plan was a three-year period and confirmed that the Committee would receive regular updates on the progress made which would be scheduled into the Committee's forward workplan.<br><br>Helen Sweetland (HS), Independent Member, questioned how the priorities within the plan were identified. JW advised that the priorities were built from the maternity services reports and priority list.<br><br>*The Committee NOTED the ongoing work to implement and embed improvements within maternity services.*<br>Implementation progress update on the Configuration of Midwifery-Led Units<br><br>Jennifer Winslade (JW),Director of Nursing, provided the Committee with an overview of the progress made in the reconfiguration of Midwifery-led birthing units. |

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| | The Committee noted that the service had initiated an agreed temporary change model in May 2022 as a direct result of significant staffing challenges to ensure safe staffing levels across the Health Board. Following this change an independent review of the community-led midwife birthing services had been completed along with a comprehensive public engagement exercise in September 2023. The Committee noted that this work culminated in the Board approving the permanent service reconfiguration.<br><br>JW provided the Committee with an overview of the improved outcomes following the introduction of the reconfigured service that included:-<br>Staffing,<br>o Sickness: 6.01%, although it was noted that short term sickness had increased in the Grange hospital.<br>o Community Midwives report improved work life balance.<br>o The service had actively and successfully recruited during 2023 which had resulted in a significant decrease in vacant posts.<br>Transfer Rates, National average transfer rate from free standing birth unit was 36-45% for first time mothers and 9-12% for women who was having subsequent births. An increase was noted in August 2022, but overall, in line with national picture.<br>Families living near to GUH, YAB and YYF continue to have birth options closer to home.<br>Inequity for families (NHH and RGH) as unable to offer choice of place of birth close to home, however no concerns have been raised in regards to this.<br>No informal or formal concerns raised regarding inability to birth in RGH/NHH<br><br>*The Committee NOTED the evaluation of the reconfiguration of the midwife led units as set out in the report.* |
| PQSOC 2302/3.6 | Internal Audit Review – Medical Devices – Action Plan **Update**<br><br>Peter Carr, Director of Therapies & Health Science, Provided the Committee with an overview of the risks associated with the current governance arrangements for the management of medical devices and equipment within the Health Board. |

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| | The Committee was advised that the Health Board had been challenged in achieving compliance and noted Audit recommendations from 2017/2018 relating to the following:-<br>Presence of medical devices – It was noted that work was in progress to identify competency and compliances at ward and department level. It was noted that this action would be completed by May 2024.<br>Equipment registers – The Committee noted that this relates to the physical tracking of devices, and to provide assurance of safe medical device user training levels. The Committee noted that this action was scheduled to be completed in March 2024.<br><br>The Committee was advised that an internal audit review was currently ongoing in respect of Medical Equipment & Devices.<br><br>The Committee was advised that the Health Board was going to establish a Working Group that would sit under the QPS team to ensure that compliance with recommendations was maintained.<br><br>James Calvert (JC), Medical Director, advised of the capacity issues that are ongoing with tracking medical devices and the actions to address this.<br><br>PC assured the Committee that a paper would be brought back to a future Committee to provide an update on progress. This would be scheduled into the Committee's forward workplan.<br><br>*The Committee NOTED the report for assurance.* |
| PQSOC 2302/4 | Items for Information |
| PQSOC 2302/4.1 | WHSSC QPS Committee Annual Report<br><br>The Committee RECEIVED the report for information. |
| PQSOC 2302/4.2 | Children's Rights & Participation Forum<br><br>The Committee RECEIVED the report for information. |
| PQSOC 2302/5 | Other Matters |
| PQSOC 2302/5.1 | To confirm any key risks and issues for reporting/escalation to Board and/or other Committees<br><br>There were no key risks and issues for reporting/escalation to Board and/or other Committees. |

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| PQSOC 2302/5.2 | Any Other Urgent Business<br><br>There was no urgent business. |
| PQSOC 2302/5.3 | Date of the Next Meeting:<br><br>30th April 2024 – 09:30am |

**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 |
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| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| 13th December 2023 | PQSOC 1312/2.1 | Annual Report: Putting Things Right (PTR) Annual Report 2023<br><br>Report on human factors issues identified through PTR to the next Committee Meeting | Director of Nursing | April 2024 | On April agenda included in the Quality report item 2.1.<br><br>Complete |
| 13th December 2023 | PQSOC 1312/3.6 | Patient Quality and Safety Outcomes Performance Report, December 2023<br><br>Learning from Death Framework to be brought to a future Committee meeting. | Director of Nursing/ Medical Director | April 2024 | On April agenda item 3.3<br><br>Complete |
| 23rd February 2024 | PQSOC 2302/2.1 | Safeguarding Annual Report<br><br>Support was being provided to one local authority, as a result of their additional | Director of Nursing | September 2024 | Not Due |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| | | requirements. The Committee requested that in the next annual report a section outlining the support to staff members be included. | | | |
| 23rd February 2024 | PQSOC 2302/2.1 | Safeguarding Annual Report<br><br>Local Authority had capacity issues and noted that the Health Board was meeting with their Executive team to address this matter, but noted that the Health Board would continue to follow their process in reporting concerns. The Committee requested a further updated on this matter at the next Committee meeting in April 2024. | Director of Nursing & Head of Safeguarding. | April 2024 | On April agenda item 2.1<br><br>Complete |

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

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
|---|---|---|---|---|---|
| 23rd February 2024 | PQSOC 2302/3.3 | Focus on the Pillars of Quality<br><br>There had been an increase in the reporting of incidents, even if a patient did not suffer any harm. JW agreed that the themes of the incidents would be included in the next performance report. | Director of Nursing | June 2024 | Not Due |

*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.*


# Patient Quality, Safety and Outcomes Committee

# Performance Report

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

## APRIL 2024

# 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
  - Civica implementation plan completed – working continues with Divisions to embed in patient experience and feedback
  - Working on recording of compliments
  - PALs team fully embedded
- Incident reporting and severity of harm
  - Thematic reviews and learning
  - Pressure ulcers update
  - RAMI and crude mortality updated
  - Validation of data for Duty of Candour
- Complaints and concerns
  - Continue to focus on closure of historical complaints over 6-12 months
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

**Urgent Care**

Planned Care

Cancer

# Good Practice and Learning from Feedback

## Section 1

# Bereavement:

# The Big Conversation

- 20th March 2024
- 170 attendees (public, staff, partners, stakeholders)
- 9 round table discussions
- 51 Messages to loved ones
- Bereavement Collaborative- 50 expressions of interest
- Evaluation Report
- 5 borough Big Conversation events in May 2024
- Peoples feedback will inform the new Bereavement Model

THE BIG CONVERSATION (Bereavement)

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

## Morning Programme

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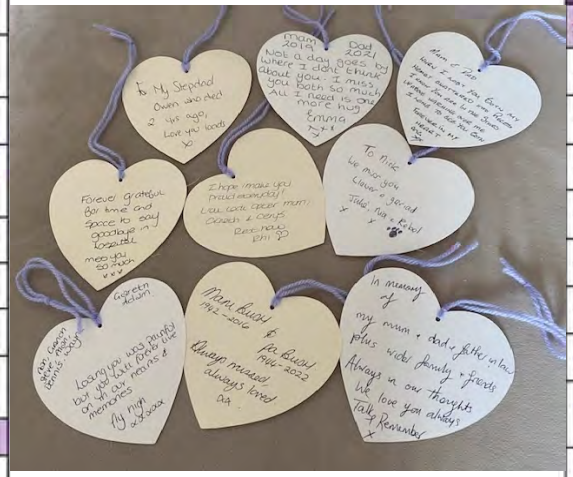
| **9:00am** | **Arrival, Registration and Refreshments** |
| 9:25am | **Chair's Welcome**<br>Carol Taplin, Specialist Chaplain, Aneurin Bevan University Health Board |
| 9:30am | **Opening Remarks**<br>Jenny Winslade, Executive Director of Nursing/Executive Lead for End-of-life Care and Bereavement, Aneurin Bevan University Health Board. |
| 9:40am | **Opening Address**<br>Nicola Prygodzicz, Chief Executive Officer, Aneurin Bevan University Health Board |
| 9:50am | **Improving bereavement support in Wales: The new national framework for the delivery of bereavement care and the research which informed it**<br>Dr Emily Harrop, Marie Curie Research Fellow, Cardiff University |
| 10:10am | **Advance and Future Care Planning: Making your wishes known**<br>Dr Clifford Jones, Assistant Medical Director, Aneurin Bevan University Health Board |
| 10:25am | **Living with Loss and Post Traumatic Growth**<br>Rhian Mannings, Chief Executive Officer 2 Wish |
| 10:40am | **The 'Hard to Reach' Myth**<br>Chris Dunn, Chief Executive Officer, Diverse Cymru |
| 10:55am | **Bereavement Support for People Affected by a Death by Suicide**<br>Bethan Bowden, Consultant in Public Health, Aneurin Bevan Gwent Local Public Health Team |
| **11:10am** | **Refreshments** |
| 11.30am | **Bereavement Support for People with Sensory Loss**<br>Non Ellis, Equality, Diversity, and Inclusion Specialist, Aneurin Bevan University Health Board |
| 11.45am | **Religion, Spirituality and Pastoral Care**<br>Alan Tyler, Senior Chaplain and Farid Khan, Imam, Aneurin Bevan University Health Board |
| 12:00pm | **The Impact of the New Death Certification Reforms**<br>Dr Jason Shannon, Lead Medical Examiner for Wales |
| 12:15pm | **The Local Vision for Improved Bereavement Services**<br>Tanya Strange, Head of Nursing, Patient Experience and Involvement and Louise Jones, Bereavement Lead Nurse, Aneurin Bevan University Health Board |
| **12:30pm** | **Lunch and Networking** |



THE BIG CONVERSATION (Bereavement)

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

## Afternoon Programme

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| **Please see Room/Table Numbers in Main Foyer** | |
| **1:15pm** | **Round Table Conversations - Preparing for loss and bereavement support for:** |
| • People with **sensory loss and disabilities** | |
| • People from **Black, Asian and Minority Ethnic** Communities | |
| • People who have lost a **child or young person** | |
| • People who have lost someone under **traumatic circumstances** (including suicide) | |
| • People whose loved ones have died in **hospital/inpatient** setting | |
| • People who have lost loved ones in the **community** | |
| • People with identified **religious and spiritual**, and pastoral support at end of life | |
| • End of life care and bereavement support for people with **cognitive impairment** (including dementia) | |
| • **Advance and Future Care Planning**: Making your wishes known | |
| **2:15pm** | **The Big Conversation - Attendees to return to Main Hall** |
| 2:15pm | **Feedback from all discussion groups to inform the Big Conversation**<br>Chairs: Grant Usmar, CEO Hospice of the Valleys; Carol Taplin, Specialist Chaplain; Tanya Strange, Head of Nursing, Patient Experience and Involvement |
| 3:15pm | **Closing Remarks**<br>John Moss, National Bereavement Framework Programme Manager, NHS Wales Executive |
| **3:30pm** | **Event Close** |

# Big Conversation Bereavement Feedback

## FEEDBACK: *WHAT DID YOU FIND MOST USEFUL ABOUT TODAY (COMMON THEMES)*

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| *To know I am not alone in my grief* | Having honest conversations- ability to **speak freely** | **Power of personal stories (numerous mentions)** |
| **Networking and variation of attendees in conversation groups** | **Variety of presentations and round table discussions** | **Learning about the changes of the new Death Reform process** |
| **'Eye opening' informative presentations** | **AFCP (numerous mentions)** | **Awareness of what's available** |
| **Really good programme, various contributors** | **Hearing about the lived experience of participants (numerous mentions)** | **That change is coming- we need to listen to people's experience** |

Learning that there is an obvious **need to talk about bereavement.**

Lack of support can result in **negative grief.**

Sensory loss and bereavement- **opened my mind.**

**Round table** conversations.

**Need to learn** so other families don't go through what we did

Knowing **you are not alone.**

Ability to **share experiences.**

Everyone now knows that **change is needed.**

Presentations highlighted the fact that **grief is widespread**

**Emotional day** but very worthwhile.

**Information** available.

That **grief can affect all ages.**

***" Today, my voice was heard".***

## FEEDBACK: STAYING CONNECTED AND BEREAVEMENT COLLABORATION

**We asked:** *Would you be interested in helping us **shape** the bereavement model?*

**58** people provided written feedback. Of those, **50** people said they wanted to work with us to develop the new bereavement model.

Including the people already engaged, and those who have asked to be involved through social media, this means we will have around **80 people** engaged through our **bereavement collaborative.**

It is likely that **more people** will come forward as we engage in Big Conversations across all 5 boroughs.


## FEEDBACK: DO YOU THINK WE NEED TO HAVE MORE CONVERSATIONS ABOUT BEREAVEMENT

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| **100% of feedback received supported the need for more conversations** | "Yes. We also need more education across the sector to help bereaved people." |
| **"Absolutely more conversations"** | "Yes, specifically around pregnancy/baby loss." |
| **"Yes, and allow people to know what's available"** | "Absolutely! Bereavement still feels like a taboo topic despite everyone experiencing it." |
| **"We need more Big Conversations as it raises important issues from all the public including diverse groups"** | "Yes. Need a broader range of people's experiences with bereavement services." |
| **"Yes, death is feared and not talked about enough"** | "Yes, the more the better." |
| **"Yes- could have a rolling conference focussing on different themes?"** | "Absolutely necessary." |
| **"Yes, if points raised are listened to and acted upon and not just a tick box."** | "Yes, sharing people's stories to implement change is vital." |
| **"Definitely- more conversations should be encouraged to normalise death and dying"** | "Yes, this is just the start." |
| | "Yes, so people know they are not alone." |
| | "Need to have these discussions across Wales!" |

## COMMENTS AND SUGGESTIONS

*"Maybe, once someone loses a loved one in hospital, let staff take them into another room and **talk to them**, and explain what services are available and maybe tell them you will be in touch with them to arrange a meeting with a bereavement councillor within the Health Board to see how the family are doing"?*

*"**Pregnancy loss under 20 weeks**' gestation needs to be made as important as those pregnancies over 20 weeks. Maternity has protected bed status and 1:1 care. Gynaecology staff deal with baby loss daily, but no protected beds. All baby loss matters, to support our women, we need to be supported to protect them and give the best care possible".*

*"We need to be confident we can meet **strict funeral timelines** depending on culture".*

*"Look at allocating '**Bereavement Champions**" like Dementia Champions across the Health Board to raise awareness and improve education".*

*"Could the model follow a model similar to the **6 principles of trauma** informed practice as this follows a lot of what has been missing".*

# Volunteering





## Key Volunteer Highlights During 2023

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| Our volunteers have provided **over 8183** unpaid volunteer hours. | Our Welcomer volunteers at NHH and YYF have supported over **3651** people since August 2023. | We have **20** spoken languages by **34** volunteers, including **9** Welsh Speaking Volunteers and **1** BSL Volunteer. | We have **27** Telephone Befrienders supporting **32** patients, mostly on a weekly basis. |
| We recruited **92** new volunteers in **2023**. | We have launched our **Volunteer to Career** Programme and are the first Health Board in Wales to do so. | **7** volunteers have gained paid employment through our **volunteer to career** programme. | Listening to patients, staff and volunteers, we have created **7 new** volunteer role profiles during 2023. |
| We have supported **5** people to become experts by experience. (Mental Health, Gastroenterology and Stroke). | We have provided **49** training sessions for volunteers. | We have provided volunteer and work experience opportunities for **3** people with additional needs. | We held an annual volunteer **celebration event** in June 2023. |
| We have attended **37** volunteer promotion events across the geographical area. | We now have **130** Hospital Befrienders and End of Life Companions. With our team supporting **321** volunteer inductions during 2023. | We have worked closely with Therapy teams to create **Stroke Peer Support** Volunteers. | We have worked closely with **Cancer Services** and created new volunteer roles including Befrienders, Welcomers and Peer Support. |
| We have worked closely with the **Alcohol Care Team** and are creating a volunteer led dedicated alcohol support group | Through our partnership with Cardiff University, over **75 pharmacy students** will have gained patient experience volunteering opportunities. | **52** volunteers have supported the **Ukraine Resettlement** and **Mass Vaccination** Centres. | We have delivered **9** Personal Wellbeing Sessions with over **51** volunteers attending |
| We have presented our Volunteering model at local and **national** events. | **Helpforce Cymru** and **The Bevan Commission** have published a national case study on our Volunteer to Career model. | **Volunteer Long Service**<br>**26** completed **50 hours.**<br>**18** completed **100 hours.**<br>**12** completed **200 hours.**<br>**7** completed **300 hours.**<br>**4** completed **400 hours.**<br>**1** completed **500 hours.**<br>**1** completed **700 hours**<br>**1** completed **800 hours.** | In 2023, the Volunteer Service has won a **Volunteer Award** and have been finalists in **3** other awards. |

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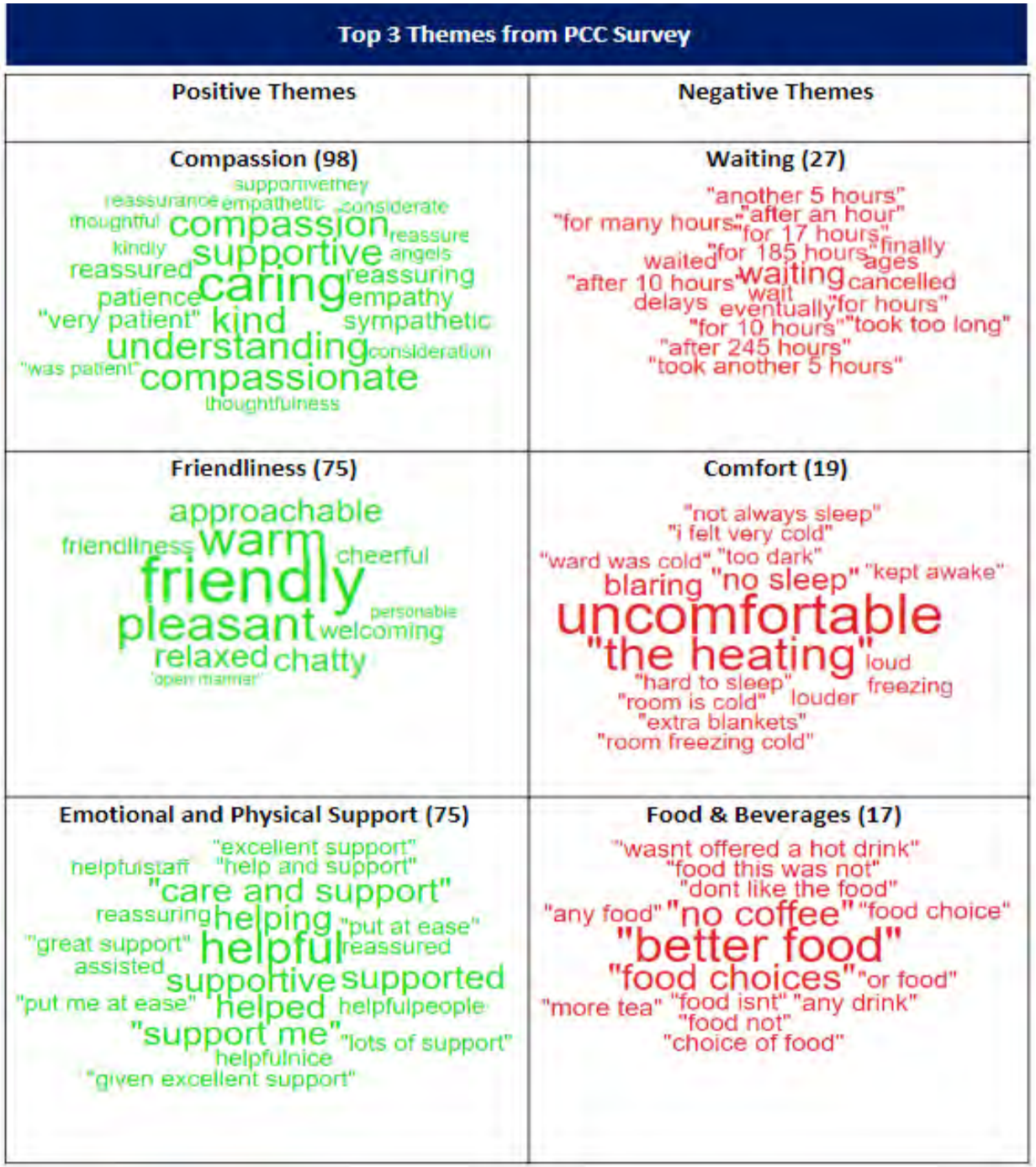
Patient Feedback: Listening and Learning

# Top 3 Themes from PCC Survey



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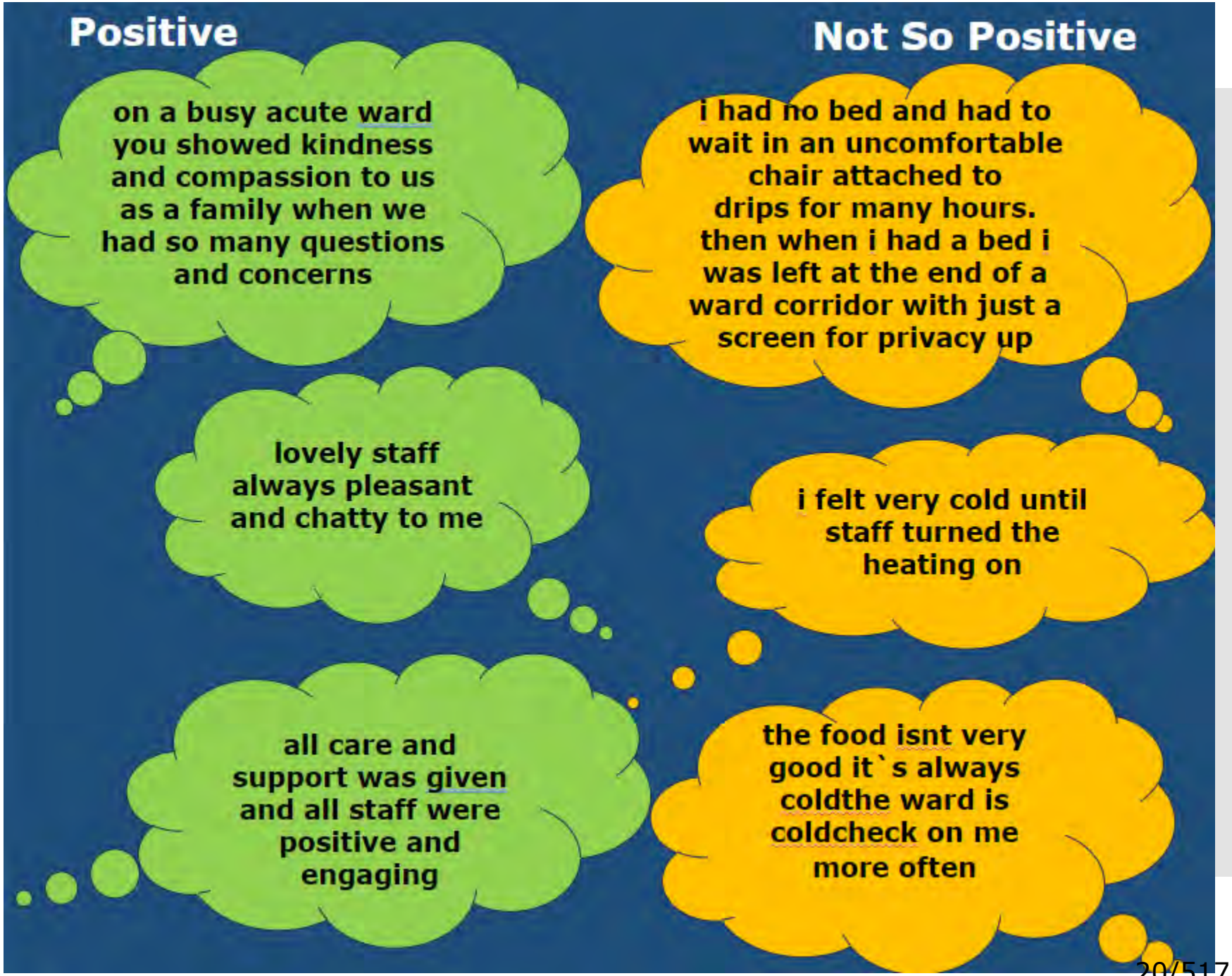
Patient Feedback: Listening and Learning

# Patient Comments **from PCC** Survey



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Patient Feedback: Listening and Learning

# Patient Experience Feedback (CIVICA)

## Patient Experience Feedback - 1st January 2024 - 31st March 2024

Total Surveys Completed = 570

Person Centred Care (PCC) Survey Completed = 539

Satisfaction Score – Benchmark 85

All Surveys

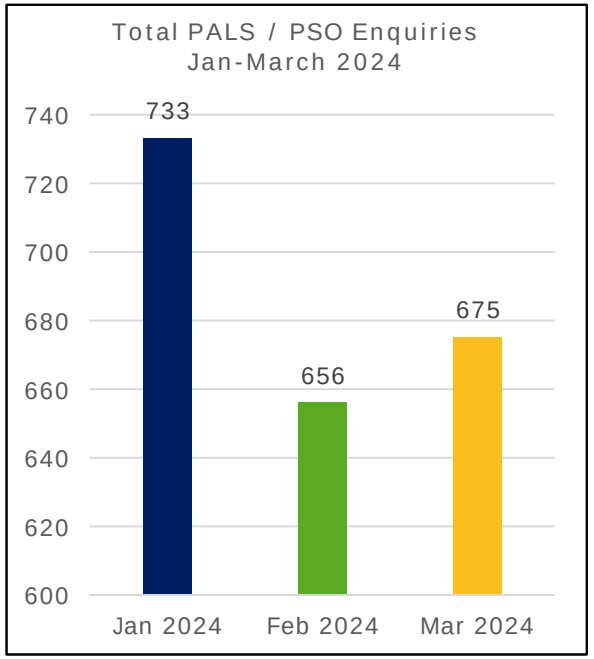

PCC Survey

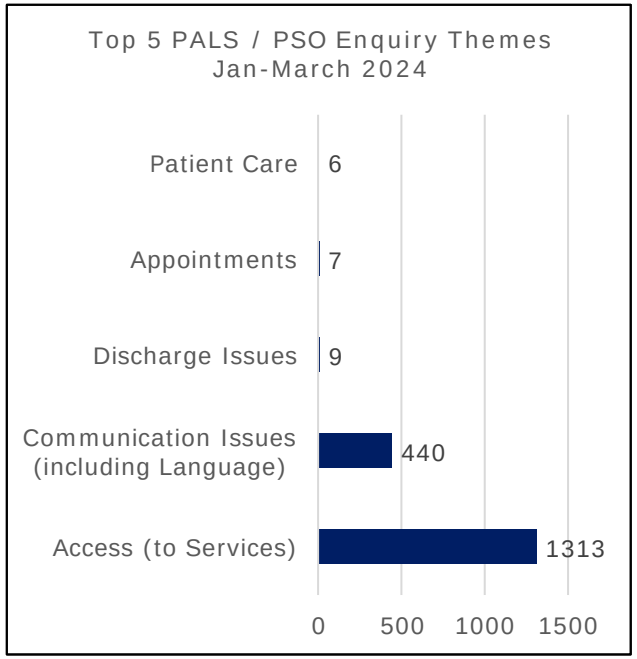

**Patient Scoring against closed questions on PCC Survey – Heat Map (Health Board Wide by Borough)**

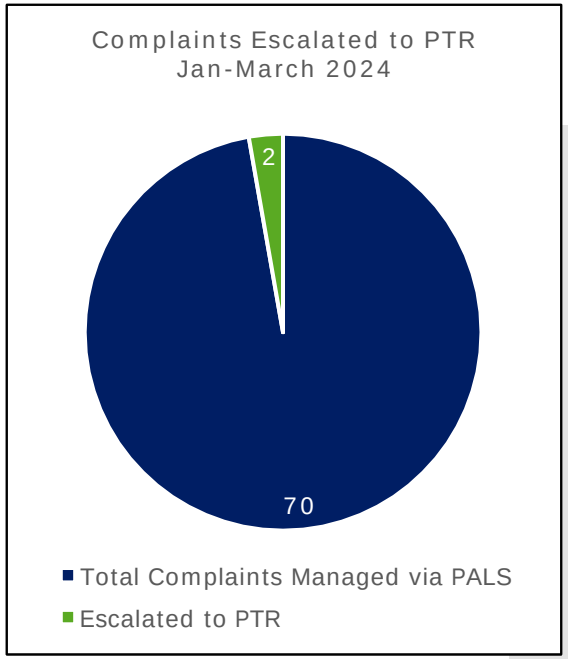
Borough | Site | Location/Department | Division | Directorate | Specialty

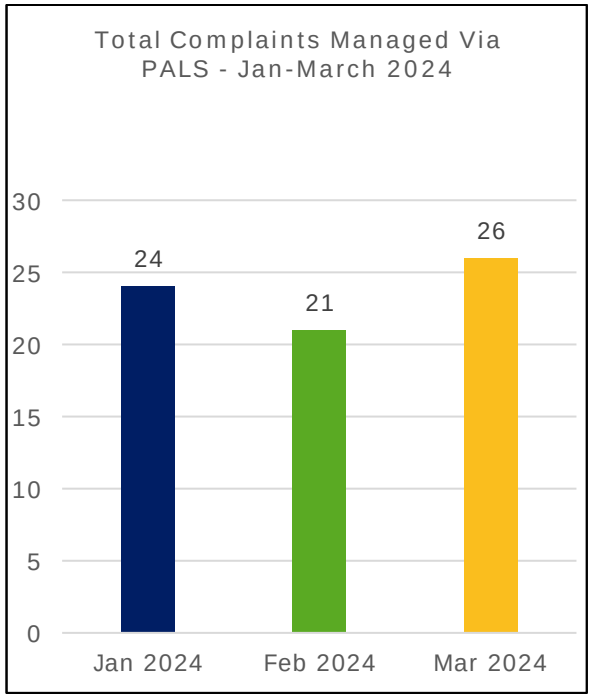
| Borough | Responses | 2 - I felt listened to | 2 - I was able to make my own decisions about my care | 2 - I had care and support from staff who understood my needs and | 2 - I had the support of my family (or friends) when I needed | 2 - I felt safe | 2 - I felt physically comfortable | 2 - I was given information and advice that I could understand to help | 2 - I was told who to contact if I need care and support in the future | Overall |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Person Centred Care | Person Centred Care | Person Centred Care | Person Centred Care | Person Centred Care | Person Centred Care | Person Centred Care | Person Centred Care | |
| Blaenau Gwent | 46 | 81 | 75 | 92 | 88 | 93 | 84 | 82 | 73 | 84 |
| Caerphilly | 68 | 98 | 95 | 97 | 93 | 99 | 95 | 98 | 98 | 97 |
| Gwent | 20 | 83 | 88 | 87 | 75 | 90 | 87 | 89 | 89 | 86 |
| Monmouthshire | 133 | 88 | 80 | 92 | 95 | 96 | 89 | 90 | 75 | 88 |
| Newport | 138 | 93 | 85 | 94 | 97 | 95 | 90 | 89 | 82 | 91 |
| Torfaen | 130 | 88 | 81 | 90 | 93 | 93 | 83 | 87 | 79 | 87 |
| | Overall | 90 | 83 | 93 | 94 | 95 | 88 | 89 | 81 | 89 |
| | Benchmarks | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 |

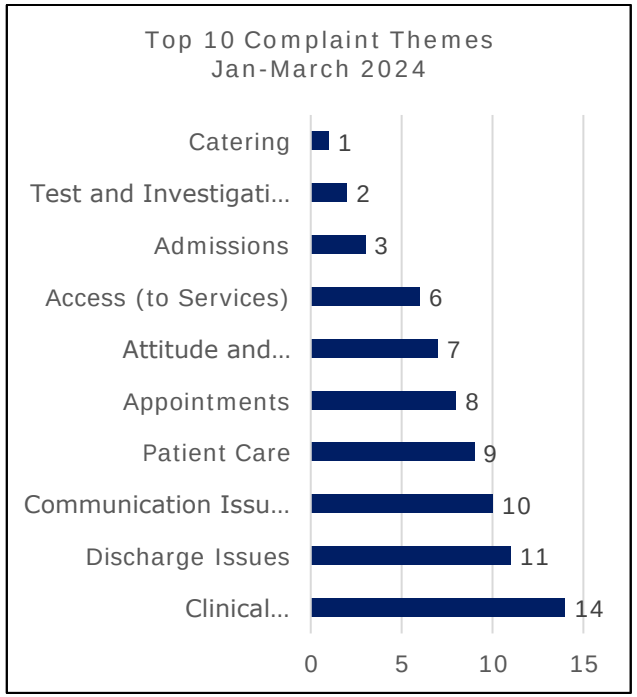
# Patient Advice and Liaison Service (PALS)

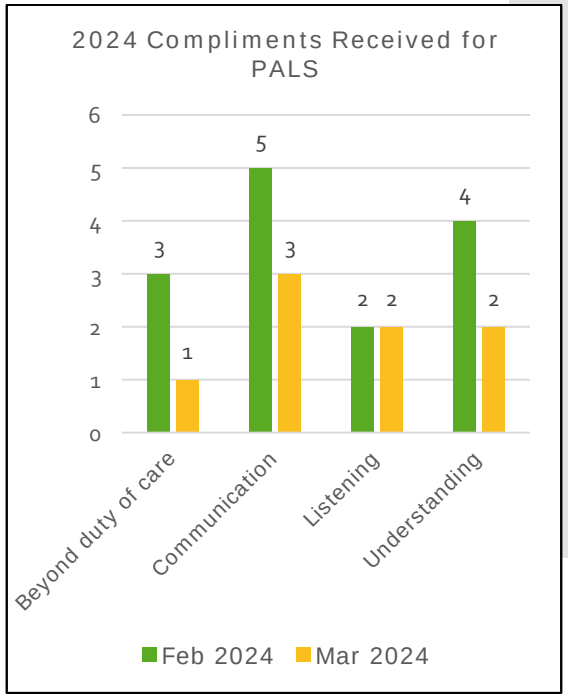


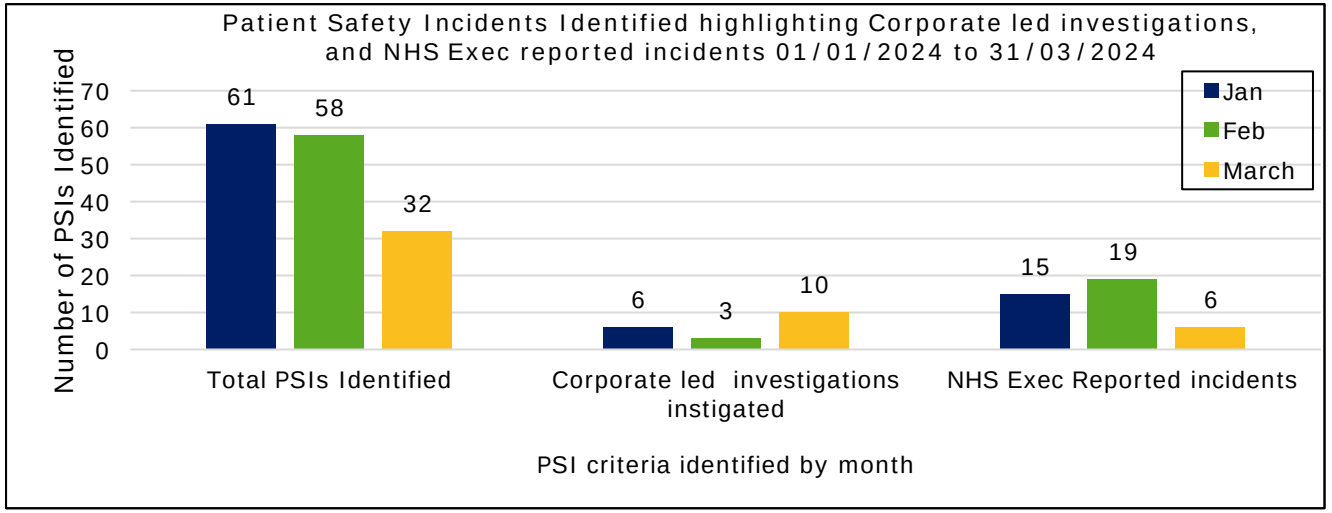




6 Pillars of Quality
1
Patient and staff experience and stories
2
Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
3
Complaints, Concerns and Compliments
4
Health, Safety and Security
5
Infection Control and Prevention
6
Safeguarding

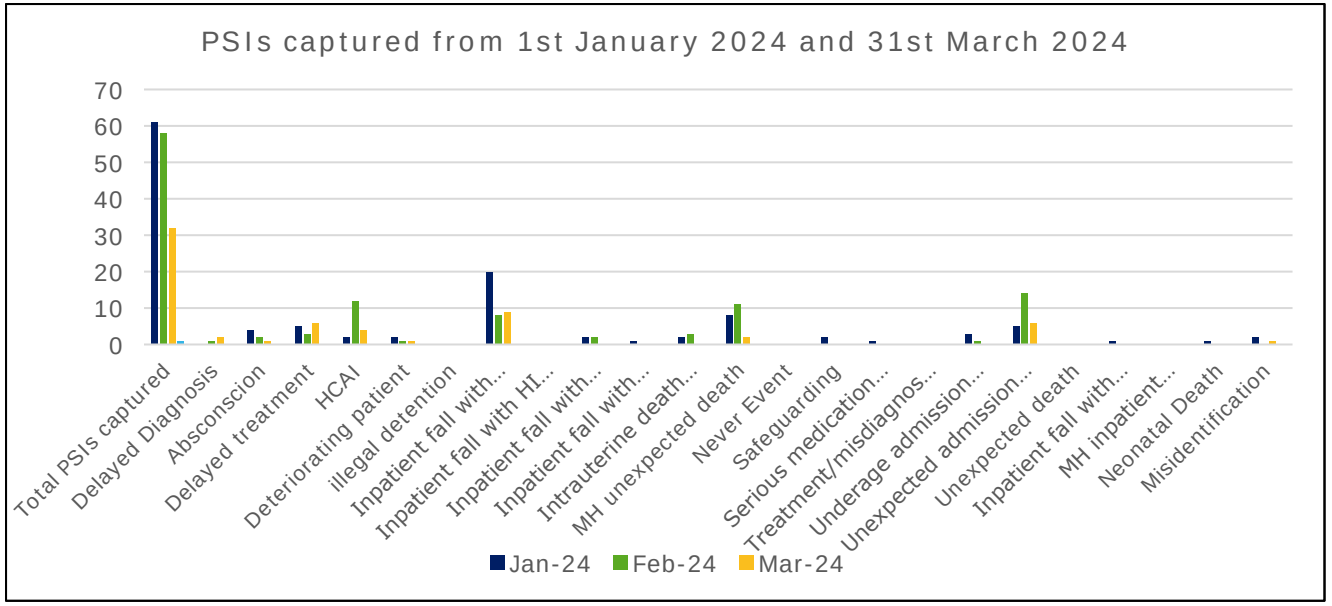
# Section 2

# Patient Safety Incidents




A total of 210 Patient Safety Incidents were identified during January, February and March 2024. 61, 58 and 32 respectively. MH Unexpected Death, Unexpected Admission to NICU and Inpatient fall with # were the top themes.

There were 30 EWNs reported to WG during this period, 13 in January 12 in February and 5 in March. Themes included varied safeguarding issues, absconsions, misidentification of patients and PRUDiCs.




## Themes

### Ophthalmology Delays

Ophthalmology report incidents of glaucoma patients lost or delayed to follow up. Each case assessed for harm. Currently one completed PSI, one in progress and a further 7 awaiting review. Currently, 5437 glaucoma patients awaiting a follow-up appointment. Of which 3882 are now past their target date. Diagnostic hub and risk stratification tool are now in place. Further capacity for virtual reviews is being sought. Ongoing discussion with primary care re contract reform due to commence in April and may impact ODTC capacity.

### Missed Cancers

The Health Board continues to receive incidents of missed cancer diagnosis via a number of avenues, including patients lost to follow-up appointments, or missed on radiological reporting. There have been three new PSIs in this quarter.

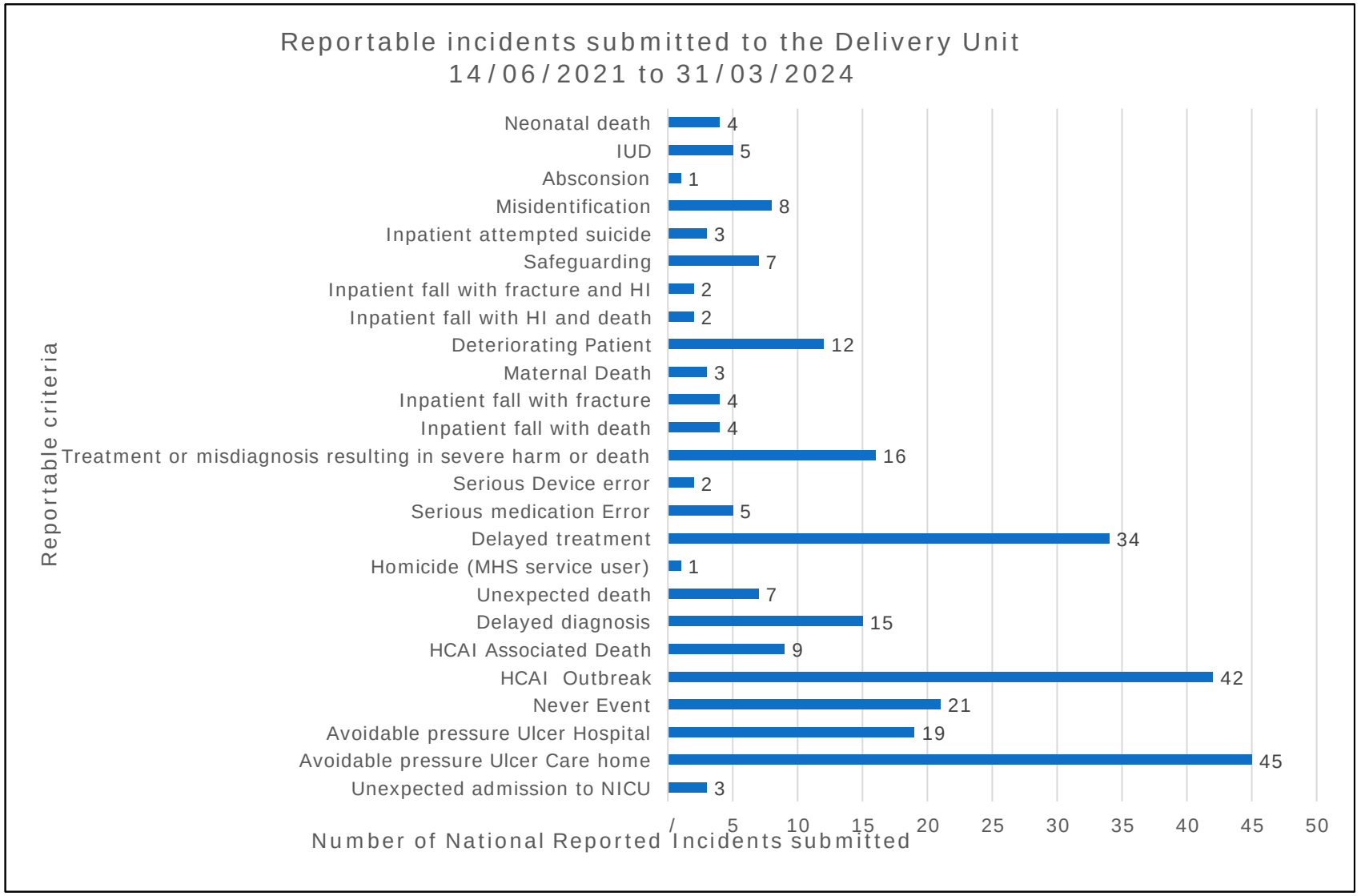
### PSI Team

The PSI team have developed a new Patient Safety Incident Report template with guidance notes, drawing on best practice, human factors methodology/ tools and from feedback received from staff, patients, families and HM Coroner. This is currently out for consultation and feedback from key Health Board stakeholders.

# Review of Patient Safety Incident Process

| **Issue** | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| SI process currently sub-optimal to meet needs of organisation. | Historic process no longer fit for purpose<br><br>Varying processes across Corporate and Divisions<br><br>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 |
| | | Ongoing meetings with EDoN and Corporate PSI Team to identify barriers to effectiveness | Director of Nursing/ PSI team | Ongoing |
| | | Divisional engagement and 1-2-1's undertaken.<br><br>Outcomes to be communicated. | Assistant Director of Nursing | Complete<br><br>January 2024 |
| | | QPSOG is being reconfigured in line with the Learning Framework. | Assistant Director of Nursing/Assistant Director for Quality and Patient Safety | Ongoing |

# National Reportable Incidents




The Health Board reported 15 NRIs in January, 19 during February, with a significant decrease to 6 during March 2024.

2 new reporting criteria emerged during this reporting period. Intra-uterine deaths are now required to be reported if EMBRRACE reporting criteria is met and all HCAI associated deaths are also now reported.

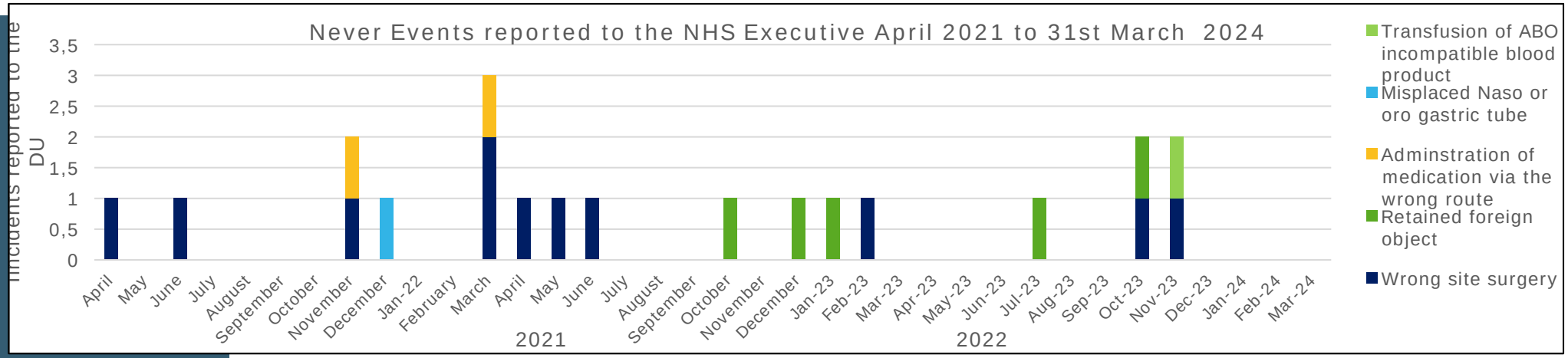
No Never Events were reported during this reporting period.

# National Reportable Incidents

| Learning from NRIs | Improvement |
|---|---|
| Wrong body released to funeral directors. | ➢ Daily procedure for flagging same or similar names<br>➢ Development of a Mortuary Collection form.<br>➢ Visual prompts within the Mortuary to encourage and ensure the safety aspect of undertaking 3-point ID checks.<br>➢ Process flow chart implemented<br>➢ Standard Operating Policy for the release of bodies from the Mortuary, reviewed, updated and circulated.<br>➢ Competency programme full review and update.<br>➢ Human Factors training for all staff working within the Mortuary/CAD service.<br>➢ Investigation outcomes and follow up report shared with the Human Tissue Authority.<br>➢ ABUHB representation on the recently established National APT and HTA group, to improve on shared learning and fully participate in All-Wales initiatives. This will help to share best practices and align service delivery. |
| 15-month delay in ODTC appointment Hospital.<br><br>By the time the gentleman had experienced irreversible sight loss with associated visual disability - classed as legally blind. | ➢ Booking centre manager ensures validation officer within the team has protected time to validate Glaucoma patients on a weekly basis.<br>➢ Clinical staff responsible for selection of patients when reducing clinics<br>➢ Implementation of traffic light risk score system to identify risk.<br>➢ Development of data collection clinics to support the reduction of waiting list times. |
| A lady attended her General Practitioner (GP) with left sided chest pain and breathlessness. A chest x-ray was arranged. Following the chest x-ray results, the GP referred urgently in line with the Urgent Suspected Cancer pathway. The CT scan identified a mass in the superior segment of the left lower lobe of her lung. She was diagnosed with poorly differentiated adenocarcinoma of the left lung with chest wall involvement.<br><br>A review of the previous trauma CT scan of a year previous noted a suspicious nodule (23mm solid lesion) present in the left lower lobe; however, this was not reported on. | ➢ Case shared in the Radiology Events and Learning Meeting (REALM) locally, to provide learning and reflection around reporting bias, and the possibility of incidental findings in the reporting of trauma imaging.<br>➢ Learning disseminated to clinical teams to re-enforce review and appropriate follow-up of imaging. |
| A lady with significant coronary artery disease underwent a planned diagnostic angiogram. She experienced chest pain after this procedure and underwent a second angiogram, where 2 further stents were inserted. She scored highly on the National Early Warning Score (NEWS) and deteriorated throughout the night. She was taken to the Intensive Care Unit to be stabilised and commenced on inotropes before being transferred to University Hospital Wales (UHW). She had a cardiac arrest shortly after arriving at UHW but was able to be resuscitated. She underwent a third coronary angiogram and an insertion of a balloon pump. Sadly, she died later that day. Primary cause of death was cardiogenic shock following the coronary angiogram with hypertension being the secondary factor. | ➢ Standardisation of the use of the Care Flow electronic recording system by nursing staff on the Acute Cardiac Unit.<br>➢ Qualified nurses on ACU to attend the Acute Life-Threatening Recognition and Treatment (ALERT) training course and to have 80% compliance with National Resuscitation training.<br>➢ The cardiology team to have a structured and formal handover process.<br>➢ Continue regular Cardiology Morbidity and Mortality (M and M) meetings for learning.<br>➢ Increased awareness of the transfer practitioner and continued utilisation of this service.<br>➢ The utilisation of the transfer practitioner will ensure the All-Wales transfer document is complete on inter-hospital transfers.<br>➢ To share the report and action plan to staff members involved in this case. |

# Never Events

0 Never Events reported during January, February and March 2024.
The PSI team are currently engaging with the NHS England Never Events consultation in conjunction with NHS Wales colleagues.




| Never Event Workstreams | Improvement Work |
|---|---|
| 2 NE SI's closed in period | Key safety themes identified and prioritised as a key area of improvement focus. Patient Safety Incidents Team supporting ongoing Never Event investigation using a systems approach and methodology (fishbone diagrams) to ensure high quality reviews. |
| | There will be changes to the All-Wales Transfusion Policy to ensure a standardised approach to the checking procedure across the wards for blood components and products. This will include the process for checking barrier-nursed patients. |
| | 'Back to Basics' programme of training and education for Theatre staff (Scrub, Anaesthetic and Recovery staff) has been commenced. Run on a monthly basis since January 2024, each month focuses on a key topic such as swab counting, standardisation of practice, diathermy practice, and safe handling of medication in theatre for example. This has been incredibly successful and now is being scaled and spread to other areas such as Cardiac Catheter Lab (GUH) and Endoscopy(RGH) where topics can be made bespoke to staff training needs. |
| | Standardisation of the World Health Organisation (WHO) Safety Checklist is being currently reviewed across Theatres. |
| | Tackling Safer Culture sessions have been rolled out, the QPS Scheduled Care Team, focusing on 'Pause for the Gauze' locally in advance of the national roll out of NatSIPPs 2. This has been extended across all sites. |
| | Theatre Safety Bulletins have been developed to improve overall theatre engagement across Theatre Teams. Bulletins contain information on ongoing Theatre Safety Improvement Work and any training updates or information around incidents in theatre. Each Theatre department produces their own Bulletin, and these are shared with other Theatre areas. |
| | QPS/Theatres have been working alongside the Communications Team to develop an Intranet Page to raise the profile of the Operating Department Practitioner (ODP) role and Theatre Nurse role. |

# Wider Learning on Incidents

| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| The need for increased awareness and education around systems thinking and Human factors has been highlighted in ongoing Patient Safety Incident investigations to move away from linear Root Cause Analysis (RCA) methodologies and towards a systems-based lens. This will benefit clinical teams, investigating officers and support QPS in patient safety priorities. | Apart from the current provision of 'Introduction to Human Factors', there is currently no formal Human Factors training available in NHS Wales or ABUHB. | The Health Board to scope the potential for formal training provision from external providers as per below;<br>Creating Patient Safety eLearning \| CHFG - Clinical Human Factors Group<br>Health Services Safety Investigations Body - Education Prospectus (NHS) (turtl.co)<br>Training Courses \| CIEHF (ergonomics.org.uk) | Head of PSI | 30 June 2024 |
| PSI documents no longer align with recording actions on RL Datix | Updating of PSI Policy and move over to RL Datix. | Update and circulate for consultation new Report template and Guidance. Amend as per comments. Launch April 2024. | PSI Manager | 22 April 2024 |

# Mortuary Learning

| |
|---|
| EWN's and NRI's submitted |
| Rapid review and make safes implemented<br>- *Staff de-brief and awareness raising*<br>- *Visual aids to remind 3-point checks*<br>- *Enhanced Mortuary signage*<br>- *Introduction of new Mortuary Collection Form*<br>- *SOP reviewed, updated and circulated*<br>- *Positive highlighting of same/similar names in the Mortuary*<br>- *Live occupancy lists alongside Mortuary Register* |
| Communications team briefed and updated throughout |
| Senior Coroner for Gwent briefed and updated throughout |
| Senior representatives of Health Board met with affected families, Family Liaison Officers supporting |
| 1st incident: Patient Safety Incident investigation completed together with substantive Action Plan |
| 2nd incident: investigation underway |
| Meeting held with NHS Executive and Clinical Executives to share experience and further enhance learning |
| Well Being services provided to staff and support ongoing |
| Meeting with Funeral Directors held to strengthen safe systems and processes for release |
| Changes underway to Competency Programme for Anatomical Pathology Technicians (APT), including incorporation of Human Factors training. |

# Human Factors Programme

## Background:

Developed in partnership with medical, nursing, admin and managerial staff, during the early months following the opening of GUH.

The programme aims to create and sustain a culture in the workplace that promotes patient safety, improved team performance and staff wellbeing.

The programme works by embedding the human factors approach. This looks at designing better systems and to listen and learn from the staff involved. This is achieved by bringing the various stakeholders together and creating protected spaces for exploring issues, identifying solutions and generating actions.

The first stage is introducing human factors concepts and its application to the particular workspace. This is achieved by running half day workshops for the MDT.

The mainstay of the programme is running regular " safe listening spaces", using simulation as a tool. The discussions that are generated following this event, provides the learning and action points for meaningful change.

While the initial focus was on the Emergency theatres in GUH, the project has now been spread to other areas of the HB.

A Human Factors Training Page has been created for the Health Board's Intranet.

# Human Factors Programme

## Current activities and progress:

Theatre CEPOD (ongoing simulation sessions, two weekly sessions with protected time). Longest running (over 3 years). Multiple improvements and changes made following systems testing.

Elective Obstetric Theatres (half day session and simulation sessions). Designed to play out a critical event for the multi-disciplinary theatre team and then an in-depth de-brief for the whole team follows. The safety culture survey is being tested with staff and it has been well received, resulting in several important changes being made.

Cardiac Catheter Laboratories (ongoing simulation sessions). The intervention Cardiology department have embraced the Human factors programme with much enthusiasm. All the staff attend the two half day sessions and are now actively engaged with the regular simulation sessions. Many changes have been made including adopting the Team briefing at the start of their procedural lists. This project was presented as a poster at the recent HEIW's Sharing Training Excellence in multi-professional education. The poster won the best poster prize at this event.

Human Factors for Practice Facilitation staff (half day session), committed to supporting nurse educators, who can spread the message of Human factors more widely, especially in the wards.

Scheduled introductory sessions for Paediatrics with the aim of expanding the simulation work into paediatrics.

Currently an application for funding has been submitted to the Q exchange programme around the human factors work in theatres and spreading this to ward areas. A Human Factors Approach to Building Safety Culture across boundaries | Q Community (health.org.uk)

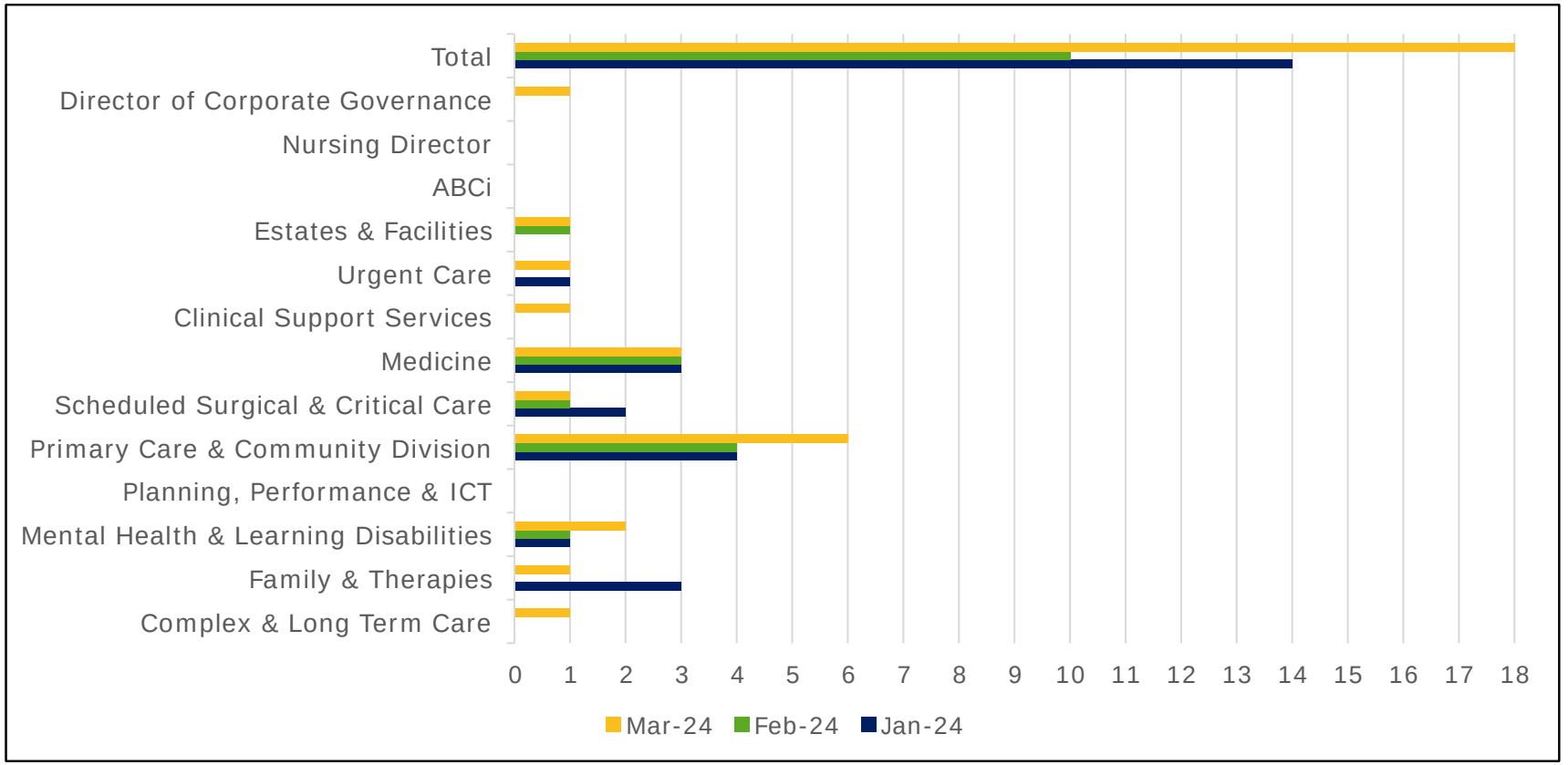
# Duty of Candour

# Incidents Affecting Patients

Since 1 April 2023 there have been 24,895 incidents affecting patients reported on the Datix Cymru system.

At the time of preparing this presentation there are currently 1,452 incidents whereby the field '*Following the Initial/Management review, what level* ***of adverse outcome was considered?***' has not been completed.

There have been 42 incidents that have triggered the Duty of Candour between January and March 2024.. *This figure is based on the initial/management review field recorded as Moderate or above.*



# QPS Updates

There have been several structural changes to centralise the Quality Patient Safety (QPS) teams and resources which now include QPS, PTR, Legal Services and the Quality Improvement (QI) teams. The changes are realising several benefits including:

The retention of knowledge, skills and experience across the teams.

Improving consistency and collaboration in the delivery of person-centred care.

Enhanced knowledge and skills of PTR regulations, legal knowledge and required timelines.

Effective triangulation of the complaints and incident processes, ensuring improved quality, timeliness and person-centred response.

Supporting a culture of shared learning and a triangulated approach to quality, patient safety and experience.

Improved Divisional access to support, knowledge and guidance.

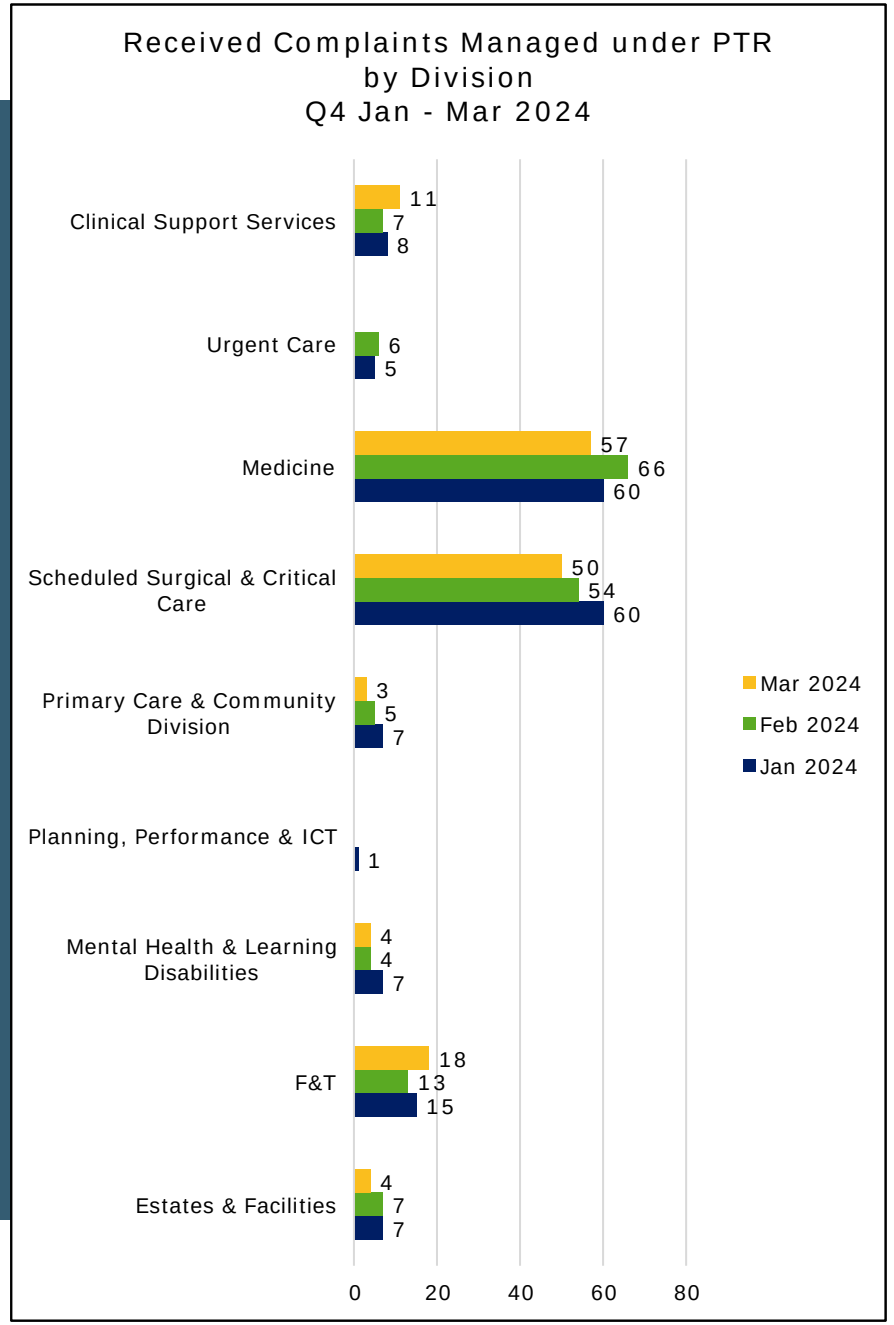
Bespoke training to support staff undertaking investigations.

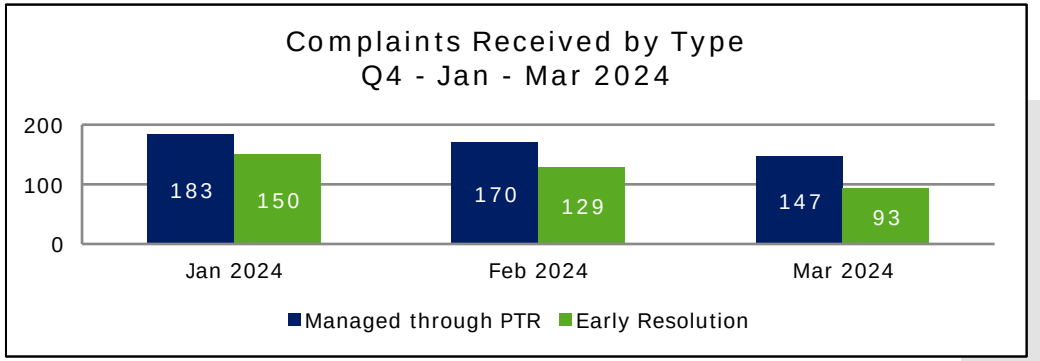
Development of a Listening and Learning Framework.

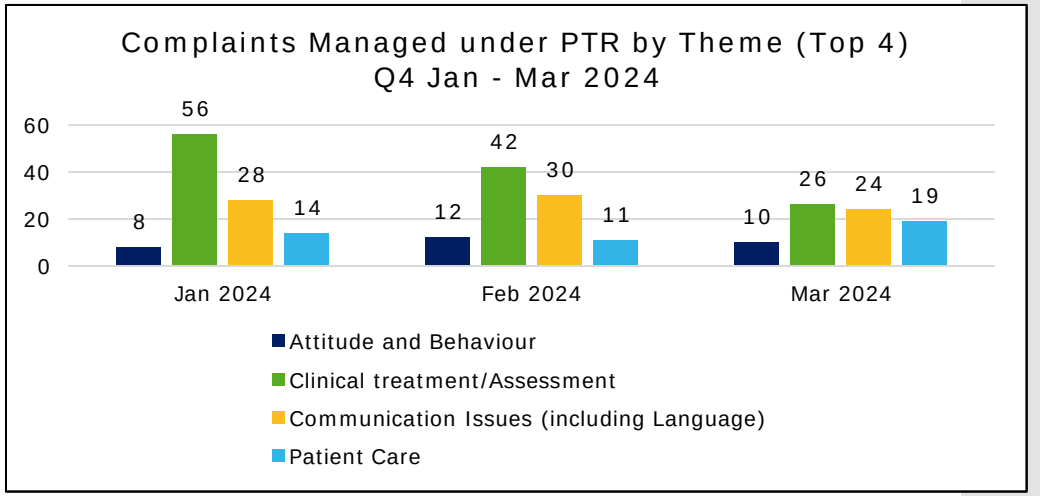
Development of a Learning Repository.

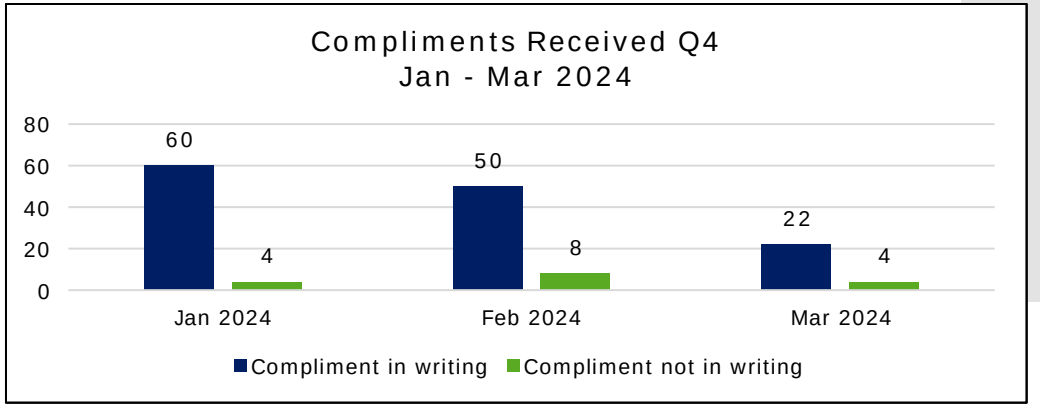
Next steps include a review of the Health Board's Quality, Patient Safety and Experience assurance meetings. This is a key objective within the Quality Strategy and will strengthen ward to board accountability.

# Complaints and Compliments

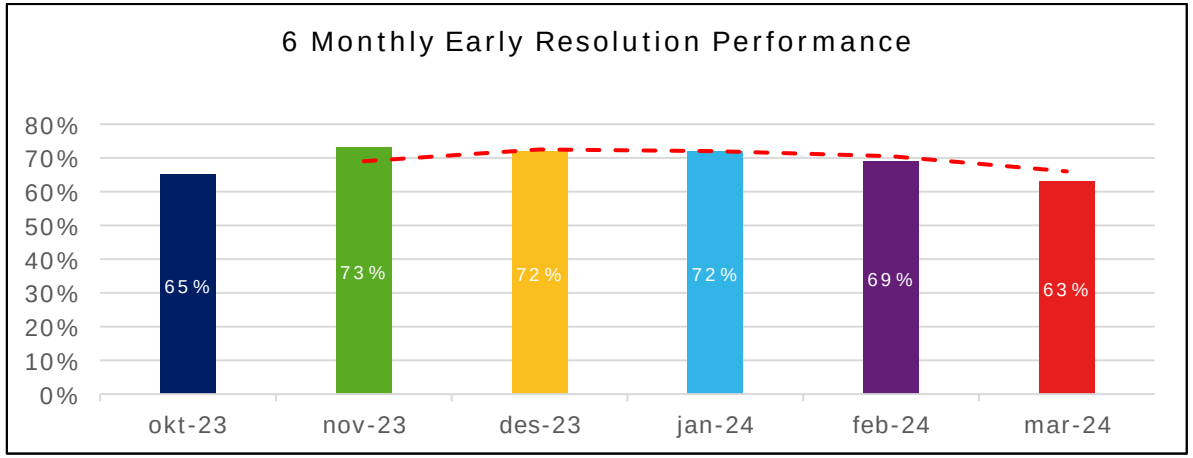


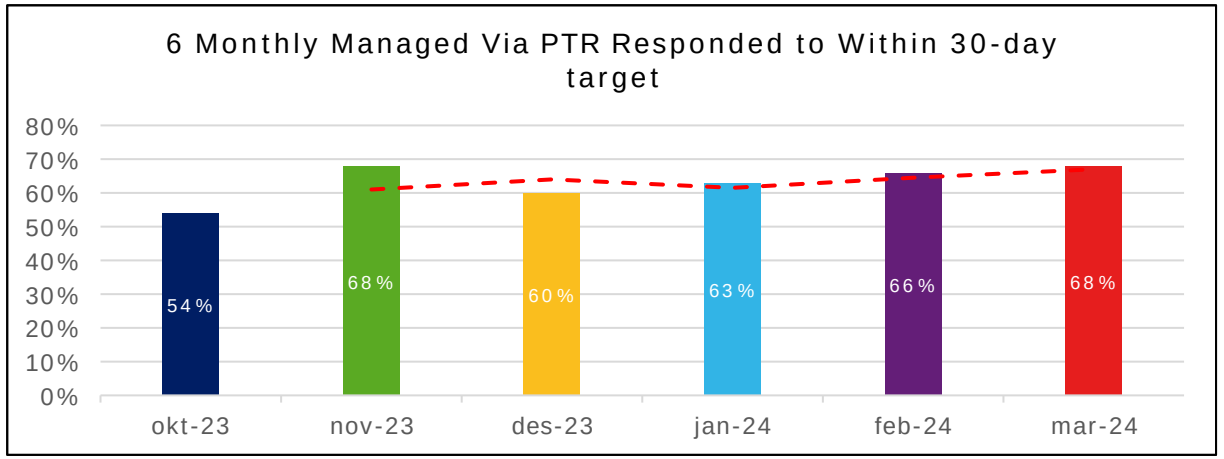



# Complaints and Compliments

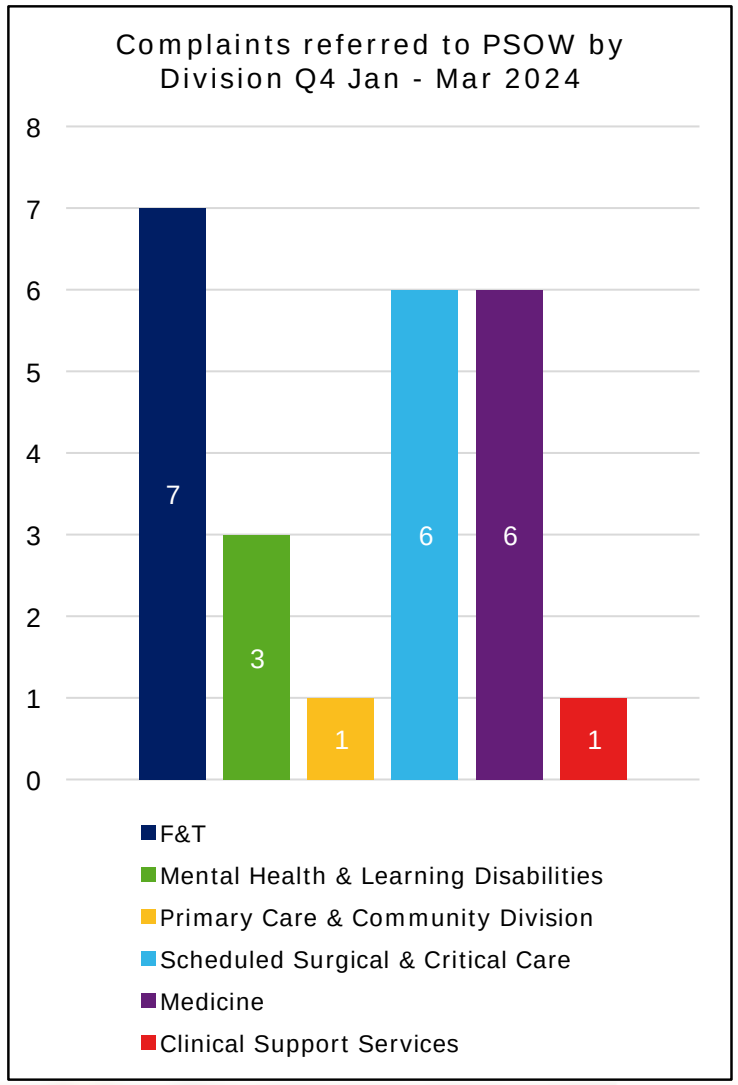


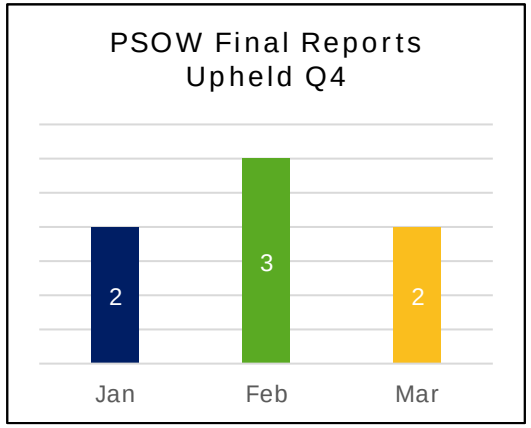



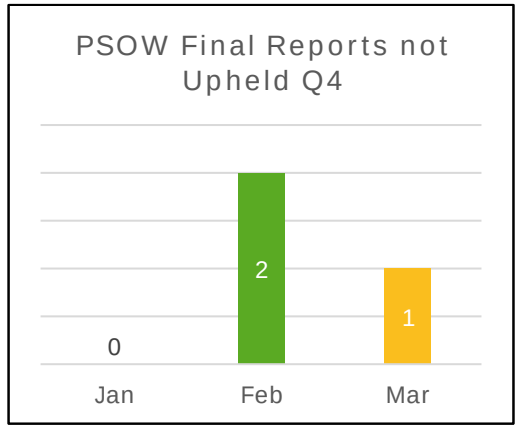

| Trajectory for Improvement by Division/ Directorate | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 |
|---|---|---|---|---|---|---|
| 01 Chief Executive | 75% | 75% | 75% | 75% | 75% | 75% |
| 02 Nursing Director | 75% | 75% | 75% | 75% | 75% | 75% |
| 03 Planning Performance & ICT | 75% | 75% | 75% | 75% | 75% | 75% |
| 04 Family & Therapy Services | 60% | 63% | 65% | 68% | 72% | 75% |
| 05 Scheduled Surgical & Critical Care | 60% | 63% | 65% | 68% | 72% | 75% |
| 06 Primary Care & Community | 45% | 50% | 54% | 62% | 69% | 75% |
| 07 Mental Health & Learning Disabilities | 45% | 50% | 54% | 62% | 69% | 75% |
| 08 Urgent Care | 55% | 60% | 65% | 68% | 71% | 75% |
| 09 Medicine | 45% | 50% | 54% | 62% | 69% | 75% |
| 10 Estates & Facilities | 90% | 90% | 90% | 75% | 75% | 75% |
| 11 Complex Care | 75% | 75% | 75% | 75% | 75% | 75% |
| 12 Other | 75% | 75% | 75% | 75% | 75% | 75% |
| 13 Clinical Support Services | 60% | 63% | 65% | 68% | 75% | 75% |
| Health Board | 55% | 59% | 65% | 68% | 72% | 75% |

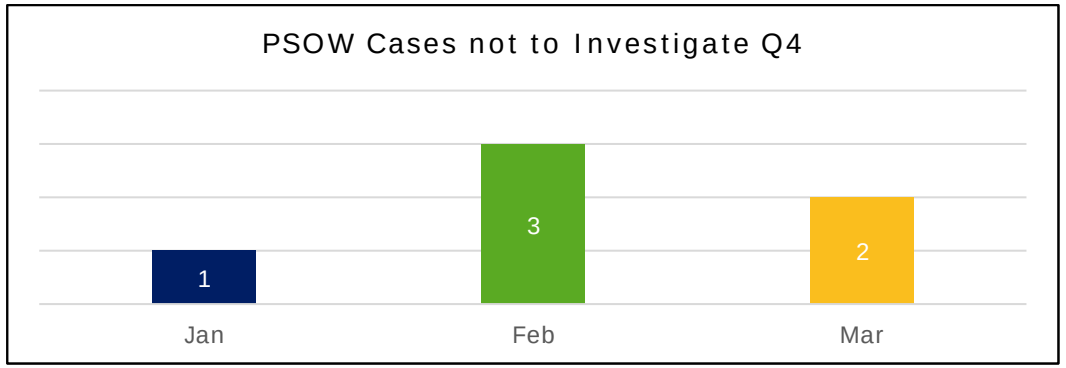
The target of 75% of PTR issues managed within 30 days indicates a positive improvement month on month for the upcoming financial year. In some areas compliance is already exceeding the proposed trajectory.

# Ombudsman (PSOW)



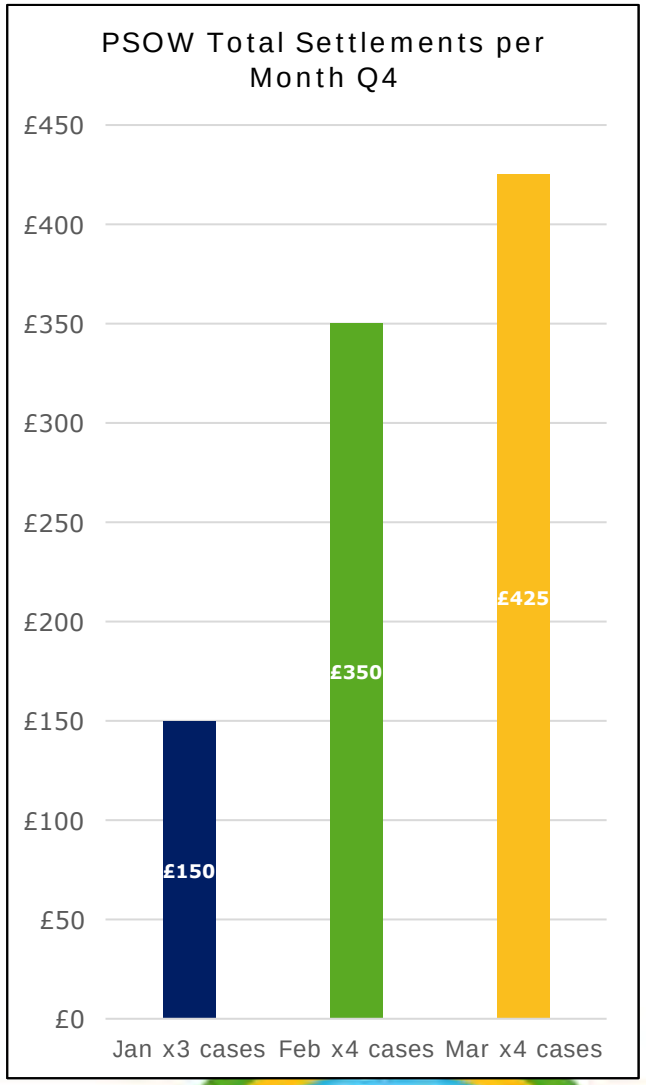




The top 3 subject areas whereby PSOW have been involved relate to:

1. Clinical Treatment/Assessment
2. Communication Issues
3. Complaints Handling



# Health, Safety & Security

## Health and Safety Executive Engagement

There have been no new concerns raised by the Health and Safety Executive (HSE) during quarter 4 of 2023/24.

The Health and Safety Executive (HSE) have one active case with the Health Board relating to an investigation of a patient fall at Nevill Hall Hospital, which occurred in 2019.

## South Wales Fire & Rescue Service Activity

The Health Board have recently been issued with two enforcement notices relating to fire safety at Residences at Nevill Hall Hospital (Gerylyn and Bron Haul).

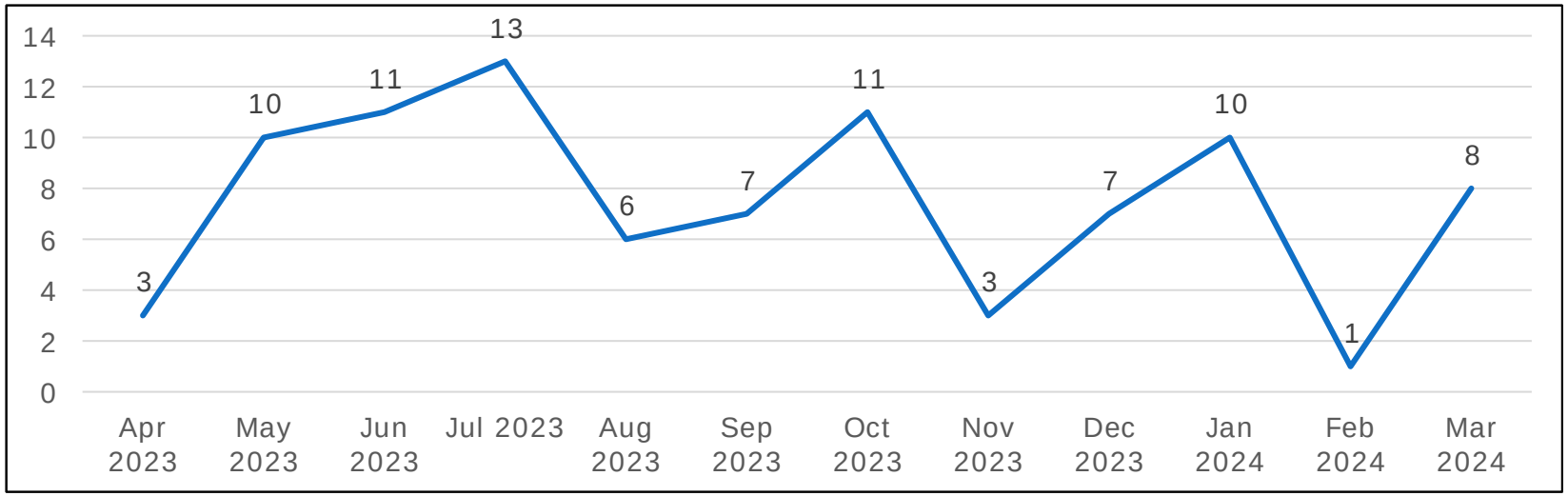
Action plans have been developed to ensure the Health Board complies with the requirements of the notices.

A working group has been established to monitor the progress against the actions.

# Health, Safety & Security

## Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period April 2023 to March 2024 the Health Board have reported 90 incidents to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).




67.7% of these cases were reported within the legal timeframes within the legislation.

# Health, Safety & Security

## Health and Safety Statutory and Mandatory Training

At end of March 2024 training compliance for the Health Board was reported as:

| | |
|---|---|
| Health & Safety | 87% |
| Violence & Aggression | 85% |
| Manual Handling | 55% |

There has been no change in the compliance with Violence & Aggression compared with the previous report, however, the compliance with Health & Safety, Fire Safety and Manual Handling have all increased by 1%.

# Health, Safety & Security

## Health and Safety Improvement Plan 2023/24

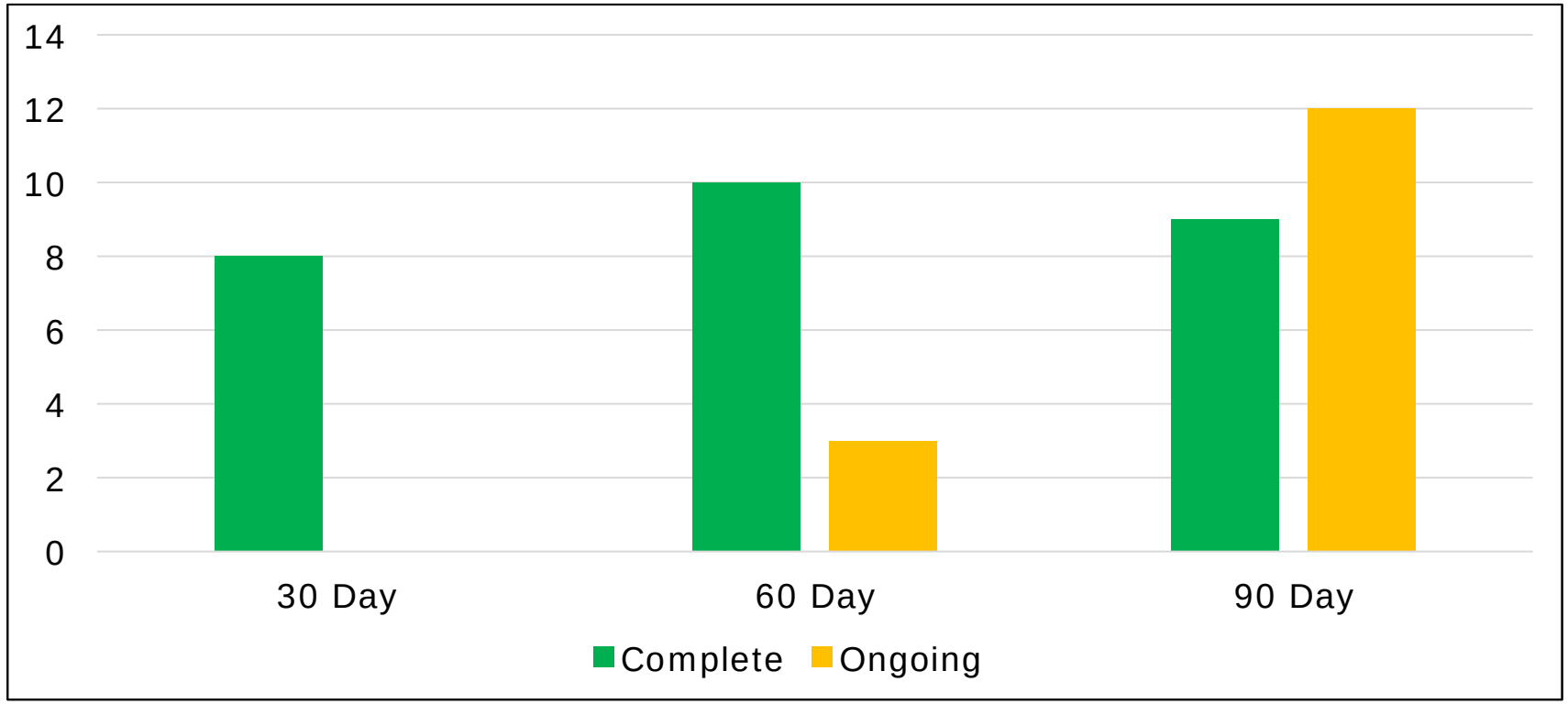
Seven risk areas for focus have been identified for improvement in 2023/24. These are:

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

# Health, Safety & Security

## Health and Safety Improvement Plan 2023/24

The chart below provides the position as at end of March 2024 of the 30, 60, 90 day actions within the improvement plan.



# Health, Safety & Security

## Health and Safety Workplace Inspections

A target was set to conduct health and safety workplace inspections for all Inpatient areas at Acute Hospital sites by end of March 2024. As at end of March 2024 100% (51 inspections) have been completed with an average compliance score of 88.2%.

The table below provides a breakdown of the inspections across each of the Acute Hospitals.

| Acute Site | Total Number of Inspections Completed | Site Compliance % (Average) |
|---|---|---|
| Grange University Hospital | 16 | 90.1% |
| Nevill Hall Hospital | 8 | 89.6% |
| Royal Gwent Hospital | 18 | 84.8% |
| Ysbyty Ystrad Fawr | 9 | 91.2% |

# Health, Safety & Security

## Fire Risk Assessments

As at 31 March 2024, the Health Board have conducted 96% of the fire risk assessments due for review during 2023/24.

This end of year performance will represent a marked improvement on the 2022/23 position of 66% shared with the Board in November 2023.

## Health and Safety Strategy & Culture Plan

Over the course of the next six months a 3-year strategy and work plan will be developed to enhance the health and safety culture within the Health Board.

This will be ratified at the Health and Safety Committee and approved by the Executive Committee and Board by the end of September 2024.

# HSE – Falls Incident Regulation 28/RIDDOR Reporting

| Regulation 28 Report to Prevent Future Deaths<br>Reporting under RIDDOR |
|---|
| Incident relates to a 93-year-old gentleman who was admitted to NHH following a fall. Multiple comorbidities, cognitive impairment, unable to manage at home. Recurrent falls whilst in hospital.<br><br>Fall resulted in a fatal head injury |
| Serious Incident Investigation undertaken by the Health Board<br>Coroner inquest outcome concluded death was contributed to by neglect Regulation 28 issued to the Health Board<br>Incident reported under RIDDOR – HSE visit 15th June 2023 |
| Key Incident finding related to: -<br><br>Documentation not updated in line with required levels of supervision.<br>Overall documentation to inform actions needed was not completed or updated as required and therefore did not translate into the necessary care plan. |
| Improvements and Learning: -<br><br>Falls Policy for Hospital Adult Inpatients produced as a revision of the policy at the time of incident<br>Development and implementation of the Person-Centred Enhanced Observation Framework Toolkit<br>Implementation of improved monitoring/ Audit to include DECI & 1 patient:1 day<br>Enhance the functionality of the Falls Review Panel as an action/learning forum<br>Improvement in means to provide resources in support of patients with enhanced care needs<br>Establishment of a SOP defining lines of responsibility and accountability associated with RIDDOR Reporting.<br>Wider access to falls data to ward level for analysis to inform learning and actions |
| Executive Briefing 18th April 2014 |

# COVID-19 Investigations

## Programme Highlights

Programme completed on time.
2883 Nosocomial COVID-19 Investigations Concluded
No cases referred to Legal & Risk
Bereaved relative digital story produced for National learning

## Case Load Snap Shot

1357 Definite Health Care Acquired Infections
713 Deceased cases
Average patient age 77
51% Female cases / 49% Male cases
415 Review letters
Wave 2 had the highest number of > Moderate harm cases
47% of cases in Royal Gwent Hospital
2006 cases linked to outbreaks

## Learning

Record keeping cited as fundamental issue in 60% of cases reviewed:
- Nursing and Clinical Notes – Content & Legibility | Control documents | Scanned Notes | Datix

## Residual Actions

Programme end wrap up and assurance activities by 30 April 2024
Learning Implementation Plan to be agreed and actioned

# Infection Prevention & Control

## All Wales comparison – WG Goals

| | C. difficile | MRSA bacteraemia | MSSA bacteraemia | E. coli bacteraemia | Klebsiella sp bacteraemia | P. aeruginosa bacteraemia |
|---|---|---|---|---|---|---|
| Aneurin Bevan UHB | 38.55 | 1.52 | 20.29 | 59.35 | 22.66 | 4.23 |
| Betsi Cadwaladr UHB | 41.7 | 1.16 | 24.99 | 79.63 | 22.67 | 4.65 |
| Cardiff and Vale UHB | 22.35 | 2.57 | 28.88 | 68.24 | 23.74 | 3.56 |
| Cwm Taf Morgannwg UHB | 28.38 | 2.03 | 29.05 | 85.13 | 26.57 | 4.73 |
| Hywel Dda UHB | 47.26 | 2.6 | 25.97 | 100.49 | 28.05 | 7.53 |
| Powys THB | 18.67 | 0 | 0.75 | 1.49 | 0 | 0 |
| Swansea Bay UHB | 65.2 | 1.83 | 34.95 | 67.02 | 24.51 | 5.22 |
| Velindre NHST | | | | | | |
| Wales | 38.89 | 1.82 | 25.61 | 72.61 | 23.5 | 4.63 |

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

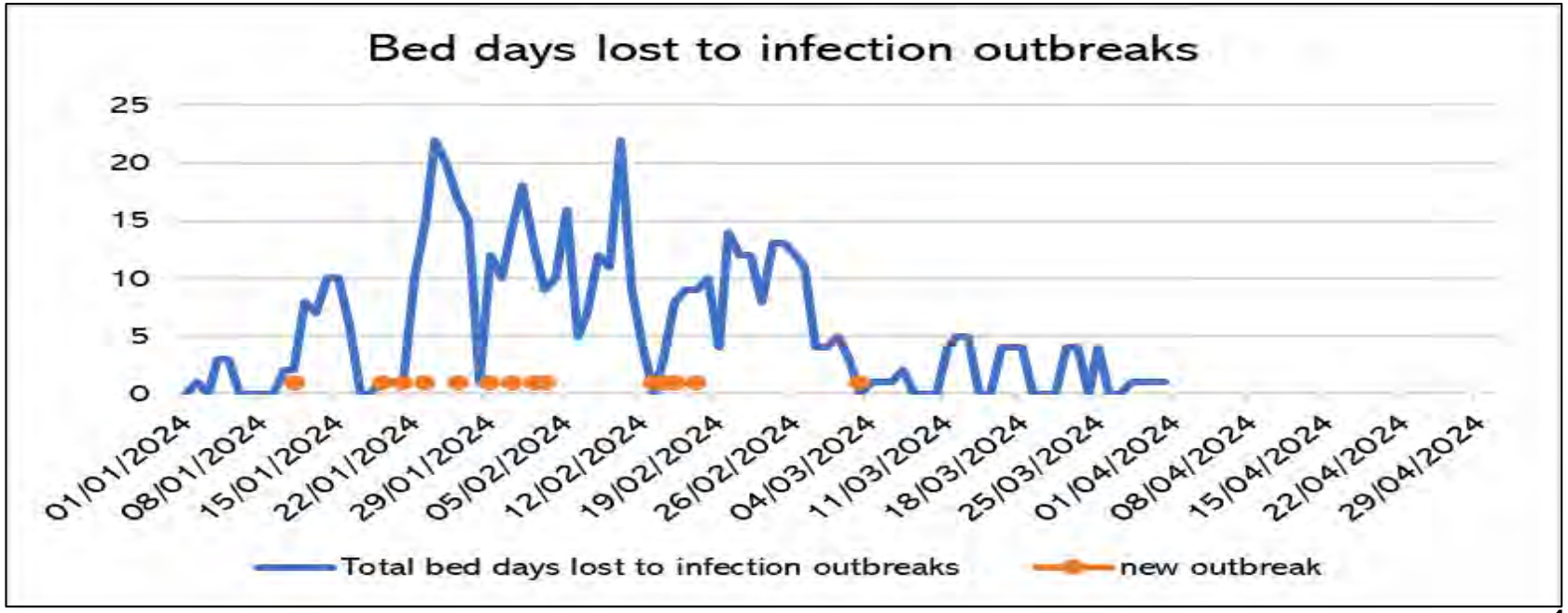
| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| 3 wards closed at Nevill Hall due to increase of C difficile infection 4/3, 3/1 & 3/4 | Antibiotics prescribed without Microbiology advice<br>Antibiotics prescribed out of guidance<br>Failing to withhold PPI while on antibiotics<br>Isolation<br>Lapse with mattress checking<br>Cleaning and ownership of shared equipment<br>Soiled commode<br>Gaps with cleaning schedules due to low staffing establishment<br>Low compliance with hand hygiene | Antibiotic audits fedback to medical teams<br>Geno sequencing indicates no onward hospital transmission<br>Staff reminded to isolate patients when symptoms commence if suspecting infection<br>Staff reminded to check mattresses at least weekly. Ensure shared equipment is cleaned/wiped down between use.<br>Use "I am Clean" stickers<br>Decant HPV clean implemented<br>Visit ward with hand decontamination unit | Antibiotic Pharmacist<br>Ward Manager/ Senior Nurse<br>Infection Prevention | Completed |
| Increase in gram negatives blood cultures in comparison to previous financial year.<br><br>One area (community ward) identified 2 cases of Klebsiella associated with urinary catheter antimicrobial sensitives different strain<br><br>Below all Wales rate for all areas of measurement. | Majority of cases identified on admission<br>Increased antimicrobial resistance<br>Poor documentation compliance with device management<br>Associated with secondary respiratory | RCA meeting for all BSI associated with urinary catheter and line infection<br>Promotion of ANTT<br>Promotion of procedure packs for blood culture collection and insertion of medical devices<br>Monitoring of medical device care bundles via AMAT | Antibiotic pharmacist<br>Ward Manager/Senior Nurse<br>Infection Prevention | Ongoing |

# Infection Prevention & Control

An increase of diarrhoea & vomiting outbreaks coupled with Covid and Influenza circulating resulted in 528 bed days lost due to infections. Three wards at Nevill Hall experienced lost beds due to an increase of C difficile infection. Beds closed to allow deep clean to take place.

Impact of prolonged bed closures managed promptly by: -

- ✓ Risk assessment of patient movement
- ✓ Ensuring patients with same illness cohorted
- ✓ Compliance with fundamental infection prevention measures
- ✓ Correct use of appropriate PPE
- ✓ Public Comms to restrict visiting



# Infection Prevention & Control

| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| Suspected Pertussis (whooping cough) – ED GUH | Index case in ED waiting area for 12 hours on 22nd – 23rd January 2024 | Contact tracing exercise undertaken to identify patients exposed for at least one hour<br>Warn & Inform letter sent to 51 parent's and GP | Infection Prevention | Completed 09/02/24 |
| Suspected Pertussis (whooping cough MIU NHH & CEAU GUH | Index case presented at GP out of hours NHH on 11th Feb & 12th Feb, transferred to CEAU GUH on 12th Feb | 2 patient contacts – checked for vaccination status<br>Staff contacts wearing PPE | | |
| Shingles exposure | Patient with confirmed shingles on Gwanwyn ward | Contact tracing exercise undertaken to identify staff and patient immune status | Infection Prevention | Completed 25/01/24 |
| 4 wards closed due to Covid outbreak<br>11 wards closed due to d&v outbreaks<br>1 ward closed due to influenza | Lapse with PPE – staff, visitors & patients<br>Sub standard cleaning<br>Staff knowledge of IP measures<br>Visitors attended with known symptoms<br>Additional capacity & boarding | Encouraged correct use of appropriate PPE<br>Enhance cleaning and recording<br>Bespoke ward based practical training<br>Restricted access posters displayed at ward entrance<br>Comms circulated for visiting | Infection Prevention<br>Ward Manager/<br>Senior Nurse | At time of outbreak |
| Patient with healthcare associated invasive group A strep on D4E, Royal Gwent Hospital | Possible staff member working with symptoms of sore throat | Staff and patient contacts risk assessed for signs of infection- sore throat, skin soft tissue infection or concerns about infection at any site<br>Staff member visited GP for treatment<br>4 patient contacts received prophylaxis antibiotics<br>Ward and inform letters sent to patient contacts | Infection Prevention<br>Ward Manager<br>Senior Nurse | Completed February 2024 |
| Invasive group A strep identified on admission to AMU | Patient admitted with worsening skin rash for 2 days prior to admission. Considered vasculitic rash secondary to bacteraemia. | Patient commenced antibiotic treatment<br>Patient isolated<br>No patient or staff contacts | Infection Prevention | March 2024 |
| Measles exposure within GP OOH and CEAU resulting in three further cases identified measles positive. | Child not isolated on presentation to the department | Contact tracing of patients and staff (71)<br>Incident Management Team held via Public Health<br>Under 6 month children offered HNIG<br>Warn and inform letters sent<br>Increased comms<br>Review MMR status<br>Promote mask fit testing | Incident Management Team | March 2024 |

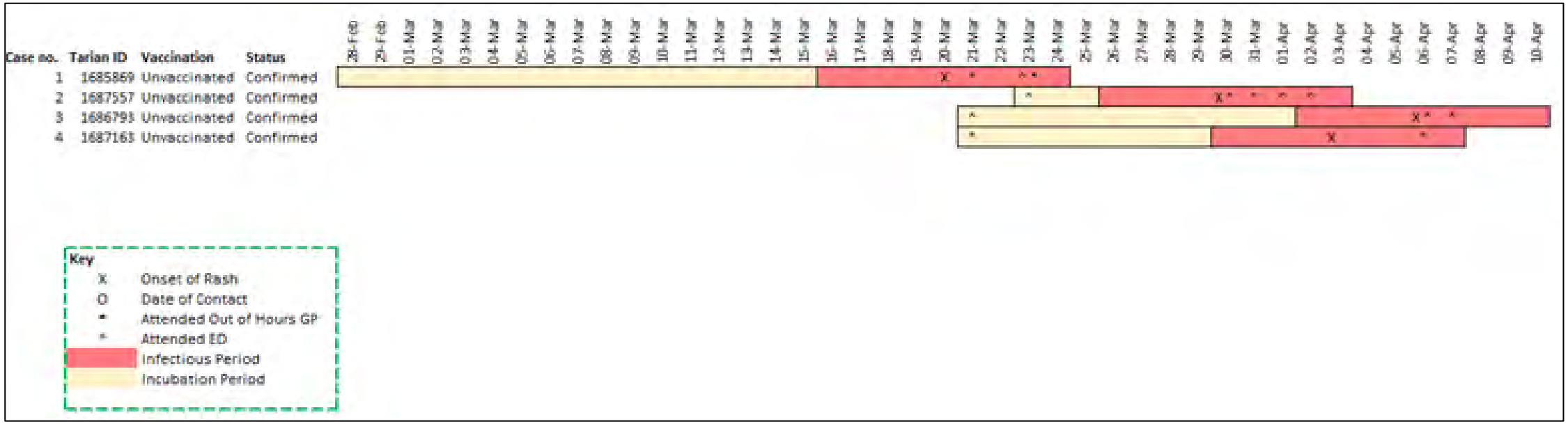
# Measles Outbreak Update

4 confirmed cases of which 3 onward transmission from exposure in waiting area all unvaccinated
Contact tracing a total of 140 children, MMR history and direct exposure reviewed resulting in:-

- 2 clinics for under 6 months resulting in 15 babies receiving HNIG, everyone received warn and inform letters, and exclusion advice dependant on MMR history advocated, medical alerts placed on children for the incubation and infectious period
- 6 staff members medically excluded

Actions:-

- Revisited patient pathways, screening questions amended, hub relocated outside ED, enhanced cleaning, declutter of environment, air changes checked, promotion of mask fit testing and vaccination
- Primary care reviewed action card to formalise the process developed re the management for:-
  - Identified contacts, staff working in practice, and unvaccinated patients



# Safeguarding

# Training and Development

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

| Training Module | Compliance % |
|---|---|
| Adult Safeguarding Level 1 | 87% |
| Children Safeguarding Level 1 | 86% |
| Adult Safeguarding Level 2 | 90% |
| Children Safeguarding Level 2 | 88% |

Compliance with Adult Safeguarding Level 1 is above the agreed threshold of 80%, for the first time, though improvement plans remain in place at Divisional Level to ensure that training compliance is maintained.

Level 3 Children's and Adults continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR and that compliance data can then be analysed.

# CIW Review of Safeguarding Arrangements

In 2023 CIW undertook a rapid review of child protection arrangements in Wales, with much of the focus being on multi agency working. ABUHB is working collaboratively with partners from the Gwent Safeguarding Board to address the findings of the report, which require an effective multi agency solution. In addition, internal work has been undertaken to:

Ensure Health Visiting or School Nursing provide up to date reports, highlighting the health needs of children prior to the Initial child protection conference

Work with Local Authorities to ensure that health staff are invited to strategy meetings and child protection conferences, in order to ensure any relevant information can be provided and that we have an avenue to actively contribute to the decision making process

Ensure that health contributions to Strategy meetings and conferences takes in to account the wider family and that relevant information is shared with providers proportionately and in line with legislation.

Ensure that there are internal pathways for the outcomes of meetings to be shared with all departments supporting the patient and that there is flagging of systems to invite conversation with the corporate safeguarding team when a child is referred to a new service.

# Current Risks/ Challenges

| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| Safeguarding Level 3 Training Non Compliance | Delays in being mandated via ESR | Safeguarding Team working with Divisional leads to establish how this training can be "prioritised" and "delivered" to such a large cohort. | Head of Safeguarding | Q1 2024/25 |
| Decommissioning of Specialist Domestic Abuse Service in General Practice | Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme | Public Health, Primary Care, Safeguarding and VAWDASV working collaboratively on a transition programme to ensure that the work previously provided by a commissioned service is supported through exiting services. | Public Health | Q2 2024/25 |
| Non compliance with MAPPA Statutory Duties | There is no identified Strategic Lead for MAPPA and no specific resources to support operational responsibilities | Safeguarding and Public Health to work collaboratively to scope whether this duty can be supported from existing resources. | Head of Safeguarding | Q1 2024/25 |
| Statements and Court Reports for Child protection are not being prepared in a timely manner | Absence of a SoP or process for Development/Approval of Statements and Reports | Identification of the Safeguarding Hub as the SPOC and development of a SoP in regard of how requests are managed. | Deputy Head of Safeguarding | Q1 2024/25 |

# Update following Annual Report

# Strategy **Meetings –** Local Authority Variance

The Safeguarding Annual Report for 2022/23 reported that one of the Local Authority areas were inviting ABUHB representation at a lower number of strategy meetings than was expected.

Discussions have been held with Senior Managers in Safeguarding for the outlying Local Authority and rationale was offered that this had been related to some sickness/absence, but was now resolved and an improvement could be expected.

Review of the data has highlighted a marked increase in invitations to strategy meetings for this Local Authority area, since the meeting took place.

Monthly meetings will take place between ABUHB and the Local Authority to monitor progress.

# Escalated risk concerns

Section 3

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

## Overall Status Summary

Since July 2023 the MH&LD Division has been subject to internal escalation
A number of quality improvement actions were identified, and these were prioritised into a 30, 60, and 90-day improvement plan.
The Plan has also addressed broader efforts in workforce modelling, leadership, clinical engagement, performance, risk management, and service transformation.
NHS Exec Oversight has been in place
Appointment of an Improvement Director (currently acting Divisional Director)
Appointment of a Divisional Director – starts in May
Progress on quality, safety, and governance in MHLD has been routinely reported through the Executive Committee, Patient Quality Safety & Outcomes Committee the Board, and externally through IQPD.
NHS Exec Colleagues have agreed to co-produce a paper for the Quality Delivery Board and will continue to monitor delivery of improvements through IQPD and JET meetings
Feedback from the NHS Executive on the improvement plan has been addressed, and there is a commitment to aligning better with the Health Board's Quality Strategy and the new accountability/escalation framework.

## Progress / Achievements

What went well this period and upcoming Deliverables

Progress/Achievements:

- Setting The Scene workshop to engage with staff on the setting the vision and ideas for service improvement.
- Ongoing support from the QPS team to better align the division with the Quality Strategy and embed processes.
- A strong focus on improved safety governance in line with HB processes from the Nursing Team
- Multi-professional clinical leadership opportunities developing
- Wider Team support to Implement a process to systematically assess workforce risks and incorporate them into the risk register and the IMTP process.
- Models of care: The teams are keen to look at doing things differently and will start having discussions with the directorates.
- Increased corporate divisional governance in place – fortnightly
- Improved learning from deaths processes

Deliverables and Focussed pieces of work

- Thematic review process
- Ward accreditation in line with HB processes
- Audit strategy
- Daily briefings and escalation processes further embedded at BAU
- A review of serious incidents is ongoing, and the Executive Director for Nursing and Chief Operating Officer continue to monitor ongoing issues with safeguarding, serious incident reporting, and disciplinary processes
- Embed Right Care right person and the new rolling out

## Challenges

Interim Senior Leadership Team currently in place.
Concerns regarding the embeddedness of governance and assurance in relation to the quality and safety of care.
Concerns regarding structures to support strong clinical professional leadership
Additional scrutiny and focus on patient safety and safeguarding, staff engagement, cultural and improvement initiatives.
Some of these actions require a longer-term cultural improvement programme to sustain the change.
Ongoing issues with WCCIS (patient information system) and the necessary work arounds for validated information.
Continued focus on 1A/1B performance and the necessary actions to address the waiting list issues, such as validation, triage and rules.
Continue to review staff engagement and communication across the Division.

# MH/LD Position of the 90 day plan

## Plan Progress

The improvement plan, originally intended to be completed by the end of December, has been delayed due to the need for additional scrutiny and provision of evidence. Suitable revised target dates have been established.

Below is a current summary of the progress made with the improvement plan and outstanding actions:

| | | |
|---|---|---|
| 30 Day Actions | 18 Completed | Outstanding 1 action:<br><br>Missing Persons Policy - currently out for Health Board consultation |
| 60 Day Actions | 16 Completed | Outstanding 2 actions:<br><br>Strengthening OOHs arrangements<br>Safe staffing in-patient SBAR to Execs |
| 90 Day Actions | 2 Completed | Outstanding 2 actions:<br><br>Commissioning Arrangements<br>Missing persons policy in commissioned services |

## Risks

- The 90 day plan has been largely delivered however there remains work to embed the actions and improvements in some areas.
- Post the recent NRI there is an urgent piece of work on patient search, observation policy and practice, safeguarding reporting and escalation.
- Wider large scale programme of improvement led by the Improvement Director focused on governance and assurance, quality, safety, modernisation and wider service redesign.
- High consequence thematic safety issues to be included within the safe care collaborative.
- Governance review underway.
- Oversight by Board/Executive and support from NHS Executive colleagues.

# External Assessments

## Health Inspectorate Wales - Inspections and National Reviews

No inspections have been undertaken since last PQSOC

## Talygarn Unit, County Hospital (Inspection)

Date of Inspection: 5-7 February 2024

Immediate Improvement Notice Letter Received: 8 February 2024

Immediate Improvement Response submitted: 16 February 2024

Final Improvement Plan submitted: 09 April 2024

## Llais Gwent Region Visits

No inspections have been undertaken since last PQSOC

# Framework for Speaking up Safely in the NHS

- Soft launch of the internal raising concerns bespoke email address.
- HR have collated the data from their internal raising concerns bespoke email address (which has now been decommissioned), wellbeing survey data to use as baseline.
- Transition from internal system to external.
- External Employee Assistance Programme and Speaking Up service commenced on 1 March 2024.
- Steering Group set up with ABUHB Stakeholders based on those who attended 3 October session and also those we missed. 1st meeting, ToR and overall ambition to be set out, 2nd meeting, invite PhD student to share findings on Managers raising concerns.
- Shape a 2 year plan, with strong emphasis on evaluation.

# Claims, Redress and Inquests

## January – March 2024

During this period, national press coverage Coroner Prevention of Future Deaths Reports (Reg 28's).

Over last 12 months, Coroners in Wales wrote 41 "prevention of future deaths reports" and more than half were issued to Betsi Cadwaladr University Health Board.

Further concerns included poor preparation for inquests, and large back logs of inquests yet to be listed (350-400 in Betsi)

## Assurance from ABUHB perspective – Reg 28 reports

Our Regulation 28 Reports (Prevention of Future Deaths) have remained very static and stable over the last 10 years.

We have had 25 reports over a 10 year period, representing a yearly average of 2.7 per annum.

Our highest in any 1 year has been 5, but in others only 2 and 0.

# Claims, Redress and Inquests

## Assurance from ABUHB perspective – Inquest Management

With a new Senior Coroner for Gwent arriving in 2019 we planned for an increase in inquests and more investigatory approach.

We invested in the Inquest team, with dedicated resource to this important portfolio

Over the intervening period we have focussed on ensuring we are prepared for inquests, particularly the front loading of our learning, actions plans, and increasingly additional accompanying learning statements to provide assurance to Coroner and families.

Coroners are under direction from the Chief Coroner to issue PFD's if they remain unassured, and so our numbers are very positive.

We currently have 202 live inquests that we are managing. We know from the All-Wales inquest networks other Health Boards are incurring backlogs of much higher numbers.

We are working hard to enable the Gwent Coroner to hear our inquests faster than we had historically.

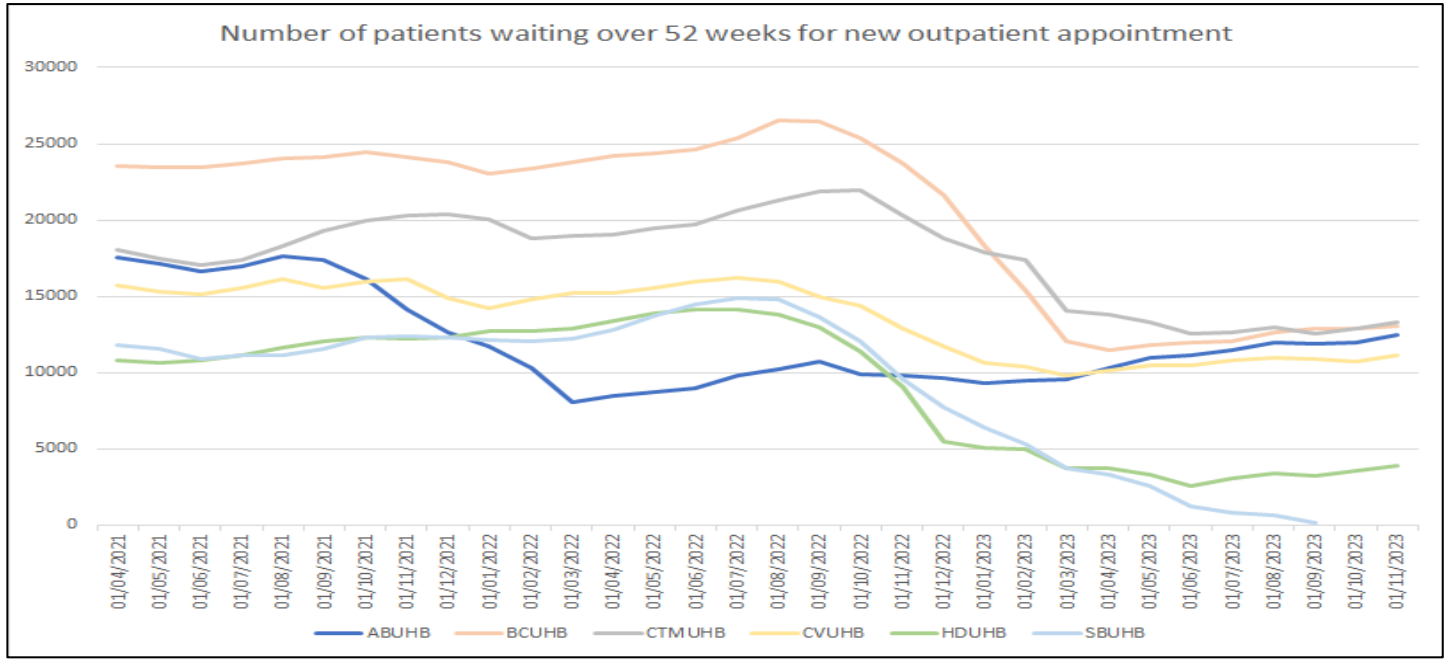
# Coroner Regulation 28 Requests – per year of issue

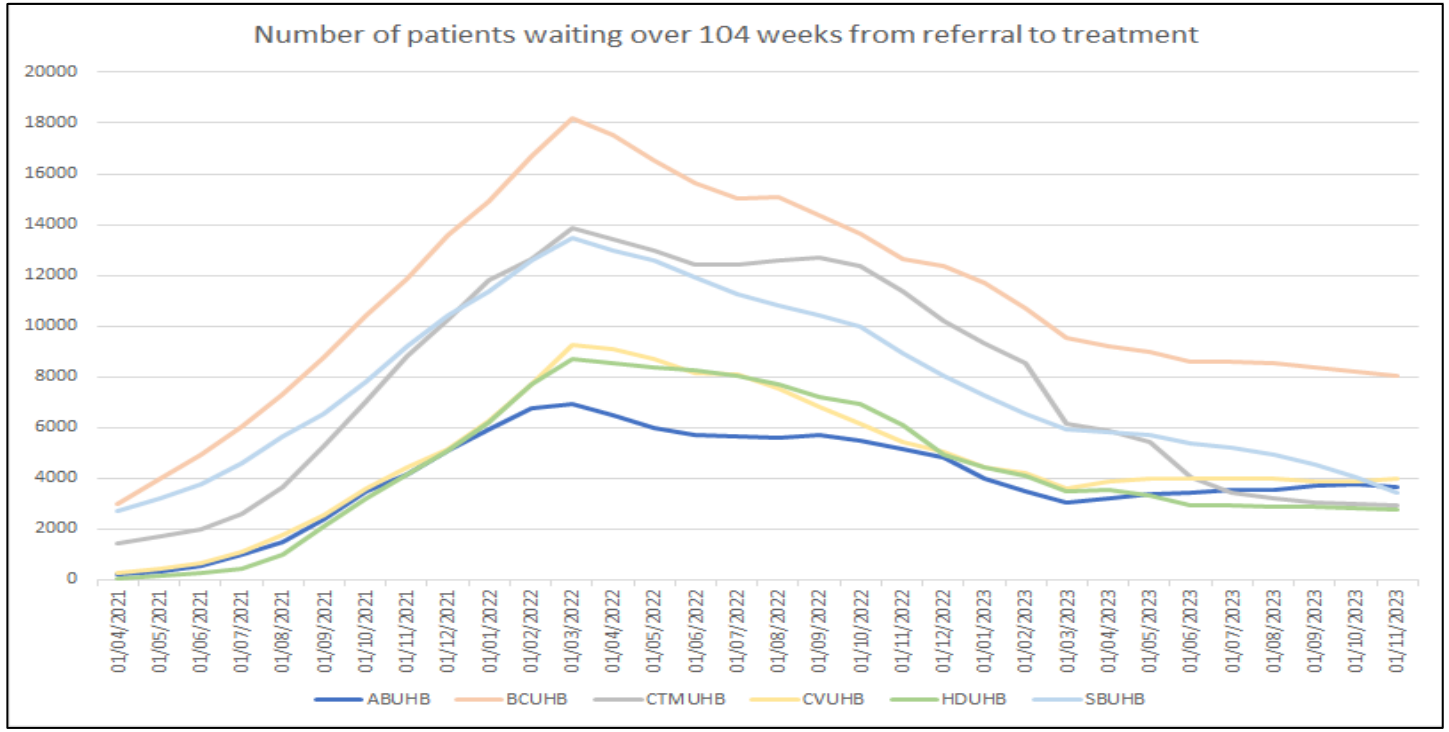
| Matter | Incident Date | Incident |
|---|---|---|
| 2023 - 2024 | | |
| 1.MS | 4/5/2020 | Concerns with paper referral between SALT + ENT |
| 2.KM | 9/9/2022 | Comms with family / Lack of 7 day crisis service to older adult mental health patients |
| 3.LB | 1/2/2023 | ABUHB ambulance handover delays |
| 4.CM | 5/12/2020 | Poor nursing care RGH, YYF and GUH |
| 5.NE | 1/5/2023 | No SI investigation of the fall; Failure to maintain 1:1 observation despite high risk of falling YAB Tyleri Ward |
| **2022 – 2023** | | |
| 1.MR | 2/2/2021 | Fatal fall in hospital, Tyleri Ward, YAB |
| 2.GW | 23/8/2021 | MH patient failed by 2 teams – MH and ENT |
| 3.LJ | 12/3/2022 | 2 year delay in receiving CBT, still on waiting list at time of death |
| 4.MW | 5/4/2021 | X3 inpatient falls, Bargoed Ward, YYF |
| 2021 - 2022 | | |
| 1.BW | 22/6/2020 | A breakdown in communication and collaboration between primary and secondary care |
| 2.VW | 16/01/2020 | Staffing levels in ED |
| 2020 - 2021 | | |
| 1.AR | 3/12/2019 | Delay in emergency ambulance attending due to hospital delays in ABUHB |
| 2.RA | 9/10/2018 | Mental Health Serious Incident investigations to include third party organisations where relevant (GP in index case) |
| 3.AJ | 13/11/2019 | Inpatient fall where 1:1 care had been identified but had not been implemented, NHH THIS IS NOW SUBJECT TO HSE INVESTIGATION CURRENTLY |
| 4.ER | 21/10/2019 | Inpatient fall where omissions were identified in care planning and staffing levels Oakdale Ward, YYF |
| 2019 - 2020 | | |
| 0 | 0 | No Reg 28's issued |
| 2018 - 2019 | | |
| 1.DG | 6/1/2018 | Delay in emergency ambulance attending due to hospital delays in ABUHB |
| 2017 - 2018 | | |
| 1.EC | 26/01/2015 | GP practice (non ABUHB managed) issued with Reg 28, with ABUHB also providing its own response |
| **2016 – 2017** | | |
| 1.VK | 7/1/2015 | Fall sustained when using a bedside commode, Ward C6 West, RGH |
| 2.GL | 23/9/2013 | Discharged from Talygarn then committed suicide |
| 3.CR | 14/8/2016 | Delay in emergency ambulance attending because of hospital delays in ABUHB |
| 4.PD | 19/1/2016 | Unforeseen adverse reaction to general anaesthetic which caused cardiac arrest |
| 2015 - 2016 | | |
| 1.RH | 13/04/2013 | Maternal death Obs & Gynae |
| 2.AW | 26/6/2015 | Warfarin monitoring in GP practices |
| 3.AC | 16/04/2015 | Management of MRSA infected wound / TVN service availability |
| 4.MC | 19/05/2015 | INR monitoring |

| Summary of Data – Key Themes | |
|---|---|
| Over the 9-year index period 2015-2023 | 25 Regulation 28 Reports issued in total<br><br>Yearly average 2.7 per annum |
| Fall cases | 6 Reg 28's relating to Falls<br><br>2 specifically reference lack of 1:1 care |
| Mental Health | 5 Reg 28's relating to MH services |
| Ambulance | 4 Reg 28's relating to ambulance delays<br><br>Most recent 2023 issued to ABU/WAST/WG |

There were no Regulation 28's issued in January or February. There was one issued in March 2024.

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

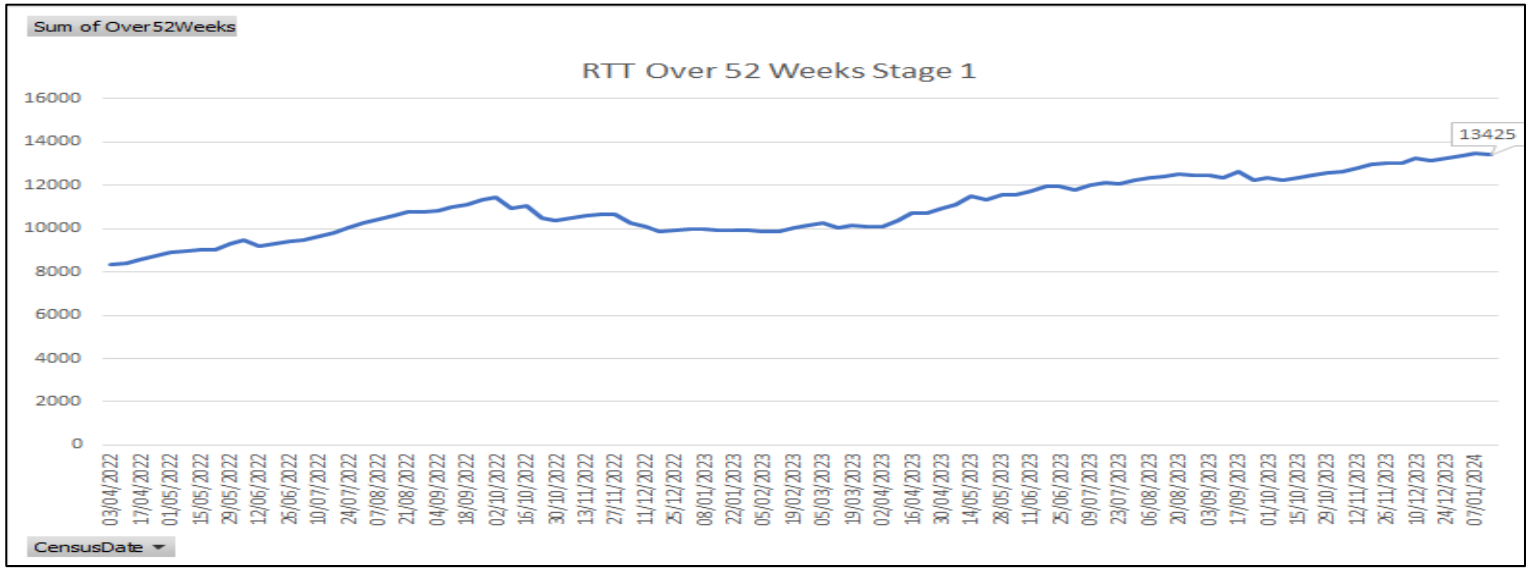


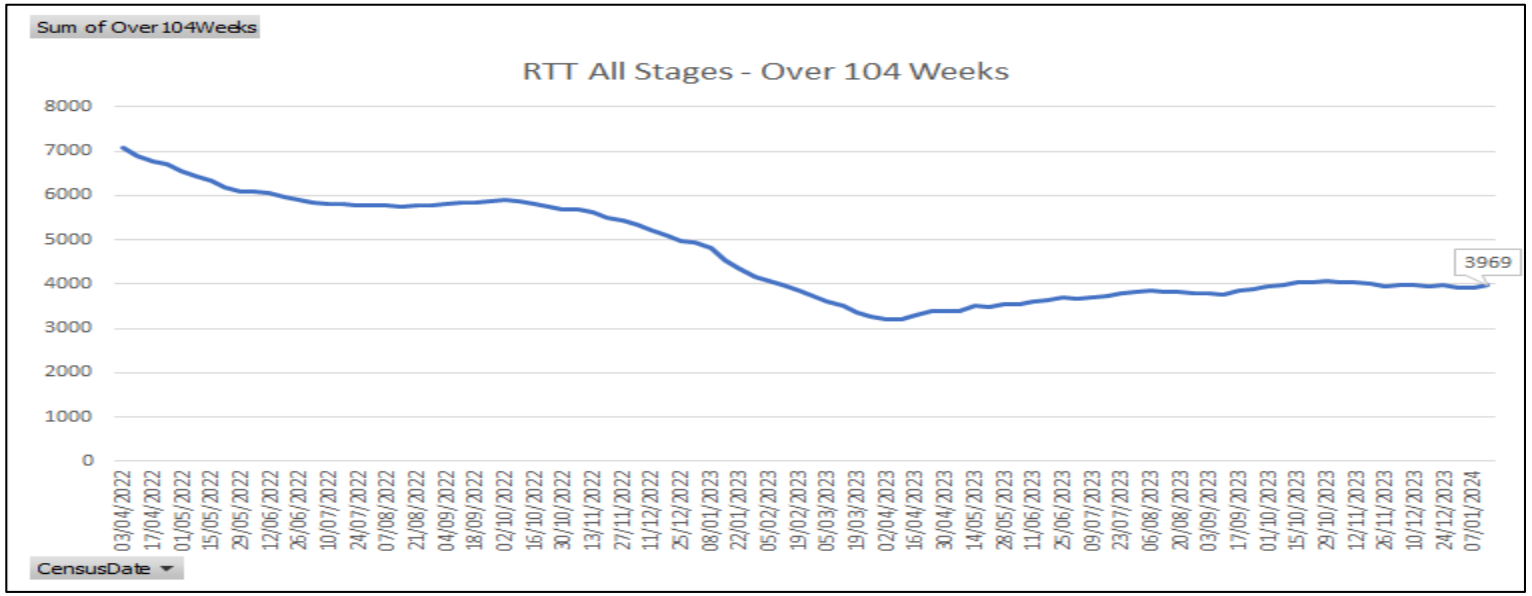
# Planned Care

## RTT Weekly Snapshot *(reportable activity only)*

**RTT – Stage 1 (New Outpatients) Over 52 Weeks**




**RTT – All Stages Over 104 Weeks**



# Planned Care Recovery Programme: Theatres Maximisation Programme

| Managerial Lead: | Becky Owen-Pursell | SRO: | Julie Poole/Charlotte Thomas | Reporting Period: | March 2024 |
|---|---|---|---|---|---|

## Programme Objective

To increase theatre utilisation and elective capacity for ABUHB planned care patients by focussing on three areas of improvement: scheduling, utilisation and standardisation of process and approach.

## What Went Well this Period

**Utilisation & Performance** Theatre Innovations Meeting has started with revised agenda and attendee list. Clear objectives and good turnout from surgical specialties. Aligned data pack for GIRFT
**Safety** - QI Safety Advisor for Theatres now in post. Undertaking QI training
**BC & Developments** - ORMIS upgrade in a test stage

## Key Milestones and Deliverables for the Next Period

**Utilisation & Performance** – launch of TUG meeting
**Safety** - Explore further on the reusable harmonic scalpels
**BC &** Developments - Complete ORMIS upgrade testing

## Key Risks

Ongoing challenges of capacity in the system
Availability of capital and revenue funding
Limitations in ORMIS data
Working within limited resources – transformational fund bid put forward for programme management support

# Planned Care Recovery Programme: Outpatients

| Programme Manager: | Julie Poole/Carla Hiscott | SRO: | Julie Poole | Reporting Period: | February 2024 |
|---|---|---|---|---|---|

## Programme Objective

The Outpatient Transformation Programme aims to modernise and transform the delivery of outpatients across the Health Board, and in doing so reduce waiting times and provide an equitable service for all patients.

## What Went Well this Period

WG has part-funded RGH Outpatient Treatment Unit until end of March 2024. 2014 patients attended unit April 2023-Jan 2024. A Business case has been drafted for full funding of the Unit.
Work ongoing with DHCW to undertake proof of concept development of Automated Clinic Booking System on MS Teams App, with aim of increasing clinic efficiencies and utilisation across AB. Two weekly sprint runs in place. Pilot to be undertaken for Royal Gwent Main Outpatients.
Six week clinic utilisation audit commenced for RGH Main Outpatients Feb 24.
Hospital Initiated Cancellations - number of HIC within 6 weeks Months 1-10 decreased from 28,515 2022-2023 to 26,063 2023-2024. Task and Finish Groups in place to focus on avoidable reasons for cancellations. Biggest reductions in Annual Leave/Study Leave, Sickness and Admin Error. Hospital Cancellation Policy in development.
Advice Only – 11,812 Advice Only Attendances April - Feb 2023/2024 (April - Feb 2022/2023 numbers were 9920, an increase of 1892 for same time period).
DNA's – currently 5.7% (target 5%). Focus on cohorts with high DNA rates. Work being undertaken with Gastroenterology and Public Health focusing on Hepatology to understand patterns for DNA's and potential reasons why, along with analysis of secondary care activity following DNA to understand impact. Patient contact to be undertaken to further explore reasons. Potential to role out to other specialties following pilot.

## Key Milestones and Deliverables for the Next Period

Continuation of Clinically led workshops - Programme of meetings for 2024/2025 being established to include action focused follow up meetings – next meetings being arranged with General Surgery and Neurology.
Business case for Outpatient treatment Unit – to go through PIP in March 2024.
Clinic utilisation audit of YYF to commence.
Two way e-advice (CWS development) – design and development work to be undertaken Quarter 1, Go live Quarter 2
Consultant Connect – discussions underway for potential use in Emergency Eye Clinic. Exploration of use in T&O.
Updating of Directorate Outpatient plans aligned to new three year strategy and targets (March). To include delayed follow up 100% past target plans in line with 30% reduction target, SOS and PIFU, virtual clinics and group clinics (face to face and virtual).

## Key Risks

Ongoing challenges of capacity of system
Business Case submissions are being prioritised within the HB due to the financial position

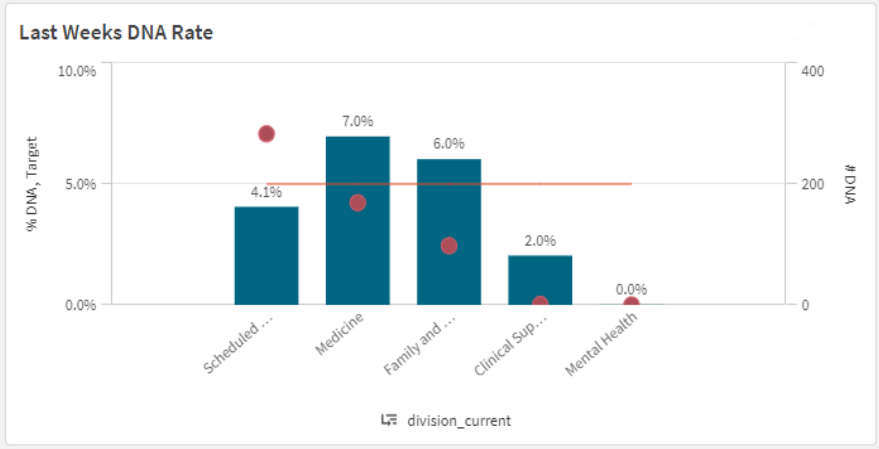
# DNA Rates

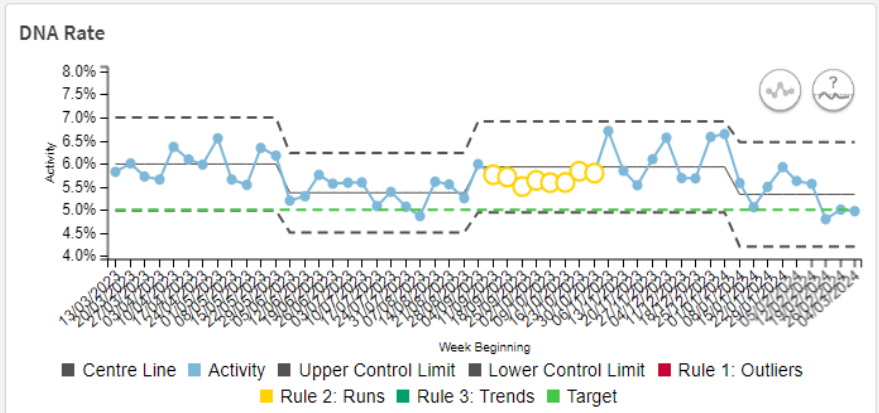
| Last week DNA Rate | DNA Rate Current Year | DNA Rate Prev Financial Year |
|---|---|---|
| 5.0% (551 / 11094) | 5.7% (28573 / 503620) | 6.6% (33351 / 504388) |

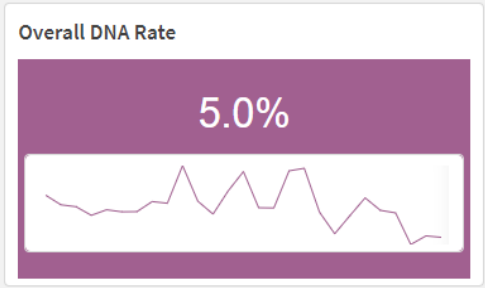
Division->Specialty->Ser...

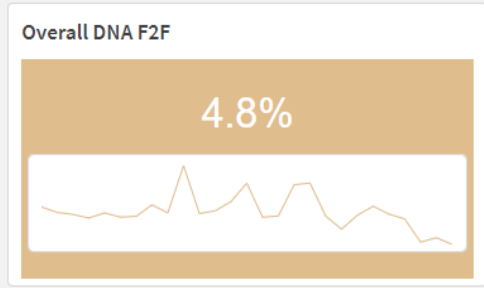
Reportable

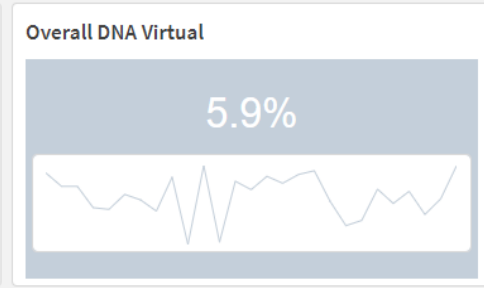
| Service Type | Attendance Category | Consultation Method | Outcome |
|---|---|---|---|
| Acute | Follow Up Attendance | Face to face appointment | Attended - Future Decision U... |
| Community | New Attendance | Virtual clinical appointment (... | Cancelled by Hospital |

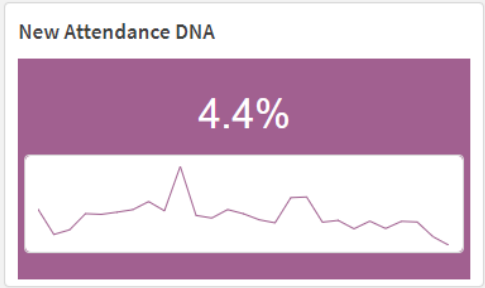


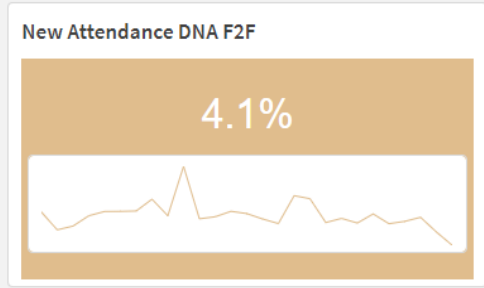



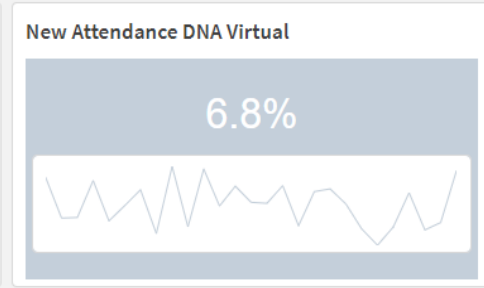



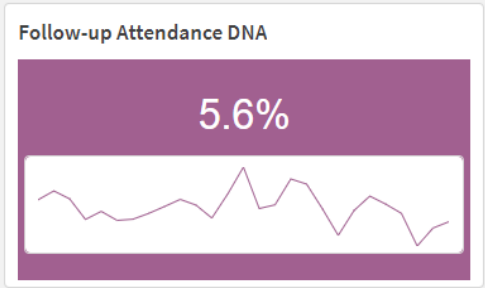



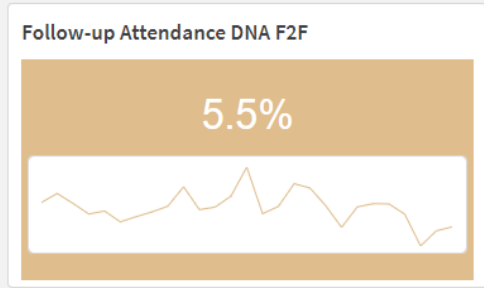



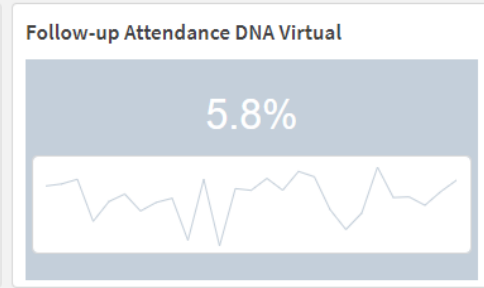



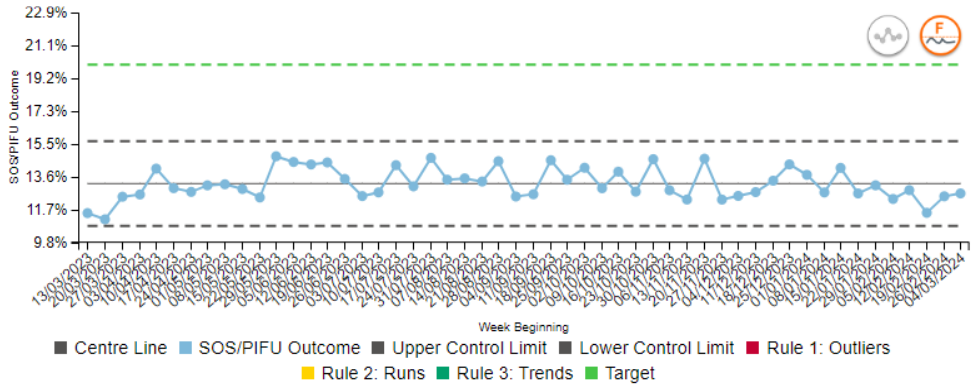



# Outcome SOS/PIFU

| Last weeks SOS/PIFU Outcome | SOS/PIFU Outcome Current Year | SOS/PIFU Outcome Previous Year |
|---|---|---|
| 12.6% (1039/8230) | 13.2% (52172 / 394187) | 11.9% (46148 / 388466) |

Division->Specialty->Service->Clin... | Reportable | Service Type | Attendance Category

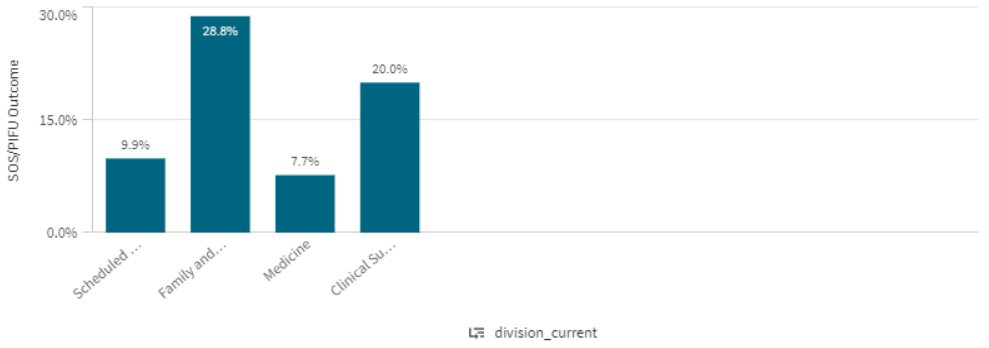
## PIFU Outcomes



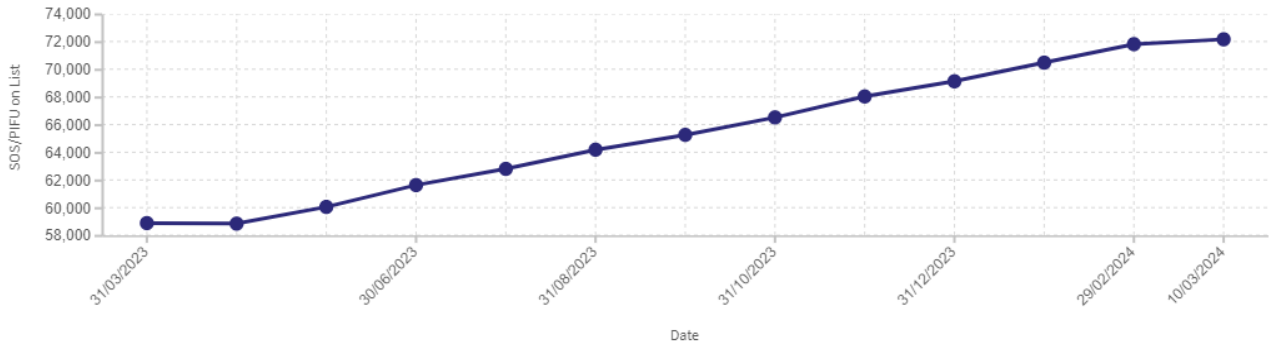

## SOS/PIFU Outcomes

| division_current | SOS/PIFU Outcomes | Last weeks SOS/PIFU Outcomes | Last weeks SOS/PIFU Attendances | Change in last 5 weeks | Change from 13 weeks |
|---|---|---|---|---|---|
| Family and Therapies | | 28.8% | 401 | -0.0% | -1.5% |
| Clinical Support Services | | 20.0% | 6 | 7.2% | -17.5% |
| Scheduled Care | | 9.9% | 490 | -1.2% | -1.1% |
| Medicine | | 7.7% | 142 | 0.2% | 1.9% |

## Last weeks SOS PIFU Outcomes




## SOS/PIFU Patients on List



# Virtual Activity

| Last weeks Virtual Attendance Rate' | Current Fiscal YTD | Previous Fiscal Year |
|---|---|---|
| 18.7% (2091/11202) | 23.0% (119049/517985) | 24.5% (125582/512968) |

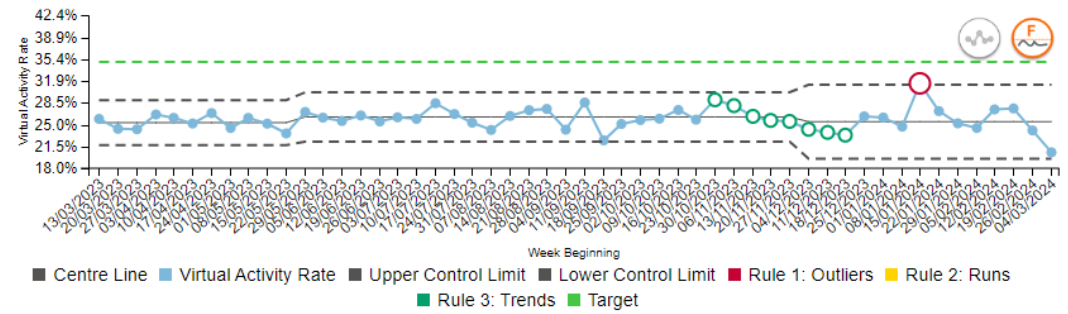
Service Type: Acute; Community

Division->Specialty->Service->...: Clinical Support Services; Family and Therapies

Reportable: Yes; No

Attendance Category: Follow Up Attendance; New Attendance

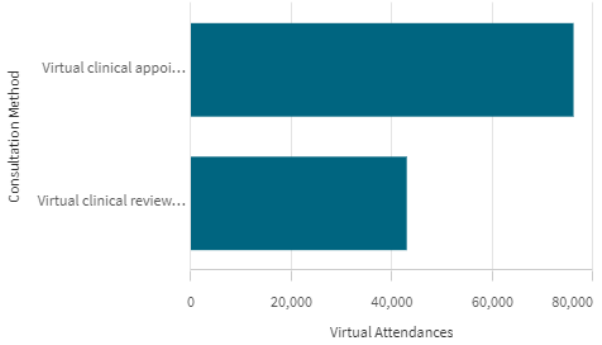
Virtual Attendances Rate - New | Virtual Attendance - New



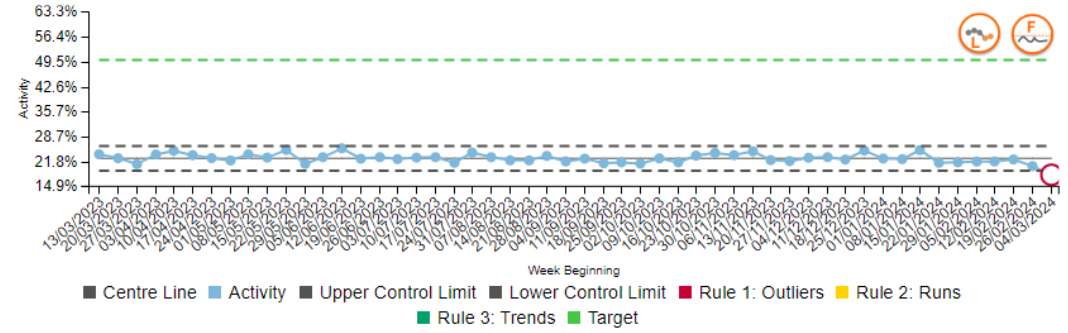

Virtual Outpatient Attendance Rate

| division_current | Virtual Attendances | Virtual Attendance Ra |
|---|---|---|
| **Totals** | **2,091** | **18.7** |
| Scheduled Care | 1,209 | 1 |
| Medicine | 588 | 2 |
| Family and Therapies | 267 | 1 |
| Clinical Support Services | 14 | 2 |
| Mental Health | 13 | 6 |

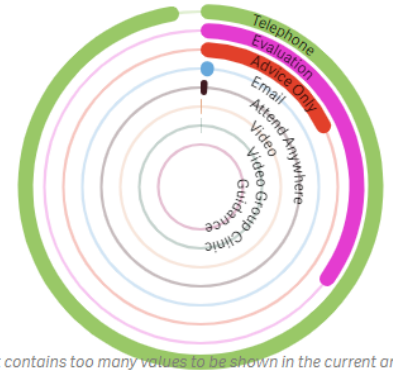
Virtual Outpatient Attendance by consultation method




Virtual Attendances Rate - Fo... | Virtual Attendance - Follow up




Virtual Outpatient Attendance by Virtual Slot Type




** The data set contains too many values to be shown in the current area.*

# Total FU Waiting List

| Current Follow Up Waiting … | Change in last 5 weeks | Change in last 13 weeks | Change from EO previous FY |
|---|---|---|---|
| 131,972 | 773 | 2,356 | 7,574 |

| division_current | Follow Up Waiting List | Current Follow Up Waiting List | Change in last 5 weeks | Change in last 13 weeks |
|---|---|---|---|---|
| Family and Therapies | | 14,362 | 65 | 513 |
| Medicine | | 49,270 | 670 | 1,156 |
| Mental Health | | 330 | -63 | 50 |
| Scheduled Care | | 67,947 | 100 | 636 |
| Urgent Care | | 63 | 1 | 1 |

# FU 100% Past Target

| Current over 100% past tar… | Change in last 5 weeks | Change in last 13 weeks | Change from EO previous FY |
|---|---|---|---|
| 27,404 | 112 | 1,357 | 5,800 |

| division_current | Over 100% Past Target | Current over 100% past target | Change in last 5 weeks | Change in last 13 weeks | Average Follow Up OP attendances of last 5 weeks | % Attendance against 2019/20 |
|---|---|---|---|---|---|---|
| Clinical Support Services | | 0 | 0 | 0 | 25 | 234.1% |
| Family and Therapies | | 1,074 | 21 | 114 | 363 | 105.8% |
| Medicine | | 9,666 | 418 | 672 | 1,176 | 106.0% |
| Mental Health | | 80 | -33 | -11 | 0 | - |
| Scheduled Care | | 16,530 | -296 | 580 | 3,641 | 104.9% |
| Urgent Care | | 54 | 2 | 2 | 0 | 0.0% |

# Planned Care Recovery Programme: Waiting Well

| Service Improvement Manager: | Carol Phelps | SRO: | Rich Morgan-Evans | Reporting Period: | March 2024 |
|---|---|---|---|---|---|

## Programme Objective

To support people to make informed decisions about their health care, by giving them more information and the skills to better manage their health and condition whilst waiting for appointments or treatment.

## What Went Well this Period

Recruitment of 3 x Band 3 Call Handlers live on Trac, closing day 25th March.
Phase 2 started of 3Ps project (March 2024 - April 2025)
Keeping Well Posters displayed in designated areas
AB Funding confirmed from the WG Planned Care Transformation Fund for 2024/25
Analytics - Keeping Well landing page continue to see increase in hits
WPAS team confirmed no issues with data recording of patient info on WPAS

## Key Milestones and Deliverables for the Next Period

Patient engagement feedback and produce bilingual brochures including tips for Keeping Well.
Arrange engagement sessions with DMs
Patient Waiting Times approved for publication on the Keeping Well Webpage. Further conversations ongoing.
Development of ABUHB 3Ps and SPOC Comms & Eng Plan ongoing.
1 x Band 5 RN recruitment to be approved for Trac.
AB 3Ps Progress meeting with WG arranged for 22nd March.
Engagement awareness sessions planned at Local Medical Committee, Outpatients Steering Group and Neighbour Hood Network
Publish 3Ps Webpage on Pulse

# Health & Care Pathways

| Exec Lead: | Dr James Calvert | SRO: | Owain Sweeting | Reporting Period: | March 2024 |
|---|---|---|---|---|---|

## Programme Objective

The Health Pathways Programme aim is to provide clinicians with clear, up to date information to support patients under their care. The programme will deliver pathways that are streamlined and efficient in order to make the best use of the right clinical teams for the right patient at the right time.

## What Went Well this Period

1. Activities-to-launch plan produced, focusing on pathways which will be completed soon and suspending work on delayed pathways
2. Exercise conducted to agree priorities for 2024-25, including priorities as lead region, support region and pathway localisation
3. Project Manager commenced in post 18/03
4. 24 pathways completed, 6 in wider review and 25 in final draft

## Key Milestones and Deliverables for the Next Period

1. Continue writing up pathways and request pages in preparation for launch
2. Meeting with National Programme Team and all regions to agree 2024-25 pathway allocation
3. Introduce quality improvement register to identify all opportunities for better pathway optimisation discovered during editing process
4. Define process / criteria for implementing ‘detached follower’ in the event that local and national pathway elements do not align

## Key Risks

Viability of intended launch date due to industrial action, delays with national pathways and capacity of Streamliners (Technical Writing Team)
Optimising HealthPathways as part of phase 2 will require prioritisation of developments within Informatics
Alignment of national guidance and local pathways – feedback from SMEs and LMC

# Planned Care Academy Training

| Project Lead: | Cynthia Henderson | SRO: | Rich Morgan-Evans | Reporting Period: | February 2024 |
|---|---|---|---|---|---|

## Programme Objective

Aim is to develop a structured training and development programme for staff irrespective of location, that supports proactive management of elective patients on waiting lists. The  focus will be on prospective tracking  reducing the need for correction and validation. The prime objective is continuous service improvement through a robust and dedicated training resource.

## What Went Well this Period

1. Draft Training Plan ready for review.
2. Superuser team established and creating new training materials and quick reference guides. Good progress to date.
3. Review undertaken of recent training stats for WPAS to inform training timetables.
4. Draft training  timetable completed with all modules incorporated in structured way to deliver tailored and targeted training.

## Key Milestones and Deliverables for the Next Period

1. Continue with the development of the training guides, quick reference documents and scenario training with assessment and competence evaluation.
2. Create a communication plan ready for a May start date to be agreed and dependent on the identification of the required training resource.
3. Testing of training, links with ESR and online training material.

## Key Risks

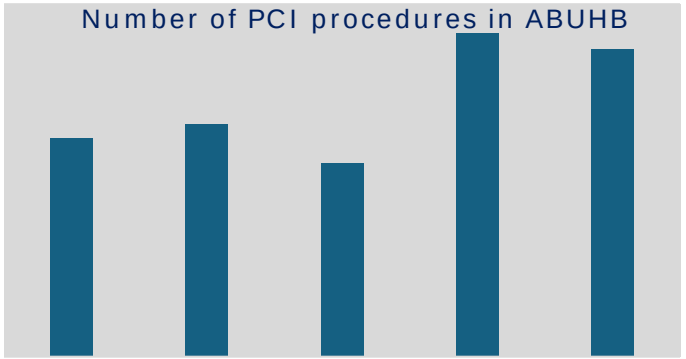
Decision awaited on how WPAS team will be structured to deliver training.
Capacity of Directorates to engage and provide input into the training materials as requested SOPs have not been made available in the last 6 months. This will reduce the capacity of the team to provide bespoke specialty training.
Releasing staff for training when the programme starts.

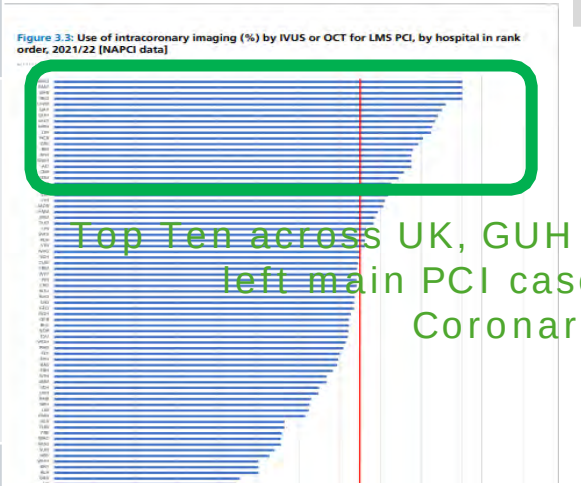
# Clinical Effectiveness

Section 4

| Audit Title: | National Audit of Percutaneous Coronary Intervention (NAPCI) April 2021-March 2022 Published June 2023 | Clinical Lead:<br><br>Dr Shawmendra Bundhoo |
|---|---|---|
| Rationale: | The NAPCI report reviews 97,765 PCI procedures which has increased by around 7000 procedures since 2020/21.<br>PCI activity has recovered but has not returned to the numbers seen during the pre-pandemic.<br>The report highlights the increased adoption of intracoronary imaging for PCI, involving the left main stem as per best practice guidelines, increasing use of same day discharge for elective cases and use of more potent P2Y12 inhibitors in PCI cases undertaken in patients with STEMI. | |
| Objectives: | The report focuses on several specific quality improvement (QI) metrics for the delivery of PCI services.<br>These are derived from national and/or international standards and guidelines.<br>A number of important metrics reported here which relate to the management of patients with acute coronary syndromes are also included in the joint MINAP/NAPCI Heart Attack report. | |
| Presented at Clinical Standards and Effectiveness Group – 21st March 2024 | | |

Key message 1:
There has been an increase in the number of PCI procedures performed in the UK during this audit period (compared to COVID-19 pandemic 2020/21). Total PCI procedures increased by approx. 7,000, from 90,708 in 2020/21 to 97,765 in 2021/21. This represented a return to nearly 98% of the 100,112 cases reported in the pre-pandemic year. The number of primary PCIs for patients with ST-elevation myocardial infarction (STEMI) had returned to pre-pandemic levels. PCI for other acute coronary syndromes was virtually at pre-pandemic levels but elective PCI numbers were significantly lower.

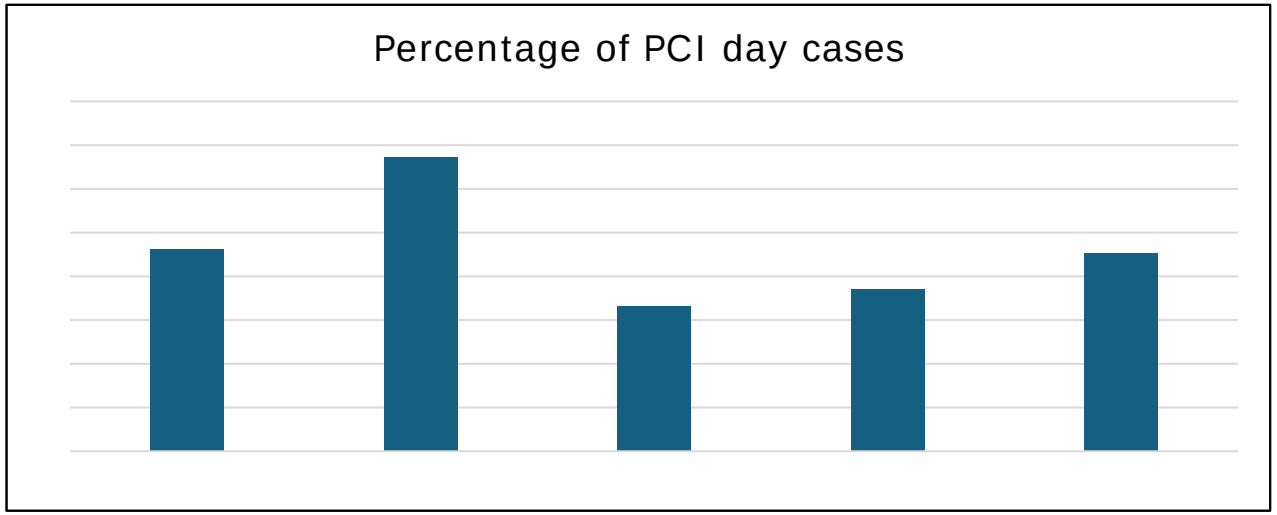


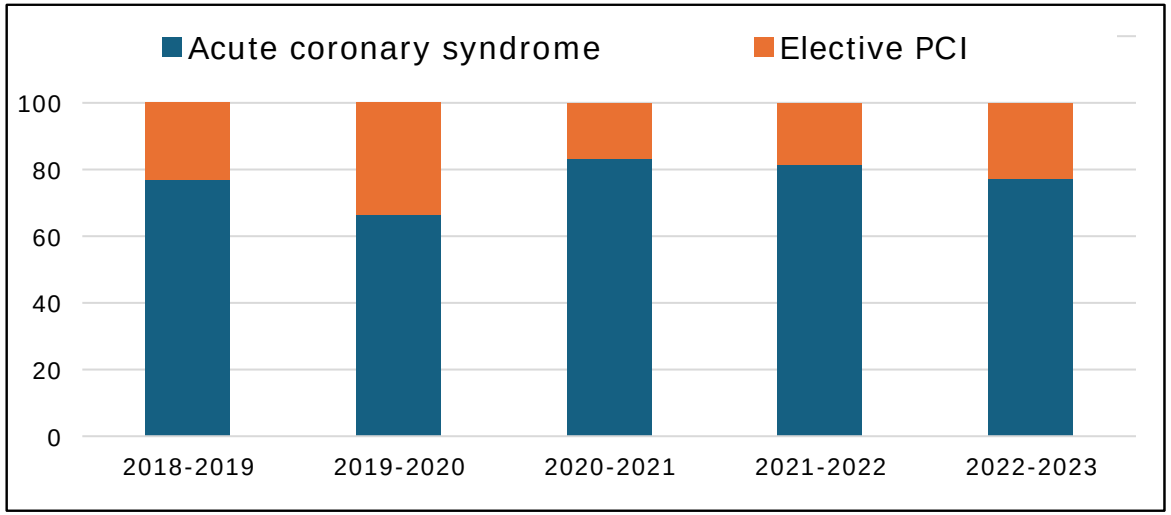




Top Ten across UK, GUH - 94% of all left main PCI cases had Intra Coronary Imaging

Key message 2:
There has been a gradual improvement in the use of intracoronary imaging from 50.7% in 2017/18 to 70.5% in 2021/22, although we report wide differences in practice between hospitals, with a number of units performing intravascular imaging in <50% of Left Main Stem (LMS) PCI.

Key message 3:
Day case PCI for elective procedures: There has been an increase in day case elective work over the last 4 years from 63.8% in 2018/19 to 71.4% in 2021/22, with significant variability nationally, with some centres performing day case PCI in almost all elective cases, and some where almost all patients are kept in overnight following their procedure. The Health Board is currently 22.7% elective same day discharge.




Key message 4:
There has been a significant increase in newer P2Y12 antiplatelet use over time, increasing from 44.2% use of prasugrel and ticagrelor in 2014 to 55.3% in 2021/22. The most commonly used newer P2Y12 agent in 2021/22 was ticagrelor (37.3%) and prasugrel was only used in 18% of cases.

*Poor data capture*
*Confusion between admission and procedure medications*
*Planning to simplify data entry focusing solely on procedure pharmacology on Mc Kesson*
*Ticagrelor is the drug of choice in ABUHB patients admitted with acute coronary syndromes who require PCI*
*Clopidogrel is used instead of Ticagrelor when patient is on other anticoagulants namely novel oral anticoagulant agent or warfarin*
*ABUHB patients undergoing primary PCI in UHW receive Prasugrel. Prasugrel is continued if repatriated patients require staged PCI in GUH*

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

| Risk level | Description |
|---|---|
| None | Standards met and findings demonstrate no risk to patient safety |

| Report Successes: | |
|---|---|
| 1 | Compliant with national standards to perform unprotected left main PCI using intra coronary imaging |
| 2 | Same day discharges are occurring in >75% of elective PCI cases |

| Report Concerns: | |
|---|---|
| 1 | Need to have mandatory fields in Mc Kesson to capture dates of admission and discharge for elective cases |
| 2 | Limited data captured on antiplatelet pharmacology in patients presenting during daytime with STEMI |

| Report Recommendations: | | S.M.A.R.T Actions: Responsible: Due Date: Progress: |
|---|---|---|
| 1 | Operators undertaking Left Main Stem PCI should use intracoronary imaging (either IVUS or OCT) to guide interventional strategy and optimise stent expansion and apposition, in line with international consensus statements around best practice. | This is current practice. No further action at present. To continue with current standard of practice. |
| 2 | Hospitals should modify their pathways and ward structures to maximise the use of day-case procedures so reducing avoidable overnight stays for patients. | Consistently >75% over the last 5 years – more complex cases post Covid-19. In order to modify services this requires more in-depth data capture for elective patients undergoing day case PCI. Clinical lead to progress. |
| 3 | Hospitals should review their STEMI protocols to see where improvements can be made in the use of newer antiplatelet agents, in particular Prasugrel, during primary PCI. | This will be captured when GUH will be offering a dedicated 24/7 Primary PCI service. All ABHUB patients who undergo PPCI at UHW receive Prasugrel. GUH is not a dedicated Primary PCI centre. Patients' self-presenting to GUH requiring Primary PCI receive Ticagrelor. Patients who are on anticoagulants requiring PPCI receive Clopidogrel to reduce the risk of bleeding complications. |

| Clinical Leads Local Recommendations: (if applicable) | | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | To have certain mandatory parameters to be captured on Mc. Kesson for outpatient attendances to determine date of admission and discharge | | Dr. S. Bundhoo | | |

| Audit Title: | National Prostate Cancer Audit (NPCA) State of the Nation report<br>Data collection period: 1 January 2019 – 31 January 2023<br>Published January 2024 | Clinical Lead:<br>**Mr Adam Cox –**<br>Consultant Urological Surgeon |
|---|---|---|
| Rationale: | Prostate cancer is the most common solid cancer in men with over 46,000 new cases diagnosed each year in the UK and its incidence is increasing. There are concerns about over-diagnosis and over-treatment in men with low-risk disease, while men with locally advanced or high-risk disease may not be getting the radical treatments that they need. | |
| Objectives : | Its aim is to evaluate the patterns of care and outcomes for patients with prostate cancer in England and Wales, and to support services to improve the quality of care. | |

Presented at Clinical Standards and Effectiveness Group 21st March 2024

| Management | Specialist MDI | National | Health Board Database |
|---|---|---|---|
| No. of men diagnosed with low-risk localised disease | 40 | 3680 | ABUHB internal database records higher case ascertainment. |
| Percentage of men with low-risk localised disease receiving radical treatment | 5 % | 9 % | |
| No. of men diagnosed with locally advanced disease | 100 | 11503 | |
| Percentage of men diagnosed with locally advanced disease receiving radical treatment | 68 % | 69 % | Comparable to N/A |

| Data Quality | Diagnosing Trust | Clinical Lead update |
|---|---|---|
| No. of Cancer Registry records | 344 | Query the quality of the data presented for ABUHB. |
| Performance Status recorded | 100 % | |
| PSA completed | 72 % | *The Health Board figure would be in the high 90% as this is a standard diagnostic test.* |
| Gleason Score completed | 72 % | *A grading score that is routine for all patients, expectations of high 90%.* |
| TNM completed | 79 % | |
| Risk group assigned | 86 % | *This result can be impacted on if risk group assigned before staging scans are performed* |

| Outcome | Treatment Centre | Health Board Database |
|---|---|---|
| No. of men who received radical prostatectomy (Apr 2021 – Mar 2022) | 37 | 57 |
| Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy | 10 % | Increase in numbers will impact this % - Max 1 readmission in 12 months. Readmission can include post op contacts, telephone advice, clinic. |
| No. of men who received radical prostatectomy (Sep 2019 – Aug 2020) | 42 | HB Database records 80 cases Sep 19-Aug 20. HB have cases 67 in 12 months. |
| Adjusted percentage of men experiencing at least one GU complication | 10 % | England recording 10% and Wales 5%. |

| Risk level | Description |
|---|---|
| None | Standards met and findings demonstrate no risk to patient safety |

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

| Report Successes: | |
|---|---|
| 1 | First UK centre to do same day discharge for robotic prostatectomy |
| 2 | Recently appt a 3rd Consultant Oncologist to the MDT |
| 3 | Recently appt Consultant Radiologist to the MDT |
| 4 | Business case approved for intuitive da-vinci surgical robot in Aneurin Bevan |

| Report Concerns: | |
|---|---|
| 1 | Data on re-admission is inaccurate |
| 2 | Data on number of surgical cases is inaccurate |

| Report Recommendations: | | S.M.A.R.T Actions:<br>Listed in AMaT as Responsible: Due Date: Progress: |
|---|---|---|
| 1 | Aim to achieve high completeness of key data items at the point of collection by NHS organisations in England, particularly tumour, node and metastasis (TNM) staging variables. Action by: NHS England and Health Boards in Wales; Prostate cancer teams (local and Specialist MDTs) within NHS Trusts | Done in real time with Cancer Services Coordinator with any missing data requested by Royal College.<br>Review plan for data acquisition with Cancer Lead. |
| 2 | Continue to advocate active surveillance for men with low-risk prostate cancer.<br>Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons, Prostate Cancer UK) | Already doing this – better than NA on accurate data -<br>8% England<br>9% Wales |
| 3 | Investigate why men with high-risk/locally advanced disease are not considered for radical treatment and aim for 75% offered radical treatment.<br>Action by: NHS England and Health Boards in Wales; Cancer Alliances (CA). | AB better than the 68% recorded as data inaccurate.<br>69% England and 69% Wales |
| 4 | Review variation between providers in rate of GU/GI complications and 90 day readmission rates.<br>Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons); Cancer Alliances | Genitourinary complications returns for England was 7%, Wales 8% & ABUHB 10% however inappropriate returns (clinic/telephone advice) will impact this result for the Health Board.<br>No Gastrointestinal data for ABUHB, however Wales is performing better than England at 5% compared to 10%.<br>In England 13% of men were re-admitted within 3 months following surgery, that was 9% for Wales, ABUHB recorded as 10% however CL states that possibly one legitimate return was experienced in ABUHB. |
| 5 | Cancer Alliances should review processes of care to ensure equitable implementation of new technologies and pathways of care as evidence evolves.<br>Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons); Cancer Alliances | Urology Cancer Network for Wales continuously evaluates service provision across the Health Boards, introducing new technologies, pathways of care, medication. |

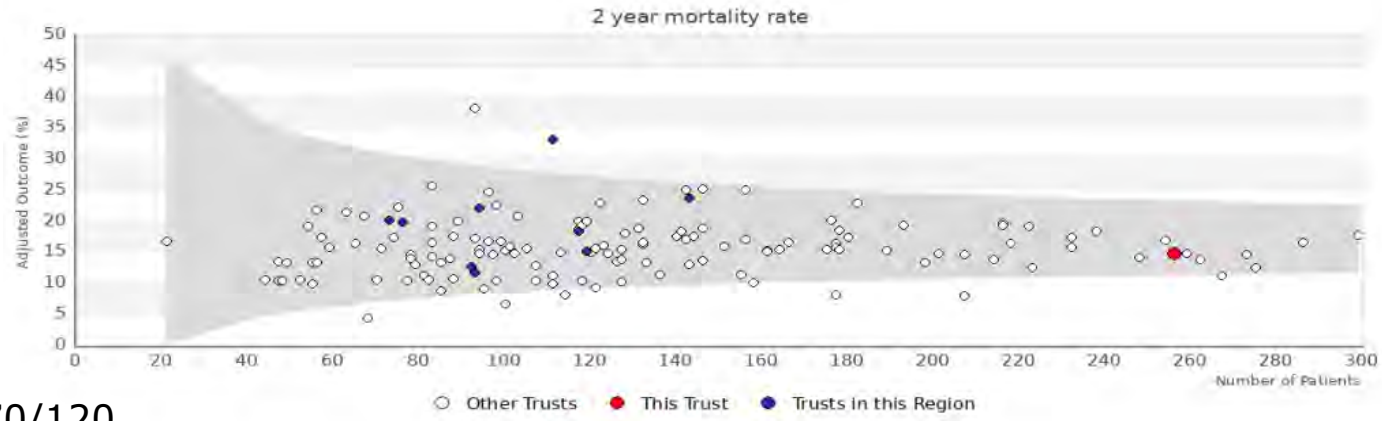
| Clinical Leads Local Recommendations: (if applicable) | | S.M.A.R.T Actions: |
|---|---|---|
| 1 | Employ 1-2 CNS to support recent resignation and the PSA patient self-management software | Write business case |

| Audit Title: | **NBOCA – National Bowel Cancer Audit – State of the Nation Report An audit of** the care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2021 and 31 March 2022. Published 8 February 2024. | Clinical Lead: Mr Keshav Swarnkar |
|---|---|---|
| Rationale: | The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for patients diagnosed with bowel cancer in England and Wales. It supports hospitals in England and Wales to improve the quality of the care received by patients. | |
| Objectives: | NBOCA collects data on items which have been identified as good measures of clinical care. It compares variation between English NHS trusts or hospitals, and Welsh MDTs, as well as changes in care over time. | |

Presented at Clinical Standards and Effectiveness Group – 21st March 2024

| **Patients having major resection:** | **Trust** | **Network** | **National** |
|---|---|---|---|
| Circumferential resection margin: Negative (%) | 85 | 86 | 83 |
| Rectal volume | 75 | N/A | 4377 |

| **Patients in APER/Hartmanns estimate:** | **Trust** | **Network** | **National** |
|---|---|---|---|
| Number of patients in APER/Hartmanns estimate | 171 | 1145 | 19644 |
| APER/Hartmanns (%) | 42 | 45 | 37 |




| Trust | Number | Adjusted | Observed |
|---|---|---|---|
| Aneurin Bevan University Health Board MDT | 256 | 14.8% | 17.1% |
| Other trusts within the region: Wales | | | |
| Cardiff MDT | 93 | 11.7% | 11.4% |
| West Wales General & Prince Phillip MDT | 143 | 23.7% | 29.1% |
| Prince Charles Hospital MDT | 76 | 19.7% | 22.1% |
| Princess of Wales MDT | 73 | 20% | 28.7% |
| Royal Glamorgan Hospital MDT | 92 | 12.7% | 17.9% |
| Swansea MDT | 117 | 18.3% | 22.8% |
| Ysbyty Glan Clwydd MDT | 94 | 22.1% | 22.9% |
| Ysbyty Gwynedd MDT | 119 | 15% | 21.8% |
| Ysbyty Maelor MDT | 111 | 33% | 30.2% |

# Aneurin Bevan University Health Board - Data Quality:

| All Patients: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 461 | 2335 | 35779 |
| Case ascertainment (%) | Good | Good | Good |
| | | | |
| Data completeness of: | | | |
| – Pre-treatment TNM (%) | 91 | 96 | 86 |
| – Performance status (%) | 100 | 98 | 89 |

| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 291 | 1436 | 19631 |
| ASA grade 1 (%) | 9 | 6 | 9 |
| ASA grade 2 (%) | 45 | 49 | 53 |
| ASA grade 3 (%) | 39 | 37 | 31 |
| ASA grade 4+ (%) | 4 | 7 | 2 |
| ASA grade not recorded (%) | 4 | 1 | 4 |
| | | | |
| Data completeness of: | | | |
| 7 Audit items for risk-adjustment (%) | 91 | 95 | 87 |

| All Patients: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 461 | 2335 | 35779 |
| Seen by Clinical Nurse Specialist (%) | 91 | 88 | 88 |

| All patients deemed potentially curative | Trust | Network | National |
|---|---|---|---|
| Number of potentially curative patients | N/A | N/A | N/A |
| Undergoing major resection (%) | N/A | N/A | N/A |

| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 291 | 1436 | 19614 |
| Distant metastases (%) | 8 | 8 | 5 |
| Urgent or emergency surgery (%) | 19 | 18 | 15 |
| At least 12 lymph nodes excised (%) | 87 | 89 | 84 |
| Laparoscopic surgery attempted (%) | 57 | 65 | 72 |
| Risk-adjusted length of stay > 5 days (%) | 62 | 60 | 55 |

| Patients having major resection for stage III colon cancer: | Trust | Network | National |
|---|---|---|---|
| Number of patients in audit | 135 | N/A | 10747 |
| Adjuvant chemotherapy (%) | 42 | N/A | 62 |

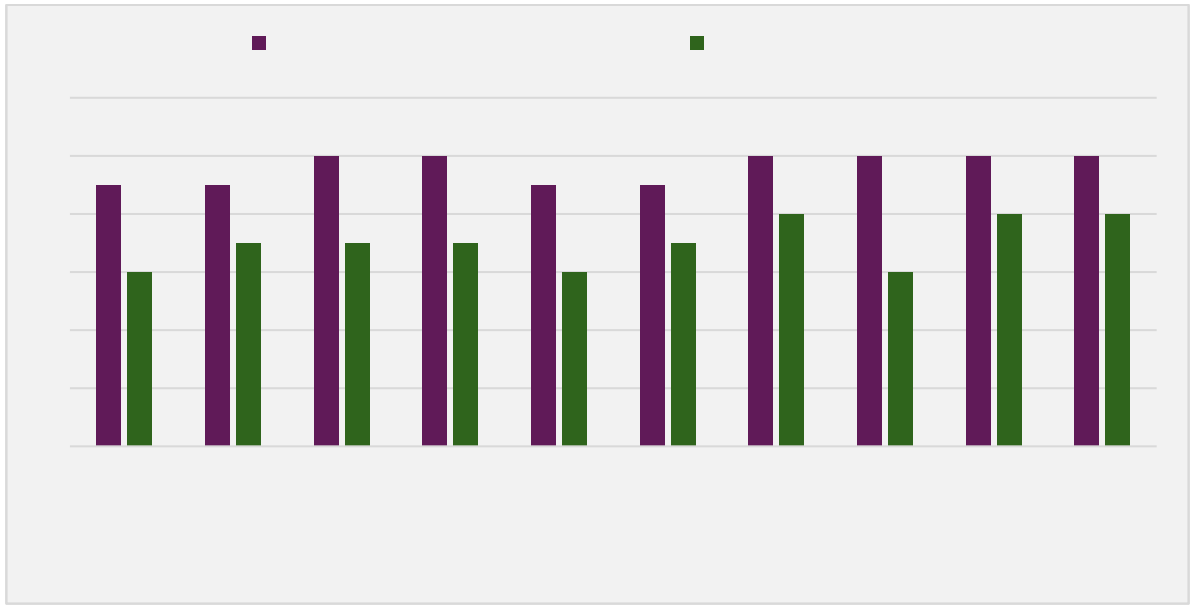
| Patients receiving chemotherapy after major resection for stage III colon cancer: | Trust | Network | National |
|---|---|---|---|
| Number of patients in audit | N/A | N/A | 6608 |
| Severe acute toxicity after adjuvant chemotherapy (%) | N/A | N/A | 22 |

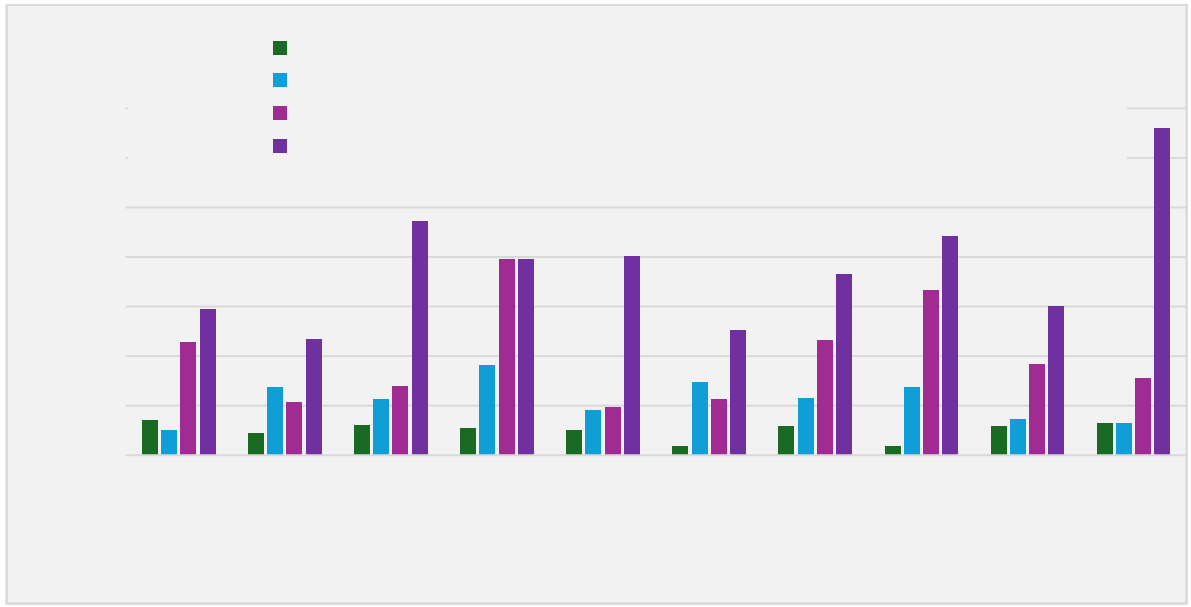
| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 62 | N/A | 4251 |
| Neoadjuvant therapy (%) | 34 | N/A | 33 |
| Circumferential resection margin: Recorded (%) | 89 | 91 | 89 |

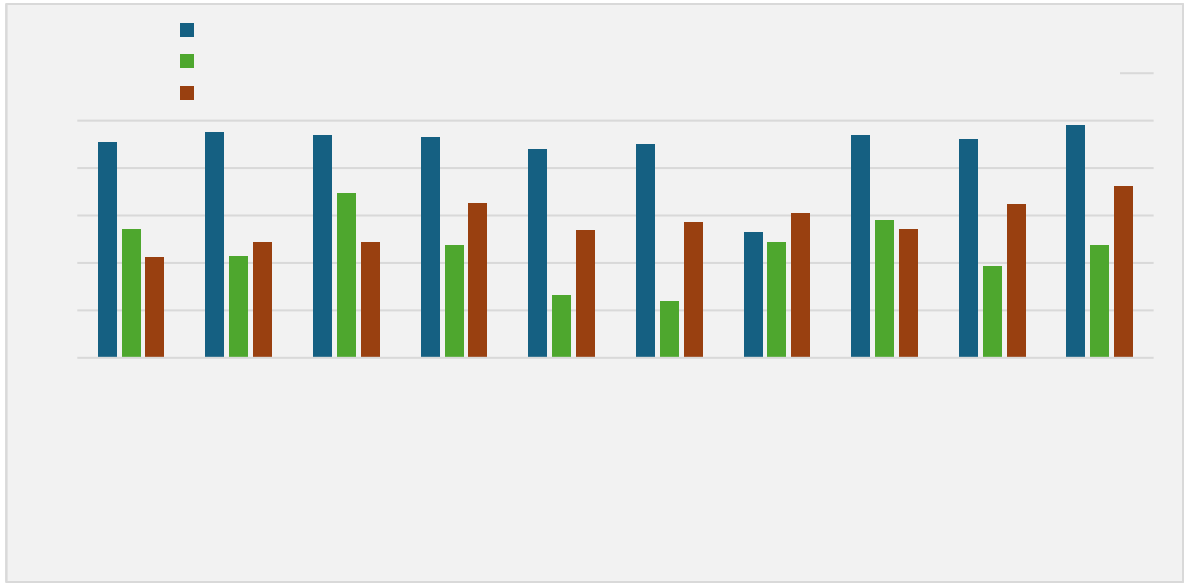
**Key:**

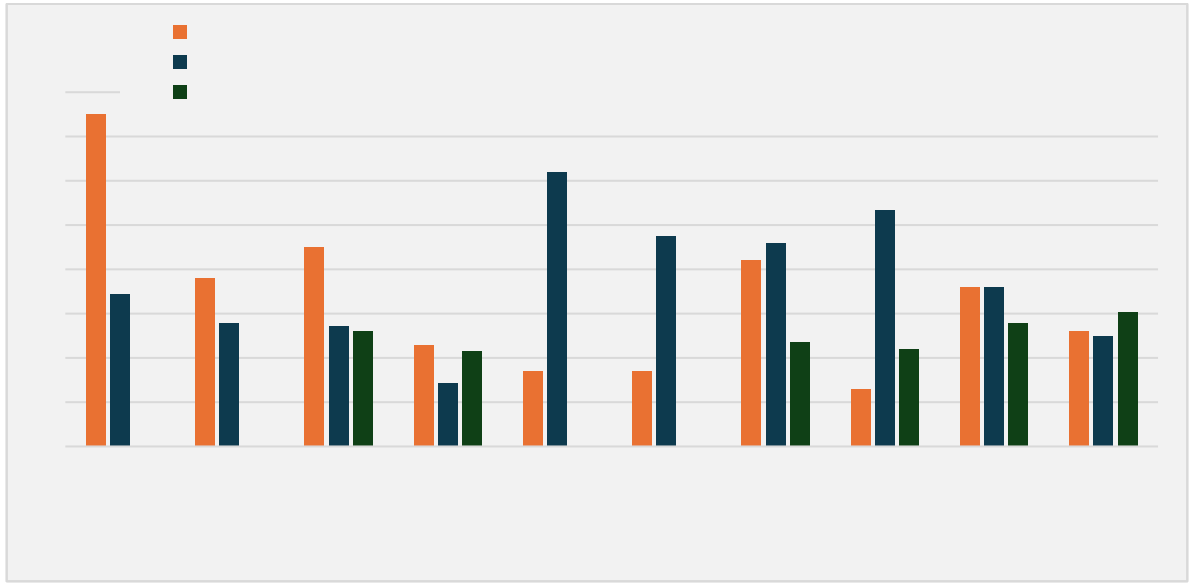
- > 80%
- 50 - 80%
- < 50%

# Quality Improvements Targets – results for Welsh Health Boards









## Conclusion and Risk

| Assurance Level | | |
|---|---|---|
| Significant | The project has mostly achieved the standards or criteria being audited against | Yes |
| **Risk Level** | | |
| Minor | Single failure to meet internal standards/Minor implications for patient safety if unresolved | Yes |
| **Has this audit been placed on a Risk Register (N/A if above risk is None)** | | **YES** |

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | Good case ascertainment |
| 2 | Laparoscopic surgery > 50% |
| 3 | Quality assured rectal cancer resections |
| 4 | Comparable 2 year mortality rates |
| 5 | Good engagement with CNS |

| Report Concerns: | |
|---|---|
| 1 | Reversal of diverting loop ileostomy > 18/12 |
| 2 | Unplanned readmissions within 30 days |
| 3 | Inadequate colonic stenting service |

| Clinical Leads Local Recommendations: (if applicable) | | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Theatre space availability for cancers | Increase capacity | Theatre Group | 6/12 | |
| 2 | Colonic Stenting service | Audit colon stent results in last 24 months | K Swarnkar | 6/12 | |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | With future NBOCA reports utilising "gold standard" cancer registry data collected by the National Disease Registration Service (NDRS) in England, and the Wales Cancer Network in Wales, NDRS regional Data Liaison Managers should support hospitals/trusts/MDTs with coding, data entry, and quality assurance for the Cancer Outcomes and Services Data set (COSD). Data set items of focus include:<br>• TNM Stage<br>• ASA grade<br>• Seen by Clinical Nurse Specialist (CNS)<br>*Intended audience: NHS England, NDRS and Public Health Wales* | Data collected on CANISC in real time in MDT | Cancer service-MDT coordinator | | |
| 2 | In keeping with the NHS Workforce Plan, NHS England, Welsh Health Boards and Cancer Alliances should ensure everyone with bowel cancer has access to a clinical nurse specialist (CNS). NHS England, Welsh Health Boards and Cancer Alliances should investigate and address factors preventing patients' accessing a CNS.<br>*Intended audience: NHS England, Welsh Health Boards and Cancer Alliances* | Already achieved in ABUHB. Prospective NBOCA data | CNS | | |
| 3 | Cancer Alliances should participate and engage with the NBOCA/ Royal College of Surgeons of England quality improvement project to enable more timely reversal of ileostomy.<br>*Intended audience: Cancer Alliance* | Book theatre after WSCE to fix date. | Colorectal surgeon | 12/12 | |
| 4 | Cancer Alliances should monitor and investigate regional and institutional variation in rates of adjuvant chemotherapy following resection of stage III colon cancer and ensure evidence-based chemotherapy policies are in place.<br>*Intended audience: Cancer Alliances* | Velindre Cancer Centre | Dr H Williams | 12/12 | |
| 5 | Cancer Alliances should monitor and investigate regional and institutional variation in severe acute toxicity after adjuvant chemotherapy. Cancer Alliances should encourage the utilisation of appropriate risk stratification tools for severe acute toxicity including frailty scoring, and integration of geriatric expertise and rehabilitation into chemotherapy decision making.<br>*Intended audience: Cancer Alliances* | Velindre Cancer Centre | Dr H Williams | 12/12 | |

# For Information

# Section 5

# Listening and Learning from Feedback

| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Deteriorating Patient (PALS)** | Family of deteriorating patient contacted PALS Team as they were concerned, they were not being kept informed of their mums condition. | PALS Officer contacted the clinical team to express families concern. Team arranged MDT discussion with patient and family. | Family anxiety around deteriorating mother addressed through MDT discussion. Family aware of mothers deteriorating condition and her wish not to have proactive treatment, preferring to be kept comfortable. | PALS will keep in touch with daughter as she has had a number of bereavements in the last year. She may need signposting to bereavement support in the future. |
| **Loss after Miscarriage** | Contacted by senior nurse to say that a patient had lost a baby before 20 weeks, and she was struggling with coming to terms with her loss. | Patient Experience leads met with senior nurse and patient. She outlined her experience and the changes she wished to see from a service perspective. This included women being fully informed of what may happen if they choose termination when the child's chance of survival is unlikely. This patient also wanted to see the bereavement offer for women who lose babies under 20 weeks improved. | Patient invited to Big Conversation Bereavement event. Engaged in child loss round table conversation. Has now told of her experience on film which will be taken to a listening and learning event. Patient has agreed to be part of the bereavement collaborative and wishes to volunteer to help other women who may experience traumatic loss. Patient story will be used to improve experiences for all women who lose babies under 20 weeks. | To be introduced to the Volunteer Manager to explore volunteering opportunities.<br><br>To be invited to the bereavement collaborative.<br><br>Edited film to be presented to Executive Committee, to the gynaecology senior leadership teams and possible in-person attendance at Board.<br><br>Operational procedures to be reviewed. |

# Listening and Learning from Feedback

| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Neurodiversity Attendance at the Accident and Emergency Department** | Feedback received by patient about their experience at the ED department and the difficulties they encounter when accessing health care. | Met with patient who has neurodiversity and mother of child who is neuro diverse. Their experience stories have been filmed and shared with ED for learning. Agreement reached that we would pilot a Patient Participation Panel (PPP) in ED representative of patients, families, staff and partners. 1st meeting arranged for 22/04/24. | Learning from people's experience and taking positive action will mean that people who are neuro-diverse will have an improved experience of healthcare services. | Undertake pilot in ED and evaluate. |
| **Bereavement** | Meetings with COVID bereaved relatives and feedback from other bereaved relatives has indicated that the Health Boards bereavement offer needs to be improved. | Big Conversation: Bereavement held on 20/03/24. Attended by 170 people including people who have been bereaved, public, staff and stakeholders. | Extremely well evaluated. 50 people have expressed an interest in joining the bereavement collaborative. Peoples feedback will inform the new bereavement model. | Publish Big Conversation evaluation report. Invite people to the Bereavement Collaborative. Roll out Big Conversations across all 5 boroughs May-July 2024. |
| **Dementia Advanced Care Planning** | Feedback from the Advanced Care planning group has identified a need to adapt and improve the information, understanding and skill for Future care planning in dementia care. | 2 workshops will be arranged to take place with representatives from across agencies in Gwent who provide care for people with dementia.<br><br>The first workshop will be on May 14th at Ty Siriol Unit, County Hospital. | The objective will be to identify areas of practice already available, consider current and future needs and actions to improve the actions around ACP. | An evaluation and next steps will be produced and presented at the Dementia Hospital steering Group, EOLC Board and ACP group. |

# Listening and Learning from Feedback

| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Dementia Identification in Hospital** | Feedback from the Engagement workstream 1, Workstream 4, Hospital Dementia Charter as well as the National Audit of Dementia (NAD) has identified the need to identify people with dementia in hospital, this will support identification of service provision, person centred care and patient experience feedback. | An Alert has been introduced into the hospitals for input of alert code 136 on Clinical workstation for people with a diagnosed dementia diagnosis. | The impact of this alert will be monitored through the NAD group as well as the Dementia Hospital Steering Group. | Ongoing review and actions at each of the steering groups as well as presentations to the Gwent Dementia Board. |
| **Dementia- Communication following Diagnosis at Memory Assessment Clinics** | Feedback from the Community Engagement events have indicated that the current process of receiving communication following formal diagnosis from the MAS (Memory Assessment Service) should be reviewed. | A review the communication pathways following diagnosis within the 9 MAS clinics in Gwent will take place through the Older Adult Menta Health MAS managers meeting and outcomes considered in May 2024 group. | Following the scoping of current practice a template letter will be drafted for consideration by the Citizens listeners and the MAS work streams. | Evaluated via Workstream 1 and 2a and B. |

| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Carer reported that a medic from the memory clinic rang her at home and gave the husband's dementia diagnosis to the carer over the telephone** | The carer was very distressed as she was unsure what the diagnosis meant as she is not medically trained. The carer said her husband is early onset dementia and was unsure why the medic did not speak directly to him. The carer felt it was inappropriate to give the diagnosis over the telephone and that it took a further 2 months to get an explanation about the diagnosis. | This experience was shared in the carers workstream. Sarah Ball from the OAMH team was present and took the details and forwarded to Patrick Chance.<br>Dementia diagnosis and how it is communicated to patients is being reviewed in the MAS workstream. | The carer felt distressed and confused by her experience. Her husband felt excluded and is concerned about his future and they both expressed distrust in health services and worry about the future. | This feedback has been given to the memory clinic and the CD made aware.<br><br>Improving how a dementia diagnosis is communicated will be reviewed at the workstreams.<br><br>We will continue to engage with people with lived experience to learn about people's experiences to ensure that we are improving our services. |

# Listening and Learning from Feedback

| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Meaningful engagement and activities** | Following a review of the Meaningful Engagement and Activities in Hospital programme the feedback was positive. Reviews such as the Community Health council covid dementia review highlighted the need for improvements in dementia engagement in care homes. | An Improvement of care funding case was made to NHS Charities to support the extension of the hospital Engagement and activities programme into these areas as well as prison health care units. This bid was successful, and a steering group has now been formed to lead on this implementation programme. 2 staff members have been recruited for the 18 month period to support the programme. | A series of measures will be considered as part of the evaluation at 6 monthly reporting periods. | Evaluated via the Meaningful Engagement steering group, reported to the Workstream 4 Dementia Hospital Charter Group and NHS Charities. |
| **Care fit for VIPs** | Following the implementation of the VIPS toolkit into 15 areas in April 2023 feedback was received by staff in relation to support and guidance for implementing the toolkit.<br>It was highlighted that an ongoing support group would be beneficial along with specific workshops for each area.<br>Improvement Cymru have also provided some sessions to complement the core support in place. | Monthly support group via teams open to all areas.<br>Workshop facilitated by Specialist Dementia Practitioner offered to each of the 15 areas.<br>A series of sessions provided by improvement Cymru open to all 15 areas. | An increased uptake of engagement with the online toolkit following workshop sessions.<br>Improvement cycles implemented in all areas to improve the services provided for people living with Dementia in hospital wards. | Feedback sessions for 1 year review for all areas scheduled for April 2024.<br><br>In person visit scheduled for all areas for April 2024 to capture feedback and evaluation.<br><br>PowerPoint presentation to evaluate 1 year on implementation Care fit for VIPS into 15 ward areas to be produced and shared. |

# Listening and Learning from Feedback

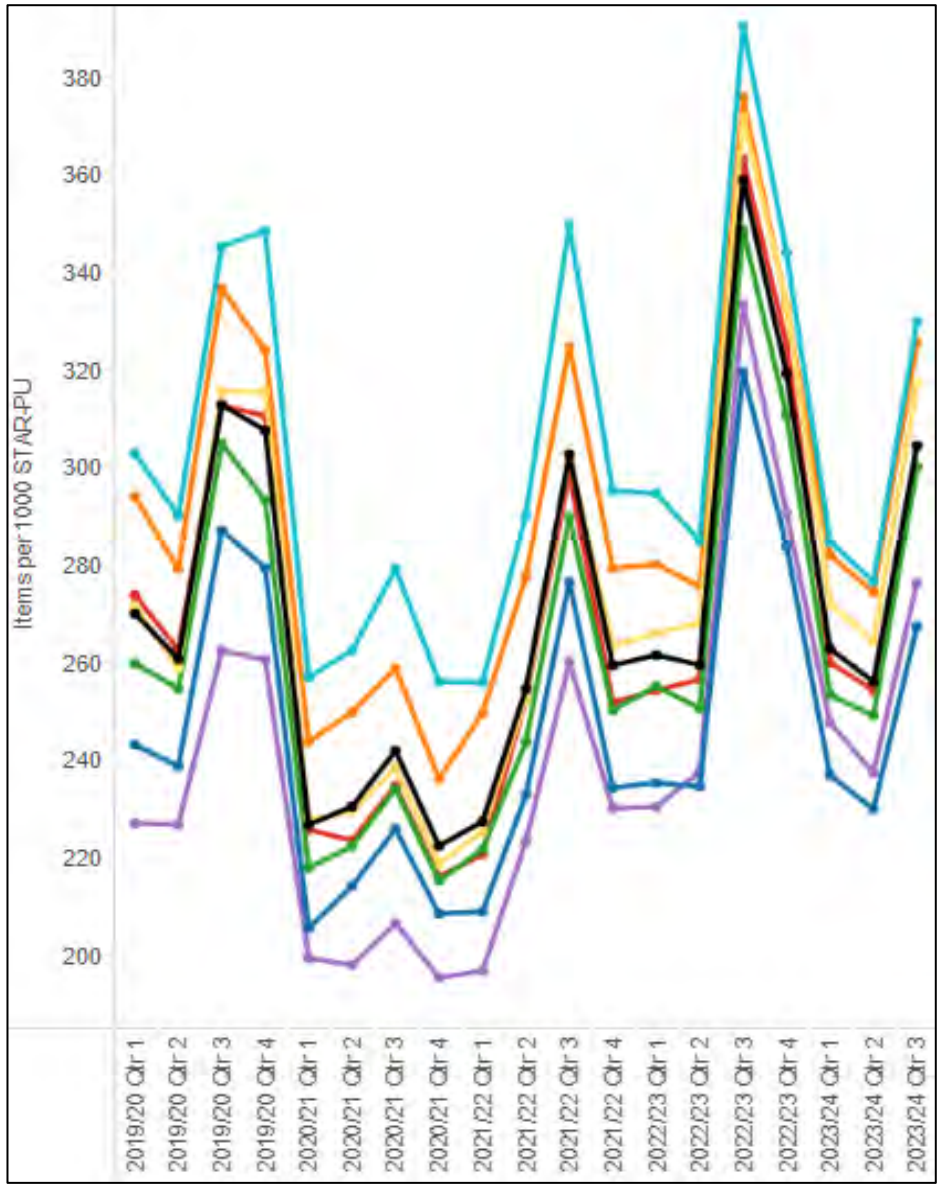
| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Capacity Assessments for people living with dementia** | Feedback from a carer about engagement with social workers in hospital setting at a discharge meeting. The social worker told the person living with dementia that the house he lived in was half his and that he could leave and go home at any time. This approach caused distress to his carer as she had expressed concerns about her husband's safety in the home and her ability to provide safe care. At no point was the carer trying to deny her husband access to his home. The carer also reported at a subsequent meeting that the same social worker also commented 'that she wouldn't want her husband and child to do to her what we were trying to do with my husband i.e., get him in permanent residential care'.<br>The discharge home was arranged even though a carers assessment was not in place and the home had not been assessed. The hospital admissions were because of falls and dehydration which the carer raised as concerns when caring for her husband. | The carer put her experience in writing and spoke about it at a carer's forum. The carer gave permission for Sonya Foley to forward to Joanne Holbrook in Newport Social Services who said she will raise with the team.<br>Sonya contacted Tom Grace regarding capacity assessment for advice. This case was discussed in the carers workstream and the hospital workstream. Social workers are being included in both workstreams to discuss capacity assessments and hospital discharge. | The carer was so distressed at the initial meeting that she cried for the first time in 20 years and then her vertigo came on her and she passed out and banged her head. The social worker had left her and her husband crying in the room as he thought his wife didn't want him to come home. The carer had to arrange for a friend to collect her as she couldn't drive home and she spent several hours in A&E. The carer is keen to share her experience and encourage people to ensure compassion when giving any information and to consider all involved in the care package. The carer understood the legalities around capacity but given her own health needs which were deteriorating, she was concerned about caring for her husband. The carer has cared for her husband for 5 years since he was diagnosed with mixed dementia. | Training and awareness around dementia for all working in social services.<br><br>Ensuring that carers and people living with dementia are provided with information around capacity assessments and the process.<br><br>Ensure that at discharge meetings, carers assessment have been put in place.<br><br>Ensure all staff are aware that value judgments must ever be made about a patient or their family and that professional boundaries should be maintained at all times.<br><br>Bringing these themes to the workstreams to improve dementia care and support. |

# Listening and Learning from Feedback

| Theme | Feedback | Action Taken | Impact | Next Steps |
|---|---|---|---|---|
| **Collaboration between Divisions**<br><br>**(PALS)** | Patient contacted PALS team about being on the waiting list for procedure and delays that have occurred, there was already a formal complaint in place and the patient had received contact but no update with reducing the delay. | PALS team found out that the procedure required surgeons from 2 different specialities over two divisions. There was an ongoing delay with one speciality, PALS linked with the leading division for support and were able to work alongside both divisions to resolve the delay with the procedure. | The PALS team linked regularly with the patient to provide support whilst the divisions were working together to resolve the delays. The leading division were able to arrange a date for the near future and relayed this to the patient. Following the support from the PALS team and the early resolution, the patient has now withdrawn the formal complaint. | Patient now has appointment at the end of May for procedure. |
| **Care Closer to Home**<br><br>**(PALS)** | Patient daughter contacted PALS regarding her father being in a hospital some distance from home, additionally the daughter was also caring for her mother who had recently been discharged from hospital. | PALS Officer was able to ascertain that the gentleman was awaiting a rehabilitation bed in CCH. The PALS team liaised with the relevant hospital teams and discharge team to request a bed when available and explained the difficulties the daughter was experiencing. | The hospital teams working alongside the discharge team were able to secure a bed in the closest rehabilitation hospital and the transfer took place within 48 hours. | The daughter emailed the PALS team to thank them and compliment the support and actions taken by the teams involved. This has taken a huge weight off her shoulders, whilst providing care for both parents. |

# Welsh Government targets

# Antimicrobial prescribing: primary care




Data is only available to end of Q3 but ABUHB will not achieve the minimum 25% reduction in antimicrobial usage in primary care from the 2013/14 baseline (ABUHB is the yellow line on the graph, tracking above the black all-Wales average).

Blaenau Gwent, Torfaen and Caerphilly remain the highest prescribing localities in Wales.

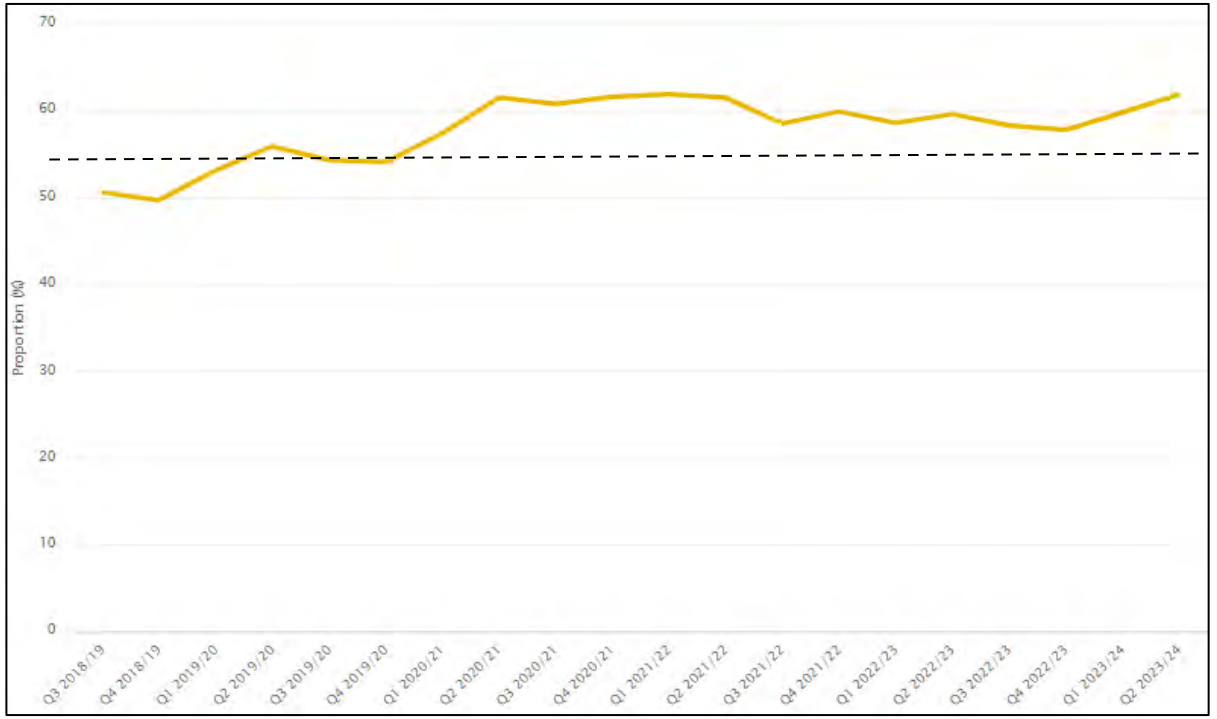
Audit and feedback cycles have been completed in 5 high-prescribing practices, and the audit undertaken in a 6th, awaiting feedback. Cycles to be scaled up from April 2024 when the new 0.4WTE pharmacist is in post.

Supervised MPharm project to investigate use of doxycycline in high prescribing practices. Learning to be shared with practices and reviewed by Antimicrobial Working Group.

Data are only available to the end of Q2 however ABUHB continues to achieve proportion of antibiotic usage within the WHO 'Access' category to ≥55% of total antibiotic consumption.

# Welsh Government Targets

# **Antimicrobial prescribing:** secondary care

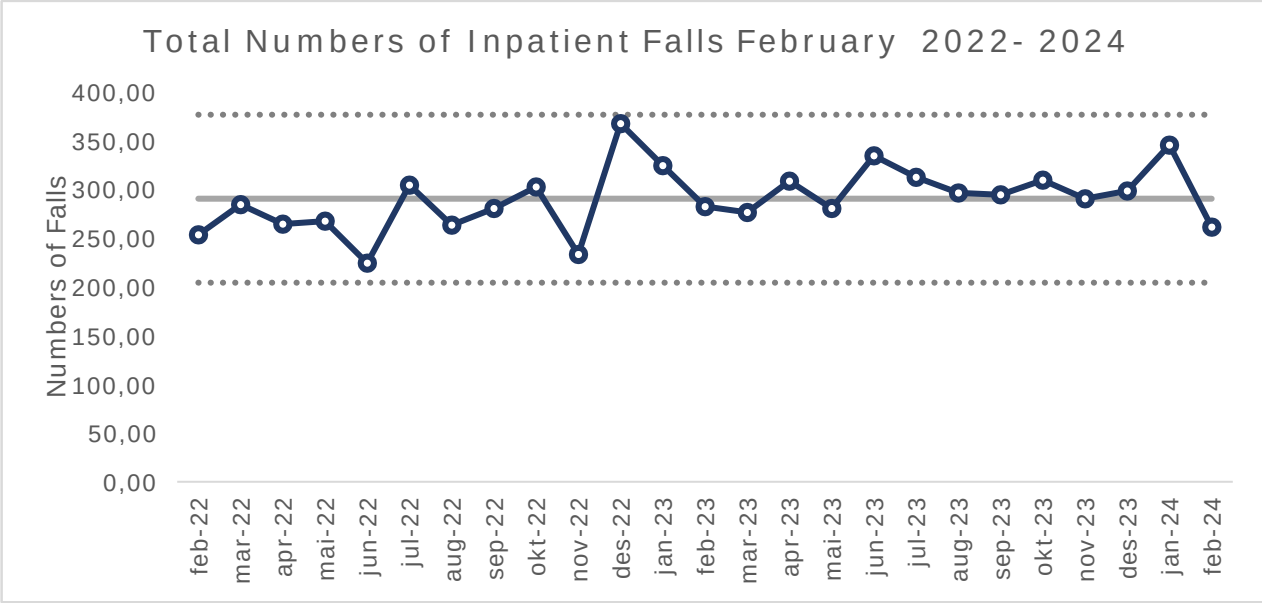



Point Prevalence Survey (PPS) demonstrated an increase in secondary care prescribing rate from 29.5% in November 2022 to 34.3% in November 2023. PPS also demonstrated deficiencies in UTI diagnosis and management. UTI educational sessions planned for secondary care teams. Weekly AMS ward rounds continue at the four sites. In 23/24 FY 1263 patients were reviewed and 1782 interventions made to optimise antimicrobial prescribing, including stopping treatment in 15% patients.

Completion of antimicrobial stewardship (AMS) audits by medics remains poor. AMS team working with QPS team to add antimicrobial stewardship audits to assurance dashboards.

Quinolone safety checklist launched, which has supported response to MHRA alert in January 2024. Review of antimicrobial guidelines underway in response to alert.

# Total Numbers of Inpatient Falls




## April 2024 - Context

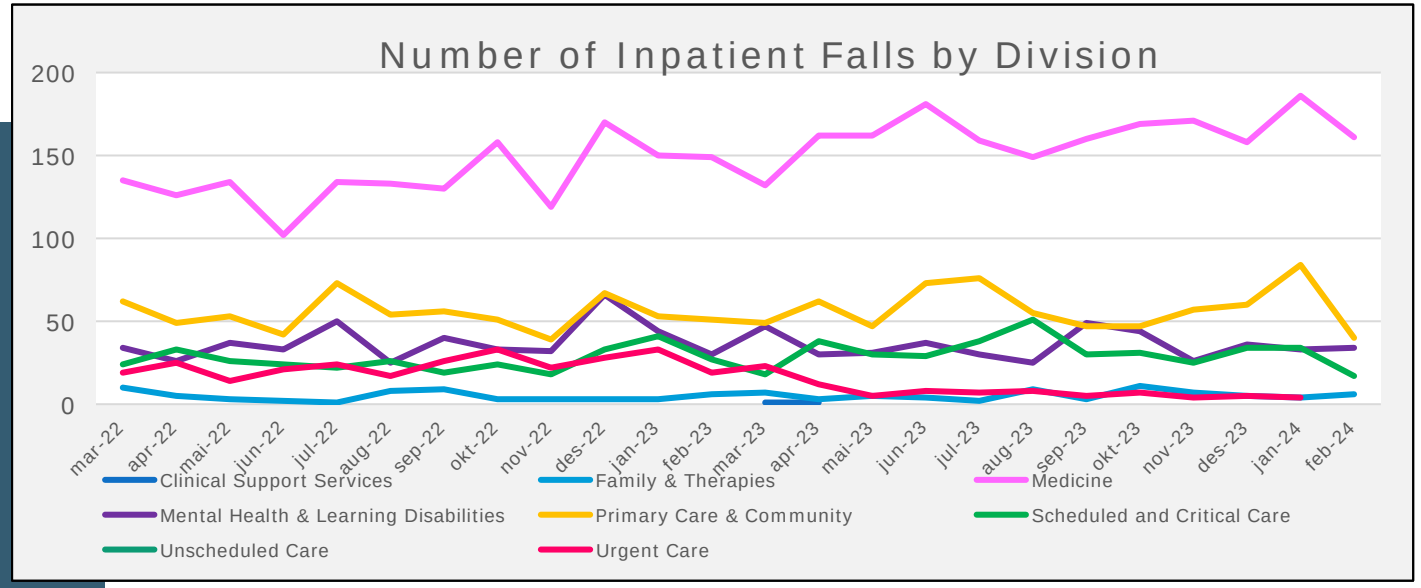
The data used in this chart has been retrieved from RLDatix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period February 2022-24.

With the information available for Q4 2023-24, 44 patients have experienced more than 2 falls with an average of 3.6 per patient. Further work is being undertaken to sub categorise the falls incidents aligned to RLDatix definitions to further enhance the data collection information.

| Definitions | What the chart tells us | Variation |
|---|---|---|
| Reported fall incidents in Aneurin Bevan University Health Board (ABUHB).<br><br>This data was retrieved from RLDatix as the information source. | For the given period of analysis, the mean average fall of fall incidents is 290.<br><br>Following the period August –December 2023 in which the numbers of falls incidents remained on a steady trajectory along the centreline January 2024, saw a rise to a value more closely aligned to the upper control limit. A subsequent decrease in incidents has been seen in February 2024. | January 2024 saw the second highest value of reported incidents for the period of analysis whilst February 2024 represents the lowest value for reported incidents since November 2022. |

# Inpatient Falls Data by Division




April 2024 - Context

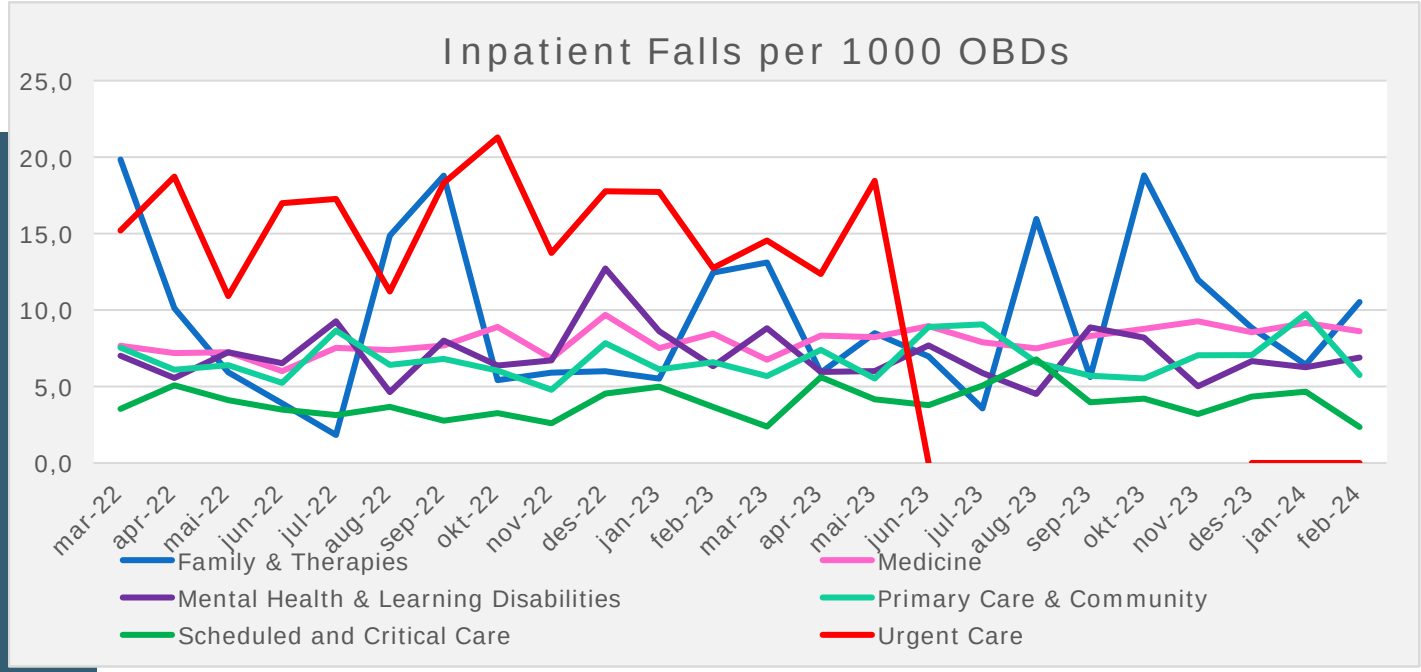
The data used in this chart has been retrieved from RLDatix.

As expected, the highest numbers of falls remain linked with those ward that are populated by our frailer and older patients.

To Note the Emergency Department and Clinical Support Services do not hold a bed base.

| Data Sharing | What the chart tells us | Key Variations per Division |
|---|---|---|
| All data is available to ward level for review and discussion.<br><br>Any areas of concern are flagged to QPS Improvement and Development Managers for investigation.<br><br>Falls with fractures are presented at the weekly Executive Huddle. These discussions are informed by a weekly data review. | The information provided represents that per Division for the total numbers of inpatients falls for the period March 2022 to February 2024. | Scheduled and Critical Care<br>Peak value see in August (51) with a constant trend to January 2024. However, February has seen incident numbers decrease significantly to 17.<br><br>Clinical Support Services<br>3 incidents of falls were recorded for inpatients attending for diagnostics in February 2024.<br><br>Mental Health & Learning Disabilities<br>Peak value seen in September and October 2203 (49 & 44 respectively) a with significant decrease was seen in November(26). Values beyond this time have been represented by a steady trajectory.<br><br>Primary Care and Community<br>For the period of analysis, the Division saw a rise in falls reported incidents in January 2024 (86) to its highest value since July. This has been followed by a decline in incidents by >50% in February 2024 (40).<br><br>Medicine<br>Peak value seen in January 2024 (186) with a downwards trajectory into February (161). |

# Inpatient Falls Data by Division




April 2024 - Context

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

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

For note a value for Urgent Care is no longer calculated as this previously represented a Division which has been subject to change and does not hold a bed base.

## What the chart tells us

The information provided represents Inpatients Falls per 1000 Occupied Bed Days (OBD's) per Division for the period March 2022 to February 2024.

For 2023 three out of five Divisions saw a value aligned to or below the National Average of 6.6.

January 2024 has seen a rise to a value of 8 with a subsequent decline in February to 6.8.

This trend appears to correlate with corresponding peaks in falls incidents across several Divisions.

## Key Variations

**Scheduled Care OBD's**

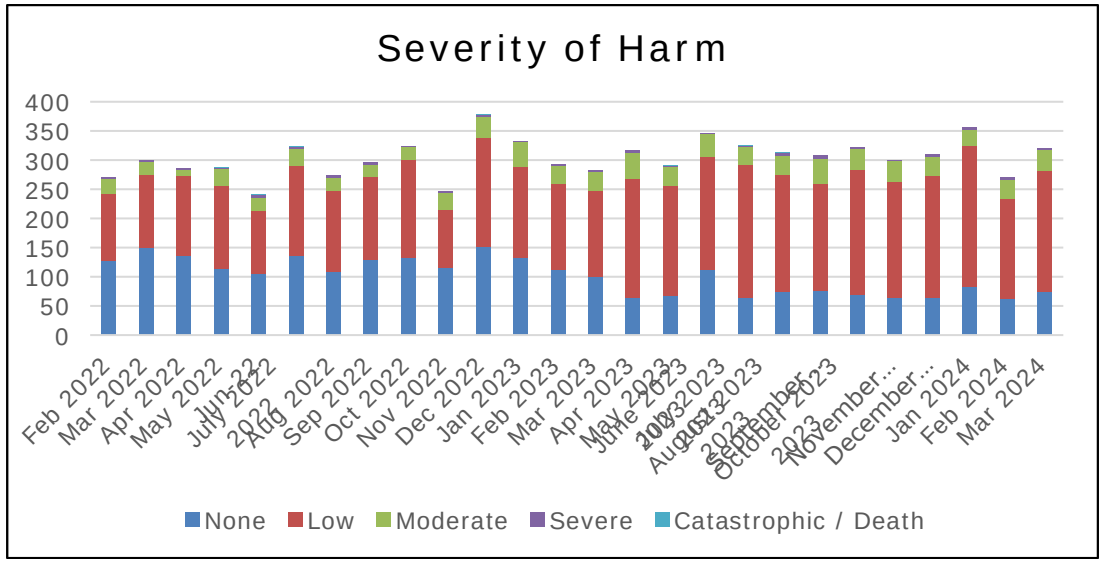
The Division has seen a figure of 2.4 for the month of February following a continued downwards trajectory from August 2023. This value is 36% lower than the National Average

Families and Therapies OBD

Although the available data demonstrates a significant peak for the Division in February placed in context this represents a low number of falls relating to a small bed base.

# Inpatient Falls Data

# Severity of Harm



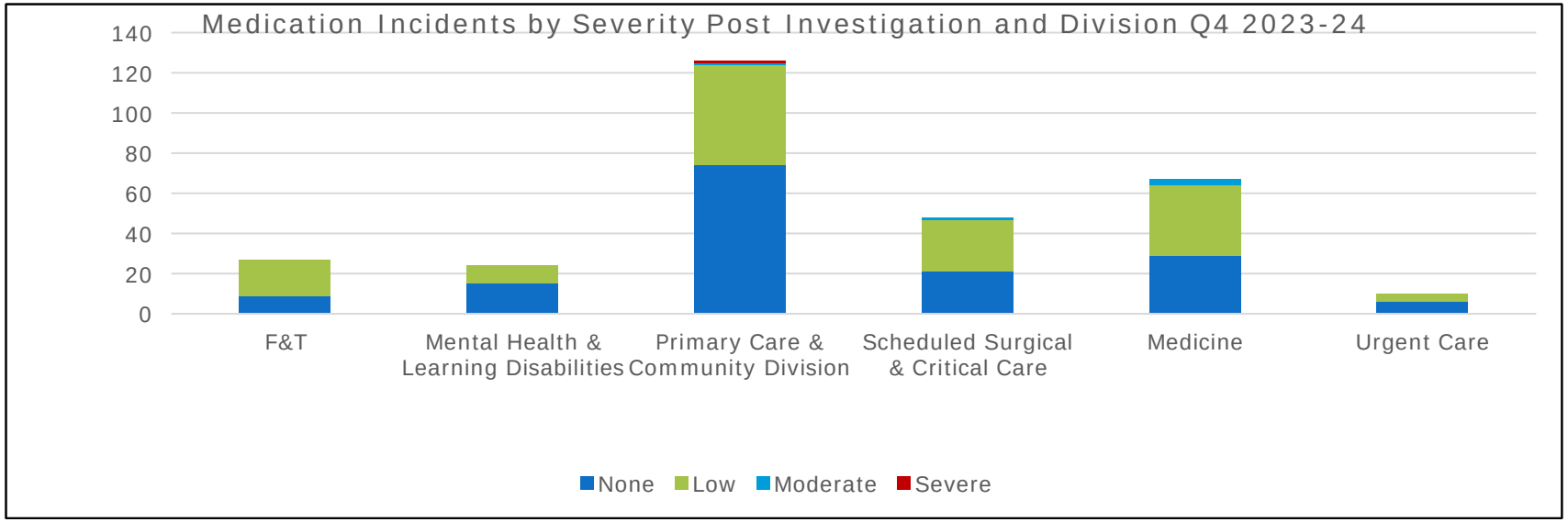

April 2024 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period February 2022- March 2024.

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).<br><br>This data was retrieved from RLDatix as the information source. | Of the total numbers of falls incidents reported for which the the severity of harm is categorised for the given period is 7916. Of this figure the following is identified.<br><br>89% No or low harm<br>10% - Moderate harm<br>0.9% Severe harm<br>0.1% Catastrophic | For 2024 to date no incidents were reported as catastrophic at the time compiling this report with no change post investigation. |

# Medication Safety Group (MSG)



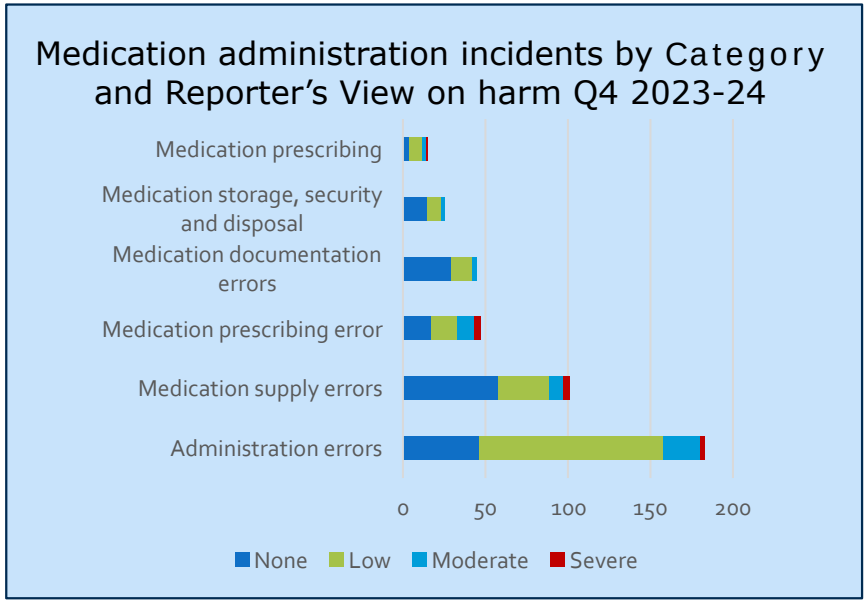

| Reporters View on Levels of Harm | | | | |
|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 |
| None | 188 | 194 | 187 | 174 |
| Low | 88 | 128 | 197 | 205 |
| Moderate | 21 | 60 | 77 | 57 |
| Severe | 7 | 7 | 8 | 12 |
| Catastrophic | 0 | 0 | 0 | 0 |
| Total | 304 | 389 | 469 | 448 |

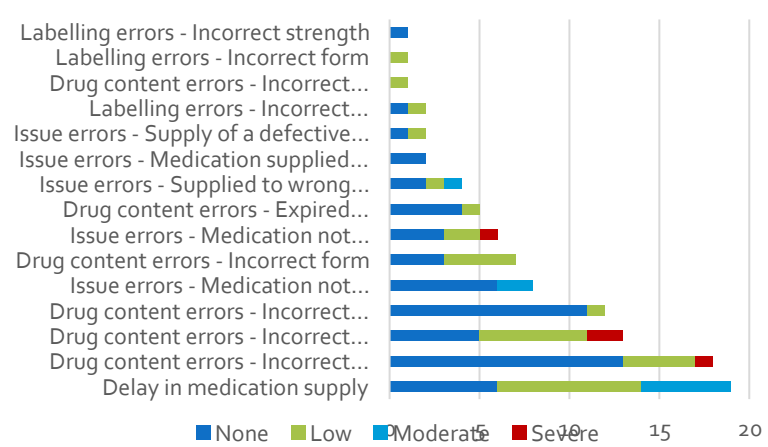
Data for Q4 was scrutinised in terms of type of incidents, themes and areas of concern.
Total 448 incident reported January to March 2023. Total 306 incidents reviewed and investigated.

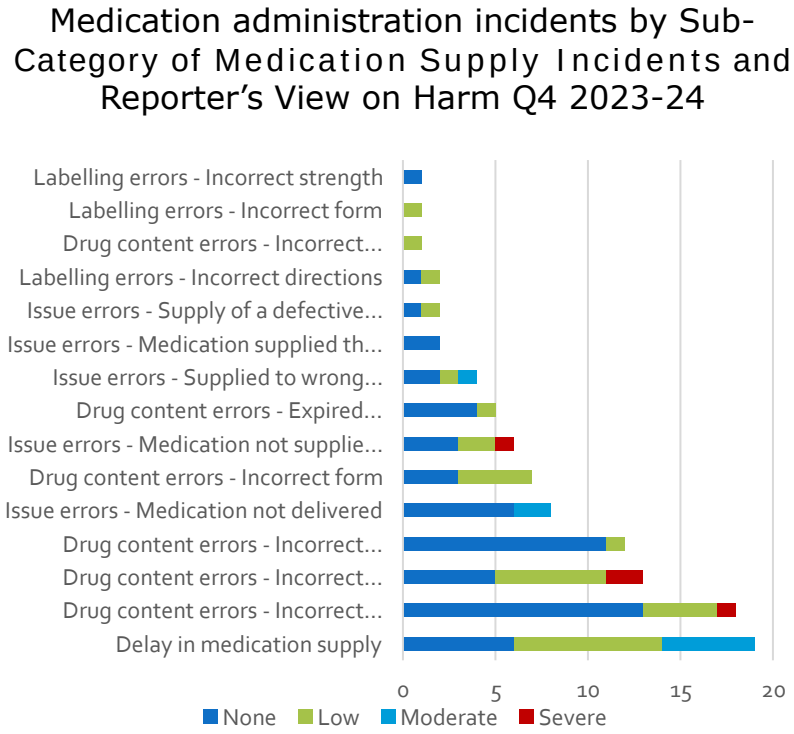
Focused Outcomes

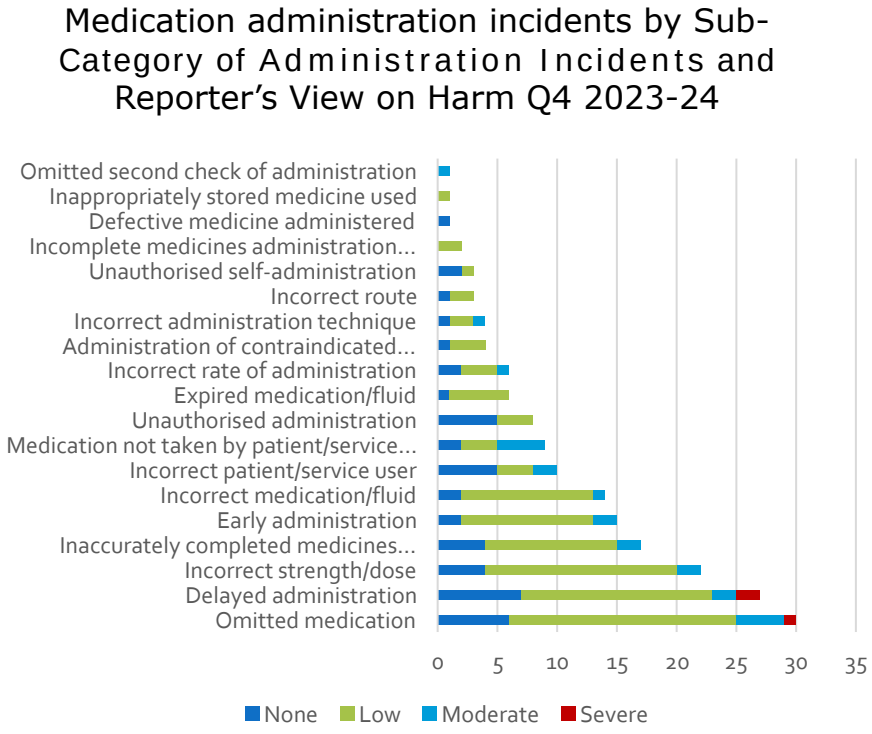
Continue to deliver on the corporate action plan for anticoagulant incident review e.g., pharmacy intervention report, thematic review, SOP update.
Support DICE with teaching session on insulin/ VRIII in areas requiring support e.g., ED.
Develop and issue an Internal Alert on Desmopressin following a trend of missed doses of this critical medication.
Continue to support Mental Health and Neurology to deliver on the Sodium Valproate action plan as per MHRA.

# MSG: Medication Incidents

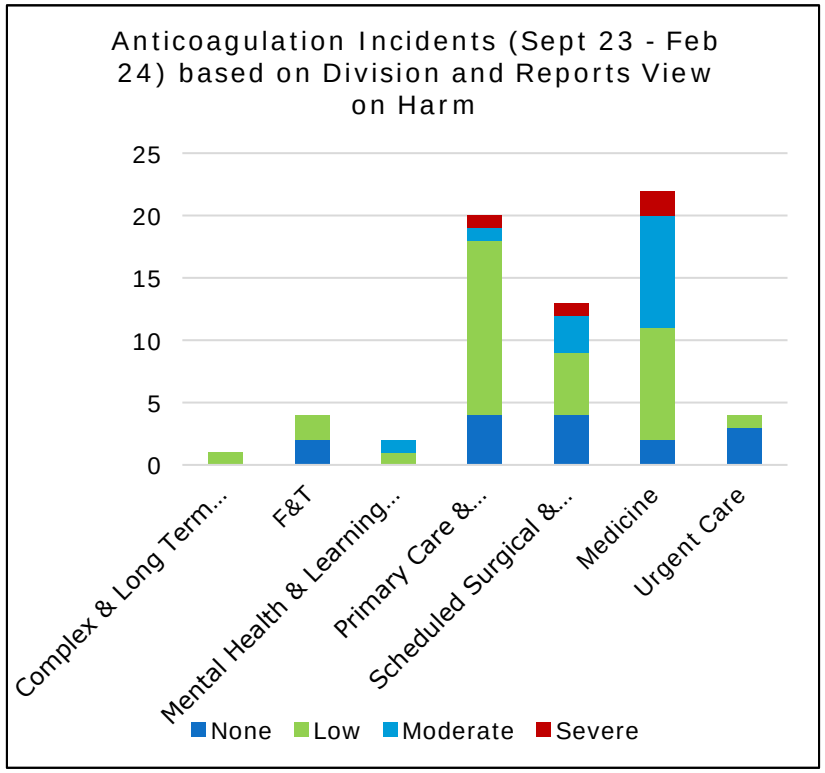


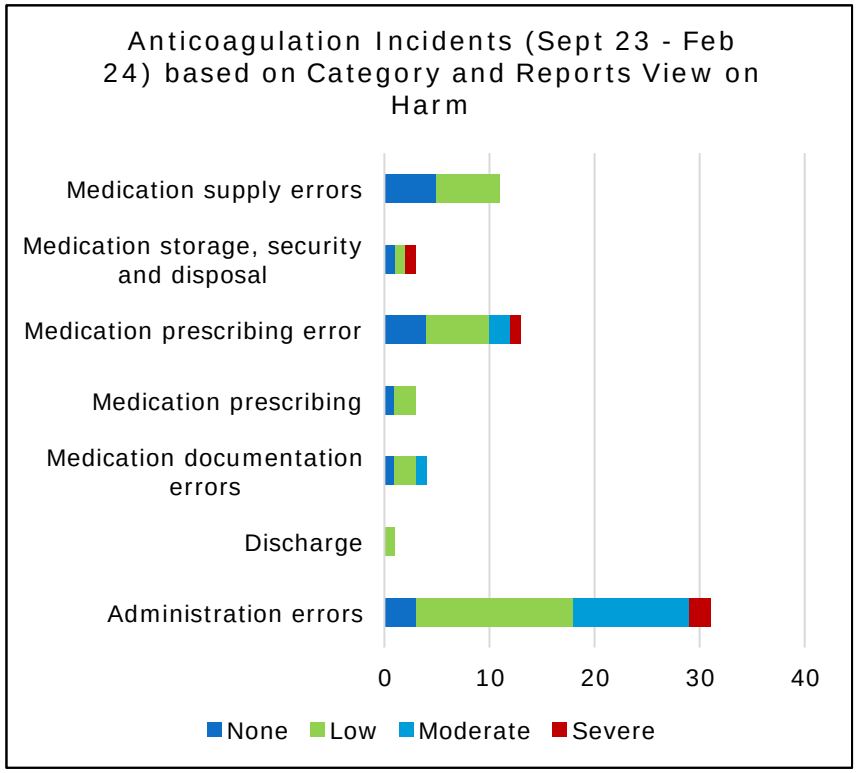



# MSG:
## Anticoagulation



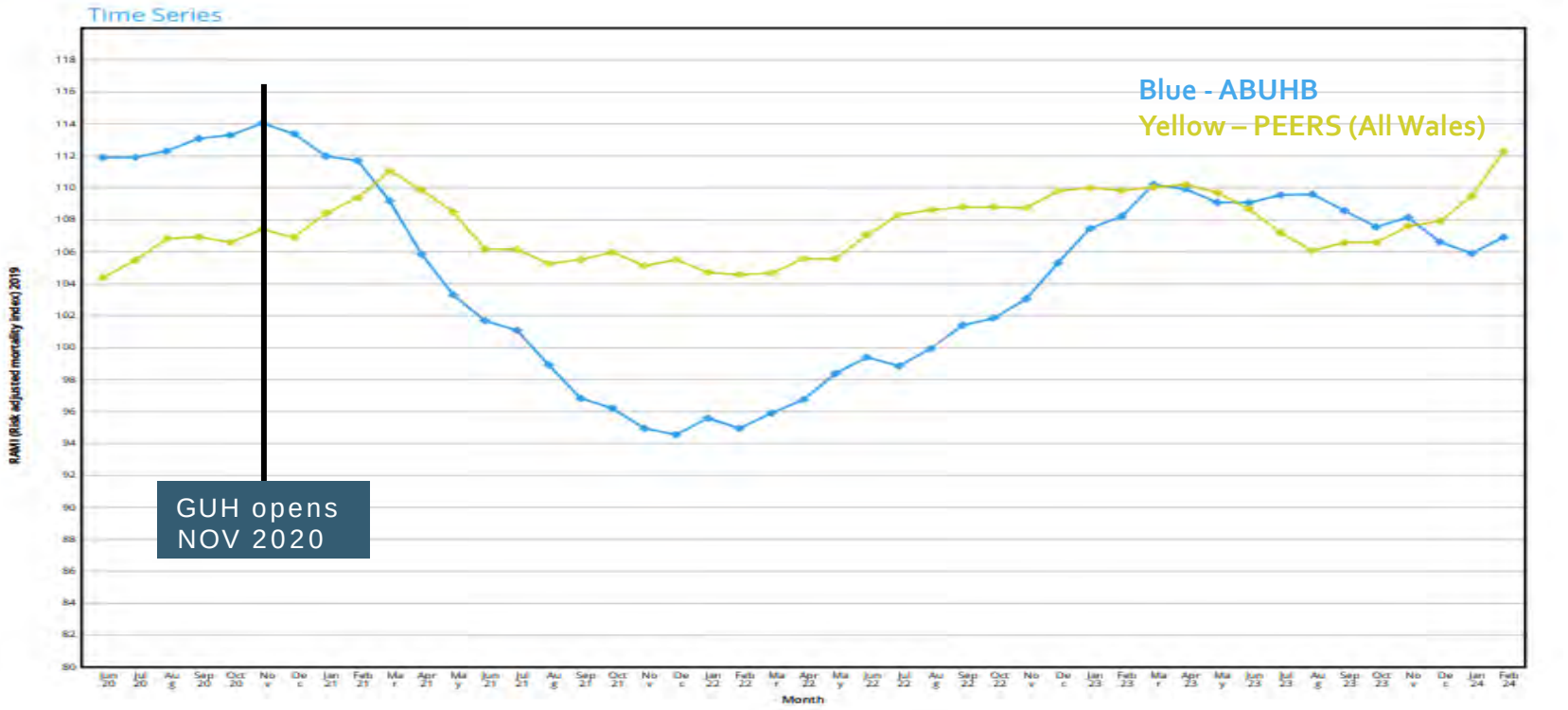

Anticoagulation Workstream

- Workshop held with primary care pharmacists who had raised concerns about patients discharging on DOACS from acute admission units across the Health Board.
- Pharmacy Intervention data collection for all issues identified with all anticoagulation to support a thematic review.
- All Datix reports for 12 month period pulled and analysed for themes and trends
- Bow-Tie model used in conjunction with the Yorkshire Contributory Factor Framework to determine key issues and potential resolution.
- Examples of good practice across Wales scoped – education pack and competencies developed for Pharmacy Technicians at Cwm Taf to be considered for roll out at ABUHB
- Feedback to the MDT group with discussion on how the action plan is progressing and agree new actions.

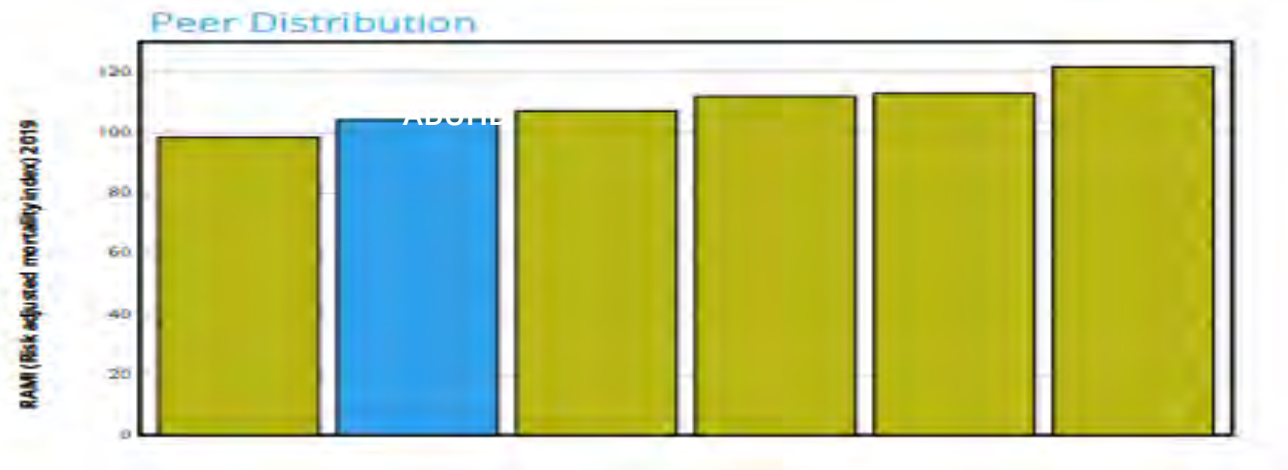
# MSG Action Plan

| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| Anticoagulation incidents consistent and high-risk potential | Multifactorial as per thematic review | As per corporate action plan | MSG | July 2024 |
| Insulin incidents consistently reported | Multifactorial, but lack of knowledge/ confidence a strong theme. | Continue to support DICE to identify areas requiring Insulin education. | MSG | Ongoing |
| Desmopressin – multiple incidents of missed doses of this critical medication | Lack of knowledge about drug and risks of omitted doses. | Internal Alert – pending sign off | MSG | April 2024 |

# RAMI (Risk adjusted mortality index)

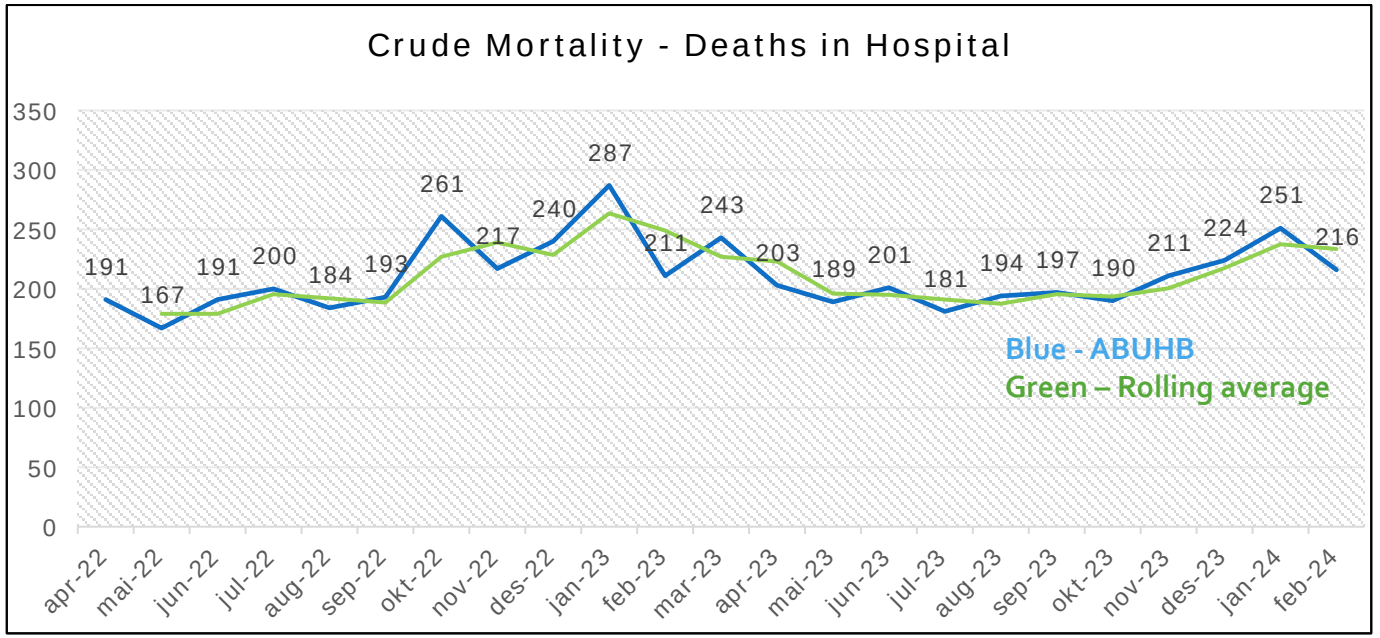



Feb 2024 RAMI is 107




Currently performing 2nd of 6 within All Wales peer group

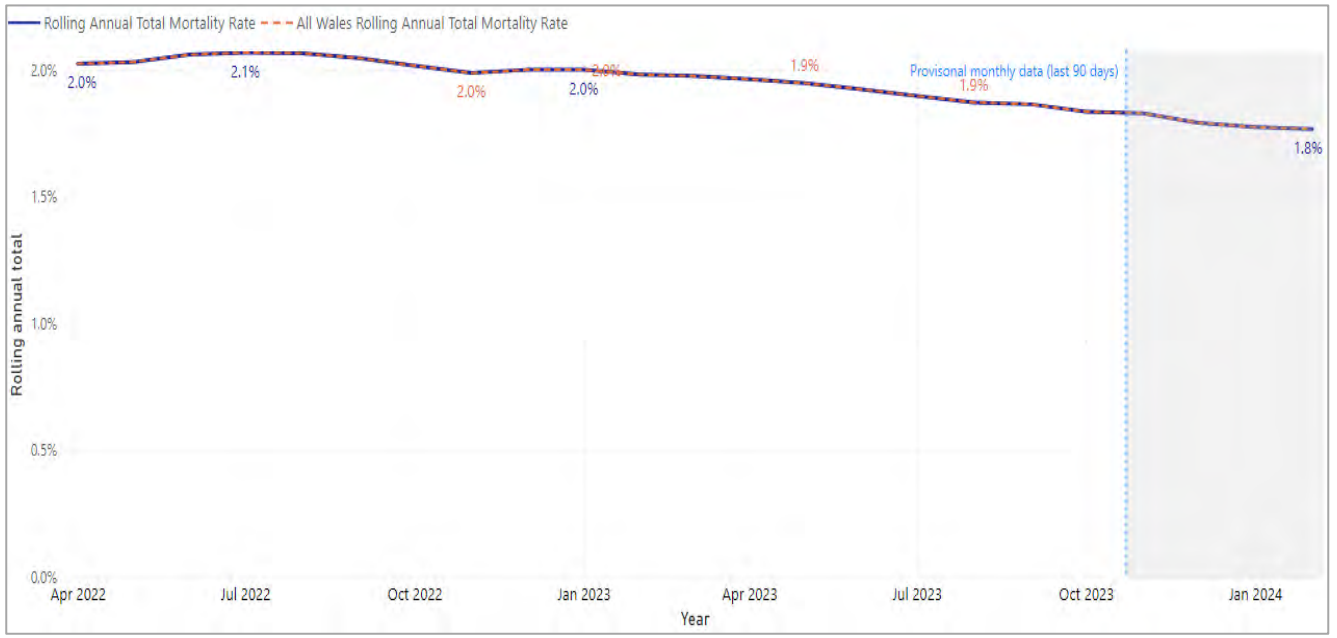
# Crude Mortality in Hospital




Whilst the Health Board RAMI has varied significantly, the crude mortality and mortality rate are flat and consistent.

This emphasises the need for an individual mortality report to undertake deep dives in high mortality specialties.

Mortality Rate



# Actions

| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| Understanding mortality data and how we implement learning from mortality | There is a need to understand what is reported to PQSOC and to Board for mortality.<br><br>England produce a Learning from Death framework which enables a standardised mortality report. | Mortality report available for this PQSOC. Learning from Death Framework under development and progressing to first draft. This will include learning from the Medical Examiner service and the mortality review screening panel. We are reviewing our end to end mortality process. | Medical Director's QPS team | On-going |
| Reliability of mortality data | Consistency of mortality reporting and data. | Mortality report available for this PQSOC, proposing a framework for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports crude mortality. We are part of the All Wales Mortality review group working to standardise reporting of mortality. | QPS Team and Information Manager | Ongoing |
| Clinical coding | The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity. | Work with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time. | QPS Team, DDT team and Information Manager | Ongoing |
| Mortality Data and Clinical Outcomes | Developing a governance process around mortality outliers | QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation. | Information Manager, DDT and QPS Team | On-going |
| | Develop process for when to undertake a review of case notes | Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide. | | |
| | Mortality indicators not avaible to all | Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data. | | |

# Pressure Ulcer Faculty

# Introduction and Aims

Following the COVID-19 Pandemic, the Health board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's). Divisions report data via the HAPU Steering Group and the Quality and Patient Safety Operational Group.

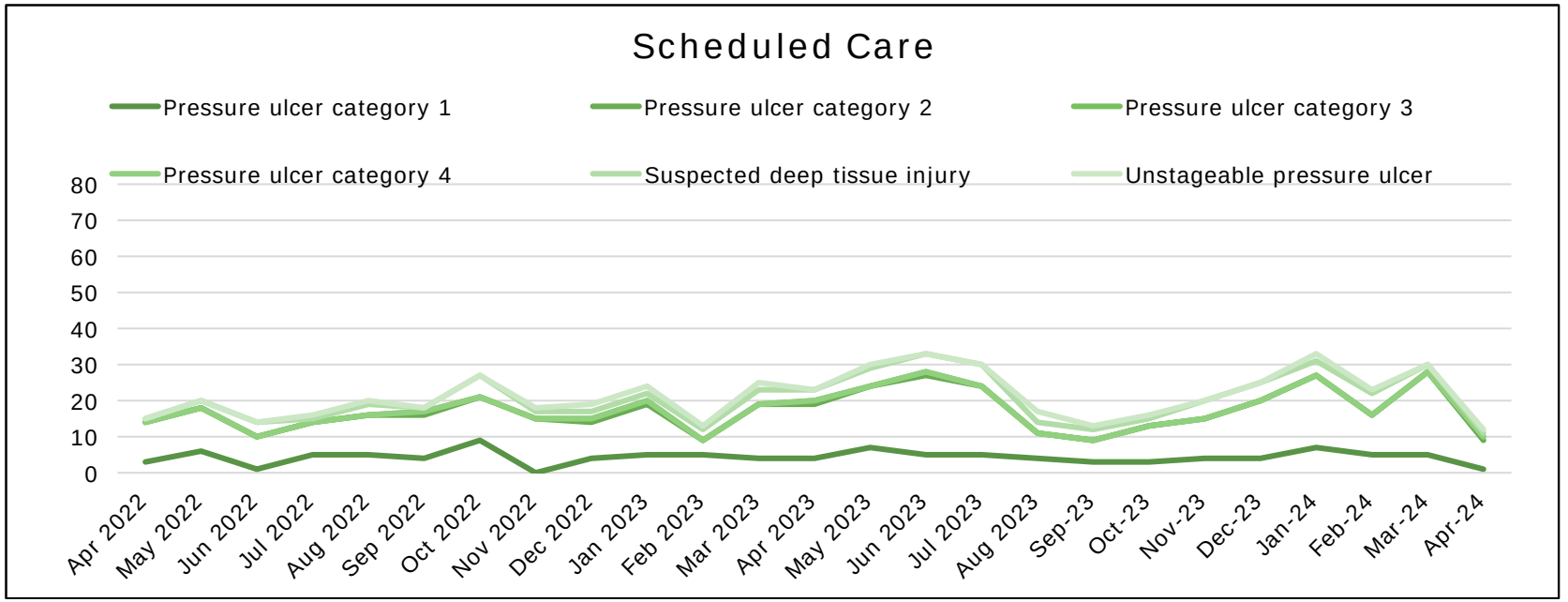
The Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers. With the success of the previous pressure ulcer prevention and reduction collaborative in July 2018, the Pressure Ulcer Faculty 2023 has been developed, led by the Nursing Directorate and Senior Nurses from Medicine, Unscheduled Care, Urgent Care and Community Care nursing; with support from ABC*i*.

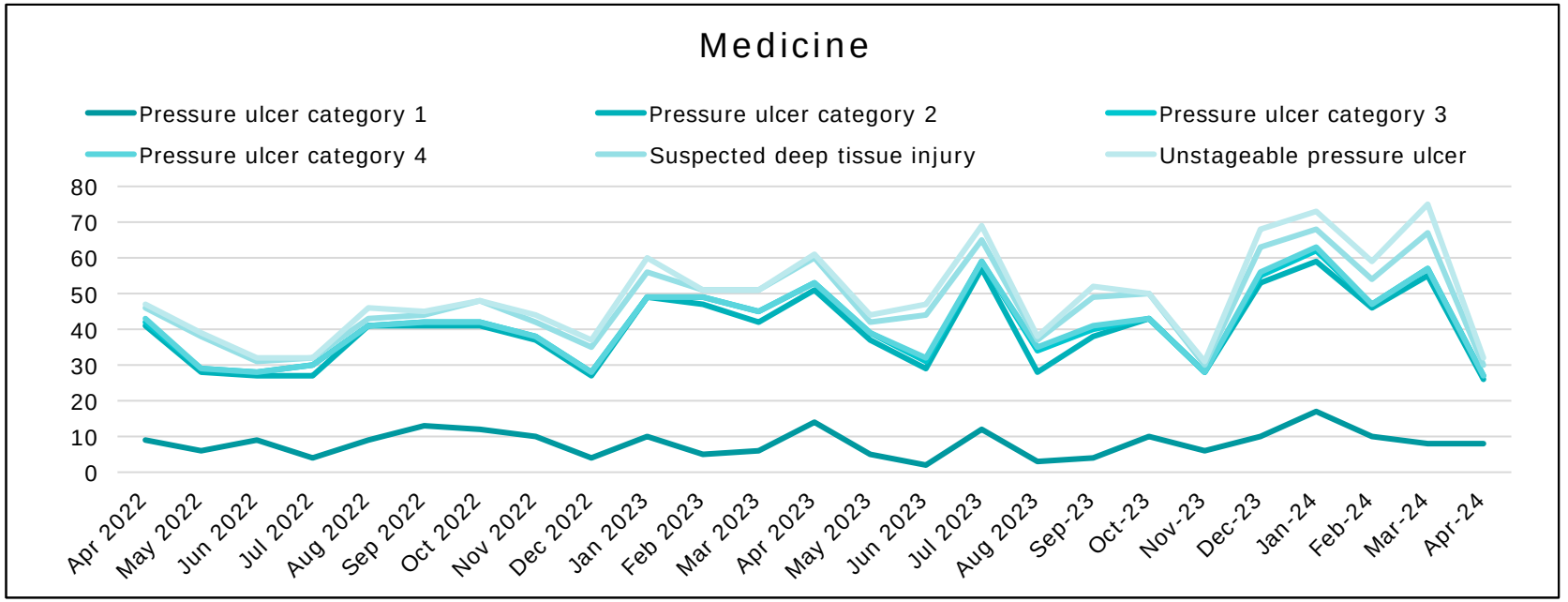
## Aim of the Faculty

- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty.

- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty.

# Data HCA Pressure Ulcer Incidents by Division



# Pressure Ulcer Faculty

# Aims and Progress

- Downward trend noted from January to April 2024
- TVNs to develop a pre-recorded PowerPoint teaching package
- PANDO APP to be used to support timely wound review and timely treatment
- PDSA Cycle in progress to support test for change across all sites within ABUHB
- PDSA cycle to be agreed at faculty meeting February 2024
- SharePoint file set up to share all resources
- Sharing of developed Posters across Divisions
- Driver diagram updated
- Pressure Ulcer Pilot commenced February 2024
- Next steps evaluate data collected at April meeting so signs of improvement

# 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.
- Continue to develop Quality operating framework, implementation plan and assurance framework. To ensure triangulation of data.
- Working with planning and data, digital and technology to refine QOF for 2024/25.
- Workplan being refined, including deteriorating patients, NRIs and never events in theatres and radiology.
- Reviewing QPSOG and establishing a forum for learning. Including membership and purpose of the Group and developing a listening and learning framework. This included the development of a learning repository.
- 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 being 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.

# COVID-19 Investigations Programme Risks

| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| Redeployment | 1 x staff member not yet redeployed. Challenge due to registrant status. | HR paper to Execs/WG.<br>FTC extended to 30 April 2024.<br>Line manager assessing alternative placement options.<br>Staff Member seeking employment | Head of COVID-19 Investigation Team/HR. | 30 April 2024 |
| Residual NNCP Enquiries | Team disbanded. | Enquiries directed to PTR Team.<br>Managed Head of COVID-19 Investigation Team | Head of COVID-19 Investigation Team. | 30 June 2024 |
| Live wave case reviews in line with Duty of Candour. | Out of scope of the NNCP framework. | Data triangulation undertaken.<br>Assessment of potential workload in progress. Report to be submitted. | Head of COVID-19 Investigation Team. | 30 April 2024 |

# Nursing Staffing Levels Wales Act 2016

| Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical/surgical and paediatric inpatients wards | | | | | |
|---|---|---|---|---|---|
| Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses | Total number of incidents/ complaints – 1st Jan-31st March 2024 | Number of closed incidents/complaints – 1st Jan-31st March 2024 | Total number of incidents/ complaints <u>not closed</u> and to be reported on/during the <u>next</u> reporting period<br>- | Number of incidents/<br>complaints when the nurse staffing level (planned roster) was not maintained | Number of incidents/complaints where failure to maintain the nurse staffing level<br>(planned roster) was considered to have been a contributing factor |
| Hospital acquired pressure damage (grade 3, 4 and unstageable) | 14 -grade, 3, 4 & unstageable<br>Plus 5 SDTI (Not reported to WG) | 7 0f 14 are closed.<br>All found to be Unavoidable | 7 of 14 remain Open<br>In addition, there are:<br>3 HAPU's still Open from Dec 23<br>1 HAPU's still open from Sep 23<br>3 HAPU's still open from May/June 23 | 0 of the 7 closed<br>*Unavoidable HAPU's will not be reported in future NSLWA report/ | 0 |
| Falls resulting in serious harm or death (i.e. level 4 and 5 incidents) | 0 level 5 Catastrophic<br>12 falls with head injury or fracture | 8 of 12<br>2/8 closed as moderate harm<br>(6/8 have been closed as Low or no harm) | 4<br>In addition, there are:<br>1 injurious falls still open from Oct 23<br>2 injurious falls still open from July/August 23<br>3 Injurious falls still open from May & June 23 | 1<br>*Only *incidents closed as Moderate harm or above will be reported in future NLWA report i.e. injurious harm not caused by an act or omission of the Health Board will NOT be reported.* | 0 |
| Medication errors never events | 0 | 0 | 0 | 0 | 0 |
| Any complaints about nursing care | 20 | 0 of 20 | 20<br>73 complaints remain open from April 23-end of March 24- not known how many are wholly or partially to do with nursing. | Not Known at this time | Not known at this time |
| Infiltration/ extravasation injuries | 0 | 0 | 0 | 0 | 0 |

# Nursing Staffing Levels Wales Act 2016

| Issue | Cause | Remedial Actions | Who | When |
|---|---|---|---|---|
| Complaints have been closed without the staffing Act Questions answered. | 1). In Complaints feedback, PTR teams are not always initiating the drop-down box "is this complaint wholly or partially to do with nursing".<br><br>2). Senior nurses are not always assigned as IO even though Nursing input is required- if this is the case the senior nurses do not have access to the complaint. | Education of PTR teams/divisional hubs and senior nurses.<br><br>Recent changes in DATIX have made the staffing Act Questions mandatory. | Divisional Nurses<br><br>Nurse Staffing Programme Lead | April 2024 |
| Delay of closure of some DATIX relating to injurious falls | waiting for presentation to Falls Panel | Ward managers to be reminded to close DATIX timely following presentation to Falls Panel | Divisional Nurses<br><br>Senior Nurses | April 2024 |
| It is anticipated there will be a reduction in reportable incidents of(Moderate harm or above in future NSLWA reports | The introduction of the Duty of Candour has highlighted that previous Datix were closed on actual harm rather than harm caused by an action or omission of the Health Board. We are now seeing Datix being closed correctly according to level of harm caused by the organisation and not on the injury sustained. | Ward managers and senior nurses have received training/education on closing investigations timely and accurately. | Datix Team<br><br>QPS teams | April 23 and ongoing. |
| There are pockets where root cause analyses of pressure areas are delayed | Divisions to speak to senior nurses to understand barriers to timely investigations | Divisional leads to support RCA's | Senior nurses, Divisional leads. | January 2023 ongoing. |

**Nursing Staffing** Levels Wales **Act 2016**

# Stroke Reconfiguration
## Ward recalculations

Centralisation of Stroke rehabilitation to YYF - 5 wards affected:

C5E RGH Stroke Rehab - Closed. (Staff will merge with D6E COTE and move location to D5W.

Oakdale Ward YYF (previously Bedwas) – Repurposed from COTE to 30 bedded Stroke Rehab Ward. Outcome- High RN vacancies- change to Core Care Model (Cost neutral) benefits of band 4 AP & WA. Roster template - LD 3/1/4, N 2/4. Establishment 40.68 including WM.

Bargoed Ward YYF – Repurposed from a shared Stroke Rehab/COTE Ward to 30 bedded Stroke Rehab. Outcome- Core Care model already in place and works well. No change to current roster template- LD 3/1/4, N 2/4. Establishment 40.68 Including WM.

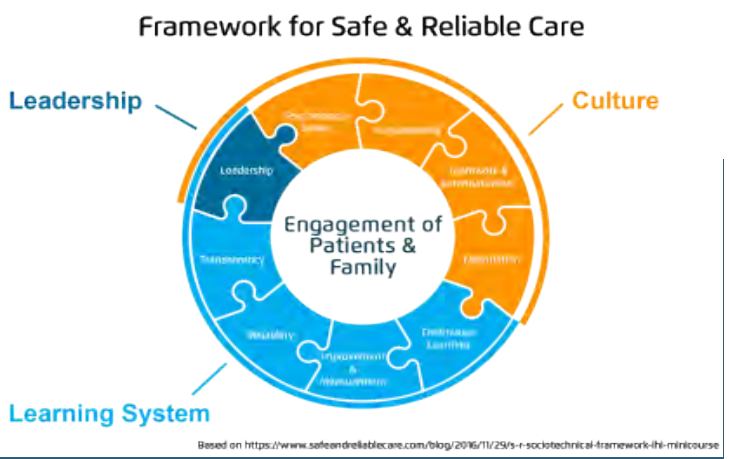
EFU YYF (previously (Oakdale ward) Repurposed from shared EFU and COTE to a 28 bedded EFU. Outcome- Current roster template works well- No changes to current template. LD 4/4, N 2/4 Establishment 40.68 including WM.

Ward 3.4 NHH – Repurposed from a 24 bedded Stroke Rehab ward to 24 bedded COTE ward with capacity to surge to 28 beds. Outcome- Core care Model already in place – No change to current template with a view to review need for extra HCSW by night in the Spring re-calculations. LD 3/1/4, N 2/3. Establishment 37.90 including WM.

# 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 | Safe use of NG tubes remains on on-going concern, however ABUHB has now declared compliance with this alert. This will report through the Nutrition and Hydration Group and the QPS Clinical Audit team will be undertaking an audit in due course. | Compliant |
| 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, approved by CSPG and added to intranet. ABUHB declared compliance with this in Jan 24. | Compliant |
| PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients | 29-Sep-23 | Project led by Peggy Edwards. Health Board working group and meeting every 8 weeks to progress. Work is still on-going. | In-progress |
| NatPSA 2023 013 Valproate-Compliance deadline: 31/01/2024 | 31-01-24 | Organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. This is being progressed within neurology and MHLD and a gap analysis and SBAR of outstanding actions needed to comply is being developed. Risks are being escalated within the Division. | In-progress |
| PSA017 Identified Safety Risks with the Euroking Maternity System. Compliance deadline: 28/06/2024 | 28-06-24 | This PSA being led by Peggy Edwards. Important to note the Health Board does not use this system. However, all organisations need to review actions 5 and 6, therefore the focus is on these actions and in progress. | In-progress |




# Safe Care Collaborative

# Jan-Mar 2024

Organisational Update: Stage-Action Period 8

- Learning Session 5, March 20th– Face to Face Learning Session held at the ICC with a focus on building Learning Systems. Teams presented storyboards of their work.
- SCC Close - Final Celebration event being held on 14th May 2024
- **ABUHB Deteriorating Patients Collaborative –** planning phase
- **ABUHB Deteriorating Patients Collaborative –** Local day in February & April was cancelled due to Industrial Action.
- Leadership programme of work – schedule of executive Safety Walkarounds Programme set up until March 2024.
- Quality Outcomes Framework– Working to refine QOF in conjunction with Public Health. Quarter 3 report completed reported to the executive team. Information team to develop a Qlik dashboard based on 'Making Data Count' format already used for the ABUHB Performance Dashboard
- QI Skills Development– Improvement in Practice training with Improvement Cymru for staff from Primary Care, Mental Health and Collaborative work has been completed. Quality Coach training completed in March with additional 9 coaches
- **OCP – QPS & QI Teams to Nursing Directorate –** QPS staff moved over, focus now on integrating QI Unit
- **Improvement Advisor – Theatres** scoping and initiating work

Team Update:

- **Project Outcomes –** potential to generate Safety Culture outcomes for all teams
- Storyboards - Updated for Learning session 5
- **Ward C0 –**Up until the end of March, there hasn't been a Cardiac Arrest for 125 days. Next stage of visual management, screen accessible for full MDT at handover between shifts.
- Monmouthshire – Reduction in Package of Care hours for medically optimised patients. Sustained reduction in median LOS. Deep dive identifying ALOS increase due to inability to discharge outlying patients
- AMU – Implemented 4 hourly observations. Will be testing visual management of Careflow data. Stickers being used in medical notes to highlight outcome of board round discussions
- OT Early Intervention – 30-60 minute saving for each patient during 3 month telephone evaluation rather than face to face adopted as common practice. Testing memory strategy information provision to patients waiting.
- **Theatres –** Improvement Advisor in post, scoping work to reduce Never Events. Testing Safety Culture survey as part of Human Factors. Q Exchange funding bid submitted to Q Community.

| Workstream | ABUHB Team | Score |
|---|---|---|
| Acute | Medical Assessment Unit at GUH | 2.5 |
| | Ward C0 (ENT surgical ward) at GUH | 3.5 |
| | Theatres – Human Factors | 1 |
| Ambulatory | North Monmouthshire Integrated Team | 3.5 |
| Community | OT/MH Early Intervention for Cognitive Impairment Team | 3 |
| Leadership | Executives, Leaders for Safety, Faculty | 3.5 |

| Score | IHI - Stage of Project Scoring |
|---|---|
| 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 |

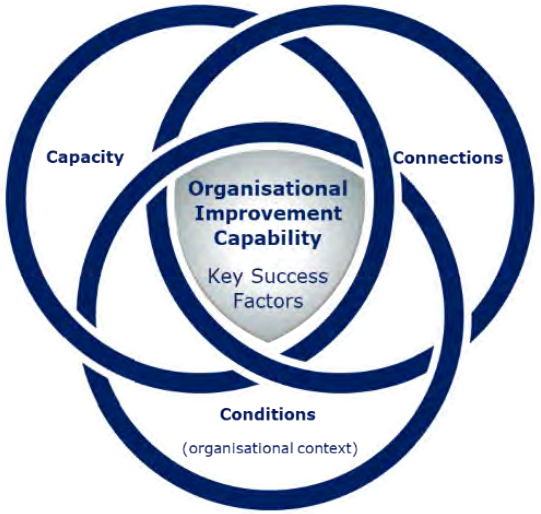
# Quality Improvement

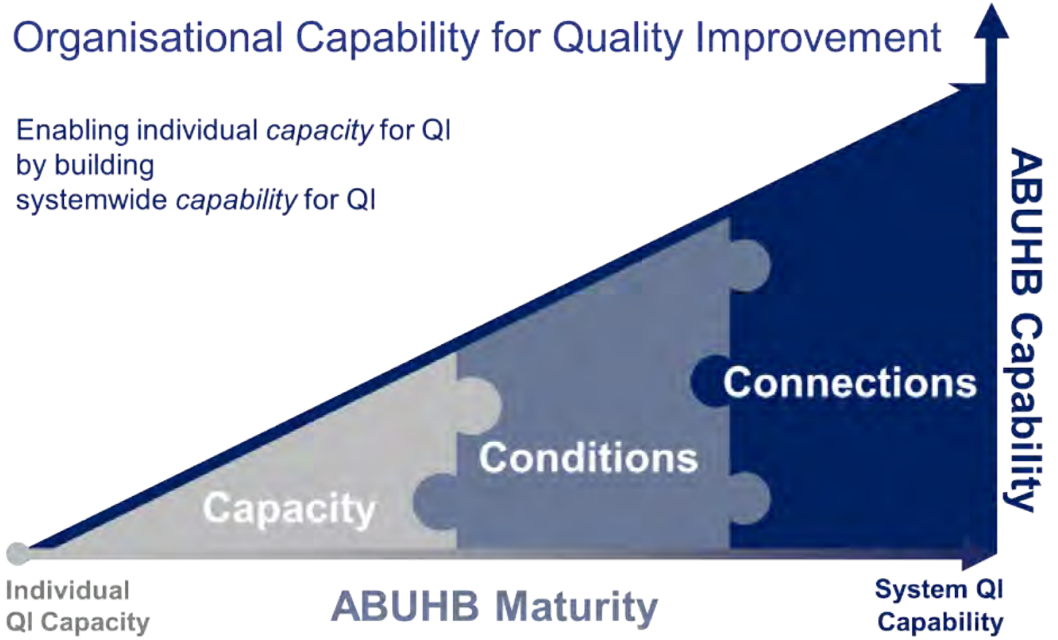
## Direction

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."

Organisational QI Capability is "the organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance".

Quality Improvement forms part of the ABUHB Quality Strategy. Our plan is to grow and mature our organisational capability for Quality Improvement (QI), by building capacity, conditions and connections which will enable staff to use QI methodology for solving complex problems, and in so doing provide a consistent approach to testing change ideas, learning and informing our decisions.



# Quality Improvement

## Next Steps

Our QI strategy is to build:

**Capacity for QI – knowledge,** skills, experience

- QI Coaches integrated into divisions
- QI Knowledge and Skills Development Framework

**Conditions for QI – Enablers** for QI

- Clinicians as QI Leaders
- Data systems supporting QI
- Resources to support teams working to improve services
- Patient involvement in QI
- Human Factors and Safety Culture

**Connections for QI – QI** Networks sharing learning

- QI Networks, both internal and external
- Strategic Partners
- Safe Care Partnership/Collaborative
- QI Collaboration

Progress - Integrating QI Coaches

QI / Quality Coach development programme

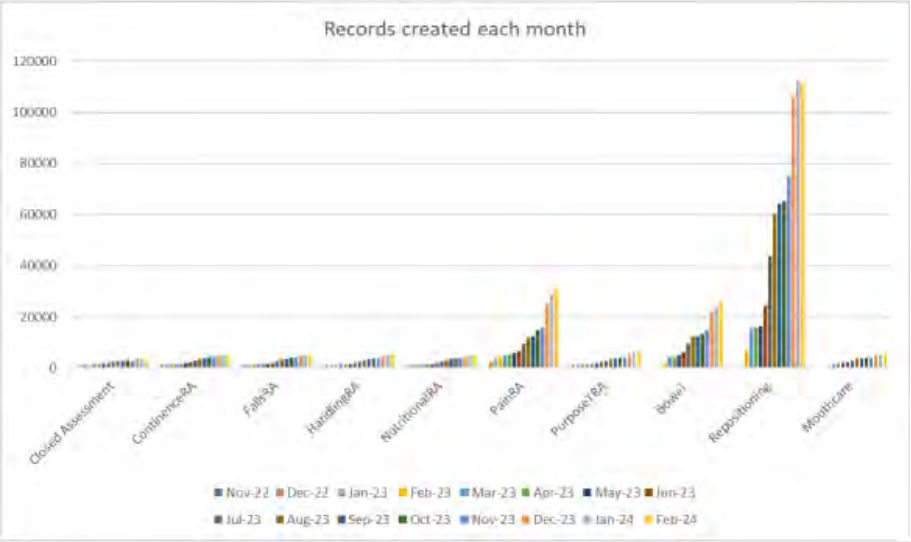
- Skills Development Framework in progress
- Working with Improvement Cymru to support QI training
- Completed new Quality Coach Training pilot in March
- PocEd QI and PocEd Measurement sessions dates set for 2024

Spread & Scale Academy - Quality Coaching

- ABCi, AMD for QI, Head of QPS, Asst Head pt Safety attended Spread and Scale Academy – project to increase QI Coaching Capacity within ABUHB
- AIM – to unleash NHS Staff agency to deliver the safe & high quality care, that they and their patients need, through 1,000,000 minutes of improvement coaching over the next four years
  - 300 Quality Coaches in 4 years
  - Coaching half a day per month
  - Coaching 3 teams per month
- 90 day plan in progress to initiate work

# Welsh Nursing Care Record

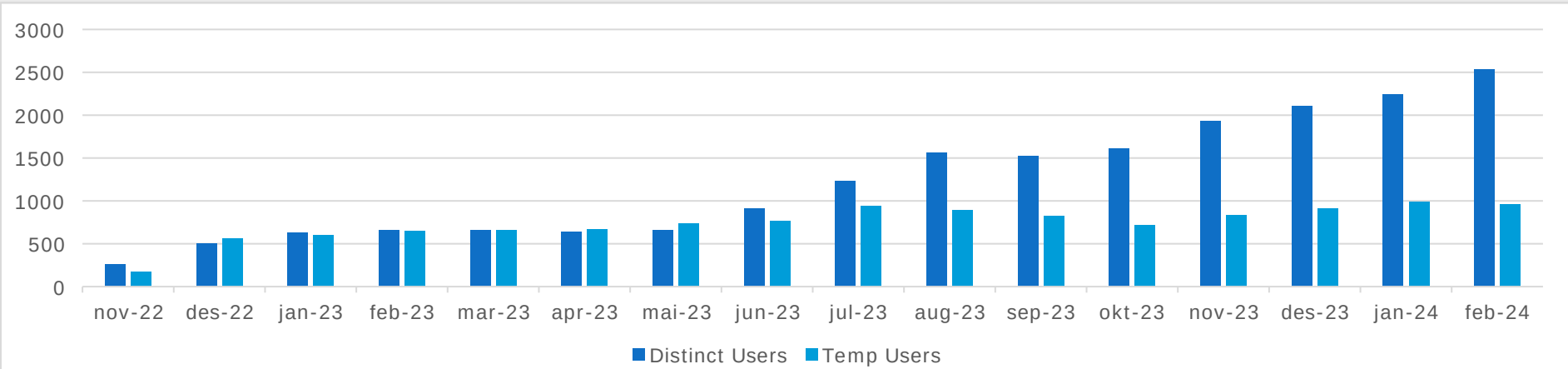
- GUH/RGH/NHH and YYF now live (40 wards across four sites).
- Returning to RGH to implement in the community wards (STW)
- V2.4 due 10 April 2024





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

NB Agency staff are provided with temp Nadex so part of distinct users numbers

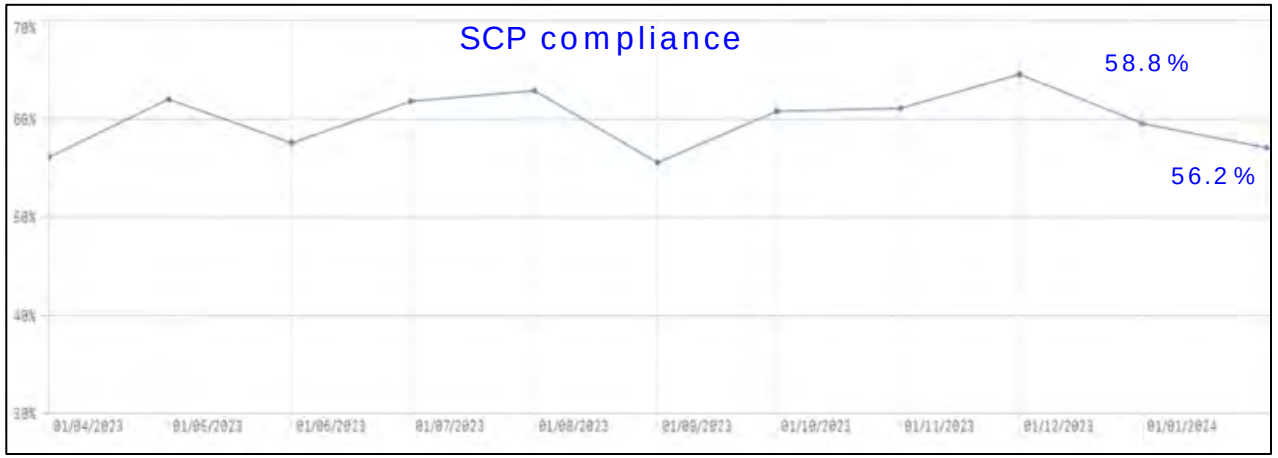


# Welsh Nursing Care Record

| 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)<br>➢ WCP provided for all nursing staff | DHCW | Q1 |
| 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 – *prototype now available and will be tested* | 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<br>➢ 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<br>➢ Engagement with Bank to ensure access<br>➢ Out of hours support from Service desk | Directors of Digital / Ward Managers | Ongoing |
| Lack of WPAS skills means that WNCR patient lists are not always correct and digital records cannot be started | WPAS is updated by RPA and there are exceptions which require manual intervention | ➢ Improvement programme started to reduce known exceptions | RPA team / WPAS team | Ongoing |

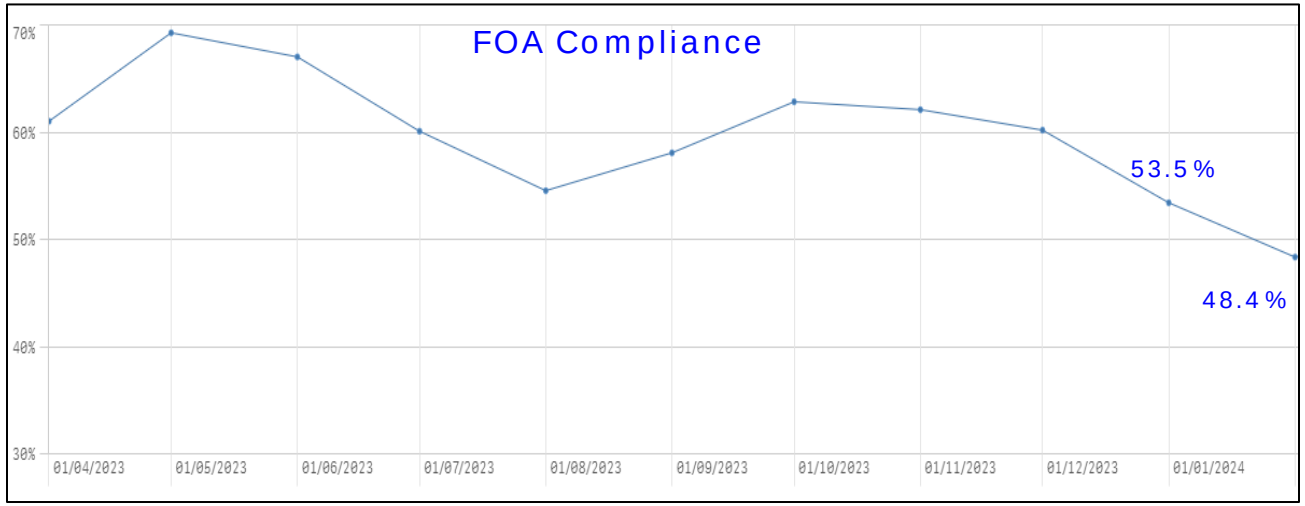
# Cancer – 62 Day Performance

## SCP Compliance: January and February 2024




January '24 compliance was 58.8% which was as predicted.

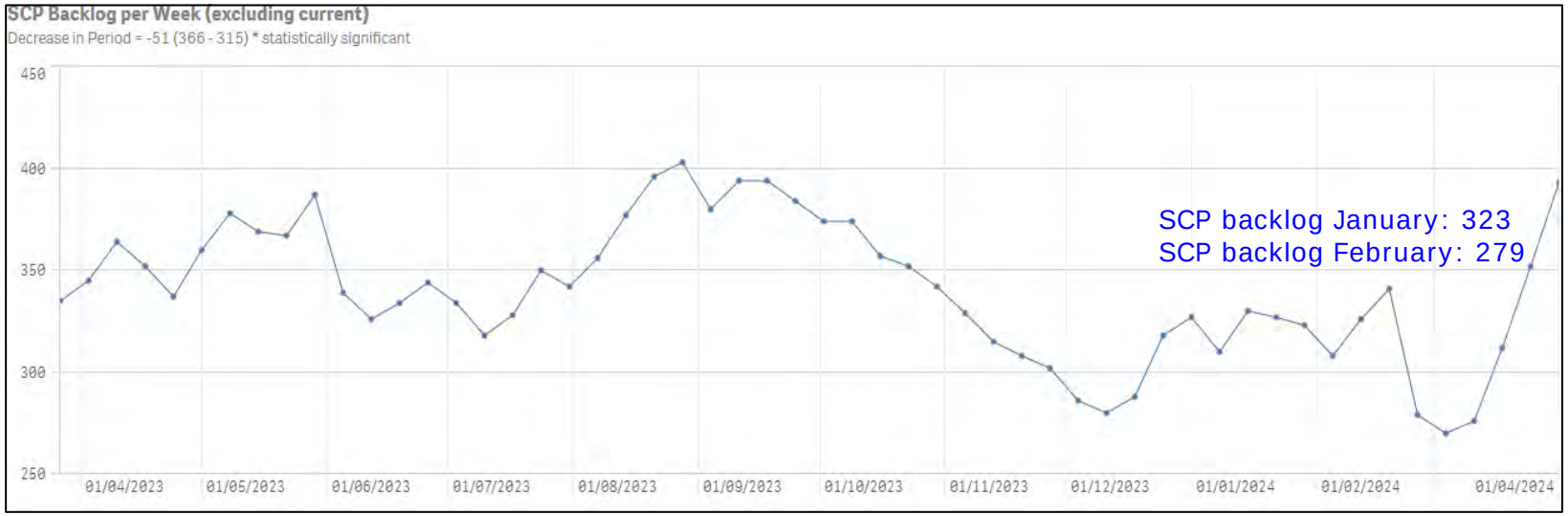
February '24 compliance was 56.2%, which was also predicted.

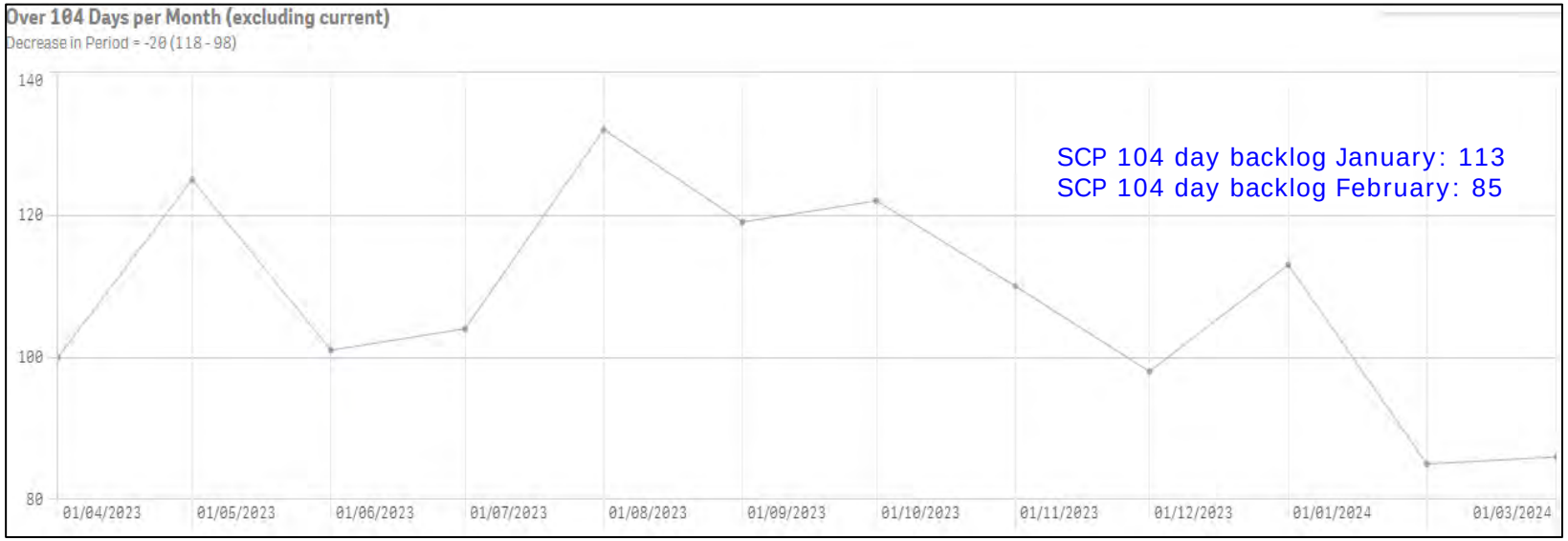



14 day compliance has deteriorated in both January and February as a result of reduced capacity.

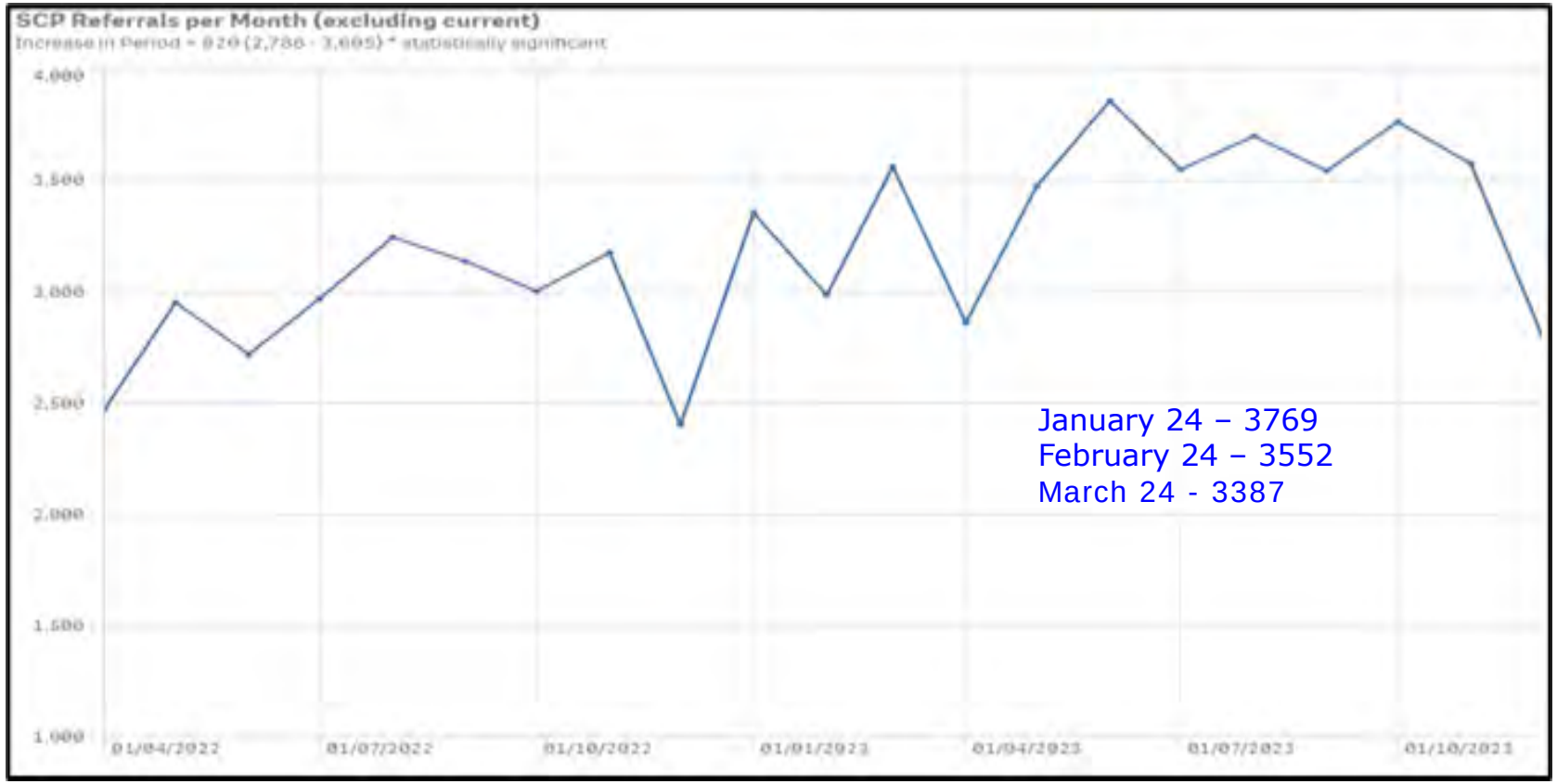
# Cancer Backlog

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



# SCP Demand



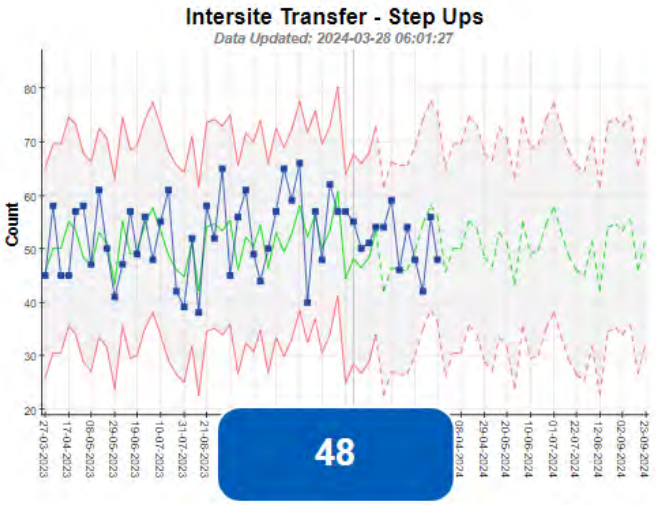

Demand has levelled off but remains high.

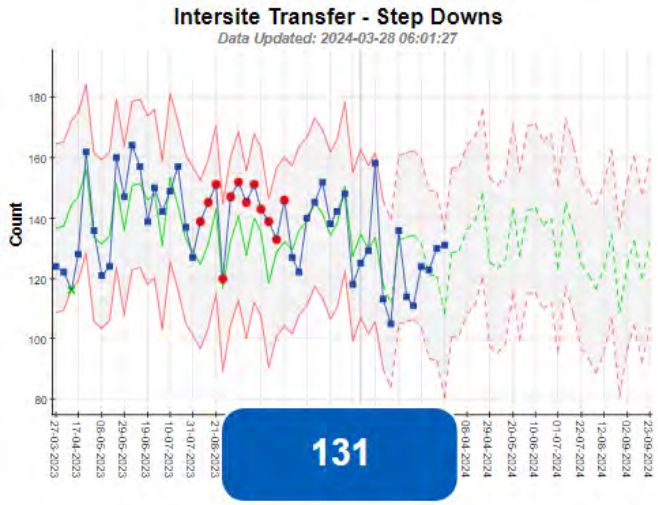
# Risks

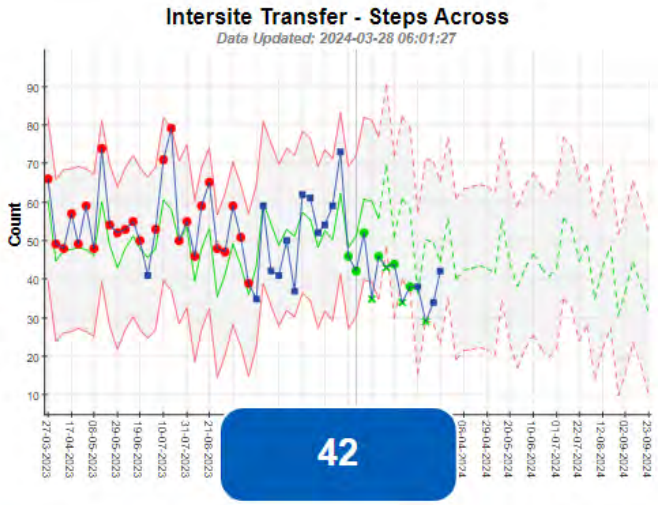
| Issue | Cause | Remedial Action | Who | When |
|---|---|---|---|---|
| Significant delays to FOA for suspected gynae-oncology patients. | Junior doctor industrial action during Q4 2023/24.<br><br>Consultant backfill/WLI payment rates dispute resulting in loss of capacity | Directorate continues to explore solutions | Division Management staff | Anticipate evidence of improvement during Q1 2024/25 |
| Cancer pathways not meeting 62 day SCP compliance (exception is skin) | Referral demand remains high.<br><br>Lack of sufficient timely access to diagnostic capacity | Planned Improvement Task and Finish groups have been attended by all disciplines involved in urology, gynae and H&N pathways. Lower GI group will meet for the first time in May 2024.<br><br>The programme of work makes use of the learning from Toyota training and inclusion of National Optimal Pathway mapping against milestones. | Macmillan National Optimal Pathway Manager<br><br>Divisional General Managers | Progress will be ongoing.<br><br>Anticipate incremental improvement by the end of Q2 2024/25 |
| Significant loss of Endoscopy capacity in January, February and March | Junior doctor industrial action during Q4 2023/24.<br><br>Backfill/WLI payment disputes resulting in loss of activity | Services will mitigate as much loss as possible during IA. | Divisional General Managers & Clinical Directors | End of Q4 2023/24 |
| Loss of breast OPA capacity | Breast Unit opened in YYF in February 2024.<br><br>Introduction of new one stop model for patients to have all diagnostic tests at one visit. Loss of capacity as the new model embeds. | Service plan to limit capacity loss by providing additional clinics post move as appropriate | Directorate Manager | Q1 2024/25 |

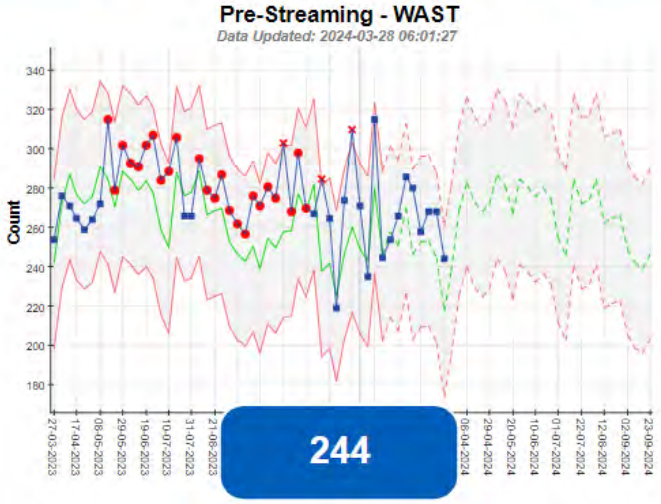
*Goal 2: Signposting people with urgent care needs to the right place, first time*

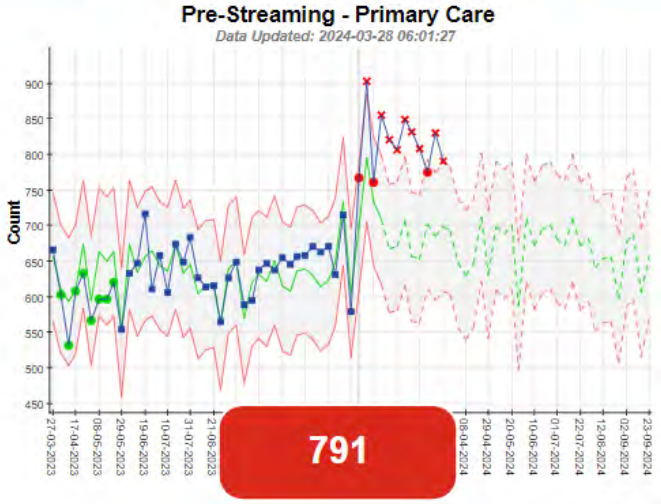
# Flow Centre



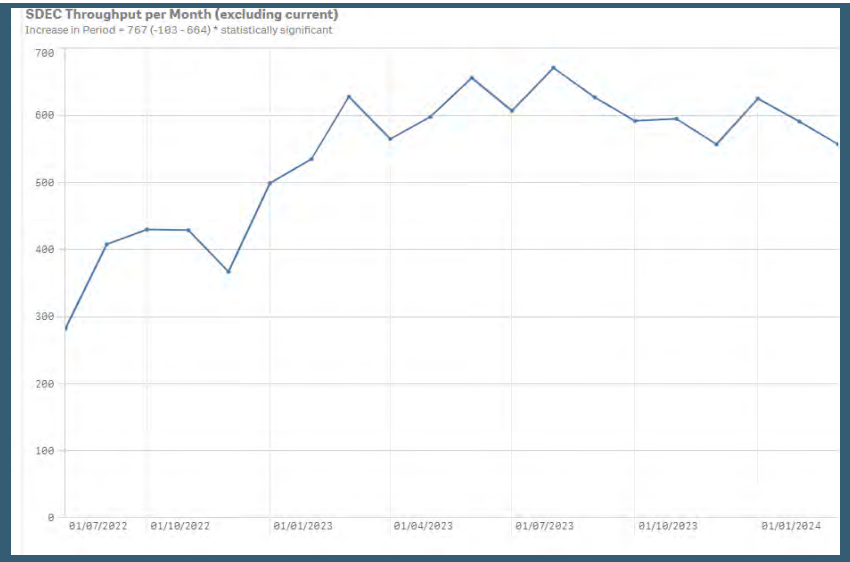



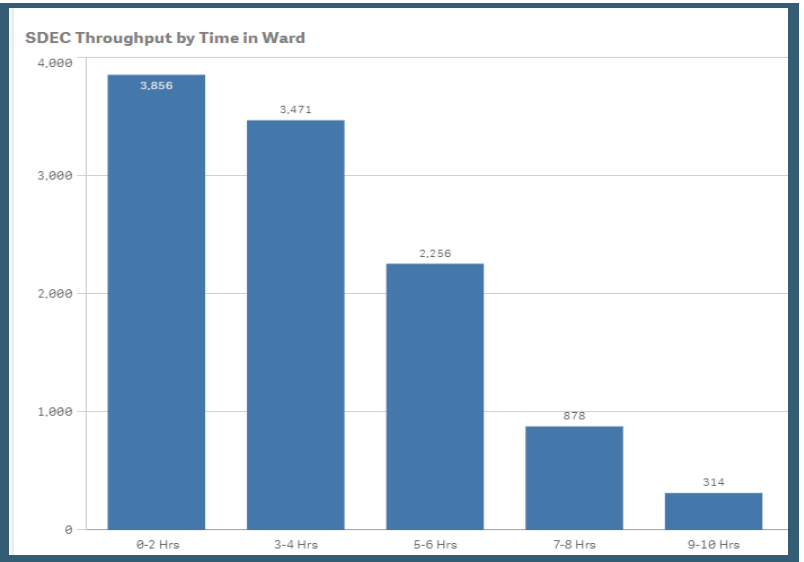

**Step Across to Community**

**WAST Pre-Streaming**

**PC Pre-Streaming**

# SDEC GUH at a Glance 8/8/22 – 3/04/24



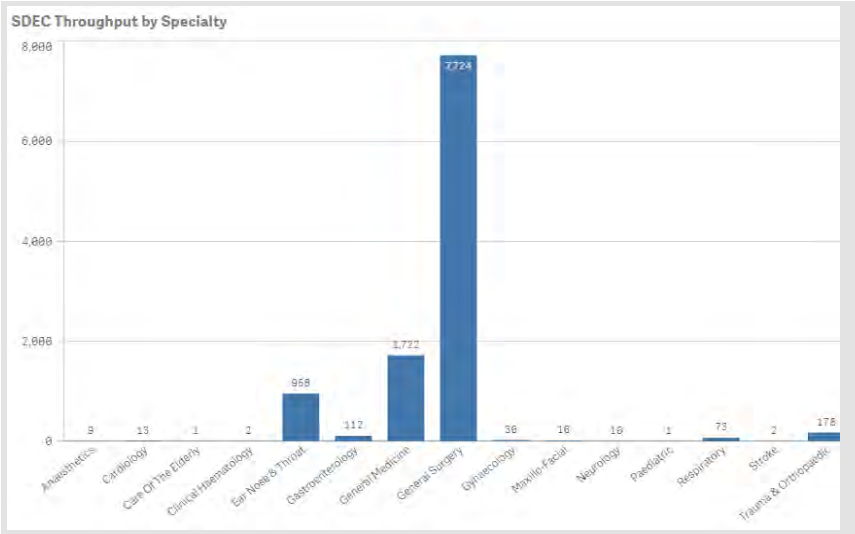

10855 Patients seen

Average 33 Patients per day

8833 patients Discharged Same Day (82%)

Median time 3:55 hours

1887 Admissions

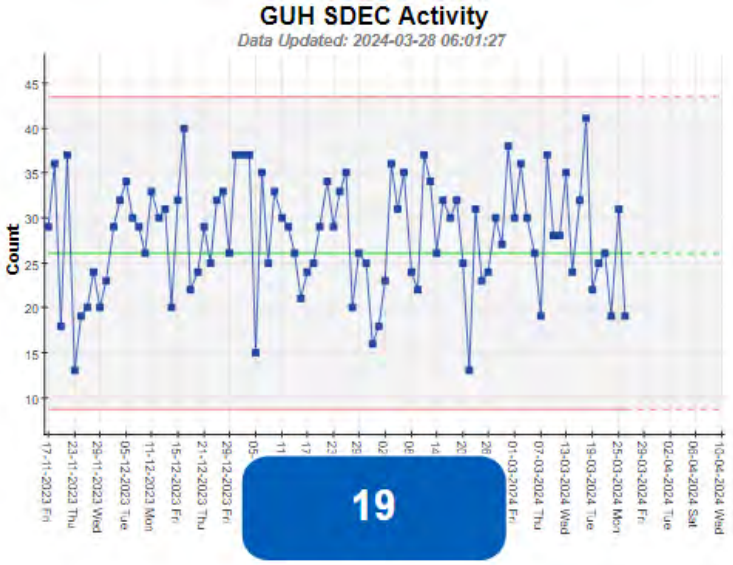


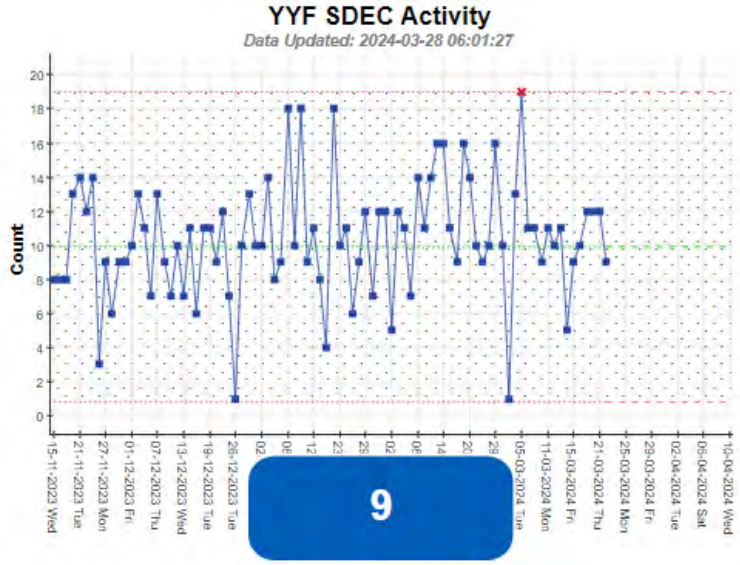

## Progress Summary:

Average daily patient throughput up to 33
Surgical model working very well, great feedback from Primary Care
Medical Model GP referral process now in place
Medical referrals have stabilized to around 30 per week,
Reviewing pathways for direct referral from ED/MAU to SDEC
Flow Centre added an SDEC advice line for Primary Care and WAST
Reviewing process for next returning patients from ED
Reviewing links with frailty Ambulatory care strategy

**Goal 3: Clinically safe alternatives to admissions to hospital**

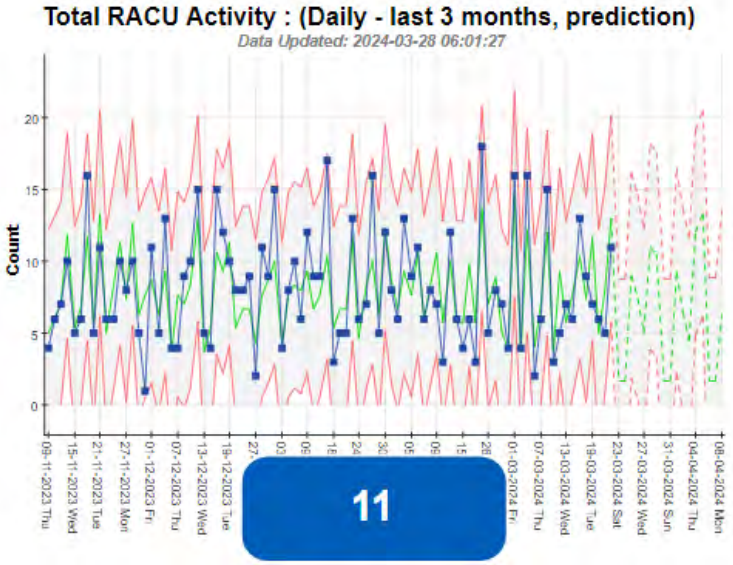
# Alternatives to Admission

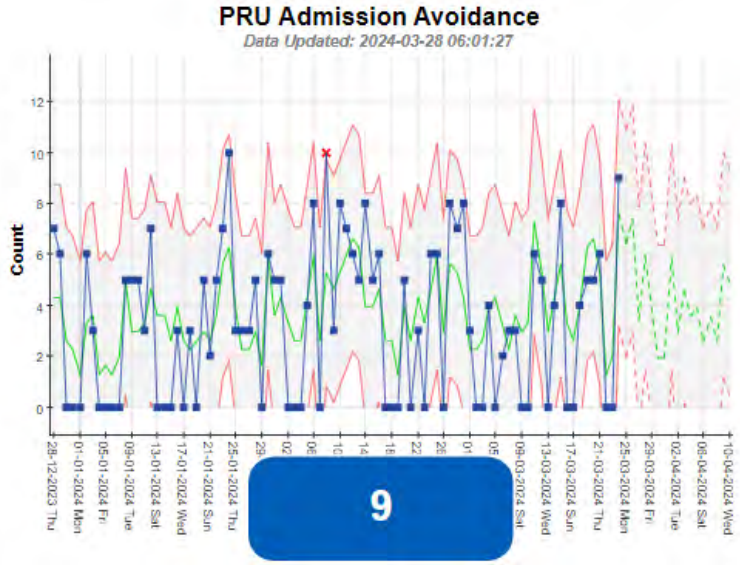


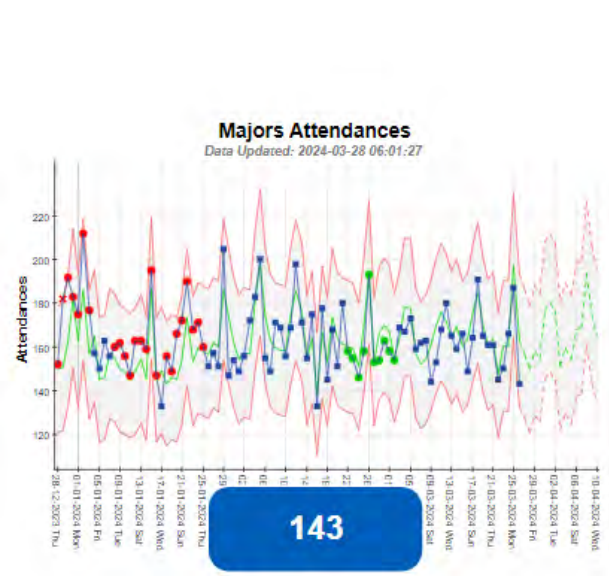

Data Updates & Forecasting:

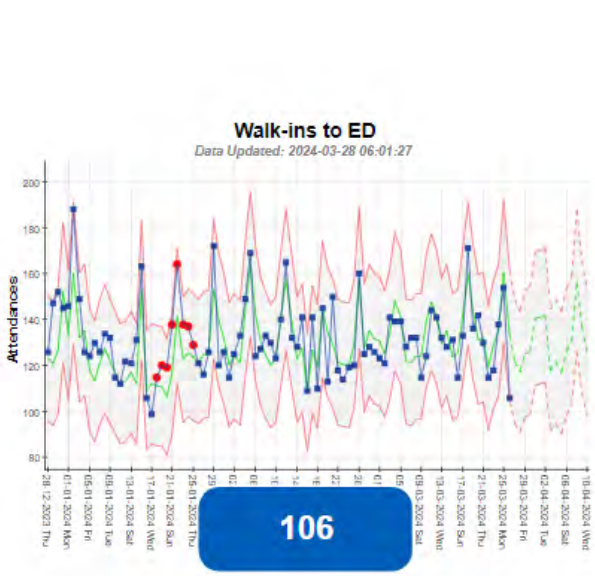
GUH SDEC has been seeing around 20-40 patients/day
YYF SDEC has been slightly higher than normal between 8 and 18/day recently

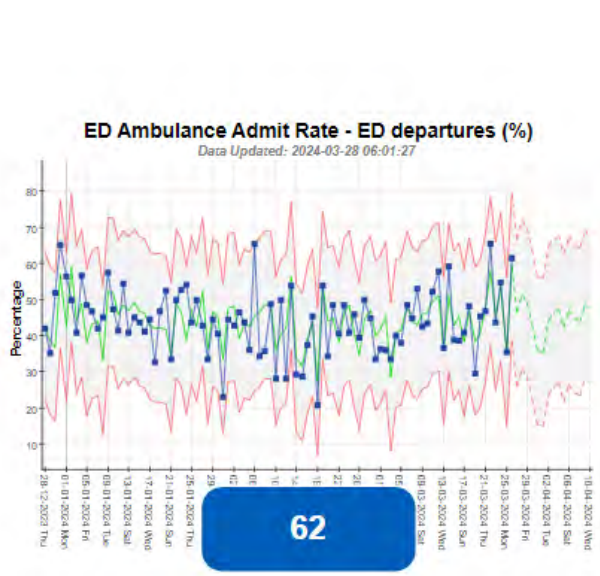


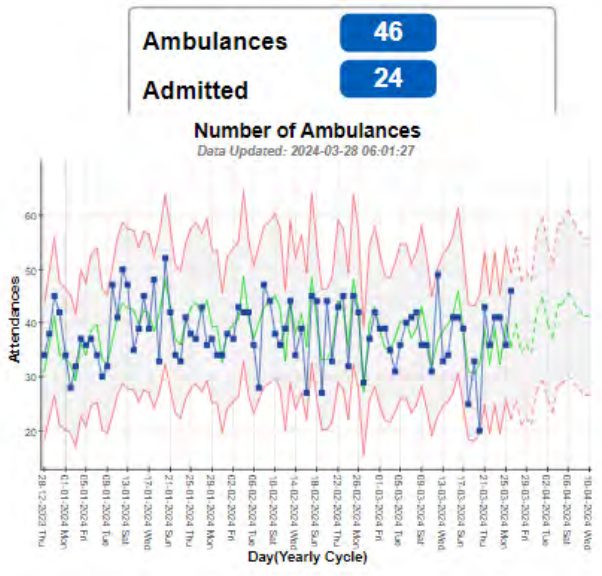



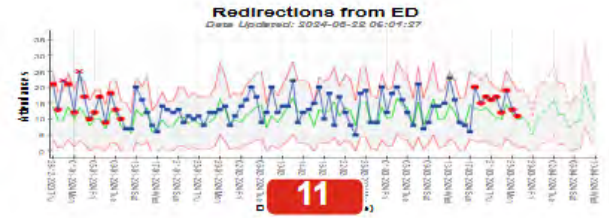
# GUH ED Activity

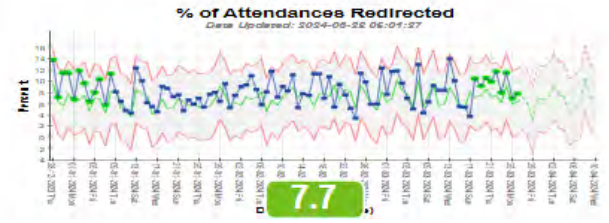


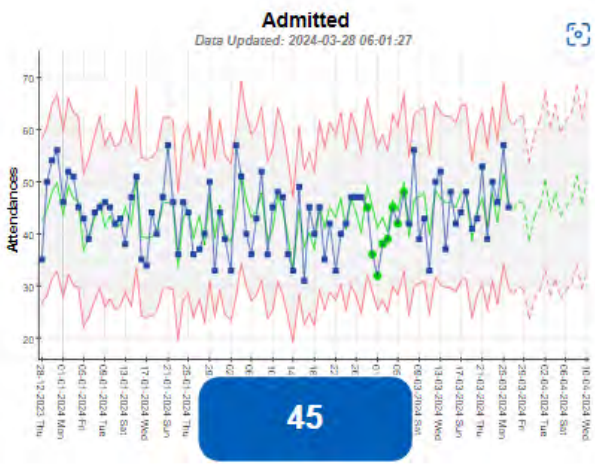



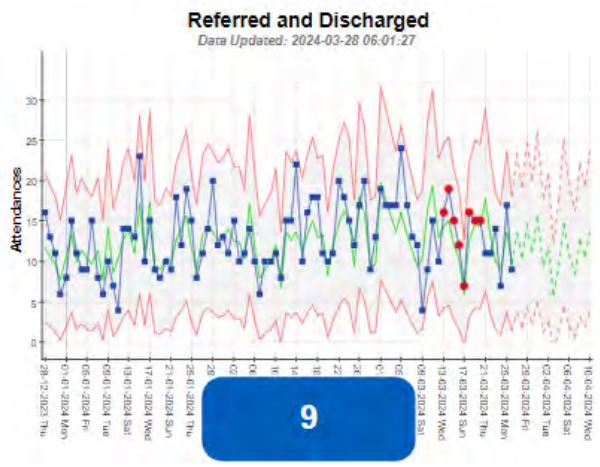



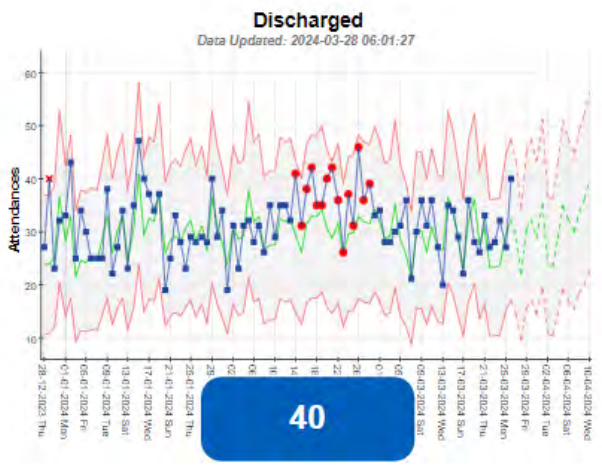



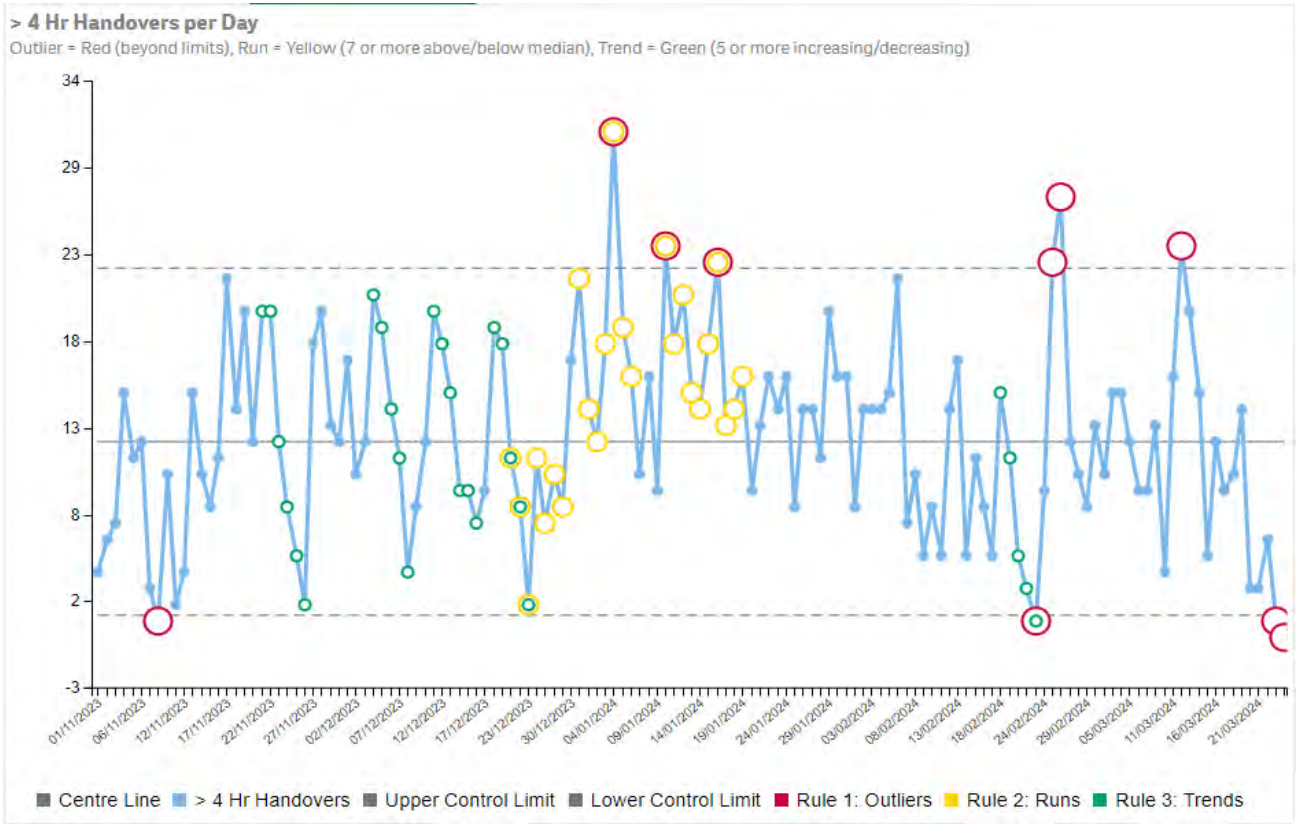



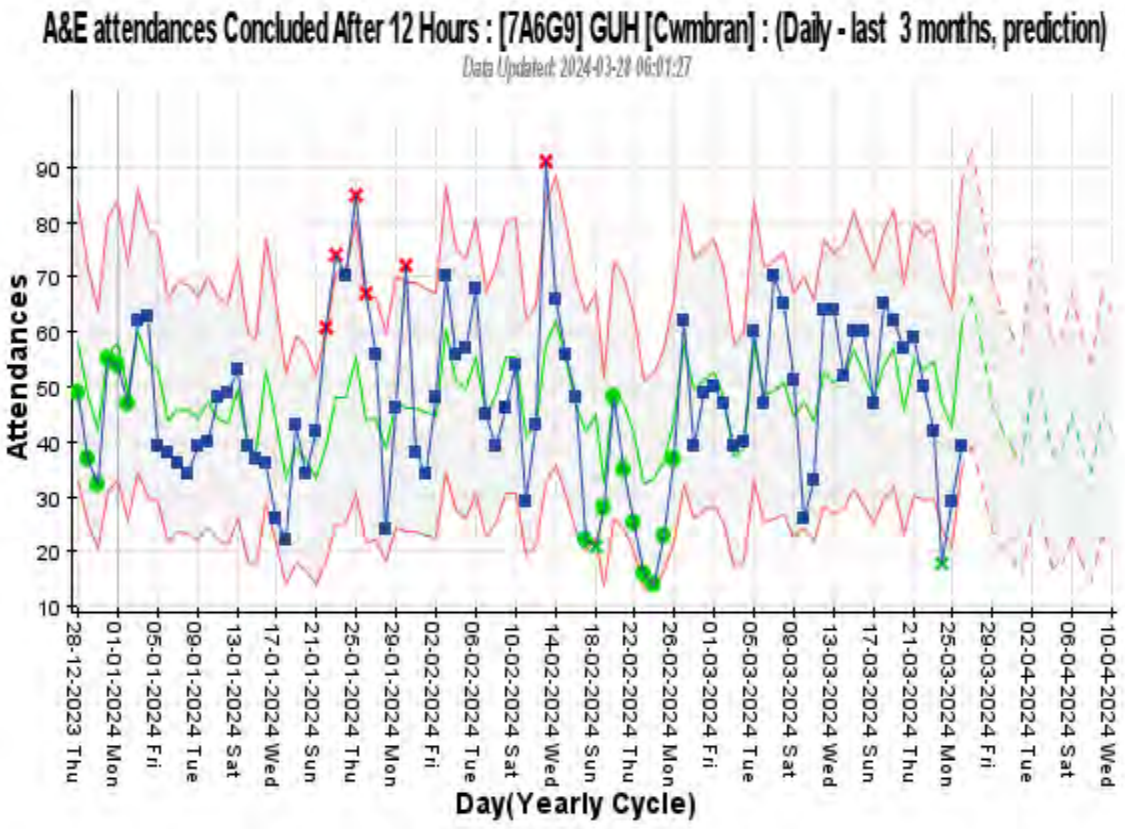



## Goal 4: Rapid response in physical or mental health crisis




Data Updates & Forecasting:

Around 12 patients a day waiting over 4 hours for ambulance handovers at GUH, although this has reduced in the past few days after a period of high variability.
Around 47 patients a day spending over 12 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<br>Ongoing recruitment<br>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<br>Emergency Department Establishment was increased following the move to the GUH<br>Challenging place to work due to increased attendances, increased acuity, environmental challenges, inadequate flow | Recruitments drives for Registered Nurses and HCSWs<br>Student streamlining<br>Recruitment of internationally trained nurses<br>Robust sickness management<br>Practice Educators working clinically alongside junior staffing<br>Senior Nurse Point of Contact (POC)<br>Block-booking of staff secured and robust processes in place to manage roster<br>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<br>Poor patient flow<br>Pathways of Care<br>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)<br>Escalation plan in place to support movement of patients<br>Comprehensive review of available spaces with Capital Planning colleagues at GUH (Main Wait, Sub-wait and SDEC)<br>Full Capacity Protocol (FCP) in place<br>Expansion of ED Main Wait in progress with anticipated completion date of January 2025.<br>SDEC in GUH open. Predominantly scheduled care utilising but medicine usage increasing along with other pathways such as ED direct referrals and WAST direct access<br>Acute Release Area (ARA) commissioned from 8 January 2024 which can support 6 patients outside of ED to facilitate timely handover of ambulances. This portacabin is now being decommissioned and removed with work starting 15 April 2024 | General Manager / Divisional Director / Divisional Nurse / Divisional Management Team | Ongoing |

# Questions

| | |
|---|---|
| CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN<br>ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING | |

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Listening and Learning Framework |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Jennifer Winslade, Executive Director of Nursing |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Leeanne Lewis, Assistant Director for Quality & Patient Safety<br>Tracey Partridge-Wilson, Deputy Director of Nursing |

| Pwrpas yr Adroddiad (dewiswch fel yn addas)<br>Purpose of the Report (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

| ADRODDIAD SCAA<br>SBAR REPORT |
|---|
| <u>Sefyllfa / Situation</u><br><br>This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.<br><br>This framework will compliment and build on divisional and directorate assurance arrangements by adding a strategic approach to support the Health Board to learn lessons from a range of internal and external sources. This will form part of our learning repository, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice. |
| <u>Cefndir / Background</u><br><br>Aneurin Bevan University Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of healthcare organisations. Creating a culture of learning within the NHS is crucial for organisational improvement. It ensures positive experiences for patients and the delivery of person-centred, high-quality services, whilst supporting staff |

wellbeing. The Health Board is committed to promoting a culture which values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety, quality and experience.

Within the Health Board our commitment to learning is evident within both the Quality Strategy and Patient and Involvement Strategy. With set ambitions to develop a process and framework through which we will learn from patient safety incidents, audit, review and feedback from our patient, relatives, cares, staff, and communities.

The NHS Wales Duty of Quality Statutory Guidance and Health and Care Quality Standards published in April 2023 recognise our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality management and quality improvement and innovation. Learning is seen as one of the six quality enablers in the new Health and Care Quality Standards. This supports the existing Putting Things Right Regulations (2011) which are currently undergoing a comprehensive review.

## Asesiad / Assessment

This framework is intended to support staff and enable the Health Board to become a Listening and Learning Organisation. The following principles will underpin the framework to consistently review our practice through the lens of Quality, Patient Safety and Experience:

Develop and embed a culture of continuous learning and improvement across the Health Board, identifying opportunities to seek feedback, draw on good practice, understand and minimise the risk of poor practice or duplication.

Supporting staff to be open about mistakes which allows valuable lessons to be learnt so the risk of errors reoccurring can be minimised. The learning environment must support all staff to raise and respond to concerns about patient safety.

Stakeholders such as Patients, Carers, Clinical Teams, Clinical Educators, Workforce and Organisational Development, Equality leads, Clinical Audit, Quality Improvement Teams and our external stakeholder partners will be key investors in building knowledge and learning.

Divisions take ownership and responsibility for disseminating learning to all their employees, colleagues, using appropriate methodologies and evidence that this has been implemented appropriately.

Staff should be fully involved in learning activities and be invited to contribute their perspectives within a positive learning environment that fosters a safe space for learning.

Improvement is sustained through monitoring, and learning makes a real impact on Quality Patient Safety, Experience, and Outcomes. Sustained improvement is evidenced through review and monitoring.

Through the creation of People Participation Panels and our ongoing engagement, people who use our services, and our communities, are informed and fully engaged with Health Board service improvement and are encouraged and supported to contribute to our continuous learning processes.

The Health Board will share its learning with other organisations in the interests of national and global improvements to quality and safety of healthcare.

The Health Board is committed to engaging our patients, service users, families, and carers in identifying what the learning should be. Creating an environment where people feel comfortable and have opportunities to ask questions, ask for feedback, be respectfully critical, and suggest ideas is vital.

The framework provides roles and responsibilities within the framework and details our systemic approach to learning, ensuring learning is continually captured within an accessible Learning Repository and builds an Organisational Memory.

Argymhelliad / Recommendation

The Committee is requested to APPROVE the development of a Listening and Learning Framework.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3.3 Quality Improvement, Research and Innovation<br>3.1 Safe and Clinically Effective Care<br>6.3 Listening and Learning from Feedback<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Getting it right for children and young adults |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>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<br>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<br>Choose an item.<br>Choose an item. |

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

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| | Is EIA Required and included with this paper |
| Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment (EIA) completed | Choose an item.<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working<br><br>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<br>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives |

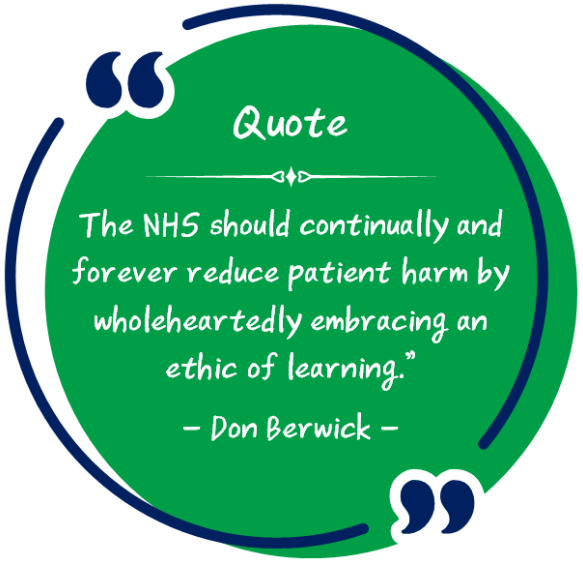
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

# LISTENING & LEARNING FRAMEWORK

# Contents

# Introduction

Aneurin Bevan University Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of healthcare organisations. Creating a culture of learning within the NHS is crucial for organisational improvement. It ensures positive experiences for patients and the delivery of person-centred, high-quality services, whilst supporting staff wellbeing. The Health Board is committed to promoting a culture which values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety, quality and experience.




Within the Health Board our commitment to learning is evident within both the Quality Strategy and Patient and Involvement Strategy. With set ambitions to develop a process and framework through which we will learn from patient safety incidents, audit, review and feedback from our patient, relatives, cares, staff, and communities.

This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.

This framework will compliment and build on divisional and directorate assurance arrangements by adding a strategic approach to support the Health Board to learn lessons from a range of internal and external sources. This will form part of our learning repository, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

## Key Quality for Health Care Organisations:

- Staff who feel psychologically safe
- Operating in a Just Culture, one that is constructive and a fair evaluation of the actions of staff involved in patient safety incidents
- Actively listening to those who use the services and key stakeholders
- Valuing and respecting diversity
- Open and honest culture (Duty of Candour
- A shared vision
- Good leadership at all levels
- Continuous self-reflection to assess performance in real time
- A sense of teamwork and openness and support for learning
- Strong learning ethos
- Staff engagement

## Learning Outcomes can include:

- Improved safety and reduced harm
- Improved patient and family experience
- Informed decision-making
- Increased efficiency or productivity
- Enhanced job satisfaction
- Better communication and teamworking
- Less stress or frustration
- More effective leadership
- Service redesign
- Reduced costs and appropriate use of NHS resources (Prudent Health Care)

# Purpose

This framework is intended to support staff and enable the Health Board to become a Listening and Learning Organisation. The following principles will underpin the framework to consistently review our practice through the lens of Quality, Patient Safety and Experience:

- Develop and embed a culture of continuous learning and improvement across the Health Board, identifying opportunities to seek feedback, draw on good practice, understand and minimise the risk of poor practice or duplication.

- Supporting staff to be open about mistakes which allows valuable lessons to be learnt so the risk of errors reoccurring can be minimised. The learning environment must support all staff to raise and respond to concerns about patient safety.

- Stakeholders such as Patients, Carers, Clinical Teams, Clinical Educators, Workforce and Organisational Development, Equality leads, Clinical Audit, Quality Improvement Teams and our external stakeholder partners will be key investors in building knowledge and learning.

- Divisions take ownership and responsibility for disseminating learning to all their employees, colleagues, using appropriate methodologies and evidence that this has been implemented appropriately.

- Staff should be fully involved in learning activities and be invited to contribute their perspectives within a positive learning environment that fosters a safe space for learning.

- Improvement is sustained through monitoring, and learning makes a real impact on Quality Patient Safety, Experience, and Outcomes. Sustained improvement is evidenced through review and monitoring.

- Through the creation of People Participation Panels and our ongoing engagement, people who use our services, and our communities, are informed and fully engaged with Health Board service improvement and are encouraged and supported to contribute to our continuous learning processes.

- The Health Board will share its learning with other organisations in the interests of national and global improvements to quality and safety of healthcare.

# Learning in Health Care

NHS Wales Duty of Quality Statutory Guidance and Health and Care Quality Standards published in April 2023 recognise our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality management and quality improvement and innovation. Learning is seen as one of the six quality enablers in the new Health and Care Quality Standards. This supports the existing Putting Things Right Regulations (2011) which are currently undergoing a comprehensive review.

# Our Approach to Learning

Organisational learning is more than the dissemination of safety information to staff. The biggest risk to successful learning is the failure to relate lessons to frontline clinical and nonclinical, e.g., housekeeping, portering and clerical.

Taking a systematic approach to learning involves a conscious decision to capture valuable lessons that will inform best practices and future activities to give the greatest chance of improved outcomes. Making access to data and learning resources easier is a priority for ABUHB. Appendix B details the key reports relating to organisational learning.

The Health Board is committed to engaging our patients, service users, families, and carers in identifying what the learning should be. Creating an environment where people feel comfortable and have opportunities to ask questions, ask for feedback, be respectfully critical, and suggest ideas is vital.

- Ensure learning from patient safety data and good practice. Quality, Patient Safety and Experience is an integral part of learning and should support a responsive approach in relation to emerging themes and trends.
- Ensure that patients, relatives, carers, staff and communities and key stakeholders have their voice heard and that this informs improvement, service delivery, change programmes and planning.
- Ensure that relevant performance data is captured, analysed and reported to inform decisions and priorities.
- Ensure that the Health Boards expectations are clear in respect of Organisational learning to support continuous improvement.
- Ensure that the workforce is suitably skilled, that they have access to relevant training and supervision and learning is of appropriate quantity and quality.
- Ensure we support a Just, Learning and Restorative Culture, avoiding blame when things go wrong so that our workforce feel safe and supported to raise concerns (Speaking Up Safely), as they are confident that we will learn from them.
- Ensure that the Health Board Strategies and Plans are informed, and focused, on relevant priorities that are meaningful to the population.
- Ensure that learning is continually captured within an accessible Learning Repository and builds an Organisational Memory.

# Our Approach to Seeking and Sharing the Learning

| LISTENING | LEARNING | SHARING LEARNING | IMPLEMENTING LEARNING | MONITORING LEARNING |
|---|---|---|---|---|
| Actively seeking experience feedback | Incidents | Listening and Learning Forum | Policies Group | Board Committees |
| Making it quick/easy to give feedback and facilitating a range of formats/languages | Complaints | Professional Fora | SMART Action Planning | Board Assurance Framework |
| Making it quick/easy for teams to submit the feedback that they receive | Claims | SharePoint/Learning Hub | Thematic Reviews | Quality, Patient Safety & Outcomes Committee |
| Analysis of feedback and way to quickly/easily share this back to services. | Inquests | Audit Meetings | Improvement Projects | Audit & Risk Committee |
| Dashboard reports for instant access to experience, compliments, incidents, complaints, themes & trends | Public Service Ombudsman for Wales | Grand Round | Learning from Events Reports | Safeguarding Committee |
| 'You said, we did' in public areas so that everyone can see that we take action as a result of their feedback | Audit and Research | Mortality/Morbidity Meetings | Training & Education | Divisional Quality & Safety Meetings |
| Creation of People Participation Panels inclusive of patients, carers, staff and other stakeholders | Peer Review | Safety Huddles | You Said, We Did | Directorate Quality & Safety Meetings |
| Evidence of a Just Culture, Human Factors & Psychological Safety | Patient Safety Reviews | Communication (Social Media, Newsletters, Bulletins, Alerts) | | Divisional Assurance Meetings |
| | Internal Reviews | Learning from Events Reports | | Performance Reports |
| | External Reviews | National Networks | | Incident/Complaints/Risk themes & trends/Triangulation with Performance & Assurance |
| | National Learning | Patient Stories at PQSOC and Board Meetings | | Patient/staff Feedback themes and trends |
| | Statutory Safeguarding Reviews and Domestic Homicide Reviews | People Participation Panels | | Training compliance |
| | | | | Audits |
| | | | | Quality Assurance Checks |
| | | | | Learning from Events Reports (LFER'S) |
| | | | | Ward Accreditation |
| | | | | Falls Review Panel |

# Roles and Responsibilities within a Learning Framework

All staff have a responsibility for contributing and responding to learning and improvement activity by:

- Celebrate and share your learning
- Complete a 'We Listened and Learned!' Sharing e-sheets (Appendix 2) to let others know and contribute to organisational knowledge and learning
- Link your learning to where it originated from i.e., incident, feedback, inquest, research for further information
- Ensuring any action planning is SMART – Specific, Measurable, Attainable, Relevant and Timely
- Learning environment must support all staff to raise and respond to concerns and 'Speaking up Safely'

All colleagues who lead and manage other people have a responsibility to:

- Ensure that patients are at the centre of learning and know that their concerns and experiences are listened to and not dismissed.
- Provide space, time and opportunities for individual and team learning.
- Ensure colleagues attend training and learning events.
- Ensure appropriate use of Datix modules to ensure actions and learning are captured to support Health Board responsibilities in relation to Putting Things Right Regulations.
- Encourage a Just, Learning and Restorative culture without blame to encourage people to raise concerns/incidents.
- Support colleagues when things go wrong.
- Showcase your local learning through Divisional Forums and any relevant organisational forums that celebrate good practice and improvement (i.e. Nursing & Midwifery Forum)
- Engaging in the Divisional Quality Assurance, Patient Safety & Patient Experience meetings.
- Providing performance information to the Divisional Quality Assurance, Patient Safety & Patient Experience Meetings to enable the groups to monitor data linked to learning.
- Providing a representative on the Health Board's Clinical Policy Group and Clinical Effectiveness Group to support, contribute to and drive recommended implementations/changes to Board documents and audits.
- Ensuring that lessons learnt are widely disseminated through changes to policies and procedures, updating of internal training programmes and through the implementation of action plans.
- Embedding learning into practice and using systems of evaluation, audit, and survey to quantify the impact of learning on practice.
- Sharing findings from external inspections, internal reviews and Quality Assurance and audit activity.
- Carers and families should be engaged through the Duty of Candour.
- Embedding learning, quality, and experience objectives in PADR's.
- Patients also need to be encouraged to speak up when things go wrong.

# Learning, Monitoring, Assurance and Governance

Oversight and monitoring is critical to ensure changes have the expected impact on outcomes, e.g., improved quality patient safety and patient experience, staff wellbeing, etc. Situations and demands will continue to change and organisational learning is a cycle with feedback triggering new insights and new learning.

The Health Board uses a variety of methods to monitor recommendations and actions arising from identified learning.

## COMMITTEES/GROUPS

The Health Board have various Board Committees and groups which have responsibility for receiving learning and monitoring improvements. Divisions will have quality assurance monitoring and evaluation systems. However, the Board and its Committees have responsibility for monitoring from a strategic cross-organisational perspective.

## LEARNING FROM EVENTS – THEMES & TRENDS

A database for recording and monitoring learning themes has been developed – a learning repository (see Appendix 1). This allows the Health Board to identify recurring themes so that appropriate action can be taken. This may entail:

- A thematic learning event
- Improvement approaches
- Targeted Communications
- Targeted Training
- Further audit work

## ACTION PLANNING

All investigations, reviews and audits result in the development of an outcome focussed action plan. A SMART plan should be aligned to the investigation that clearly sets out the actions that will need to be taken in response to the report to provide assurance. These actions should be pulled from the learning and recommendations that have been identified in the investigation.

Datix actions module facilitates a well-defined description of the goal to be achieved; tasks/steps that need to be carried out to reach the goal; people who will be in charge of carrying out each task; when will these tasks be completed (deadlines and milestones); resources needed to complete the tasks and measures to evaluate progress.

The majority of actions can be themed together in a plan that is monitored by an Organisational Tracker. Responsible individuals and review dates are clearly identified, and the various groups can review progress and/or re-audit specific actions. Progress updates will identify how progress has been made and will evidence the difference this has made to service quality, safety, experience, and effectiveness. This is a key element of measuring impact and evidencing Learning from Event.

## PERFORMANCE REPORTS

There are various performance reports utilised within the Health Board at divisional and organisational level for monitoring performance. These assist by holding leaders to account, assessing the current position, sharing findings with appropriate people and promotes transparency, candour, and good governance. These reports can identify areas for improvement and enables evidenced based decision making. Good information sharing within these reports serve to provide information in respect of early warning systems, processes to escalate concerns and take timely remedial action.

## ANNUAL REPORT

Our Annual Report is part of a suite of documents that provides our communities, regional partners, stakeholders, and the general public with information about the Health Board in terms of the care we provide and what we do to plan, deliver and improve healthcare, in order to meet changing demands and future challenges. It provides information about our performance and how we plan to improve upon this. It also acknowledges the importance of working with our service users, listening to their feedback, whilst ensuring that we deliver better services to meet their needs in the most effective, efficient, safe, and sustainable ways.

## AUDITS & QUALITY ASSURANCE

The Health Board has a Clinical Audit and Outcome Review Plan Annual Rolling Programme. The findings and recommendations from national clinical audit, outcome reviews and all other forms of internal reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by Health Boards and Trusts in Wales.

## LEARNING FROM EVENTS REPORTS

The Health Board are required to submit Learning from Events Reports to the Welsh Risk Pool for the reimbursement of claims and redress cases. This process begins when an incident takes place managed by the relevant Division, and supported by the Central Legal team who monitor and evidence that the learning has been completed and is embedded into operational and clinical practice.

## EDUCATION, TRAINING & COMPLIANCE

The use of technology and e-learning platforms has gained prominence in supporting organisational learning within the NHS. There are significant benefits of utilising online learning modules, virtual simulations, and mobile applications for staff training and development. These technologies provide flexible learning opportunities, enhance knowledge retention, and support continuous learning in a digital age. Monitoring training compliance is carried out in several ways within the Health Board. All mandatory training and compliance is captured on the NHS Wales Electronic Staff Record (ESR), other more localised training is held by line managers. Training compliance is important to evidence individual awareness and provide assurance of organisational preparedness to manage key quality and patient safety issues.

# LEARNING & QUALITY IMPROVEMENT

Improving quality is about making health care safe, timely, effective, efficient, equitable, and at it's core, patient-centred. This is best achieved through the systematic application of improvement science.

## QUALITY IMPROVEMENT (QI)

(QI) is about giving the people closet to issues affecting care quality the time, permission, skills, and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement.
(Quality improvement made simple (health.org.uk)

By embedding QI approaches into routine operational practice, as part of a wider organisational Quality Management System, we can deliver sustained improvements, not only in the quality, experience, productivity, and outcomes of care, but also in the lives of the people working in health care.

Whilst QI is everyone's business, we have a central ABCi QI Unit that aims to build QI capability and capacity for change across our organisation, engaging with colleagues, and partners to drive learning and QI efforts. We recognise that it is important to create the right conditions for improvement, and these should include the support of senior leaders, supportive and engaged colleagues and patients, and access to appropriate resources and skills.


## GOVERNANCE

The Quality, Patient Safety and Outcome Committee will receive regular reports identifying the themes and trends of organisational learning, how learning is being utilised and how this understanding and this has impacted upon outcomes for patients and colleagues.

# Appendix A: Learning Repository

*(The Learning Repository will have embedded links to the learning sources)*

| Themes | | Source 1 | Source 2 | Source 3 |
|---|---|---|---|---|
| 1 | Falls | | | |
| 2 | Pressure Damage | | | |
| 3 | Medication Errors | | | |
| 4 | Communication | | | |

# Appendix B: Sources of Learning and Approaches to Sharing and Improvement

| | Area of potential learning / new learning | Who is responsible for identifying what the learning should be and sharing this? | How will learning be shared? | Where will oversight and monitoring occur, including learning outcomes? |
|---|---|---|---|---|
| 1 | *Aggregated analysis of patient safety data to determine patterns, themes, and trends* | *Corporate Quality & Safety Teams*<br>*Local leads* | *Face to face safety briefings*<br>*Education programmes (rolling induction)*<br>*Digital platforms* | *Corporate & Directorate/Divisional Board meetings and patient safety reports and dashboards.* |
| 2 | *Analysis of individual incidents* | | | |
| 3 | *Analysis of individual complaints* | | | |
| 4 | *Analysis of individual claims / redress* | | | |

# Appendix B: Sources of Learning and Approaches to Sharing and Improvement

| Area of potential learning / new learning | | Who is responsible for identifying what the learning should be and sharing this? | How will learning be shared? | Where will oversight and monitoring occur, including learning outcomes? |
|---|---|---|---|---|
| 5 | *Clinical audit* | | | |
| 6 | *Healthcare Inspectorate Wales inspections (internal & external)* | | | |
| 7 | *Independent reviews and public inquiries (internal & external)* | | | |
| 8 | *Patient, service user, family, and public engagement activities.* | | | |
| 9 | *Patient, service user, family, and public feedback e.g., patient stories* | | | |

# Appendix B: Sources of Learning and Approaches to Sharing and Improvement

| | Area of potential learning / new learning | Who is responsible for identifying what the learning should be and sharing this? | How will learning be shared? | Where will oversight and monitoring occur, including learning outcomes? |
|---|---|---|---|---|
| 10 | *National networks (See Appendix C)* | | | |
| 11 | *Working collaboratively and learning with colleagues across the health system and wider (e.g. Joint Investigation Framework)* | | | |
| 12 | *Learning from Deaths (mortality reviews)* | | | |
| 13 | *Feedback from the Medical Examiner Service* | | | |
| 14 | *National alerts, thematic reviews e.g. NHS Wales Executive reports.* | | | |

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| | Area of potential learning / new learning | Who is responsible for identifying what the learning should be and sharing this? | How will learning be shared? | Where will oversight and monitoring occur, including learning outcomes? |
|---|---|---|---|---|
| 15 | *Board level engagement activities walkarounds, 15 Steps etc.* | | | |
| 16 | *Staff engagement activities, surveys, exit interviews, safety culture assessments, appraisals etc.* | | | |
| 17 | *Engagement / feedback from Trade Union Partners.* | | | |
| 18 | *Service reconfiguration, projects, and programmes.* | | | |
| 19 | *Educational organisations & surveys e.g., Health Education and Improvement Wales, Universities etc.* | | | |

# Appendix B: Sources of Learning and Approaches to Sharing and Improvement

| | Area of potential learning / new learning | Who is responsible for identifying what the learning should be and sharing this? | How will learning be shared? | Where will oversight and monitoring occur, including learning outcomes? |
|---|---|---|---|---|
| 20 | *Professional bodies e.g., Health& Care Professional Council, General Medical Council, Nursing and Midwifery Council, Royal Colleges etc.* | | | |
| 21 | *Quality improvement projects / programmes.* | | | |
| 22 | *Planning processes including the development and implementation of the Integrated Medium Term Plan.* | | | |
| 23 | *Internal and external audit reports e.g., internal audit and Audit Wales.* | | | |
| 24 | *WRP National Learning Advisory Panel including publications e.g. Doctrina.* | | | |

# Appendix B: Sources of Learning and Approaches to Sharing and Improvement

| | Area of potential learning / new learning | Who is responsible for identifying what the learning should be and sharing this? | How will learning be shared? | Where will oversight and monitoring occur, including learning outcomes? |
|---|---|---|---|---|
| 25 | *WRP Learning from Events Hub (in development).* | | | |
| 26 | *Safety II – learning from what went well.* | | | |
| 27 | *National clinical audits including Stroke (SSNAP), falls & fragility fracture audit programme, National Vascular Registry, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE).* | | | |

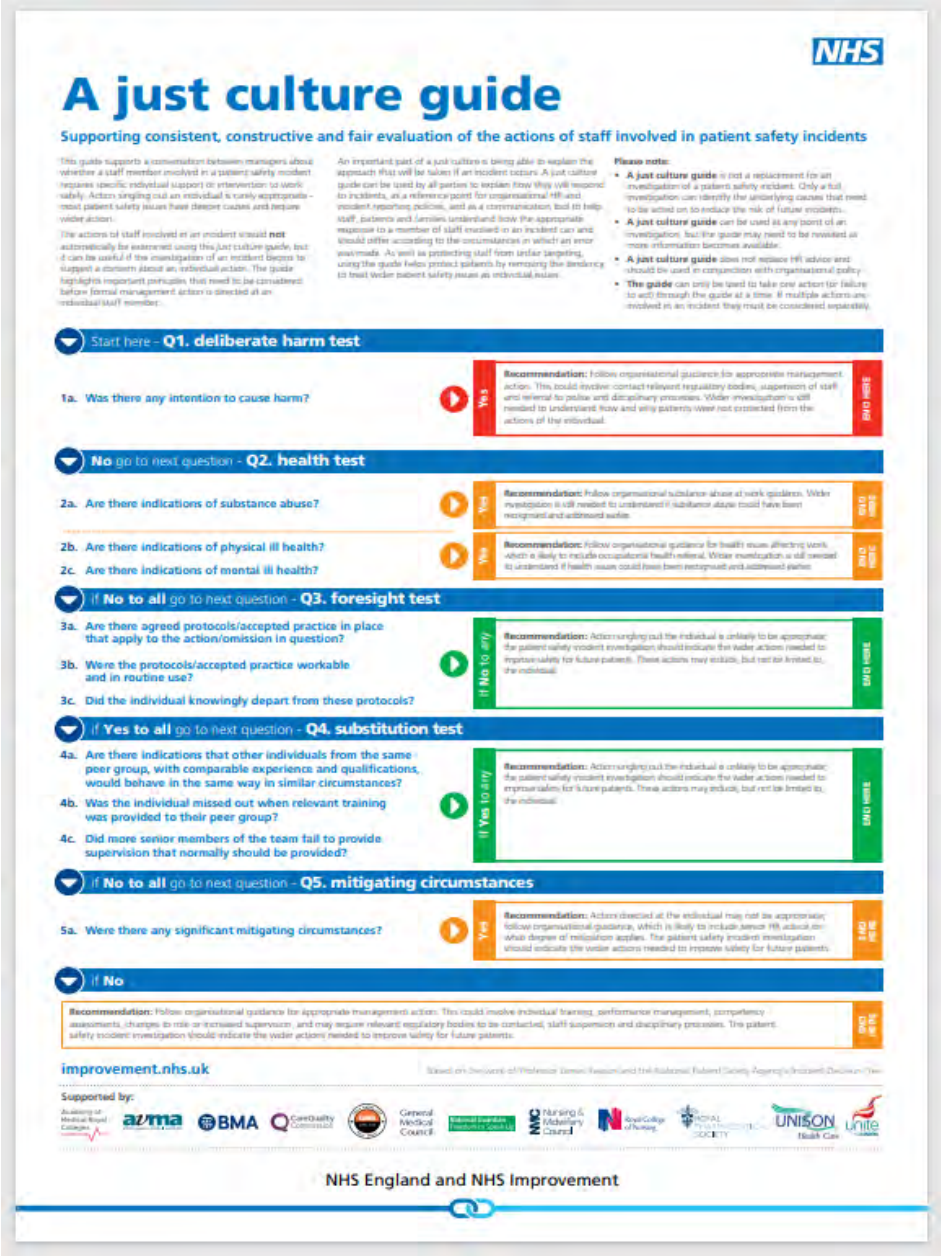
# Appendix C: Key Reports Containing Learning
## *(Corporate and Local)*

| | Report | Key Content | Overseeing Local Group / Committee / Board | Overseeing Corporate Group / Committee / Board |
|---|---|---|---|---|
| 1 | *Learning from Deaths Report*<br><br>*Example* | *Outcomes & learning from mortality reviews with patterns, themes, trends, collective intelligence, and RAMI.* | *Medical Directorate Clinical Board* | *Quality Committee*<br>*Health Board / Trust Board* |

# Appendix D: We Listened and Learned!
## *(Internal e-document)*

| What is the main theme? | Where id the learning come from? | Is there a Datix number? | Who is the Lead contact? (email) | *What did you do with the Learning/Did you make any changes/improvements?* | *How will this learning help improve quality & **safety*** |
|---|---|---|---|---|---|
| | | | | | |

# Appendix E: A Just Culture Guide



NHS

## A just culture guide

**Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents**

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate – most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be determined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

**Please note:**

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used as any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

**Start here – Q1. deliberate harm test**

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve contact relevant regulatory bodies, suspension of staff and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

**No** go to next question – **Q2. health test**

2a. Are there indications of substance abuse? Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. Are there indications of physical ill health?
2c. Are there indications of mental ill health? Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question – **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?
3b. Were the protocols/accepted practice workable and in routine use?
3c. Did the individual knowingly depart from these protocols?

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question – **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?
4b. Was the individual missed out when relevant training was provided to their peer group?
4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question – **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances? Yes → **Recommendation:** Actions directed at the individual may not be appropriate; follow organisational guidance, which is likely to include advice HR about the degree of culpability applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

**if No**

**Recommendation:** Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor Sidney Dekker and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement

Agenda Item:

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

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Patient Quality, Safety and Outcomes - Committee Forward Work Plan 2024/25 |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Director of Corporate Governance |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Head of Board Business |

| Pwrpas yr Adroddiad (dewiswch fel yn addas)<br>Purpose of the Report (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

The Patient Quality, Safety and Outcomes Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 to enable the Committee to: -

- Fulfil its Terms of Reference; and,
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference.

### Cefndir / Background

The purpose of the Patient Quality, Safety and Outcomes Committee is to support the Board by seeking assurance in respect of all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services.

In line with good governance practice, a Committee Forward Workplan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The workplan can therefore be utilised as a tool

for informing and pre-empting committee business and support the agenda setting process.

## Asesiad / Assessment

The Committee is requested to approve the Committee forward workplan as outlined in Appendix 1 noting that the workplan will be presented at each Committee meeting for oversight and noting.

## Argymhelliad / Recommendation

The Committee is requested to:

RECIEVE and APPROVE the proposed Committee workplan for 2024/25 and NOTE that it will be brought forward to each future Committee meeting for oversight.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol:<br>Corporate Risk Register Reference and Score: | The monitoring and reporting of committee business is a key element of the Health Boards assurance framework |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>Choose an item.<br>The Committee Forward Programme monitors delivery of objectives. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau: | N/A |

| | |
|---|---|
| Glossary of Terms: | |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board: | N/A |

| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
|---|---|
| Resource Assessment: | A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: |
| Workforce | Not Applicable |
| Service Activity & Performance | Not Applicable |
| Financial | Not Applicable |
| Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed | No does not meet requirements<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Not Applicable<br>Choose an item. |

Annual Programme of Business for 2024-25

Patient, Quality, Safety and Outcomes Committee

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

Aneurin Bevan University Health Board's Standing Orders;
The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
The outcomes of the Committee's self-assessment for 2023/24
The Board's Strategic Risk Register; and
Key statutory, national and best practice requirements and reporting arrangements.

| Area of Focus as per the Committee's Terms of Reference: |
| --- |
| The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services.<br>In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:<br>a. The robustness of the Health Board's Clinical Quality Governance arrangements;<br>b. the experience of patients, citizens and carers ensuring continuous learning;<br>c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and<br>d. the effectiveness of arrangements in place to support Improvement and Innovation. |

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

| MATTERS TO BE CONSIDERED | Lead | Frequency of Report | Schedule of Meetings | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | QTR 1 | | QTR 2 | QTR 3 | | QTR 4 |
| | | | 30th April | 4th June | 2nd July | 2nd Sept | 10th Dec | 4th Feb |
| **Preliminary Matters** | | | | | | | | |
| Attendance and Apologies | Chair | SI | √ | √ | √ | √ | √ | √ |
| Declarations of Interest | All members | SI | √ | √ | √ | √ | √ | √ |
| Minutes of the Previous Meeting | Chair | SI | √ | √ | √ | √ | √ | √ |
| Action Log and Matters Arising | Chair | SI | √ | √ | √ | √ | √ | √ |
| Reflections of the meeting held | Chair | SI | √ | √ | √ | √ | √ | √ |
| **Committee Governance** | | | | | | | | |
| Development of Committee Annual Programme of Business 2025/26 | Chair & DoCG | AN | | | | | √ | |
| Review of Committee Programme of Business 2024/25 | Chair | SI | √ | √ | √ | √ | √ | √ |
| Annual Review of Committee Terms of Reference 2024/25 | Chair & DoCG | AN | | | | | √ | |
| Annual Review of Committee Effectiveness 2024/25 | Chair & DOCG | AN | | | | | √ | |
| Outcome of Annual Review of Committee Effectiveness 2024/25 | Chair & DOCG | AN | | | | | | √ |
| Committee Annual Report 2023/24 | Chair & DOCG | AN | √ | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Committee Annual Report 2024/25 | Chair & DOCG | | | | | | | √ |
| Committee Risk Report | DOCG | SI | √ | √ | √ | √ | √ | √ |
| NHS Wales Joint Commissioning Quality Committee Report | DOCG | SI | √ | √ | √ | √ | √ | √ |
| Quality Governance Framework | | | | | | | | |
| Quality Strategy - Quality Outcome framework | DoN | AN | | | | | √ | |
| Quality Annual Report 2023/24 | DoN | AN | | | | √ | | |
| Quality Assurance Framework Annual Review and Evaluation of Progress | Clinical Executives | AN | | | | | | √ |
| Primary Care Quality Report | COO | Bi-AN | | | | √ | | |
| Performance Report on the Pillars of Quality, to include:-<br><br>Patient experience and stories<br>Incident reporting - falls/ pressure ulcers medicines management and mortality<br>Healthcare Inspectorate Wales Operational Plan<br>Complaint, concerns and compliments<br>Health Safety and Security<br>Infection Prevention and Control<br>Safeguarding<br>Clinical Negligence Claims and Coroners Inquests Report | DoN /MD & DOTHS | | | √ | √ | | √ | √ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Quality & Engagement (Wales) Act, Preparedness and Implementation<br>Tracking of Improvement Actions Arising from Inspections and Reviews<br>Cleaning Standards Annual Report<br>Infection Prevention and Control<br>MCA & DOLs<br>Child and Adolescent Mental Health Quality Outcomes Report, including self-harm and suicide<br>Operational Quality updates on:<br>o Cancer<br>o U&EC<br>o Planned Care | | | | | | | | |
| Pillars of Quality Interim Report | DoN | | √ | | | √ | | |
| Mental health and learning disabilities assurance | DoN | SI | √ | √ | √ | √ | √ | √ |
| Healthcare Inspectorate Wales Annual Report | DoN | | √ | | | | | |
| Report on National Review of Consent to examination and treatment standards in NHS Wales | MD | | | | | | √ | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Stroke Delivery Group Annual Report | DOTHS | | | | | | √ | |
| Commissioning Assurance Framework, Development, and Implementation | Clinical Executives | AN | | √ | | | | |
| Commissioning Outcomes Report | Clinical Executives | Bi-An | | | | √ | | √ |
| Putting Things Right Annual Report 2023/24 | DoN | AN | | | | √ | | |
| Maternity Services: Organisational Improvement and Action Plan | DoN | Bi-An | | | √ | | | √ |
| Learning from Death Report | MD | Bi-AN | √ | | | | √ | |
| Listening and Learning Framework | DoN | An | √ | | | | | |
| Listening and Learning Framework Outcomes report | DoN | Bi-an | | | | √ | | √ |
| Safe Care | | | | | | | | |
| Medical Devices Annual Report | DoT&HS | AN | | | | | √ | |
| Radiation Protection Group Annual Report | DoT&HS | AN | | | | | √ | |
| Falls and Bone Health Management Annual Report | DoT&HS | AN | | √ | | | | |
| Health and Safety Compliance Annual Report | DoT&HS | AN | | | √ | | | |
| Human Tissue Act Group Annual Report | DoT&HS | AN | | | | √ | | |
| Pharmacy and Medicines Management Annual Report | MD | AN | | | | | √ | |
| Safeguarding Annual Report | DoN | AN | | | | √ | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Effective Care | | | | | | | | |
| Research and Development Annual Report | MD | AN | | | | √ | | |
| Blood Management Annual Report | MD | AN | | | | √ | | |
| Organ Donation Annual Report | MD | AN | | | | √ | | |
| Annual Report on Clinical Audit Activity 2023 – 2024 | MD | AN | | √ | | | | |
| Clinical Audit Outcomes Report (Local and National) | MD | Quarterly | | √ | | √ | | √ |
| Overview of Audit Recommendation Tracking (relevant to the Committee) | DoCG | Quarterly | √ | | √ | | √ | |
| Internal Audit Reports relevant to the remit of the Committee | Clinical Executives | SI | √ | √ | √ | √ | √ | √ |
| External Audit Reports relevant to the remit of the Committee | Clinical Executives | SI | √ | √ | √ | √ | √ | √ |
| Nutrition and Hydration Committee Annual Report | DoT&HS | AN | | | | | √ | |
| Clinical Effectiveness and Standards Committee Report | MD | | | | | | √ | |
| Patient Centred Care | | | | | | | | |
| Children's Rights & Participation Forum | DoN | Bi-AN | | | √ | | | √ |
| Dementia Care Annual Report | DoN | AN | | | | √ | | |
| Child and Adolescent Mental Health Crisis Hub and Safe Accommodation | DoN | AN | | √ | | | | |

| Lead Officer | |
|---|---|
| Key | |
| CEO | Chief Executive |
| DoCG | Director of Corporate Governance |
| DoF&P | Director of Finance & Procurement |
| DoSP&P | Director of Strategy, Planning & Partnerships |
| COO | Chief Operating Officer |
| DPH | Director of Public Health |
| DoT&HS | Director of Therapies & Health Science |
| DoW&OD | Director of Workforce & Organisational Development |
| DoN | Director of Nursing |
| MD | Medical Director |
| DOD | Director of Digital |
| Chair | Chair |

| Frequency of Inclusion | |
|---|---|
| Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions | |
| SI | Standing Item |
| An | Annual |
| 1/4ly | Quarterly |
| BI | 1/2 yearly |

| Schedule of Meetings | |
|---|---|
| **√** | Scheduled agenda item in FWP |
| **D** | Deferred from this agenda |
| **√D** | Deferred Scheduled agenda item |
| **W** | Withdrawn from FWP |
| **T** | Transferred to another Committee |
| **IC** | Matter discussed In Committee |

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

# Patient Quality, Safety and Outcomes Committee

## Annual Report for 2023-24

April 2024

CONTENTS

## Foreword

## Chair's Foreword

I am pleased to present the Patient Quality, Safety and Outcome Committee's (the Committee's) Annual Report for the year ended 31 March 2024.

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

In particular, I welcome the approval of the Quality Strategy by the Board in March 2024, which will ensure that quality is embedded in our culture and that we are delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do.

Finally, I would like to express my personal appreciation to all who contributed to the patient quality, safety and outcomes agenda over the last 12-months.

Diolch yn Fawr / Thank you

Pippa Britton
Chair
Patient Quality, Safety and Committee

## 1. Introduction

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

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

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

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

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

1.4 This report describes how the PQSOC discharged its role and responsibilities during the period 1 April 2023 to 31 March 2024.

## 2 2023-24 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for PQSOC in 2023-24 is attached to this report (see Appendix 2).

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

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

## 3 PQSO Committee Meetings and Membership

3.1 During 2023-24, PQSOC met Six times via Microsoft Teams- in April 2023, June 2023, July 2023, October 2023, December 2023 and February 2024. Detail of the Independent Members and Executive Directors who attended these meetings is provided at Appendix 3.

3.2 The Committee comprised the following Independent Members:

- Pippa Britton Chair
- Louise Wright Vice Chair
- Paul Deneen
- Helen Sweetland

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

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

3.4 The Committee's agenda and papers were made public, save where it was necessary to meet 'in private', which it did on four occasions in 2023-24. Private meetings are held where it would not be appropriate to discuss a matter in public, due to issues of patient or staff confidentiality, commercial confidentiality, or discussion of serious incidents or escalated concerns which would not be in the public interest.

## 4 PQSOC Reporting Arrangements

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

## 5. PQSOC Work Programme: 2023-24

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

5.2 The Committee received a regular Committee Risk Report that details the summary of the key risks allocated to the Committee and the position of each risk. At the end of the year the Committee had 3 risks identified as a level of Extreme (20) which were:-

There was 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. – Risk level 20

There was a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. – Risk level 20

There was a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. – Risk level Extreme 20

5.3 During the year as part of managing risks, the Committee received an updated in relation to the management of medical devices and equipment within the Health Board. The Committee was advised of the challenges in achieving compliance with the 2017/18 Internal Audit recommendation. The Committee was assured that work had progressed to confirm the location of devices at ward level, noted improvements with staff competency whilst using devices and that the action was scheduled to be completed by May 2024. The Committee was advised that a Working Group within the QPS team would be established to ensure that compliance with recommendations was maintained and that a progress report would be brought back to the Committee in 2024.

5.4

At the February 2024 meeting, the Committee was provided with an overview of the internal and external audit recommendations resulting from the planned audit reviews that fall under the remit of the Committee. The audit reports were:

Health & Safety
Medical Equipment and Devices
Medicines Management
Monitoring Action Plan
Discharge Planning

Dementia Service
Structure Assessment
Putting Things Right: Advisory Review

The Committee was assured that appropriate action plans were in place to cover all recommendations with progress updates being provided to the Audit, Risk, Assurance Committee.

5.5

The Committee also received an update on the progress made in the development of the business case to replace the Pharmacy Robot at the RGH. The Committee was advised that the lifespan of the robot had been exceeded and was increasingly failing and noted that contingency plans had been developed should this occur. The Committee noted that the risk had been included in the corporate risk register and that a decision to procure and fund from next year's capital budget, a replacement pharmacy Robot had been made.

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

Duty of Candour Triggers

At the last meeting of the year, the Committee was advised that since 1 April 2023 to February 2024 there had been 20,807 incidents affecting patients reported on the Datix Cymru system, noting since the implementation of duty of candour reporting there had been an increase in incidents. The Committee noted that this was due to incidents being reported even if a patient did not come to harm.

In February 2024, it was agreed that the performance report would include a breakdown of reporting themes to improve the understanding.

Infection Prevention and Control

During the year the Committee noted that the main areas of infection concern was C.Difficile, and was advised that a deep dive had taken place on all patients testing positive since April 2023.

At the April 2023, the Committee received an update on Covid cases and noted that 32 positive incidents had been reported in respect of patients in hospitals. The Committee also noted that Covid-19 testing guidance had changed and that Covid would now be managed as a seasonal illness.

## Covid-19 Investigations

At the April 2023 meeting, the Committee noted that Wave 1 of Covid Investigations was 100% complete and was advised that Wave 2 and 3 was underway. The Committee was assured that the Health Boards reporting on this matter had been identified as one of the best.

## Fall incidents

Throughout the year the Committee received regular updates in respect of falls. At the April 2023 meeting, the Committee was advised that there had been a significant increase in falls throughout December 2022, when hospitals were under extreme winter demand and pressure. However, the Committee was assured to note at the December 2023 meeting that performance had improved and noted that there was now a consistent approach in place with regards to falls management as a result of the implementation of the falls policy that had been released in 2021.

## Health, safety and security

At February 2024 meeting, the Committee was advised that throughout the year there had been 94 incidents reported to the Health and Safety Executive (HSE), in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The Committee was also informed that the HSE had notified the Health Board of a breach in relation to health and safety law, as a result of the failure to report a fall at Nevill Hall Hospital in 2019 within the specified timeframe.

The Committee noted that 7 risk areas had been identified as a focus for improvement in 2024, and was assured that these would be progressed through the implementation of an action plan.

## Complaints, concerns and compliments

At the February 2024 meeting, the Committee was assured that progress had been made in responding to complaints with a 30-day period, although there was an acknowledgment that further work was required to achieve better compliance. The Committee was advised that a new Head of Complaints had been appointed earlier in the month and this role would be instrumental in securing improvements with compliance.

## HIW Inspection

At the last meeting of the year, the Committee was advised that a HIW inspection had been undertaken in January 2024, at the Talygarn Unit, County Hospital. Following the inspection the Committee was advised that an improvement notice had been issued in respect of the inspection which had been responded to.

5.7 The Committee was provided with an overview of the Maternity Services three-year improvement plan and agreed to receive regular progress updates. The Committee was assured that when implemented this would:

ensure the consistent provision of high quality individualised maternity care,
a approach to individualised, and,
a reduction in health inequalities.

5.8 Annual Reports

Throughout 2023/24, the Committee received the following Annual reports: -

Blood Management

The Annual Blood Management report provided the Committee with an overview of the progress made in addressing the priorities in respect of this area. The report acknowledged the assistance of the Hospital Transfusion Committee, and noted that one issue that remained was in respect of the level of compliance with traceability reporting and noted that a training plan was in place to address this matter.

Pharmacy and Medicines Management

The Committee received the Annual Pharmacy and Medicine Management report which confirmed progress in the four priority areas of safe prescribing; antimicrobial stewardship; cost efficiency; and access to medicine.

The report also outlined the following risks:-

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

The Committee was assured that the business case to renew the pharmacy robot had been developed.

Research and Development

The Research and Development strategy was presented to the Committee, noting that the Research and Development was a University Health Board function, and the Health Board would produce an annual report to showcase the work being undertaken on the implementation of the strategy throughout the year and an update on its future strategic development. The Committee noted that the aim was to develop an infrastructure where research and development could flourish and where the Health Board could maximise the benefits of its investment in the new Clinical Research Centre at the Royal Gwent Hospital.

Infection Prevention and Control

At the July 2023 meeting, the Committee received the Annual Infection Prevention and Control report. The report confirmed that statistically the Health Board was in the lower average rate for all infections in Wales. The report identified that it had been a challenging year for the team and that a restructure had taken place and the teams function now included infection prevention in the wider community.

The following was highlighted:-

The team were finalists for the Houdini Programme for the NHS Awards in Wales.

Covid and flu data showed lower hospital onset in comparison to other Health Boards.

The team has supported the following serious incidents, that included, a sporadic case of CJD, M-pox agenda, patient pathways and assessment of patients, increase in wound infections in trauma and orthopaedics, and Group A Strep infection.

Safeguarding

The Committee receive the statutory Annual Safeguarding report that highlighted:-

A learning Group had been established to monitor the progress of the recommendations of the priorities for 2022/23.

There were challenges around the national requirements for training compliance in respect of Level 3 Children and Adults. The Committee noted that this was as a result of the size of the cohort

requiring this training and was assured as to how the matter would be addressed.

Increase in the numbers of children being harmed, that had resulted in attendance at strategy meetings.

Increase in adult safeguarding concerns with a Datix submitted for each incident reported

The Committee was also informed that support was being provided to one local authority, as a result of their capacity issues and noted that a progress update would be provided at the April 2024 meeting.

Annual Clinical Audit Activity Report 2022/23

During the year the Committee received the Annual Clinical Audit Activity Report 2022/23, which included details of the Health Board's participation in the National Clinical Audit and Outcomes Review Plan for the present financial year. The Committee requested that future audit reports include a clear timeline of action, that when triangulated with data will enable greater assurance.

The Committee noted the following:-

The Clinical Audit team was to develop a clinical audit programme for 2023/2024.

the Health Board policy on Clinical Audit was to be updated.

AMaT audit management system would be implemented across the Health Board.

5.9 The Committee received an overview of the of the Health Boards priority outcomes that aligned to the 6 Pillars for the Quality Strategy framework that included how the outcomes would be delivered, measures and continuously improved:-

Priority 1 – Deliver PATIENT CENTRED care which involves patients, relatives, families, careers and system partners in the planning of care and opportunities to improve patient safety.

Priority 2 - Provide SAFE care. We aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

Priority 3 – provide TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time.

Priority 4 – Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome.

Priority 5 – provide care that is EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste.
Priority 6 – Provide EQUITABLE care, ensuring equal opportunities for individuals to attain their full potential for a healthy like which does not vary in quality and is non-discriminatory.

5.10

In October 2023, the Committee received the National Incident Reporting Policy that detailed the arrangements of revised incident reporting. The Committee was assured that the Health Boards Patient Safety Incident Reporting & Management Policy had been reviewed to align with the expectations set out in the new national policy that was published in May 2023.

In particular the Committee noted the following:-

Quality and patient safety resources would fall under the Nursing Directorate.

Clear engagement practices in respect of the management of incident investigations with families were in place.

A learning framework would be produced to ensure that learning from incidents informs quality patient safety planning processes.

A family liaison officer/point of contacts would be identified to support families/patients throughout investigations.

Staff support was provided throughout the investigation process.

5.11

In December 2023, the Committee received a report that detailed the outcomes of the review into Never Events that had been completed by Theatres. The review identified the following themes to be addressed that included wrong site injections and retained swabs. The Committee was assured that the Orthopaedic and Radiology Governance leads would continue to work with the Anaesthetist team to standardised the process across all Theatres.

## 6. Patient Centred Care

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

Alcohol Care Team
Children's Rights and Participation Forum
Tyleri Ward Community Resource Team.

## 7. Self-assessment and Evaluation

7.1 The outcome of the current years self-assessment that was reported to the Committee on 13th December 2023 confirmed that the results of the individual self-assessment, combined with the analysis of the three completed self-assessments determined that the Committee was 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. |

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<br>A programme of training for independent members to be developed<br>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 | 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 |
| 3 - Patient Experience and Involvement | | | |

| | | | |
|---|---|---|---|
| 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 |

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.

## 8. Key Areas of focus in 2024/25

8.1 As a result of the work of the Committee in 2023/24 the following areas of focus were identified:

Explore ways of ensuring greater assurance and opportunities for committee members to be better appraised of patient experience matters.

Strengthened focus on reporting of Joint Committee activity to this Committee.

Secure a greater understanding of those improvement projects through better reporting to the Committee and to capture this on the forward work plan for the Committee.

Health and Safety Assurance reporting to be strengthened to include a focus on risk and assurance gaps.

Agendas to include an item on reflection upon meeting to aid ongoing self evaluation.

## 9. Conclusion

9.1 This report provides a summary of the diverse and often complex work undertaken by the PQSOC during 2023-24, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

Appendix One


# Patient, Quality, Safety and Outcomes Committee

## Terms of Reference – 2022/23

Version: Approved

Date: March 2022

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

## 1. INTRODUCTION

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

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

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

## 2. PURPOSE

2.1 The scope of the Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience,

quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

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

2.1 ADVICE

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

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

2.2 ASSURANCE

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

a. The robustness of the Board's Clinical Quality Governance Arrangements;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and
d. the effectiveness of arrangements in place to support Improvement and Innovation.

## 3 DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

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

D. Seek assurance on the arrangements in place to support Research and Development and Improvement and Innovation, including:

- an overview of the research and development activity within the organisation;
- alignment with the national objectives published by Health and Care Research Wales (HCRW);
- an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for compliance with Health and Safety Regulations and Fire Safety Standards are sufficient, effective and robust, including:

- the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls,

patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

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

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

Authority

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

The Committee may seek any relevant information from any:

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

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

Access

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

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

Sub Committees

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

Committee Programme of Work

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

## 4 MEMBERSHIP

### Members

4.1 Membership will comprise of five (5) members:

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

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

### Attendees

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

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

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

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

other Executive Directors not listed above;

other Senior Managers and
other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

### Secretariat

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

### Member Appointments

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

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

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

### Support to Committee Members

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

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

## 5 COMMITTEE MEETINGS

### Quorum

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

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

## Frequency of Meetings

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

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

## Openness and Transparency

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

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

## Withdrawal of individuals in attendance

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

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

In these circumstances, when the Committee is not meeting in public

session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

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

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

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

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

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

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

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

## 7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is

considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

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

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

## 8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

Quorum
Issue of Committee papers

## 9. CHAIR'S ACTION ON URGENT MATTERS

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

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

## 10. REVIEW

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

| Matter to be Considered by Committee | Frequency | Responsible Lead | Scheduled Committee Dates 2023/24 | | | |
|---|---|---|---|---|---|---|
| | | | 26th July | 11th October | 13th December | 7th Feb |
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| Matter to be Considered by Committee | Frequency | Responsible Lead | Scheduled Committee Dates 2023/24 | | | |
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| Matter to be Considered by Committee | Frequency | Responsible Lead | Scheduled Committee Dates 2023/24 | | | |
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| Matter to be Considered by Committee | Frequency | Responsible Lead | Scheduled Committee Dates 2023/24 | | | |
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| Matter to be Considered by Committee | Frequency | Responsible Lead | Scheduled Committee Dates 2023/24 | | | |
|---|---|---|---|---|---|---|
| | | | 26th July | 11th October | 13th December | 7th Feb |
| | | | | | | |
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| *Review of Quality Governance Arrangements* | | | | ✓ | | |
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| 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 | | | | | | ✓ |
| Committee Self-Assessment Results | | | | | ✓ | |

Appendix Three

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

| Attended | Did Not Attend | Not a Member/Required Attendee |
|---|---|---|

| Meeting Dates | April | June | July | October | December | February |
|---|---|---|---|---|---|---|
| Independent Members | | | | | | |
| Pippa Britton | | | | | | |
| Louise Wright | | | | | | |
| Paul Deneen | | | | | | |
| Helen Sweetland | | | | | | |
| Executive Directors | | | | | | |
| Medical Director | | | | | | |
| Director of Therapies & Health Science | | | | | | |
| Director of Therapies & Health Science | | | | | | |
| Chief Executive | | | | | | |
| Director of Corporate Governance | | | | | | |

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

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Strategic Risk and Assurance Report |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Director of Corporate Governance |
| SWYDDOG ADRODD:<br>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

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.

The closing position at February 2024 was that the Committee Strategic Risk Register included four high-level strategic risks and four sub-risks. Since then, the Board approved changes to the Strategic Risk Register at its meeting in March 2024. Two of the approved changes relate to the delegated responsibility of the PQSO Committee and are outlined below.

SRR 003A: 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;* to the Corporate Risk Register.

The Board approved the de-escalation of sub-risk SRR 003A to the Corporate Risk Register, which will be monitored by the Executive Committee.

SRR 010: There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. *Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.*

The Board approved the reduction in score for SRR 010 as the 'Likelihood' of the risk occurring had changed from 'Likely' (risk score 4) to 'Possible' (risk score 3) on the basis that 80% of the Health, Safety, and Fire Improvement Plan 2023-24 had been implemented.

In recognition of the approved changes, the PQSO Committee Strategic Risk Register now includes three high-level strategic risks with three sub-risks, for which the Board has delegated responsibility for receiving and scrutinising assurances.

## Asesiad / Assessment

### Committee Risk Register

Table 1 displays the status as at April 2024 for the three strategic sub-risks delegated to the PQSO Committee. The three sub-risks have been reviewed and updated to provide the Committee with up-to-date information on the internal control system and sources of assurance for each sub-risk.

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

*Table 1*

| Risk Ref: | Risk Description | Sub-Risk | Risk Level | Within Appetite |
|---|---|---|---|---|
| SRR 005<br>Theme<br>Service Delivery<br>Appetite<br>Open<br>Score 16 and below | There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. | Due to inadequate arrangements to support system-wide patient flow. | High<br>3 x 4<br>(12) | Y |

| | | | | |
|---|---|---|---|---|
| SRR 008<br>Theme<br>Transformation & Partnership Working<br>Appetite<br>Open<br>Score 16 and below | There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public. | Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement. | High<br>2 x 4<br>(8) | Y |
| SRR 010<br>Theme<br>Compliance & Safety<br>Appetite<br>Minimal<br>Score 8 and below | There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. | Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments. | Extreme<br>3 x 4<br>(12) | N |

It should be noted that, while the risks have been updated to include improved control and assurances, the risk score or level for two of the sub-risks has not changed; but, because these are still well within the Health Board's risk appetite for the risk domain, the Committee can be assured that these risks are effectively mitigated. Work will continue with risk owners to manage the risk and ensure that the controls and assurances in place prevent the potential risk from occurring.

The decrease in SRR 010's risk score and exposure, while encouraging, remains outside of the Health Board's agreed-upon risk appetite for the Compliance and Safety risk domain, as shown in Table 1. However, the Improvement Plan has not been completed in its entirety, and there are still improvements to be made, which may result in the score reducing even further in the coming months.

Monitoring of SRR 010 will continue to be a key focus of the Committee, and the outcome of the scheduled Internal Audit of Health and Safety in 2024/25 will provide the Committee with the intelligence it needs to determine whether the Improvement plan is having the desired effect or whether the Board needs to make a formal decision on whether it is willing to accept the residual risk being held if the risk score does not move to within appetite.

Corporate Risk Register (CRR)

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 a high-level operational risk that was escalated to the CRR following the established escalation process outlined in the Risk Management Framework. The Pharmacy Directorate manages and updates the risk, with oversight from the Executive Committee due to the potential impact on the organisation and the investment required to eliminate the risk.

Enhanced oversight by the PQSO Committee provides an additional layer of control and assurance that the risk is managed appropriately and does not cause significant disruption to the organisation's operations.

The full risk assessment is attached as Appendix C.

*Table 2*

| Risk Ref: | Risk Description | Sub-Risk | Risk Level | Within Appetite |
|---|---|---|---|---|
| CRR 004<br>Theme<br>Service Delivery<br>Appetite<br>Open<br>Score 16 and below | There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. | Due to the current Pharmacy layout/robot at RGH being over 18 years old and not fit for purpose. | Extreme<br>(20) | N |

Furthermore, initial meetings with Directors have been held to discuss any potential high-level operational risks in their areas of responsibility that require the Executive Team's support and management via the Corporate Risk Register. Follow-up meetings will be scheduled throughout May to finalise their risk portfolio before an Executive Time-Out Session in June to review all strategic and corporate risks to ensure they are still reflective of the current operating environment and are being managed and monitored appropriately. A combined Risk Report will be presented to the Board at its meeting in July 2024.

The closing position as at April 2024 is that the Committee Strategic Risk Register includes three high-level risks with three sub-risks and one corporate risk.

## Argymhelliad / Recommendation

The Committee is requested to:

- NOTE the delegated strategic risks;
- NOTE the delegated corporate risk;
- NOTE the work being undertaken to reduce the risks to within appetite level; and,
- NOTE the ongoing work to improve risk management across the quality and patient safety domain.

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

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>Glossary of Terms: | N/A |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>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)<br>Impact: (must be completed) | |
|---|---|
| | Is EIA Required and included with this paper |
| Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment (EIA) completed | No does not meet requirements<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. |

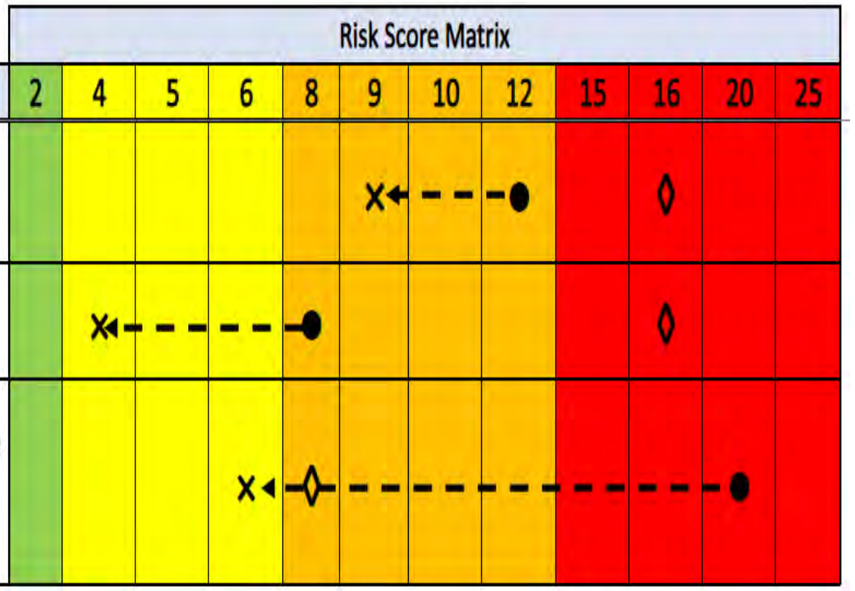
| | |
|---|---|
| | If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk |
| Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio<br>Well Being of Future Generations Act – 5 ways of working<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | N/A |



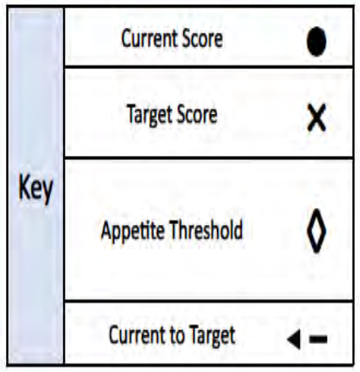
| Risk ID | Monitoring Committee | Risk Theme | Risk Owner | Risk Description | Reason For The Risk | Impact | Current Risk Score | | | | Risk Appetite | | Actions to Reduce Risk to Target | Assurance that the Risk is being manged effectively | Target Risk Score | | | | Review of Risk | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Likelihood Of The Risk Occuring | Impact Of Risk Occuring | Current Risk Score | Risk Level | Current Status Against Appetite | Risk Appetite and Threshold Explained | | | Likelihood Of The Risk Occuring | Impact Of Risk Occuring | Target Risk Score | Risk Level | Last Reviewed | Next Review |
| SRR 005 | Patient, Quality, Safety and Outcomes Committee | Service Delivery | Chief Operating Officer | There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system | a) Due to inadequate arrangements to support system-wide patient flow | • Avoidable deaths or significant harm<br>• Delays in releasing ambulances from hospital sites back into the community<br>• Delayed discharges from acute and non-acute settings resulting in deteriorating patients<br>• Litigation & Financial Penalties<br>• 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.<br>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:<br>Focus<br>Processing power<br>Capacity<br>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.<br>Regional flow processes not always supported with neighbouring HBs (Health Board) | Medium | 3 | 3 | 9 | Moderate | 01/04/2024 | 01/07/2024 |
| SRR 008 | Patient, Quality, Safety and Outcomes Committee | Transformation and Partnership Working | Director Of Nursing | There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners | Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement | • Adverse impact on patient experience<br>• Failure to deliver health board priorities, required improvements and achieve longer-term sustainability<br>• Reputational damage and loss of public confidence<br>• Failure to deliver Duty of Quality | 2 | 4 | 8 | Moderate | Below Appetite Level | Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure. | • Corporate Engagement Team<br>• Patient Experience and Involvement Strategy- organisational ownership<br>• Person Centred Care (PCC) Surveys via CIVICA<br>• PCC KPI's (support PCC Quality pillar)<br>• 'You said…… we did' public facing information for service areas.<br>• PLO service at GUH<br>• Introduction of PALS Service (Oct 23)<br>• Volunteer Patient Experience Feedback<br>• Collaboration to recruit community listeners to support Dementia Awareness<br>• Digital patient stories to support listening and learning.<br>• Patient Experience and Involvement Strategy<br>• DATIX | Medium | 2 | 2 | 4 | Low | 01/04/2024 | 01/07/2024 |
| SRR 010 | Patient, Quality, Safety and | Compliance and | Executive Director of Therapies | The Health Board will fail to protect the Health and Safety of staff, patients and | Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's | • Unintended physical harm;<br>• Punitive actions from the Health and Safety Executive (HSE);<br>• Increased levels of staff sickness; | 3 | 4 | 12 | High | Above | Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible; a | • Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices.<br>• Health and Safety Policies and Procedures<br>• Dedicated Health and Safety site on ABPULSE<br>• Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999 | Negative | 2 | 3 | 6 | Moderate | 01/04/2024 | 01/07/2024 |

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SRR 010 | Safety and Outcomes Committee | Safety | Therapies and Health Science | visitors in line with its duties under the Health and Safety at Work Act 1974 | the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments. | • Loss of estate due to unsafe environments;<br>• Financial implications;<br>• Adverse publicity; and,<br>• Reputational damage | 3 | 4 | 12 | High | Appetite Level | practicably possible. a negligible/low likelihood of occurance of the risk after application of controls. | requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'.<br>• Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression)<br>• Partial Programme of Health and Safety Monitoring (Active & Reactive)<br>• Corporate and Directorate Health and Safety Risk Register established. | Negative | 2 | 3 | 6 | Moderate | 01/04/2024 | 01/07/2024 |

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




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

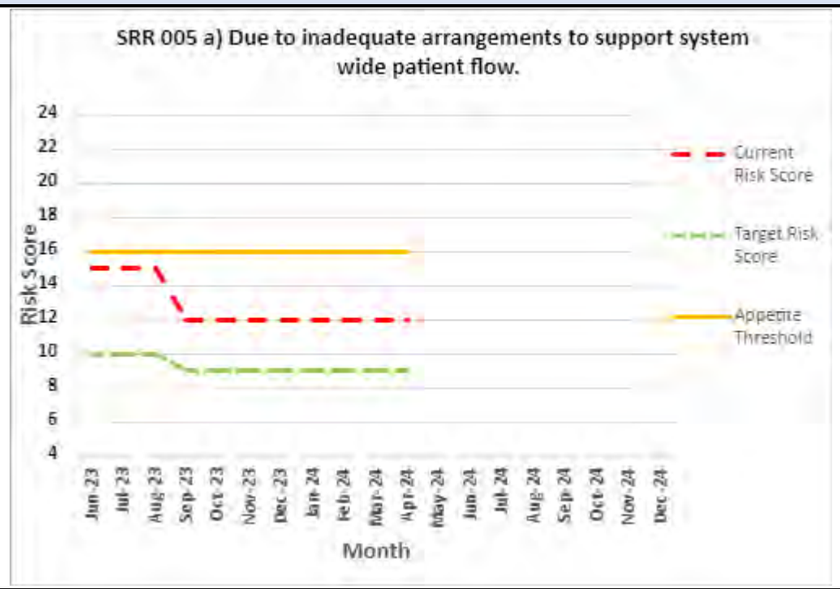


| RISK THEME | SERVICE DELIVERY | | | |
|---|---|---|---|---|
| **Strategic Risk (SRR 005)** | **There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.** | | | |
| **Strategic Threat** | **a) Due to inadequate arrangements to support system-wide patient flow** | | | |
| **Impact** | ➢ Avoidable deaths or significant harm<br>➢ Delays in releasing ambulances from hospital sites back into the community<br>➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients;<br>➢ Litigation & Financial Penalties<br>➢ 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)*<br>x | 3 *(Possible)*<br>x |
| **Initial Date of Assessment** | 01 June 2023 | **Impact** | 4 *(Catastrophic)* | 3 *(Minor)* |
| **Last Reviewed** | 01 April 2024 | **Risk rating** | **= 12**<br>*(High)* | **= 9**<br>*(High)* |
| **Next Review Due** | 01 July 2024 | | | |

**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**<br>*(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**<br>*(Are further controls possible to reduce risk exposure within tolerable range?)* | **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance/ Actions to Address Gaps**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Assurance Rating**<br>*(Overall Assessment)* |
|---|---|---|---|---|
| Escalation Policy.<br>Performance and Accountability Framework<br>Major incident Procedures<br>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.<br>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.<br>fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven.<br>Enhanced monitoring in place for U&EC<br>Range of performance measures/metrics in place | Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Workshops in diary.<br><br>Improve regional acceptance of flow processes with neighbouring Health Boards. | **Level 1 Operational**<br>*(Implemented by the department that performs daily operation activities)*<br>The Escalation Framework has been enacted and is effective in mitigating threats and impact to services.<br>Performance report against measures/metrics<br>**Level 2 Organisational**<br>*(Executed by risk management and compliance functions.)*<br>Divisional Assurance reviews.<br>Performance against measures/metrics reported to the Executive Committee<br>**Level 3 Independent** | **Gaps in Assurance**<br>Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers.<br><br>The impact of the Performance and Accountability framework in improving patient flow<br>**Action to Address Gaps in Assurance**<br>Close monitoring and reporting of the frameworks in practice to support learning and improvements. | **Reasonable Assurance** |

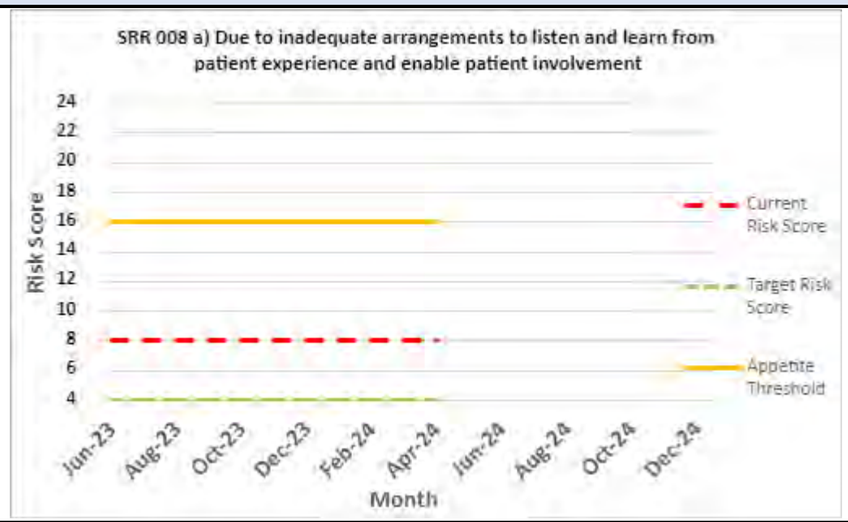
| | | | | |
|---|---|---|---|---|
| Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards.<br>Maximum Capacity Plan – Executive team 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.<br>Planned care recovery meetings with the NHS execs.<br>Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.<br>WG – IQPD meetings to review areas of focus. | | *(Implemented by both auditors internal and external independent bodies.)*<br>**Internal Audit Reviews**<br>1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024.<br>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<br>➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability<br>➢ Reputational damage and loss of public confidence<br>➢ 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)<br>x | 2 *(Unlikely)*<br>x |
| **Initial Date of Assessment** | 01 June 2023 | **Impact** | 4 *(Major)* | 2 *(Minor)* |
| **Last Reviewed** | 01 April 2024 | **Risk rating** | **= 8**<br>*(High)* | **= 4**<br>*(Moderate)* |
| **Next Review Due** | 01 July 2024 | | | |

**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**<br>*(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**<br>*(Are further controls possible to reduce risk exposure within tolerable range?)* | **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance/ Actions to Address Gaps**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Assurance Rating**<br>*(Overall Assessment)* |
|---|---|---|---|---|
| Corporate Engagement Team<br>Patient Experience and Involvement Strategy- organisational ownership<br>Person Centred Care (PCC) Surveys via CIVICA<br>PCC KPI's (support PCC Quality pillar)<br>'You said…… we did' public facing information for service areas.<br>PLO service at GUH<br>Introduction of PALS Service (Oct 23)<br>Volunteer Patient Experience Feedback<br>Collaboration to recruit community listeners to support Dementia Awareness<br>Digital patient stories to support listening and learning.<br>Patient Experience and Involvement Strategy | Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress.<br>PCCT staff training to support Civica data entry and retrieval.<br>Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners.<br>Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG<br>Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put | **Level 1 Operational**<br>*(Implemented by the department that performs daily operation activities)*<br>Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.<br>Concerns are fed back to divisional teams when identified.<br>Outcome of the volunteer feedback to drive improvements.<br>Patient Experience and Involvement Team undertaking Culturally Competent Accreditation<br>Immediate feedback and escalation to clinical teams following PALS queries and concerns<br>**Level 2 Organisational**<br>*(Executed by risk management and compliance functions.)* | **Gaps in Assurance**<br>No SMS provision to increase the number of PCC surveys.<br>No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns.<br>Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped.<br>Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.<br>**Action to Address Gaps in Assurance** | **Reasonable Assurance** |

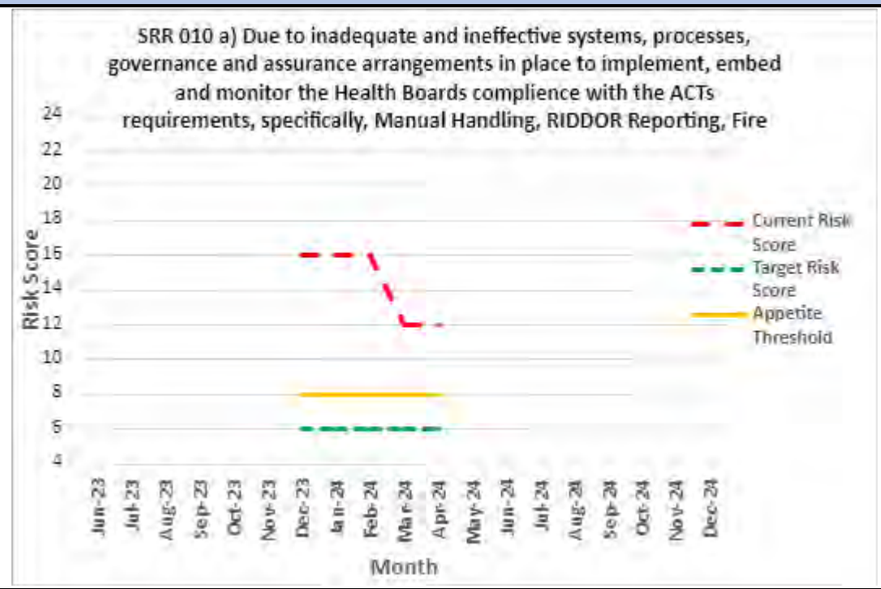
| | | | | |
|---|---|---|---|---|
| DATIX<br>Oversight of Medical Examiner reports to determine patient experience actions<br>Public Engagement- Big Conversation Bereavement held 20th March 2024<br>People Participation Panel ED in Progress | data. No SMS provision.- Discussions with VBHC to pilot SMS in ED through DrDoctor<br>National directives around new national surveys that need to be managed additional to internal roll out programme.<br>Volunteer feedback to be reviewed to identify themes. | Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO)<br>Listening and Learning reported through QPSOG/ Outcomes Committee<br>Implemented PALS DATIX Module<br>**Level 3 Independent**<br>*(Implemented by both auditors internal and external independent bodies.)*<br>LLais Reports<br>HIW inspections<br>Advocacy reports | Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED<br>PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms.<br>Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. | |

| RISK THEME | COMPLIANCE & SAFETY | | | |
|---|---|---|---|---|
| **Risk No: SRR 010** | **There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974** | | | |
| **Strategic Threat** | Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments. | | | |
| **Impact** | ➢ Unintended physical harm;<br>➢ Punitive actions from the Health and Safety Executive (HSE);<br>➢ Increased levels of staff sickness;<br>➢ Loss of estate due to unsafe environments;<br>➢ Financial implications;<br>➢ Adverse publicity; and,<br>➢ Reputational damage | | | |
| **Lead Director** | Director of Therapies & Health Science | **Risk Exposure** | **Current Level** | **Target Level** |
| **Monitoring Committee** | Patient Quality, Safety and Outcomes Committee | **Likelihood** | 3 (*possible)*<br>**x** | **2** (*Unlikely)*<br>**x** |
| **Initial Date of Assessment** | 01 December 2023 | **Impact** | ***4*** *(Major)* | **3** *(Moderate)* |
| **Date Reviewed** | 01 April 2024 | **Overall Risk Rating** | **= 12** *(High)* | **= 6** *(Moderate)* |
| **Date of Next Review** | 01 July 2024 | | | |

**Risk Appetite Level - MINIMAL.**
Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.

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

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




| **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)* |
|---|---|---|---|---|
| Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices.<br><br>Health and Safety Policies and Procedures<br><br>Dedicated Health and Safety site on ABPULSE<br><br>Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'.<br><br>Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression)<br><br>Partial Programme of Health and Safety Monitoring (Active & Reactive) | Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern.<br>Health and Safety Governance and reporting arrangements (Health and Safety Committee)<br>Develop and Implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System<br>Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments)<br>Consultation and communication with the workforce regarding compliance with the Act<br>New ways of working with Divisions to ensure accountability for health and safety is recognised.<br>Implement key performance indicators to monitor health and safety compliance.<br>Review the governance arrangements for the Health & Safety Committee | **Level 1 Operational** *(Implemented by the department that performs daily operation activities)*<br><br>Health and Safety compliance data extracted from ESR and Datix and reported<br><br>**Level 2 Organisational** *(Executed by risk management and compliance functions.)*<br><br>Established monitoring of H&S at the Executive Committee<br><br>Corporate H&S report risk and assurance to the Health and Safety Committee<br><br>Established monitoring of H&S at the PQSO Committee<br><br>**Level 3 Independent** | **Gaps in Assurance**<br><br>Implementation of a health and safety performance report<br><br>Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act.<br><br>Compliance on completion of risk assessments and mitigating actions<br><br>**Action to Address Gaps in Assurance**<br><br>Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework.<br><br>Review the membership and ToRs of the Health and Safety Committee | **Reasonable Assurance** |

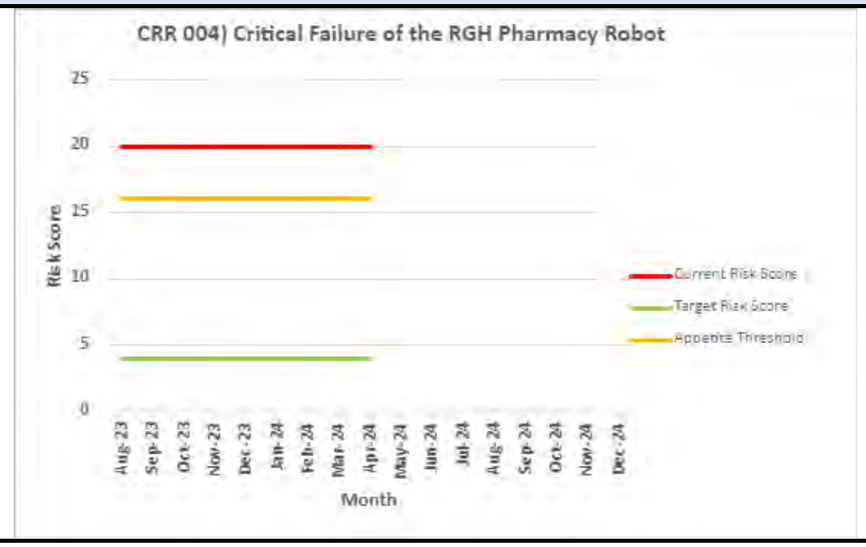
| | | | | |
|---|---|---|---|---|
| Corporate and Directorate Health and Safety Risk Register established. | Health and Safety Policies and Procedures to be reviewed.<br>Board Training /development<br>Onboard further Manual Handling trainers across the organisation to improve compliance.<br>Scope for training non-Health Board staff<br>Learning from events to be documented and communicated to the organisation. | *(Implemented by both auditors internal and external independent bodies.)*<br>Performance reviews at All Wales Health and Safety Management Steering Group<br>Internal Audit – H&S processes Review to be included in 2024/25 Plan.<br>South Wales Fire & Rescue Service fire safety audit programme.<br>Health and Safety Executive reviews/inspections. | Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan | |

| 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. Central to providing this function is the robot at the RGH Pharmacy Site effective – its 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 a potential impact on patient safety and flow. There have been several critical failures over the last few months that have lasted a few days and meant that the system has had to enact Business Continuity. This indicates the high fragility of the system and the very real likelihood of a total system crash that is unrepairable. | | | |
| **Impact** | ➢ Unintended patient harm from missed doses of medicines due to the disruption in supply.<br>➢ Impact on patient flow through our hospitals due to the delay in supplying medicines at discharge; reduced ability to process TTHs<br>➢ 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.<br>➢ 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)*<br>*x* | **1** *(Rare)*<br>x |
| **Initial Date of Assessment** | **01 July 2023** | **Impact** | **4** *(Major)* | **4** *(Major)* |
| **Last Reviewed** | **16 April 2024** | **Risk rating** | **= 20**<br>*(Extreme)* | **= 4**<br>*(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 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 and appetite threshold. The target level to be achieved is **within** the set appetite threshold.




| **Key Controls**<br>*(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**<br>*(Are further controls possible to reduce risk exposure within tolerable range?)* | **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance/ Actions to Address Gaps**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Assurance Rating**<br>*(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 before top-up trigger from RGH.<br><br>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.<br><br>A contingency plan is in place and is 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:<br><br>**Short Term -** To reduce the 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.<br><br>**Medium Term** - Redirect Omnicell automation from RGH to GUH for assigned Omnicells with the least diverse stockholding. This will require approximately 3-4 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 the release of Omnicell orders.<br><br>**Long Term** - Replacement of the Robot. | **Level 1 Operational**<br>*(Implemented by the department that performs daily operation activities)*<br>Check critical levels of stock reported daily.<br><br>The operational status of the Robot is monitored at the Pharmacy, Divisional Senior Leadership Team, and at Divisional Assurance meetings.<br><br>**Level 2 Organisational**<br>*(Executed by risk management and compliance functions.)*<br>Operational status of the robot and service delivery monitored by the Executive Committee through the Corporate Risk Register Report<br><br>Management of the risk is monitored by the PQSO Committee<br><br>Recorded and updated on Datix.<br><br>**Level 3 Independent** | **Gaps in Assurance**<br>Reporting on the number of medication incidents or patient harm related to a critical failure.<br><br>**Action to Address Gaps in Assurance**<br>Ensure that any medication-related DATIX reports are reviewed at the point of robot failure to determine the impact.<br><br>Ensure that the impact on staff is assessed following any critical failure, lessons learned, and contingency plan updated where necessary. | **Reasonable** |

| | | | | |
|---|---|---|---|---|
| | Executive Committee has agreed RGH robot as a priority from Capital monies in the 2024/25 program. Exec approval confirmed 11/04/24 for replacement project to proceed, awaiting Chairs Action to generate PO.<br><br>Project delivery anticipated in Q2/Q3 of 24/25. | *(Implemented by both auditors internal and external independent bodies.)*<br>Not applicable | | |

Agenda Item: 3.2

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

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Audit Recommendations Tracker |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Director of Corporate Governance |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Head of Corporate Risk and Assurance |

| Pwrpas yr Adroddiad (dewiswch fel yn addas)<br>Purpose of the Report (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

This report is presented to the Patient Quality, Safety, and Outcomes (PQSO) Committee to provide greater transparency and oversight into the implementation of internal and external recommendations resulting from planned audit reviews that fall under the purview of the PQSO Committee's agenda.

### Cefndir / Background

All NHS Wales bodies are subject to inspection by independent auditors, known as Internal (NHS Wales Shared Services Partnership [NWSSP]) and External Audit (Audit Wales), which provide an organisation with independent assurance.

The purpose of audit and assurance is to assess the presence and effectiveness of relevant controls and procedures. The audit findings provide valuable recommendations and insights to assist management in making improvements in the audited areas and across the Health Board.

The role of the Corporate Governance Directorate is to record and track the findings, which are then reported as a standard item to the Audit, Risk and Assurance Committee for assurance, ensuring that the actions in place to implement the

recommendations are carried out and completed within an appropriate time frame based on the assurance outcome and the priority rating of individual recommendations.

## Asesiad / Assessment

At the end of Quarter 4 (January 2024 – March 2024) there are 26 active recommendations across seven audit reports owned by the Clinical Executives; these are listed below: -

Medical Equipment and Devices (2017/18)
Medicines Management (2021)
Monitoring Action Plans (2022)
Discharge Planning (2022)
Dementia Services (2022)
Structured Assessment (2022)
Putting Things Right: Advisory Review (2022/23)

Table 1 below summarises the 26 recommendations by 'Year,' 'Executive Lead,' and 'Priority Rating. The colour coding within the tables is explained below. Further detail regarding the 26 recommendations can be found in Appendix A.

| Key – Recommendation Priority Rating | | | |
|---|---|---|---|
| N/A | Low | Medium | High |

*Table 1*

| All Recommendations by Year,' 'Executive Lead,' and 'Priority Rating | | | | | |
|---|---|---|---|---|---|
| Year | Lead Director | | | | Total |
| | Director of Nursing | | | Medical Director | Director of Therapies & Health Science | |
| 2017 | - | | | - | 2 | 2 |
| 2021 | - | | | 1 | - | 1 |
| 2022 | 1* | 7 | 7 | 4 | - | - | 19 |
| 2023 | 2 | | 2 | | - | - | 4 |
| Total | 23 | | | 1 | 2 | 26 |

*Denotes one external audit recommendation. The remaining 25 are internal audit recommendations.

The recommendations are grouped into two categories: 'overdue' and 'not yet due'.

'Overdue' represents recommendations that have passed their original or revised implementation date, while 'Not Yet Due' refers to recommendations that have an original or agreed-upon revised implementation date but have not triggered as 'overdue', so no update has been requested.

Table 3 represents the 3 recommendations Overdue.

*Table 3*

| Number of Overdue Recommendations by Lead Director | | | | |
|---|---|---|---|---|
| Year | Lead Director | | | Total |
| | Director of Nursing | Medical Director | Director of Therapies & Health Science | |
| 2022 | 2 | - | - | 2 |
| 2023 | 1 | - | - | 1 |
| Total | 3 | - | - | 3 |

Table 4 represents the 23 recommendations Not Yet Due.

*Table 4*

| Number of Not Yet Due Recommendations by Lead Director | | | | |
|---|---|---|---|---|
| Year | Lead Director | | | Total |
| | Director of Nursing | Medical Director | Director of Therapies & Health Science | |
| 2017 | - | - | 2 | 2 |
| 2021 | - | 1 | - | 1 |
| 2022 | 1* 7 5 4 | - | - | 17 |
| 2023 | 1 2 | - | - | 3 |
| Total | 20 | 1 | 2 | 23 |

While it is important for the Committee to be reassured that work is underway to implement the three overdue recommendations, there are 15 recommendations where the original deadlines as specified in the final reports have passed, and these recommendations should receive equal scrutiny.

At its meeting on 16 April 2024, the Audit Risk and Assurance (AR&A) Committee reviewed the Audit Recommendation Tracker for the reporting period of Quarter 4, 2023/24 (January 2024 – March 2024) and approved its closing position, which included the status of the recommendations in this report. The AR&A Committee will continue to monitor progress towards implementation and is responsible for scrutinising and receiving assurance on behalf of the Board.

## Argymhelliad / Recommendation

NOTE the position of the 26 audit recommendations.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: | Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary. |

| | |
|---|---|
| Corporate Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd: Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>Choose an item.<br>Integral to the delivery of the IMTP |
| Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP | Governance |
| Amcanion cydraddoldeb strategol Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| Gwybodaeth Ychwanegol: Further Information: | |
|---|---|
| Ar sail tystiolaeth: Evidence Base: | N/A |
| Rhestr Termau: Glossary of Terms: | All terms are explained within the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board: | N/A |

| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
|---|---|
| Resource Assessment: | A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: |
| Workforce | Not Applicable |
| Service Activity & Performance | Not Applicable |
| Financial | Not Applicable |
| Asesiad Effaith Cydraddoldeb | 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.<br>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<br>Well Being of Future Generations Act – 5 ways of working<br><br>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<br>Choose an item. |

| Audit Type | ABUHB Ref No: | Report Title | Assurance Rating | Director | Priority | Recommen-dation No. | Recommendation | Management Response | Deadline Agreed in Final Report | Months passed Agreed Deadline | Proposed Revised Deadline | Months passed Revised Deadline | Date Revised Deadline was approved by ARAC Comittee | Final Report Deadline Status | Revised Deadline Status | If closed and not complete please provide justification and ensure evidence is avaliable | Progress of work underway | Barriers to implementation including any interdependencies | How is the risk identified being mitigated pending implementation? | What evidence is available to close/complete the recommendation? | Reporting Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal | 2017.00 | Medical Equipment and Devices (2017/18) | Limited | Director of Therapies and Health Science | High | R1 | R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. | The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management. | 31/03/2018 | -71.87 | 30/04/2024 | | | Overdue | Not Yet Due | | March 2024: The Health Board is compliant with the parts of the recommendation that, (a) registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details, (b) that the register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed, (d) discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded, and (e) going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. The Health Board is currently partially compliant concerning the part of the recommendation that (c) each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. "A centrally managed industry standard pan-organisation medical equipment register (Softpro Medusa) is in place and operational. The database records medical equipment management information on each item of equipment, including the location where each item is deployed. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralised register via an on-line Customer Portal. The database is overseen by the Health Board's Medical Electronics and Bio-medical Engineering (EMBE) service. There is a programme of periodic register accuracy reviews and of auditing the review processes. The register captures equipment lifecycle stage events and changes to the departments to which particular equipment is allocated. A rolling review programme applied during EBME's routine actions. This will be automated once the RF tracking system is fully implemented. • There is an identified need to create a user guide for using the Medusa Customer Portal. The EBME Service is compiling this information. • The QPS Risk Management team has an audit of non-medical equipment not already recorded in the database ready to deploy. | January 2024: The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle. EBME have not had the resources to create the Customer Portal instructions and disseminate them. The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's. | January 2024: The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified: · Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate. · Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. · Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually. · Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this. | Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH. | 31/03/2024 |
| Internal | 2021.20 | Medicines Managment | Reasonable | Medical Director | Medium | R2 | R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required. | The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed. | 31/03/2023 | -12.00 | 31/05/2024 | | | Overdue | Not Yet Due | | Update March 2024: Policy extended with review date 31st May 2024. Revised policy due to be provided to Clinical Policy & Standards Group 9th May 2024. Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023. A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and Policy Group in November 2023 for approval. | Delay due to HMRC licencing requirements | | ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6 | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Low | R2 | Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings | This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal. | 01/06/2023 | -9.97 | 30/09/2024 | | | Overdue | Not Yet Due | | March 2024: The challenge of raising awareness of the benefits of this biographical tool is part of an ongoing programme of improvements through the Meaningful Activities and engagement training delivered monthly from the patient Experience and Involvement team. The national Improvement Cymru team are facilitating an All Wales Biographical tool discussion and implementation group which will help support this message of this tool. Dates unconfirmed as being led by Improvement Cymru. Review September 2024 Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network. | | | Michelle to confirm | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Medium | R3 | It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system | We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff | 01/07/2023 | -8.98 | 01/10/2024 | | | Overdue | Not Yet Due | | March 2024: Applying an Alert to WCCIS was not achievable. The system is not HB wide and time limited. As part of the National Audit of Dementia and the Dementia Hospital Steering group and alert has been introduced for the CWS (Clinical Work Station). An alert will be displayed on patient record using an input code of 136. A briefing document, flow chart and review process is in place to monitor the impact of this as a measurement of people with dementia on our inpatient wards and attending out patient departments. The GP read codes for dementia diagnosis have been reviewed by WG and a reminder document disseminated across MAS and NCN. Primary care divisions. | | | | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Low | R3 | Training should be provided to ensure a consistent approach for the electronic and paper records completion | We will review the training components and update where required, to ensure a consistent approach is adopted | 01/07/2023 | -8.98 | 31/07/2024 | | | Overdue | Not Yet Due | | March 2024: No further action via WCCIS. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work. | Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements. | Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia. | | 31/03/2024 |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Low | R4 | Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time. | Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream | 01/08/2023 | -7.97 | 31/10/2024 | | | Overdue | Not Yet Due | | March 2024: The Dementia Hospital Steering Group implements the All Wales Dementia Hospital Charter and as such are reviewing the KPI for measurement. The CWS Alert will help us to provide a framework to capture, admission, discharge, hospital moves and incidents. This Alert has been introduced in March 2024 and will be monitored and actions evolve as information is reviewed. The patient flow team have a regular invite to participate in the Dementia Hospital Steering Group.<br>Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work. | | | | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Low | R4 | Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process. | Patient Flow Team to consider this specific aspect, linked to the developed KPI's above | 01/09/2023 | -6.95 | 31/07/2024 | | | Overdue | Not Yet Due | | March 2024: Invitations have been sent to the Patient Flow Team to join the hospital dementia group. Still awaiting representation to be confirmed.<br>Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language team. | | | Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely. | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Low | R4 | There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff. | The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme. | 01/09/2023 | -6.95 | 31/08/2024 | | | Overdue | Not Yet Due | | March 2024: Colleague from the Welsh language team are members of the Dementia Hospital steering Group. Language preference and choice have been included on the patient bedside boards introduced to the COTE and medicine wards. The patient Experience and involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility.<br>Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews. | | | Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews. | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Low | R5 | Local initiatives with success stories should be channelled and discussed at existing forums. | Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards. | 01/09/2023 | -6.95 | 30/06/2024 | | | Overdue | Not Yet Due | | This is an ongoing action, monthly team meetings facilitate an opportunity to share feedback and consider how we use this feedback to influence practice and services. Patient feedback is used as a basis of QPS, Internal and external reporting. A 1 year reporting of VIPS will take place in April 2024. | | | | 31/03/2024 |
| Internal | 2023.02 | Putting Things Right; Final Advisory Review | Reasonable | Director of Nursing | Medium | R1 | A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so. | A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses. | 31/03/2024 | 0.00 | 30/09/2024 | | | Overdue | Not Yet Due | | March 2024: The OCP has now concluded on 9th February 2024. Centrailising all PTR teams to ensure PTR regulations are adhered to. Trajectory has been devised for all divisons the Health Board has comitted to be within the 75% Welsh Government target by September 2024. | | | | 31/03/2024 |
| Internal | 2023.02 | Putting Things Right; Final Advisory Review | Reasonable | Director of Nursing | High | R4 | Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently. | An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families | 31/12/2023 | -2.98 | 30/06/2024 | | | Overdue | Not Yet Due | | March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor complaince. The PALS service are now managing all grade 1 and 2 concens. | | | | 31/03/2024 |

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| Internal | 2023.02 | Putting Things Right; Final Advisory Review | Reasonable | Director of Nursing | High | R6 | Actions to address the circumstances that have led to individual complaints and those that have been identifed to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups. | Review all QPS resourses being undertaken via an OCP which will include learning. | 31/12/2023 | -2.98 | 30/09/2024 | | | Overdue | Not Yet Due | | March 2024: The organisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Listenting and learning operational group commenced March 2024. Listenting and learning framework under development. Will be completed End of May 2024. QI coaches training September 2024. | | | | 31/03/2024 |
| External | 2022.03EA | Structured Assessment 2022 | Not Rated | Director of Nursing | N/A | R3 | R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items. | A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items. | 31/03/2023 | -12.00 | 31/12/2024 | | | Overdue | Not Yet Due | | March 2024: Digital Story repository now being considered on an all Wales basis. In the meantime, the Patient Experience Team will oversee all digital stories and manage in person attendance at Board. Where possible these will align to presented papers .<br>June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. All Wales Experience Team reviweing. Review December 2024<br>Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023. | | | | 31/03/2024 |
| Internal | 2023.02 | Putting Things Right; Final Advisory Review | Reasonable | Director of Nursing | Medium | R5 | Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance. | Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require followng OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability frameowrk between the ursing Directorate and the Operational Divisons for QPS. | 31/12/2023 | -2.98 | | -1487.93 | | Overdue | | | March 2024: The orgaisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Working with datix team to ensure that actions are assigned on the datix system. | | | | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Medium | R2 | There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia | This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this | 01/06/2023 | -9.97 | | -1487.93 | 12/09/2023 | Overdue | Overdue | | March 2024: "OAMH dementia wards complete the Kings Fund audits on the three dementia wards.<br>They are piloting the ABUHB Accreditation audits on Cedar Park which will be rolled out on al OAMH wards which include environmental audits.<br>Ligature risk assessment audits are part of the ward OAMH yearly review. General hospital wards do not routinely use the Kings fund audits on wards, but the tool has been used to support individual ward improvement plans as part of the VIPS hospital dementia Friendly Hospital Charter implementation programme.<br>UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards. | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | Medium | R7 | We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further | The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of speciality, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme. | 01/10/2023 | -5.97 | | -1487.93 | | Overdue | Overdue | | March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review | | | | 31/03/2024 |
| Internal | 2017 | Medical Equipment and Devices (2017/18) | Limited | Director of Therapies and Health Science | Medium | R2 | R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency. | From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance. | 31/03/2018 | | 31/05/2024 | | | Overdue | Not Yet Due | | "Nov 2022: An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised.<br>• Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress.<br>• An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment.<br><br>Aug 2023:<br>• New infusion device service and training manager now in post.<br>• New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard.<br>• Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB.<br>• Training sessions delivered and open to substantive and bank staff to book.<br>• Strategic plan to incorporate cascade trainers into the training provision to increase compliance." | January 2024: Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale | "January 2024: The dominant risk factor related to this recommendation is that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster, this is assessed as a having a current risk exposure level of 9 (high). The following mitigation actions are identified: - Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update consolidated infusion training database accordingly - this would give assurance the organisation is running at an appropriate infusion training compliance level by providing an accurate denominating figure - Increase capacity for provision of infusion device training, including using manufacturer's training resource for revalidation training using a cascade training model This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post.<br>Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates.Need for fixed infusion device training base escalated and venue being sought." | New QPS Infusion Device Service Training Manager now in post.Consolidation of the infusion device training records aim to be achieved by end of Sept 23, Development of a dashboard to indicate compliance levels aim to be achieved by December 2023.Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies. | 31/03/2024 |

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| Internal | 2022.18 | Monitoring Action Plans | Reasonable | Director of Nursing | Low | R2 | Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report | The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced | 01/05/2023 | | 30/04/2024 | | | Overdue | Not Yet Due | | " Januray 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified.""This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks.<br>In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."" | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | Medium | R2 | We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended. | "The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation. " | 01/04/2024 | | | | | Not Yet Due | | | | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | High | R3 | All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification. | The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day | 01/04/2024 | | | | | Not Yet Due | | | | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | High | R3 | Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced. | The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual. | 01/04/2024 | | | | | Not Yet Due | | | | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | High | R3 | A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites | In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site. | 16/07/1905 | | | | | Not Yet Due | | | | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | Medium | R4 | A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported | Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy. | 01/01/1900 | | | | | Not Yet Due | | | | | | | 31/03/2024 |

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| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | Medium | R5 | Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded. | Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy. | /04/2024 | | | | | Not Yet Due | | | | | | | 31/03/2024 |
| Internal | 2022.19 | Discharge Planning | Limited | Director of Nursing | High | R6 | We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout | The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC | 01/04/2024 | | | | | Not Yet Due | | | | | | | 31/03/2024 |
| Internal | 2022.27 | Dementia Services | Reasonable | Director of Nursing | Medium | R1 | Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on. | The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response We agree with the current approach in the absence of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the implementation of these. However, as this will be closely integrated with performance metrics and current monitoring arrangements, we recommend | 01/07/2024 | | | | | Not Yet Due | | | | | | | 31/03/2024 |

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| CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN<br>ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING | |

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| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Learning from Deaths Report |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Dr James Calvert, Medical Director |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Leeanne Lewis, Assistant Director for Quality & Patient Safety |

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

## ADRODDIAD SCAA
## SBAR REPORT

Sefyllfa / Situation

UK Government has passed the legislation requiring scrutiny of all in-patient hospital and community deaths that are not referred directly to the Coroner by a Medical Examiner. This signals completion of the final recommendation of the Shipman Enquiry.

To ensure the Health Board benefits from the scrutiny of deaths by the Medical Examiner and to enable triangulation of other sources of information available with respect to patients deaths a “Learning from Death Framework” is under development. The attached submission is the first draft.

The aim is to publish a bi-annual report on the Health Board’s learning from deaths of patients under our care. The learning from deaths framework will describe a process of Ward-to-Board reporting and monitoring of mortality, through analysis of mortality data, trend analysis and triangulation of results with other sources of mortality information including our own mortality data and national clinical audit data, Medical Examiner reviews, Mortality and Morbidity (M&M) reviews and Inquests.

The framework aims to provide a stratified model of mortality data sub-divided into three tiers which will allow review of:

Tier One mortality indicators e.g. the Risk Adjusted Mortality Index (RAMI) which adjusts risk for individual patient risk factors/co-morbidities, crude all

cause and inpatient mortality. These system level indicators will include comparisons with peers.

Tier Two mortality indicators e.g. Divisional mortality indicators that will support a proposed approach to mortality oversight. Learning from deaths will be supported by identifying trends in mortality data that require additional action and scrutiny. These measures will include:

- Systematic reporting of mortality at Divisional Quality and Safety meetings or a similar forum.
- Triangulation of information from the Medical Examiner where increases in mortality rates are noted, e.g. if stroke deaths are observed to increase, thematic reviews of Medical Examiner referrals relating to this specific patient group will be undertaken to identify any contributory factors.
- Case note reviews will be undertaken where a Tier one mortality indicator raises concern about outcomes in a particular clinical area.
- Presentation of mortality themes and trends at the Health Board Mortality Review Group to support organisational learning.

Tier Three Mortality Indicators e.g.: Mortality indicators agreed in each Directorate based on results of national audit or benchmarking exercises. There are multiple clinical databases in use across the organisation and mortality data is included in many of these resources.

- Where an existing mortality measure does not exist, the Directorate and Quality and Patient Safety Team will work together to develop bespoke measures from CHKS (a health care intelligence system procured by the UHB).
- Reviewing National Clinical audit data available to specialities and consideration of benchmarking.

This framework will allow the Health Board to ensure our services are safe and effective and will facilitate scrutiny of outcomes of care.

Cefndir / Background

Thanks to advances in medicine over the past 100 years, we're all living longer, healthier lives. Approximately 1% of the UK population will die each year and the majority of these deaths will be predictable and observed in the 75 years and older age range.

Aneurin Bevan University Health Board provides care to patients from birth to death. Most patients experience excellent care from the NHS in the period leading up to their death. However, some patients do not experience the quality of care that they expect and to which we aspire. This can result from multiple contributory factors, identification of which can sometimes allow us to identify system-wide issues requiring improvement.

All deaths in Wales now receive independent scrutiny by The Medical Examiner Service, hosted by NHS Wales Shared Services Partnership. The ME Service provides scrutiny of all deaths that are not investigated by the coroner.

Medical Examiners (ME) are experienced doctors with additional training in death certification and the review of documented circumstances of death. The ME will ensure that an accurate cause of death is recorded and identifies any concerns surrounding the death itself which can then be further investigated if required, the views of the bereaved are also taken into consideration. The ME Service provides external, independent scrutiny of the quality-of-care delivery and reports back episodes of patient for the Health Board to investigate further.

Asesiad / Assessment

A learning from death report has been produced for the period October 2022 to December 2023.

Data collated for this report is attached and demonstrates that:

The Health Board's Risk adjusted Mortality Index (RAMI) is 108 compared to 103 in 2021.

Since the opening of the GUH data showed an improvement in the Health Board's Risk Adjusted Mortality Index over time for a substantial period but has gradually increased since Feb 2022. Whilst the Health Board is still performing better than the Welsh peer value average there has been an overall increase in RAMI which mirrors an increase in RAMI across Wales.

Whilst the Health Board RAMI has varied significantly; the crude mortality and mortality rate are flat and consistent. The difference in trends between RAMI and crude mortality arises as a result of the "risk adjustment" that takes place when a RAMI is calculated. Risk adjustment is based on coded data. Currently, the Health Board are not coding up to 19.5% of clinical episodes. Also, at present, the Health Board does report on depth of coding. Depth of coding describes the number of additional risk factors captured by coders, e.g. diabetes, hypertension. Availability of this data significantly affects accuracy of RAMI. Finally, there is differential case ascertainment of episodes of care with 100% of deaths coded meaning that deaths are overrepresented in the coded data.
Crude mortality has been reviewed since the outset of Covid as a measure of excess deaths relating to Covid, these deaths have decreased dramatically

Reporting of stillbirth, neonatal and maternal deaths follow a robust internal process and is reported to MBRRACE (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) and is case specific.
Death by suicide shows considerable variability from month to month but no particular trends are observed. In terms of other clinical trends, local data bears many similarities in terms of demographics, to national data collected

through both RTSSS and NCISH. Across all age groups, more men than women die by suicide or suspected suicide. This is significantly more likely in younger men aged 26 – 55 with the greatest difference between men and women in the 36–45-year category.
The Health Board Emergency Department admitted Mortality is better than peer comparators.
30-day MI inpatient mortality has increased compared to last year and is now 6.2% compared to 3.7% last year.

30-day inpatient stroke mortality is 10.1%, compared to 10% last year. This is still lower than the All-Wales peer value of 13.1% and is the lowest in Wales. The rate of mortality in hospital within 30 days of elective surgery was 0.03%, compared to 0.07% last year. This is lower than the All-Wales peer value of 0.15%.

The rate of mortality in hospital within 30 days of non-elective surgery is 1.5%, compared to 1.6% last year, which is still lower than the All-Wales peer value of 1.8%.
There is ongoing work to develop a Standard Operating Procedure to provide guidance for all staff involved in the mortality peer reviews. This will detail the deep dive process for the review of case notes.

For this reporting period, there have been a total of 797 referrals from the Medical Examiner's service. This is 24% of all in-patient deaths. 292 of these cases have been taken to the Mortality Review Screening Panel.

Learning has been disseminated in a newsletter to enable organisational learning from the ME reviews. The outcomes and themes from these reviews have been included in the report.

Argymhelliad / Recommendation

The Committee is requested to note development of a number of mortality indicators and the development of a Learning from Deaths framework. Comments are invited to support framework development.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3. Effective Care<br>3.1 Safe and Clinically Effective Care<br>3.3 Quality Improvement, Research and Innovation<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Getting it right for children and young adults |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>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<br>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<br>Choose an item.<br>Choose an item. |

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

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| | Is EIA Required and included with this paper |
| Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment (EIA) completed | Choose an item.<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working<br><br>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<br>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives |

# Mortality Data Learning from Deaths

OCTOBER 2022 TO DECEMBER 2023

# Introduction

This is a learning from deaths report for the period October 2022 – December 2023, to update PQSOC on established mortality indicators.

Following the completion of the Learning from Death Framework once agreed by Clinical Executive Leads, the Health Board will publish a bi-annual report on how we respond to and learn from deaths of patients who die under their management and care.

The development of the learning from deaths framework will support an approach of systematic ward to Board reporting and monitoring of mortality. This will include robust and accurate mortality data that can be made readily available to allow the identification of trends.

This will include the subsequent triangulation of condition specific mortality data with information from the Medical Examiner.

The framework will reinforce our commitment to undertake mortality reviews which will involve a systematic exercise to review a series of individual case records using a structured methodology. This will identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

# Introduction

The framework proposes a stratified model of mortality data sub-divided into three tiers allowing oversight:

Tier 1 Mortality **Indicators:** Health Board level **-** Reporting on RAMI, crude all cause and inpatient mortality, and comparison with peers.

Tier 2 **Mortality Indicators:** Divisional level - The identification of Divisional mortality indicators, this will further support the proposed approach to mortality oversight.

Tier 3 **Mortality Indicators:** Directorate level - Once Tier Two indicators are established work will progress to identify appropriate indicators in each Directorate.

This will enable a presentation of mortality themes and trends at the Health Board's Mortality Review Group to support organisational learning.

The development of mortality indicators will also involve working with the public health team. This will enable us to understand causation, how mortality is analysed, reported as a whole system approach and form part of the mortality framework.

A governance framework will be developed as part of the Learning from Death Framework to support a systematic approach to considering condition/procedure specific mortality in each Directorate which will include:

Systematic reporting of mortality data through Directorate Quality and Patient Safety meetings.

Triangulation of mortality data with the Medical Examiner reviews and Mortality and Morbidity (M&M) reviews and Inquests.

Formal assurance and escalation reporting system from M&M reviews.

Assurance and exception reporting to the Patient Quality and Safety Committee (PQSOC) meetings.

# ABUHB Sources of Data for Learning from Deaths

**Tier 1**

**External controls**

- Risk Adjusted Mortality Index (RAMI)
- ABUHB Crude Mortality Data
- All Cause Mortality Data
- Medical Examiner Service Scrutiny (inpatient deaths, to include community in due course)
- His Majesty's Coroners Processes

**Tier 2**

**Internal Mortality Control**

| Scheduled Care Division | Families and Therapies Division | Medicine Division | Primary Care and Community (including Complex Care) | Urgent Care Division | Mental Health and Learning Difficulties Division |
|---|---|---|---|---|---|
| M&Ms | PRUDiC | M&Ms | | M&Ms | |

**Tier 3**

**National Audit**

| Scheduled Care Division | Families and Therapies Division | Medicine Division | Primary Care and Community (including Complex Care) | Urgent Care Division | Mental Health and Learning Difficulties Division |
|---|---|---|---|---|---|
| Local mortality measures | Local mortality measures | Local mortality measures | Local mortality measures | Local mortality measures | Local mortality measures |
| | | | | | Suicide |
| | | | | | |
| NELA | Maternity and Neonatal Board | Cardiology – MNAP | NACEL | | NCISH |
| NHFD | MBRACE | Stroke – SSNAP | | | |
| National Cancer audits | NMPA | | | | |
| ITU - ICNARC | | | | | |

# Tier one Mortality Indicators RAMI

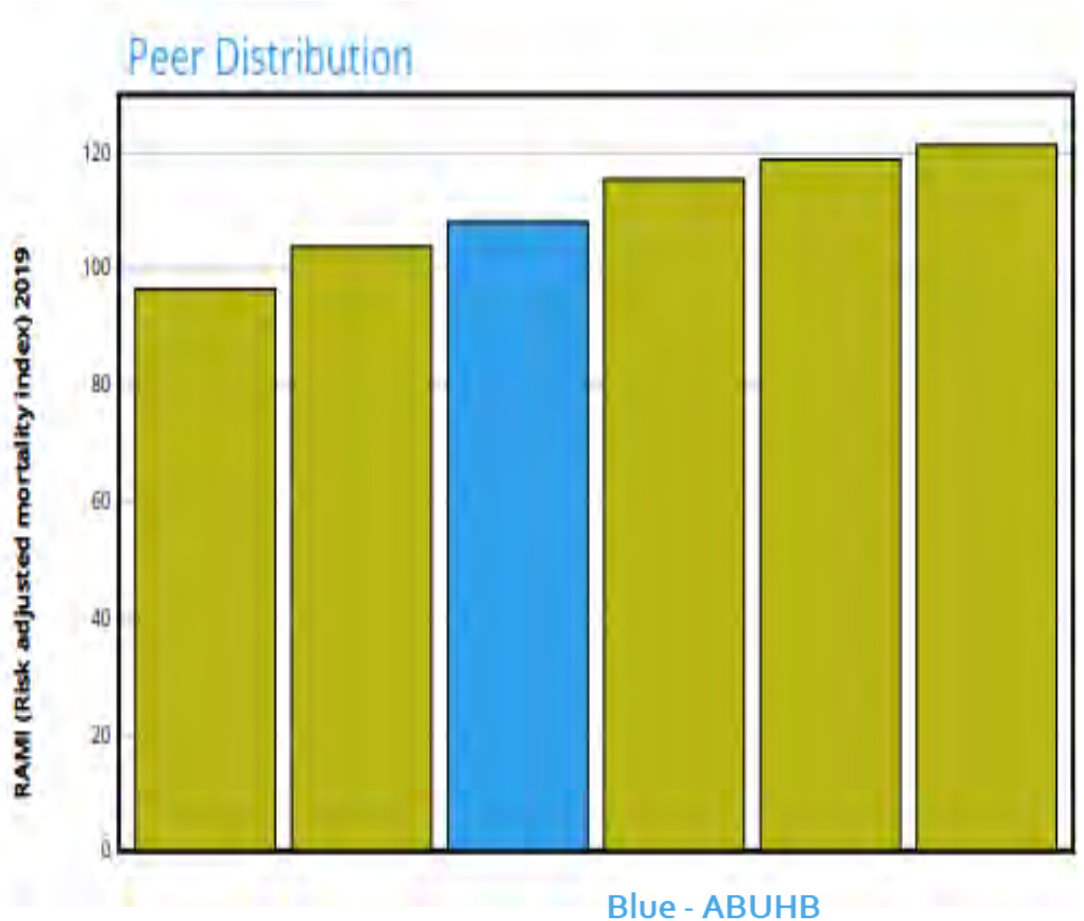
The Health Board's Risk adjusted Mortality Index (RAMI) is 108 compared to 103 in 2021.

The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations.

The accuracy of RAMI is dependent on the completion and accuracy of clinical coding.

In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers numerous sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit.

Palmer advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI).



# Coding

In October 2022 – December 2023 17.06% of the Health Board's finished consultant episodes were uncoded.

The national target for clinical code is 95% coding completion one month post episode discharge. The Health Board are currently coding at 80% because of increasing activity. The plan to achieve the national level is:

- Introduction of a new clinical coding structure, which will lead to a more thorough and robust process around improving clinical coding accuracy and compliance, clinician engagement, and making the team work more efficiently.
- Further development of coding automation through Robotic Process Automation (RPA) to assist us in reaching recommended coding completeness levels and allowing clinical coders to concentrate on the more complex coding. Such as patients with long length of stay

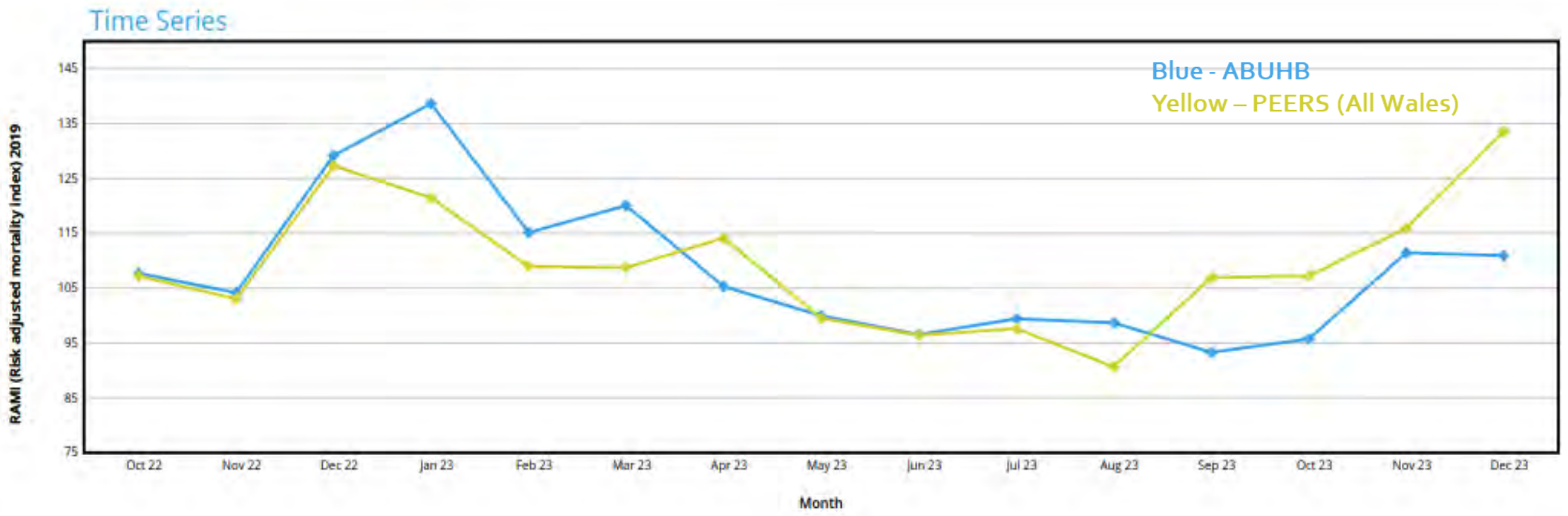
The Health Board has consistently scored well above the accuracy targets compared to all-Wales scores. Table demonstrates the results from the latest DHCW audit 2023/24 – the targets are 90% for primary diagnosis and procedure and 80% for secondary)

| Code Type | Total Number of Codes | Total Number of Correct Codes | Percentage Correct |
|---|---|---|---|
| Primary Diagnosis | 331 | 314 | 94.86% |
| Secondary Diagnosis | 1569 | 1477 | 94.14% |
| Primary Procedure | 196 | 186 | 94.90% |
| Secondary Procedure | 349 | 307 | 87.97% |

Depth of coding describes the number of additional risk factors captured by our coders, e.g. diabetes, hypertension. Availability of this data significantly affects accuracy of RAMI. The extent to which we code co-morbidities is we code all relevant co-morbidities documented within the patient record. Best practice for depth of coding is code main condition treated, all relevant procedures/interventions and all relevant co-morbidities within the patient record.

Improving the depth of coding and standardising our depth of coding will improve our accuracy of mortality data

# Tier one Mortality Indicators
# RAMI




ABUHB is currently performing better than the Welsh Peer Value average as an overall value of RAMI

Consistent and linear performance against Welsh Peers from April 2023

ABUHB is the 3rd best performing Health Board within the Welsh Peer Group

# Tier one Mortality Indicators RAMI

| | Local Numerator | Local Denominator | Oct 22 - Dec 23 | Peer Value | Performance |
|---|---|---|---|---|---|
| RAMI (Risk adjusted mortality index) 2019 | 3102 | 2805 | 110.58 | 106 | |
| 314 - Rehabilitation Medicine | 241 | 353 | 68.31 | 55.07 | |
| 110 - Trauma & Orthopaedics | 85 | 88 | 96.61 | 95.33 | |
| 328 - Stroke Medicine | 126 | 129 | 97.92 | 75.35 | |
| 300 - General Internal Medicine | 1068 | 1080 | 98.89 | 116.07 | |
| 100 - General Surgery | 258 | 250 | 103.22 | 103.45 | |
| 430 - Geriatric Medicine | 619 | 549 | 112.72 | 76.07 | |
| 320 - Cardiology | 83 | 68 | 121.74 | 106.40 | |
| 302 - Endocrinology and Diabetes | 31 | 22.9 | 135.14 | 94.57 | |
| 301 - Gastroenterology | 142 | 79 | 179.52 | 95.92 | |
| 340 - Respiratory Medicine | 324 | 154 | 211.03 | 127.80 | |
| 190 - Anaesthetics | 125 | 33 | 378.1 | 270.27 | |

RAMI filtered by specialty with a sample size of 25 patients or more

Lowest RAMI – Rehabilitation Medicine (Still higher than the Welsh Peer value)

Highest RAMI – Anaesthetics

ABUHB do not have the best performing RAMI in any of the selected specialties

Respiratory Medicine – Other HB's do not code under a generic RM code as much as ABUHB (Source Head of Information – ABUHB)

# Tier one Mortality Indicators
# Crude Mortality

| | Local Numerator | Local Denominator | Oct 22 - Dec 23 | Peer Value | Performance |
|---|---|---|---|---|---|
| Mortality Rate | 3449 | 132494 | 2.6031% | 3.359% | |
| 300 - General Internal Medicine | 1166 | 46164 | 2.5734% | 5.068% | |
| 430 - Geriatric Medicine | 749 | 6699 | 11.181% | 11.288% | |
| 340 - Respiratory Medicine | 339 | 4739 | 7.153% | 7.867% | |
| 314 - Rehabilitation Medicine | 283 | 3942 | 7.179% | 9.332% | |
| 100 - General Surgery | 261 | 28273 | 0.9231% | 1.2494% | |
| 301 - Gastroenterology | 147 | 21131 | 0.6957% | 0.8233% | |
| 328 - Stroke Medicine | 136 | 1816 | 7.489% | 11.849% | |
| 190 - Anaesthetics | 131 | 635 | 20.630% | 2.9106% | |
| 110 - Trauma & Orthopaedics | 91 | 16074 | 0.5661% | 1.3925% | |
| 320 - Cardiology | 84 | 2562 | 3.279% | 2.6340% | |
| 302 - Endocrinology and Diabetes | 40 | 459 | 8.715% | 6.512% | |

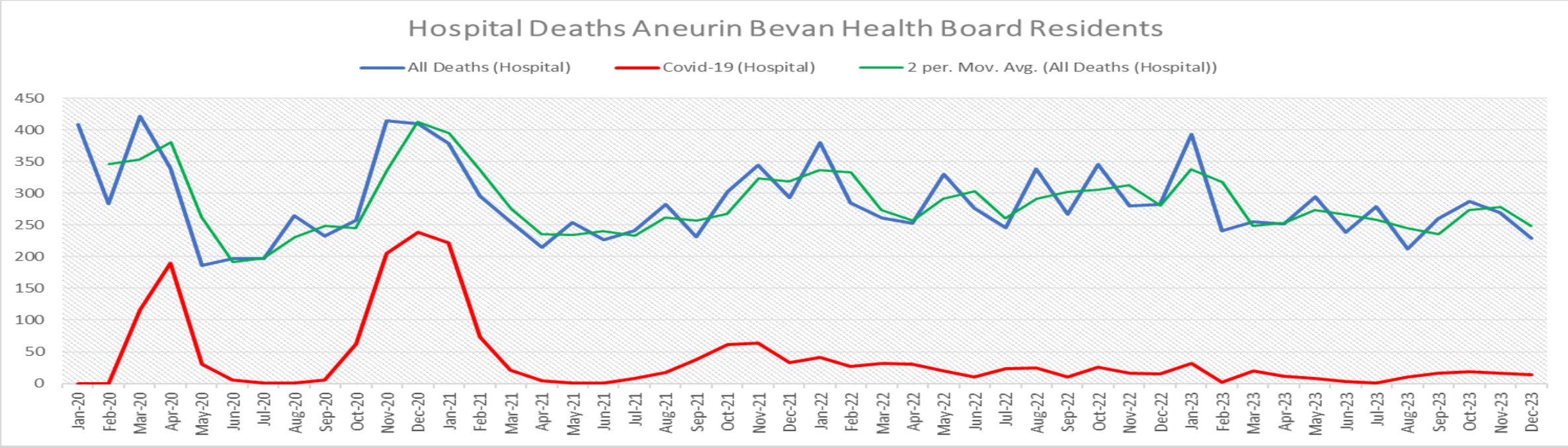
Selected specialties to reflect the RAMI specialties with a sample size of 25 patients or more

Less deaths within ABUHB per specialty compared to Peers

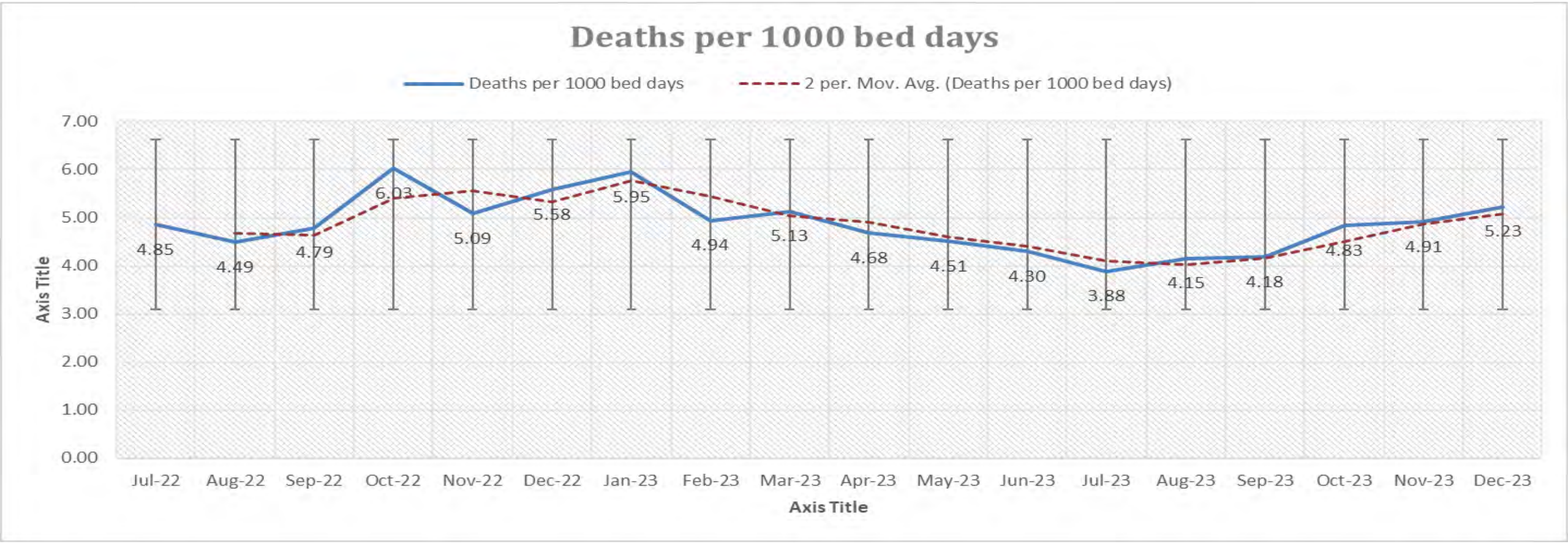
Outlier – Anaesthetics – 18% more deaths than the peers value – Deep dive required to assess if this is a factual representation or a difference in coding of deaths compared to other Health Boards.

# Tier one Mortality Indicators
# Crude mortality

Crude mortality compares the number of deaths across the entire population to the average for the same reporting period over the previous four years and supports identification of trends above or below this average. The measurement of all cause crude mortality was useful from the outset of Covid as a measure of excess deaths relating to Covid. The below illustrates crude all-cause mortality in Aneurin Bevan University Health Board as well as deaths where Covid was mentioned on the death certificate.

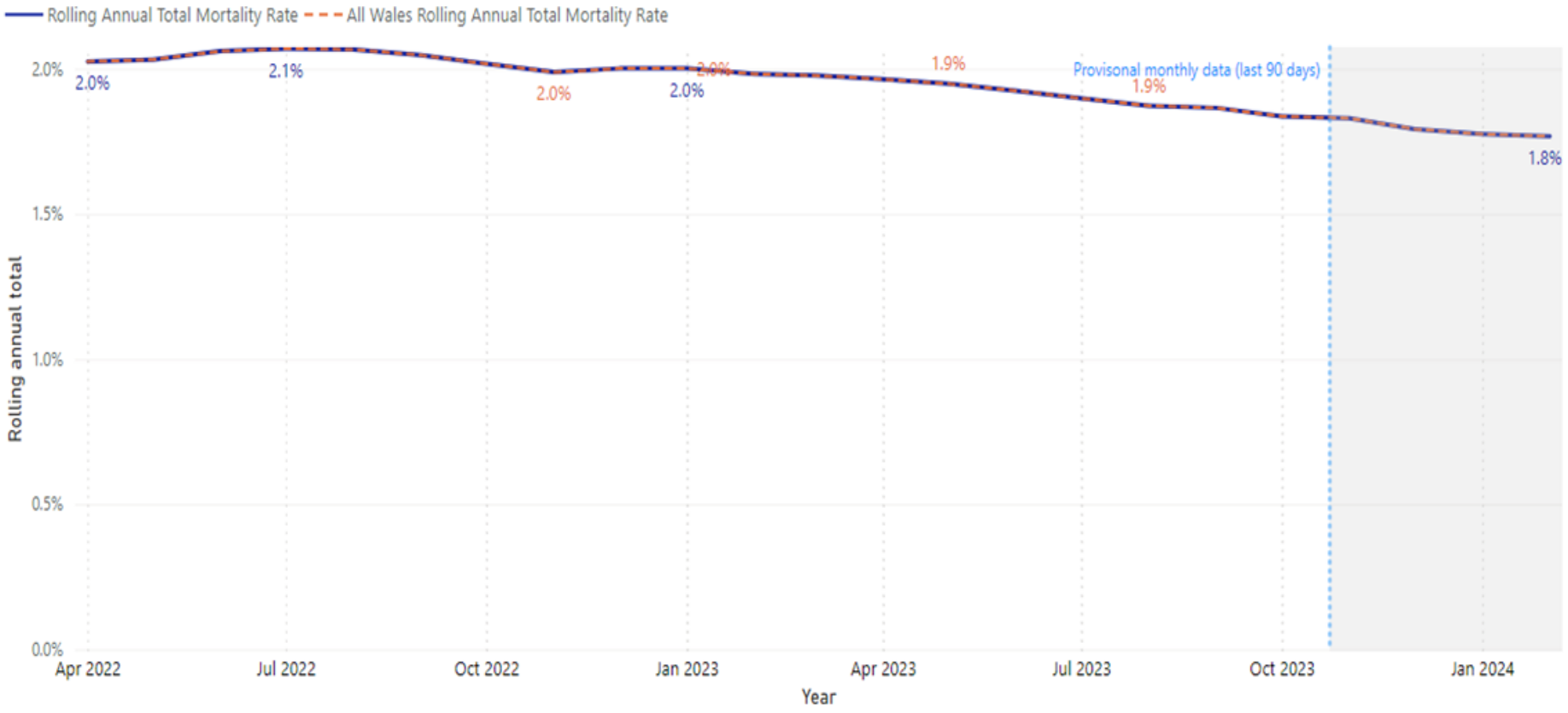


# All-Cause Mortality




Deaths per 1000 occupied bed days – steady decline from January 23 to July 23 (18-month lowest point of 3.88)
Increase to 5.23 December 23 however lower than December 22

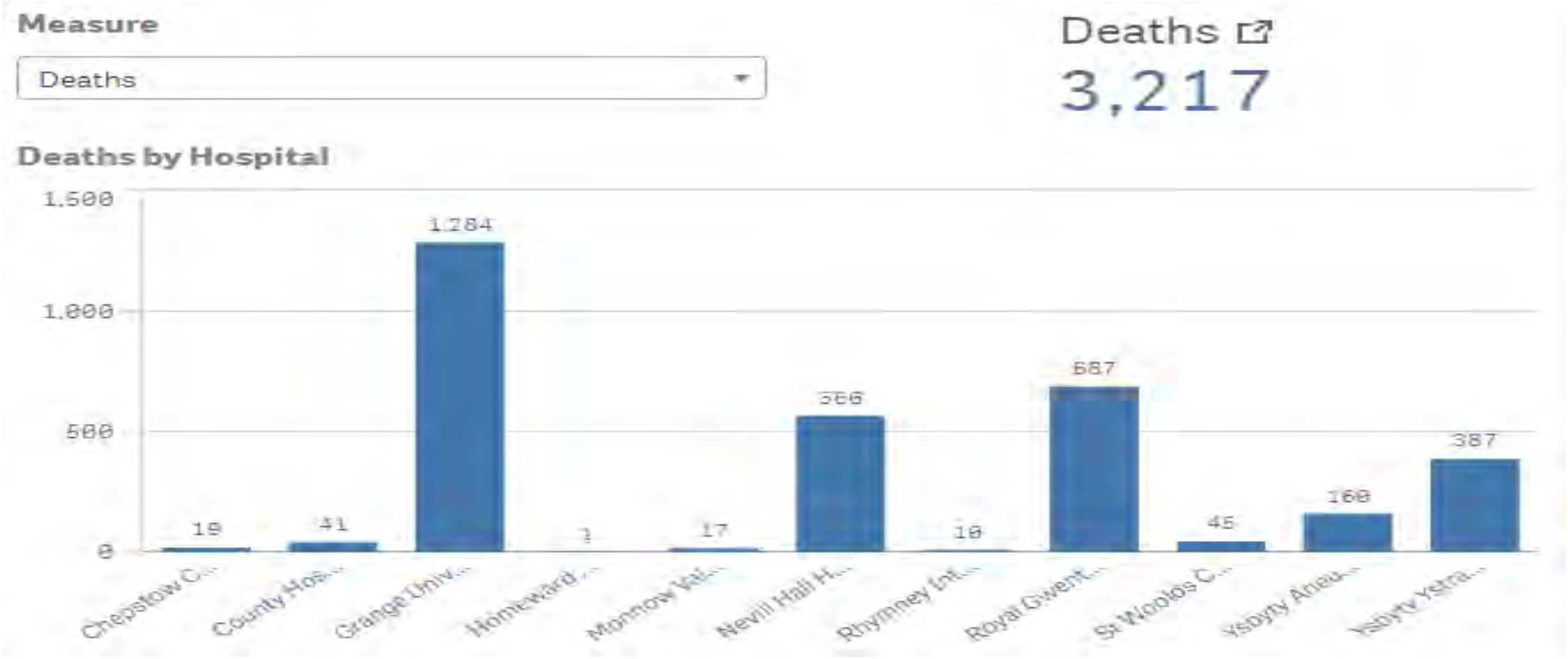
# Rolling Mortality Rate



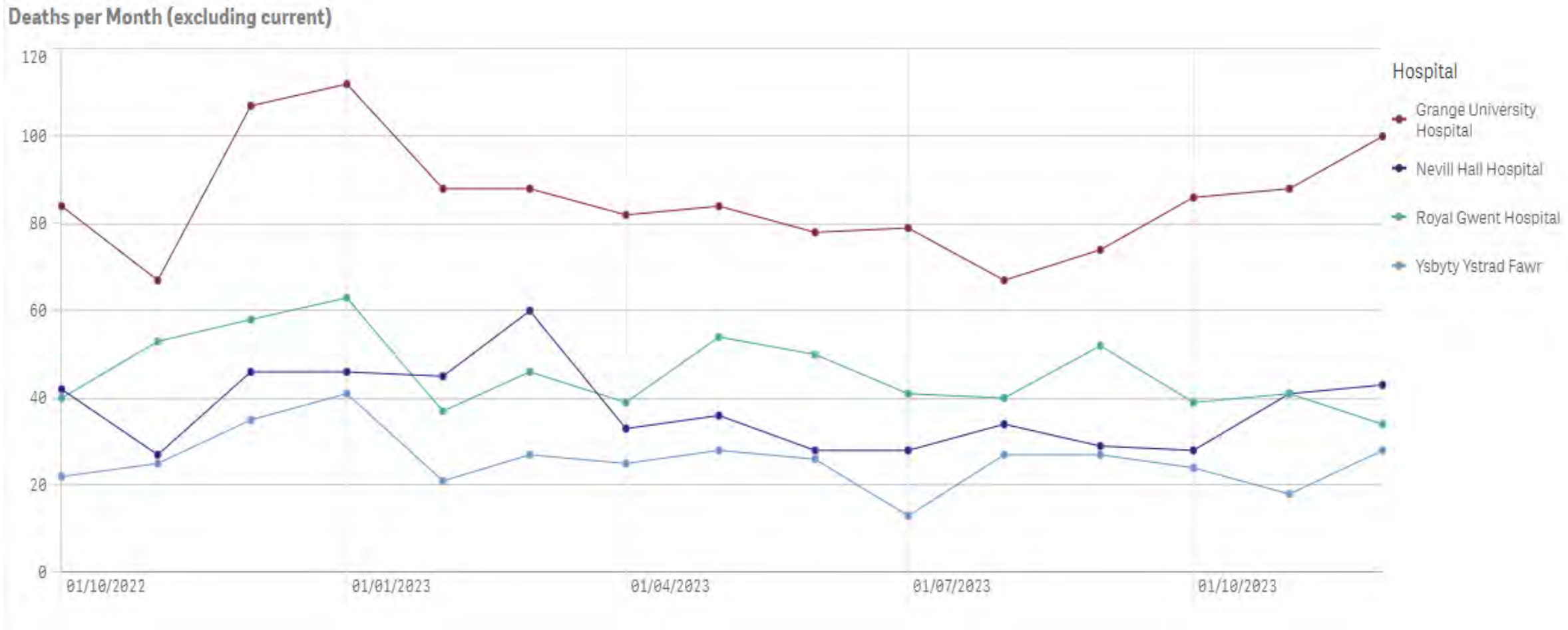

Whilst the Health Board RAMI has varied significantly, the crude mortality and mortality rate are flat and consistent.

This emphasises the need for an individual mortality report to undertake deep dives in high mortality specialties.

# All-Cause Mortality per site



# All-Cause Mortality per site (GUH + ELGHs)



# Tier 2 Mortality Indicators

The identification of Divisional mortality indicators will further support the proposed approach to mortality oversight. Learning from death can be achieved by identifying trends in mortality data that require additional scrutiny. These measures will include:

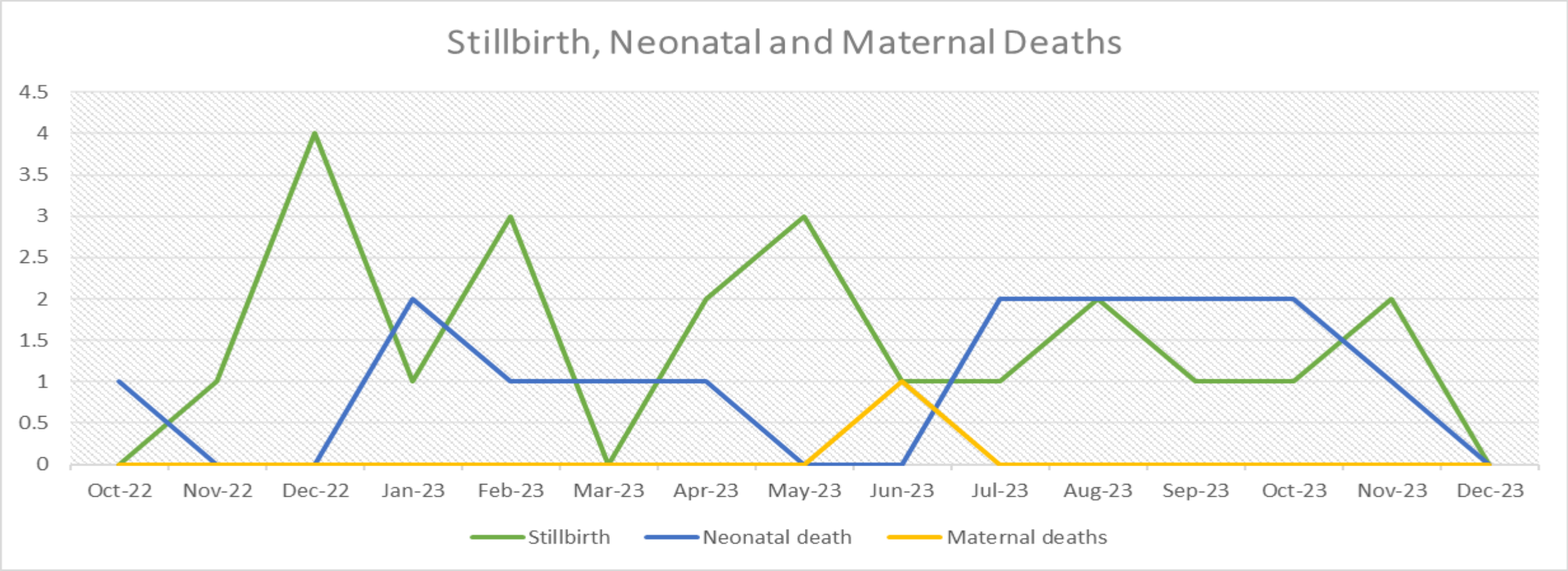
- Systematic reporting of mortality at Divisional Quality and Safety meetings or a similar forum.
- Triangulation of information from the Medical Examiner where increases in mortality rates are noted, e.g. if stroke deaths are observed to increase, thematic reviews of Medical Examiner referrals relating to this specific patient group should be undertaken to identify any contributory factors.
- Case note reviews will be the basis for providing assurance in the absence of other patient specific clinical reviews.
- Presentation of mortality themes and trends at the Health Board Mortality Review Group to support organisational learning.

| Family and **Therapies** | Medicine | Urgent **Care** | Mental Health | PCC | Surgery |
|---|---|---|---|---|---|
| Maternal mortality | Stroke Mortality | ED mortality descriptors | Inpatient Suicide (population measure) | Locality specific mortality | 30-day post elective surgery inpatient mortality |
| Perinatal Mortality/ 1,000 births | Cardiology / MI | | Learning disability deaths | | 30-day post non-elective surgery inpatient mortality |
| Still Birth/ 1,000 births | | | | | |

Table illustrates the proposed mortality indicators identified in collaboration with the Divisions that will allow reporting of Tier 2 mortality data.

These will be refined to ensure the metric provides a rate with the number of cases per 100 or 1000 in due course.

# Number of Stillbirth, Neonatal and Maternal Deaths




Neonatal and Perinatal mortality including still birth is reported to MBRRACE (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) and is case specific.

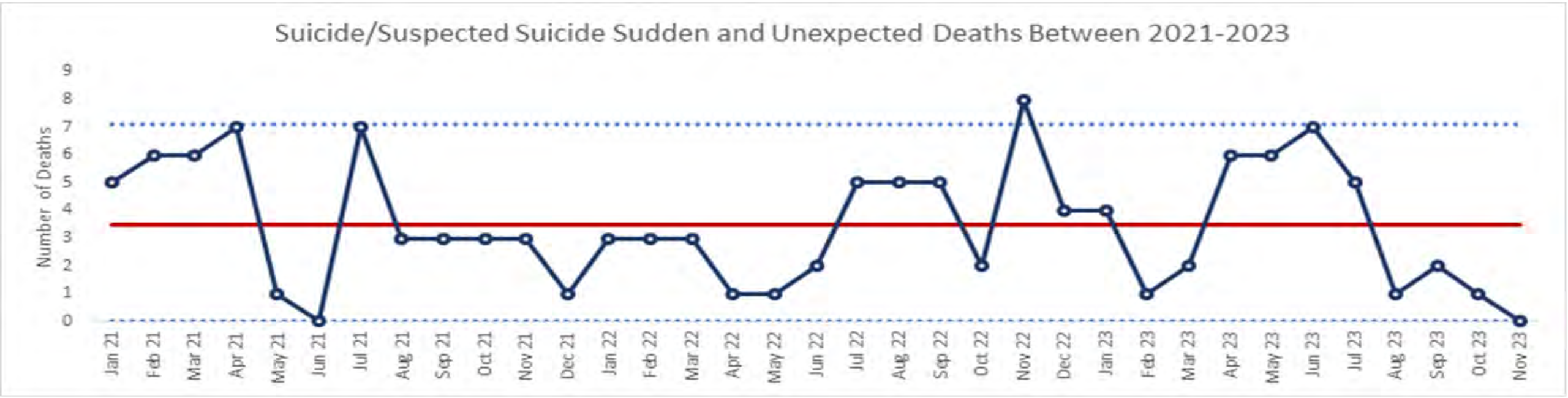
# Death by Suicide

- From 1 April 2022 to 31 March 2023 there were 356 deaths by suspected suicide of Welsh residents with rate of death by suspected suicide of 12.3 per 100,000 people.
- In the Health Board area the rate of death by suspected suicide was 12.6 per 100,000 people with no statistically significant difference in comparison to other health board areas or the All-Wales rate.
- The highest rates of deaths by suicide occurred in males aged 35-44 years followed by males aged 25-34 years. For females, the highest rate of death by suicide was seen in those aged 25-34 years.

- Across Wales, rates of deaths by suicide were higher in men in comparison with women, in those living in the most deprived areas compared to those living in the least deprived areas and for people who were unemployed in comparison to those in employment. This replicates the trends that are evident within the local data.

- Across Wales 47% of people (168/356) who died by suspected suicide had 'mental illness' recorded as an associated factor with 22% of people (80/356) having alcohol and substance misuse reported. Of the 356 deaths by suicide 96 (27%) were 'known to mental health services', however for 108 deaths (30%) this information was not known so it is possible that this figure is an under-estimate.
- The data on mental illness and whether the person was known to mental health services was gathered from Police systems not health systems. Therefore, this should be interpreted with caution particularly as the definition of "known to mental health services" was not uniformly collected or validated across Wales. The annual report 22/23 does not provide Health Board level data for deaths by suspected suicide of people known to mental health services though this would be anticipated to be included in future iterations.

# Death by Suicide




- No trends in suicide rate by month or season. Considerable variability month to month due to low numbers.
- In terms of other clinical trends, local data bears similarities in terms of demographics, to national data collected through both RTSSS and NCISH. Across all age groups, more men than women die by suicide or suspected suicide. Suicide is significantly more likely in younger men aged 26 – 55 with the greatest gender difference between men and women in the 36-45 year category.

# Tier 3 Mortality Indicators

Once Tier 2 indicators are agreed with divisions work will progress to identify directorate level indicators. There are multiple clinical databases in use across the organisation and mortality data is collated in many of these resources.

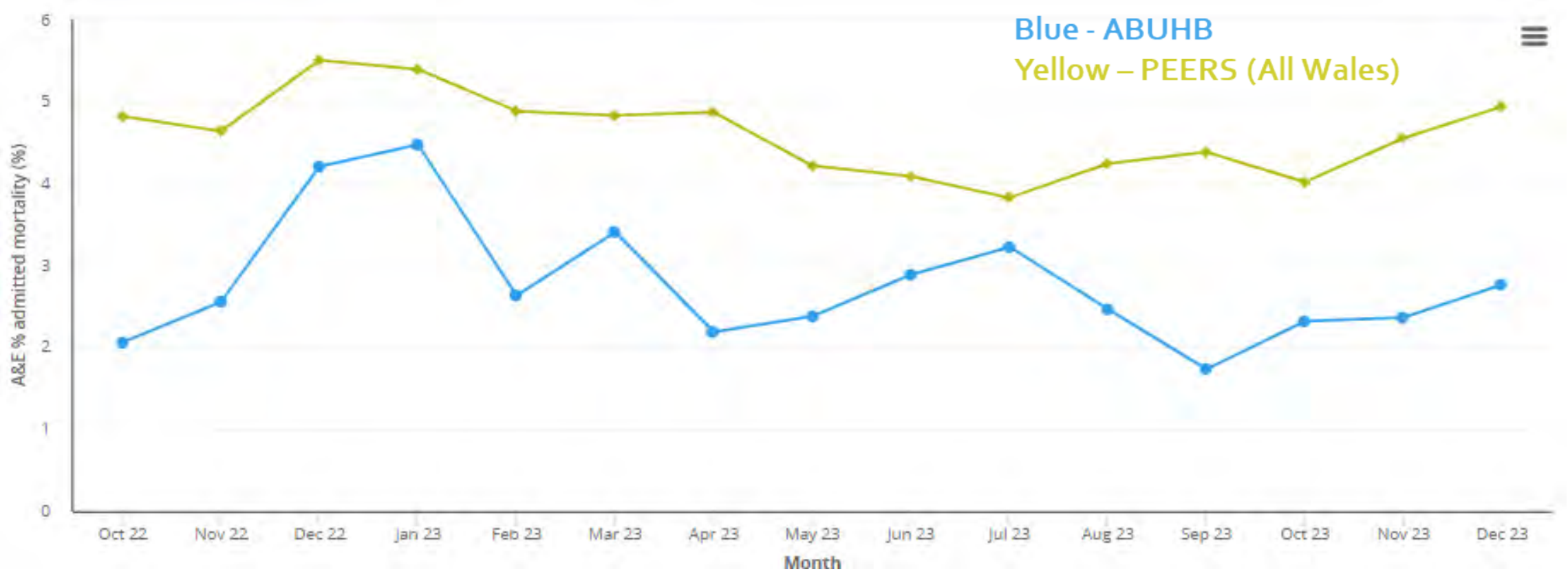
National Clinical Audit data will be used to triangulate and benchmark mortality data for directorates.

Where an existing mortality measure is not in place, the Directorate and Quality and Patient Safety Team will work together to develop bespoke measures from CHKS (a health care intelligence system procured by the UHB).

A governance framework will be developed as part of the Learning from Death Framework to support a systematic approach to considering condition/procedure specific mortality in each Directorate which will include:

- Systematic reporting of mortality data through Directorate Quality and Patient Safety meetings.
- Triangulation of mortality data with the Medical Examiner reviews and Mortality and Morbidity (M&M) reviews and Inquests.
- Formal assurance and escalation reporting system from M&M reviews.
- Assurance and exception reporting to the Clinical Board Quality and Patient safety meetings .

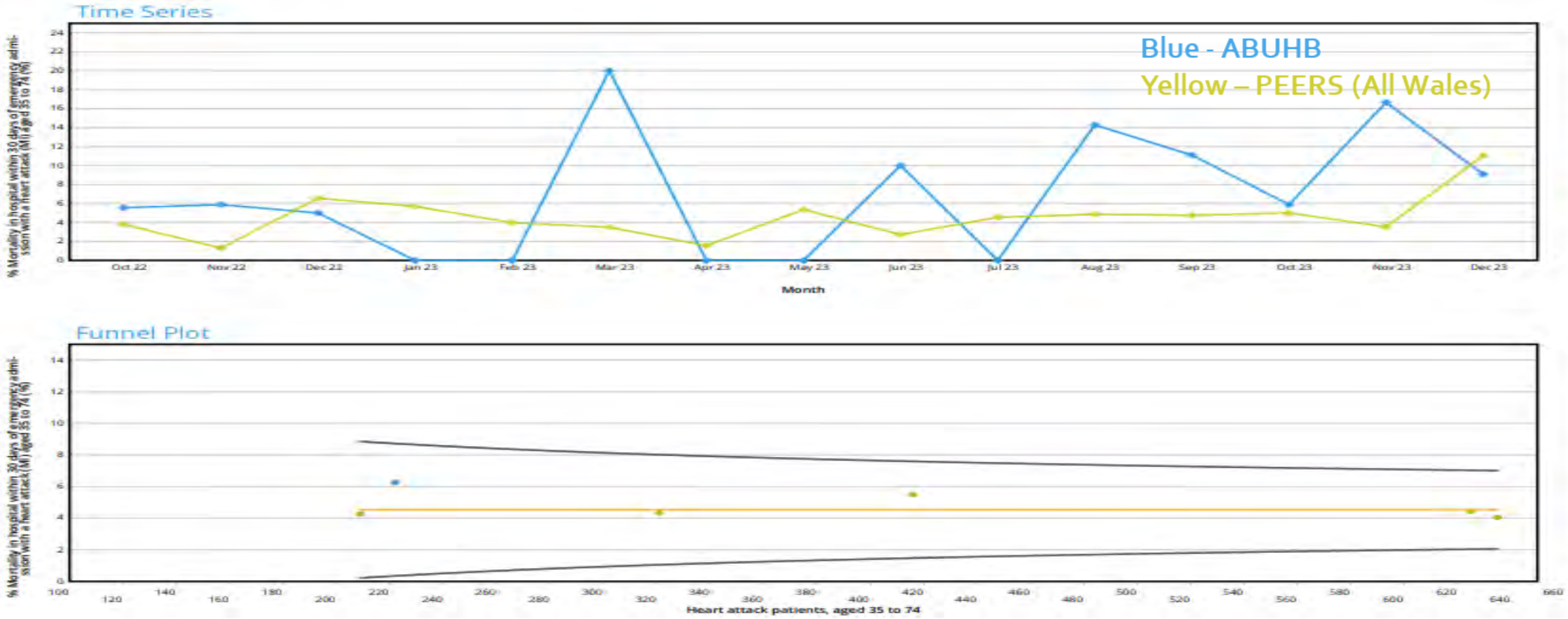
# Emergency Department admitted Mortality




The Health Board's Emergency Department admitted Mortality is better than peer comparators

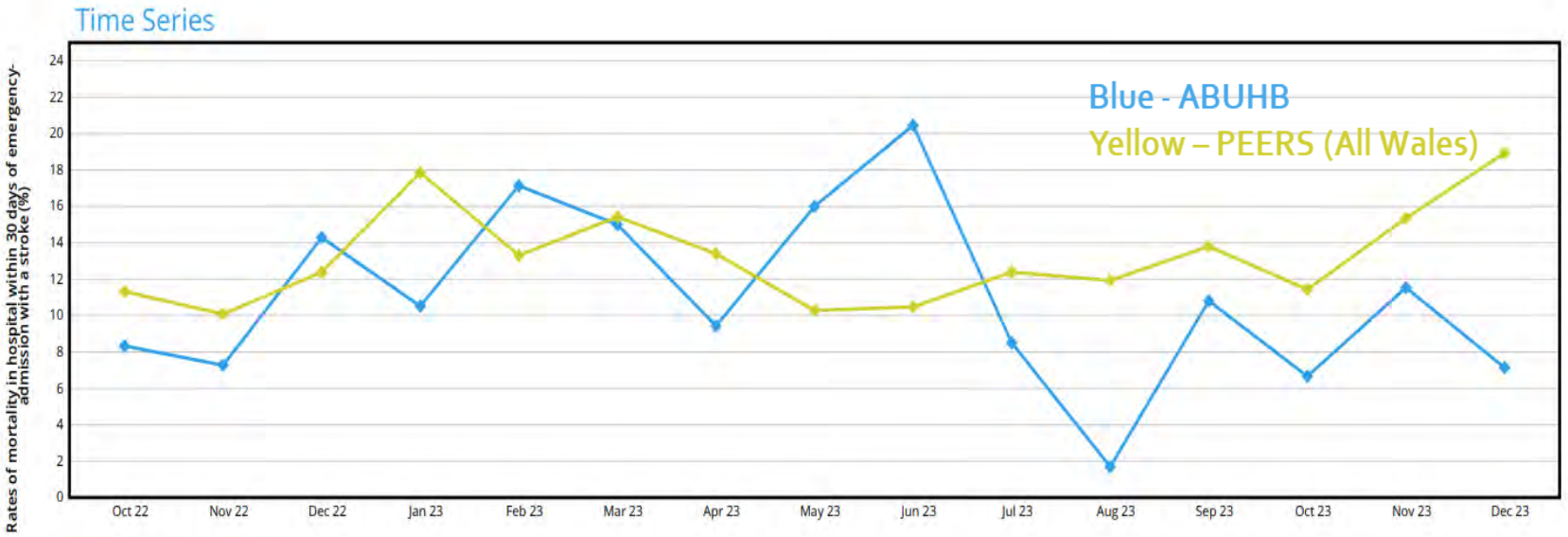
Currently unable to show an initial Admission RAMI value – This will be referred to CHKS

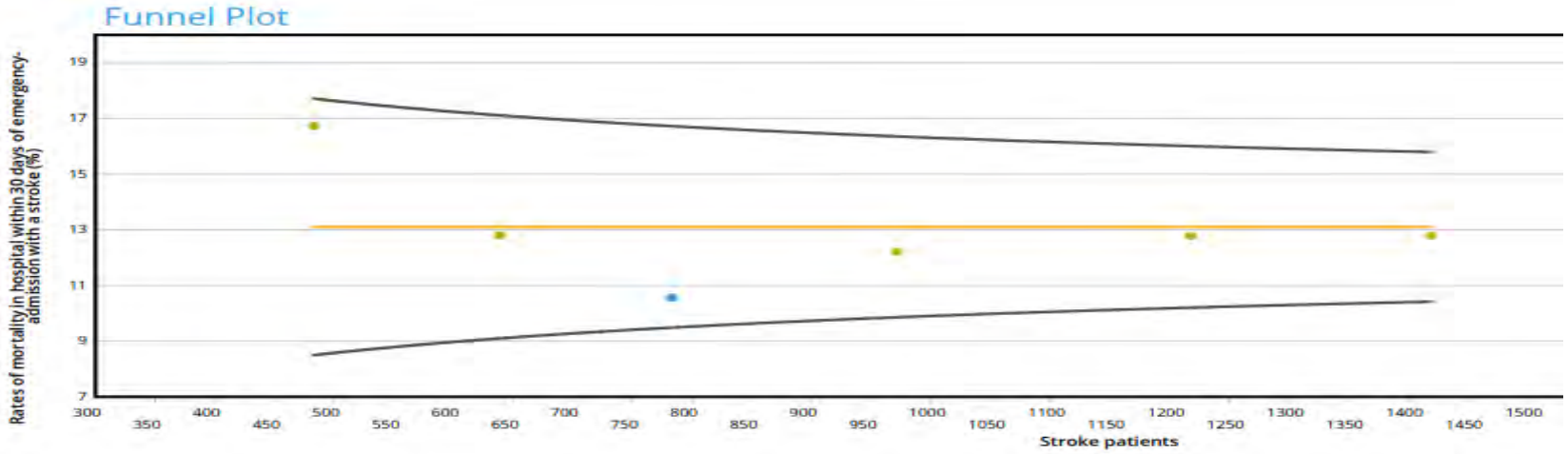
# Specific Condition Mortality MI




30-day MI inpatient mortality has increased and is now 6.2% compared to 3.7% last year. We will look to undertake a deep dive for this mortality indicator.

# Specific Condition Mortality (Stroke)



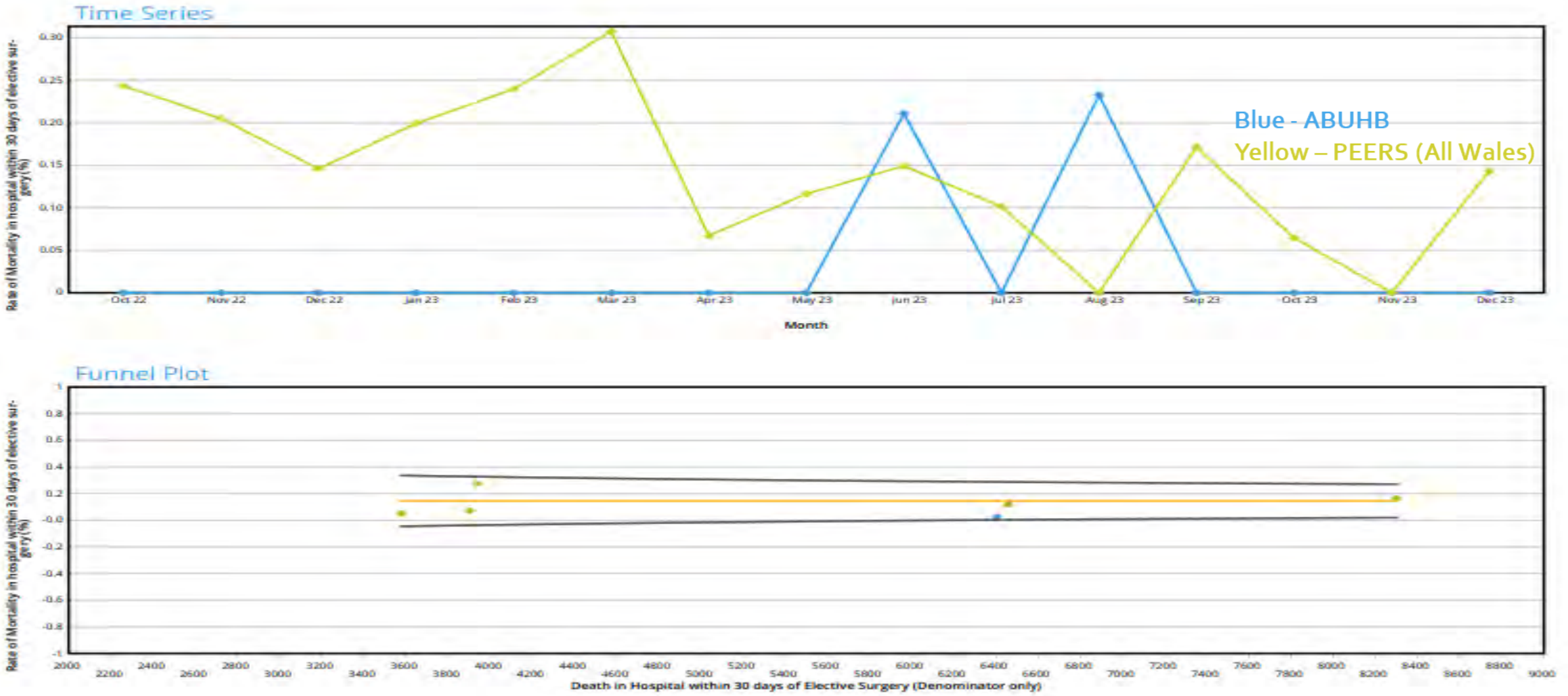

30-day inpatient stroke mortality has been variable over time. This year's mortality is 10.1%. This is lower than the All-Wales peer value of 13.1% and is the lowest in Wales.

Biggest risks and challenges across the Stroke pathway

Protecting the urgent intervention pathway – front door to HASU
Sustaining a fragile rehabilitation pathway, especially in terms of medical and therapy cover
Uncertainty with National Programme and focus on HASU rather than whole pathway
Bristol Thrombectomy service – operating hours
Public awareness – FAST campaign and seldom heard groups
Building on the things we do well:

- Good thrombolysis rates, good performance for review by stroke consultant within 24hrs.
- Lowest stroke mortality in Wales
- Community Neuro Rehab Service – exemplar model for Wales but national funding cut
- Niwrostiwt Neurological Conditions Recovery College – NHS Wales Awards runner up
- In-house 'Living Well After Stroke' service
- Peer Support and volunteer roles in YYF

# Surgery mortality - Elective

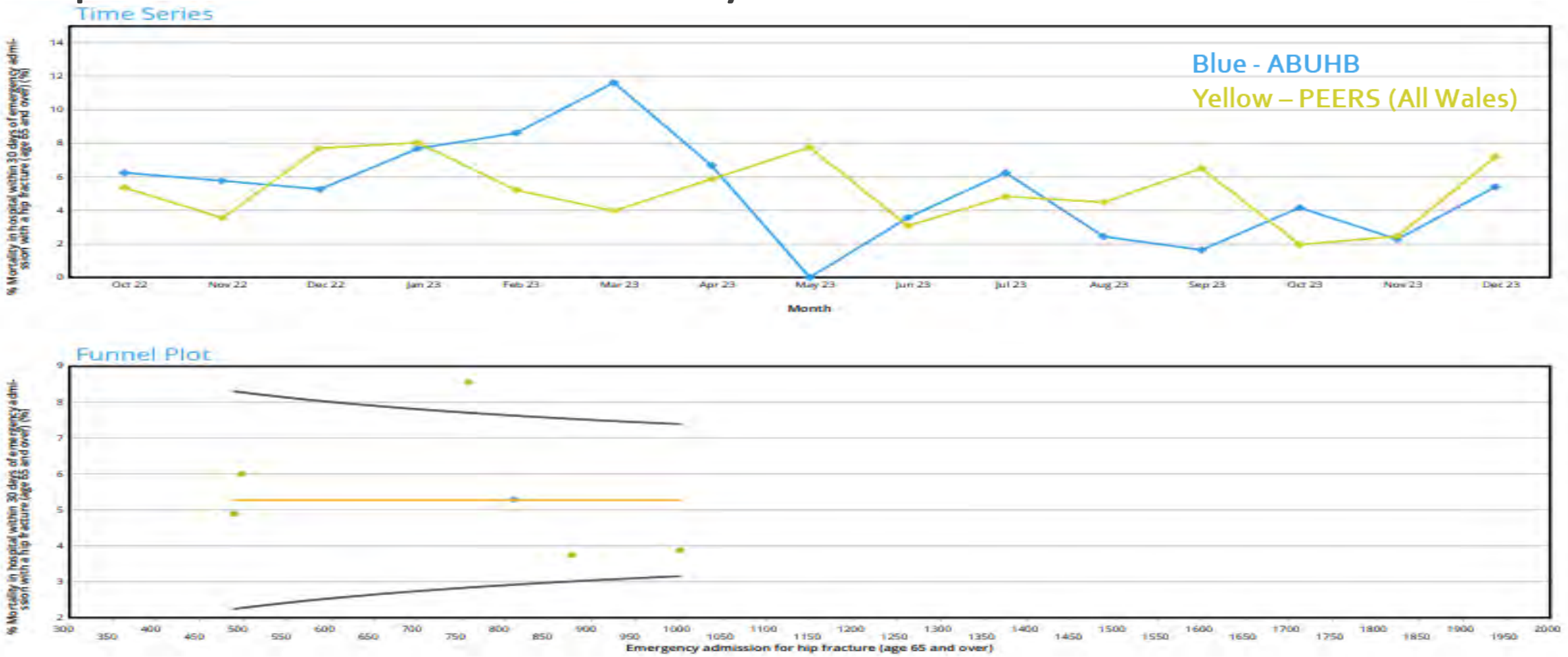



The rate of mortality in hospital within 30 days of elective surgery was 0.03%, compared to 0.07% last year. This is lower than the All-Wales peer value of 0.15%.

# Surgery mortality – Non Elective


The rate of mortality in hospital within 30 days of non-elective surgery has increased from 1.5%, as compared to 1.6%, which is still lower than all the All-Wales peer value of 1.8%.

# Hip Fracture mortality




% Mortality in hospital within 30 days of emergency admission with a hip fracture (Age 65+).
Mortality rate 5.3% for period of reporting, compared to 4.6% for previous year.
Mortality rate now varying in line with peer median value.

# Ongoing work

The Health Board is developing a Standard Operating Procedure (SOP) for staff involved in mortality peer reviews.

The main aim of the mortality review process is to identify opportunities for improving patient safety and enhancing the quality of care. This can be broken down into the following objectives:

- Identify and minimise problems in the care provided preceding an inpatient death in all hospital sites
- Review the quality of end of life care
- Share examples of excellent practice

National reports of the themes and trends associated with the deaths of people with learning disabilities, perinatal and maternal deaths are reviewed to determine local lessons to be learned from the nation-wide system of reviews. Health Board specific action plans are reported to the PQSOC, as is the case for other national reports.

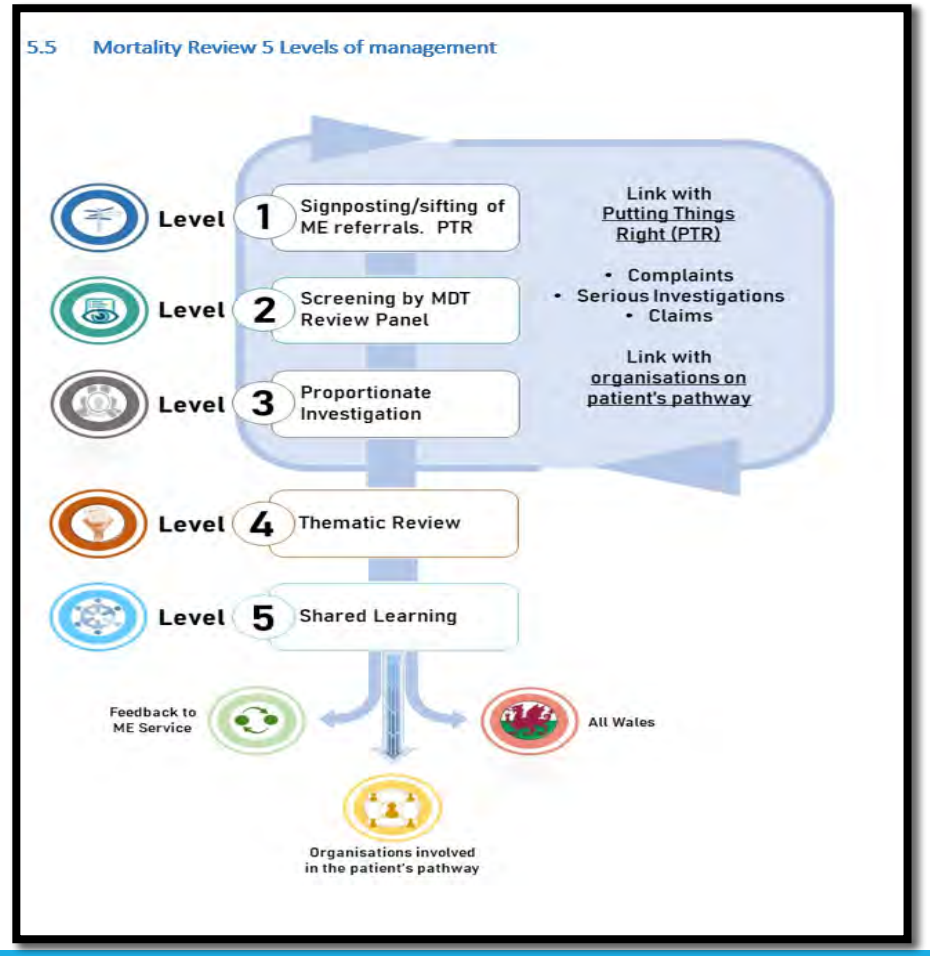
# The Medical Examiner Service

The Medical Examiner Service in NHS Wales is hosted by NHS Wales Shared Services Partnership. The service provides independent scrutiny of all deaths not investigated by the coroner. Scrutiny is undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. They will ensure that an accurate cause of death of recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

To ensure the highest level of independent scrutiny of the cause of, and circumstances surrounding, a death, all Medical Examiners and Medical Examiner Officers in Wales are directly employed by NHS Wales Shared Services Partnership, and Medical Examiners will generally not be involved in the scrutiny of deaths in the area in which they work. Updates can be found at: Medical Examiner Service - NHS Wales Shared Services Partnership.

The ME system provides external, independent scrutiny of the quality-of-care delivery and reports back episodes of patient for the Health Board to investigate further.

# Medical Examiner
# ABUHB Mortality Review Process




All mortality cases referred to the Health Board by the ME are subject to an initial review (level 1). This establishes what further action (if any) is required, and helps avoid duplication of work e.g. if the case is already under review via an established process.

Following the level 1 process, if the case requires further investigation, it will go on to be reviewed at level 2. A summary of these cases are discussed at the Mortality Review meeting, ensuring panel are happy with the justification of not being progressed to a level 2 review.

Level 2 mortality review involves the case is assigned to a member of the ABUHB Mortality Review Screening Panel. This is a multidisciplinary group with cross divisional representation that meets weekly. An assigned panel member reviews and presents the case to the group. The panel establishes whether further investigation is required. These actions are then clarified and sent out to the relevant team or clinician for completion.

Requested actions might include; case review at mortality and morbidity (M&M) meetings, referral for investigation under PTR processes, consideration at the ABUHB Falls Review Panel, Infection Prevention and Control Review and Hospital Acquired Thrombosis Review. This work constitutes a level 3 review.

The ME service was gradually implemented. In April 2023, all hospital sites were covered. Areas not currently covered are neonates, paediatrics and maternity.

Primary Care deaths will be reviewed by the ME service in due course, we are awaiting a start date for implementation.

This table illustrates the outcomes and actions associated with the ME referral cases processed within the Health Board.

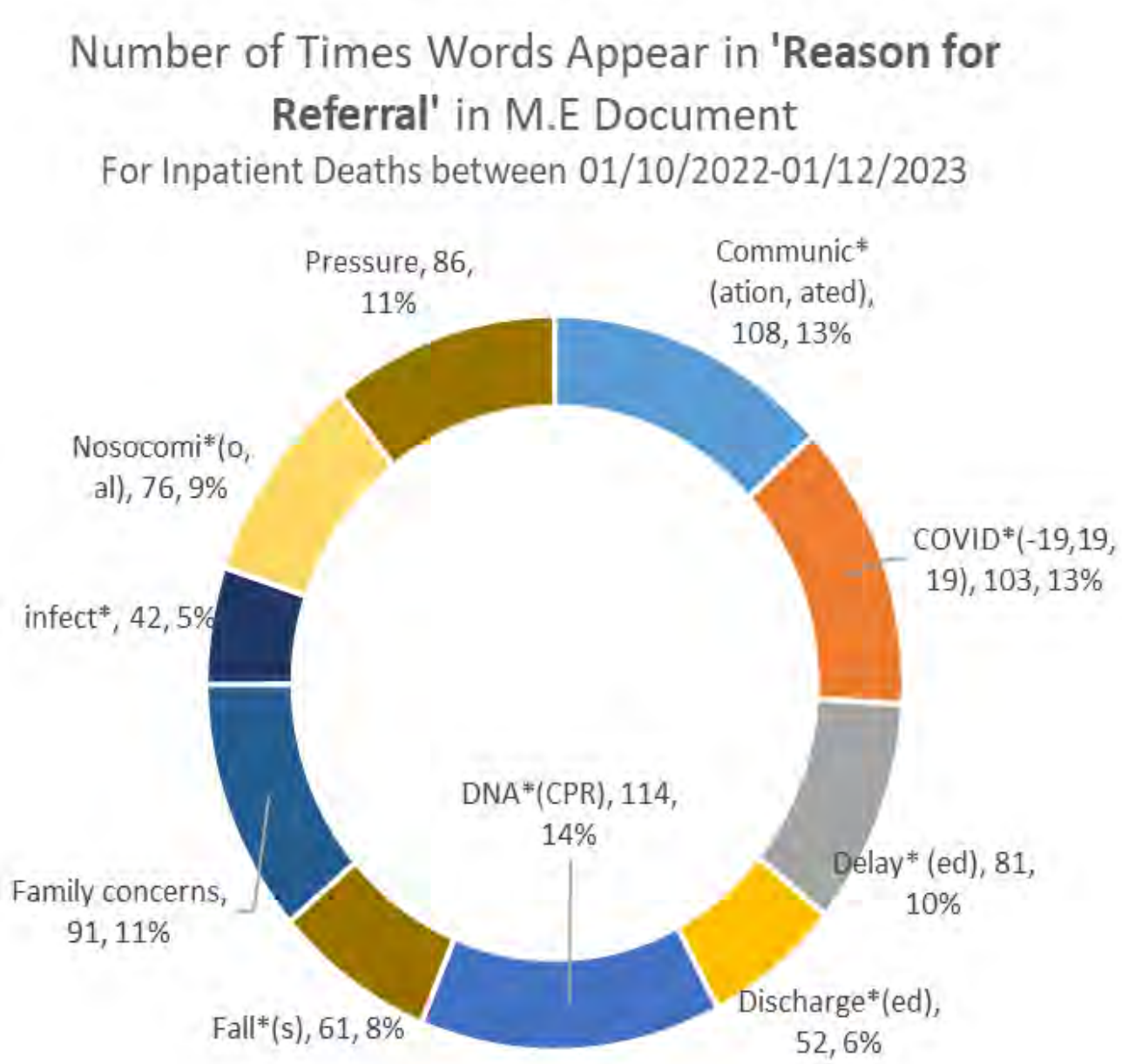
As the ME service has been implemented, the recent data set is larger than the previous set.

Fewer cases have been sent on to HM Coroner; 19% down from 32% in the previous data set. It is challenging to make comparisons with ME data as the ME service was not fully established in 2022.

More cases are being closed at level 1, with an increase from 10% to 25%. This is due to the ME case referrals received do not have any clinical concerns with care and not taken to panel. Or are already being investigate.

Fewer cases being sent to PTR. The mortality team have worked closely with PTR and PALS to change processes. The bereaved are given the contact details for PALS by the MEO (Medical Examiner Officer). They are able to contact the Health Board if they wish, and at a time and place which suits them.

| 01/10/2022-01/12/2023 | | |
|---|---|---|
| Total ME Referrals Nº | 797 | |
| No Further Action Nº | 196 | 25% |
| **Referred to...** | | |
| IP&C | 104 | 13% |
| Putting Things Right | 29 | 4% |
| QPS lead | 3 | 0% |
| Significant Learning Event | 0 | 0% |
| M&M | 56 | 7% |
| Awareness | 64 | 8% |
| SI* | 29 | 4% |
| Clinical Review | 75 | 9% |
| Concise Review | 1 | 0% |
| Divisional Review | 1 | 0% |
| ME referred to Coroner | 153 | 19% |




This chart demonstrates the commonly recurring words in the reason for referral as identified through a thematic analysis of referrals.

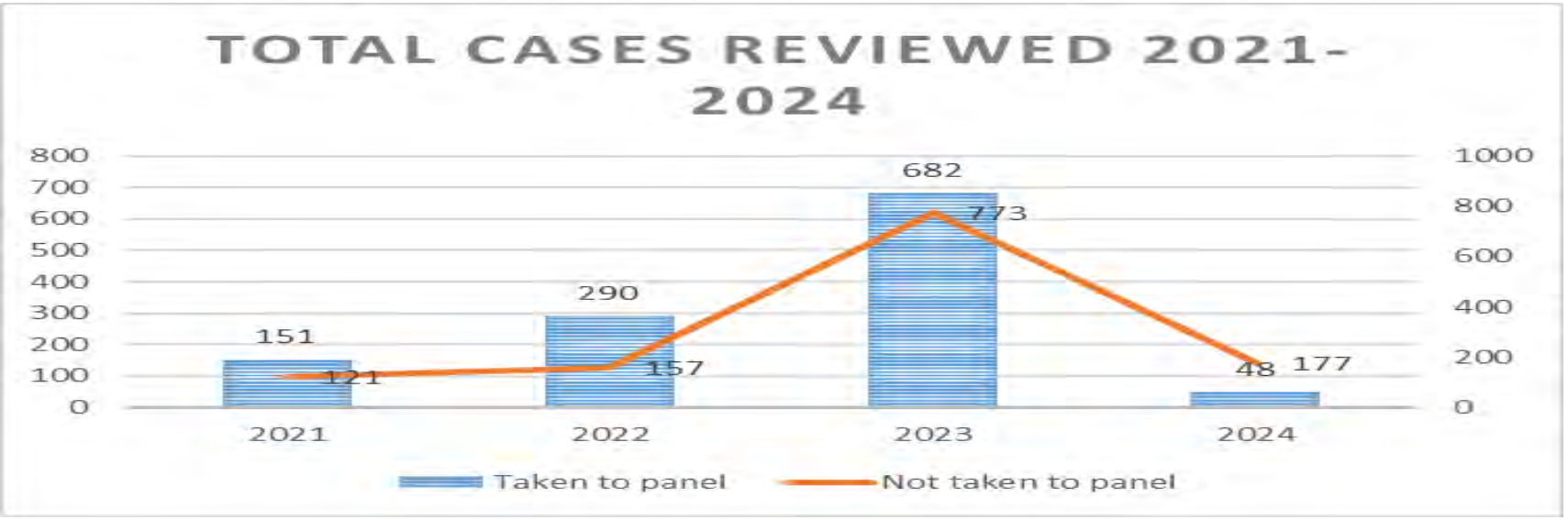
DNACPR (14%) is highlighted in 14% of ME referrals. This is an increase but may reflect the work going on across Wales in relation to this domain of practice (including an All Wales mortality thematic review and auditing from HIW). The Mortality Review Screening Panel believe the increased frequency of DNACPR as a reason for referral is due to increased reporting rather than a deterioration or change in practice.

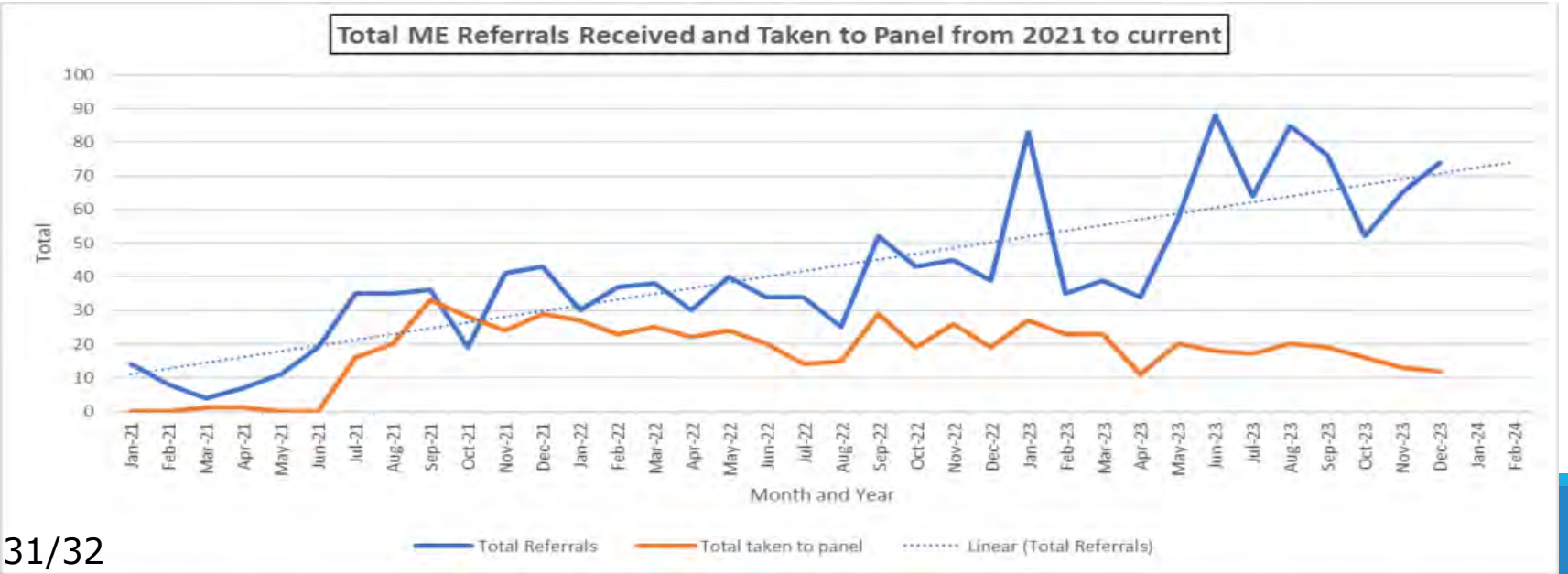
Communication remains a frequent reason for referral (this includes communication with families, between clinicians and from the Care After Death Team).

Covid (nosocomial or community acquired) as a reason for referral has decreased in the last year. This is likely due to a combination of both reduced reporting and testing, and reduced frequency of cases.

Referrals due to pressure damage have increased from 7% to 11%, partly due to the more recent data set being larger. During 2023 all cases which were examined by the ME Service were referred to the HB if the patient had a history of pressure damage (whether hospital acquired or not).

# ABUHB Mortality Review Service Growth




The chart demonstrates the growth of the ABUHB Mortality Review Screening Process since the ME service was implemented and spread to all hospital sites.

The number of cases received has increased significantly since 2021.
In addition, the number of cases that do not need to proceed past level 1 has increased.

The ME service was implemented without additional resource or investment and this work has been absorbed by the Medical Directors' team, at the detriment to the resource available within clinical audit.

# Next steps

Work with coding team and undertake coding review with notes to improve the reliability of the RAMI.

Agree mortality framework and establish mortality indicators

Work with Directorates to establish mortality indicators

Develop a Mortality Review Committee

Increase engagement with clinicians regarding mortality processes

Improve identification of learning from mortality reviews

Establish Mortality and Morbidity meetings throughout all Directorates

Develop and implement the mortality review process for deep dives into directorates with high RAMI

Triangulation of mortality data with ME service and patient safety incidents

Develop a Standard Operating Procedure for a deep dive process and notes review

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Higher Risk Surgical Patients Update |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | James Calvert, Executive Medical Director |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Dr James Tozer<br>Clinical Director for Anaesthetics |

## Pwrpas yr Adroddiad / Purpose of the Report

Er Sicrwydd/For Assurance

## ADRODDIAD SCAA / SBAR REPORT

### Sefyllfa / Situation

This paper provides information for the purposes of assurance as an update since approval was given by the executive team to use the Surgical High Care (SHC) unit at RGH for patients with a pre-op mortality estimate of 5% - 10%.

### Background

At its June 2023 meeting the Executive Committee approved the use of the Surgical High Care (SHC) unit at RGH (previously known as POCU) for patients with a pre-op mortality estimate of 5% - 10%. This was agreed in order to best support planned care recovery, higher acuity, surgical procedures and higher risk anesthetic patients. This was originally configured around a cumulative mortality risk of 5%.

However, the need to recover services post COVID and recognising that delays in timely care presented a clinical risk in and of themselves, the Executive Committee agreed that it was necessary to adopt a risk model of up to 10% mortality as a balance of risks to maintain patient safety whilst ensuring timely treatment for patients.

## Asesiad / Assessment

During the reporting period 01 July 2023 – 31 December 2023 there were 555 admissions to the Surgical High Care (SHC) unit at RGH.

*Transfers*

There were 15 (fifteen) patient transfers from the SHC unit at RGH to GUH during this period, giving an overall transfer rate of 2.7%.

Amongst the patients transferred, 13 were transferred to critical care (3 (three) as a level 3 transfer, and 10 (ten) as a level 2 transfer) and 2 (two) were transferred to a ward at GUH. This shows a critical care transfer rate of 2.3%, and a level 3 transfer rate of 0.5%.

No transfers occurred in the higher risk group (predicted mortality >5%) or in those deemed high risk by cardiopulmonary exercise testing (CPET).

5 patients were transferred and returned to theatre (no deaths).

*Morbidity and Mortality (M&M) review*

In the 6-monthly M&M meeting held in January 2024, 6 (six) patients were reviewed, of whom 4 (four) had died. All deaths occurred in orthopaedic patients. The 2 (two) remaining patients underwent colorectal surgery and required level 3 transfer. The overall in-hospital mortality rate for this period was 0.7%. Data submitted to ICNARC from the SHC unit in the period 01 April 2023 to 31 December 2023 showed an in-hospital mortality of 0.6% against an expected mortality of 1.4% (95% predicted range 0.4-2.4%).

Only one of the six patients had a predicted mortality of >5%. Their predicted mortality was calculated during the M&M review as 7%. They also had a high frailty score of 6. This patient had their initial surgery in September 2023, and had remained an inpatient until the second operation in November 2023. Although the patient had been through the appropriate pre-assessment process before their initial surgery, this process was not repeated before the second operation as there is currently no service for in-patients to be seen in pre-assessment clinic. Immediately following the second operation, the patient had been discussed with the critical care team due to requiring a high level of cardiovascular support. The decision was made to monitor at RGH and discuss again as necessary. A further discussion took place the day after surgery due to ongoing deterioration, but it was felt that escalation was not appropriate, and a decision made for comfort care. The M&M review group thought it was likely that the patient would have been considered as a planned admission to critical care post-operatively if they had been an in-patient at GUH. It was also felt that in cases such as this, where a patient is initially considered for escalation to critical care, that regular ongoing discussions should take place between the SHC and critical care consultants.

In the other 3 cases where patients died, it was felt that RGH was an appropriate site for their surgery. Frailty was a common theme amongst the patients discussed. In one of the cases, despite having a predicted mortality of <5%, the patient had severe medical problems resulting in significant functional limitations, and the M&M group questioned the decision to offer this patient surgery, given that an alternative treatment option was available and had been discussed. The group also felt that escalating this patient's care to GUH, as had been the case, was not necessarily in this patient's best interest given the severity of their pre-existing medical conditions.

Both colorectal patients, who had a complicated post-operative course and required a level 3 transfer, had a predicted mortality of <5%. They had both attended CPET clinic pre-operatively for further risk stratification, and in both cases they were stratified as low-risk according to CPET criteria. The M&M review group felt that surgery in RGH was appropriate

and both patients suffered unpredictable post-operative complications. Both patients were discharged from hospital.

Following discussion of the six cases at the M&M meeting the following recommendations were agreed to be implemented:

1) In cases where patients have been discussed with critical care post-operatively and it is felt that escalation would be appropriate, ongoing daily discussions between SHC and critical care should take place to ensure that the window for transfer is not missed. This can be done by dialling into one of the MDT meetings (either 8am or 12.30pm).
2) For in-patients at RGH requiring surgery, consider discussing with critical care pre-operatively to help determine the most suitable site of surgery as well as best post-operative plans.
3) To review the need for patients with high frailty scores to be seen routinely in a face-to-face pre-assessment clinic (PAC) by a consultant anaesthetist. Dr Victor Francis (lead consultant for orthopaedic PAC) has been approached regarding this and is currently drafting a revised document detailing which patients require face-to-face review prior to surgery.
4) To review the possibility of an in-patient PAC process - either on the ward, or for the patient to be transported to clinic. This has also been discussed with Dr Francis for consideration.
5) To continue reviewing transfers and mortality on a 6 monthly basis, with the next review date planned for July 2024.

*Conclusion*

It is believed that the data is satisfactory and meets the required standards to ensure consistency and accuracy. The demonstrated outcome rates are below expected mortality rates and the transfer rates remain low with no resulting harm to patients who were transferred to critical care.

As such, it is recommended to continue with the current clinical model of care with its concurrent data collection and quality assurance with the agreed 6 monthly update to Executive Committee.

## Argymhelliad / Recommendation

The Patient Quality and Safety Outcomes Committee is asked to receive the report as assurance that the organisation is adhering to the programme of work and assisting in delivering safe and effective care.

| Amcanion: (rhaid cwblhau) / Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 3. Effective Care<br>5. Timely Care<br>6. Individual care<br>7. Staff and Resources |
| Blaenoriaethau CTCI<br>IMTP Priorities<br>Link to IMTP | Adults in Gwent live healthily and age well |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives | 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<br>Choose an item.<br>Choose an item.<br>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:<br>Parties / Committees consulted prior to University Health Board: | Executive Team |

| Effaith: (rhaid cwblhau) / Impact: (must be completed) | |
|---|---|
| Asesiad Effaith Cydraddoldeb / Equality Impact Assessment (EIA) completed | No does not meet requirements |
| Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio / Well Being of Future Generations Act – 5 ways of working<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Long Term – Improving the experience of trainees, which in turn results in overall improvement of patient care and staff experience, will aid in achieving the long term Healthier Wales ambition. |
| | Integration – Delivery of improvements, outlined in the plan, will ensure system resilience and improved patient safety; in collaboration with partner organisations including HEIW. |
| | Involvement – Patient experience, staff experience and feedback from external stakeholders (including HEIW and the Royal College of Physicians) has been taken into consideration when developing improvement actions. |
| | Collaboration – The delivery and ongoing work outlined has required collaboration across the organisation and with external stakeholders (especially HEIW). |
| | Prevention – Implementation of the improvement plan provides a heightened response when unwell patients self-present at our hospital sites, which has been previously been acknowledged as an area of concern. The improvement plan also provides assurance that concerns around the care of deteriorating inpatients are progressed. |

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

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | 3-year Welsh Government Assurance Report on Compliance with the NSLWA 2021-2024 |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Jennifer Winslade - Executive Director of Nursing |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Linda Alexander – Deputy Director of Nursing |

| Pwrpas yr Adroddiad (dewiswch fel yn addas)<br>Purpose of the Report (select as appropriate) |
|---|
| Er Sicrwydd/For Assurance |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

Section 25A of the Nurse Staffing Levels (Wales) Act 2016 sets out the overarching responsibility of all Welsh Health Boards to have due regard for the duty on them to provide sufficient nurses to allow time to care for patients sensitively wherever they are receiving nursing services.

This Caveated 3-year Welsh Government Assurance report (5 April 2021- 31 January 2024) provides an overview of the measures taken to calculate and maintain nurse staffing levels throughout the 3-year reporting period and to provide assurance of the Health Boards compliance with the Act

### Cefndir / Background

The Nurse Staffing Act Levels (Wales) Act 2016 includes:

Section 25A
Overarching duty to have regard to providing sufficient nurses time to care for patients sensitively (came into force April 2017).

Section 25B
Duty to calculate and take steps to maintain nurse staffing levels, including: -

Identification of a designated person to calculate nurse staffing level.
Take all reasonable steps to maintain the nurse staffing level.

Make arrangements to inform patients of the nurse staffing level. (came in to force April 2018)

Section 25C
Prescribes the triangulated approach to calculate the nurse staffing level. (Came into force April 2018).

Section 25D
Relates to statuary guidance released by Welsh Government about the duties under sections 25B and 25C.

Section 25E
Duty to submit a Nurse Staffing Levels report setting out the extent to which the nurse staffing levels have been maintained and the impact that not maintaining staffing levels has had on care provided to patients. (Came in to force April 2018)

Section 25E states that health boards must submit their 3-year reports to the Welsh Government within 30 days of the end of the reporting period (5 May 2024). However, investigations of serious incidents of harm can often take months to complete, meaning incidents from the latter quarter of the three years would still be open and the data in May 2024 incomplete. Therefore, health boards will submit caveated reports in May 24 to ensure compliance with statute and a final uncaveated report will be submitted October 2024.

## Asesiad / Assessment

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses required and staff to whom nursing duties have been delegated by a registered nurse to deliver the planned roster. It is acknowledged there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment; however, these staff are not included within the data for this report.

2021-2022
The Autumn 2021 re-calculations identified a need to significantly increase the nursing establishments on seventeen of the 25B wards. The spring and autumn recalculations demonstrated a notable increase in patient acuity, particularly relating to level 4 and 5 enhanced care patients. The complexities of caring for enhanced care patients in single rooms was highlighted.

2022-2023
A total of 14 wards under s25B required amendments to previously agreed rosters. Recalculations revealed a further need to increase the Registered Nurses (RN) and Health Care Support Worker (HCSW) establishment by 34.39 WTE on 25B wards.

2023-2024
Changes to previously agreed rosters were required on 6 wards, 2 wards in Scheduled Care were approved and presented to Executive Committee in August 2023. The proposed changes of establishment to 4 wards in the Division of Medicine were put on hold whilst the reconfiguration of stroke services took place.

The Autumn calculations confirmed the majority of 25B wards as having the correct establishment to meet the needs of patients. Cost neutral amendments for 2 wards in Scheduled Care were agreed. The proposed establishment changes previously identified in the Spring calculations on the 4 wards in the Division of Medicine remained on hold.

The extent to which the planned roster has been maintained

To date ABUHB has not had the digital capability to demonstrate the extent to which the planned roster has been maintained within 25B wards, as such, the health Board has been unable to include this information in the annual assurance reports for this 3-year reporting period. Furthermore, the newly adopted Safecare system which has been successfully rolled out to all 25B wards is currently unable to produce the required data.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate

Clear processes are in place to identify, investigate and escalate from ward to Board any deviations from the planned roster and any potential harm as a consequence:

Hospital Acquired Pressure Ulcers: throughout the 3-year reporting period there have been a total of 4 incidences where the planned roster was not met, only 1 of these incidents was staffing levels considered to be contributory factor.

Patient Falls with serious harm: over the 3-year reporting period there have been 3 incidences where it is considered nurse staffing levels have been a contributing factor, despite all reasonable steps taken to maintain staffing levels.

Complaints: This is a complex metric to report as complaints are often multifaceted. Throughout the 3-year reporting period there have been 10 incidents where staffing levels were considered to be a contributory factor.

Medication Never events: Nil to report.

Infiltration/Extravasation: 8 incidences in total none of which were serious, staffing was not a contributory factor in any of the incidences.

Argymhelliad / Recommendation

The Committee is asked to formally receive and NOTE the information contained within the Nurse Staffing Levels (Wales) Act 2016 Three-Year Assurance Report.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 2. Safe Care<br>5. Timely Care<br>3.1 Safe and Clinically Effective Care<br>7.1 Workforce |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| | Is EIA Required and included with this paper |
| Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment (EIA) completed | Choose an item.<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | |

| Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government | | | |
|---|---|---|---|
| Health Board | Aneurin Bevan University Health Board | | |
| Reporting period | The reporting period is 6th April 2021 - 5th April 2024. This is a caveated report due to the timeframe for closing serious incidents and will only include data relating to serious incidents closed by 31st January 2024.<br><br>The caveated report must be submitted to Welsh Government by 4th April 2024 which will include all serious incident prior to April 5th, 2024, will be presented to Board in September 2024 and submitted to Welsh Government 16 October 2024. | | |
| | 2021/2022 | 2022/2023 | 2023/2024 |
| Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board | 25 May 2022 | 24 May 2023 | 29 May 2024 |
| Number of adult acute medical inpatient wards where section 25B applies | Lowest: 19<br>Highest: 24 | Lowest: 21<br>Highest: 21 | Lowest: 21<br>Highest: 21 |
| Number of adult acute surgical inpatient wards where section 25B applies | Lowest: 9<br>Highest: 13 | Lowest: 12<br>Highest: 13 | Lowest: 13<br>Highest: 13 |
| Number of paediatric inpatient wards where section 25B applies | Lowest: 1 (50 beds)<br>Highest: 1 (50 beds) | Lowest: 1 (50 beds)<br>Highest: 1 (50 beds) | Lowest: 1 (50 beds)<br>Highest: 1 (50 beds) |
| Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B | adult acute surgical inpatient wards | adult acute surgical inpatient wards | adult acute surgical inpatient wards |
| | 4 (wards re-purposed to support Covid-19 pathways) | 0 | 0 |

VERSION 12092023
Date approved by the Reporting Subgroup: 11/09/2023.
Date approved by All Wales Nurse Staffing Group: 25/09/2023.

| | | | |
|---|---|---|---|
| | Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in adult acute medical inpatient wards | Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in adult acute medical inpatient wards | Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in adult acute medical inpatient wards |
| | 4 (wards repurposed to support Covid-19 pathways) | 0 | 4 Medical wards |
| | Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in paediatric inpatient wards<br><br>0 | Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in paediatric inpatient wards<br><br>0 | Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in paediatric inpatient wards<br><br>0 |
| Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards. | The second wave of the Covid-19 pandemic coupled with the early opening of the Grange University Hospital (GUH) in November 2020 proved a challenging time for the Health Board. Multiple re-purposing of wards across the Enhanced Local General Hospitals (ELGH's) sites was necessary to support the intended clinical futures model. In addition, many wards were re-purposed to manage complex Covid pathways, maintain patient safety and re-establish business as usual.<br><br>In line with the Clinical Futures model:<br><br>Wards at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH) were closed permanently or re-purposed to become semi acute medical/older adult wards or elective surgery/step-down wards.<br>The Royal Gwent Hospital created green pathways to re-establish elective surgery services.<br>Ysbyty Ystrad Fawr (YYF) hospital was dedicated to accepting Covid 19 positive patients, consequently all wards underwent temporary re-purposing.<br><br>Maintaining a record of the changing purpose of wards to manage Covid-19 pathways and the reconfiguration of services, as a consequence opening the GUH, proved to be extremely difficult as ward reconfigurations were rapid and frequent. | | |

| | |
|---|---|
| Informing patients | The 2016 Act requires Health Boards/Trusts to inform patients of the nurse staffing level on each 25B ward.<br><br>Following the 6 monthly recalculation cycles, the agreed planned rosters must be displayed at the entrance of each 25B ward using the All-Wales informing patients templates. Templates must be displayed in Welsh and English with the date recalculations were presented to Board. To note, the re-purposing of wards to manage the pandemic made this incredibly challenging and on occasions the Health Board was non-compliant. Compliance at times does pose a challenge when wards are re-purposed or temporarily move location.<br><br>Additionally, wards must have available easy to read frequently asked questions (FAQ's) regarding the Nurse Staffing Levels (Wales) Act 2016 and information on how to raise a concern regarding nurse staffing levels. The Nurse Staffing Act Programme Lead ensures all 25B wards have access to the necessary leaflets, ward templates are updated following each presentation of recalculations to Board.<br><br>Information on the Nurse Staffing Act and the FAQ's is available on the ABUHB website under Health & Advice, Patient Information Leaflets.<br><br>For further assurance, future recalculation meetings will require ward managers and senior nurses to confirm ward templates are up to date and Nurse Staffing Act (Wales) 2016 leaflets are on display. Monthly confirmation of compliance is also built into the recently introduced ward accreditation programme.<br><br>As from January 2024, all 25B wards in ABHUB are required to display the actual daily staffing levels alongside the planned roster template, it is anticipated this may take time to embed. |

| Section 25E (2a) Extent to which the nurse staffing level is maintained.<br><br>As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period. | |
|---|---|
| Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020. | Number of wards: 32 |
| | RN: 510.01 |
| | HCSW: 505.67 |

| | | 2021/2022 | 2022/2023 | 2023/24 |
|---|---|---|---|---|
| Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards | Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during first cycle (May) | Number of wards: 32 | Number of wards: 33 | Number of wards: 34 |
| | | RN: 538.24 | RN: 594.1 | RN: 601.1 |
| | | HCSW: 553.61 | HCSW: 641.6 | HCSW: 713.85 |
| | WTE of required establishment of adult acute medical and surgical inpatients wards funded following first (May) calculation cycle | Number of wards: 32 | Number of wards: 33 | Number of wards: 34 |
| | | RN: 538.24 | RN: 594.1 | RN: 595.47 |
| | | HCSW: 553.61 | HCSW: 641.6 | HCSW: 700.46 |
| | Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during second cycle (Nov) | Number of wards: 33 | Number of wards: 32 | Number of wards: 34 |
| | | RN: 594.1 | RN: 582.31 | RN: 599.68 |
| | | HCSW: 641.6 | HCSW: 695.33 | HCSW: 720.22 |
| | WTE of required establishment of adult acute medical and surgical inpatients wards funded following second (Nov) calculation cycle | Number of wards: 33 | Number of wards: 32 | Number of wards: 34 |
| | | RN: 594.1 | RN: 582.31 | RN: 594.05 |
| | | HCSW: 641.6 | HCSW: 695.33 | HCSW: 706.24 |
| | WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster) | WTE: 33 | WTE: 33 | WTE: 34 |

Accompanying Narrative:
Following the 2nd wave of the Covid 19 pandemic and the associated challenges, health boards received a letter from the Chief Nursing Officer in December 2020 which confirmed the routine bi-annual All Wales Nurse Staffing Acuity audit would not proceed in January 2021. However, ABUHB, took the decision to progress with local acuity audits and the subsequent spring recalculations in view of the early opening of the GUH and the repurposing of the ELGH's.

Spring and Autumn 2021
The Spring 2021 calculations proved to valuable and demonstrated a need for new establishments and the repurposing of wards to settle. It must be acknowledged the opening of GUH in addition to added complexities of re-purposing wards, opening of extra capacity beds, winter pressures, and maintaining Covid pathways made tracking of staffing establishments very challenging. The Autumn 2021 re-calculations identified a need to increase the nursing establishments on seventeen wards. The spring and autumn acuity audits demonstrated a notable increase in patient acuity, particularly relating to level 4 and 5 enhanced care patients. The complexities of caring for enhanced care patients in single rooms was highlighted.

Spring and Autumn 2022
Recalculations illustrated a further need to increase the Registered Nurses (RN) establishment by 4.25 WTE and the Health Care Support Worker (HCSW) establishment by 34.39 WTE on 25B wards.

Professional discussions in the recalculation cycles and data from the June acuity audit reflected the upward trend of increased patient dependency on care of the older adult wards in the ELGH's and the increased use of temporary staffing. There was a marked increase in level 3 complex care patients as well as an increase in level 4 and 5 patients requiring enhanced care, which was significantly higher than pre-pandemic levels.

One 25B ward in Scheduled care was temporarily closed, (D7E), staff were redeployed to support vacancy deficits in other wards until the ward re-opened in October 2022. A total of 14 wards under s25B required amendments to previously agreed rosters.

Spring and Autumn 2023
The Spring 2023 recalculation continued to highlight high levels of acuity/dependency in the older adult wards. Professional discussions included new initiatives to manage enhanced care patients and trialling new roles such as "activity coordinators." Changes to previously agreed rosters were required on 6 wards, 2 wards in Scheduled care were approved and presented to Executive Committee in August 2023. The proposed changes of establishment to 4 wards in the Division of Medicine were put on hold whilst the reconfiguration of stroke services took place. The Board recognised there was a need to support the proposed establishments in the interim period using temporary staffing.

Autumn 2023 calculations confirmed the majority of 25B wards as having the correct establishment to meet the needs of patients. Cost neutral amendments for 2 wards in Scheduled Care were agreed. The proposed establishment changes previously identified in the Spring calculations on the 4 wards in the Division of Medicine remained on hold.

In collaboration with the E-rostering team and finance partners, roster templates are changed, and budgets aligned for all 25B wards where changes to the agreed templates are approved by the "Designated Person" (Executive Director of Nursing) and presented to Board.

The variation in the required establishment verses the funded establishment in year 2023/2024 is related to the 4 wards in the Division of Medicine where the proposed staffing changes remained on hold.

Exceptional recalculation meetings for the 4 wards in the Division of Medicine, involved in the stroke reconfiguration, were undertaken early February 2024. The calculations will be presented to the Executive Committee in April 2024, the outcomes of which will be outlined in the un-caveated 3-year report to Welsh Government.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. These staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Vacancy Position

Current Registered Nurse vacancies for ABUHB is reported as 290.01WTE. Workforce sustainability has been a significant corporate risk during this 3-year reporting period in the delivery of safe and effective care. This is not unique to ABUHB, with most health boards across Wales facing similar recruitment and retention challenges. Despite targeted efforts to reduce vacancies and offer incentivised pay rewards there has been a reliance on temporary staffing. However, it must be acknowledged over the last 12 months the Health Board has seen significant reduction in HCSW agency and Registered Nurse off-contract agency. The Health Board continues to take all reasonable steps to maintain staffing levels, the Executive Committee have given full support to convert temporary staffing into substantive posts and where necessary over recircuit into HCSW vacancies.

Recruitment and Retention

Staff well-being has been a major organisational priority following the Covid pandemic, developing a resilient, agile, and competent workforce to serve our communities is essential. Fully cognisant of the national shortage of registered nurses, the Health Board is committed to improving recruitment and retention and making ABUHB an employer of choice.

ABUHB is fully engaged in student streamlining and has committed to the recruitment of 75 International nurses annually for the next 3 years. Some of the approaches deployed to attract staff during the past 3 years include targeted recruitment events, promoting the health Board through social media, advertising career pathways, flexible working and continuous education and development opportunities.

In 2023 the Health Board launched its robust Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026 (Appendix I) sets out progress against the priority actions articulated within the strategy).

ABUHB aims to deliver its People Plan ambition of being an employer of choice and for nursing to be the career of choice.

The Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026 focuses on:

- Recruitment Effectiveness
- Recruitment Experience
- Brand and Marketing

| | | | | |
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| Career Development and Educational Opportunities – Growing our Own.<br>Attraction and Retention | | | | |
| Required establishment (WTE) of paediatric inpatient wards prior to extension of the 2nd duty of the Act (October 2021) | | Number of wards: 1 (50 Bedded) | | |
| | | RN: 70.22 | | |
| | | HCSW: 17.66 | | |
| Extent to which the required establishment has been maintained within paediatric inpatient wards. | | 2021/2022 | 2022/2023 | 2023/24 |
| | Required establishment (WTE) of paediatric inpatient wards calculated during first cycle (May) | | Number of wards: 1 | Number of wards: 1 |
| | | | RN: 70.22 | RN: 70.22 |
| | | | HCSW: 17.76 | HCSW: 17.76 |
| | WTE of required establishment of paediatric inpatient wards funded following first (May) calculation cycle | | Number of wards:1 | Number of wards: 1 |
| | | | RN: 70.22 | RN:70.22 |
| | | | HCSW: 17.06 | HCSW: 17.06 |

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| | Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second cycle (Nov)<br><br>NB (*) The 1st calculation was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act on 1st October 2021. | Number of wards:1 | Number of wards: 1 | Number of wards: 1 |
| | | RN: 70.22 | RN: 70.22 | RN: 70.22 |
| | | HCSW: 17.06 | HCSW: 17.06 | HCSW: 17.06 |
| | WTE of required establishment of paediatric inpatient wards <u>funded</u> following second (Nov) calculation cycle<br><br>NB (*) The 1st calculation was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act on 1st October 2021. | Number of wards: 1 | Number of wards: 1 | Number of wards: 1 |
| | | RN: 70.22 | RN: 70.22 | RN: 70.22 |
| | | HCSW: 17.06 | HCSW: 17.06 | HCSW: 17.06 |
| | | 2021/2022 | 2022/2023 | 2023/2024 |
| | WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster) | WTE: 1 | WTE: 1 | WTE:1 |

Accompanying Narrative:

In February 2021, The Senedd extended the NSLWA to include Paediatrics and the regulations came into force in October 2021. The reporting dates remain aligned to the existing reporting schedule for adult acute medical and surgical wards. The three-year reporting period is tethered to the date of the Act's commencement, not the coming-into-force date of these regulations. Therefore, the information on paediatric wards will be missing for the first six months of this 3-year reporting period.

In preparation of the extension of the Act and the opening of GUH, the Paediatric team undertook a robust roster calculation, which was presented to the Executive Team in September 2021. The January 2022 acuity audit and subsequent Spring 2022 re-calculations confirmed the calculated establishment was appropriate. The themes from the professional discussions included:

The time-of-day acuity levels are captured and the need to include High Dependency Unit (HDU) patients, to ensure accurate acuity capture.

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The recognition of a very junior nursing workforce within the Directorate.
The once yearly Pediatric Registration Programme hampers recruitment.
The Division is developing a different workforce model, to include Assistant Practitioners.
The current establishment can facilitate fluctuating acuity levels and bed occupancy.

The 2023 acuity audits demonstrated a high level of acuity, alongside increased turnover, and length of patient stay. Professional discussion concluded the establishment did not require adjustment. Despite 19.48WTE RN vacancies, risk is reduced as RN deficits are covered by substantive staff via the nurse bank.

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| Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards and paediatric wards. | NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained, and to provide assurance that all reasonable steps have been taken to maintain the required nurse staffing levels. As such, extensive work has been undertaken to implement a national informatics system to enable health boards to meet the reporting requirements of the Act and the Once for Wales approach to ensure consistency.<br><br>Each health board has implemented the Allocate Safecare system at different times during the 3-year reporting period and has therefore continued to rely on the Health Care Monitoring System (HCMS). Some health boards have been able to adapt and extract the data analysis to aid reporting.<br><br>To date ABUHB has not had the digital capability to demonstrate the extent to which the planned roster has been maintained within 25B wards, as such, the health Board has been unable to include this information in the annual assurance reports for this 3-year reporting period. Furthermore, the newly adopted Safecare system is currently unable to produce the required data.<br><br>Within this Health Board, the roll out of Safecare to all 25B wards was completed by June 2023, further support to embed the system into everyday practice is required on a few wards.<br><br>It has recently become known that Allocate Safecare are required to undertake amendments to the Safecare reporting system to enable health boards to extract the data to meet reporting requirements.<br><br>Providing the amendments can be completed on time it is anticipated the following information will be available for reporting in the ABUHB annual assurances report for May 2024.<br><br>Shifts where planned roster met and appropriate.<br>Shifts where planned roster met bot not appropriate.<br>Shifts where planned roster not met but appropriate. |
| Process for maintaining the nurse staffing level for Section 25B wards | The Health Board has been proactive in considering ways of maintaining sufficient and safe nurse's staffing levels.<br><br>The Health Board has a well-established process to manage and escalate nurse staffing deficits ensuring all reasonable steps have been followed to maintain nurse staffing levels, these include: |

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| | A ratified Nurse Staffing Operational Framework, the purpose of which is to standardise and inform staff groups of their responsibilities and of processes and procedures for ensuring appropriate and carefully considered nurse staffing in all areas. Specifically, the overarching duty, s25A, is referenced within the Policy.<br><br>Staffing deficits across the Health Board are reported weekly to include:<br><br>➢ Filled and unfilled Registered Nurse (RN) shifts against planned rosters<br>➢ Filled and unfilled Health Care Support Worker (HCSW) shifts against planned rosters<br>➢ Percentage of substantive staff versus agency staff populating rosters to gauge quality, safety, and continuity of care.<br><br>A workforce tracker is presented to the Executive Team detailing progress on recruitment, bank and agency usage, turnover, and absenteeism.<br><br>A monthly Strategic Workforce (NSLWA) meeting is held with representation from all clinical Divisions, with the purpose of overseeing the implementation of the Act and monitoring key workforce and staffing metrics.<br><br>Daily review of nurse staffing levels by the divisional and site teams – to manage and mitigate risk.<br><br>The development of new and innovative roles has been crucial in maintaining nurse staffing levels across the Health Board.<br><br>The deployment of staff between wards and across sites to fill short notice deficits.<br><br>Senior nurses and site teams are encouraged to use the sunburst view in the Safecare system to assess staffing levels, staffing deficits and patient acuity. Red flags and professional judgements assigned to 25B wards help inform decision making when considering the deployment of staff.<br><br>Ratified Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026.<br><br>On occasion, there has been a requirement to reduce capacity to maintain appropriate staffing levels. |

| Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2) | | | | | |
|---|---|---|---|---|---|
| | | Hospital acquired pressure damage (grade 3, 4 and unstageable) | Falls resulting in serious harm or death (i.e. 4 and 5 incidents). | Medication errors never events | Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR |
| | | TOTAL | TOTAL | TOTAL | TOTAL |
| Number of closed incidents/complaints occurring during current year & those that were carried over from the previous year | Year 1 | 54 | 40 | 0 | 209 |
| | Year 2 | 35 (including 7 carried over from year 1) | 28 (including 8 carried over from year 1) | 0 | 84 (including 18 carried over from year 1) |
| | Year 3 | 2 Avoidable (including 2 carried over from year 2) | 6 (including 2 carried over from year 2) | 0 | 44 (including 15 carried over from year 2) |
| Total number of incidents/ complaints not closed and to be reported on/during the next reporting period | TOTAL | 11 | 4 | 0 | 43 |
| Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained | Year 1 | 3 | 0 | 0 | 6 |
| | Year 2 | 2 | 3 | 0 | 18 |
| | Year 3 | 5 | 0 | 0 | 2 |
| Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor | Year 1 | 0 | 0 | 0 | 0 |
| | Year 2 | 2 | 2 | 0 | 8 |
| | Year 3 | 0 | 0 | 0 | 2 |

NOTE: There is a marked reduction in reportable incidents in year 3 for HAPU's and falls- the reasons for this are explained below.

Accompanying Narrative:

Based on a review of the health boards/trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 requesting a review of the current reporting process. A sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process; standardise reporting in line with the Duty of Candour set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020 and to broaden the reporting scope of incidences of harm to provide more meaningful data.

The findings and recommendations of the Reporting Sub-Group were presented to the Executive Nurse Directors in August 2023 who approved the recommendations to take effect from the next reporting period i.e. 6th April 2024 – 5th April 2027.

The quality indicators for the adult in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm, or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (complaints refer to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR).

The measures going forward will include:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents / complaints not closed and to be reported on /during the next year.
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained.
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained.
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

Following the Executive Nurse Directors agreeing the recommendations in August 2023 it became apparent that the Duty of Candour (DoC), which came into force on 1st April 2023, would impact the reporting metrics.

Previous reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. This change to reporting is not specific to ABUHB but will impact on reporting from all health Boards.

Therefore, to align with patient safety incident reporting to Welsh Government from 6th April 2023 this report, and all future reports, will report on closed patient safety incidents which have been validated with a reportable level of harm (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

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Consequently, despite the broadening of reporting criteria, the number of incidents reported within this 3-year report, and subsequent, annual assurance reports may be lower than those in previous years.

ABUHB transitioned to the new reporting system, RL Datix, during 2021-2022, the start of this reporting period saw a notable increase in Health Care Acquired Pressure Ulcers (HAPUs) compared to the end of the previous reporting period. The reasons for this increase is multifaceted and attributed to:

- Increased acuity
- Increased length of stay
- Inclusion of avoidable HAPU reporting which ABUHB had not previously reported
- Reliance on temporary staffing to manage additional capacity and the pandemic winter surge

It must be acknowledged, the figures in year 1 and 2 include all hospital acquired pressure ulcers, (Avoidable and Unavoidable), following an in-depth root cause analyses by senior nurses in the divisions.

As explained above- year 3 of this reporting period shows a marked decrease in reportable incidences of HAPUs and Falls following the clarification on what constitutes a patient safety incident.

Year 3: includes data closed by 31 January

A total of 26 Hospital Acquired Pressure Ulcers - 11 of which remain open and still require investigation, 15 are closed and following investigation were deemed unavoidable.

Following the clarification of what a reportable safety incident is, ABUHB reportable falls have dropped significantly. ABUHB had previously included moderate harm incidents as opposed to only reporting severe and catastrophic harm.

There has been a significant reduction in complaints in comparison to the previous 3-year reporting period, with 43 complaints remaining open. It must be noted that most complaints are multifaceted.

| Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards | | | | | | |
|---|---|---|---|---|---|---|
| | | Hospital acquired pressure damage (grade 3, 4 and unstageable) | Falls resulting in serious harm or death (i.e. 4 and 5 incidents) | Medication errors never events | Infiltration and extravasation injuries | Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR |
| | | TOTAL | TOTAL | TOTAL | TOTAL | TOTAL |
| Number of closed incidents/complaints occurring during current year & those that were carried over from the previous year | Year 1(*) | 0 | 0 | 0 | 2 | 0 |
| | Year 2 | 0 | 0 | 0 | 4 | 0 |
| | Year 3 | 0 | 0 | 0 | 2 | 1 |
| Total number of incidents/ complaints not closed and to be reported on/during the next reporting period | TOTAL | 0 | 0 | 0 | 8 | 1 |
| Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was <u>not</u> maintained | Year 1 (*) | 0 | 0 | 0 | 0 | 0 |
| | Year 2 | 0 | 0 | 0 | 0 | 0 |
| | Year 3 | 0 | 0 | 0 | 0 | 0 |
| Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor | Year 1 (*) | 0 | 0 | 0 | 0 | 0 |
| | Year 2 | 0 | 0 | 0 | 0 | 0 |
| | Year 3 | 0 | 0 | 0 | 0 | 0 |
| NB (*) for year 1 paediatric inpatients only reported incidences and complaints the 1st October when the 2nd year duty of the Act was extended | | | | | | |

The work of the Reporting Sub-Group included the measures for the paediatric inpatient wards. Changes to the paediatric measures will come into effect at the beginning of the next reporting period i.e., April 2024.

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The quality indicators for the paediatric inpatient wards will be as follows:

Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
Falls resulting in moderate harm, serious harm, or death (i.e., level 3, 4 and 5 incidents).
Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
Infiltration and extravasation injuries
Any complaints received involving nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

Number of closed incidents/complaints occurring during current year and those that were carried forward from the previous year.
Total number of incidents/complaints not closed and to be reported on/during the next year.
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had not been maintained.
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained.
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

| Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate | |
|---|---|
| Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards | By way of assurance, the Health Board has in place:<br><br>A well embedded process to investigate all Grade 3, 4 and unstageable Health Care Acquired Pressure Ulcers (HAPU's) through root cause analysis (RCA) which considers a range of variables which may have contributed to the incident. Any HAPU's deemed avoidable are reported to Welsh Government and are considered for Redress Panel, enabling a process of reflection and learning.<br><br>A Falls Review Panel is well established, where all variables are considered, to include nurse staffing levels. Falls closed as moderate level of harm or above on DATIX are considered for Redress Panel. Organisational shared learning events have taken place in relation to falls. The Division of Medicine has also introduced SWARM (immediately following a patient fall staff congregate to determine what has happened, why it happened, and what can be done to prevent further falls) rounds in some areas to reduce harmful falls.<br><br>Complaints is a complex metric to capture due to the multi-faceted nature of complaints, which rarely pertain to nursing care alone. For this reason, there are 43 complaints which have been deemed partially or wholly due to nursing which continue to be investigated and will be included in the next reporting period.<br><br>All medication Never Events are investigated as serious incidents and reported to Welsh Government.<br><br>Hospital Acquired Pressure Ulcers (HAPU)<br>2021/22: Following investigation there were 3 HAPUs where the planned roster was not met. A failure to maintain the planned roster was not considered to be a contributary factor. |

2022/23: 9 closed HAPUs were deemed to be avoidable, with 1 HAPU attributed to the planned roster not being met, on close investigation there were other contributing factors involved which may have attributed to this.

2023/24: 2 HAPUs were carried over from 2022 to the 2023/2024 report. Both were found to be avoidable following a root cause analysis. The planned rosters were met in both incidences and the staffing levels were not considered to be a contributary factor. The 15 closed HAPUs for 2023/24 were deemed unavoidable, the remaining 11 are under investigation as of the end of January 2024.

Patient Falls

2021/22: Moderate harm as well as severe and catastrophic levels of harm which included all fractures and head injuries irrespective of whether the injuries were caused by an act or omission whilst in NHS care. The staffing levels were not considered to be a contributing factor in the 40 incidences reported.

2022/23: Moderate harm as well as severe and catastrophic incidents of harm were again reported. The report included 12 hip fractures and 2 head injuries, 3 of which were attributed to the planned roster not being met. On these occasions all reasonable steps were taken to meet the required staffing levels, despite this, shifts remained unfilled. During recalculation meetings no specific themes were identified, it was noted that many of the falls occurred on the Care of The Older Adult wards. Divisional work has been undertaken to ensure all registered staff complete falls risk assessment training.

2023/24: There were 6 incidences closed with a severe/catastrophic level of harm, 2 of which were carried over from 2022 and investigated as serious incidents. The planned rosters were met on all 6 incidences. Patients had been assessed to mobilise independently and in 2 cases the falls were witnessed.

Complaints

The NSLWA reporting requirements in regards complaints remains challenging, there remain a high number of closed complaints where the Nurse Staffing Act questions are incomplete within Datix. The Nurse Staffing Act question had been completed for 22 of the 43 closed incidents, there were 3 occasions where the planned roster was not met. The professional judgement referred to high temporary staffing, junior staff on duty and high vacancies. More work is required to raise staff awareness regarding the importance of completing all sections of the incident reporting fields in Datix. These fields are currently not mandatory; senior nurses do not receive a prompt to complete hence the questions can easily go unnoticed. It is anticipated the completed 3-year report will demonstrate an improvement in the quality and detail of information provided.

Infiltration/Extravasation

The paediatric senior nurse has confirmed all 8 incidences of infiltration/extravasation injuries during this 3-year reporting period, pumps were sent to medical electronics to be checked, no issues were identified, and the planned staffing roster was met on each occasion.

NB: It is important to note there are still outstanding incidents on the adult medical and surgical wards which

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| | require investigation to determine causation which fit this reporting period, they will be added to the next reporting period. |
| Conclusion & Recommendations | Conclusion:<br>During the three-year reporting period the Health Board has continued to face unprecedented challenges. Increased demand in services, ongoing Covid-19 pressures, extra capacity, and workforce deficits, high use of temporary staffing which increases risk and patient safety.<br><br>Innovative ways of working to strength and stabilise the workforce have been introduced.<br><br>The Nursing, Midwifery and SCHPN Workforce Strategy has been implemented to strengthen and grow the workforce.<br><br>Clear processes are in place to identify, investigate and escalate from ward to board any deviations from the planned roster and any potential harm from the consequences.<br><br>Safecare informatics system has been successfully rolled out to all 25B wards.<br><br>It is envisaged the required amendments to the reporting elements in Safecare will enable the Health Board to comply with the reporting requirements of the NSLWA in future reports.<br><br>Recommendations:<br>Continue to provide staff education and training sessions in relation to the requirements of the Act.<br><br>Improve compliance in closing incidents relating to the Nurse Staffing Act reported on Datix.<br><br>Ensure information is available and displayed on all 25B wards informing service users of the Nurse Staffing Levels (Wales) Act 2016.<br><br>Participate in the All-Wales Scoping of Multi Professional Workforce Models. |

Agenda Item:

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| Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN<br>ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING |

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| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Clinical Audit Plan 2024/25 and Annual Clinical Audit Activity Report 2023/24 |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Dr James Calvert, Medical Director |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Joanne Stimpson – Clinical Audit Lead<br>Leeanne Lewis, Assistant Director for Quality & Patient Safety |

| Pwrpas yr Adroddiad (dewiswch fel yn addas)<br>Purpose of the Report (select as appropriate) |
|---|
| Er Sicrwydd/For Assurance |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

Clinical audit is one tool available for assessing whether clinical services are safe and effective.

It is one input into our Quality Management System (QMS). Clinical audit provides assurance against compliance with clinical standards and provides an opportunity to identify and minimise risk, waste, and variation in clinical practice from guideline defined standards of care.

The results of audit are used to plan and prioritise domains of care requiring improvement with the aim of improving patient outcomes.

The Health Board's focus has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan.

The Health Board complies with the requirements of Welsh Government by participating in all mandatory national clinical audits. Our audit plan balances national audit priorities with directorate/division/service/ clinician priorities.

The focus of the Clinical Audit Team in the last year has been to implement the Health Board's Clinical Audit Strategy through meeting and engaging with Divisions to ensure that the structures and processes to allow effective clinical audit are in place.

This paper serves to provide a summary of Clinical Audit Activity from 2023-2024 and sets out the plan for 2024-2025.

## Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by Welsh Government (WG) annually.

The plan is one of the cornerstones in the drive to improve quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements.

The plan details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. The Health Board's audit plan is based on NCAORP.

Following an Internal Audit report and recommendations in November 2022, the focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy. There has been engagement with Divisions and work undertaken on making the clinical audit process more effective.

Work has included:

- Producing standardised audit reporting templates, which has enabled more consistent reporting and improved scrutiny of action plans.
- Review of the ToR of the Clinical Effectiveness Committee (where audit outcomes are reviewed)
- Implementation of the web-based Audit Management and Tracking system (AMaT) has helped facilitate tracking of audit results and the development of action plans.

Local audit plans have been developed by Directorates and are recorded in AMaT. AMaT has been used to build audit proformas, capture data, produce results and develop SMART action plans, all within the same platform. This has allowed many

of the recommendations within the internal audit report to be met. See Appendix One for updated action plan.

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided through reporting to the Patient Quality and Safety Outcomes Committee (PQSOC) which provides scrutiny of National Clinical Audit performance and monitoring of improvement plans.

Clinical audit is an important component of our commitment over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system.

Asesiad / Assessment

The updated Clinical Audit Plan for 2024/25 and Clinical Activity Report for 2023/24 is now available. The Health Board's Annual Clinical Audit Plan and Clinical Audit Activity report is to be ratified by Patient Quality and Safety Outcomes Committee (PQSOC) in April. The activity report summarises all the audits presented at CSEG for the last twelve months between April 2023 – March 2024.

There is now a well-defined process for the scrutiny of National Clinical Audit Reports, which utilises completion of standardised audit reporting templates in AMaT to clearly delineate examples of good practice, practice that needs improvement and SMART action plans required to address these areas.

Audit reports are then 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 registers 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.

The nine-month publication schedule for the NCACORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) has been shared with Directorates. The dates align with presentation of results at Clinical Standards and Effective Group (CSEG). The annual audit plan will continue to ensure mandatory participation in all national clinical audits and national confidential enquiries, including participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

AMaT is also utilised to record compliance with NICE guidance and HTW adoption, which can then be used to identify areas for future clinical audits.

Once National Clinical Audits (NCA) are published on the Healthcare Quality Improvement Partnership (HQIP) webpage, they 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 reach out for assurance on completion of key results, audit actions and improvement plans. We will be requesting for these to be reported to CSEG and placed on AMaT to align with the reporting of all other audits in the future.

Audit Management and Tracking (AMaT) is also being widely used across the Health Board for conducting and reporting on local audits agreed in the audit plan. The volume of audits being undertaken and the number of action plans being recorded is rising.

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

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

Ongoing training in the use of AMaT will ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

The clinical audit team are developing organisational and governance structures within AMaT to support full engagement in audits. This includes consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

The next audit activity report by the clinical audit team will review how learning from clinical audit can be fed back to clinical areas and that audit results are triangulated with other sources of information on the quality of clinical services as part of our QMS.

Argymhelliad / Recommendation

| |
|---|
| Agree to the Clinical Audit Plan for 2024-2025 and receive assurance from the Audit Activity Report for 2023-2024 that the Health Board is meeting its obligation to undertake clinical audit. |

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol:<br>Corporate Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 2.1 Managing Risk and Promoting Health and Safety<br>2.6 Medicines Management<br>2.9 Medical Devices, Equipment and Diagnostic Systems<br>3.1 Safe and Clinically Effective Care |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Getting it right for children and young adults<br>Adults in Gwent live well healthily and age well |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>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<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | |
| Rhestr Termau:<br>Glossary of Terms: | NA – National Average<br>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<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br><br>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<br>Choose an item. |

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

# Aneurin Bevan University Health Board

# Clinical  Plan



# 2024/2025

## Clinical Standards and Effectiveness Group

## Introduction

The Health Board is committed to delivering safe and effective care to the population of Gwent.

Aneurin Bevan University Health Board uses Clinical Audit as part of a quality improvement cycle that measures concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and changed before being re-audited with the aim of improving reliability and outcomes of care.

Clinical audit is recognised by healthcare commissioners and regulators as an effective mechanism for providing assurance about the quality-of-care service users receive. The Health Board's Executive Committee are required by Welsh Government, to certify that they have effective systems, processes and procedures in place to monitor and audit compliance against clinical standards. This is managed in line with the Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit and Patient Outcomes Programme (NCAPOP), which follows a 9-month publication schedule.

The Health Board's audit plan follows the National Clinical Audit 9-month rolling agenda and takes into consideration local audits at speciality and ward level across all sites across the Health Board.

## What is Clinical Audit?

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

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.

Before embarking on a clinical audit, it is important to ascertain whether the topic has been previously audited across the organisation to compare results.


Figure One: The audit cycle

## Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way.

Benefits of clinical audit include:

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

## Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage. Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice.

All Divisions within the Health Board should develop robust local audit plans. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

## Principles of the clinical audit plan

In developing the Aneurin Bevan University Health Board annual audit plan the following approach has been followed:

- Auditing of clinical standards, ensuring the quality of care that patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway in line with current best evidence.
- Ensuring that variations in outcomes of care are understood and there is a coherent approach to the assessment of good practice.
- Ensuring that directorates participate in all National Clinical Audits (NCAs), National Confidential Enquiries (NCEPOD) and service reviews relevant to the services that it provides.
- National audits, which are not on NCAPOP, but which are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls).
- NICE guidance and HTW adoption. Audit is not mandatory, but implementation and audit of NICE guidance can be subject to external review.
- Projects requiring re-audit after changes in practice.
- Ensuring that all clinical audit activity within directorates is registered.
- Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Ensure healthcare professionals are enabled to participate in clinical audit to satisfy demands of their relevant professional bodies (for example, for revalidation and professional development).
- Ensure the necessary resources, governance and organisational structures are in place to support engagement in audits, reviews and national registers included in the annual Plan.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified

Aneurin Bevan University Health Board has a Clinical Audit Strategy 2022-2025 with four priorities:

**Aneurin Bevan University Health Board has Four Priorities:**

1. Scrutiny of national clinical audit performance with robust development, monitoring, and progression of Improvement plans

2. Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

3. Trainees are supported to participate in audits that support clinical governance

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

This can be read in conjunction with the Health Board's Clinical Audit Policy and The Quality Strategy.

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

## Aligned to Priority One in the Clinical Audit Strategy - There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

All National Audit Reports will be reviewed by Divisions, Clinical Directors and Clinical Audit Leads

Divisions will work with Clinical Directors to develop an action plan where improvements are identified following audit

The Division will support presentation of National Audit results and improvement plans at the Clinical Standards and Effectiveness group within two months of the audit publication date

There will be ongoing monitoring of the improvement plan by the Division

The National Audit results and improvements will be included in the Annual Clinical Audit Activity Report

The outcome of the improvement plan will be included in the presentation to Clinical Standards and Effectiveness Group the following year, following publication of the next annual report

# Recommendations from Clinical Audit


1. Clinical Audit reports and outcomes identify recommendations for service improvement and QI work where data shows variation from standard of care
2. National and Local audit recommendations are reviewed by the ABUHB Clinical Lead
3. Risks are identified by clinical leads/teams, to ensure risks are escalated and recorded on risk register

The process of clinical audit is managed through the Clinical Standards and Effectiveness Group (CSEG). Steps are:

1. National report published
2. QPS audit team link with Clinical Lead/representative with audit results
3. Results presented at CSEG by Clinical Lead
4. SMART actions agreed against standards and/or good practice highlighted
5. Action plan placed on AMaT
6. Presented to Patient Safety and Quality Outcomes Committee (PQSOC)

## What is AMaT ?

Aneurin Bevan University Health Board has fully implemented AMaT (Audit Management and Tracking. AMaT is a software package designed to make auditing easier, faster, and more effective. Utilisation has been rolled out over the past 12-18 months, including training staff and ensuring AMaT utilisation at all steps of the audit cycle to allow assurance that audit results and outcomes are tracked by the organisation and teams are supported with the process.

Audit is a vital part of healthcare, helping to improve patient care, manage risk, and comply with reporting requirements. It can be time-consuming, labour-intensive, and often slow to deliver results and actions. AMaT has enabled more control over audit activity. The standardised reporting template has been utilised in the system to enable reporting at CSEG. It has provided real-time insight and reporting for clinicians, wards and the quality and patient safety audit department. It is being used for completing local audits and tracking actions and improvement plans for National Clinical Audit.

AMaT has been straight forward to implement and presented to Divisions as part of the Clinical Audit Strategy. Data can be inputted and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

The tracking of audits has been made easier with users being able to allocate SMART actions across their teams and provides data results instantly, numerically or graphically. Key successes, concerns, risk and assurance can also be recorded.

## Clinical Audit Plan

Aneurin Bevan University Health Board's Clinical Audit Plan reflects national and local drivers for quality improvement.

The 'Plan' is used by the Quality and Patient Safety Team (QPS) to have a defined map of publications throughout the year and can organise these in line with the Clinical Audit Strategy:

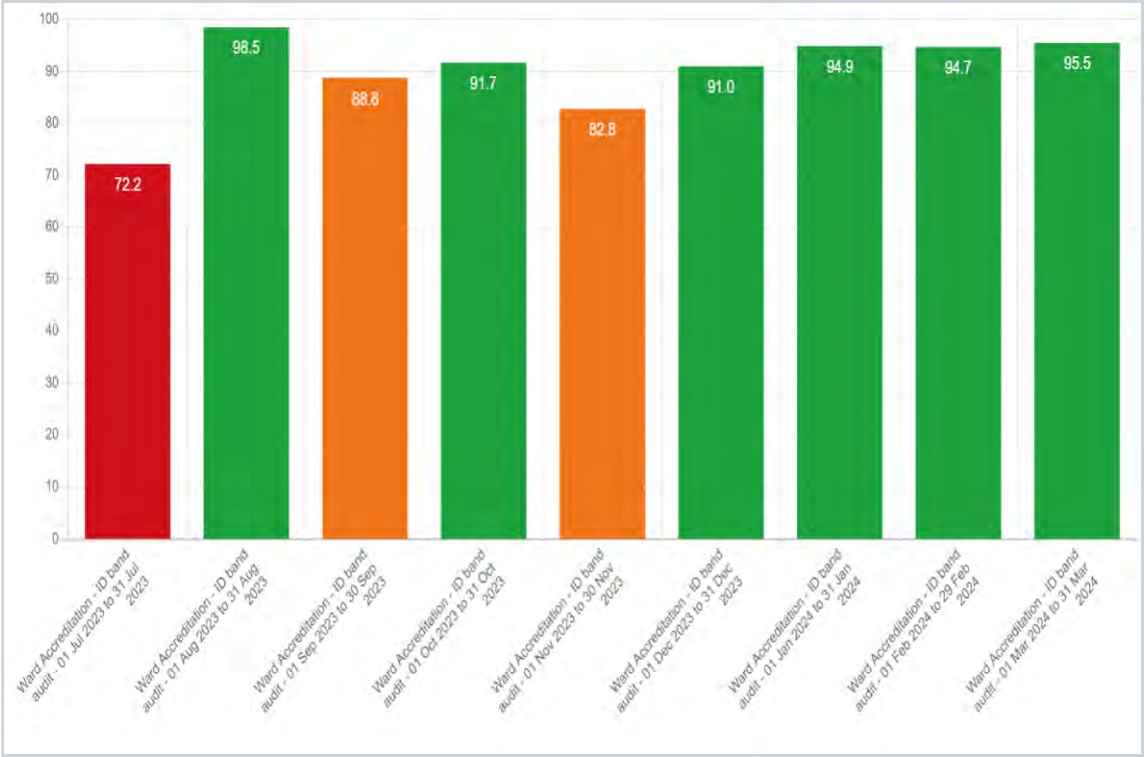
- The Clinical Audit Plan will be added to and refined annually as Clinical Audit processes develop in the Health Board.
- It provides a prioritised list of planned clinical audit activity.
- The National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) and NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR) is published on a rolling nine-month programme.
- The current audit plan includes audit publication dates scheduled between April 2024 & April 2025.
- All National Clinical Audits (NCA's) will be managed in AMaT.
- The standardised AMaT audit report template will be used, ensuring consistency of reporting to PQSOC.
- Local audits must be registered via AMaT to ensure results are visible.
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) participation is included in our plan (The NCEPOD process is designed to assist in improving standards of care by undertaking confidential reviews of patient care and publishing national recommendations in areas studied).

# As defined in Priority 2 - Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

Divisions have been identifying audits that provide assurance and any improvement work associated with areas of priority including:

- Serious Incidents
- Poor Clinical Outcomes
- New Guidance
- Mortality Reviews / M&M

All audits are being registered on AMaT. The system is being used to build proformas and undertake the audit. Results are presented as dashboards – providing visual and easy to understand data/charts. Here are examples of local audits on AMaT relating to ward accreditation and IP&C.




| | Main frequency | Auditor | Compliance and submissions over last 3 audits | | | Current | Due in | Progress | Data | Drafts | Plan | Overdue actions | Manage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Environmental | M | Ward Staff | A 84.9% (1/1) | G 91.8% (1/1) | G 90.7% (1/1) | | 26 days | Click to audit | - | - | | | ACTIONS |
| Get Up, Get g | M | Nursing Staff | R 66.7% (1/1) | G 100.0% (1/1) | G 100.0% (1/1) | | 26 days | Click to audit | - | - | | | ACTIONS |
| Hand Hygiene | M | Ward Manager | G 100.0% (20/20) | G 100.0% (20/20) | G 100.0% (20/20) | | 26 days | Click to audit | - | - | | | ACTIONS |
| Hospital t | M | Nursing Staff | R 71.4% (8/8) | R 69.9% (8/8) | A 78.6% (8/8) | | 26 days | Click to audit | - | - | | | ACTIONS |

## Appendix One – National Clinical Audit and Outcome Review Plan

This is published on a rolling nine-month Programme and will be updated monthly on the Quality and Patient Safety Clinical Audit Intranet Page. National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) and NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). Publication notification date 11th April 2024

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 11/04/2024 | NCA | SSNAP - Sentinel Stroke National Audit Programme | Sentinel Stroke National Audit Programme quarterly data only report (Oct-Dec 2023) | Stroke Board |
| 11/04/2024 | Audit | NLCA - National Lung Cancer Audit | National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales) | CSEG Jul 2024 |
| 11/04/2024 | Audit | NELA - National Emergency Laparotomy Audit | National Emergency Laparotomy Audit State of Nation report 2024 | CSEG May 2024 |
| 09/05/2024 | NCA | 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. | CSEG Jul 2024 |
| 13/06/2024 | NCA | NRAP - National Respiratory Audit Programme (was NACAP) | National Respiratory Audit State of the Nation report | CSEG Jul 2024 |
| 11/07/2024 | NCA | NDA - National Diabetes Audit (adults) | National Diabetes Inpatient Safety Audit (NDISA) State of the Nation report, May 2018 - Oct 2023; Eng & Wal. | CSEG Jul 2024 |
| 11/07/2024 | CORP | Medical and Surgical Clinical Outcome Review Programme | Medical and Surgical Clinical Outcome Review Programme - Endometriosis report | CSEG Oct 2024 |
| 11/07/2024 | NCA | Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People | Epilepsy12 State of the National report, England and Wales (2021-23) | Particially Participating |
| 08/08/2024 | NCA | NRAP - National Respiratory Audit Programme (was NACAP) | National Respiratory Audit Programme Primary Care Report (cohort TBC) | CSEG Sep 2024 |
| 08/08/2024 | NCA | NAD - National Audit of Dementia | National Audit of Dementia: Memory Assessment Services Spotlight Report | Dementia Team ONLY |

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 12/09/2024 | NCA | NatCan - National Cancer Audit Collaborating Centre (was NCACC) | National Primary Breast Cancer Audit (NaoPri) - State of the Nation | CSEG Dec 2024 |
| 12/09/2024 | NCA | NatCan - National Cancer Audit Collaborating Centre (was NCACC) | National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation | CSEG Dec 2024 |
| 12/09/2024 | NCA | NatCan - National Cancer Audit Collaborating Centre (was NCACC) | National Ovarian Cancer Audit (NOCA) - State of the Nation | CSEG Dec 2024 |
| 12/09/2024 | NCA | NatCan - National Cancer Audit Collaborating Centre (was NCACC) | National Pancreatic Cancer Audit (NPaCA) - State of the Nation | CSEG Dec 2024 |
| 12/09/2024 | NCA | NatCan - National Cancer Audit Collaborating Centre (was NCACC) | National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation | CSEG Dec 2024 |
| 12/09/2024 | NCA | NatCan - National Cancer Audit Collaborating Centre (was NCACC) | National Kidney Cancer Audit (NKCA) - State of the Nation | CSEG Dec 2024 |
| 12/09/2024 | NCA | FFFAP - National Falls & Fragility Fracture Audit Programme | National Hip Fracture Database State of the Nation 2024 | CSEG Oct 2024 |
| 10/10/2024 | NCA | FFFAP - National Falls & Fragility Fracture Audit Programme | National Audit of Inpatient Falls State of the Nation 2024 | Falls and Bone Health Group |
| 10/10/2024 | NCA | NEIAA - National Early Inflammatory Arthritis Audit | National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report | CSEG Jan 2025 |

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 10/10/2024 | NCA | NPDA - National Paediatric Diabetes Audit | National Paediatric Diabetes Audit PREMS report 2024 (24/07/2023 - 23/01/2024) | Data to Clinical Lead ONLY |
| 10/10/2024 | NCA | NNAP - National Neonatal Audit Programme | National Neonatal Audit Programme 2024 report | CSEG Jan 2025 |
| 10/10/2024 | CORP | MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme | Maternal, Newborn and Infant Clinical Outcome Review Programme Saving lives, improving mothers care report | Family and Therapies to provide update |
| 14/11/2024 | NCA | NRAP - National Respiratory Audit Programme (was NACAP) | National Respiratory Audit Programme Combined Organisational Report | CSEG Jan 2025 |
| 14/11/2024 | NCA | NVR - National Vascular Registry | National Vascular Registry state of the nation report 2024 | CSEG Jan 2025 |
| 14/11/2024 | NCA | SSNAP - Sentinel Stroke National Audit Programme | Sentinel Stroke National Audit Programme State of the Nation 2024 | Stroke Board |
| 14/11/2024 | CORP | Medical and Surgical Clinical Outcome Review Programme | Medical and Surgical Clinical Outcome Review Programme: End of Life Care report 2024 | CSEG Jan 2025 |
| 14/11/2024 | N/A | NCMD - National Child Mortality Database | National Child Mortality Database Child Death Reviews Data year ending 31/03/2024 | Family and Therapies to provide update |

## Corporate Audits

The Clinical Audit Team facilitate audits throughout the year. These can be scheduled in advance with defined dates to be undertaken, or triggered by governance issues that arise during the year which require further investigation. The Clinical Audit Team assist with Health Board specific audits.

These audits are all managed on AMaT and will be accomplished with the support of a Clinical Lead within that area of expertise.

All audit results will go through the Clinical Standards and Effectiveness Group, with the same process as for National Audit and these are documented in the same way, providing assurance, successes and concerns and action plans which will be monitored.

| | | | |
|---|---|---|---|
| Audit Title: | | Clinical Lead: | |
| Rationale: | | | |
| Objectives: | | | |
| CSEG date: | | | |
| Report Successes: (to be completed by the Clinical Lead) | | | |
| Report Concerns: (to be completed by the Clinical Lead) | | | |
| Assurance level | | Description | Select |
| Risk level | | Description | Select |
| Report Recommendations: (national) | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: | |

## Current Corporate Audits

- DNACPR
- Consent
- Quality of notes audit
- Mortality review audits

# Local Audits to be completed in 2024/25

| Urgent Care Audits |
| --- |
| Time to ECG from book in in chest pain and time seen by Dr |
| Time to XR from request |
| Non-essential cannulations |
| Asthma management and documentation in >16yo |
| Trauma call activation and who attended |
| Time to formal CT/MRI report |
| Time of referral to time seen by medical team |
| WP10 prescription and documentation |
| Seizure checklist |
| Time of referral to time seen by surgical team |

| Dermatology |
| --- |
| Hidradenitis audit |
| Camouflage clinic audit |
| Paediatrics high-cost drugs |

| Medicine | |
| --- | --- |
| DECI | PSAAG audit |
| FOC | D2RA audit |
| H&CS | Fridge temperatures |
| 1pt 1 day | Resus trolley |
| Infection control dashboard | Falls |
| Hand hygiene | Diabetic |
| Call bells | Continence |
| Wrist bands | Nutrition and hydration |
| Enhanced care | Fluid balance audit |
| Dementia audit | Care flow audits |
| Kings fund audit | Fridge temperatures |
| Nutritional audit | Resus trolley |
| Ward assurance audits | Being implemented |

**The above audits are listed with the divisions as a plan going forward into 2024/2025**

# Local Audit on AMaT

Local audits are managed in AMaT. Audit activity is shown in the tables below:

Currently there are 101 ward based audits listed for 2024/2025:


| Action Status | Count |
|---|---|
| Action no longer relevant | 24 |
| Fully Complete | 1335 |
| New | 284 |
| Overdue | 608 |
| Partially complete | 12 |
| Partially complete (Overdue) | 41 |
| Unable to Complete | 14 |
| Total | 2318 |

As soon as the audit is completed, actions can be allocated if the audit shows a need for improvement. Once completed and signed off there is an audit trail of the action(s). The current action log in AMaT ward area can be seen here, with 1,335 completed action s out of a total of 2,318.

## Conclusion

There has been a large amount of audit activity added to AMaT daily since its initiation in June 2022. The Clinical Audit Team are on hand to provide training structured to the needs of the users. To date ~600 staff have received bespoke training and the systems holds more than 1300 users.

The implementation of AMaT improved the efficiency and accountability of local audits. It has allowed teams to analyse audit to identify and evidence good practice and areas needing improvement which can be shared via management teams.

Planning for National Clinical Audits, which have set publication dates, is easier than planning local audit. Audit can be challenging for clinical teams when there are competing priorities of managing service pressures and focusing on delivering patient focused services.

Future work will ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

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

HQIP

Healthcare Quality Improvement Partnership

N QI CAN

# CLINICAL AUDIT AWARENESS WEEK 2024

## PROMOTIONAL TOOLKIT

**24-28 JUNE 2024**

- Patient Safety Lunch & Learn, Monday 24th June 2024
- Patient and Public Involvement Lunch & Learn, Tuesday 25th June 2024
- Healthcare Inequalities Lunch & Learn, Wednesday 26th June 2024
- Influencing Change Lunch & Learn, Thursday 27th June 2024
- Sustainability Lunch & Learn, Friday 28th June 2024.

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# ANEURIN BEVAN UNIVERSITY HEALTH BOARD

# CLINCIAL AUDIT ACTIVITY REPORT 2023/2024

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## Introduction

Welcome to the Aneurin Bevan University Health Board Clinical Audit Activity Report 2023/2024. Clinical Audit is one element of a Quality Management System that helps us to understand how well we deliver care measured against published standards.

## Reflections on Clinical Audit Across the Health Board

Following the Internal Audit report on Clinical Audit in November 2022, there has been increased engagement with Divisional Management Teams to focus on the implementation of the Health Boards Clinical Audit Strategy.

The Health Board's strategic focus on National Clinical Audit has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan (NCAORP). The Quality and Patient Safety (QPS) audit team have worked with clinical leads to ensure results of all National Clinical Audits are discussed at the Clinical Standards and Effectiveness Group (CSEG). Some National audits are also discussed at Boards and Committees throughout the Health Board (e.g. stoke, falls).

## Reflections on Clinical Audit Across the Health Board Continued.....

With the introduction of AMaT (Audit Management and Tracking system) in June 2022 there has been a focus on training staff to utilise the system. Currently there are more than 1,300 users across the Health Board. AMaT is used to build the audit proforma, capture data and produce results with an action plan. This license has been extended for a further two years.

There has been improved engagement with Clinical Leads throughout the audit process to discuss results. This has enabled the development, monitoring and completion of improve (SMART) action plans. These are discussed at the Clinical Standards and Effectiveness Group (CSEG). Actions are logged on AMaT and actions are tracked by progress and date.

A standardised Clinical Audit Activity reporting template has been developed in AMaT. This supports review of audit results by CSEG and is used for onward ratification at the Patient Quality and Safety Outcomes Committee (PQSOC). The template ensures risks are discussed and can be escalated to PQSOC, once they have been raised within the Division and placed on the risk register.

Divisional teams have been asked to identify clinical audits as part of their local audit plans. This allows scrutiny and assurance of issues arising from quality and safety risks identified from Datix, complaints and outcomes of care.

Future audit work will include reviewing how the learning from audit is triangulated. This will include working with the Value-Based Health Care team and consider how patient experience is being captured and how this can be linked to audit results.

This report will cover the National Clinical Audits (NCAs) the Health Board participated in for the period April 2023 to March 2024.

Results of clinical audit forms part of our wider Quality Management System in development in the Health Board since Implementation of the Duty of Quality in April 2023.

Audit outputs and activity contribute to the "effectiveness" domain of the Duty of Quality.

To deliver care that is effective, reliable, and based upon the best evidence available. To increase the proportion of patients who receive evidence-based care. To reduce variations in the quality of care. To identify and implement evidence-based best practice guidance. Deliver consistently effective and reliable care.

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

| | |
|---|---|
| Safe | Our aim is to:<br>Ensure that our healthcare system is high quality, highly reliable and safe and that we avoid preventable harm to patients; maximising the things that go right and learning from when things go wrong to prevent them occurring again.<br>People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented.<br>We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time.<br>Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns. |
| Timely | Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. |
| Effective | Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery. |
| Efficient | Our health care system takes a Value-Based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people. |
| Equitable | Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system. |
| Person-centred | Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience. |

## What is Clinical Audit?

Clinical Audit forms part of the system for improving standards of clinical practice. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services. Clinical audit takes place as part of a quality improvement cycle that measures the concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and implemented before being re-audited with the aim of improving reliability and outcomes of care.

- High quality, safe care for patients using our services.
- Cost-effective clinical services to ensure that care is both sustainable and effective
- National Audit engagement at a local level.
- Compliance with regulatory requirements from NHS Wales Health and Social Services and Public Health Wales.
- Reports on the compliance with clinical standards that can be used for assurance.
- Quality improvement projects and local audits that are aligned to the Health Boards priorities for improving care.
- Demonstrable NICE compliance and best practice evidence implementation.

The Health Board (HB) is responsible for demonstrating through Clinical Audit that:

- Patients receive the best and most appropriate standards of care according to the best available evidence.
- Clinical teams can identify opportunities for changes in practice to improve the quality of patient care.
- Processes are tested to ensure they are working effectively to improve patient outcomes, experience, safety and quality of care.
- Appropriate re-audits are undertaken to ensure changes are sustained and have made improvements to the quality of patient care.
- The HB outcomes are above the National average by participating in National Clinical Audits within the National Clinical Audit & Patient Outcomes Programme (NCAPOP) and make National Clinical Audit data available in accordance with HQIP guidance.
- The HB can demonstrate to stakeholders that clinical audits are being appropriately managed and actioned in line with the NHS standard Acute Services Quality Contract and are available for scrutiny by Public Health Wales (PHW) and other external agencies.

## The National Clinical Audit and Patient Outcomes Programme (NCAPOP)

NCAPOP audits are commissioned and managed on behalf of NHS Wales by the Healthcare Quality Improvement Partnership (HQIP). The programme comprises more than 30 national audits related to some of the most commonly-occurring conditions. These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On a local level, NCAPOP audits provide local trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients. Most of these projects involve services in England and Wales; some also include services from Scotland and Northern Ireland.

As well as the 30-plus national clinical audits, NCAPOP also encompasses the four Clinical Outcome Review Programmes (CORP). These help assess the quality of healthcare and stimulate improvement by enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

## What is our Clinical Audit Strategy?

The Health Board has a Clinical Audit Strategy which sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

- People First
- Personal Responsibility
- Passion for Improvement
- Pride in What We Do

The Health Board Audit Strategy has Four Priorities:

- Scrutiny of National Clinical Audit performance with robust development, monitoring, and progression of improvement plans
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- Trainees are supported to participate in meaningful clinical audits that support clinical governance
- Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

# Clinical Audit and AMaT – Audit Management and Tracking

AMaT is an innovative system designed to make auditing easier, faster, and more effective. Data can be input and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

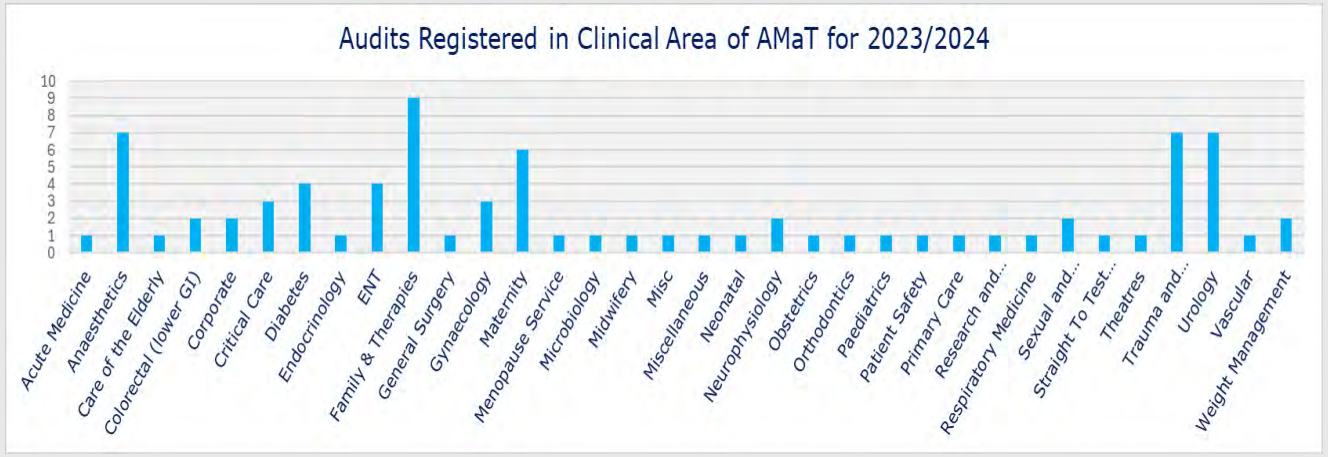
During 2023/2024, 80 projects were added to AMaT.

| Project Type | Count |
|---|---|
| Clinical Audit Project | 45 |
| Other | 1 |
| Patient Questionnaire (feedback, satisfaction, etc.) | 3 |
| Quality Improvement Project | 21 |
| Service Evaluation | 9 |
| Staff Questionnaire (feedback, satisfaction, etc.) | 1 |
| Total | 80 |

National Audits do not capture data within AMaT, however the audit process is managed in the system, using various section:

- Audit results and criteria
- Guidance (NICE, HTW, HIW, AWMSG)
- Conclusions and assurance (inc Risk)
- Key success and key concerns
- Recommendations
- Action plans

Projects were recorded under many specialties, and this will grow as the Health Board expands its use of AMaT. Recommendations can be documented, and actions given with timelines.




The Health Board action status within the clinical area shows:

| Action Status | Count |
|---|---|
| Fully Complete | 17 |
| New | 27 |
| Overdue | 3 |
| Partially complete | 1 |
| Partially complete (Overdue) | 1 |
| Total | 49 |

It is difficult to give a forward plan of projects within the Clinical Area as these usually are registered at the time of commencing the audit, even if this a retrospective audit.

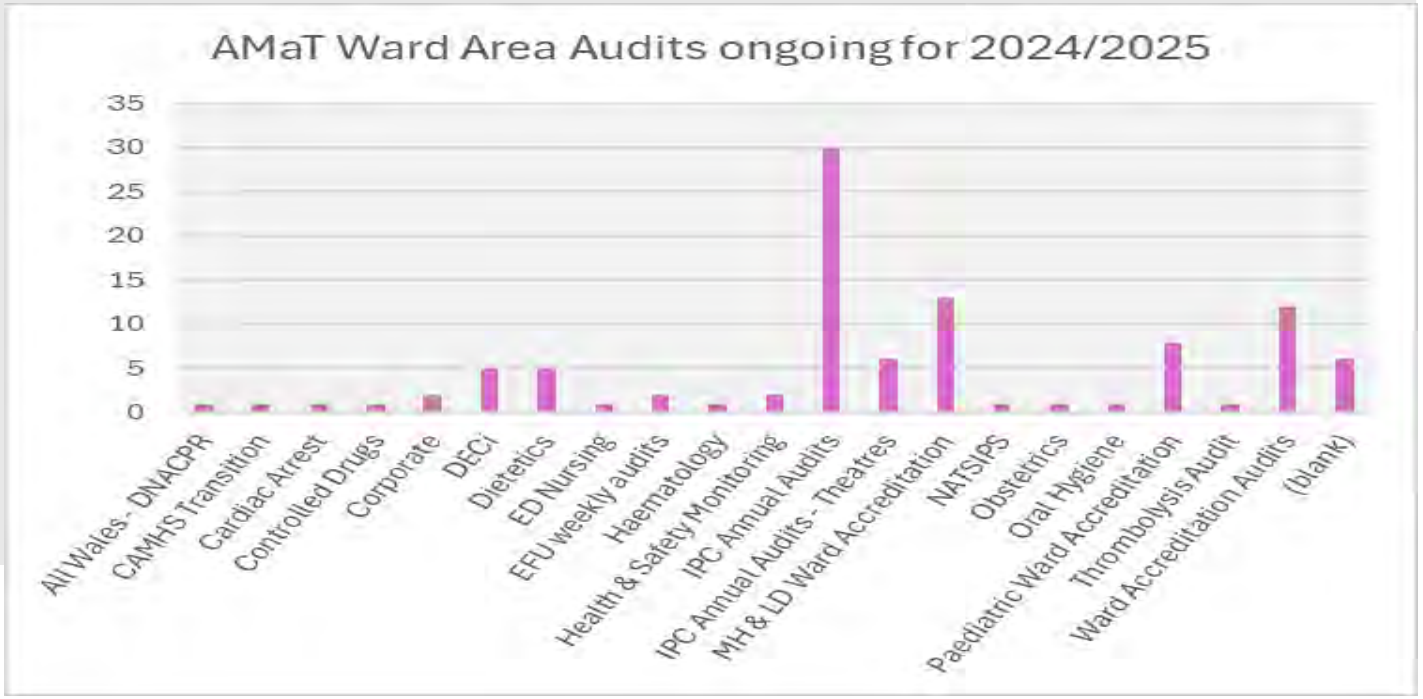
## Ward Area Audits in AMaT

Ward Area is the area in AMaT which will display all audits being undertaken at ward/theatre level. These can be set within projects and the results can be viewed in the dashboard area. Action can be allocated and audited within each audit.

There are a total of 101 audits currently registered and active in Ward Area. An audit can be linked to one ward, 10 wards or all wards across the sites/Health Board.
These have generated 2,318 actions with 1,335 being fully completed to date.

Of the 101 audits registered a number are still active and included in the plan for 2024/2025. Action status for completed 2023/2024 audits are:

| Action Status | Count |
|---|---|
| Action no longer relevant | 24 |
| Fully Complete | 1335 |
| New | 284 |
| Overdue | 608 |
| Partially complete | 12 |
| Partially complete (Overdue) | 41 |
| Unable to Complete | 14 |
| Total | 2318 |




AMaT
Audit Management and Tracking

## Risk and Governance

The Health Board will develop an organisational structure to ensure everything we do is quality-driven.
The Health Board will empower local leaders and managers to ensure patient experiences of our service is delivered locally with excellence. This requires continuous monitoring, action and delivery of quality improvements.

This will aid in strengthening Health Board governance structures through Board-to-Floor reporting that promotes cross Divisional and multi-professional working.
Clinical Leads provide assurance through the Clinical Standards and Effectiveness Group (CSEG) which reports to the Patient Quality and Safety Operational Committee (PQSOC).

The Health Boards Audit Clinical Leads will use the following Assurance and Risk levels against services delivered and can demonstrate if any area audited has been placed on a Health Board Risk Register:


| Assurance Level | |
|---|---|
| Full | The project has fully achieved the standards or criteria being audited against |
| Significant | The project has mostly achieved the standards or criteria being audited against |
| Limited | The project did not achieve the standards or criteria being audited against |
| Very limited | The project failed to achieve the standards or criteria being audited against |

| Risk Level | |
|---|---|
| None | Standards met and findings demonstrate no risk to patient safety |
| Low | Peripheral element of treatment or service suboptimal |
| Minor | Single failure to meet internal standards/Minor implications for patient safety if unresolved |
| Moderate | Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on |
| Major | Non-compliance with national standards/Significant risk to patients if unresolved |
| Catastrophic | Gross failure of patient safety if findings not acted/ Gross failure to meet national standards |

# What we did well in 2023/2024……

Lung Cancer – Excellent patient support from Clinical Nurse Specialists

Diabetes – Increased insulin pump therapy coverage

Myocardial Ischemia – Increased referral for rehabilitation

Early Inflammatory Arthritis – Increased referral within 3 days

Paediatric Diabetes – Successful family engagement sessions

Bowel Cancer – Quality assured rectal Cancer resections

Percutaneous Coronary Interventions – Improved same day discharge

Fracture Liaison Service – More falls assessment being carried out

Pregnancy in Diabetes – Earlier contact for women with Type 1 diabetes

Vascular Services – Overall good clinical outcomes for patients

Diabetes in Primary Care – increase in obtaining Care Process and Treatment Targets since the pandemic

Neonatal care – Increased Neonatal staffing in line with national standards

Prostate Cancer– Same day discharge for robotic prostatectomies

Heart Failure – Improved medication reviews and reduced 30-day re-admission rates

*ALL SUCCESSES CAN BE SEEN IN THE NATIOANAL AUDIT REVIEWS IN THE APPENDICES*

| | |
|---|---|
| *We have standardised the reporting template to ensure continuity between audits* | *We have formed relationships with Clinical Leads to improve participation and promote confidence in audit* |
| *We have supported Clinical Leads to design audit* | *We have implemented AMaT and trained over 600 staff* |

# Did we achieve our goals for 2023/24

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



Goals can be ever changing and developing – the above ongoing goals are part of an evolving process

## Challenges

The Internal Audit Report on Clinical Audit published November 2022 gave the Health Board limited assurance. There has been ongoing work to fully embed clinical audit within clinical teams. Working collaboratively with the Divisional Management teams, Directorates and Clinical Leads will ensure the Clinical Audit Strategy is fully embedded and IA recommendations met.

The internal report highlighted that the current staffing establishment for clinical audit is under resourced. Whilst the use of AMaT has supported audit to be more efficient, the implementation of AMaT has been carried out by one member of the team. Current financial pressures have not allowed the opportunity to carry out a resource mapping exercise.

Local Audit plans have been developed in AMaT. Reporting of these by Divisions has been challenging. There are currently 95 local audits registered in the "WARD AREA" in AMaT. Many of these audits are replicated across all or many sites across the Health Board. There are also 124 registered local audits reported in AMaT Clinical area, some of these also cover many areas across the Health Board.

There has been lots of work by the audit team to look at the risk and assurance processes that underpin reporting of clinical audits. Further work will look at the new risk management policy and ensure audit risk is being captured in the same way. Currently, all audit Assurance and Risk levels are recorded and a record is made if the outcomes are also recorded on a Risk Register and at what level, this can be corporate or divisional. All this information is captured in AMaT and if a risk identified these audits are not signed off until a risk register entry has been formulated with appropriate risk mitigations.

Healthcare Quality Improvement Partnership (HQIP) future planning is set out 9 months ahead, using their publication schedule. This is updated in a timely manner but does not allow a two-year forecast as request by the assurance and audit committee.

All audits registered in AMaT will have recommendations which local actions plans are based on. Completion of these is monitored by the Quality and Patient Safety Clinical Audit Lead. Continued tracking of these actions has been made easier by AMaT, but still involves chasing and following up by the audit team.

Clinical priorities superseding audit responsibilities remains a challenge for busy clinical teams.

# Patient Experience captured through audit……..


More and more audits are taking into the account the views of patients. We are increasingly asking family, carers and friends, what they thought of the treatment provided by the Health Board and how we can improve this.

Dimensions of Person-Centred Care

Through this Strategy, the Health Board are committed to:

- Respecting people's values, preferences and expressed need
- Improving information and education
- Improving access to care
- Improved provision of emotional support to relieve fear and anxiety
- Involving family, friends and people who matter to the individual
- Providing continuity and secure transition between healthcare settings
- Providing physical comfort
- Delivering co-ordinated care

*"I was reluctant to share my story but seeing how you have used my feedback and made the changes you have is really encouraging. Thank you for listening".*

*"Just because I had a good healthcare outcome, doesn't mean my experience was good. The NHS saved my life, but I felt embarrassed when my dignity wasn't preserved"*

National Audits with patient related quality improvement measures are:

- National Early Inflammatory Arthritis Audit (NEIAA)
- National Audit of Care at End of Life (NACEL)
- National Dementia Audit (NAD)

## Key objectives for 2024/2025

- Continue to work closely with Divisions to develop local audit plan.
- Continue to fully embed AMaT and run additional training sessions and raise audit awareness.
- Contnue to develop governance and reporting structure within AMaT.
- Work on tracking of audit results and recommendations, ensuring actions and findings from national and local clinical audits are monitored at an appropriate forum and are utilised to inform future planning within the Health Board.
- Review mechanisms to triangulate the learning from clinical audits and other sources of information to improve services.
- Work collaboratively with the value based healthcare team to review impact of measures that compliment audit and benchmarking results.
- Work with patient experience and involvement team to review how CIVICA and patient experience data can strengthen audit data.
- Review our quality and safety structures and resource within the audit team and understand gap analysis for effective participation in Clinical Audit.

## Conclusion

Much has been achieved by the audit team in the last 12 months in implementing the Clinical Audit Strategy. The focus has been on working closely with Divisions, Directorates and Clinical leads to ensure clinical audit is prioritised. This remains a challenge with the competing priorities of managing service pressures and focusing on delivering patient focused services during a period of high demand.

Throughout 2023/24 the Clinical Audit team have worked to raise the profile of Clinical Audit and to integrate it as part of core services and "business as usual".

Implementation of AMaT has improved efficiency of audit completion and effectiveness of monitoring completion of actions arising from audit. Using AMaT to produce a standardised template for reporting, and SMART action plans has provided assurance to CSEG and PQSOC.

This report contains a compendium of national audit reports for the last 12 months.

Future work will ensure learning from audit is shared across the organisation and communicated to staff and patients.

Patient experience, quality, and safety is at the centre of our work to secure improvement in the quality of care and services we deliver and to improve outcomes for the population we serve.

Clinical audit is an important component of our EFFECTIVE commitments over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system in the wake of the Covid-19 pandemic.

## Did you know.....

One of first clinical audits was undertaken by Florence Nightingale during the Crimean War of 1853–55. On arrival at the medical barracks hospital in Scutari in 1854, Nightingale was appalled by the unsanitary conditions and high mortality rates among injured or ill soldiers. She and her team of 38 nurses applied strict sanitary routines and standards of hygiene to the hospital and equipment. Nightingale had a talent for mathematics and statistics. She and her staff kept meticulous records of the mortality rates among the hospital patients.
Following changes in infection control practice the mortality rate for injured soldiers fell from 40% to 2%, and the results were instrumental in overcoming the resistance of the medical establishment and officers to Nightingale's procedures. Her methodical approach, as well as the emphasis on uniformity and comparability of the results of health care, is recognised as one of the earliest programs of outcome management.

| Appendices No. | Audit Name: |
|---|---|
| Appendices 1 | National Lung Cancer Audit Annual Report (NLCA) (slides 19-24) |
| Appendices 2 | National Heart Failure Audit (NHFA) (slides 25-32) |
| Appendices 3 | Management of Heart Attack: analyses from the Myocardial Ischaemia 2023 Summary Report (MINAP)(slides 33- 41) |
| Appendices 4 | National Audit of Percutaneous Coronary Intervention (NAPCI) (slides 42-44) |
| Appendices 5 | National Paediatric Diabetes Audit (NPDA) (slides 45-54) |
| Appendices 6 | Fracture Liaison Service Database (FLS-DB) Annual Report (slides 55-63) |
| Appendices 7 | National Pregnancy in Diabetes Audit 2021 and 2022 (NPDA) (slides 64-73) |
| Appendices 8 | National Diabetes Audit 2021-22, Type 1 Diabetes (NDA) (slides 74-79) |
| Appendices 9 | National Diabetes Audit: Care Processes and Treatment Targets 2021-22 (Primary Care) (slides 80-87) |
| Appendices 10 | National Neonatal Audit Programme (NNAP) Summary Report 2022 (slides 88-94) |
| Appendices 11 | National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report 2023 (slides 95-102) |
| Appendices 12 | National Vascular Registry State of the Nation Report 2023 (slides 103-110) |
| Appendices 13 | National Prostate Cancer Audit (NPCA) State of the Nation report (slides 111-113) |
| Appendices 14 | National Bowel Cancer Audit – NBoCA (slides 114-118) |
| Appendices 15 | HQIP Planned Activity list for 2023/2024 (slides 119-123) |

**Appendix 1**

| | | | |
|---|---|---|---|
| Audit Title: | National Lung Cancer Audit Annual Report (for the audit period 2019 England, Wales and Guernsey and 2020 England only) Published January 2022 | Clinical Lead: | Dr Matt Jones Consultant in Medicine |
| Rationale: | This National Lung Cancer Audit (NLCA) annual report provides information on the process of care and outcomes for patients diagnosed with lung cancer between 1 January 2019 and 31 December 2019 in Wales and Guernsey and between 1 January 2019 and 31 December 2020 in England.<br>The NLCA forms part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) funded by NHS England and the Welsh Government | | |
| Objectives: | The purpose of the NLCA annual report is to understand the current quality of care and outcomes for patients with lung cancer.<br><br>The report gives detailed analysis of 2,240 patients diagnosed in Wales in 2019. | | |
| Presented at Clinical Standards and Effectiveness Group – 21st May 2023 | | | |

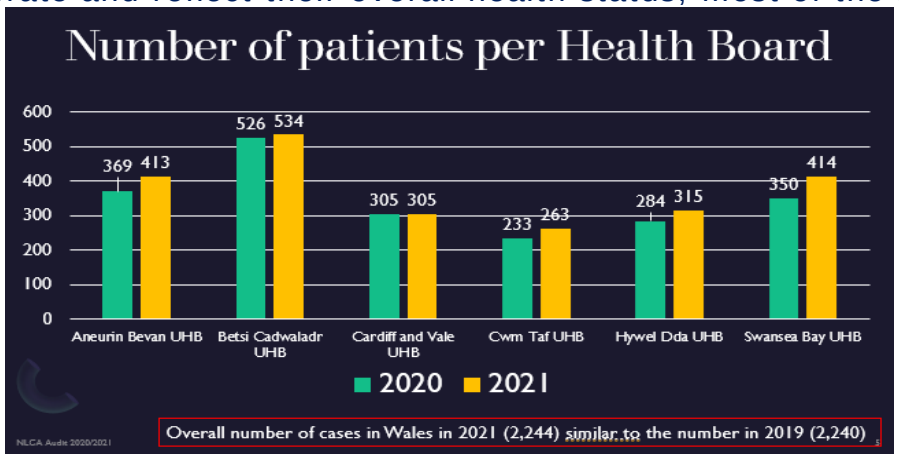
## Results

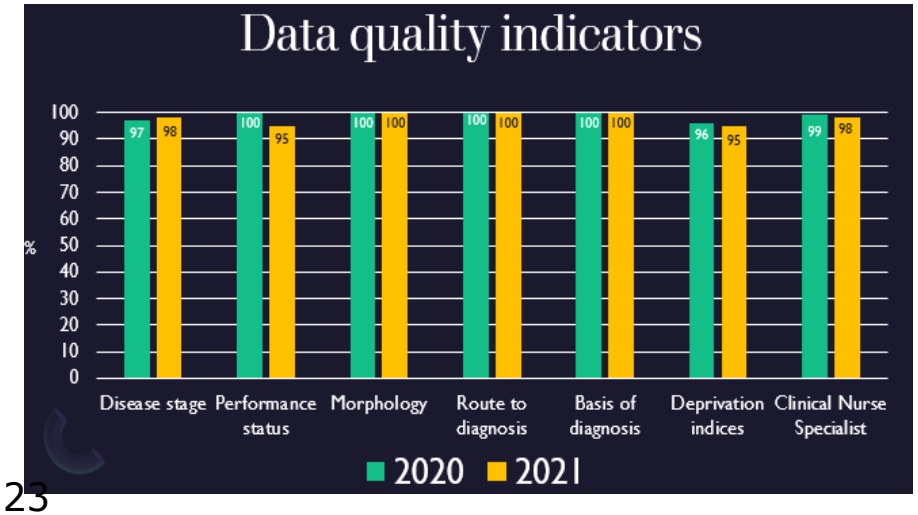
The Clinical Lead for this audit is Mr Mat Jones and the Health Board (HB) has a large Multidisciplinary Team (MDT) diagnosing over 400 cases for Lung Cancer per year, and the HB is the second largest MDT in Wales. Many patients are referred with end stage disease and with multiple co-morbidities placing a strain on the workforce. Early stage across Wales is very similar.

This data relates to 2020-2021 during the pandemic and is the first publication since the HB joined two MDT's, NHH and RGH, which had been pursued for a few years previously.

Data shows reduced numbers during 2020 and increased in 2021 and the HB is performing well in relation to Data Quality Indicators (graph below). The HB MDT are reliant upon Velindre Cancer Centre for oncology support and Cardiff & Vale for surgical support, this is where data integrity can cause issues.

The Performance Status (PS) is based on what the patient can do day to day and frailty index. This determines the type of investigations patient can tolerate and reflect their overall health status, most of the HB patients represented with stage two disease.

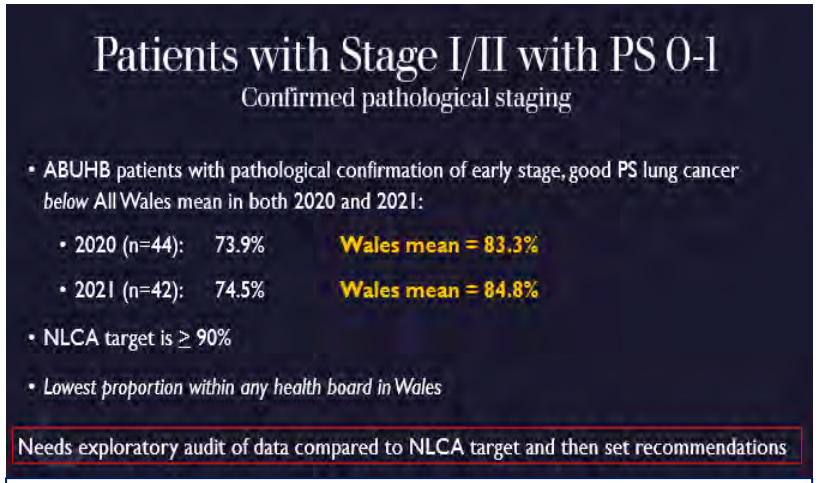



## ECOG Performance Status Scale

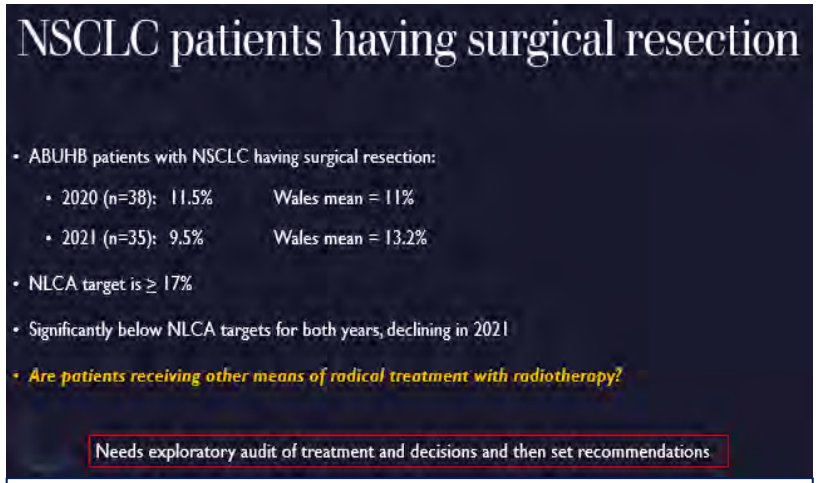
| GRADE | ECOG PERFORMANCE STATUS |
|---|---|
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours |
| 3 | Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled; cannot carry on any selfcare; totally confined to bed or chair |
| 5 | Dead |

Performance Status 3 and 4 outcomes are lower for the Health Board than the mean for Wales although the Health Board is higher than the Wales for PS 2.

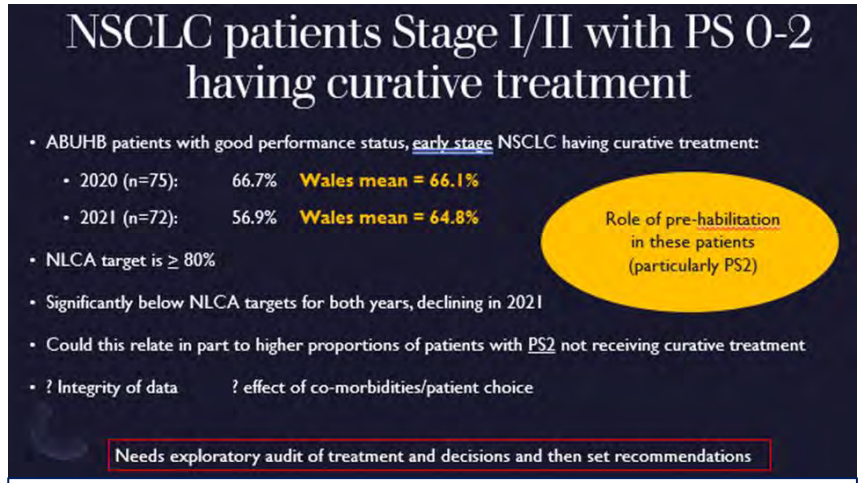



The target is high for patients with pathological confirmation of early-stage disease, Good PS lung cancer at 90% with the Health Board at 73.9% in 2020 and 74.5% in 2021, with the Wales mean at 83.3% and 84.8% for the same years, other characteristics of the patient can influence this result.

The HB currently has 5 Lung Clinical Nurse Specialists (LCNS) (not all 5 are WTE) working tirelessly to back up the service daily, and the number of patients seen exceeds the NLCA target of >90%.




For surgical resection target at 17%, however the HB was 11.5% and 9.5%, versus the Wales mean of 11% and 13.2%, below NLCA targets for both years, declining in 2021. The only HB performing well is Betsi Cadwaladr UHB. It is notable that this is the only HB where surgery is carried out in England




Non-Small Cell Lung Cancer (NSCLC) patients Stage I/II with PS 0-2 having curative treatment, are below NLCA targets for both years, declining in 2021, at 56.9% compared the Wales mean of 64.8% and the target of 80%.

## SCLC patients having chemotherapy

- ABUHB patients with SCLC receiving chemotherapy:
  - 2020 (n=32): 50% Wales mean = 57.5%
  - 2021 (n=37): 67.6% Wales mean = 70.82%
- NLCA target is ≥ 70%
- Below NLCA targets for both years, improving in 2021 - ?Covid related
- Highly variable presentation with differences in PS and stage of disease potentially accounting for differences

**Need to ensure rapid prioritisation of patients for investigation and treatment**

Small Cell Lung Cancer (SCLC) is below NLCA targets for both years, improving in 2021 in the HB and across Wales. There is a need to ensure rapid prioritisation of patients for investigation and treatment.

## NSCLC patients Stage IIIA with PS 0-2 having curative treatment

- ABUHB patients with good performance status, Stage IIIA NSCLC having curative treatment:
  - 2020 (n=29: 44.8% **Wales mean = 46.8%**
  - 2021 (n=41): 31.7% **Wales mean = 60.6%**
- No set NLCA target - England mean = 60% in 2021
- Declining proportion of patients in 2021 compared to 2020
- Could this in part relate to higher proportions of patients with **PS2** not receiving treatment
- ?Integrity of data ?effect of co-morbidities/patient choice

Heterogeneous population of patients with expanding treatment options

Needs exploratory audit of treatment and decisions and then set recommendations

The Stage IIIA with PS 0-2 having curative treatment has no set target although England's mean is 60% and the HB saw a decline in 2021 compared to 2020 and 2021 by almost half. The Health Board was 31.7% compared to the Welsh mean of 60.6%. This could be low for many reasons such as HB access to oncology, access to treatment options for these patients, effects of comorbidities, patient choice, documentation of data and potentially not offering patients curative therapy.

## NSCLC patients Stage IIIB/IV with PS 0-1 having SACT

- ABUHB patients with good performance status, Stage IIIB NSCLC having SACT:
  - 2020 (n=69): 50.7% **Wales mean = 52.5%**
  - 2021 (n=68): 48.5% **Wales mean = 56.6%**
- NLCA target > 60%
- Below NLCA target and Wales mean in both years
- ***Could this relate to delays in obtaining pathology results on patients, oncology access, patient choice – many potential aspects to explore***

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage IIIB/IV with PS 0-1 advanced disease where it's metastatic, spreading to outside of the lungs, having Systemic Anti-Cancer Therapy (SACT) below NLCA target and Wales mean in both years, this can also be impacted on by other factors such as co-morbidities and the HB has delays in the pathology pathway and rely on sending samples to Cardiff, if this was done within the HB, this would speed up the pathway getting results to patients quicker and possibly providing an option for oncological intervention before deteriorating to a lesser PS. Possible issues regarding therapeutic nihilism and patient choice, for exploration.

## Assurance and Risk

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

| Risk level | Description | Select |
|---|---|---|
| Minor | Single failure to meet internal standards/Minor implications for patient safety if unresolved | Yes |
| Has this audit been placed on a Risk Register (N/A if above risk is None) | | NO |
| If not on a risk register, why not? Actions ongoing | | |

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | Merging of MDTs across health board |
| 2 | Structured and streamlined services with adoption of Lung Cancer Physician of the Week (LCPOW) |
| 3 | High throughput of patients from multiple referral sources |
| 4 | Excellent input to patient care from nurse specialists |

| Report Concerns: | |
|---|---|
| 1 | High proportion of PS 2 patients |
| 2 | Low proportion of confirmed pathological staging for good PS, early stage disease |
| 3 | Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy, NSCLC Stage IIIA and NSCLC advanced stage good PS treated with SACT |
| 4 | Issues on data integrity – sources, validation |

| Report Recommendations: | | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and COSD in England. - Completeness should be at least 95% for performance status (PS), ethnicity and disease stage, and at least 90% for "trust first seen", route to diagnosis, seen by a lung cancer clinical nurse specialist (LCNS) at diagnosis and smoking status (to highlight inequalities and inform future strategies). | Explore the data integrity | Mat Jones | 31/12/2023 | Ongoing |
| 2 | Ensure at least 85% of patients with stage I/II PS 0–2 NSCLC undergo curative intent treatment in line with NICE guidance. | Discuss at NDT | | 08/06/2023 | Fully complete |
| 3 | Ensure at least 70% of patients with NSCLC stage IIIB-IV and PS 0-1 receive systemic anti-cancer therapy in line with NICE guidance. | | | | |
| 4 | Ensure at least 90% of lung cancer patients are seen by a lung cancer clinical nurse specialist at diagnosis. NHS 5Resource lung cancer MDTs, according to the commissioning guidance set out by the Lung Cancer Clinical Expert Group and update the guidance to reflect current best practice. | | | | |

## Appendix 2

| Audit Title: | National Heart Failure Audit (NHFA) 2023 Summary Report (2021/22 data | Clinical Lead: | Linda Edmunds – Consultant Nurse, Cardiac Rehabilitation |
|---|---|---|---|
| Rationale: | This report summarises selected key findings from the National Heart Failure Audit (NHFA), part of the National Cardiac Audit Programme (NCAP). It deals with a specific and crucial phase in the disease trajectory of patients admitted to hospital with heart failure (HF) in England and Wales. There is a particular focus on a set of quality improvement (QI) metrics, based on standards and guidelines, which aim to drive up standards of care during an acute admission to achieve better patient outcomes. | | |
| Objectives: | The National Heart Failure Audit collects data on all patients with an unscheduled admission to hospital in England and Wales who have a death or discharge with a diagnosis of heart failure in the primary position (i.e. heart failure is the main condition treated or investigated during the episode of care) with the following ICD-10 codes:<br>• I11.0 Hypertensive heart disease with (congestive) heart failure<br>• I25.5 Ischaemic cardiomyopathy<br>• I42.0 Dilated cardiomyopathy<br>• I42.9 Cardiomyopathy, unspecified<br>• I50.0 Congestive heart failure<br>• I50.1 Left ventricular failure<br>• I50.9 Heart failure, unspecified.<br>Patients admitted for elective procedures, for example elective pacemaker implantation or angiography, are not included. Patients must be 18-years and over to be eligible for inclusion in the audit.<br>Patients who are discharged alive with a length of stay of less than one day e.g those who may have been treated in an Ambulatory Care Facility in the hospital, are included in the numerator and denominator for participation. However, they are excluded from the quality improvement aspects of the audit, as they do not remain long enough in hospital for the KPIs to be collected. They are tracked for mortality | | |
| Presented at Clinical Standards and Effectiveness Group – 20th September 2023 | | | |

## Key message 1:

Echocardiography rates, for this key diagnostic test for heart failure (HF), have steadily decreased from the 90% level reported in the 2014/15 audit cycle to 85% in 2020/21. They have remained at the 85% level for the current 2021/22 cycle, for aggregate data, leaving 15% of patients without a secure diagnosis.

There is considerable variation in echocardiography use between hospitals with only 51% of hospitals meeting the >90% audit target, a 3% increase from the 2020/21 cycle, but one that requires improvement.

Marked variation in echocardiography use within institutions is also noted. Patients admitted to cardiology wards are more likely to have echocardiography than those admitted to general medical wards (92% versus 82%). Patients admitted elsewhere, but receiving specialist input to their care, have lower echocardiography rates at 89%, but considerably better than the 67% rate for patients not receiving any input from the HF specialist team. The echocardiography rate is less good in older patients, aged >75, at 83%, and overall women fare less well than men with rates of 83% and 86%, respectively.

## Key message 3:

HF patients are amongst the highest risk cardiac patients admitted to hospital, with their outcomes transformed by care on a cardiology ward and/or access to specialist HF cardiology and nurse care elsewhere. In this audit cycle, only 47% were admitted to cardiology wards (aggregate data), similar to the 48% reported in the 2020/21 audit cycle and not meeting the >60% audit target, whilst only 15% of individual hospitals met the target but with variation from 0-100%. 82% of patients were seen by a HF specialist during the admission, similar to the 81% of cycle 2020/21, and meeting the audit target of >80%, for aggregate data, but only 61% of hospitals met the target, down 4% on the previous audit cycle, with marked variation between hospitals.

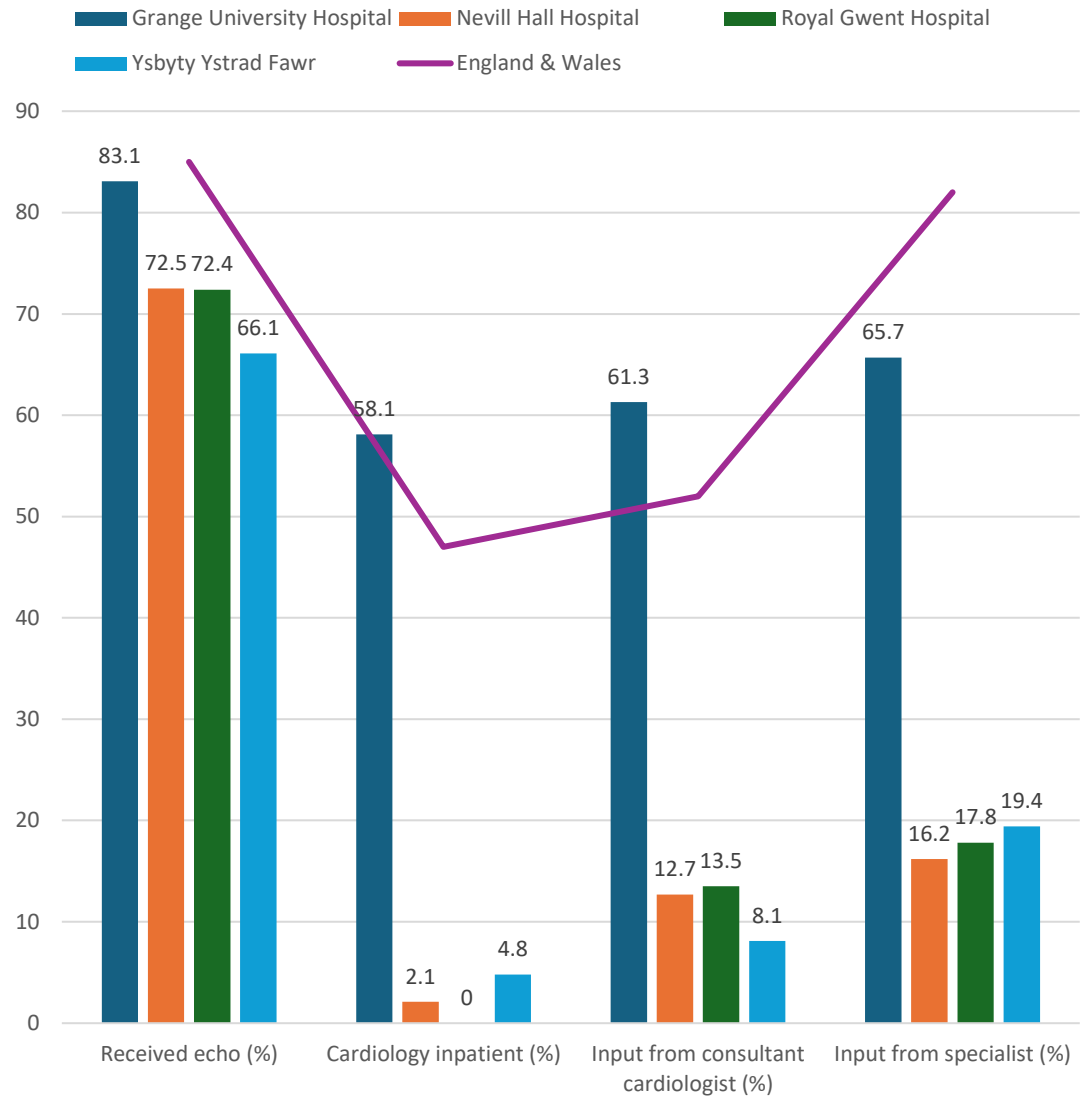
For those on Cardiology wards, 99% were seen by specialists, 92% were seen by a consultant cardiologist, a substantial improvement from the 83% of the previous cycle, and 52% were seen by HF nurses, a figure that has not changed. In contrast only 72% of patients on General Medical wards were seen by 'Any HF specialist', with 51% seeing a specialist HF nurse compared with 46% last year.

## Key Message 1 & 3 – Aneurin Bevan UHB

The above chart shows that the Health Board sites are not meeting the target of >90% receiving an Echo, in Grange University Health Board (GUH) where there is a higher rate of Inpatient admission to a cardiology ward, the rate receiving Echo is 83.1%. This is consistent across Wales with the main hospital site recording higher rates than the smaller sites. 5 hospital across Wales are meeting the target.

Patients in the main sites are more likely to be seen by a consultant cardiologist/specialist. Within the Health Board Nevill Hall Hospital (NNH) and the Royal Gwent Hospital (RGH) provide Echo at a similar rate (72.5% & 72.4% respectively), with Ysbyty Ystrad Fawr (YYF) rate 66.1%.

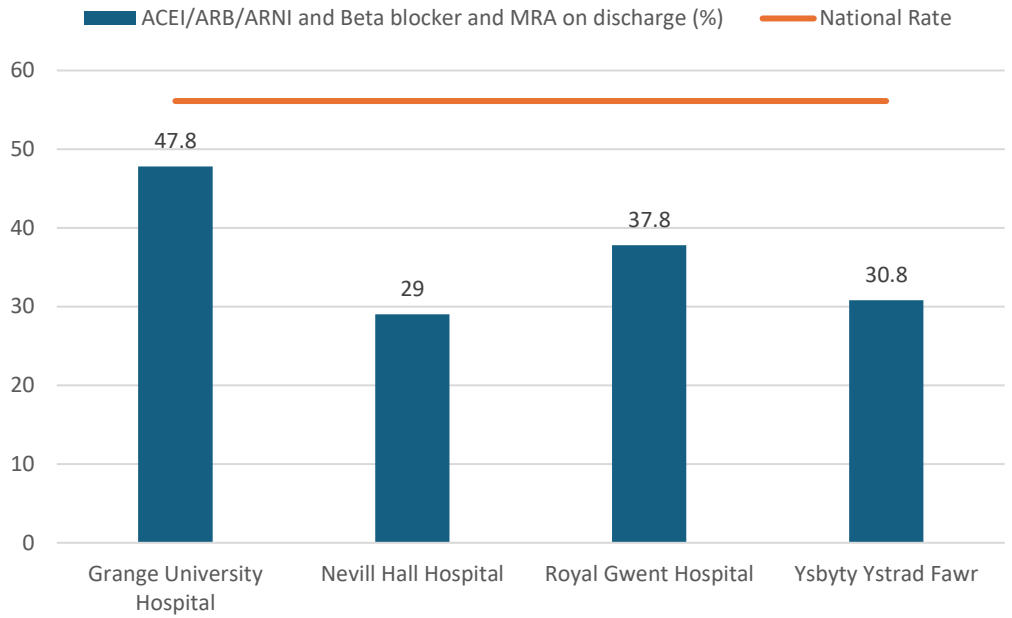
The Health Board is consistent with the message of patients are more likely to receive and Echo if admitted to a cardiology ward, with those having specialist care on other wards more likely to receive Echo.



## Key message 2:

This year the percentage of patients with heart failure attributed to systolic dysfunction (HF with reduced Ejection Fraction - HFrEF) discharged on the three classes of disease modifying therapy drugs (ACEI/ARB/ARNI, and BB and MRA) has increased from the 54% in 2020/21 (for ACEI/ARB and BB and MRA) to 56% this year for aggregate data. There remains considerable variation in prescribing patterns for the combination of, and for each of, these drugs within hospitals and between hospitals. A sharp decline in recommended prescribing in those above the 55-64 age group is again reported, though for those aged >85 beta-blocker prescribing is relatively well maintained at 84.1%.

The introduction of a revised data set, for this audit cycle onwards, allows data collection on newer drugs for HFrEF, including the angiotensin receptor/neprilysin Inhibitor (ARNI) and for the first time the use of the sodium-glucose co-transporter-2 (SGLT2) inhibitors, dapagliflozin and empagliflozin reflecting the new and emerging evidence base. In the first cycle there has been only limited adoption of the new dataset but as this increases the data for these drugs will become more secure and will be reported in more detail.

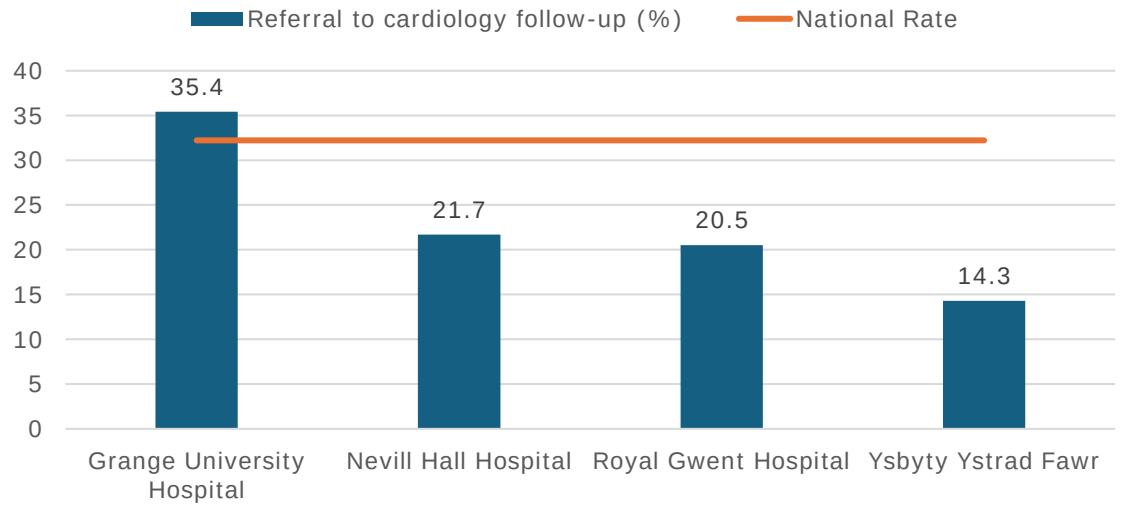


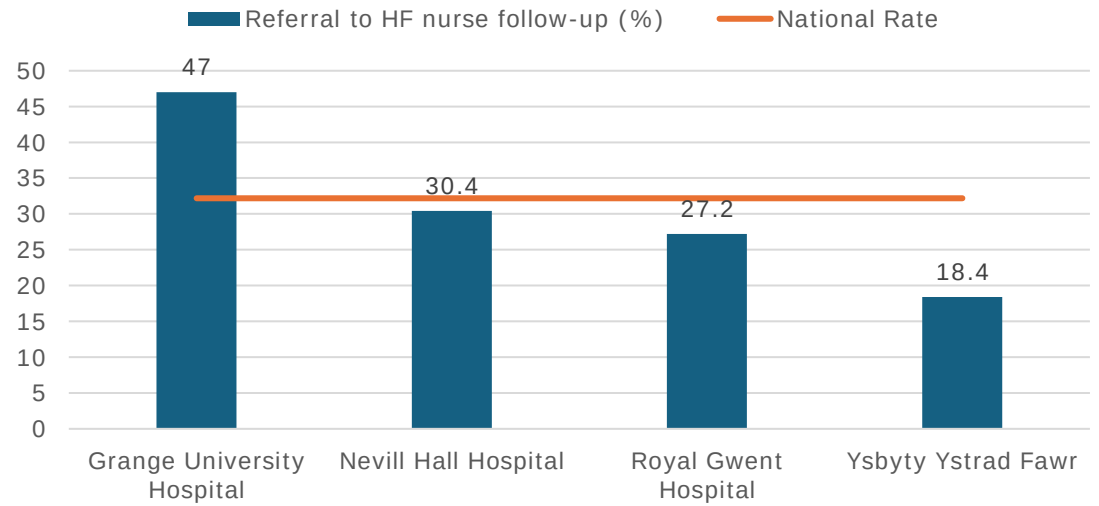

## Key Message 2 - Aneurin Bevan UHB

The National Average rate for discharge on three disease modifying therapy drugs is 56% and all sites within the Health Board are beneath this rate with considerable variation across the Health Board and compared to the rest of Wales, the Health Board has some of the lowest rates, 4 sites within the bottom 7 of 16 hospitals.

Key message 4:

Patients are especially vulnerable in the early discharge period. This is reflected in the audit standard of 100% specialist follow-up within two-weeks. Trends for both cardiology and HF nurse follow-up were decreased in the COVID-pressured audit cycle of 2020/21, when compared with the previous cycle. This audit cycle (2021/22) shows a further drop of 7% so that only 32% had cardiology follow up. The improvement of 11% since last year in timely HF specialist nurse follow up to 58% is positive but does not compensate for the lack of cardiology follow up. Timely specialist follow up in this cycle overall also fell to 40%, from 43% in the 2020/21 cycle.




Key Message 4 - Aneurin Bevan UHB

With the audit standard set at 100% for specialist follow-up, the Health Board is significantly under this, however GUH is performing better than the national average for both referral to cardiology and heart failure nurse follow-up at 35.4% and 47% respectively.

Key message 5:

A unifying theme to address all these points would be early and continuing involvement of the specialist team as first outlined in the NICE guidance of 2014.

## Assurance and Risk

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

| Risk level | Description | Select |
|---|---|---|
| Moderate | Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on | Yes |
| Has this audit been placed on a Risk Register (N/A if above risk is None) | | NO |
| If not on a risk register, why not? Actions ongoing | | |

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | Pathways in accordance with guidelines |
| 2 | Roll out of Inpatient Heart Failure service |
| 3 | Rehabilitation Hub encouraging patient self-management and reducing specialist time for complex cases |
| 4 | Improved optimisation of medication reviews |
| 5 | Reduced 30-day re-admission rates |

| Report Concerns: | |
|---|---|
| 1 | Medication on discharge rates |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Hospitals not achieving the recommended standard for the use of in-patient echocardiography for patients with acute heart failure (HF) should urgently review their clinical pathways and ensure that echocardiography is performed, ideally within the first 48 hours of admission. | The Health Board Echo rates have improved since the reduction due to the pandemic and with outsourcing the Health Board can deliver a prompter service. The inpatient heart failure service as commenced gradually throughout the sites, with the GUH to join next year, to see patients within 24 hours of referral. These patients are on International Consortium for Health Outcomes Measurement (ICHOM) pathways based on Clinical Reported Outcome Measures (CROM). Treatment can be commenced earlier commencing the four-pillar medical therapy and placed on heart failure pathway ensure two week follow up. | Mrs Linda Edmunds | 21/09/2023 | Fully complete |
| 2 | High-risk cardiac patients, including those with heart failure, should have access to a cardiology ward. | Patient pathways are currently being addressed. | Mrs Linda Edmunds | 31/03/2024 | Ongoing |
| 3 | Hospitals not achieving the standards for ensuring that a patient with acute HF is seen by a HF team should review their pathways of care and consider a quality improvement programme to improve their performance. Hospitals without a clinical lead for heart failure should appoint one (ideally a consultant cardiologist with sub-specialty training in HF). The lack of a named lead should feature on their risk register.Hospitals without access to specialist HF nurses in their hospital team or in the community should urgently seek to appoint them. | There are two cardiologists with a specific interest in Heart Failure and Specialist Nurses working as a team. | Mrs Linda Edmunds | 21/09/2023 | Fully complete |

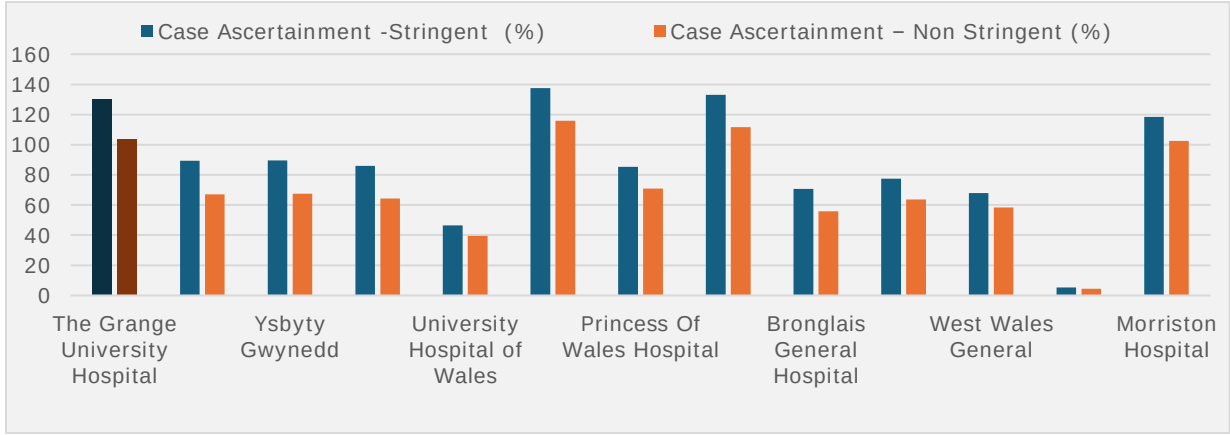
| | Report Recommendations: | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 4 | All patients with HFrEF should receive best-practice disease-modifying drugs unless there is a contra-indication. Treatment is improved by patients being managed on cardiology wards or being seen by a HF specialist team, early during an admission, and ensuring patients are not prematurely discharged from hospital. Those hospitals not meeting the expected standards should perform a clinical pathway review to investigate where improvements can be made. Hospitals should make every effort to record all medications at discharge and avoid entering 'unknowns' in their audit submissions. | This is an area of concern for the Health Board and needs further work as this is strong component of heart failure care and will be addressed as part of the inpatient service rolling out and more patient being discharged on the four therapies. This is an education program that will be reviewed at the service progresses. Data shown comparing figures from 2021 to 2023 and YYF improved from 17% to 30% and an increase from 34% to 38% for the RGH, however there was a significant reduction at NHH, from 70% to 29% this was due to a retirement of a cardiologist. | Mrs Linda Edmunds<br>31/03/2024<br>Ongoing |
| 5 | Patients should be referred for Cardiology and Specialist HF Nurse follow-up, ideally leaving hospital with their first appointment. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for HF patients. | This is expected to improve with the inpatient service rollout and with a rise in referrals caused a delay in the programme, however the team have caught up and currently at 2-3 weeks follow up, with continuous improvement.<br>All patients are offered face to face, or telephone follow up and patients under heart failure nurse have access to the MDT.<br>National funding for a 12-month period for rehabilitation for Caerphilly area, and changed the model of care giving, and introducing a heart failure hub to encourage self-management. Rehabilitation staff are supported by the heart failure service. The hubs offered care closer to home and freeing up the heart failure clinical nurse specialist to concentrate on the more complex cases. Rehabilitation rates increased for 4% to 25% (national target 33%). This reduced optimisation of medication then 14 weeks from 79 weeks and improved the 30-day re-admission rate, for the Health Board was 11% and now down to 1%. Funding has been secured to roll this out across the Health Board. | |

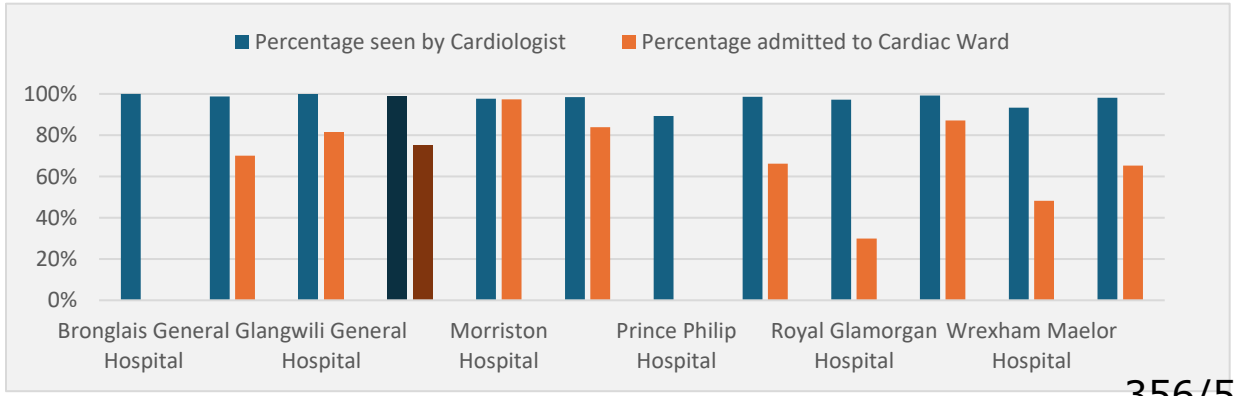
# Appendix 3

| Audit Title: | Management of Heart Attack: analyses from the Myocardial Ischaemia 2023 Summary Report - 2021/2022 Data | Clinical Lead: | Dr Nigel Brown |
|---|---|---|---|
| Rationale: | This report summarises the care provided within hospitals in England, Wales and Northern Ireland to over 85,000 people who suffered a heart attack during the 2021/22 financial year. | | |
| Objectives: | 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.<br>The data used are drawn from the Myocardial Ischaemia National Audit Project (MINAP) and the National Audit of Percutaneous Coronary Intervention (NAPCI), both of which are part of the National Cardiac Audit Programme (NCAP). | | |
| Presented at Clinical Standards and Effectiveness Group – 21st September 2023 | | | |

| 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% |

(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.



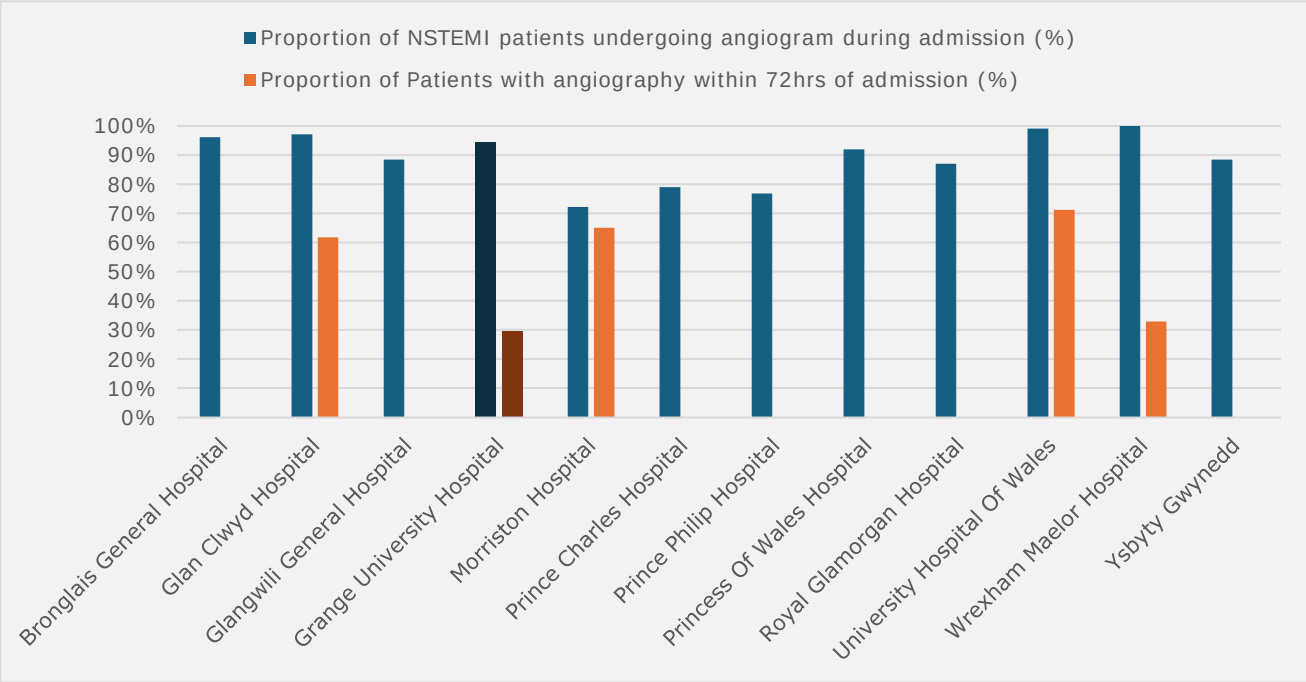



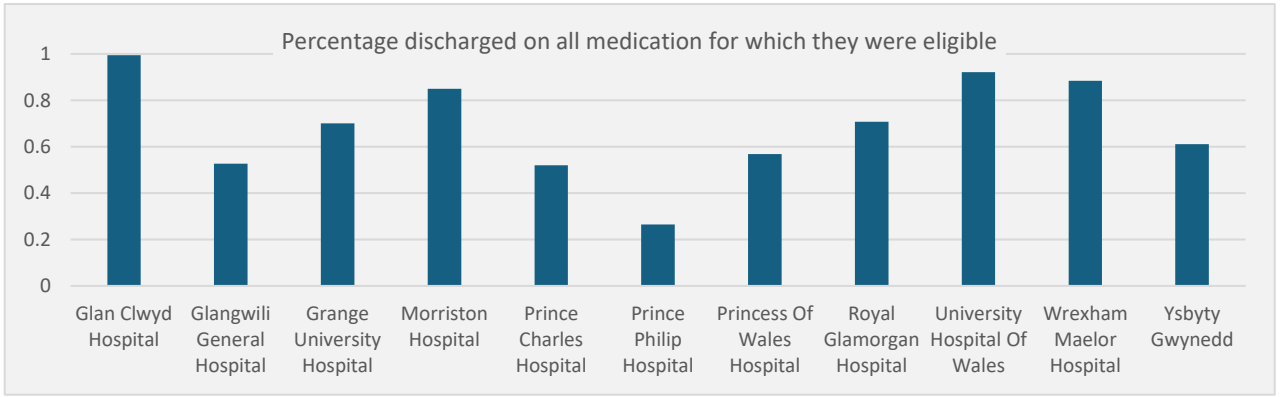
## Proportion of Patients with angiography within 72hrs of admission (%)

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 HB's 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.

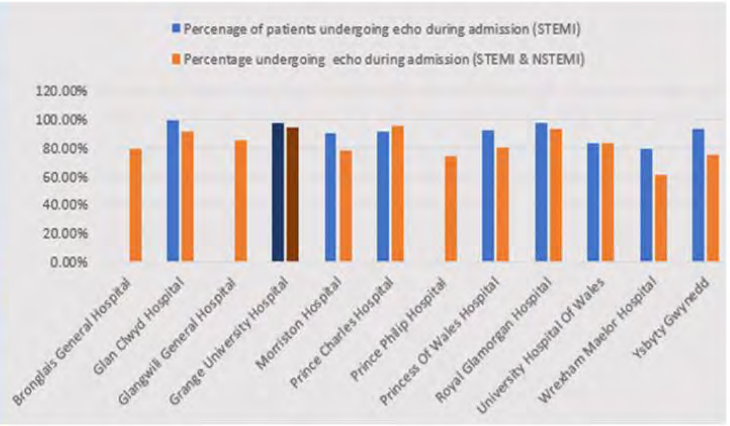
Percentage discharged on all medication for which they were eligible for ABUHB is 70.13% compared the Welsh Median of 70.44%. The National result is 89%.

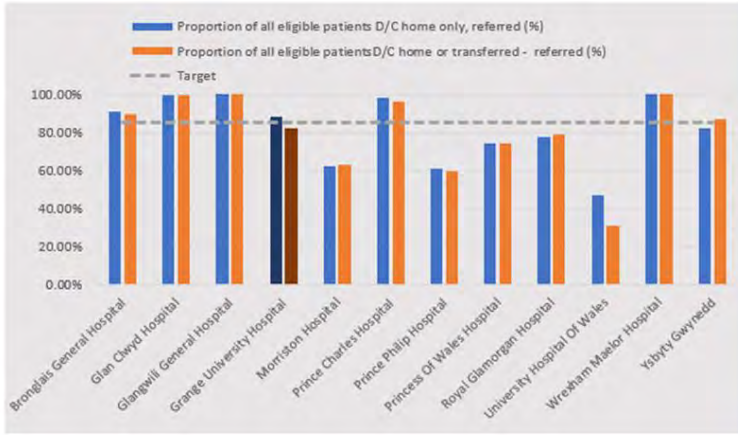
Action - We've historically done well on secondary prevention medicines at 70% equal to the Wales average this year. N.B. this may equate to only one out of 4 drugs. This may relate partly to the addition of aldosterone antagonists into a combined single data metric and/or relate to poor documentation 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 Level and Risk Level

| Assurance level | Description | Select |
|---|---|---|
| Significant | the project has mostly achieved the standards or criteria being audited against | ✓ |

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

| | |
|---|---|
| **Has this audit been placed on a Risk Register (N/A if above risk is None)<br>Actions being managed within the service.** | **No** |

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | Achieving most targets, including high provision of echocardiography. |
| 2 | Case ascertainment has improved considerably. |
| 3 | High levels of assessment by a cardiologist and angiography. |
| 4 | High referrals rates for rehabilitation. |

| Report Concerns: | |
|---|---|
| 1 | Delays to angiography/intervention. |
| 2 | Delays in step-ups from eLGH's. |
| 3 | Staffing levels and catheter laboratory constraints. |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 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.<br>Ensure harm e.g. events in patients waiting intervention captured<br><br>Retrospective review of the MINAP database to better understand detail behind delays | Dr Nigel Brown<br>21/09/2023<br>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. 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. | The Health Board performs very well with 94.64% of patients undergoing echo during admission (STEMI & NSTEMI).<br><br>This reflects excellent work by the Physiology Team at Grange University Hospital (GUH) | |

| Report Recommendations: | | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 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 Nigel Brown<br>21/09/2023<br>Fully complete |
| 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 (eg 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) | |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 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 72 hrs 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;<br>a) catheter laboratory time (elective patients/lists/complex case work/CTO's compete) and staffing constraints (medical, nursing, radiographer and physiology)<br>b) delayed transfer from eLGH's (e.g.1 patient taking a week in 2022)<br>c) weekend cover is limited to Saturday am so Friday admissions will generally wait more than 72 hours unless urgent.<br><br>Ensure harm e.g. events in patients waiting intervention captured.<br>Divisional discussion re investment in uplift in catheter laboratory capacity and possibly more formal "trigger points" for review of e.g., elective activity<br>Report to be discussed in Quality Improvement Group and at divisional level and added to the risk register. | |

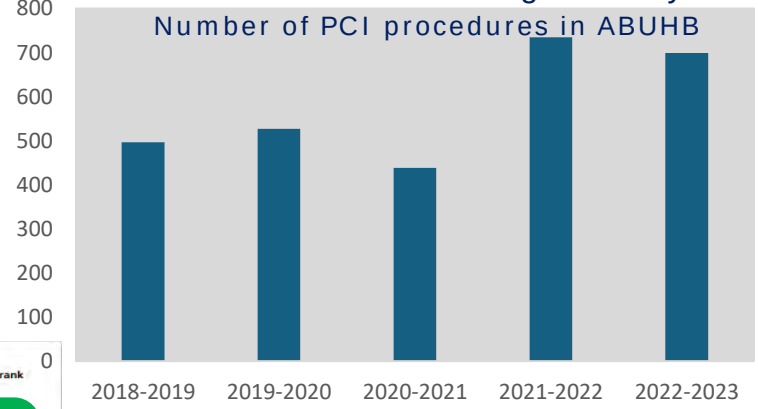
| | Report Recommendations: | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 7 | Hospitals not meeting the prescribing standard for all secondary prevention medication prior to discharge of both STEMI and NSTEMI patients should assess the quality of their data and, 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. | Dr Nigel Brown<br>21/09/2023<br>Partially complete |
| 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. | |

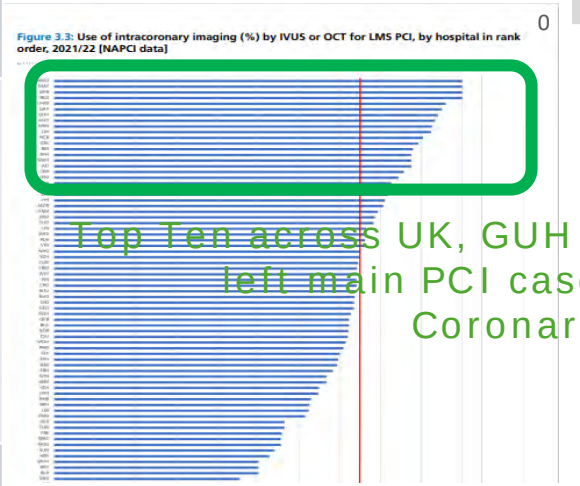
| Report Recommendations: | | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 9 | Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI heart attacks should ensure early identification of patients who might benefit (eg 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. | 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. | Dr Nigel Brown<br>21/09/2023<br>Partially complete |

# Appendix 4

| | | |
|---|---|---|
| Audit Title: | National Audit of Percutaneous Coronary Intervention (NAPCI) April 2021-March 2022 Published June 2023 | Clinical Lead:<br><br>Dr Shawmendra Bundhoo |
| Rationale: | The NAPCI report reviews 97,765 PCI procedures which has increased by around 7000 procedures since 2020/21.<br>PCI activity has recovered but has not returned to the numbers seen during the pre-pandemic.<br>The report highlights the increased adoption of intracoronary imaging for PCI, involving the left main stem as per best practice guidelines, increasing use of same day discharge for elective cases and use of more potent P2Y12 inhibitors in PCI cases undertaken in patients with STEMI. | |
| Objectives: | The report focuses on several specific quality improvement (QI) metrics for the delivery of PCI services.<br>These are derived from national and/or international standards and guidelines.<br>A number of important metrics reported here which relate to the management of patients with acute coronary syndromes are also included in the joint MINAP/NAPCI Heart Attack report. | |
| Presented at Clinical Standards and Effectiveness Group – 21st March 2024 | | |

Key message 1:
There has been an increase in the number of PCI procedures performed in the UK during this audit period (compared to COVID-19 pandemic 2020/21). Total PCI procedures increased by approx. 7,000, from 90,708 in 2020/21 to 97,765 in 2021/21. This represented a return to nearly 98% of the 100,112 cases reported in the pre-pandemic year. The number of primary PCIs for patients with ST-elevation myocardial infarction (STEMI) had returned to pre-pandemic levels. PCI for other acute coronary syndromes was virtually at pre-pandemic levels but elective PCI numbers were significantly lower.



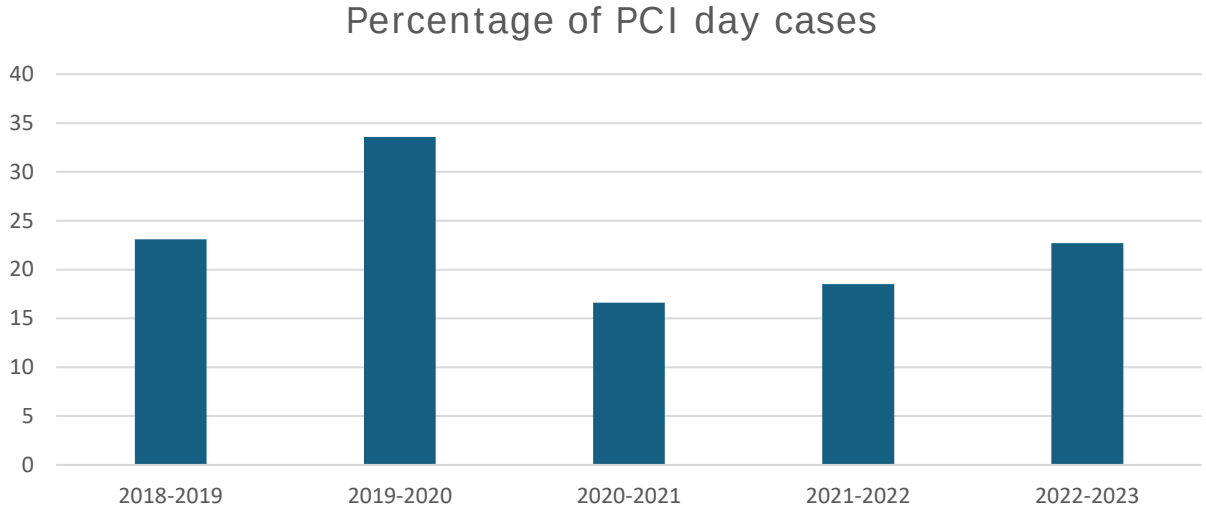



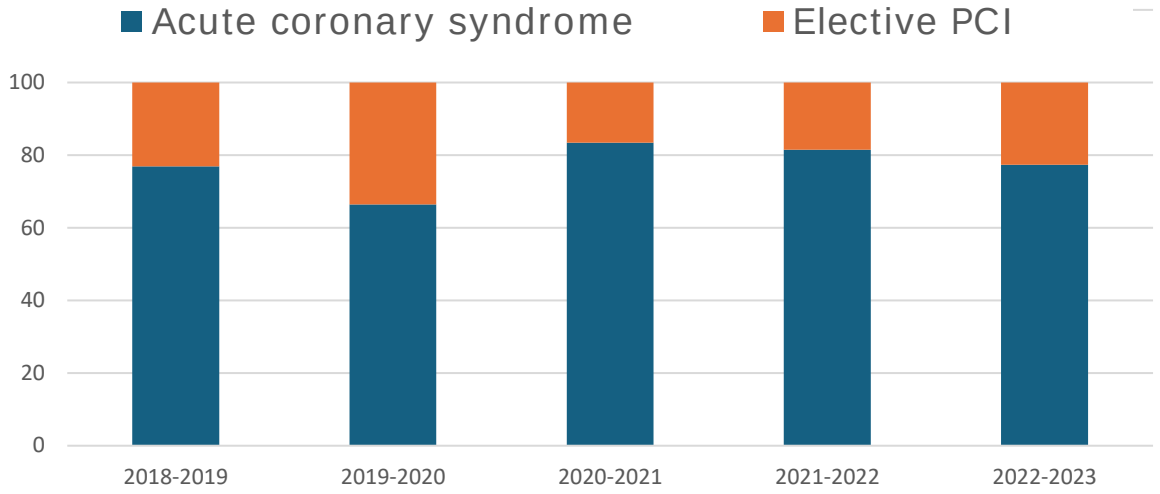

Top Ten across UK, GUH - 94% of all left main PCI cases had Intra Coronary Imaging

Key message 2:
There has been a gradual improvement in the use of intracoronary imaging from 50.7% in 2017/18 to 70.5% in 2021/22, although we report wide differences in practice between hospitals, with a number of units performing intravascular imaging in <50% of Left Main Stem (LMS) PCI.

Key message 3:

Day case PCI for elective procedures: There has been an increase in day case elective work over the last 4 years from 63.8% in 2018/19 to 71.4% in 2021/22, with significant variability nationally, with some centres performing day case PCI in almost all elective cases, and some where almost all patients are kept in overnight following their procedure. The Health Board is currently 22.7% elective same day discharge.




Key message 4:

There has been a significant increase in newer P2Y12 antiplatelet use over time, increasing from 44.2% use of prasugrel and ticagrelor in 2014 to 55.3% in 2021/22. The most commonly used newer P2Y12 agent in 2021/22 was ticagrelor (37.3%) and prasugrel was only used in 18% of cases.

*Poor data capture*
*Confusion between admission and procedure medications*
*Planning to simplify data entry focusing solely on procedure pharmacology on Mc Kesson*
*Ticagrelor is the drug of choice in ABUHB patients admitted with acute coronary syndromes who require PCI*
*Clopidogrel is used instead of Ticagrelor when patient is on other anticoagulants namely novel oral anticoagulant agent or warfarin*
*ABUHB patients undergoing primary PCI in UHW receive Prasugrel. Prasugrel is continued if repatriated patients require staged PCI in GUH*

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

| Risk level | Description |
|---|---|
| None | Standards met and findings demonstrate no risk to patient safety |

| Report Successes: | |
|---|---|
| 1 | Compliant with national standards to perform unprotected left main PCI using intra coronary imaging |
| 2 | Same day discharges are occurring in >75% of elective PCI cases |

| Report Concerns: | |
|---|---|
| 1 | Need to have mandatory fields in Mc Kesson to capture dates of admission and discharge for elective cases |
| 2 | Limited data captured on antiplatelet pharmacology in patients presenting during daytime with STEMI |

| Report Recommendations: | | S.M.A.R.T Actions: Responsible: Due Date: Progress: |
|---|---|---|
| 1 | Operators undertaking Left Main Stem PCI should use intracoronary imaging (either IVUS or OCT) to guide interventional strategy and optimise stent expansion and apposition, in line with international consensus statements around best practice. | This is current practice. No further action at present. To continue with current standard of practice. |
| 2 | Hospitals should modify their pathways and ward structures to maximise the use of day-case procedures so reducing avoidable overnight stays for patients. | Consistently >75% over the last 5 years – more complex cases post Covid-19. In order to modify services this requires more in-depth data capture for elective patients undergoing day case PCI. Clinical lead to progress. |
| 3 | Hospitals should review their STEMI protocols to see where improvements can be made in the use of newer antiplatelet agents, in particular Prasugrel, during primary PCI. | This will be captured when GUH will be offering a dedicated 24/7 Primary PCI service. All ABHUB patients who undergo PPCI at UHW receive Prasugrel. GUH is not a dedicated Primary PCI centre. Patients' self-presenting to GUH requiring Primary PCI receive Ticagrelor. Patients who are on anticoagulants requiring PPCI receive Clopidogrel to reduce the risk of bleeding complications. |

| Clinical Leads Local Recommendations: (if applicable) | | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | To have certain mandatory parameters to be captured on Mc. Kesson for outpatient attendances to determine date of admission and discharge | | Dr. S. Bundhoo | | |

**Appendix 5**

| Audit Title: | National Paediatric Diabetes Audit (NPDA)<br>Report on Care and Outcomes 2021/2022 | Clinical Lead: | Dr Davida Hawkes |
|---|---|---|---|
| Rationale: | The NPDA is part of the National Clinical Audit Outcome Review Plan and is part of the NHS Digital directory of audits relating to Diabetes care. The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological well-being, and assessment of diabetes- related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and well-being of children and young people with diabetes. In 2021/22, 100% of paediatric diabetes teams participated in the NPDA. | | |
| Objectives: | Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes. | | |
| Presented at Clinical Standards and Effectiveness Group – 20th July 2023 | | | |

National Paediatric Diabetes Audit - Aims and priorities:

- Build on and improve the previous joint adult and paediatric audit
- Collect a clinically meaningful dataset
- Engage clinicians, patients and parents
- Improve awareness of NPDA findings and maximise their use to drive national policy
- Develop the use of NPDA data in local and national quality improvements
- Use a regional network approach to data collection
- Capture patients' experiences
- Collaborate with the suppliers of the adult audit to ensure information around transition to adult care is captured
- Report at timely and regular intervals
- Develop user-friendly tools to interrogate the dataset
- Support centres wishing to develop local action plans to improve diabetes care
- Maximise the use and availability of data for research

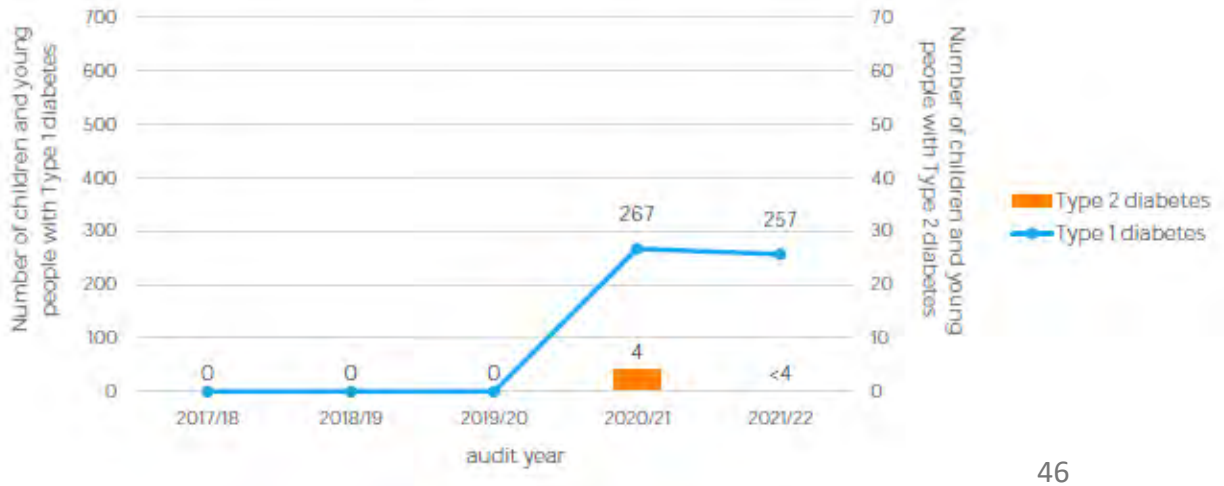
## Results

How many children and young people were receiving care from paediatric diabetes services in England and Wales in 2021/22?

The chart shows Grange University Hospital (GUH) data only.

2.5 Number of children and young people by type of diabetes, 2017/18 - 2021/22

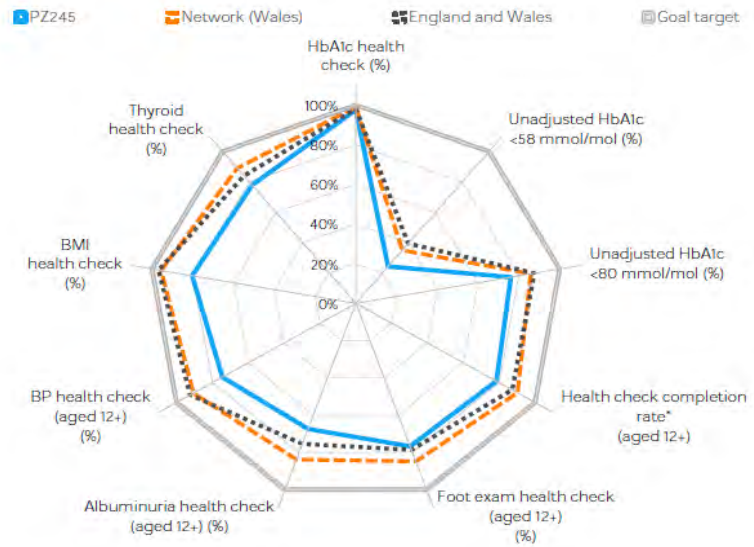
Figure 8: Number of children and young people according to diabetes type by audit year

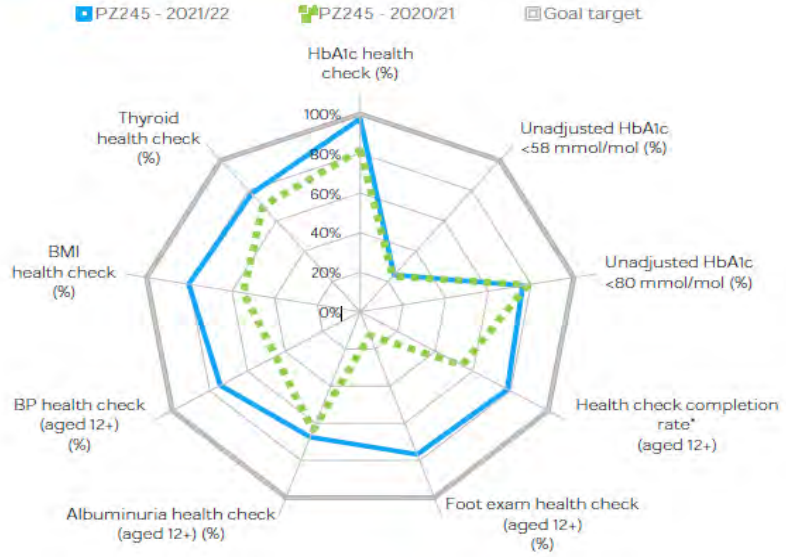


## What percentages of children and young people received all six recommended health checks in 2021/22?

The plots shows The Grange University Hospital (blue) compared to Wales (orange) and UK (black dotted line) and ABUHB 2021/2022 compared to 2020/2021.

1. HbA1c
2. BMI
3. Thyroid
4. Blood pressure
5. Albuminuria
6. Foot exam

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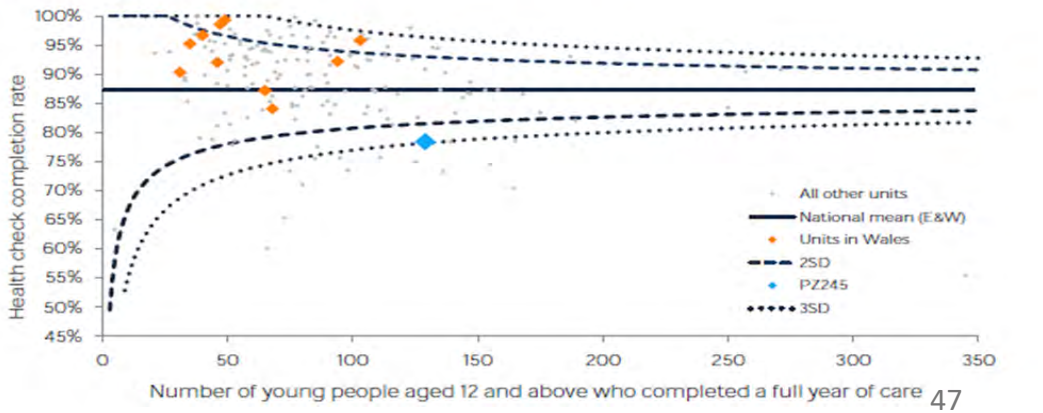
The outlier status of The Grange University Hospital, on the performance indicator for health check completion rate for 2021/22 is: ALERT.

The Clinical Lead (CL) presented the 2020/2021 report to the Clinical Standards and Effectiveness Group (CSEG) in September 2022 informing that the lack of face-to-face clinics resulting from the pandemic, was impacting on this result. During 2023 the face-to-face clinics have resumed and the impact should be seen in the next report.

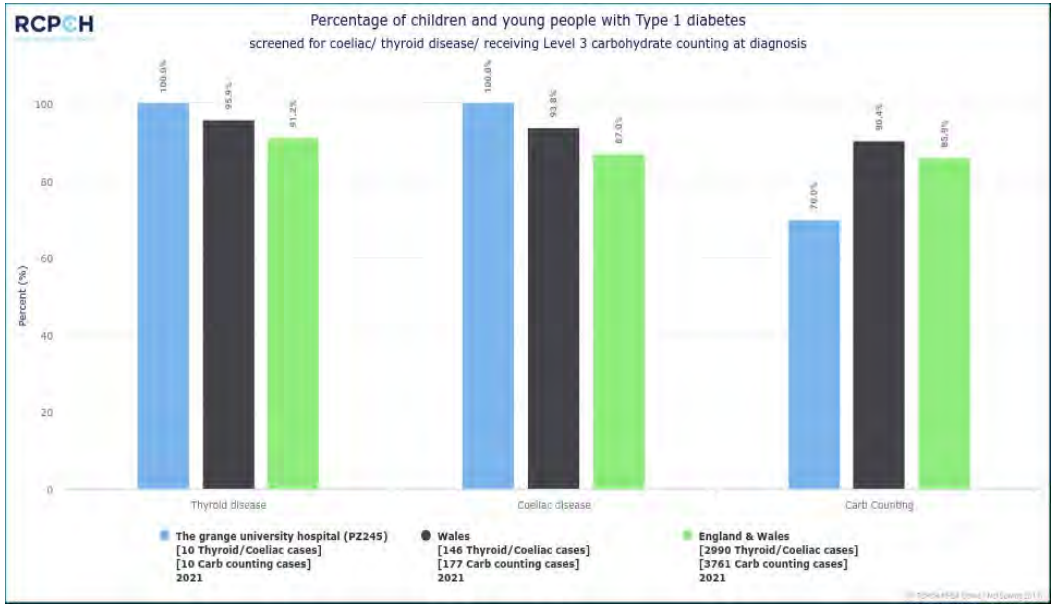
Figure 12: Health check completion rate for children and young people with Type 1 diabetes aged 12 or older who completed a full year of care



What percentage of all recommended health checks were delivered by PDUs in 2021/22? Outlier

What percentages of children and young people with Type 1 diabetes received recommended checks at diagnosis in 2021/22?

The CL stated that the Carb Counting at diagnosis was a data entry error as this is commenced at diagnosis. This remains an issue and requires an action to ensure the data reflects accurately.

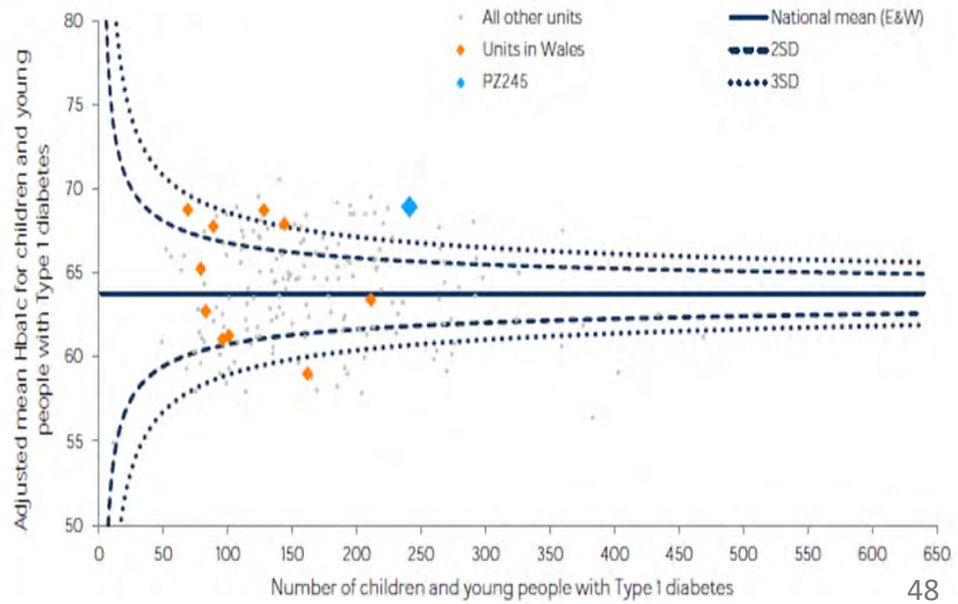



Has there been longitudinal improvement in national HbA1c?

The GUH mean HbA1c for children and young people with Type 1 diabetes was 69.7 mmol/mol. The adjusted mean was 68.9 mmol/mol. The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: ALARM.

The CL stated in September 2022 that the lack of resource funding to manage the technologies for controlling HbA1c is impacting this target and the Health Board will remain an outlier until the cost for consumables linked to vital technologies needed for children to reduce their HbA1c, therefore improving their health as children and as they grow into the adult diabetes service. A collaborative business case submitted by adult services and the paediatric diabetes team which was supported however not funded.

Figure 21: Adjusted mean HbA1c




48

What percentages of children and young people with Type 1 diabetes were using diabetes-related technologies in 2021/22? Above plot chart - ALARM status.

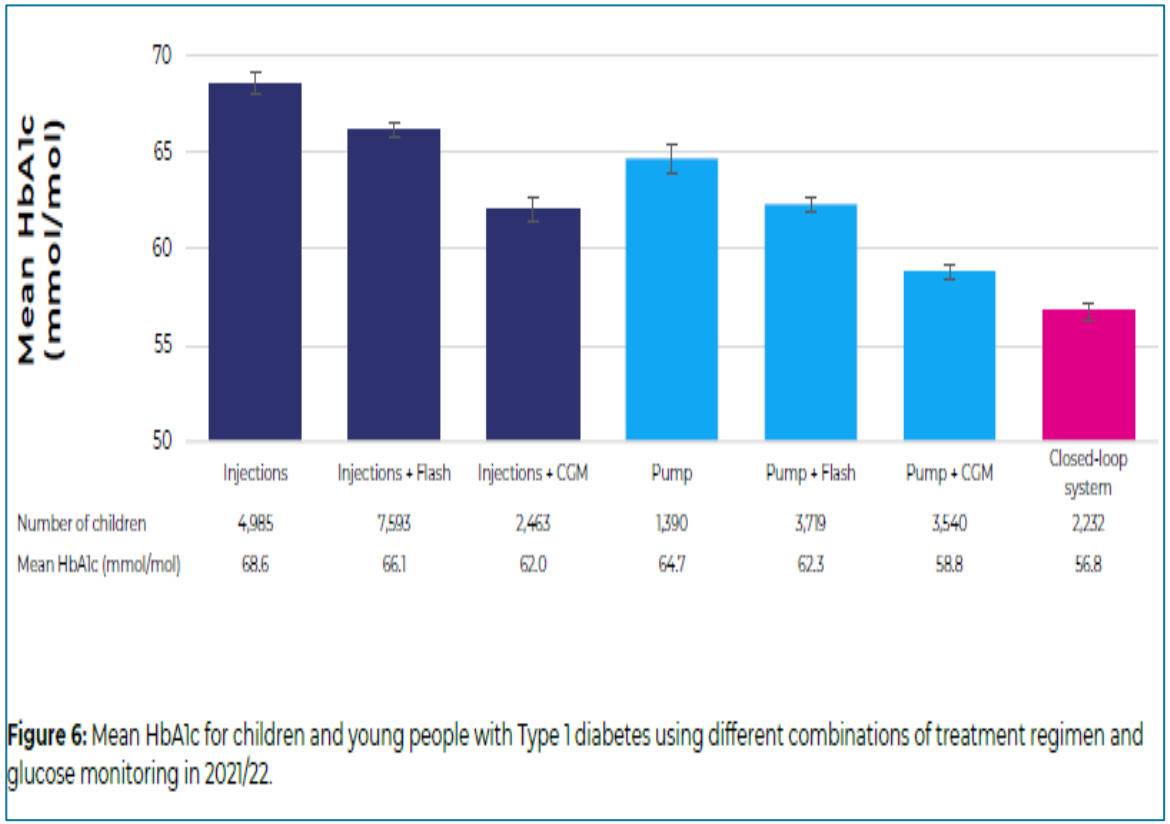
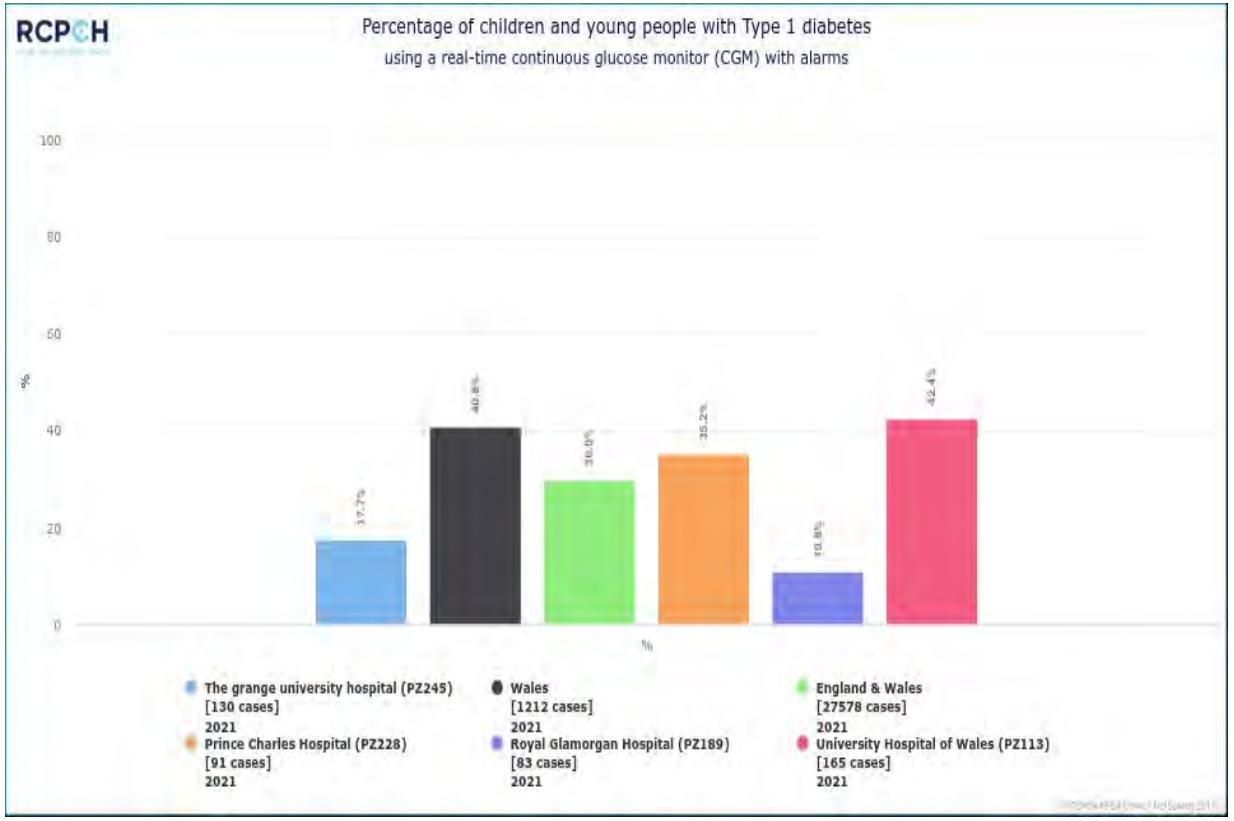
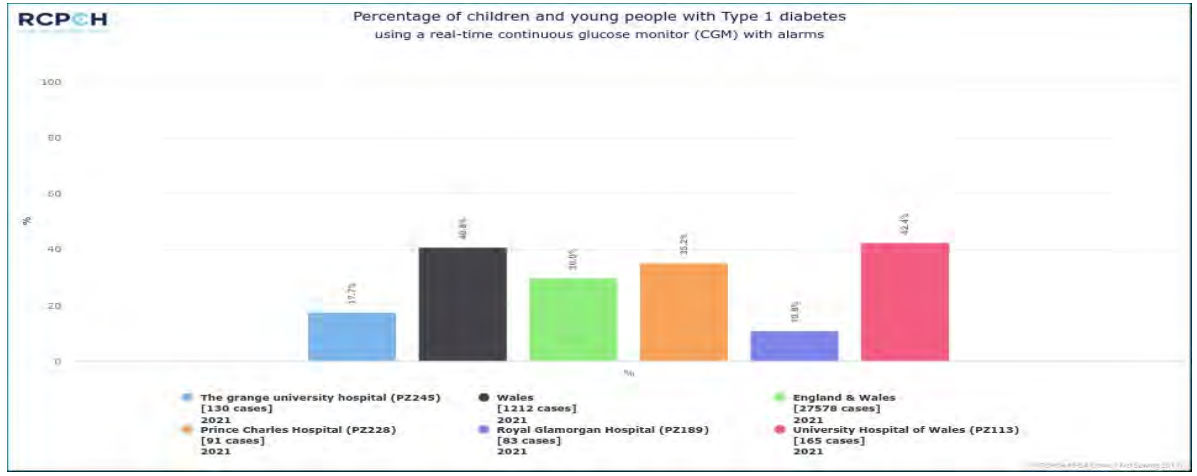


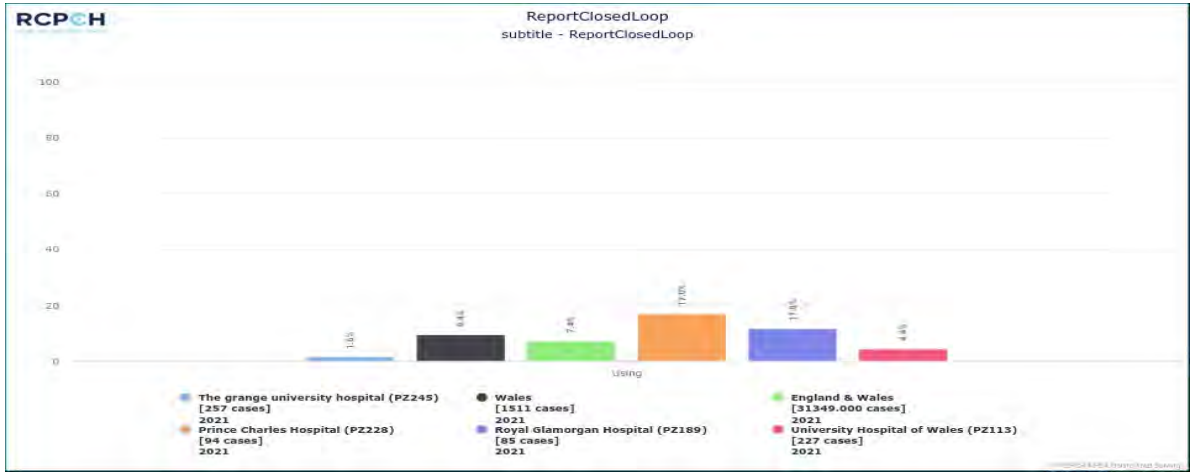

**Figure 6:** Mean HbA1c for children and young people with Type 1 diabetes using different combinations of treatment regimen and glucose monitoring in 2021/22.



## What was the average HbA1c for children and young people with Type 1 diabetes using different diabetes-related technologies in 2021/22?

The graphs below demonstrate the lower HbA1c when using advanced technologies across the UK and The Grange University Hospital displays low use of the technologies, therefore increasing and HbA1c and contributing to the ALARM status. This will not improve without the resources to obtain and manage the technologies.

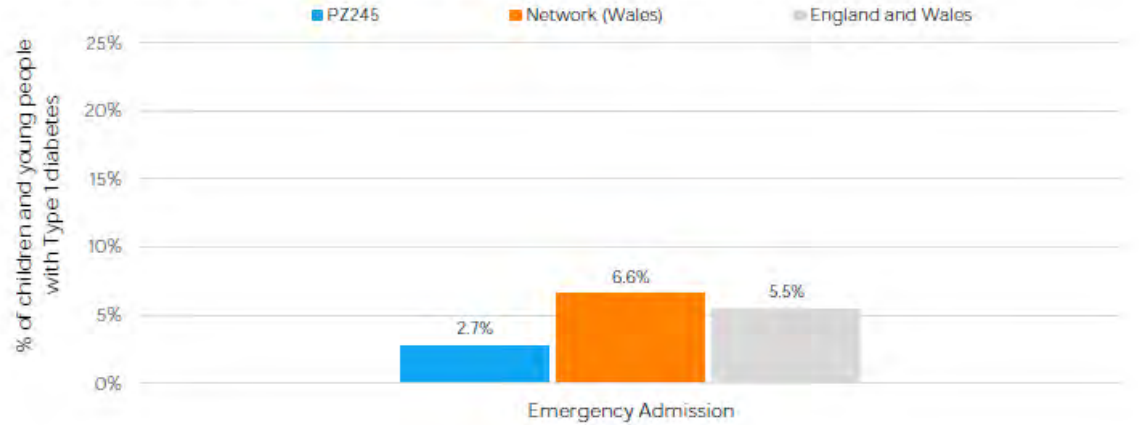



## What percentages of children and young people with Type 1 diabetes had diabetes-related hospital admissions in in 2021/22?

Percentage of children and young people with Type 1 diabetes who had at least one diabetes-related emergency hospital admission during the audit period, that was not associated with diagnosis.

Figure 39: Percentage of children and young people with Type 1 diabetes who had at least one diabetes-related emergency hospital admission during the audit period, that was not associated with diagnosis



How many children and young people with diabetes were assessed as requiring additional psychological support following assessment in 2021/22?

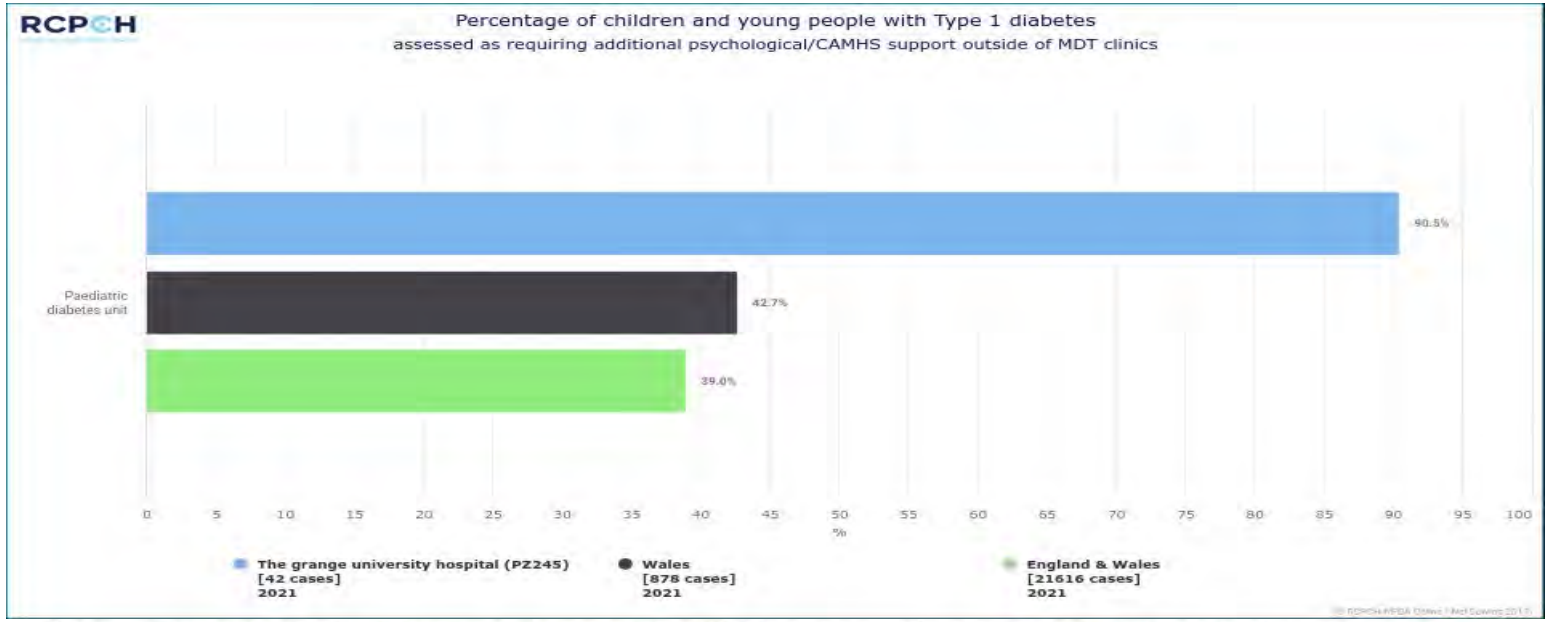
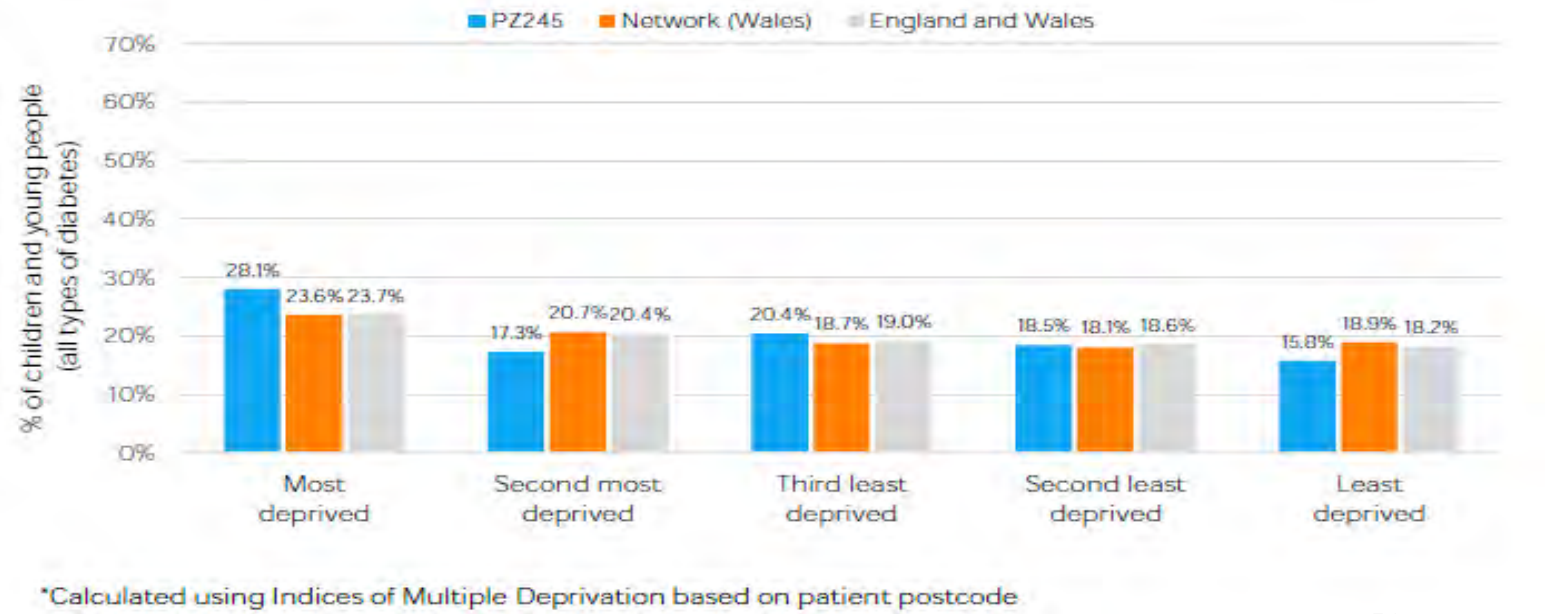



Figure 6: Percentage of children and young people within each deprivation quintile by unit, region and overall

Also noted is that Aneurin Bevan University Health Board a higher rate of CYP in the deprived areas compared to the rest of Wales and the UK.




*Calculated using Indices of Multiple Deprivation based on patient postcode

## Assurance Level and Risk Level

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

| Risk level | Description | Select |
|---|---|---|
| Major | Non-compliance with national standards/Significant risk to patients if unresolved | Yes |

| **Has this audit been placed on a Risk Register (N/A if above risk is None)** | **YES** |
|---|---|

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | The Paediatric Diabetes Team attended the Gwent Children's Diabetes Family Evening 2023.<br>Attendees: Thirty-two families (80 people) initially confirm their attendance, with approximately 60 people attending on the evening. Great feedback. |

| Report Concerns: | |
|---|---|
| 1 | The outlier status of The Grange University Hospital, on the performance indicator for health check completion rate for 2021/22 is: Alert. |
| 2 | The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: Alarm. |

| Report Recommendations: | | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|
| 1 | Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Health Boards and Regional Partnership Boards across Wales. | The alarm status related to diabetes technologies, for the audit has been on the Divisional F&T risk register for some time.<br>A joint business case submitted to PIP by adults and F&T was supported but not funded. Unfortunately, there has been no change to finances to be able to put in any additional workforce to improve this situation.<br>Issues flagged at F&T Divisional Assurance meetings. The costs for consumables was reflected and the gap in ability to improve HbA1C levels still stand.<br>Further actions from this is to submit the costs associated to diabetes to be submitted to Chief Operating Officer (LW).<br>This will be undertaken jointly by both adults and paediatric finance teams.<br><br>Risk to remain of register and further work as above.<br><br>PQSOC to be made aware of risk when submitting audit activity report<br><br>Work underway to address the gap in access to pump technology for Gwent children and young people with diabetes. | Ms Sara Garland<br>28/03/2024<br>Partially complete |
| 2 | Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential differences in outcome with different modalities of insulin delivery and blood glucose monitoring. Action by: Integrated Care Boards across England in line with the aims for diabetes care set out within Core20PLUS5 – the national NHS England approach to reducing health inequalities for children and young people. Health Boards and Regional Partnership Boards across NHS Wales and Public Health Wales. The RCPCH, to provide a better understanding of ethnic and social deprivation variability. | | |
| 3 | Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year. Action by: Clinical teams within Paediatric Diabetes Units in NHS Health Boards and Trusts across England and Wales. | | |

| Report Recommendations: | | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 4 | Awareness of diabetes symptomatology amongst the public should be enhanced to avoid newly diagnosed children and young people presenting with Diabetic ketoacidosis (DKA). Action by: The Office for Health Improvement and Disparities, NHS England, Public Health Wales and NHS Wales supported by the National Children and Young People's (CYP) Diabetes Network, and diabetes charities (Diabetes UK and JDRF). | | | | |
| 5 | Studies should be funded to derive evidence for interventions supporting pre-diabetic children young people to avoid progression to Type 2 diabetes. Action by: Funding bodies such as the National Institute for Health and Care Research, Diabetes UK. | | | | |

| Are there any potential barriers/problems to prevent the implementation of the above actions? |
|---|
| Yes |
| If yes, please describe and detail who these have been referred to: |
| Insufficient funding for Diabetes team work load. Business Case was supported in principle for this but not funded.<br>Trying to prioritise against need given situation<br>Will explore opportunities for broader approach across Paediatrics |

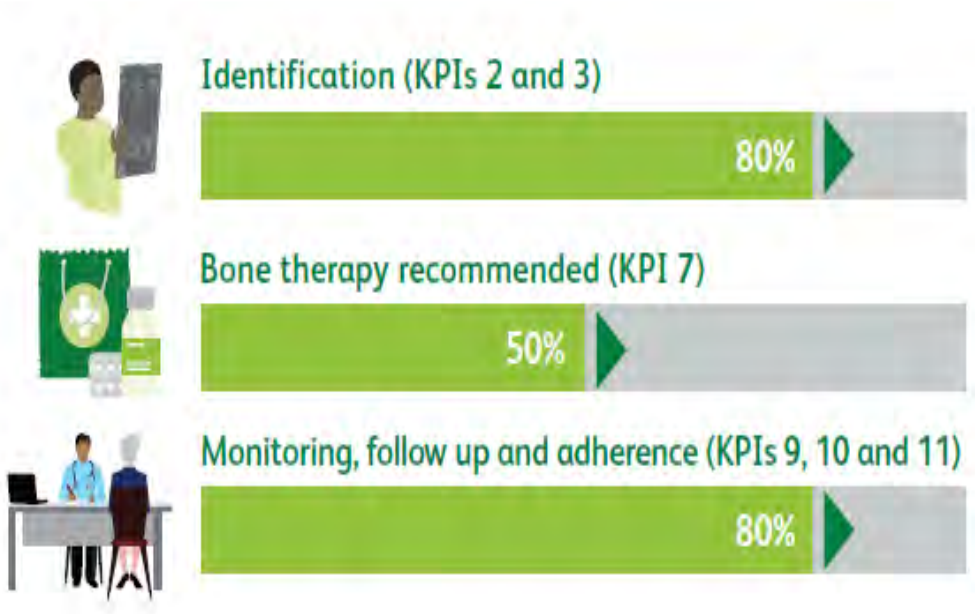
**Appendix 6**

| | | | |
|---|---|---|---|
| Audit Title: | Fracture Liaison Service Database (FLS-DB)<br>Annual report: Rebuilding FLSs to meet local patient need<br><br>Data from January to December 2021<br>January 2023 | Clinical Lead: | Dr Inder Singh<br><br>Sophie Maggs/Amara Williams/Ketan Vegad, COTE team<br>Non Pugh/Johanna Wiles, Rheumatology team |
| Rationale: | A fracture liaison service (FLS) ensures that patients aged 50 and over with a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. Made up of a team of healthcare professionals, FLSs bring clear benefits to the patient in the long term and have been shown to be clinically and cost-effective. | | |
| Objectives: | FLS-DB collects, measures and reports on 11 key performance indicators (KPI's) derived from NICE technology appraisals and guidance on osteoporosis and falls alongside the Royal Osteoporosis Society (ROS) Clinical Standards for FLSs and Quality Standards for Osteoporosis and prevention of fragility fractures. The KPI's are:<br>KPI 1 – Data completeness<br>KPI 2 – Identification (all fragility fractures)<br>KPI 3 – Identification (spinal fractures)<br>KPI 4 – Time to FLS assessment<br>KPI 5 – Time to DXA<br>KPI 6 – Falls assessment<br>KPI 7 – Bone therapy recommended<br>KPI 8 – Strength and balance training<br>KPI 9 – Monitoring contact 12–16 weeks post fracture<br>KPI 10 – Commenced bone therapy by first follow up<br>KPI 11 – Adherence to prescribed anti-osteoporosis medication at 12 months post fracture | | |
| Presented at Clinical Standards and Effectiveness Group – 25th May 2023 | | | |

| | National 2019 | National 2020 | National 2021 | ABUHB 2019 | ABUHB 2020 | ABUHB 2021 |
|---|---|---|---|---|---|---|
| KPI 1 – Data completeness | | | | | | |
| KPI 2 – Identification (all fragility fractures) | 36.4 | 33.9 | 37.9 | 13 | 18.7 | 22.6 |
| KPI 3 – Identification (spinal fractures) | 17.6 | 14.5 | 20.3 | 18.1 | 26.2 | 26.1 |
| KPI 4 – Time to FLS assessment | 68.6 | 64.2 | 66.5 | 14.7 | 3.3 | 21.3 |
| KPI 5 – Time to DXA | 46.8 | 22.7 | 31.2 | 47.6 | 16.7 | 23.3 |
| KPI 6 – Falls assessment | 61.3 | 58.4 | 60.8 | 22.8 | 18.8 | 34.7 |
| KPI 7 – Bone therapy recommended | 52.6 | 52.3 | 55.2 | 50.5 | 55.9 | 57.7 |
| KPI 8 – Strength and balance training | 6 | 5.1 | 5.6 | .8 | 1.5 | 4.8 |
| KPI 9 – Monitoring contact 12–16 weeks post fracture | 20.3 | 23.3 | 24.5 | 0 | 0 | 1.4 |
| KPI 10 – Commenced bone therapy by first follow up | 22.6 | 28.5 | 29 | 21.3 | 11.9 | 8.3 |
| KPI 11 – Adherence to prescribed anti-osteoporosis medication at 12 months post fracture | 20.4 | 23.1 | 22.3 | 17.8 | 5.4 | 18.4 |

Recommandations for fracture liaison services

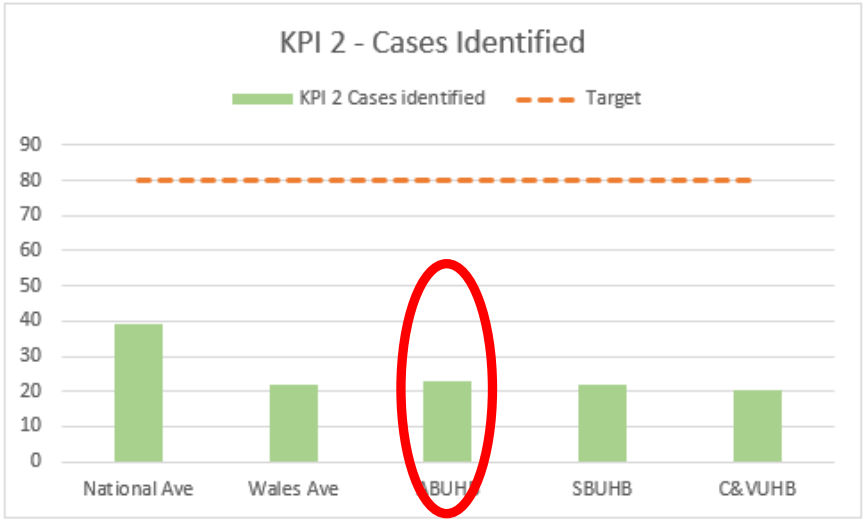
# Model – 80/50/80

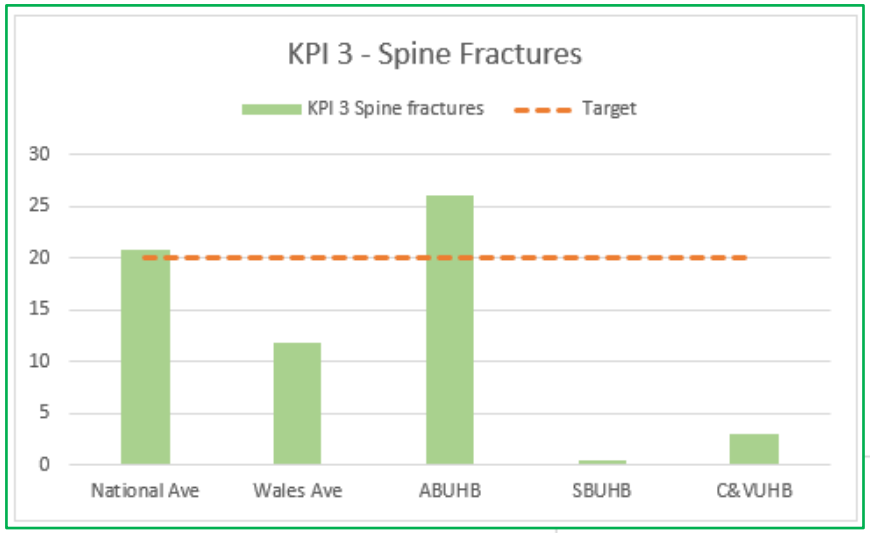


## Identification KPIs 2 and 3

KPI 2 - All FLSs submitting less than 80% of their expected caseload to the FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates - ABUHB performing at 22.7%

KPI 3 - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures - The target is 20% with ABUHB above target at 26.1%



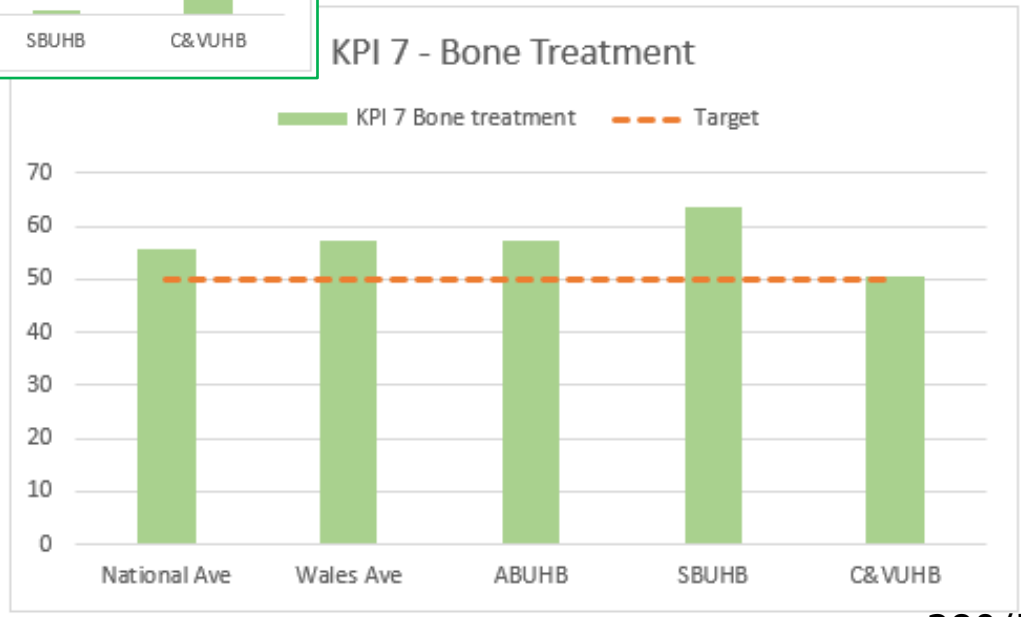




Bone therapy recommended (KPI 7)

More patients were recommended anti-osteoporosis medication in 2021 than in 2019 (56% vs 52%).

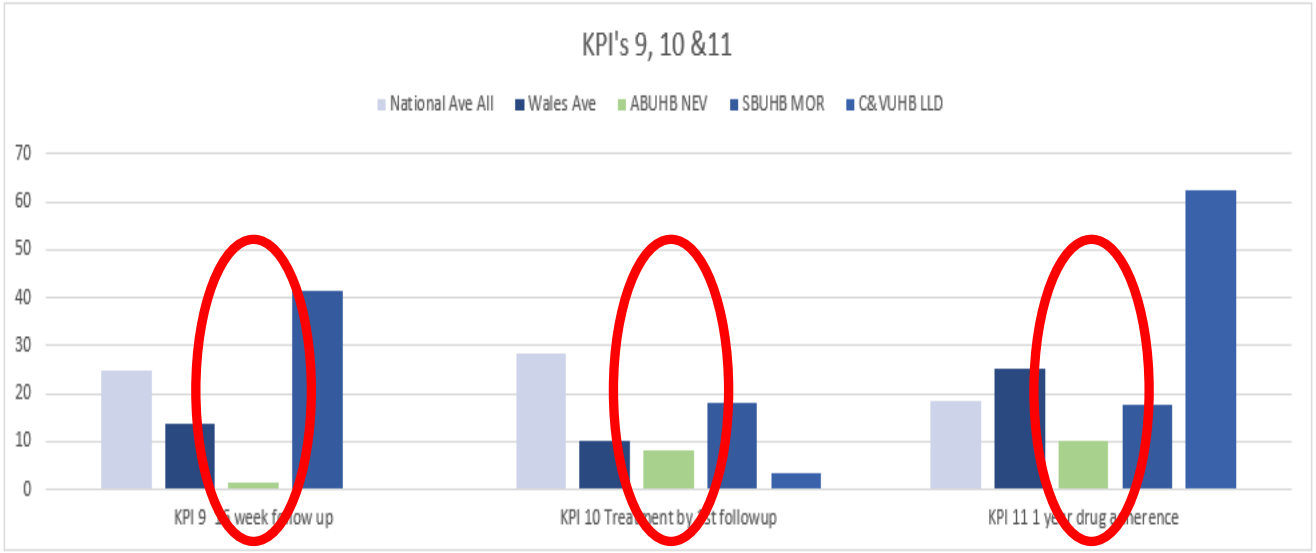
**Once we identify a fragility fracture, we do commence treatment**

**ABUHB is performing at the Welsh average of 57.5% which is better than the National Average of 55.8%**



**Monitoring, follow up and adherence (KPIs 9, 10 and 11)**

All three KPIs for monitoring and follow up have improved in 2021 in comparison with 2019. For example, the percentage of patients who were followed up within 16 weeks of their fragility fracture has increased from 41% in 2019 to 47% in 2021 – **These performance targets in ABUHB are much lower than the National Average (NA)**




Missed opportunity for ABUHB

We identified – 22% of patients (n=875) (missed 58% as per rule) – Expected fragility fractures – ABUHB = 3875

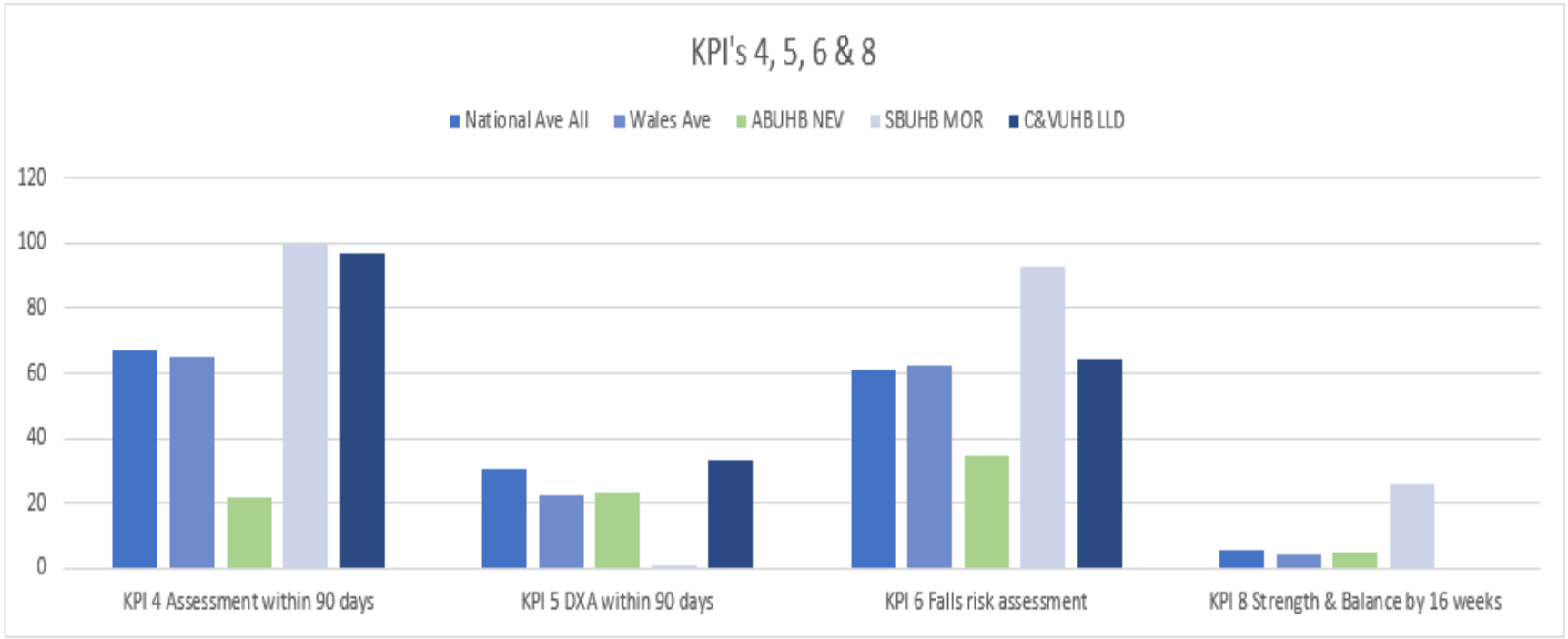
We treated 56% - so treated 12% of identified patients

We reviewed 1.4% patients at 16 weeks = 0.1% patients reviewed at 16 weeks

We reviewed 10.1% - one year drug adherence = 1.2%

Missed opportunity = 99%

## The report does not concentrate on KPI's 4, 5, 6 & 8 – we are working and improving in these areas




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

| Risk level | Description | Select |
|---|---|---|
| Moderate | Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on | Yes |

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

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | KPI 3 Spine Fracture - A major improvement was observed both in comparison to the previous and also against the national benchmark for spine fracture improved from 26% to 35% (National average=21%); |
| 2 | KPI 7 Bone Treatment - Bone treatment improved from 58% to 66% (National average=54%) |
| 3 | FLS-DB showed 42.6% (n=1651) patients identified in the year 2022, Case volume has increased by 88% compared to previous year 2021 |
| 4 | Process mapping supported the establishment of the two FLS-DB pathways: Rheumatology team to provide care for patients under 75 with the current Clinical Nurse Specialist (CNS) and COTE team to assess all patients above 75 years. Medical Division supported the pilot for 12 months by funding two new CNS. Collaboration with the Radiology assisted to generate separate weekly fracture data for the Rheumatology and COTE teams. |
| 5 | Falls assessment improved from 35% to 81% (National average=61%) |
| **Report Concerns:** | |
| 1 | KPI 2 Cases identified - Only 22.7% (n=879) of patients were identified by the FLS team, Aneurin Bevan University Health Board, Wales in 2021 (National average=40%). |
| 2 | KPI 4 Assessment within 90 days |
| 3 | KPI 5 DXA within 90 days |
| 4 | KPI 6 Falls Risk Assessment |
| 5 | KPI 8 Strength and Balance by 16 weeks |
| 6 | KPI 9 - 16 weeks Follow Up |
| 7 | KPI 10 - Treatment by first Follow Up - ABUHB is catching with 16 weeks Follow up, reached 19% in the year 2022 |
| 8 | KPI 11 - 1 year drug adherence - with ABUHB, we are not able to review patients at 1 year and currently working to improve for f-ups |
| 9 | Cases remains lower than the national recommendation of 50% (currently seeing 43% in ABUHB) |
| 10 | Further resource required for CNS/Admin |
| 11 | Wider partnership with radiology and T&O and A&E to identify new fragility fractures |

| Report Recommendations: | | Progress: |
|---|---|---|
| 1 | In this year's annual report, the FLS-DB team are encouraging services to focus on KPIs 2 and 3 (identification), KPI 7 (bone therapy recommended) and KPIs 9, 10 and 11 (monitoring, follow-up and adherence) for service improvement goals (80/50/80 model). | All recommendations are being addressed and remain ongoing to improve the Health Board FLS. |
| 2 | KPI 2 – Identification (all fragility fractures) - All FLSs submitting less than 80% of their expected caseload5 to the FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates. | |
| 3 | KPI 3 – Identification (spine fractures) - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures. | |
| 4 | KPI 7 – Bone therapy recommended - All FLSs with less than 50% treatment recommendation should review their pathways in line with NICE technology appraisals and guidance (NICE CG146, QS86, TA161, TA204, TA464, TA791), the NOGG 2021 clinical guideline for the prevention and treatment of osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs. | |
| 5 | KPIs 9, 10 and 11 – monitoring, follow up and adherence - All FLSs should continue to aim for monitoring performance for at least 80% patients who are recommended or referred for therapy. This includes patients who receive injectable therapies after referral to other clinical teams, to ensure the treatment recommendations have been actioned. | |
| 6 | To achieve these aims, the FLS-DB audit recommends that: All FLSs should have regular monthly governance meetings that report to their organisation's executive teams and use FLS-DB data in these meetings to prioritise areas for service improvement. | |

| Report Recommendations: | | Progress: |
|---|---|---|
| 7 | To achieve these aims, the FLS-DB audit recommends that: 9 All FLSs should have an active service improvement team that includes at least two patients/ carers and representation from clinicians, administration and management to complete at least one quality improvement cycle every year. | All recommendations are being addressed and remain ongoing to improve the Health Board FLS. |
| 8 | To achieve these aims, the FLS-DB audit recommends that: 10 All FLSs should use the regional benchmarking function to develop regional networks that share good practice and drive service improvement. | |
| 9 | To achieve these aims, the FLS-DB audit recommends that: 11 All FLSs should engage with the ROS and local decision makers to ensure their FLS is resourced based on local need. The ROS FLS implementation toolkit offers support for the development of services from business case right through to outcomes and performance measurement, including providing an FLS benefits calculation to cost pathways for the local population. | |
| 10 | Recommendations for senior executive decision makers ~ 12 All senior executive decision makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. Patient representatives and members of the ROS should be invited to the meeting, and it should plan for effective and sustainably resourced FLSs based and designed on the KPIs from the FLS-DB. | |
| 11 | Recommendations for senior executive decision makers ~ 13 All senior executive decision makers should ensure FLSs are commissioned to deliver the Best MSK pathway for secondary fracture prevention, participate actively with the FLS-DB mandatory national audit and complete at least one quality improvement cycle per year. | |

| | Local Recommendations: | | S.M.A.R.T Actions: | Responsible:<br>Due Date:<br>Progress: |
|---|---|---|---|---|
| 1 | To write a business plan to demonstrate the requirements for the Health Board to provide an affective FLS | | Write a business case for CNS support and Admin support for the team and review consultant sessions<br><br>We will continue to collaborate with the ROS and ensure that Health Board's focus on the strategic planning for the FLS is delivered<br><br>Medical Division is supporting us with the two WTE CNS and have funded and have been supported us to write a business case. The initial results of the pilot have already supported the further extension of the pilot for another year with the aim of drug adherence by engaging with the Community and Primary care teams. This pilot also highlights the importance of improving culture and multi-professional awareness of fragility fractures and FLS. | Complete – FLS Economic Benefits Calculator Report completed and FLS Costing Tool completed by Dr Inder Singh 18/01/2024 |

**Appendix 7**

| Audit Title: | National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)<br>Publication Date:12 Oct 2023 | Clinical Lead: | Dr Anurag Pinto – Consultant Paediatrician |
|---|---|---|---|
| Rationale: | The purpose of the NPID Audit is to report on the demographics, patterns of care and pregnancy outcomes for women with diabetes in England and Wales, and to provide services with information to help improve the quality of care before and during diabetes pregnancies. It measures the effectiveness of diabetes pregnancy healthcare against NICE Clinical Guidelines and NICE Quality Standards. NICE recommends 5mg/day folic acid supplementation for 3 months pre-pregnancy and avoidance of potentially harmful medications. NICE guidelines also recommend targets for pre-pregnancy and antenatal glucose control; and since December 2020 NICE have recommended that women with type 1 diabetes are offered continuous glucose monitoring (CGM) to help them meet their pregnancy glucose targets. The guideline recommendations are based on strong evidence that use of CGM technology improves maternal glucose and reduces obstetric and neonatal complications | | |
| Objectives: | This NPID report focuses on NICE guidance and Quality Standards for the care of diabetes in pregnancy. NICE guidelines emphasise the importance of planning for pregnancy from adolescence for women with diabetes, as part of diabetes education. It advises that women with diabetes use contraception and have monthly measurement of HbA1c, aiming to reach the pregnancy glucose target of HbA1c <48mmol/mol. This is in addition to taking folic acid (5mg/day) and avoiding medications potentially harmful to the foetus or pregnancy (e.g. angiotensin-converting enzyme inhibitors, angiotensin-II receptor antagonists, and statins that are not approved for use during pregnancy). Advice on how to lose weight should be offered to those with a body mass index (BMI) above 27 kg/m2. All pregnant women should be offered immediate contact with a joint diabetes maternity clinic, as soon as possible after confirmation of pregnancy. | | |
| Presented to Clinical Standards and Effectiveness Group – 30th November 2023 | | | |

Data is collected of pregnancy outcomes in women with pre-existing diabetes ( not gestational diabetes)

This audit has 3 key questions:

1. Were women with diabetes adequately prepared for pregnancy?
2. Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother?
3. Were adverse neonatal outcomes minimised?


Findings:

1. For the first time T2 women outnumbered T1
2. T2 women accessed service late and had poorer outcomes
3. 7/8 pregnancies started with poor preparation ( no improvement in 7 years)
4. HbA1C of <43 in 3rd trimester ( new target) improved outcomes greatly
5. First full year of data for Grange University Hospital

Actions from previous year:

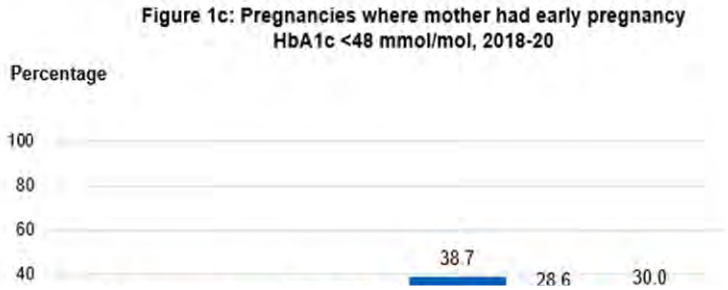
- Joint working with primary care on pre-pregnancy optimisation HbA1c,48 mmol/mol and 5mg Folic Acid (FA)30th November 2023
- Community midwifes early referral with special focus on T2
- Ongoing audit of reasons for pre-term births & SCBU admissions (particularly T2)
- Long-term planning of pregnant women with gestational diabetes and raised BMI (baby steps)

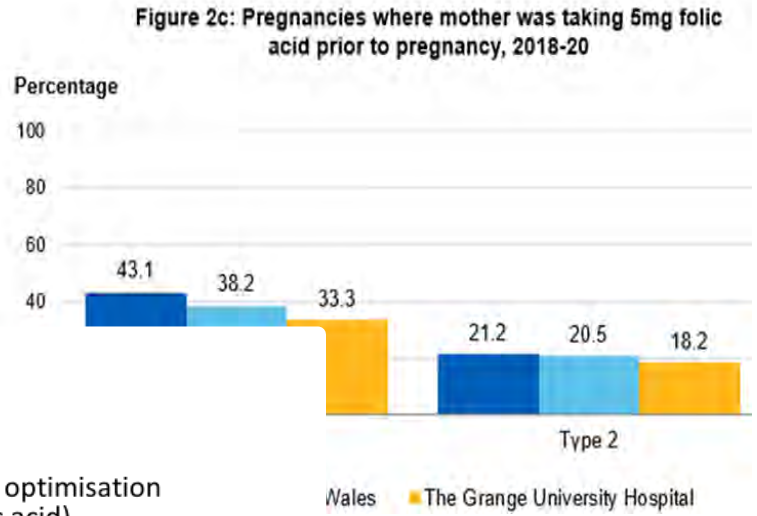
Results:

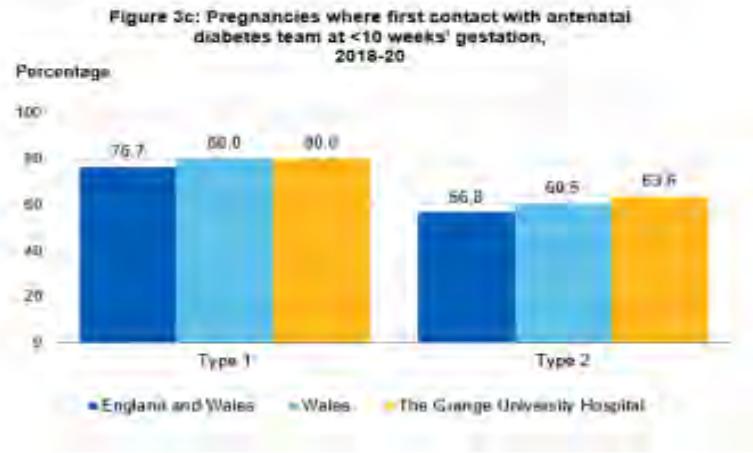
- Lower than expected recoding of FA
- Not as much pre-term (admissions to SCBU) births as expected

The use of BadgerNet will improve data moving forward.

# History NPID report 2022 – ABUHB




## Action plan- ABUHB

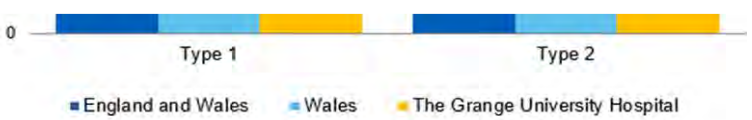
- Jointly work with Primary Care re need for pre-pregnancy optimisation of diabetes (HbA1C <48mmol/mol and being on 5mg Folic acid).

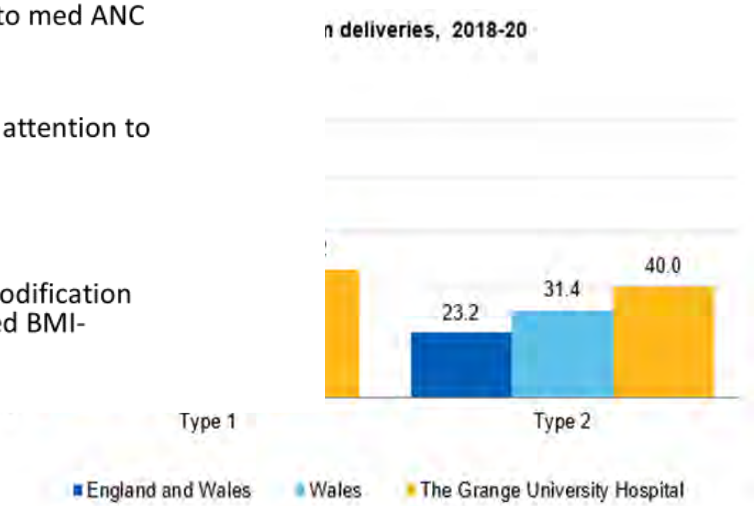
Referral into MANC: T2DM special focus – on early referral to med ANC (Message to community MWs)

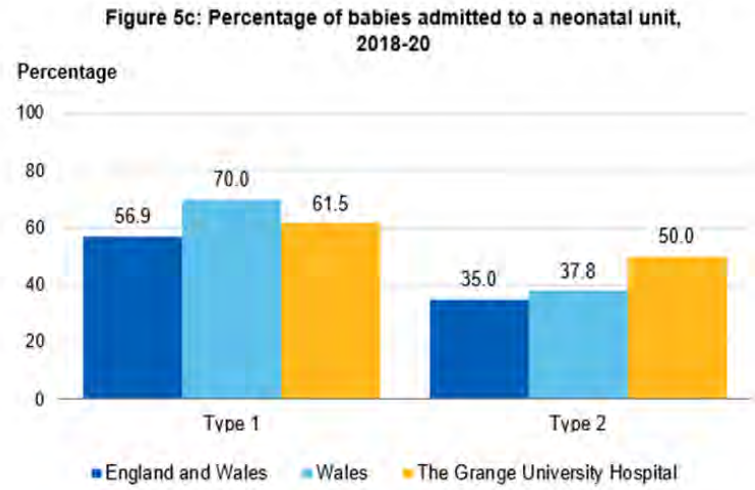
Ongoing Audit of women delivered in 2021- with particular attention to

- Reasons for preterm birth- (particularly in T2DM)
- SCBU admissions (particularly in T2DM)

Long term planning- Good quality Education and lifestyle modification strategies targeted to pregnant women with GDM and raised BMI- Baby steps



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- SCBU admissions (particularly in T2DM)

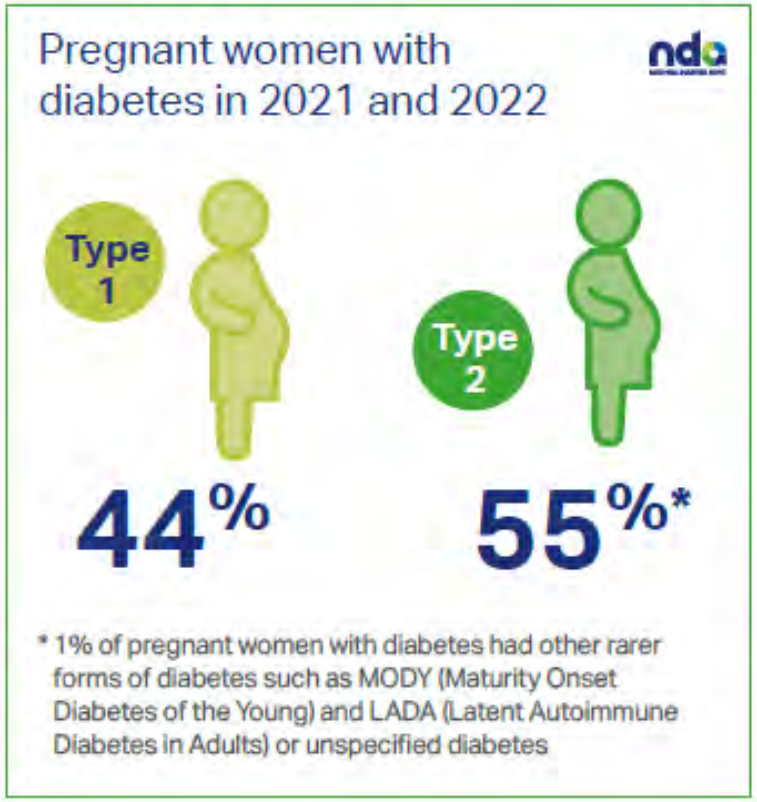
Long term planning- Good quality Education and lifestyle modification strategies targeted to pregnant women with GDM and raised BMI- Baby steps

## SUMMARY

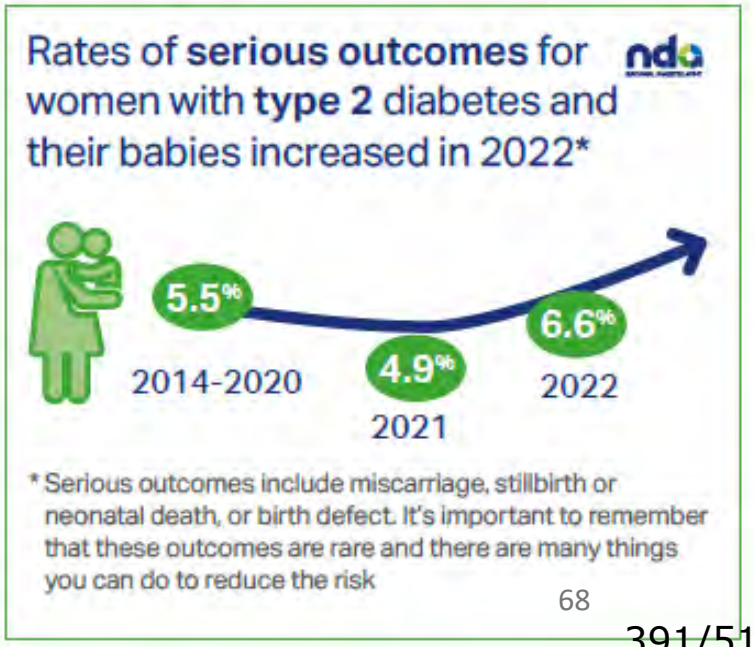
1. Evidence of Pre-conceptional planning was found in 15 women (20%) of women only.
2. A very small percentage of women had taken pre-conceptional folic acid 5mg (16%). This may be because of not clearly documenting the timing of starting 5mg of FA.( all started 5mg after 1st contact)
3. 84% had at least 2 antenatal HbA1c checks (soon after booking pregnancy and in 3rd trimester) . 70% of women who had Hba1c >86 at booking had adverse pregnancy outcomes.
4. 85% of women had AN FU as per NICE GL and 91% of women had scans as per NICE GL there was congruency in US and birth weight in 80% of the women
5. 79% of steroids were given in the optimal time frame (24hrs to <7 days)
6. 73% Of women had live births, out of which 38% were preterm deliveries
7. 25 women (45%) opted for VB and 30 (55%) women opted for planned CS.
   52% of planned vaginal births and 67% of planned caesarian births were successful.
   CSR for this group= 76%
8. 25% of livebirths required SCBU/ NICU. 15 (27% ) macrosomia and 3 ( 5%) hypoglycaemia

# National Pregnancy in Diabetes Audit 2021and 2022, England and Wales*

* This audit does not include pregnancies in women with gestational diabetes (diabetes that develops in pregnancy)





# Aneurin Bevan University Health Board results: Combined T1 & T2

| Type 1 cohort | Type 2 cohort | Total |
|---|---|---|
| 30 Cohort total | 20 Cohort total | 50 Cohort total |

<50% capture rate

**Please note the cohort number for Type 2 is too low calculate therefore figures below include both T1 and T2 for the Health Board.**

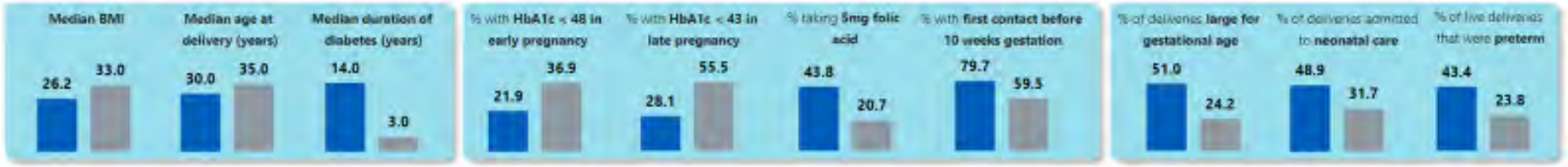
| Median BMI | Median age at delivery (years) | Median duration of diabetes (years) | % with HbA1c < 48 in early pregnancy | % with HbA1c < 43 in late pregnancy | % taking 5mg folic acid | % with first contact before 10 weeks gestation | % of deliveries large for gestational age | % of deliveries admitted to neonatal care | % of live deliveries that were preterm |
|---|---|---|---|---|---|---|---|---|---|
| 29.9 | 32.0 | 9.0 | 22.2 | 33.3 | 30.0 | 80.0 | 55.6 | 62.5 | 50.0 |

Charts below show the percentage composition of the women in the service, broken down by the variable/measure shown in the chart title. Percentages may not sum to 100 due to rounding.

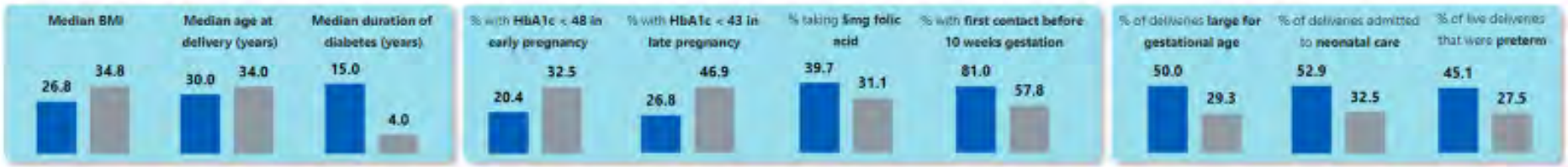

NPID 2023 report demonstrate higher levels of T2 due to manifesting earlier in age, higher rates in more deprived areas and ethnic minorities having more serious outcomes. T1 women with Continuous Glucose Monitoring (CGM) has more improved outcomes. The Health Board had 50 cases however only capturing 50% of the data relating to use of FA, HbA1c <48 in 1st and 3rd trimesters.

# National Pregnancy in Diabetes Audit 2021 and 2022
# Aneurin Bevan University Health Board Performance


National results:




Wales results:




Aneurin Bevan University Health Board results: by Type of Diabetes


**Differences in the practice of checking HbA1C –**
**at NHH ( in 2022)1/3rd had HbA1C <48 in 1st trimester**

**Late pregnancy HbA1C- (2022)-**
**75%& 27% had <48 and 42%&20%<43mmoml/mol**

**67% taking 5mg FA pre pregnancy don't have this info for both sites- and 100% from 1st contact in both sites**

Measures relating to Hba1c,48 in early pregnancy and Hba1c <43 in late pregnancy, folic acid and first contact within before 10 weeks gestation, the report had no data for the Health Board however Dr Pinto has analysed the data and there is a variation between the sites, NHH HbA1c <48 – one third in 1st trimester. For 2022 late pregnancy HbA1c <48 75% and <43 42% and 67% taking 5mg FA pre pregnancy don't have this info for both sites- and 100% from 1st contact in both sites. Data capture needs to be improved going forward.

Measures are also relating to Large for gestational age, admission to neonatal and live pre-term births.

## Assurance and Risk

| Assurance level | Description | Select |
|---|---|---|
| Significant | The project has mostly achieved the standards or criteria being audited against | Yes |
| **Risk level** | **Description** | **Select** |
| None | Standards met and findings demonstrate no risk to patient safety | Yes |
| **Has this audit been placed on a Risk Register (N/A if above risk is None)** | | **NO** |

## Successes and Concerns

| Report Successes: | |
|---|---|
| 1 | All women are using the FreeStyle Libre System Dexcom |
| 2 | Above national average for early contact in T1DM |
| 3 | Local audit shows better early and 3rd trimester HbA1C and outcomes for babies (reassurance) |
| 4 | Working with Peri-prem Cymru national project to reduce morbidity in pre-term births |

| Report Concerns: | |
|---|---|
| 1 | Data collection and feeding into NPID |
| 2 | Variation in practice across Health Board sites |
| 3 | Higher levels of Preterm birth in ABUHB population |
| 4 | Improve checks on HbA1c in early and late pregnancy |

| Reported Recommendations: | | Health Board Performance |
|---|---|---|
| 1 | Welsh Health Boards should help to further improve pregnancy outcomes by ensuring that diabetes care providers enable all women with type 1 diabetes of reproductive age to access diabetes technology (continuous glucose monitoring and hybrid closed-loop systems) to achieve their pregnancy glucose targets. | We use FSL pr Dexcom routinely in pregnant women with T1DM |
| 2 | Welsh Health Boards should ensure that providers of maternity diabetes care improve glucose lowering using culturally appropriate dietary support, glucose monitoring and intensive insulin therapy to reduce the adverse trend of serious adverse pregnancy outcomes in women with early-onset type 2 diabetes. | Consistently checking HbA1C early and in late pregnancy , aiming for TIR to >70% ( >90%) |
| 3 | Welsh Health Boards should ensure that aiming for target glucose control (HbA1c<48mmol/mol) remains an imperative in women with diabetes. They should further ensure that women with diabetes have access to effective methods of contraception to prevent unplanned pregnancy. Those planning pregnancy should be offered monthly HbA1c checks, 5mg folic acid supplementation, medications review, weight management programmes, and rapid referral to specialist care when pregnancy is confirmed. | A consistent finding of NPID audit is that 7/8 pregnancies are conceived without optimising diabetes |

| SMART Actions linked to the above REPORT recommendations: | | | | |
|---|---|---|---|---|
| Rec/Con No. | Action No: | | Responsible: | Due date: |
| Concern 3 | 1 | To investigate the high level of preterm births in the Health Board | Mrs Pinto | 31/03/2024 |
| Concern 2 | 2 | Currently updating internal guidance to incorporate New NPID guidance | Mrs Pinto | 31/03/2024 |
| | 3 | Improve cross site working to reduce variation (aspiring to involve Primary Care) | Mrs Pinto | 31/03/2024 |
| Concern 1 | 4 | Link with QPS support to ensure accurate data and maximise the volume entered | Mrs Pinto | 31/03/2024 |

| Results from Actions | |
|---|---|
| 1 | We have completed an audit ( data presented in December CG meeting) and we do have higher preterm births.<br><br>Our next step is to work upstream and find ways to prevent preterm births.<br>Responsibility to oversee this lies with our clinical leads ( Gareth Edwards- CD, Jyothi Singh - Obstetric lead, Jayne Beasley- Head of Midwifery) |
| 2 | GL updated - submitted to CEF team for ratification- Jan 2024 |
| 3 | 1st meeting has taken place, further quarterly meetings planned |
| 4 | Dr A Pinto working with QPS Team - Data for 2023 is being entered into NPID database Jan/Feb 2024 |

## Appendix 8

| Audit Title: | National Diabetes Audit 2021-22, Type 1 Diabetes<br><br>Published 12th October 2023 | Clinical Lead: | Dr Fiona Smeeton<br>Consultant in Medicine |
|---|---|---|---|
| Rationale: | This NDA report focusses on NICE guidance and Quality Standards for the routine care of people with type 1 diabetes. Everyone with diabetes should be reviewed at least once a year. Having diabetes can lead to health complications such as blindness, kidney failure, heart disease, stroke and premature death. The review should include blood tests for HbA1c (glucose control), creatinine (kidney function), cholesterol (heart risk), a urine test for albumin (kidney risk), measurements of blood pressure and weight, examination of the feet (foot ulcer risk) and review of smoking habit. These are called the 8 care processes. Retinal screening run by dedicated screening programmes, is the ninth care process. At review, treatment should be adjusted where necessary to achieve NICE recommended HbA1c and blood pressure levels; also, those with high heart risk should be prescribed a statin. These are known as the 3 treatment targets. NICE also has guidance for the use of Continuous Subcutaneous Insulin Infusion (Insulin Pumps) and Continuous Glucose Monitoring Systems (CGMS) . | | |
| Objectives: | Measurements of routine diabetes care for people with type 1 diabetes are reported in the publicly available quarterly dashboard (England GP record extracts only, for all ages: NDA England primary care quarterly dashboard), the annual care processes and treatment targets dashboard (GP record extracts plus data submitted by specialist services: NDA Core annual dashboard - England and Wales) and the NDA Type 1 dashboard - England and Wales (using the cohort validated with prescription data and including data on CGMS and pumps). Data are published at national, regional, integrated care board (ICB), sub ICB, local health board (LHB) and specialist service levels (all dashboards), and at primary care network (PCN) and practice levels (quarterly and core dashboards only). | | |
| Presented to Clinical Standards and Effectiveness Group – 30th November 2023 | | | |

# National Type 1 Diabetes Audit 2021-22, England and Wales

NATIONAL DIABETES AUDIT

Type 1 diabetes is a serious condition where your blood glucose (sugar) level is too high because your body can't make a hormone called insulin.

**227,435 adults in England and Wales have a diagnosis of type 1 diabetes.**
This report covers the period 1 January 2021 to 31 March 2022.

Having diabetes can lead to health complications such as blindness, kidney failure, heart disease and stroke. It is essential that everyone with diabetes receives certain healthcare checks every year.

The results of the checks can show whether someone is at risk of developing health complications.

Treatment should be adjusted where needed to achieve recommended HbA1c (average blood glucose) and blood pressure levels. Those with high heart risk should be prescribed a statin. These are known as the three treatment targets. Improvements are needed so all people receive the care that they need.

DIABETES UK KNOW DIABETES. FIGHT DIABETES. HQIP NHS England

## Findings

Type 1

28→33% ↑✓

Since 2019-20 achievement of **blood glucose targets** has **improved**

Type 1

**50%**

of people in England were using wearable **glucose monitors** by March 2022*

Type 1

73→70% ↓×

Since 2019–20 achievement of **blood pressure targets** has **declined**

Type 1

Care, treatment and outcomes are dependent on **geography**, **age**, **ethnicity** and **deprivation**

*Data on wearable glucose monitors are not currently available for Wales

**Find out more**

1. National Type 1 Diabetes Audit

SCAN ME

2. Audit results for your local services
National Diabetes Audit dashboards

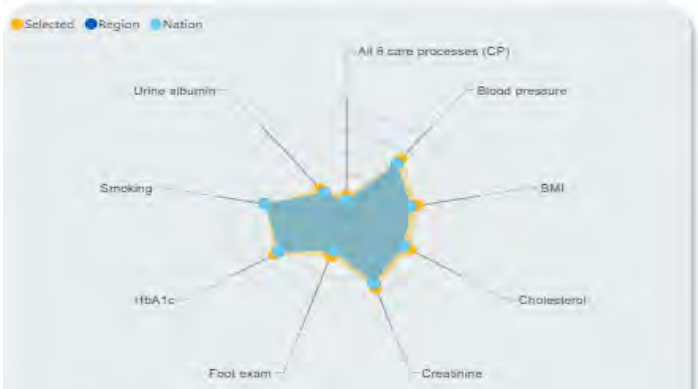
The Health Board has the highest severely obese level across Wales at 9.4% and Obese level at 14.3% compared the lowest rate of 9.4% and the 2nd highest deprivation rate across Wales with 43.2% in the most deprived area.

Wales | BMI group - Severely obese

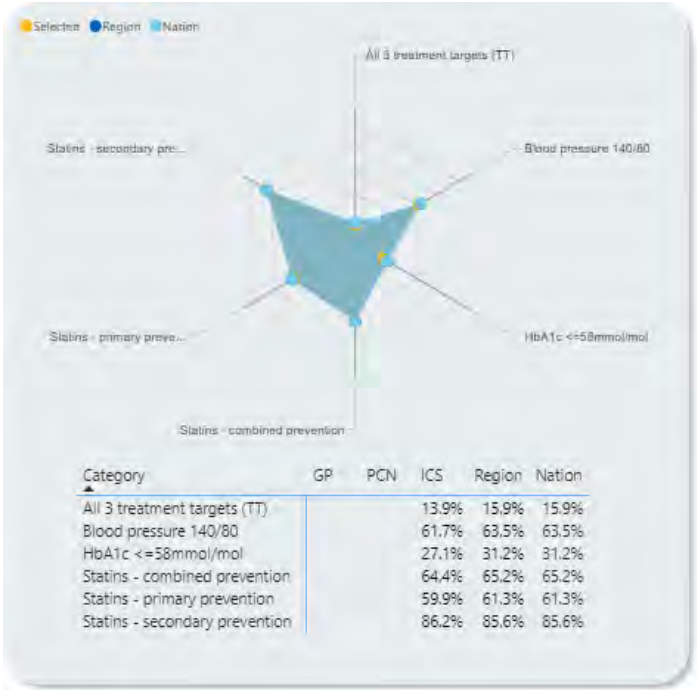
| Sub-ICB/LHB | Breakdown | % |
|---|---|---|
| Aneurin Bevan ULHB | Severely obese | 9.4% |
| Betsi Cadwaladr ULHB | Severely obese | 6.2% |
| Cardiff & Vale ULHB | Severely obese | 6.6% |
| Cwm Taf Morgannwg ULHB | Severely obese | 8.9% |
| Hywel Dda ULHB | Severely obese | 5.4% |
| Powys Teaching LHB | Severely obese | 6.3% |
| Swansea Bay ULHB | Severely obese | 5.3% |

The Health Board's most deprived areas are underperforming compared the least deprived areas for CP's however TT's are more varied across the Neighbourhood Care Networks (NCN's).

| | | |
|---|---|---|
| Aneurin Bevan ULHB | Most deprived | 43.2% |
| Betsi Cadwaladr ULHB | Most deprived | 24.2% |
| Cardiff & Vale ULHB | Most deprived | 32.7% |
| Cwm Taf Morgannwg ULHB | Most deprived | 55.0% |
| Hywel Dda ULHB | Most deprived | 20.7% |
| Powys Teaching LHB | Most deprived | 15.3% |
| Swansea Bay ULHB | Most deprived | 39.8% |




| Category | GP | PCN | ICS | Region | Nation |
|---|---|---|---|---|---|
| All 8 care processes (CP) | | | 19.7% | 15.7% | 15.7% |
| Blood pressure | | | 69.7% | 64.7% | 64.7% |
| BMI | | | 59.7% | 53.5% | 53.5% |
| Cholesterol | | | 60.4% | 54.5% | 54.5% |
| Creatinine | | | 70.2% | 65.6% | 65.6% |
| Foot exam | | | 39.1% | 33.3% | 33.3% |
| HbA1c | | | 68.8% | 64.8% | 64.8% |
| Smoking | | | 68.2% | 68.6% | 68.6% |
| Urine albumin | | | 33.9% | 29.0% | 29.0% |




| Category | GP | PCN | ICS | Region | Nation |
|---|---|---|---|---|---|
| All 3 treatment targets (TT) | | | 13.9% | 15.9% | 15.9% |
| Blood pressure 140/80 | | | 61.7% | 63.5% | 63.5% |
| HbA1c <=58mmol/mol | | | 27.1% | 31.2% | 31.2% |
| Statins - combined prevention | | | 64.4% | 65.2% | 65.2% |
| Statins - primary prevention | | | 59.9% | 61.3% | 61.3% |
| Statins - secondary prevention | | | 86.2% | 85.6% | 85.6% |

Type 1 Diabetes (T1) the Health Board is 3rd in Wales for All 8 Care Processes (CP) being achieved with 19.7% and the least performing Health Board in terms of all 3 Treatment Targets (TT) at 13.9%. In comparison the English average is 35.2% CP and 22.4% for TT. Wales and the Health Board are behind the National average (NA) rates in both areas.

Blood glucose targets have improved since 2019-2020, with the Health Board achieving the highest levels in Wales.

Glucose Monitoring for the Health Board and across Wales is poor compared to the rates in England. Funding has not been granted for technologies needed, numbers are very low across Wales compared to England.

Blood pressure targets had declined and across Wales performance is lower than England, however the Health Board is the best performing in Wales.

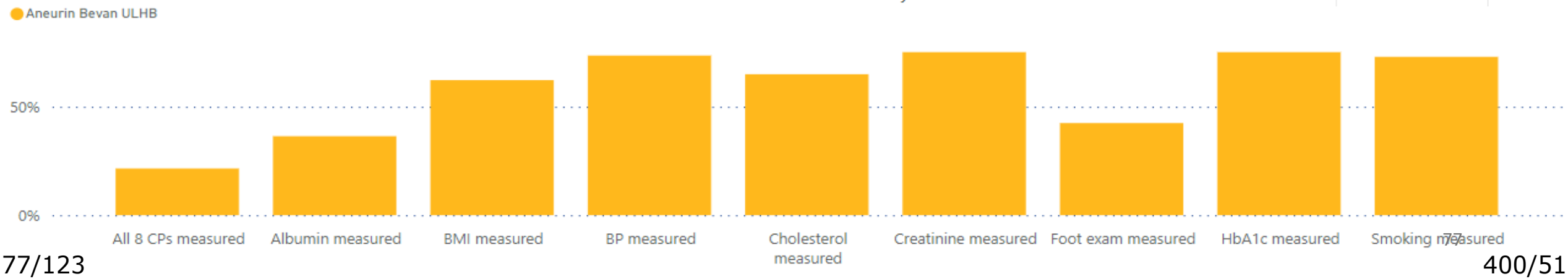
Care Processes and Treatment demonstrate similar patterns across England and Wales and for the Health Board.

Wales | Insulin regimen - Insulin pump

| Sub-ICB/LHB | Breakdown | % |
|---|---|---|
| Cwm Taf Morgannwg ULHB | Insulin pump | 34.1% |
| Hywel Dda ULHB | Insulin pump | 22.2% |
| Swansea Bay ULHB | Insulin pump | 20.6% |
| Cardiff & Vale ULHB | Insulin pump | 17.9% |
| Powys Teaching LHB | Insulin pump | 15.3% |
| Aneurin Bevan ULHB | Insulin pump | 11.2% |
| Betsi Cadwaladr ULHB | Insulin pump | 7.9% |

Wales | HbA1c measured - HbA1c measured

| Sub-ICB/LHB | Breakdown | % |
|---|---|---|
| Powys Teaching LHB | HbA1c measured | 81.1% |
| Aneurin Bevan ULHB | HbA1c measured | 75.1% |
| Cardiff & Vale ULHB | HbA1c measured | 75.0% |
| Betsi Cadwaladr ULHB | HbA1c measured | 72.3% |
| Hywel Dda ULHB | HbA1c measured | 70.7% |
| Cwm Taf Morgannwg ULHB | HbA1c measured | 66.3% |
| Swansea Bay ULHB | HbA1c measured | 57.0% |



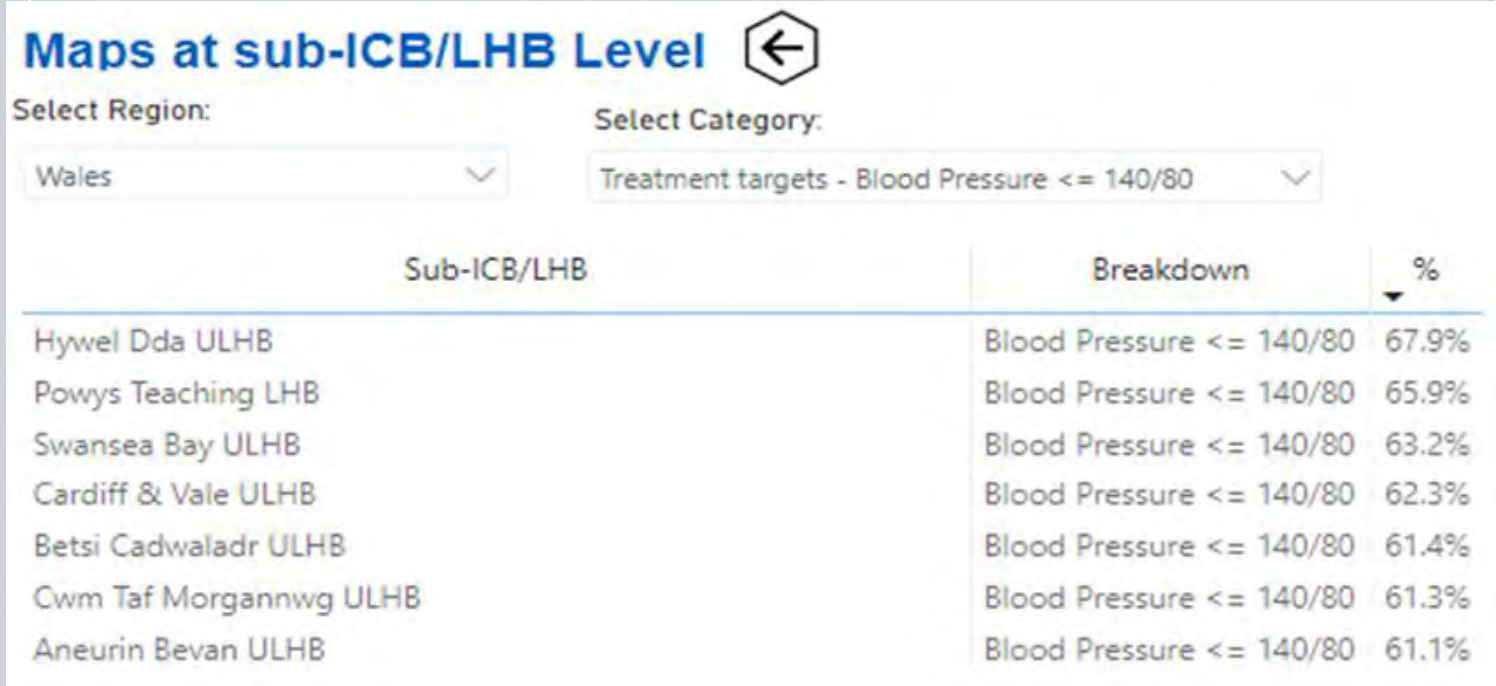
## Assurance and Risk

| Assurance level | Description | Select |
|---|---|---|
| Significant | The project has mostly achieved the standards or criteria being audited against | Yes |
| **Risk level** | **Description** | **Select** |
| None | Standards met and findings demonstrate no risk to patient safety | Yes |
| **Has this audit been placed on a Risk Register (N/A if above risk is None)** | | **NO** |

## Successes and Concerns

| Report Successes: | |
|---|---|
| 1 | Managed to maintain an increasing provision of insulin pump therapy despite not being provided with funding with the business case but this has reached capacity now and is unsustainable. |

| Report Concerns: | |
|---|---|
| 1 | Business case approved and but unfunded in 2022, the new NICE TAG states everyone with type 1 diabetes and with an HbA1c of around 58% despite optimal management should be offered insulin pump therapy. Extrapolating from this audit that equates to around 2200 of the Health Board 2470 type 1, accepting pumps not suitable for all. An estimation of need is between 1200-1500 eligible with our original business case targeted at 600 over 5 years. |

| Reported Recommendations: | | Health Board Performance |
|---|---|---|
| 1 | Commissioners of care should ensure that type 1 diabetes services have the capacity and capability to support all those who can benefit from appropriate glucose technologies and return blood pressure management to pre-pandemic levels. |  |
| 2 | In Wales, local health boards should support their providers of type 1 diabetes care to reduce apparent inequalities in use of insulin pumps. | Closed Loop System (CLS) & continuous glucose monitor (CGM) levels poor across Wales and the Health Board – not data<br><br>Action: to secure funding detailed in the approved business case |
| 3 | Commissioners of care should ensure that everyone with type 1 diabetes has access to a specialist service. | |



| Sub-ICB/LHB | Breakdown | % |
|---|---|---|
| Hywel Dda ULHB | Blood Pressure <= 140/80 | 67.9% |
| Powys Teaching LHB | Blood Pressure <= 140/80 | 65.9% |
| Swansea Bay ULHB | Blood Pressure <= 140/80 | 63.2% |
| Cardiff & Vale ULHB | Blood Pressure <= 140/80 | 62.3% |
| Betsi Cadwaladr ULHB | Blood Pressure <= 140/80 | 61.4% |
| Cwm Taf Morgannwg ULHB | Blood Pressure <= 140/80 | 61.3% |
| Aneurin Bevan ULHB | Blood Pressure <= 140/80 | 61.1% |

## Appendix 9

| Audit Title: | National Diabetes Audit:<br>Care Processes and Treatment Targets 2021-22<br>(Primary Care)<br>Published 12th October 2023 with update 14th December 2023 | Clinical Lead: | Dr Clifford Jones & Dr Heather Griffiths |
|---|---|---|---|

**Rationale:**

This NDA report focuses on NICE guidelines and Quality Standards for the routine care of people with type 1 and type 2 diabetes . Everyone with diabetes should be reviewed at least once a year. The review should include the following 8 care processes:

> blood tests for HbA1c (glucose control)
> cholesterol (heart risk)
> blood pressure measurement
> examination of the feet (foot ulcer risk)
> creatinine (kidney function)
> urine test for albumin (kidney risk)
> weight measurement (body mass index; BMI)
> review of smoking habit

The ninth care process is retinal screening, which is run by dedicated screening programmes .
At review, treatment should be adjusted where necessary to achieve the 3 NICE recommended treatment targets:

> HbA1c level ≤ 58 mmol/mol
> blood pressure level ≤ 140/80
> those with high heart risk should be prescribed a statin

**Objectives:**

The NDA supports delivery of high-quality diabetes care by enabling NHS services and organisations to:

> assess local practice against NICE guidelines
> compare their care processes, and care outcomes, with similar services and organisations
> identify gaps or shortfalls that are priorities for improvement
> track responses to change programmes
> identify and share best practice
> provide a comprehensive national picture of diabetes care and outcomes in England and in Wales

Presented to Clinical Standards and Effectiveness Group – 30th November 2023 – Update given 21st March 2024

# National Diabetes Audit Core Report 1: Care Processes and Treatment Targets 2021-22,

This data release includes the care process and treatment target measurements for the full 2021-22 audit period (1 January 2021 – 31 March 2022); presented for Wales and Aneurin Bevan University Health Board Primary Care Providers

NATIONAL DIABETES AUDIT

In Wales **16,090** adults had type 1 diabetes and **191,205** had type 2 and other diabetes in 2021-22. The number of people with type 1 and type 2 diabetes have increased since 2017-18.

Diabetes is a serious condition. When you've got type 1 diabetes, you can't make insulin. If you've got type 2 diabetes you have some insulin but either you can't produce enough or it doesn't work effectively.

Diabetes can lead to health complications such as blindness, kidney failure and heart disease. But these complications can be prevented.

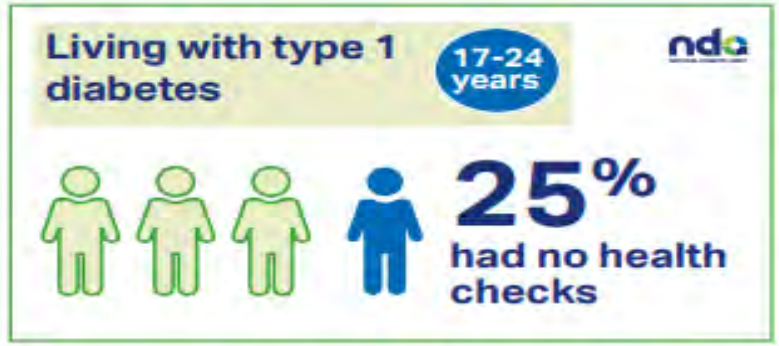
Everyone with diabetes should have healthcare checks at least once a year. Treatments may be adjusted to achieve recommended targets for HbA1c and blood pressure. Those with high heart risk should be prescribed a statin.

Completing all health checks and achieving the three treatment targets are the key to preventing complications.

DIABETES UK KNOW DIABETES. FIGHT DIABETES. HQIP NHS England

## Findings







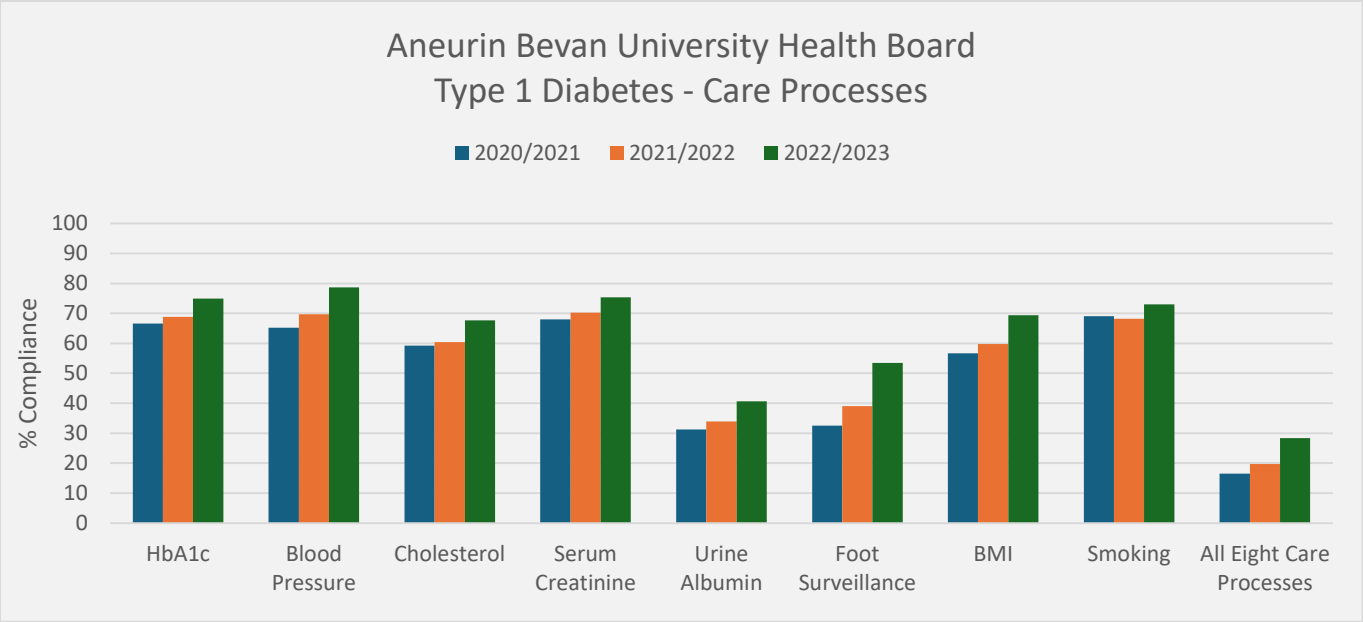
* For this report type 2 diabetes refers to those with a diagnosis of type 2 diabetes and other rarer forms of diabetes such as MODY (Maturity Onset Diabetes of the Young) and LADA (Latent Autoimmune Diabetes in Adults) or unspecified diabetes

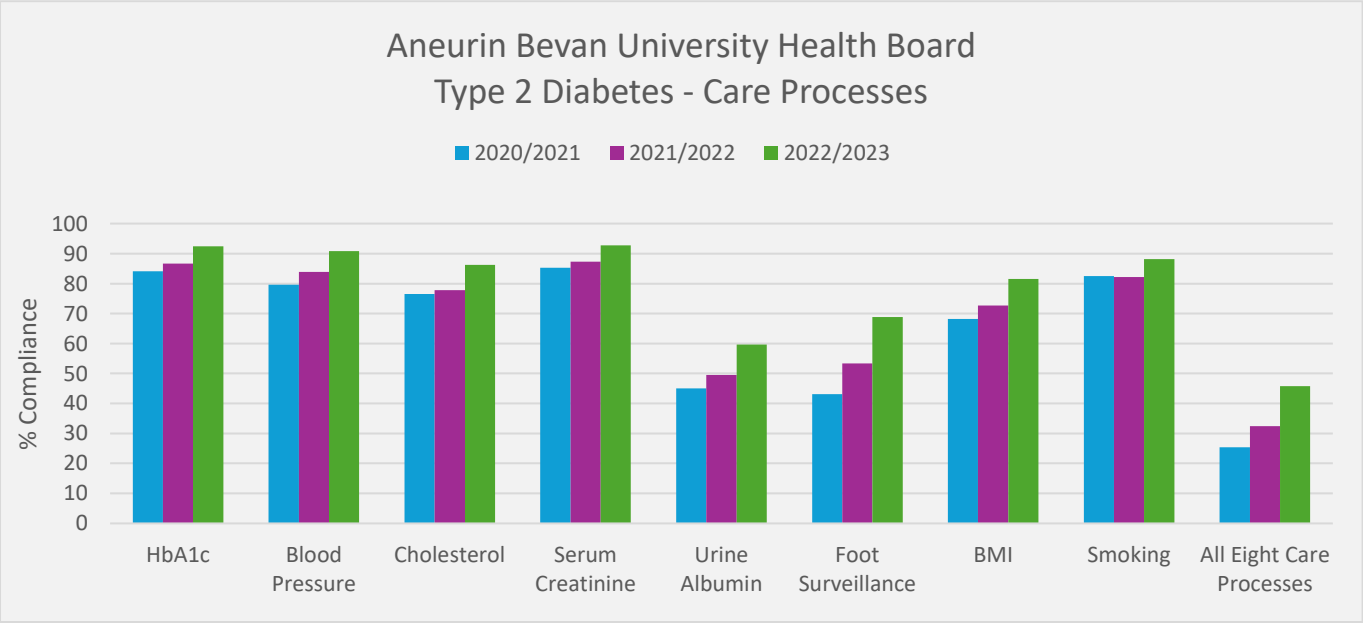
**Find out more**

1. National Diabetes Audit

SCAN ME

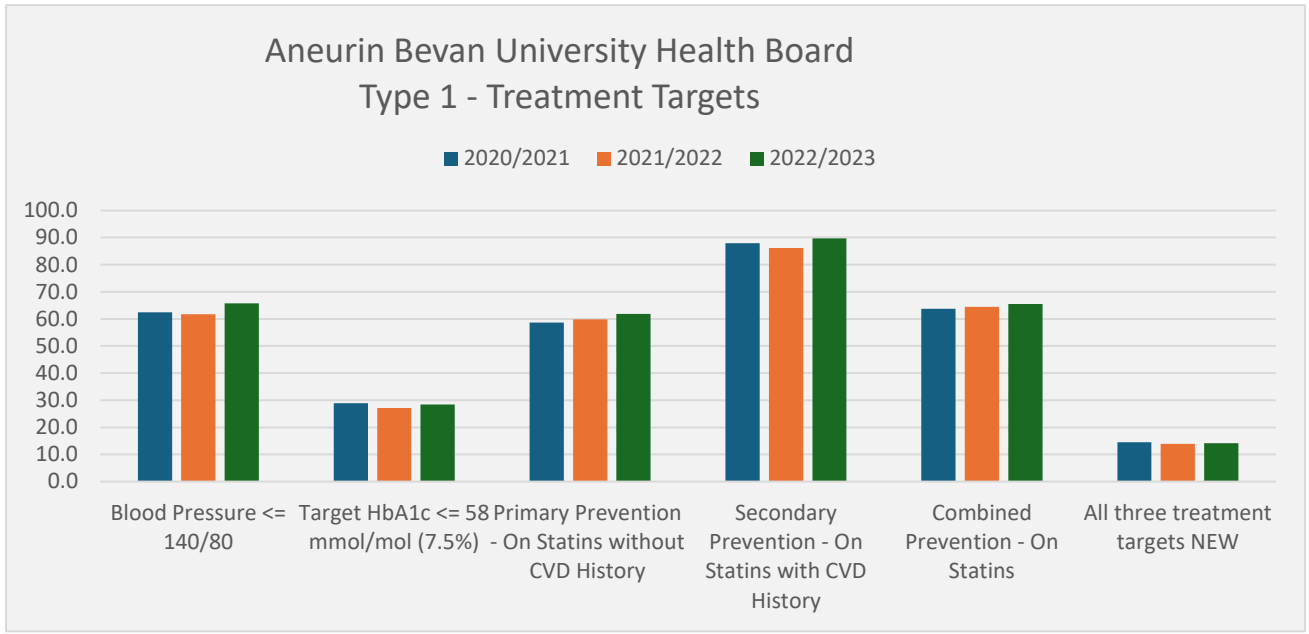
2. Audit results for your local services
National Diabetes Audit dashboards

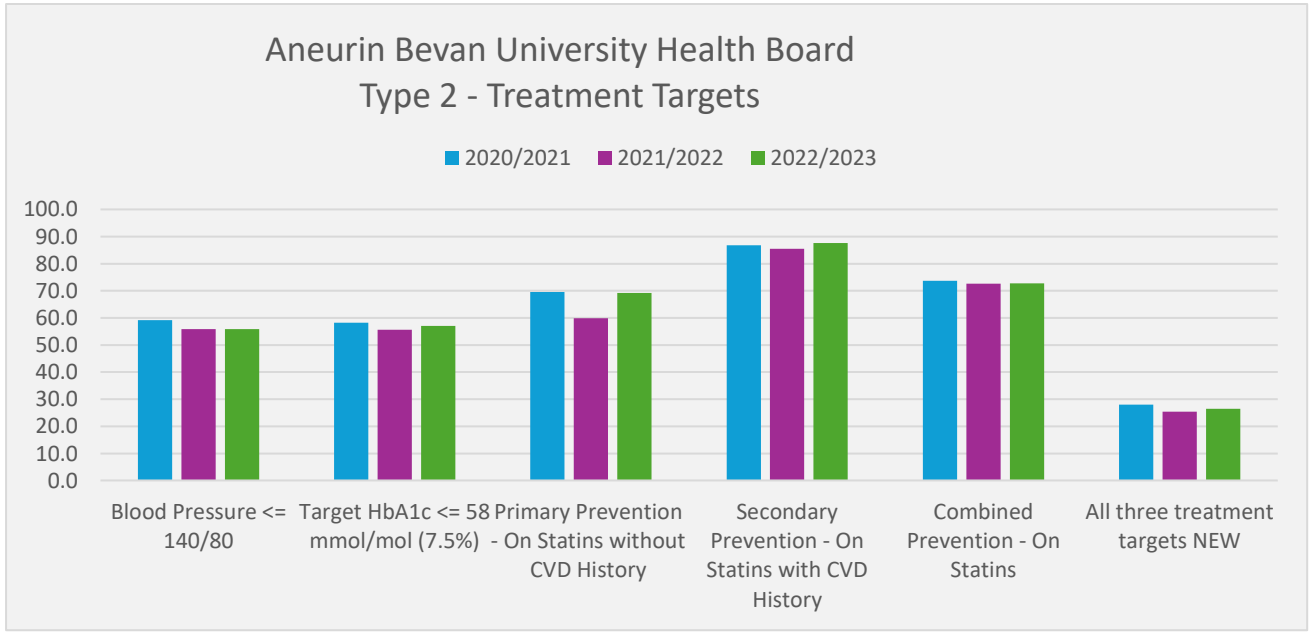



## Care Processes

The recommendations required services across the UK to work to return to pre-pandemic levels of care. The Health Boards Care Processes for all eight measures shows an improvement each of the 3 years, and for all eight combined, for both Type 1 and Type 2 Diabetes.



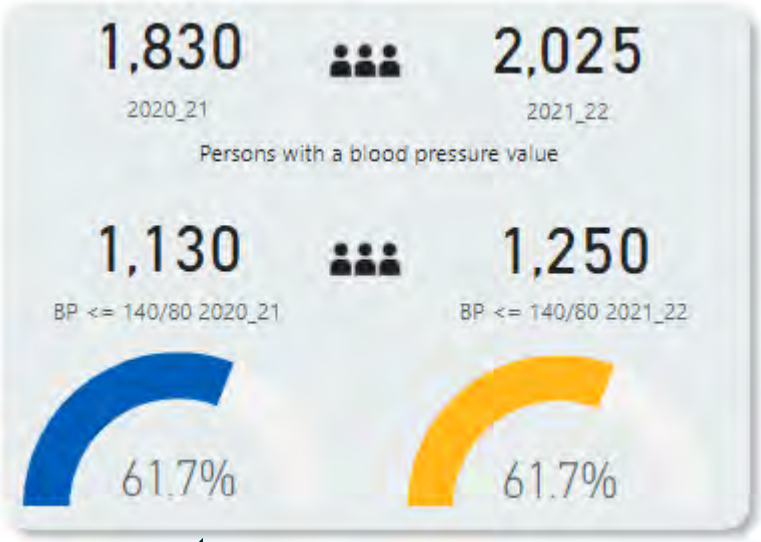




## Treatment Targets

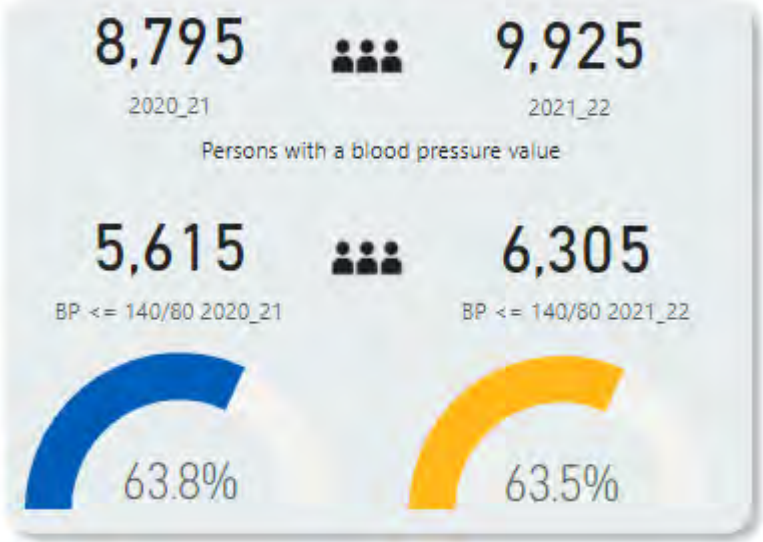
For patient with Type diabetes receiving the relevant treatment targets, there was a slight dip in performance during 2021/2022 compared to 2020/2021, however there was an improvement in all other than the HbA1c measure which remained almost level to the 2020/2021 measure.

For patients with Type 2 diabetes, all measures reduced from 2020/2021 to 2021/2022, and only Secondary Prevention on statins increased from 2020/2021. All other measures performance was lesser each year.

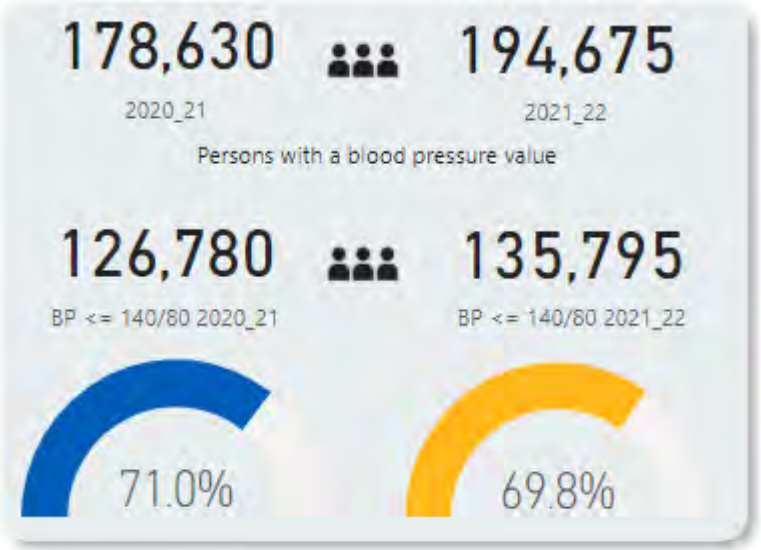
ABUHB




Wales




England




**Meeting all 3 treatment targets** – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

| | 2020_21 | 2021_22 |
|---|---|---|
| All 3 Treatment Target achieved | 14.3% | 13.9% |
| Statins Combined | 65.3% | 64.4% |
| Blood pressure <= 140/80 | 61.7% | 61.7% |
| HbA1c <58mmol/mol | 28.7% | 27.1% |

**Meeting all 3 treatment targets** – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

| | 2020_21 | 2021_22 |
|---|---|---|
| All 3 Treatment Target achieved | 15.5% | 15.9% |
| Statins Combined | 65.0% | 65.2% |
| Blood pressure <= 140/80 | 63.8% | 63.5% |
| HbA1c <58mmol/mol | 29.4% | 31.2% |

**Meeting all 3 treatment targets** – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

| | 2020_21 | 2021_22 |
|---|---|---|
| All 3 Treatment Target achieved | 21.5% | 22.4% |
| Statins Combined | 69.5% | 71.2% |
| Blood pressure <= 140/80 | 71.0% | 69.8% |
| HbA1c <58mmol/mol | 34.8% | 36.3% |

**Treatment Targets across Wales and England have improved slightly from 2020/2021 to 2021/2022, however the Health Board is performing lower than the rest of the UK and has slightly declined in the latter year.**

## Key finding 1: Impact of pandemic

In Wales with the incidence (1) of type 1 diabetes rising year-on-year from 170 in 2018-19 to 245 in 2021-22.

There has been improvement in the completion of all 8 key care processes (2) in 2021-22 across all diabetes type following the reduction seen between 2019-20 and 2020-21 (the first pandemic year). However, in both people with type 1 diabetes and people with type 2 and other diabetes, care process completion remains below pre-pandemic levels. For example: people with type 1 diabetes in Wales, HbA1c care process completion rates were 71.4% in 2019-20, 61.3% in 2020-21 and 64.8% in 2021-22

- The care processes with the greatest drop from 2019-20 to 2020-21 in people with type 1 and type 2 and other diabetes in Wales were blood pressure, BMI and foot risk surveillance

- For all people across almost all the 5 years, urine albumin/creatinine ratio (3) was the lowest performer. In 2021-22 in Wales, 29.0% of people with type 1 diabetes received this care process and 47.8% of those with type 2 and other diabetes

## Key finding 2: Inequalities in routine diabetes care delivery

Among people with type 1 diabetes and type 2 diabetes, people living in the most deprived quintile were the least likely to receive all 8 key care processes when compared to those living in less deprived areas in 2021-22.

- Younger people with type 1 diabetes and type 2 diabetes were the least likely to receive all 8 key care processes when compared to their older counterparts.

In Wales, 3.6% of people with type 1 diabetes aged 70-79 received no care processes, whereas the percentage was greater in those aged 17-24 at 25.4%. For people with type 2 and other diabetes, 3.5% of those aged 70-79 and 14.5% of those aged 17-24 received no care processes.

## Key finding 3: Treatment target achievement trends

For all people with diabetes, percentages of those with blood pressure ≤ 140/80 showed no change from 2017-18 to 2019-20 but this reduced sharply during 2019-20 (the year of the pandemic) and failed to recover in 2021-22:

- For people in Wales with type 1 diabetes the percentage fell from 71.6% in 2017-18 to 63.5% in 2021-22 (see figure 9) and in people with type 2 and other diabetes the percentage fell from 68.4% in 2017-18 to 59.6% in 2021-22

There were no appreciable changes over 5 years in achievement of the statin prescription treatment target:

- In Wales, rates for people with type 1 diabetes were 67.3% in 2017-18 and 65.2% in 2021-22 (see figure 9), while the corresponding figures for people with type 2 and other diabetes the rates were 73.5% and 71.7%

## Assurance and Risk

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

| Risk level | Description | Select |
|---|---|---|
| None | Standards met and findings demonstrate no risk to patient safety | Yes |

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

## Successes and Concerns

| Report Successes: | |
|---|---|
| 1 | There has been an increase in the completion rate of all 8 care processes in 2021-22 compared to the preceding two years |

| Report Concerns: | |
|---|---|
| 1 | Completion of the 8 care processes needs to increase further and surpass pre pandemic levels and the impact of deprivation and widening age inequality needs to improve |

| Reported Recommendations: | | Health Board Performance |
|---|---|---|
| 1 | Commissioners of care should continue to work with providers in restoring and then further improving pre-pandemic care process completion levels. | GP/primary care to continue to build on and improve the completion rate of all 8 care processes |
| 2 | Commissioners of care should work with providers to focus particularly on improving care process completion in young people and those living in the most deprived communities. The target should be levels already attained in people older than 70 years and in people living in the least disadvantaged areas. | GP/primary care needs to work with the All-Wales diabetes prevention programme to reduce the progression of prediabetes to diabetes where available – bring undertaken by GP practices based in defined NCN areas of Caerphilly and Blaenau Gwent. |
| 3 | Commissioners of care should work with providers of diabetes care to sustain progress in type 1 glucose control and restore pre-pandemic glucose control in people who have type 2 and other diabetes; and to first restore and then surpass pre-pandemic levels of blood pressure treatment target attainment in all people with diabetes. | All GP practices within ABUHB to fulfil the data collection on Unhealthy behaviours to help identify patients with obesity and so at increased risk of diabetes.<br><br>GP practices to help support social prescribing to help reduce obesity via engagement with link works/community connectors etc. |

**Appendix 10**

| Audit Title: | National Neonatal Audit Programme (NNAP) Summary report on 2022 data | Clinical Lead: | Dr Sunil Reddy |
|---|---|---|---|
| Rationale: | Established in 2006, the National Neonatal Audit Programme (NNAP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and delivered by the Royal College of Paediatrics and Child Health (RCPCH).<br><br>It assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes. | | |
| Objectives: | The audit reports key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels, and other important care processes. | | |
| Presented at Clinical Standards and Effectiveness Group – 30th November 2023 | | | |

The Grange University Hospital takes part in the National Neonatal Audit Programme (NNAP) which reports on aspects of care given to babies on neonatal units. This poster shows how selected 2022 results* for this hospital compare with overall (England, Scotland and Wales) performance.

## How our unit did across selected NNAP measures:

| Wales 2022 | ABUHB 2021 | | ABUHB 2021 | Wales 2022 |
|---|---|---|---|---|
| 51.7% | 95% | **Antenatal steroids**<br>Overall, **52%** of mothers of babies born at less than 34 weeks were given a full course of antenatal steroids in the week before delivery. | 81.1% | 85.3% |
| 62.0% | 30.2% | **Deferred cord clamping**<br>Overall, **60.4%** of babies born at less than 34 weeks had their cord clamped at or after one minute. | 80.0% | 82.2% |
| 97.2% | 95.1% | **Parental consultation within 24 hours of admission**<br>Overall, **95.9%** of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission. | 96.1% | No data |





**Antenatal magnesium sulphate**
Overall, **85.6%** of mothers of babies born at less than 30 weeks were given antenatal magnesium sulphate.





**Temperature on admission**
Overall, **76.3%** of babies born at less than 32 weeks were admitted within the recommended range of 36.5°C-37.5°C.





**Parent inclusion on consultant ward rounds**
Overall, **47.2%** of baby care days had a consultant-led ward round with at least one parent included.

The reduction in the Health Board performance for this measure is due to the change in criteria to a full course of antenatal steroids.

The reduction in this measure is due to data entry and work is ongoing with the nursing team to ensure data is accurately recorded.

**The Health Board is performing better than the National Average in 5 of 6 measures, with Antenatal Steroids less than the National and Welsh average**

The Grange University Hospital takes part in the National Neonatal Audit Programme (NNAP) which reports on aspects of care given to babies on neonatal units. This poster shows how selected 2022 results* for this hospital compare with overall (England, Scotland and Wales) performance.

**The Health Board is performing better than the National Average in 3 of 6 measures, and in the four with Welsh data the Health Board is lower than in 4 measures**

| Wales 2022 | ABUHB 2021 | | ABUHB 2021 | Wales 2022 |
|---|---|---|---|---|
| 85.37% | 59.7% | **Neonatal nurse staffing**<br>Overall, **71.1%** of nursing shifts were staffed according to recommended levels.<br>Unit rate 74.1%, Overall Rate: 71.1% | 34.9% | No data |
| | | **Bronchopulmonary dysplasia (BPD)**<br>Overall, **39.7%** of babies born at less than 32 weeks† developed BPD or died.<br>†discharged January 2020 to December 2022.<br>Unit rate 40.6%, Overall Rate: 39.7% | | |
| No data | 70.3% | **Breastmilk feeding in the first two days**<br>Overall, **49%** of babies born at less than 34 weeks received their mother's milk in the first 2 days of life.<br>Unit rate 65%, Overall Rate: 49% | Not a measure | 77.0% |
| | | **Breastmilk feeding at 14 days**<br>Overall, **79%** of babies born at less than 34 weeks received their mother's milk at 14 days of life.<br>Unit rate 76.9%, Overall Rate: 79% | | |
| 57.5% | 51.9% | **Breastmilk feeding at discharge**<br>Overall, **62.9%** of babies born at less than 34 weeks received their mother's milk at discharge home.<br>Unit rate 55.7%, Overall Rate: 62.9% | 89.2% | 58.2% |
| | | **Screening for retinopathy of prematurity (ROP)**<br>Overall, **69%** of eligible babies were screened on time for ROP.<br>Unit rate 44.6%, Overall Rate: 69% | | |

**ROP impacted by change to guidelines, early D/C, repatriation, DNA to clinic – Working closely with Ophthalmology team.**

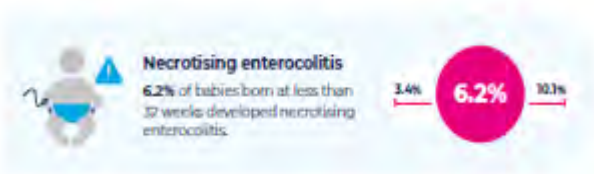
# Outcomes of Neonatal Care as define in the report for 2022: *(other than BD, all measures lower than the National Average is a good result)*

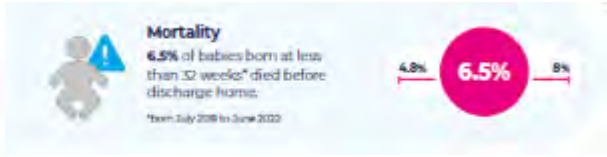
| | NEC | No NEC |
|---|---|---|
| GUH | 2.7% | 97.3% |
| Wales | 3.5% | 96.5% |
| National | 6.2% | 93.8% |

**No local data relating to mortality in Wales**

**Grange University Hospital 3.9%**

**Grange University Hospital 40.6%**



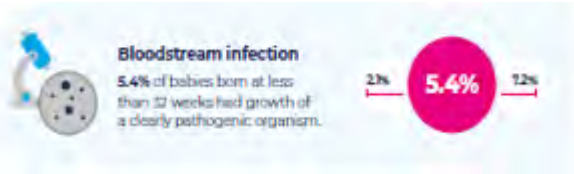





**Table 16**: Intraventricular haemorrhage (IVH) grades 3 or 4 or death, The Grange University Hospital

| | | Validated | Number Of Eligible Babies | Babies With Outcome | IVH34 | IVH34 or Death (% of eligible babies) | Missing (%) |
|---|---|---|---|---|---|---|---|
| Place of Birth | The Grange University Hospital (NICU) | ✔ | 71 | 70 | 5 (7.1%) | 7 (10%) | 1 (1.4%) |
| Unit level for comparison | NICU | ✖ | 4 178 | 3 824 | 286 (593%) | 593 (15.5%) | 354 (8.5%) |
| Network | Wales | | 282 | 274 | 20 (7.3%) | 32 (11.7%) | 8 (2.8%) |
| National rate | All participating units | | 7 181 | 6 182 | 464 (7.5%) | 906 (14.7%) | 999 (13.9%) |

**Table 17**: Cystic periventricular leukomalacia (cPVL) or death, The Grange University Hospital

| | | Validated | Number Of Eligible Babies | Babies With Outcome | cPVL | cPVL or Death (% of eligible babies) | Missing (%) |
|---|---|---|---|---|---|---|---|
| Place of Birth | The Grange University Hospital (NICU) | ✔ | 71 | 69 | 1 (1.4%) | 5 (7.2%) | 2 (2.8%) |
| Unit level for comparison | NICU | ✖ | 4 178 | 3 705 | 83 (2.2%) | 415 (11.2%) | 473 (11.3%) |
| Network | Wales | | 282 | 268 | 5 (1.9%) | 22 (8.2%) | 14 (5%) |
| National rate | All participating units | | 7 181 | 5 949 | 152 (2.6%) | 598 (10.1%) | 1 232 (17.2%) |

## Assurance Level and Risk Level

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

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

| **Has this audit been placed on a Risk Register (N/A if risk is 'None')** | No |
|---|---|

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | Deferred Cord Clamping was 30.2% for the Health Board in 2021 and increased to 61.3% in 2022 |
| 2 | Parental Consultation within 24hours of admissions, was 95.1% and has increased to 97.2%. |
| 3 | Antenatal Magnesium Sulphate was given to 81.1% of mothers in 2021 and this has risen to 88.6% in 2022. |
| 4 | Temperature on Admission has increased form 80.0% in 2021 to 82.8% in 2022. |
| 5 | Neonatal Nurse Staffing was 59.7% in 2021 and has increased to 74.1% in 2022. |
| 6 | In the 2022 report, 76.9% were recorded as receiving mother milk in the first 2 days of life, however the 2021 report stated that this target was within 14 days (not 2) and was 70.3% - with a reduction in the days, the Health Board has increased performance. |
| 7 | Bronchopulmonary Dysplasia (BPD) for the Health Board was 34.9% in 2021 and increase slightly to 40.6% however the national rate in 39.7%. |
| 8 | Breast Milk at Discharge for 2021 was 51.9% and has increased to 55.7% in 2022 - nationally this is 62.9% |

| Report Concerns: | |
|---|---|
| 1 | Parent Inclusion on Consultant Ward rounds was doing well in 2021 at 96.1% however this has reduced to 53.8% in 2022. This is mainly due to data entry issue and as a group we working on nursing education to correctly enter data - combination of many issues : screening window, early D/C, ophthalmology managed, baby moved outside of unit. Trying to mitigate this and improve screening with ophthalmology team. |
| 2 | It was previously report within the Health Board that the Retinopathy of Prematurity was an excellent service within the Health Board, at 89.2% however for 2022 this rate has reduced to 44.6% |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Neonatal networks should review their rates of adverse outcomes (mortality, BPD, NEC, bloodstream infection and preterm brain injury), and develop locally prioritised action plans to respond to these results with their constituent neonatal units, and:<br>• share these with Neonatal Network Boards, Local Maternity and Neonatal System (LMNS) Boards (and devolved nation equivalents), and with Trust/Health Board Governance Boards via ward-to-board Maternity or Neonatal Safety Champions.<br>• work with their constituent neonatal units to ensure that all services have a plan in place to validate their data entry for outcomes such as necrotising enterocolitis, bloodstream infection, and preterm brain injury. | Ongoing work with nursing team to ensure all accurate and appropriate data is entered onto BadgerNet, including parental presence on ward rounds | Dr Reddy | 31/03/2024 | Ongoing |
| 2 | NHS England, Scottish and Welsh Governments should ensure that maternity data flows describe the administration of antenatal steroids, and other perinatal optimisation interventions, and that maternity and perinatal data are linked nationally in order to:<br>• understand rates of timely exposure of preterm infants to perinatal optimisation interventions in the context of the number of women treated with steroids, magnesium sulphate and who require antenatal transfer, regardless of whether they go on to deliver significantly preterm,<br>• improve reporting of neonatal outcomes of maternity care, in line with the recommendation made in 'Reading the signals' and to support national improvement initiatives. | Ongoing work with Ophthalmology to improve the ROP rates | Dr Reddy | 31/03/2024 | Ongoing |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 3 | NHS England, Scottish and Welsh Governments should ensure that pre-term birth is optimally managed by a multidisciplinary team by:<br>• ensuring that preterm birth lead teams (including an obstetrician, neonatologist, neonatal nurse and midwife) are commissioned at all neonatal services,<br>• requiring that Integrated Care Systems (ICS), Health Boards in Scotland and Local Health Boards in Wales ensure that all neonatal services take a perinatal team approach to design and delivery of care that includes parents with diverse backgrounds and diverse experiences of neonatal care,<br>• ensuring that perinatal teams conduct reviews of preterm birth cases to identify opportunities for improvement to maximise quality of care, and the delivery of the interventions identified by national improvement initiatives | | | | |
| 4 | All Royal Colleges associated with preterm perinatal care (the Royal College of Paediatrics and Child Health, the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing and the Royal College of Midwives) should include a focus on the importance of early breastmilk feeding, and guidance on how to support parents to establish and sustain breastmilk feeding, in training relating to intrapartum care, fetal medicine care and perinatal care | | | | |
| 5 | The UK Government, Welsh Government and Scottish Government should consider ways to ensure that the implementation of medium-to-long term NHS-wide workforce plans (such as the NHS Long Term Workforce Plan in England9) deliver the recruitment, training, development and retention of neonatal nurses to improve the proportion of shifts with sufficient staffing and therefore improve survival rates and the quality of care in neonatal units | | | | |

## Appendix 11

| | | | |
|---|---|---|---|
| Audit Title: | National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report 2023<br>Data collection period: 1 April 2022 – 31 March 2023<br>Published October 2023 | Clinical Lead: | Dr Non Pugh, Consultant Rheumatologist |
| Rationale: | The National Early Inflammatory Arthritis Audit (NEIAA) Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis and is measured against NICE quality standards 33. It also assesses how inflammatory arthritis affects people's day-to-day function, mobility, sleep, wellbeing and ability to work | | |
| Objectives: | The aim of the audit is to improve the care of patients with rheumatological immune mediated inflammatory disease and reduce current variation in care provision and outcome. By collecting this data, the audit aims to recommend standardised, effective, and patient-centred care pathways.<br>Year 5 and first State of the Nation report presented data on five key metrics of care:<br>time to referral<br>time to assessment<br>time to treatment<br>response to treatment<br>patient-reported outcome measures | | |
| Presented at Clinical Standards and Effectiveness Group 25th January 2024 | | | |

QS1 - People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, are referred to a rheumatology service within three working days of presentation.

QS 2 - People with suspected persistent synovitis are assessed in a rheumatology service within three weeks of referral.

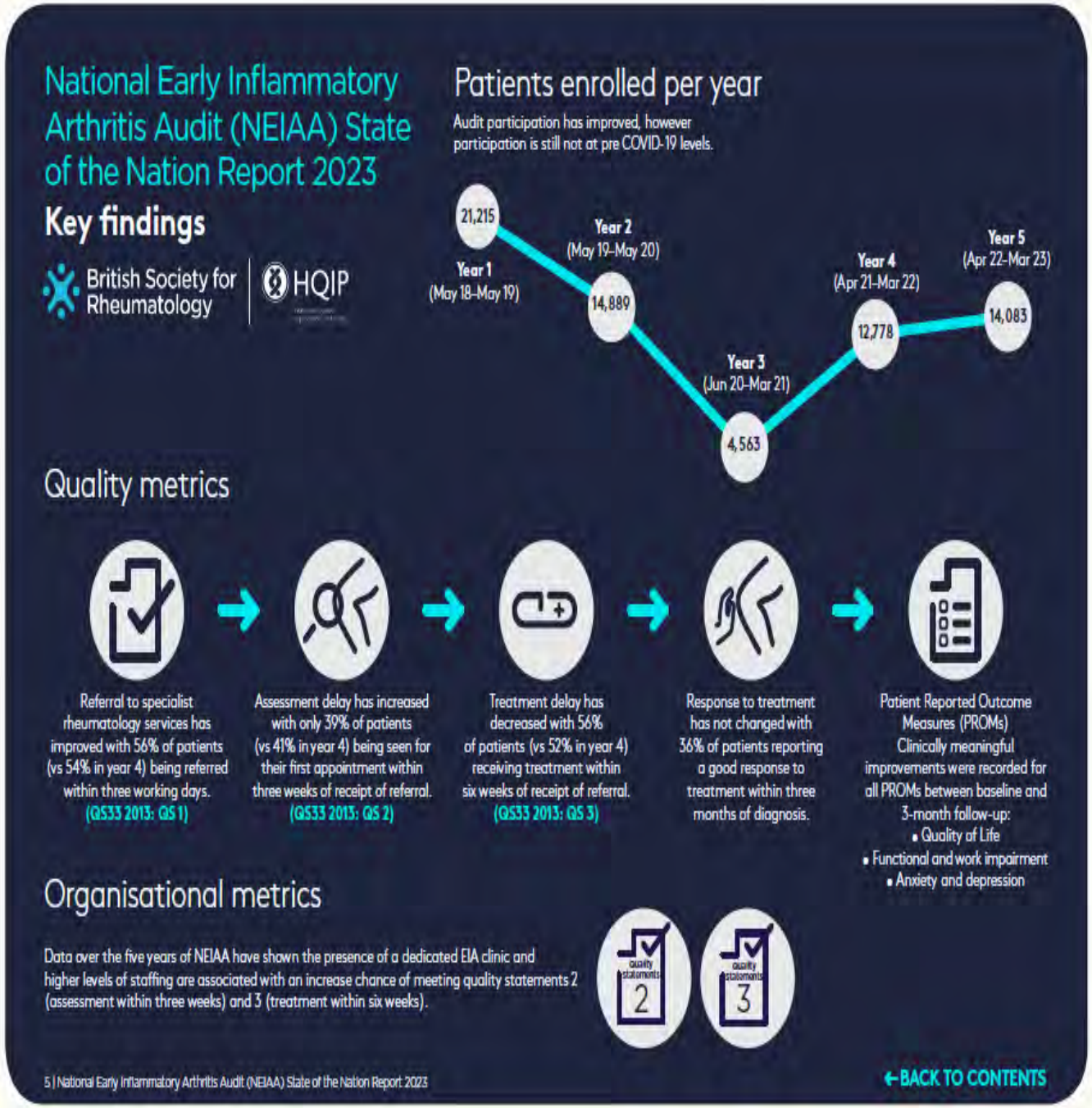
QS 3 - People with newly diagnosed RA are offered conventional disease-modifying anti-rheumatic drug monotherapy within three months of onset of persistent symptoms.

QS 4 - People with RA are offered educational and self-management activities within 1 month of diagnosis.

QS 5 - People who have active RA have their C-reactive protein (CRP) and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

QS 6 - People with RA and disease flares or possible drug-related side effects receive advice within one working day of contacting the rheumatology service.

QS 7 - People with RA have a comprehensive annual review that is coordinated by the rheumatology service.




| | |
|---|---|
| 1 | Ensure that public awareness is raised to encourage early presentation in primary care of people with suspected EIA and early referral into specialised rheumatology services. (QS33 2013: QS 1)<br><br>Action by: National Patient Charities |
| 2 | EIA pathways should be mandated in secondary care to provide timely assessment, diagnosis and access to treatment for patients with EIA.(QS33 2013: QS 2 & 3)<br><br>Action by: Integrated Care Boards (ICBs, England) and NHS Health Boards (Wales |
| 3 | NEIAA data alongside the strategies described in the elective recovery programme, GIRFT and the outpatient recovery and transformation programme must be used to inform and expediate post COVID-19 pandemic recovery strategies for secondary care rheumatology services.<br><br>Action by: Care Quality Commission (CQC, England) and Healthcare Inspectorate Wales (HIW) |
| 4 | Collection of outpatient secondary care diagnostic information should be mandated as a priority to inform service design and delivery. (GIRFT recommendations 7 and 8)<br><br>Action by: NHS England and NHS Wales |
| 5 | The rheumatology Multi-Disciplinary Team (MDT) provision should be expanded to meet the rising demand and expectations in line with recommendations in the BSR rheumatology workforce report.(QS33 2013: QS 2 and 3)<br><br>Action by: Secretary of State for Health and Social Care |

## ABUHB Data April 2022 – March 2023

Number of patients : 513- highest no. in Wales and 2nd nationally

### QS1 Referral to specialist rheumatology service within three working days.

ABUHB 83.20% (69% year 4)

National 56% (54% year 4)
All Wales 60%

### QS2 Patients being seen for their first appointment within three weeks of receipt of referral.

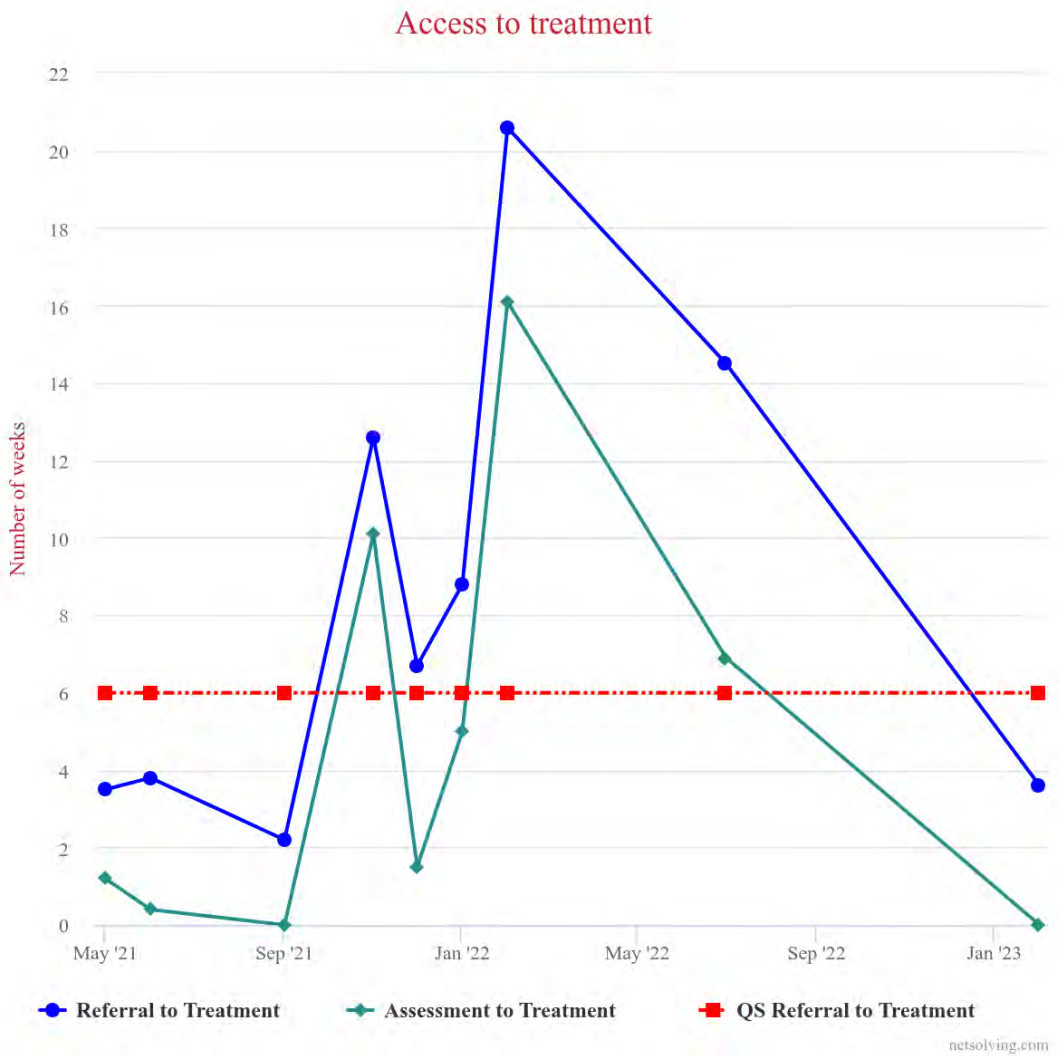
ABUHB 14 % (22% year 4)- defined as OUTLIER alarm status – **Outlier threshold for ABUHB: 34%**

National 39% (41 % year 4)
All Wales 25 %

### QS3 Patients receiving treatment within six weeks of receipt of referral.

ABUHB 19% (83% year 4)

National 56% of patients (52% year 4)
All Wales 46 %



## ABUHB Data April 2022 – March 2023

**QS4. patients with confirmed EIA offered access to education and information on self-management**

ABUHB 97 % (87)

**QS5- patients with confirmed EIA had treatment target set and agreed.**

ABUHB 97 % (77)

**QS6- patients provided with access to rheumatology specialist advice (e.g., a telephone advice line).**

ABUHB 100 % (94)

| Quality standard | ABUHB 2020 | ABUHB 2021 | ABUHB 2022 | ABUHB 2023 | National 2023 | Wales 2022 |
|---|---|---|---|---|---|---|
| QS1 % | 72 | 72 | 69 | 83 | 56 | 60 |
| QS2 % | 29 | 74 | 22 | 14 | 39 | 25 |
| QS3 % | 73 | 91 | 83 | 19 | 56 | 46 |
| QS4 % | 92 | 92 | 87 | 97 | 56 | 95 |
| QS5 % | 75 | 75 | 77 | 97 | 90 | 88 |
| QS6 % | 92 | 92 | 94 | 100 | 95 | 96 |

## NEIAA results - from April 2023

Improvements in QS2 and QS3 but audit criteria has changed as only patients with definite EIA are now included

**Aneurin Bevan UHB Rheumatology Service [from: 01/04/2023 - to: 31/12/2023]**

| Quality Statement 1 | |
|---|---|
| Total number of patients recruited | 408 |
| Number of patients referred via EIA pathway | 404 |
| Number of patients referred within 3 working days | 382 |
| % patients referred within 3 working days | 93.6% |

| Quality Statement 2 | |
|---|---|
| Total number of patients recruited | 408 |
| Number of patients referred via EIA pathway | 404 |
| Number of patients seen within three weeks | 130 |
| % patients seen within three weeks | 31.9% |

| Quality Statement 3 | |
|---|---|
| Total number of patients commencing EIA follow up | 27 |
| Number of patients started DMARD within 6 weeks | 21 |
| % DMARD started within 6 weeks of referral | 77.8% |

**Aneurin Bevan UHB Rheumatology Service [from: 31/10/2023 - to: 31/12/2023]**

| Quality Statement 1 | |
|---|---|
| Total number of patients recruited | 3 |
| Number of patients referred via EIA pathway | 3 |
| Number of patients referred within 3 working days | 1 |
| % patients referred within 3 working days | 33.3% |

| Quality Statement 2 | |
|---|---|
| Total number of patients recruited | 3 |
| Number of patients referred via EIA pathway | 3 |
| Number of patients seen within three weeks | 2 |
| % patients seen within three weeks | 66.7% |

| Quality Statement 3 | |
|---|---|
| Total number of patients commencing EIA follow up | 3 |
| Number of patients started DMARD within 6 weeks | 0 |
| % DMARD started within 6 weeks of referral | 0.0% |

## Reasons for outlier status for QS2

Outlier status was expected from regular review of the audit dashboard/reports and regular discussion at directorate and DPSQ meetings

Similar issues with clinic booking as 2021-22 as no improvements and main reason for being an outlier

Urgent clinic appointments available but ? EIA patients not booked into *urgent next available clinic* and booked same time or later than *urgent* patients

Routine waiting list reduced as new consultant initially only seeing new patients and some routine patients booked within 8 weeks but ? EIA patients booked after 4 weeks

Also booking staff shortages and new staff

Clinics at multiple sites and some patients seen later than 3 weeks as they declined an earlier appointment as requested to be seen at a different hospital but this is not captured in the audit

## Discussion with NEIAA audit lead

Having met with the team and discussed the issues with them we have identified some areas of good practice that we wish to highlight and areas where we feel the team need Trust support.

In line with recommendations from the Getting It Right First Time (GIRFT) initiative the rheumatology team are practicing Consultant level triage including 'rejecting' non-inflammatory referrals and triaging patients to protected EIA slots. Unfortunately, post-triage there are significant delays with booking the appointment.

This is partly due to in-house delays with the booking process but is also hampered by the wide geographical catchment meaning patients often turn down the first available appointment, preferring to wait for an appointment at a site nearer to home.

The team would benefit from dedicated administrative & booking support and Audit Department engagement to help manage the increasing data burden with the widening scope (data entry is mandated for new diagnosis of Connective Tissue Diseases and vasculitis from 1st September 2023).

## Assurance and Risk

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

| Risk level | Description | Select |
|---|---|---|
| Minor | Single failure to meet internal standards/Minor implications for patient safety if unresolved | Yes |
| **Has this audit been placed on a Risk Register? (N/A if above risk is 'none')** | | Yes / No |
| **If not on a risk register, why not:** | | |

## Key Success and Concerns

| Report Successes: | |
|---|---|
| 1 | QS1 improved |
| 2 | QS4, QS5 and QS6 improved |

| Report Concerns: | |
|---|---|
| 1 | QS2 results lower than previous year as no improvements in clinic booking |
| 2 | QS3 results lower as patients not booked within 3 weeks and many > 6 weeks |

| Report Recommendations: | | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Ensure that public awareness is raised to encourage early presentation in primary care of people with suspected EIA and early referral into specialised rheumatology services. (QS33 2013: QS 1)<br>*Action by: National Patient Charities* | Action is for outside of the Secondary Care | | | |
| 2 | EIA pathways should be mandated in secondary care to provide timely assessment, diagnosis and access to treatment for patients with EIA. (QS33 2013: QS 2 & 3)<br>*Action by: Integrated Care Boards (ICBs, England) and NHS Health Boards (Wales)* | Triage clinic and EIA pathway in place<br><br>For improved clinic booking within 3 weeks via changes to clinic slots and advice to booking team- see local recommendations for further details | Directorate and booking team | Nov 2023 and for 2 monthly review | Improvement in clinic booking and QS2 and QS3 |
| 3 | NEIAA data alongside the strategies described in the elective recovery programme, GIRFT and the outpatient recovery and transformation programme must be used to inform and expediate post COVID-19 pandemic recovery strategies for secondary care rheumatology services.<br>Action by: Care Quality Commission (CQC, England) and Healthcare Inspectorate Wales (HIW) | Action is for outside of the Secondary Care | | | |
| 4 | Collection of outpatient secondary care diagnostic information should be mandated as a priority to inform service design and delivery. (GIRFT recommendations 7 and 8)<br>Action by: NHS England and NHS Wales | | | | |
| 5 | The rheumatology Multi-Disciplinary Team (MDT) provision should be expanded to meet the rising demand and expectations in line with recommendations in the BSR rheumatology workforce report. (QS33 2013: QS 2 and 3)<br>Action by: Secretary of State for Health and Social Care | | | | |

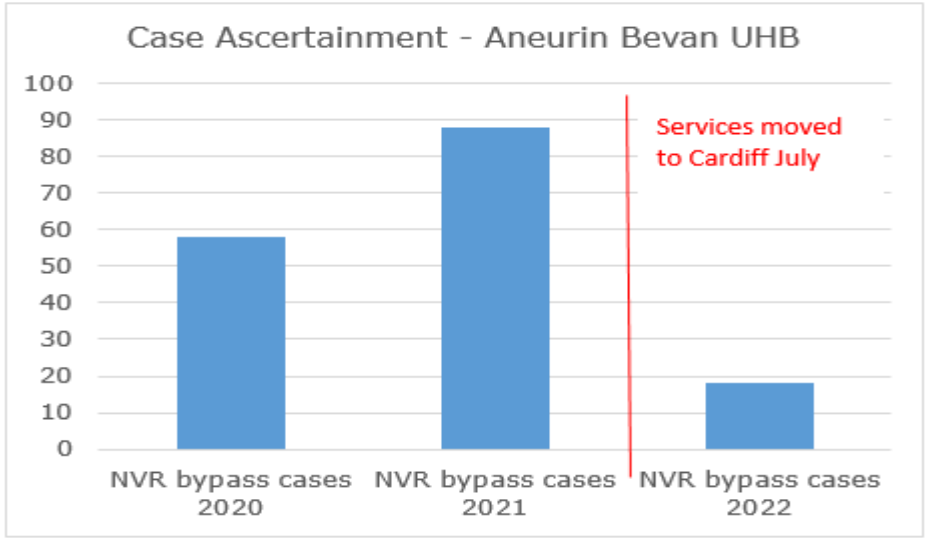
| | Clinical Leads Local Recommendations: (if applicable) | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Re: outlier status for QS2- Need improved clinic booking into urgent EIA slots within 3 weeks and this should also lead to an improvement in QS3 | Booking changes made by covering DM in October 2023-<br>creating specific EIA slots<br><br>Ensuring we have a surplus of these slots each week<br><br>Asking bookings to book within 3 weeks to ensure compliance<br><br>Cancel lower priority if needed.<br><br>Consultant determining and communicating referrals as 'EIA within 3 weeks' rather than 'next available clinic'<br><br>Improving communication with patients to highlight the importance of attending urgent appointments<br><br>Enhanced monitoring and oversight of compliance with the 3-week target | Directorate and booking teams | Nov 2023 and for regular review at directorate meetings | Changes already actioned and EIA slots in place with improvement in clinic booking, QS2 and QS3 |

**Appendix 12**

| | | | |
|---|---|---|---|
| Audit Title: | National Vascular Registry<br>State of the Nation Report 2023<br><br>Results for patients who had vascular procedures during 2022 in NHS<br>hospitals in England, Wales, Scotland and Northern Ireland | Clinical Lead: | Mr David McLain – Vascular Surgeon |
| Rationale: | The National Vascular Registry (NVR) was established in 2013 to measure the quality and outcomes of care for adult patients who undergo major vascular procedures in NHS hospitals, and to support vascular services to improve the quality of care for these patients. | | |
| Objectives: | The aim of the National Vascular Registry (NVR) is to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals, and so support vascular units in the UK to improve the quality of the care received by patients.<br>The NVR aims to improve the care of five main vascular procedures:<br>Repair of abdominal aortic aneurysm (AAA)<br>Carotid endarterectomy<br>Lower limb angioplasty<br>Lower limb bypass<br>Lower limb amputation | | |
| Presented to Clinical Standards and Effectiveness Group – 25th January 2024 | | | |

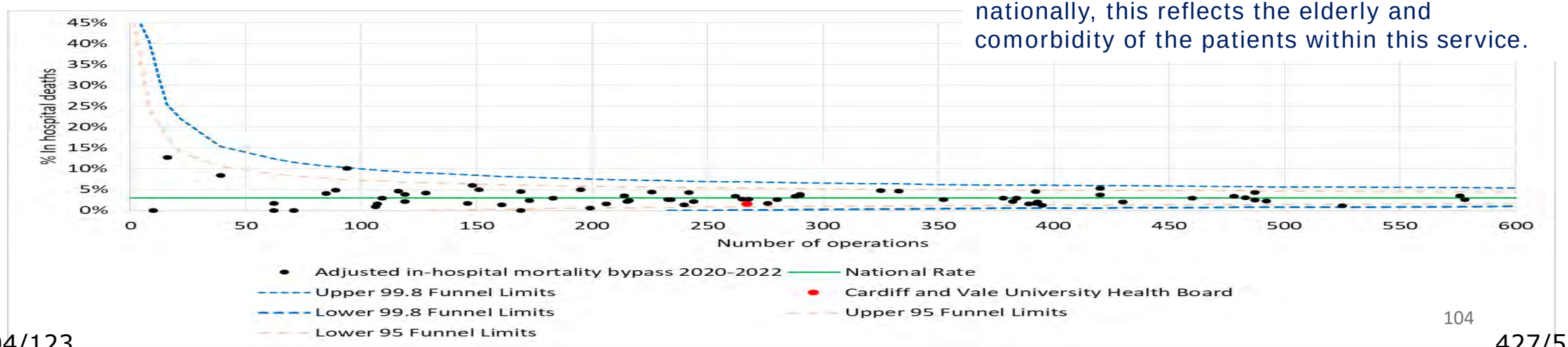
The numbers of NVR bypass cases increased from 2020 to 2021 within the Health Board with a large reduction in 2022, this was due to the service moved to Cardiff in July 2022

The Health Board NVR BYPASS has 0% 30-day readmission rate for 2022 with the Wales rate 12.7% and 3.4% Adjusted in-hospital mortality rate compared to Wales 3.0%.

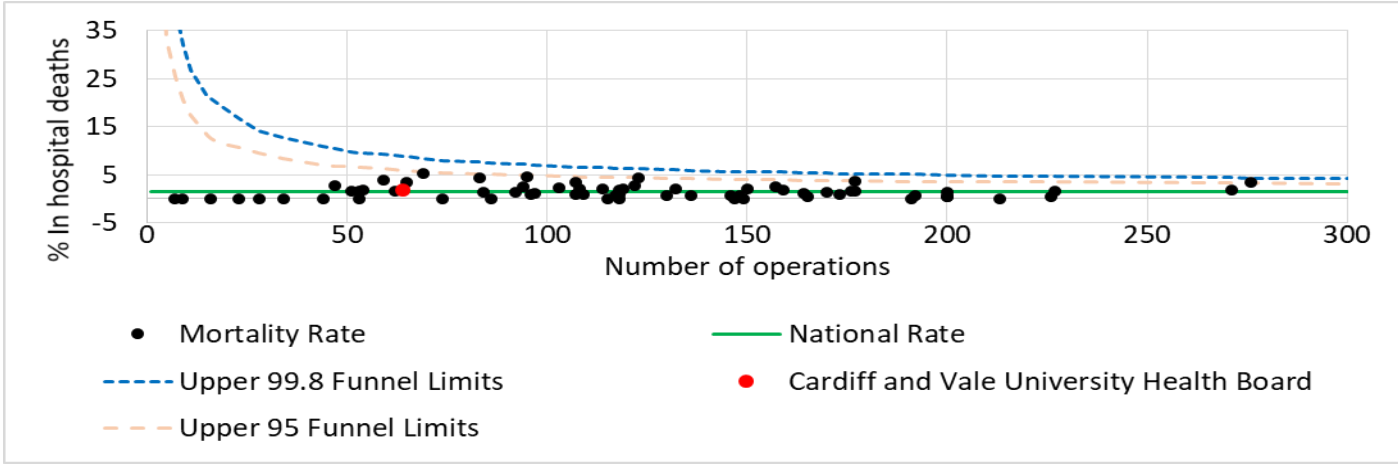



| Trust Name | NVR cases 2022 | NVR cases 2020-2022 | Median (IQR) length of stay (days) 2022 | % Adjusted in-hospital mortality 2020-2022 | Readmission within 30 days 2022 |
|---|---|---|---|---|---|
| **C&VUHB** | 130 | 267 | 9 (6-21) | 1.6% | 12% |
| **NATIONAL** | 6,432 | 17,967 | 8 (4 - 16) | 3.0% | 11.6% |

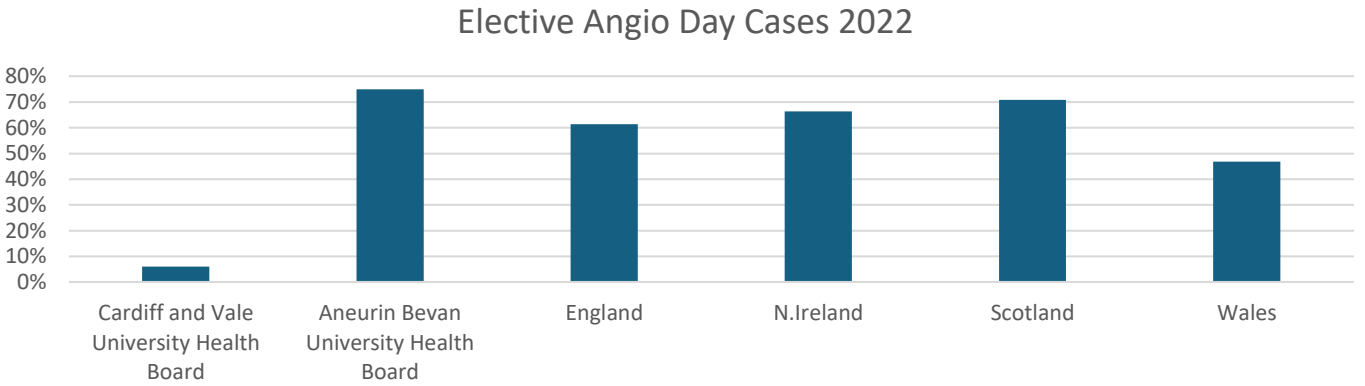
Bypass surgery median LoS for SEWVN is 9 days compared to nationally 8 days, with 1.6% adjusted in-hospital mortality compared to the national rate of 3.0% and re-admission rates within 30 days are 12% for SEWVN and 11.6% nationally, this reflects the elderly and comorbidity of the patients within this service.



The SEWVN mortality rate for AAA is on par with the rest of the UK. The aspirational target is that patients receiving surgery within 8 weeks (56 days) however the Health Board was only achieving 12% compared to 32% nationally.




Angioplasty performed in the SEWVN was 6% due to a lack of day case beds compared to the national rate of 61%, when this service was carried out in The Grange University Hospital, the rate was 75%. The Health Board patients were getting a better-quality service before the commencement of SEWVN.

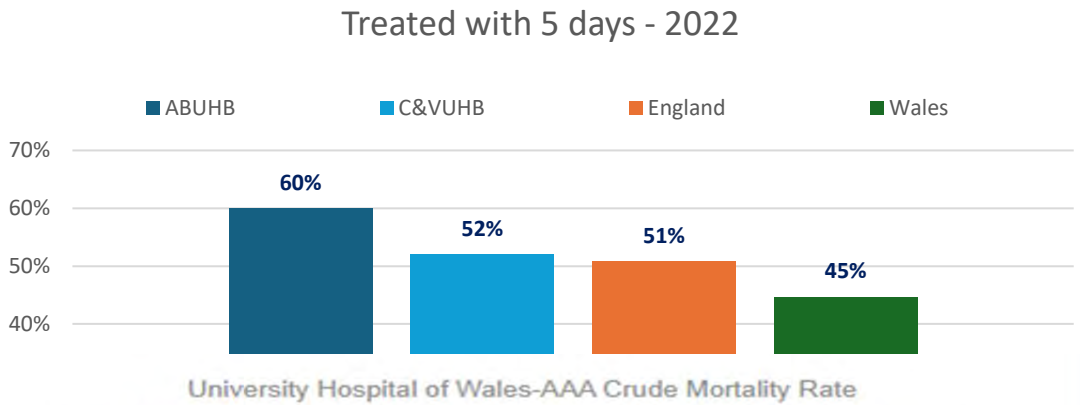


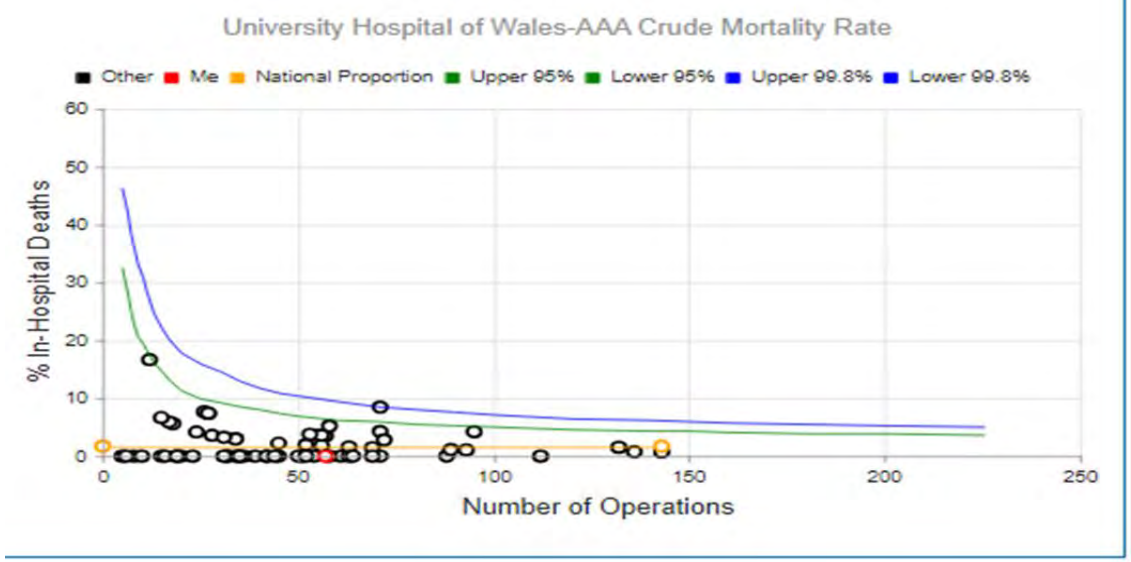

It is important where possible to perform Below Knee Amputation (BKA) rather than Above Knee Amputation (AKA) this forms the AKA:BKA ratio, which ideally needs to be under one, and the SEWVN is 0.58 compared to nationally 0.89.

The SEWVN shows 89% of the time there is a consultant in theatre which is performing better than the national rate of 74%.

| Trust Name | NVR Cases in 2022 | Median - vascular assessment to amputation (days) for non-elective admissions (2022) | Median (IQR) length of stay (days) (2022) | AKA: BKA (2022) | % Consultant Present in Theatre (2022) | % Prophylactic Antibiotics (2022) | Adjusted 30 day in-hospital mortality (2020-2022) |
|---|---|---|---|---|---|---|---|
| C&VUHB | 112 | 10 (3 - 21) | 21 (15 - 37) | 0.58 | 89% | 100% | 8.4% |
| NATIONAL | 3,505 | 7 (3 - 20) | 22 (14 - 38) | 0.89 | 74% | 90% | 6.5% |

Patients admitted non-electively (emergency) with chronic limb-threatening ischaemia (CLTI) should have a revascularisation procedure within five days and those seen at outpatients should be seen within 14 days. During 2022 the Health Board rate was 60% of patients treated within 5 days (emergency) compared to the UK average of 51% and Wales average of 45%.



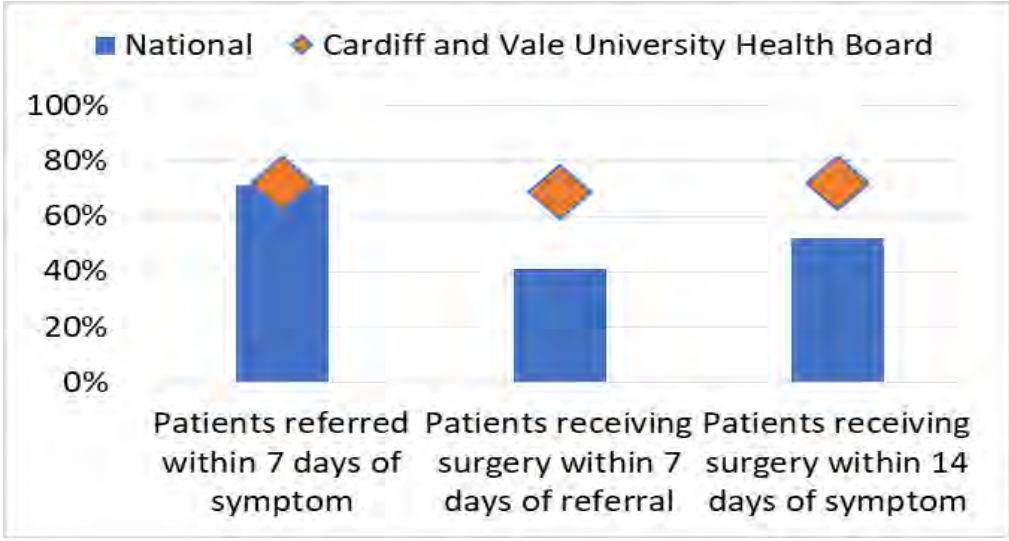




| Organisation Name | All Cases | Cases with Outcome Data | In-Hospital Deaths | Mortality Rate |
|---|---|---|---|---|
| University Hospital of Wales | 57 | 57 | 0 | 0 |

The Health Board also reported lower Length of Stay (LoS) rates due to excellent step-down rehabilitation services.


Data from the first 12 months of the SEWVN July 22 – July 23 which indicate that elective aneurysm mortality is very good at 0% and more procedures are Endovascular Aneurysm Repairs (EVAR) which is minimally invasive compared to open procedures, with 38% mortality which is respectable for the type of patients and from symptom to surgery is 13 days.

Carotid Endarterectomy (CEA) target is patients should have surgery within 14 days of their index event and that split, allows seven days for the referral to vascular surgery and then seven days from the point of referral to surgery, making the network above the national average.




The Royal College of Surgeons are providing quarterly reports, so there is not waiting to the end of the year report to react to performance.

Performance and Constraints reports relating to the first 12 months of the SEWVN July 22 – July 23 which indicate that elective aneurysm mortality is very good at 0% and more procedures are Endovascular Aneurysm Repairs (EVAR) which is minimally invasive compared to open procedures, with 38% mortality which is respectable for the type of patients and from symptom to surgery is 13 days.

| Trust Name | Trust code 7A4 | NVR Cases | No. of EVAR | Median (IQR) length of stay for open repairs (days) | Median (IQR) length of stay for EVAR (days) | Median Time (IQR) From Assessment to Procedure (days) | % of Patients Receiving Surgery Within 8 Weeks of Assessment | Risk-adjusted in-hospital mortality (2020-2022) |
|---|---|---|---|---|---|---|---|---|
| C&VUHB | | 34 | 9 | 9 (8 - 10) | 2 (2 - 2) | 128 (78 - 164) | 12% | 1.9% |
| NATIONAL | | 2,833 | 1,689 | 7 (6 - 10) | 2 (1 - 3) | 87 (48 - 146) | 32% | 1.4% |

## Assurance and Risk

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

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

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

**If not on a risk register, why not:**
**This service is outside of the Health Boards remit and is managed by Cardiff & Vales UHB.**

## Successes and Concerns

| Successes | |
|---|---|
| 1 | Clinical outcomes satisfactory. |
| 2 | Pre-centralisation – good performance for carotids and CLI times |

| Concerns | |
|---|---|
| 1 | Process measures poor since centralisation |
| 2 | Time to revascularisation |
| 3 | Time to amputation |
| 4 | Time to AAA repair |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Ensure that patients with chronic limb threatening Ischaemia (CLTI) receive care as recommended in the VSGBI Quality Improvement Frameworks (QIF) for peripheral arterial disease and are treated with sufficient urgency:<br>• aim for 60% of non-elective admitted patients to have a revascularisation procedure within 5 days, *in keeping with the 2022-23 CQUIN (rising to 65% in the 2023-24 CQUIN). Please note that the CQUIN only applies in England.* | Streamline imaging pathways and fast-track urgent inpatient imaging | | | |
| 2 | Ensure that patients who have major lower limb amputation receive care as recommended in the VSGBI Quality Improvement Framework (QIF) and avoid long delays to surgery after vascular assessment. Below knee amputation should be performed whenever appropriate. | Provide adequate and timely rehab and step-down beds<br>Provide adequate theatre time | | | |
| 3 | Ensure that pathways for patients with aortic aneurysms avoid undue delays, and make efforts to meet the recommended 8-week standard for elective repair of abdominal aortic aneurysms (AAA) | | | | |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 4 | Commissioning of vascular units to perform FEVAR / BEVAR aortic procedures should be conditional on the unit submitting data on all such cases to the NVR so that activities and outcomes can be monitored. Vascular units should enter data on all TEVAR procedures on the NVR to support regional delivery of the Acute Aortic Dissection Toolkit. | Appoint a data clerk to capture and enter NVR data on all index cases.<br>Developing a complex EVAR service. | | | |
| 5 | Ensure timely referral and expedited surgery for patients with symptomatic carotid disease with measures to reduce waiting times to carotid endarterectomy (CEA) | Largely being achieved. | | | |

| | Clinical Leads Local Recommendations: (if applicable) | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | See SEWVN Governance reports for review and recommendations.<br>Constraints/Performance | | | | |
| 2 | Challenges in SW Wales Vascular service, particularly IR provision. | | | | |

## Appendix 13

| Audit Title: | National Prostate Cancer Audit (NPCA) State of the Nation report<br>Data collection period: 1 January 2019 – 31 January 2023<br>Published January 2024 | Clinical Lead:<br>Mr Adam Cox –<br>Consultant Urological Surgeon |
|---|---|---|
| Rationale: | Prostate cancer is the most common solid cancer in men with over 46,000 new cases diagnosed each year in the UK and its incidence is increasing. There are concerns about over-diagnosis and over-treatment in men with low-risk disease, while men with locally advanced or high-risk disease may not be getting the radical treatments that they need. | |
| Objectives: | Its aim is to evaluate the patterns of care and outcomes for patients with prostate cancer in England and Wales, and to support services to improve the quality of care. | |

## Results

Presented at Clinical Standards and Effectiveness Group 21st March 2024

| Management | Specialist MDI | National | Health Board Database |
|---|---|---|---|
| No. of men diagnosed with low-risk localised disease | 40 | 3680 | ABUHB internal database records higher case ascertainment. |
| Percentage of men with low-risk localised disease receiving radical treatment | 5 % | 9 % | |
| No. of men diagnosed with locally advanced disease | 100 | 11503 | |
| Percentage of men diagnosed with locally advanced disease receiving radical treatment | 68 % | 69 % | Comparable to N/A |

| Data Quality | Diagnosing Trust | Clinical Lead update |
|---|---|---|
| No. of Cancer Registry records | 344 | Query the quality of the data presented for ABUHB. |
| Performance Status recorded | 100 % | |
| PSA completed | 72 % | *The Health Board figure would be in the high 90% as this is a standard diagnostic test.* |
| Gleason Score completed | 72 % | *A grading score that is routine for all patients, expectations of high 90%.* |
| TNM completed | 79 % | |
| Risk group assigned | 86 % | *This result can be impacted on if risk group assigned before staging scans are performed* |

| Outcome | Treatment Centre | Health Board Database |
|---|---|---|
| No. of men who received radical prostatectomy (Apr 2021 – Mar 2022) | 37 | 57 |
| Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy | 10 % | Increase in numbers will impact this % - Max 1 readmission in 12 months. Readmission can include post op contacts, telephone advice, clinic. |
| No. of men who received radical prostatectomy (Sep 2019 – Aug 2020) | 42 | HB Database records 80 cases Sep 19-Aug 20. HB have cases 67 in 12 months. |
| Adjusted percentage of men experiencing at least one GU complication | 10 % | England recording 10% and Wales 5%. |

| Risk level | Description |
|---|---|
| None | Standards met and findings demonstrate no risk to patient safety |

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

| Report Successes: | |
|---|---|
| 1 | First UK centre to do same day discharge for robotic prostatectomy |
| 2 | Recently appt a 3rd Consultant Oncologist to the MDT |
| 3 | Recently appt Consultant Radiologist to the MDT |
| 4 | Business case approved for intuitive da-vinci surgical robot in Aneurin Bevan |

| Report Concerns: | |
|---|---|
| 1 | Data on re-admission is inaccurate |
| 2 | Data on number of surgical cases is inaccurate |

| | Report Recommendations: | S.M.A.R.T Actions:<br>Listed in AMaT as Responsible: Due Date: Progress: |
|---|---|---|
| 1 | Aim to achieve high completeness of key data items at the point of collection by NHS organisations in England, particularly tumour, node and metastasis (TNM) staging variables. Action by: NHS England and Health Boards in Wales; Prostate cancer teams (local and Specialist MDTs) within NHS Trusts | Done in real time with Cancer Services Coordinator with any missing data requested by Royal College.<br>Review plan for data acquisition with Cancer Lead. |
| 2 | Continue to advocate active surveillance for men with low-risk prostate cancer.<br>Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons, Prostate Cancer UK) | Already doing this – better than NA on accurate data -<br>8% England<br>9% Wales |
| 3 | Investigate why men with high-risk/locally advanced disease are not considered for radical treatment and aim for 75% offered radical treatment.<br>Action by: NHS England and Health Boards in Wales; Cancer Alliances (CA). | AB better than the 68% recorded as data inaccurate.<br>69% England and 69% Wales |
| 4 | Review variation between providers in rate of GU/GI complications and 90 day readmission rates.<br>Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons); Cancer Alliances | Genitourinary complications returns for England was 7%, Wales 8% & ABUHB 10% however inappropriate returns (clinic/telephone advice) will impact this result for the Health Board.<br>No Gastrointestinal data for ABUHB, however Wales is performing better than England at 5% compared to 10%.<br>In England 13% of men were re-admitted within 3 months following surgery, that was 9% for Wales, ABUHB recorded as 10% however CL states that possibly one legitimate return was experienced in ABUHB. |
| 5 | Cancer Alliances should review processes of care to ensure equitable implementation of new technologies and pathways of care as evidence evolves.<br>Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons); Cancer Alliances | Urology Cancer Network for Wales continuously evaluates service provision across the Health Boards, introducing new technologies, pathways of care, medication. |

| | Clinical Leads Local Recommendations: (if applicable) | S.M.A.R.T Actions: |
|---|---|---|
| 1 | Employ 1-2 CNS to support recent resignation and the PSA patient self-management software | Write business case |

## Appendix 14

| Audit Title: | NBOCA – National Bowel Cancer Audit – State of the Nation Report An audit of the care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2021 and 31 March 2022. Published 8 February 2024. | Clinical Lead: Mr Keshav Swarnkar |
|---|---|---|
| Rationale: | The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for patients diagnosed with bowel cancer in England and Wales. It supports hospitals in England and Wales to improve the quality of the care received by patients. | |
| Objectives: | NBOCA collects data on items which have been identified as good measures of clinical care. It compares variation between English NHS trusts or hospitals, and Welsh MDTs, as well as changes in care over time. | |

Presented at Clinical Standards and Effectiveness Group – 21st March 2024

| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Circumferential resection margin: Negative (%) | 85 | 86 | 83 |
| Rectal volume | 75 | N/A | 4377 |

| Patients in APER/Hartmanns estimate: | Trust | Network | National |
|---|---|---|---|
| Number of patients in APER/Hartmanns estimate | 171 | 1145 | 19644 |
| APER/Hartmanns (%) | 42 | 45 | 37 |


| Trust | Number | Adjusted | Observed |
|---|---|---|---|
| Aneurin Bevan University Health Board MDT | 256 | 14.8% | 17.1% |
| Other trusts within the region: Wales | | | |
| Cardiff MDT | 93 | 11.7% | 11.4% |
| West Wales General & Prince Phillip MDT | 143 | 23.7% | 29.1% |
| Prince Charles Hospital MDT | 76 | 19.7% | 22.1% |
| Princess of Wales MDT | 73 | 20% | 28.7% |
| Royal Glamorgan Hospital MDT | 92 | 12.7% | 17.9% |
| Swansea MDT | 117 | 18.3% | 22.8% |
| Ysbyty Glan Clwydd MDT | 94 | 22.1% | 22.9% |
| Ysbyty Gwynedd MDT | 119 | 15% | 21.8% |
| Ysbyty Maelor MDT | 111 | 33% | 30.2% |

# Aneurin Bevan University Health Board - Data Quality:

| All Patients: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 461 | 2335 | 35779 |
| Case ascertainment (%) | Good | Good | Good |
| | | | |
| Data completeness of: | | | |
| – Pre-treatment TNM (%) | 91 | 96 | 86 |
| – Performance status (%) | 100 | 98 | 89 |

| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 291 | 1436 | 19631 |
| ASA grade 1 (%) | 9 | 6 | 9 |
| ASA grade 2 (%) | 45 | 49 | 53 |
| ASA grade 3 (%) | 39 | 37 | 31 |
| ASA grade 4+ (%) | 4 | 7 | 2 |
| ASA grade not recorded (%) | 4 | 1 | 4 |
| | | | |
| Data completeness of: | | | |
| 7 Audit items for risk-adjustment (%) | 91 | 95 | 87 |

| All Patients: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 461 | 2335 | 35779 |
| Seen by Clinical Nurse Specialist (%) | 91 | 88 | 88 |

| All patients deemed potentially curative | Trust | Network | National |
|---|---|---|---|
| Number of potentially curative patients | N/A | N/A | N/A |
| Undergoing major resection (%) | N/A | N/A | N/A |

| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 291 | 1436 | 19614 |
| Distant metastases (%) | 8 | 8 | 5 |
| Urgent or emergency surgery (%) | 19 | 18 | 15 |
| At least 12 lymph nodes excised (%) | 87 | 89 | 84 |
| Laparoscopic surgery attempted (%) | 57 | 65 | 72 |
| Risk-adjusted length of stay > 5 days (%) | 62 | 60 | 55 |

| Patients having major resection for stage III colon cancer: | Trust | Network | National |
|---|---|---|---|
| Number of patients in audit | 135 | N/A | 10747 |
| Adjuvant chemotherapy (%) | 42 | N/A | 62 |

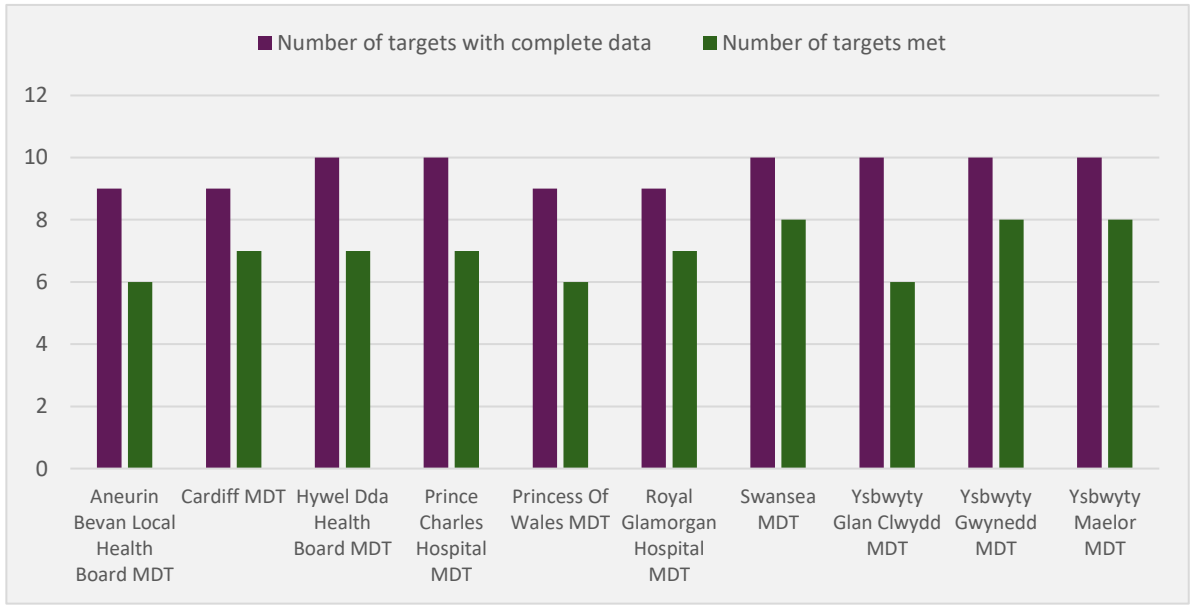
| Patients receiving chemotherapy after major resection for stage III colon cancer: | Trust | Network | National |
|---|---|---|---|
| Number of patients in audit | N/A | N/A | 6608 |
| Severe acute toxicity after adjuvant chemotherapy (%) | N/A | N/A | 22 |

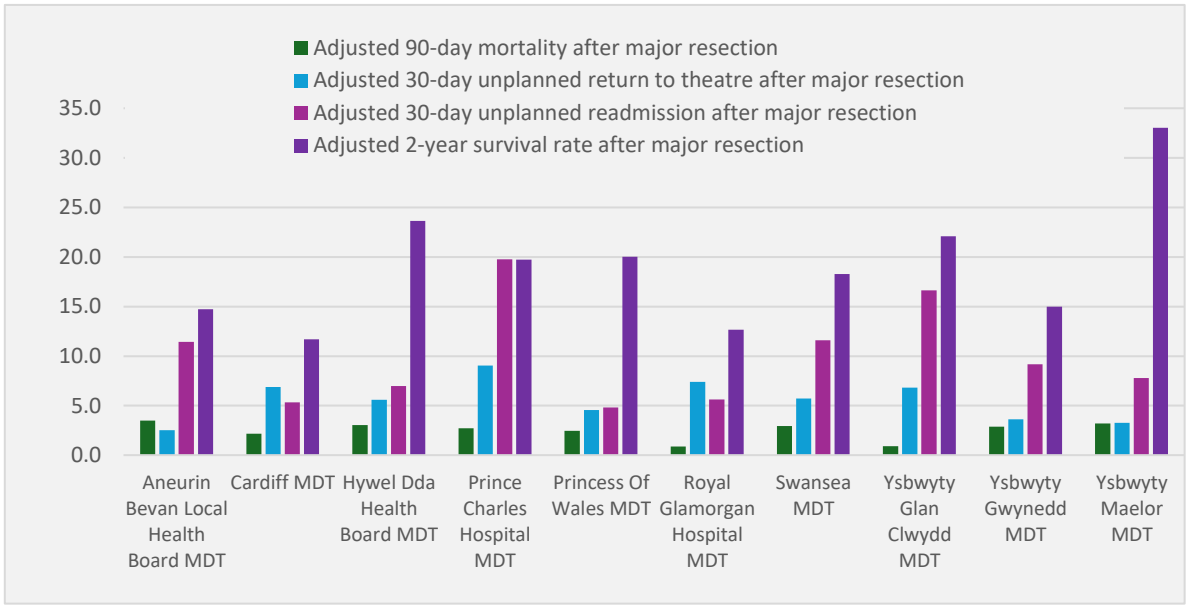
| Patients having major resection: | Trust | Network | National |
|---|---|---|---|
| Number of patients in Audit | 62 | N/A | 4251 |
| Neoadjuvant therapy (%) | 34 | N/A | 33 |
| Circumferential resection margin: Recorded (%) | 89 | 91 | 89 |

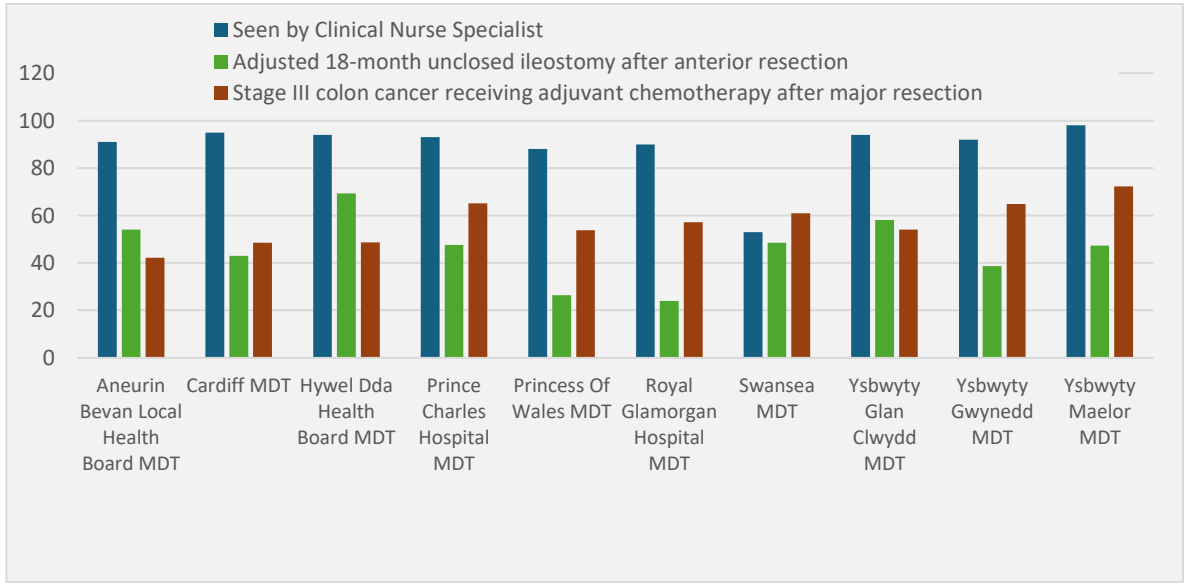
**Key:**

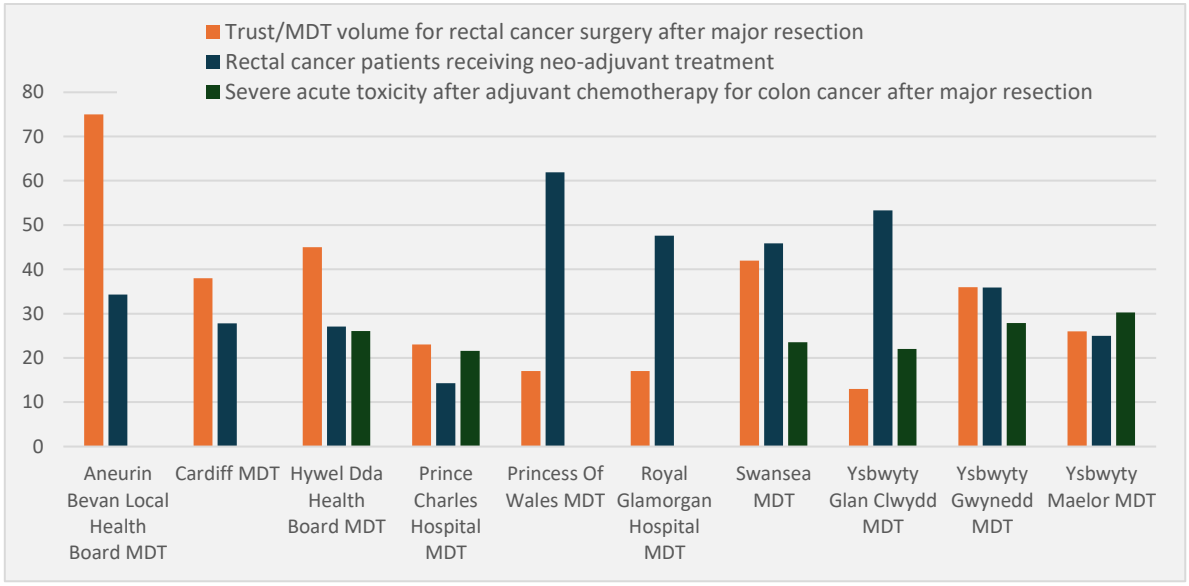
- > 80%
- 50 - 80%
- < 50%

# Quality Improvements Targets – results for Welsh Health Boards



## Conclusion and Risk

| Assurance Level | | |
|---|---|---|
| Significant | The project has mostly achieved the standards or criteria being audited against | Yes |
| **Risk Level** | | |
| Minor | Single failure to meet internal standards/Minor implications for patient safety if unresolved | Yes |
| **Has this audit been placed on a Risk Register (N/A if above risk is None)** | | **YES** |

## Key Success and Concerns

| | Report Successes: |
|---|---|
| 1 | Good case ascertainment |
| 2 | Laparoscopic surgery > 50% |
| 3 | Quality assured rectal cancer resections |
| 4 | Comparable 2 year mortality rates |
| 5 | Good engagement with CNS |

| | Report Concerns: |
|---|---|
| 1 | Reversal of diverting loop ileostomy > 18/12 |
| 2 | Unplanned readmissions within 30 days |
| 3 | Inadequate colonic stenting service |

| | Clinical Leads Local Recommendations: (if applicable) | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | Theatre space availability for cancers | Increase capacity | Theatre Group | 6/12 | |
| 2 | Colonic Stenting service | Audit colon stent results in last 24 months | K Swarnkar | 6/12. | |

| | Report Recommendations: | S.M.A.R.T Actions: | Responsible: | Due Date: | Progress: |
|---|---|---|---|---|---|
| 1 | With future NBOCA reports utilising "gold standard" cancer registry data collected by the National Disease Registration Service (NDRS) in England, and the Wales Cancer Network in Wales, NDRS regional Data Liaison Managers should support hospitals/trusts/MDTs with coding, data entry, and quality assurance for the Cancer Outcomes and Services Data set (COSD). Data set items of focus include:<br>• TNM Stage<br>• ASA grade<br>• Seen by Clinical Nurse Specialist (CNS)<br>*Intended audience: NHS England, NDRS and Public Health Wales* | Data collected on CANISC in real time in MDT | Cancer service-MDT coordinator | | |
| 2 | In keeping with the NHS Workforce Plan, NHS England, Welsh Health Boards and Cancer Alliances should ensure everyone with bowel cancer has access to a clinical nurse specialist (CNS). NHS England, Welsh Health Boards and Cancer Alliances should investigate and address factors preventing patients' accessing a CNS.<br>*Intended audience: NHS England, Welsh Health Boards and Cancer Alliances* | Already achieved in ABUHB. Prospective NBOCA data | CNS | | |
| 3 | Cancer Alliances should participate and engage with the NBOCA/ Royal College of Surgeons of England quality improvement project to enable more timely reversal of ileostomy.<br>*Intended audience: Cancer Alliance* | Book theatre after WSCE to fix date. | Colorectal surgeon | 12/12 | |
| 4 | Cancer Alliances should monitor and investigate regional and institutional variation in rates of adjuvant chemotherapy following resection of stage III colon cancer and ensure evidence-based chemotherapy policies are in place.<br>*Intended audience: Cancer Alliances* | Velindre Cancer Centre | Dr H Williams | 12/12 | |
| 5 | Cancer Alliances should monitor and investigate regional and institutional variation in severe acute toxicity after adjuvant chemotherapy. Cancer Alliances should encourage the utilisation of appropriate risk stratification tools for severe acute toxicity including frailty scoring, and integration of geriatric expertise and rehabilitation into chemotherapy decision making.<br>*Intended audience: Cancer Alliances* | Velindre Cancer Centre | Dr H Williams | 12/12 | |

## Appendix 15

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 08/02/2024 | NCEPOD | Child Health Clinical Outcome Review Programme | Child Health Clinical Outcome Review Programme - Testicular torsion report | CSEG May 2024 |
| 08/02/2024 | Audit | GICAP-NBoCA - National Gastro Intestinal Cancer Audit Prog. | National Bowel Cancer Audit National Bowel Cancer Audit State of the Nation report | CSEG Mar 2024 |
| 08/02/2024 | Audit | FFFAP - Falls & Fragility Fracture Audit | Fracture Liaison Service Database (FLSDB) Annual Report 2024: Improved FLS identification with gaps in monitoring: a call to action for national and regional planners (January-December 2022) | CSEG May 2024 |
| 08/02/2024 | CORP | 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 | MH&LD to provide update |
| 08/02/2024 | CORP | NCISH - Mental Health CORP | The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Suicide by people in contact with drug and alcohol services in the year prior to death report 2024: (cohort October 2021- September 2022) | MH&LD to provide update |
| 11/01/2024 | Audit | NDA - National Diabetes Audit (adults) | National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Detailed Analysis Report | CSEG Mar 2024 |
| 11/01/2024 | Audit | SSNAP - Sentinel Stroke National Audit Programme | Sentinel Stroke National Audit Programme quarterly data only report (Jul-Sep 2023) | Stroke Board |
| 11/01/2024 | Audit | GICAP-NOGCA - National Gastro Intestinal Cancer Audit Prog. - National Oesophago Gastric Cancer Audit | National Oesophago-Gastric Cancer Audit State of the Nation report | CSEG May 2024 |
| 11/01/2024 | Audit | NPCA - National Prostate Cancer Audit | National Prostate Cancer Audit State of the Nation report | CSEG Mar 2024 |

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 14/12/2023 | Audit | NDA - National Diabetes Audit | National Diabetes Audit 2021-22, Young People with Type 2 Diabetes State of the Nation Report | CSEG Mar 2024 |
| 14/12/2023 | Clinical Outcome Review Programme | MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme | A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death - State of the Nation Report | Family and Therapies to provide update |
| 14/12/2023 | Clinical Outcome Review Programme | MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme | A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death - State of the Nation Report | Family and Therapies to provide update |
| 14/12/2023 | Audit | PICANet - Paediatric Intensive Care Audit | National Paediatric Critical Care Audit (PICANet) State of the Nation Report 2023 | Noah's Ark Cardiff and Vale UHB |
| 14/12/2023 | NCEPOD | Medical and Surgical Clinical Outcome Review Programme | Consolidation Required: A review of the care provided to adults presenting to hospital with a diagnosis of community-acquired pneumonia | QPS providing data to Sara Fairbairn |
| 09/11/2023 | Audit | NVR - National Vascular Registry | National Vascular Registry - State of the Nation Report 2023<br>Results for patients who had vascular procedures during 2022 in NHS hospitals in England, Wales, Scotland and Northern Ireland | CSEG Jan 2024 |
| 08/06/2023 | | | NVR Short Report: Impact of the COVID-19 pandemic on vascular surgery in the UK | |
| 09/11/2023 | Audit | SSNAP - Sentinel Stroke National Audit Programme | Sentinel Stroke National Audit Programme Annual Report 2023<br>Stroke care received between April 2022 to March 2023 | Stroke Board |

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 09/11/2023 | Audit | NCMD - National Child Mortality Database | National Child Mortality Database Child Death Review Data Release: Year ending 31 March 2023 | Family and Therapies to provide update |
| 09/11/2023 | Audit | FFFAP - Falls and Fragility Fracture Audit Programme | Inpatient falls and fractures – one chance to get it right The 2023 National Audit of Inpatient Falls report on 2022 clinical data | Inpatient Falls Panel - to organised CSEG |
| 12/10/2023 | Audit | 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 | CSEG Jan 2024 |
| 12/10/2023 | Clinical Outcome Review Programme | 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 | Family and Therapies to provide update |
| 12/10/2023 | Clinical Outcome Review Programme | 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 | Family and Therapies to provide update |

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 12/10/2023 | Clinical Outcome Review Programme | 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<br>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 | Family and Therapies to provide update |
| 12/10/2023 | Audit | NNAP - National Neonatal Audit Programme | National Neonatal Audit Programme (NNAP) - Summary report on 2022 data | CSEG Nov 2023 |
| 12/10/2023 | Audit | NDA - National Diabetes Audit | National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Overview | CSEG Nov 2023 |
| 12/10/2023 | Audit | NDA - National Diabetes Audit | National Diabetes Audit 2021-22, Type 1 Diabetes - Overview | CSEG Nov 2023 |
| 12/10/2023 | Audit | NDA - National Diabetes Audit | National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022) | CSEG Nov 2023 |
| 14/09/2023 | Audit | 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) | CSEG May 2023 |
| 14/09/2023 | Clinical Outcome Review Programme | 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 | Family and Therapies to provide update |
| 10/08/2023 | Audit | NAD - National Audit of Dementia | National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report | CSEG May 2024 |
| 13/07/2023 | Audit | NPDA - National Paediatric Diabetes Audit | NPDA: Report on hospital admissions of children and young people with diabetes, 2015-2020 | CSEG Jul 2023 |

| PUBLICATION DATE | TYPE | PROJECT NAME | FULL REPORT TITLE | CSEG |
|---|---|---|---|---|
| 13/07/2023 | Audit | 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 | Family and Therapies to provide update |
| 13/07/2023 | Audit | 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) | Particially Participating |
| 13/07/2023 | Audit | NACEL - National Audit of Care at the End of Life | NACEL: Fourth round of the audit (2022/23) report | CSEG Jul 2024 |
| 13/07/2023 | Audit | NOGCA - National Oesophago-Gastric Cancer Audit | NOGCA short report: Socioeconomic differences in the impact of oesophago-gastric cancer on survival in England | England only |
| 13/07/2023 | NCEPOD | Medical and Surgical Clinical Outcome Review Programme | Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease | Unable to fully participate |
| 16/06/2023 | NICOR | Heart Failure | National Heart Failure Audit (NHFA) 2021 Summary Report | CSEG Sep 2023 |
| | | MINAP | Myocardial Ischaemia National Audit Project (MINAP) 2021 Summary Report | CSEG Sep 2023 |
| | | PCI | National Audit of Percutaneous Coronary Interventions (NAPCI) 2021 Summary Report | CSEG Mar 2024 |
| | | Cardiac Rhythm | National Audit of Cardiac Rhythm Management (NACRM) Devices and Ablation 2021 Summary Report | Unable to secure attendance at |
| 08/06/2023 | CORP - Clinical Outcome Review Programme | 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. | Unable to fully participate |
| 12/04/2023 | Audit | NLCA - National Lung Cancer Audit | NLCA: State of the Nation Report 2023 | CSEG May 2023 |

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

| | |
|---|---|
| DYDDIAD Y CYFARFOD:<br>DATE OF MEETING: | 30 April 2024 |
| CYFARFOD O:<br>MEETING OF: | Patient Quality, Safety and Outcomes Committee |
| TEITL YR ADRODDIAD:<br>TITLE OF REPORT: | Healthcare Inspectorate Wales Annual Report 2022-2023 |
| CYFARWYDDWR ARWEINIOL:<br>LEAD DIRECTOR: | Jennifer Winslade – Executive Director of Nursing |
| SWYDDOG ADRODD:<br>REPORTING OFFICER: | Tracey Partridge-Wilson – Deputy Director of Nursing |

| Pwrpas yr Adroddiad (dewiswch fel yn addas)<br>Purpose of the Report (select as appropriate) |
|---|
| Er Gwybodaeth/For Information |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

HIW have published their Annual Report for 2022-23, which sets out the key findings from their regulation, inspection, and review of healthcare services in Wales. It outlines how they carried out their function across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS and regulatory assurance work in the independent healthcare sector. It provides a summary of what HIW work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

The Health Board should examine the themes of this report to ensure that our own markers for Quality, Patient, Safety and Experience and our existing improvement plans are in line with HIW priorities.

### Cefndir / Background

During 2022 – 2023, HIW aligned their approach to seeking assurance in preparation for taking account of how well healthcare services are embedding their responsibilities against the duties of the Act.

The Annual Report provides an overview of their activity throughout 2022-2023, HIW conducted 41 quality checks, 137 onsite inspections, 1,334 completed staff

surveys (reviews and inspections) and 2,483 completed patient surveys (reviews and inspections).

Acute Hospital Inspections

The inspection of Acute Hospitals highlighted the following themes:

- High demand for inpatient beds
- Challenges with adequate staffing
- Compliance with statutory and mandatory training is variable
- The quality of discharge planning requires improvement.
- Storage of medicines/harmful substances
- Maintenance of equipment

Mental Health

- Workforce challenges
- Patient observations
- Patient information
- Risk assessment/care planning documentation.
- Safety of environment (ligature risks)
- Governance.
- Access to appointments/services

Learning Disabilities

- Safety of environment (ligature risks)

General Practice

- Accessing Appointments
- Incomplete safeguarding records and poor follow up of concerns.
- Checks of emergency equipment and drugs not completed.
- No DBS checks on staff including administrative and reception staff.
- Medicines not safely stored.
- Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control.
- Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles.

Dental Practice

- Challenges in accessing a dentist.

In 2022-2023, HIW overall summary is the same as 2021-2022 and pressures have increased. These pressures mean that HIW have seen overcrowded emergency departments, delays in ambulance handover of patients, long waits for triage and long waits for treatment to start.

Asesiad / Assessment

At this current time there are several workstreams that are ongoing which evidence that these identified issues are matters about which the Health Board have an awareness and, in many cases, work is well underway to make necessary improvements. Examples of this are:

The Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026
The Mental Health and Learning Disability 30, 60 and 90 Day Improvement Plan
Optimising Patient Flow project (Incorporating Safer Discharge)
Medication Audits
Patient Safety Incident Policy
Listening and Learning Framework
Quality Strategy
Patient Experience and Involvement Strategy
The Six Goals of Urgent and Emergency Care

## Argymhelliad / Recommendation

The Committee is requested to: -

NOTE the Annual Report.

NOTE the requirement for the Health Board on the basis of the HIW themes to continue to focus on mandatory and statutory training compliance and improved record keeping standards, quality of discharge planning reducing risks within the inpatient environment, medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | All Health & Care Standards Apply<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Experience Quality and Safety |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives | Improve the Wellbeing and engagement of our staff<br>Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services |

| | |
|---|---|
| Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item. |

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

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| | Is EIA Required and included with this paper |
| Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment (EIA) completed | Choose an item.<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | |



# Healthcare Inspectorate Wales Annual Report 2022-2023

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

## Our purpose

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

## Our goal is

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

## Our values

**We place people at the heart of what we do**

## We 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**

## We have set four strategic objectives through which we deliver our goal of influencing and driving improvement in healthcare.

### 01

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services

### 02

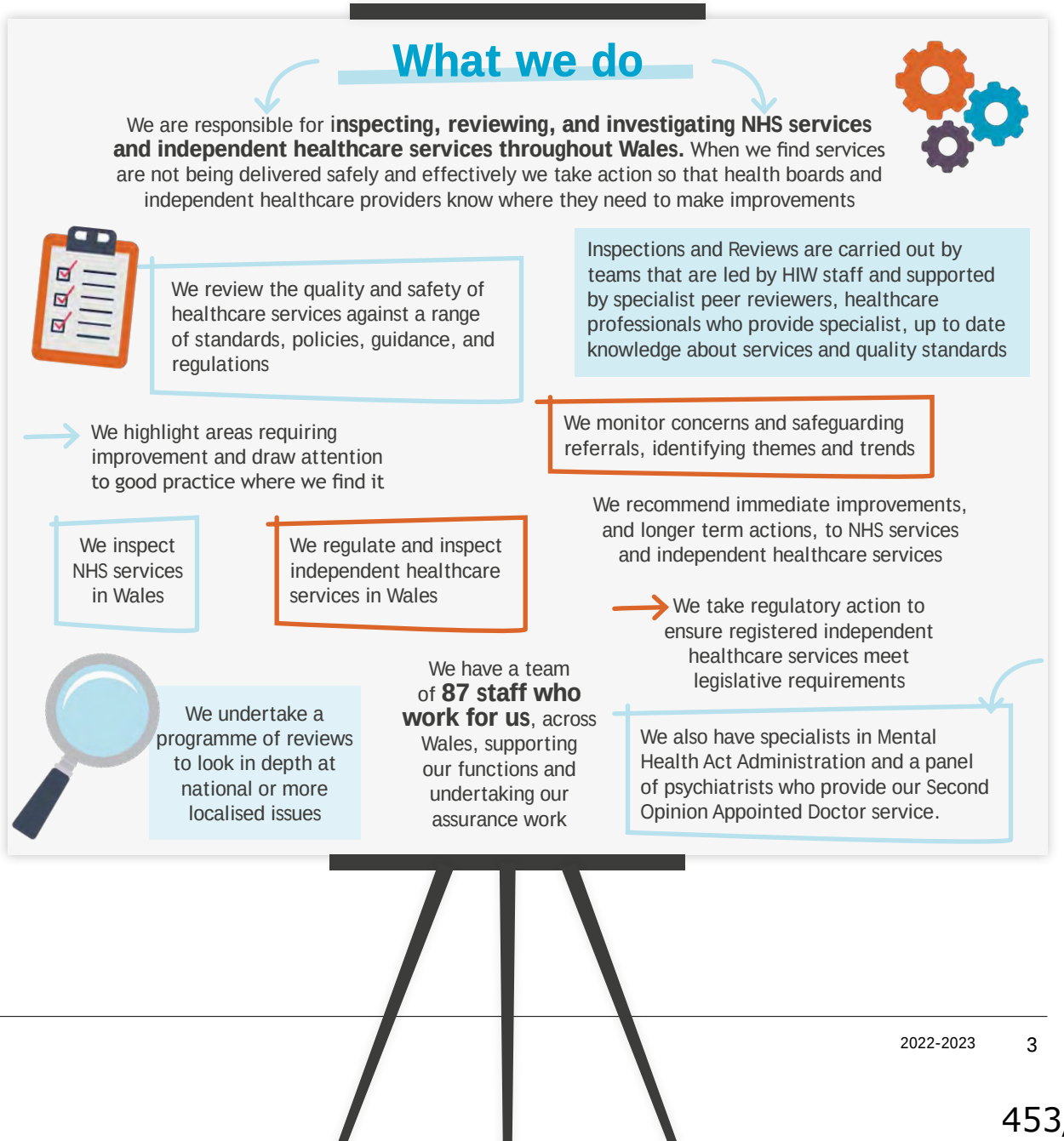
We will adapt our approach to ensure we are responsive to emerging risks to patient safety

### 03

We will work collaboratively to drive system and service improvement within healthcare

### 04

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities



# Contents

# Foreword

Alun Jones
Chief Executive

**Welcome to our Annual Report for 2022 – 2023. This Summer marked the 75th anniversary of the National Health Service (NHS), and most people living in Wales today will not have known a time without this institution.**

A key milestone this year was the introduction of The Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Act aims to strengthen the overall focus on delivering quality services, and improving engagement with the population across Wales, both in terms of better understanding their needs and improving openness and honesty when things do not go right. The key focus of HIW's work, is to provide an independent view and assessment of the quality and safety of healthcare services. During 2022 – 2023, we have aligned our approach to seeking assurance in preparation for taking account of how well healthcare services are embedding their responsibilities against the duties of the Act.

This report sets out our key findings from the regulation, inspection, and review of healthcare services in Wales. It outlines how we carried out our functions across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS, and regulatory assurance work in the independent healthcare sector. It provides a summary of what our work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

In providing an independent view of healthcare services, we seek to contribute to an understanding of the risks and challenges that are preventing services from operating effectively and impacting on the quality of care being delivered to patients.

This has once again been a turbulent year for healthcare services in Wales. Whilst there are initiatives in place to help support healthcare services cope with unrelenting demand,

> **"Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner."**

our work during this year did not find evidence of these making a clear and significant difference to services at the front line. Increasingly, we have needed to make in year changes to our programme of work to enable us to undertake inspections in the areas of highest risk. Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner. Whilst staff continued to describe their passion for working with people and supporting people with care, they were not satisfied with the immensely pressured environments of work they find themselves in on a daily basis.

Our role covers the regulation and inspection of independent healthcare services in Wales. These services represent an area of growing importance, where innovations in science and technology mean the frequent development of new treatment options and services, many of which are offered by the independent healthcare sector. Many of the specialist mental health care beds in Wales are provided by independent healthcare providers. The sector cares for some of the most vulnerable patients in Wales, dealing with high levels of risk and complex needs. Our work over this time has sought to challenge the sector to ensure that the standards and quality provided are in line with their regulatory responsibilities and provide a quality service to the patients they care for.

Our work within NHS acute hospitals has shown the intense daily pressure in patient admission areas and on inpatient wards. Within Emergency Departments across Wales, we have noted overcrowding, long waits for triage and long waits for treatment, plus ongoing delays in being admitted into the most appropriate beds. Our work over this period has also shown that within General Practice and Dentistry, access to NHS services remains a matter of real concern to patients. When we refer to access, we are describing the ability to source appointments and/or to be registered as a patient with either a GP or Dentist. Once patients are in direct receipt of care and treatment from the NHS, either within Primary or Secondary care services, they consistently told us how well they felt they were being cared for and recognised the professionalism of staff. Through our work we have once again seen a highly skilled and committed workforce, delivering care with compassion and innovation. The workforce of the NHS remains its biggest asset and building on the many positives, with staff, will remain central to navigating the challenges that lie ahead.

We have found one clear issue throughout our work, which is, that at any junction in the care and treatment pathway of a patient, there is huge potential for delay, a pause in treatment, and an overall introduction of risk that is not there at other times. Our work within mental health, for example, has found that this is the case when patients with a diagnosis and care and treatment plan are moving from one part of the service to another.

We have also continued to find that inefficiencies in record keeping and in record keeping systems introduce unnecessary risk into the continuity and quality of patient care.

Three key themes to have arisen from our concerns monitoring service, which takes calls and information from members of the public, are the difficulty in accessing a regular dentist and getting any dental care; difficulty in getting an appointment with a GP; and difficulty in accessing mental health services. This feedback from members of the public is highly concerning and is an early warning of future public health challenges which must be heeded.

Our objectives are ambitious and through them we aim to make a difference to the people of Wales by contributing to improvements in healthcare. In this report you will find some examples of how we have used our work to further this aim. I am proud of the organisation I lead, and the contribution we can make to healthcare in Wales.

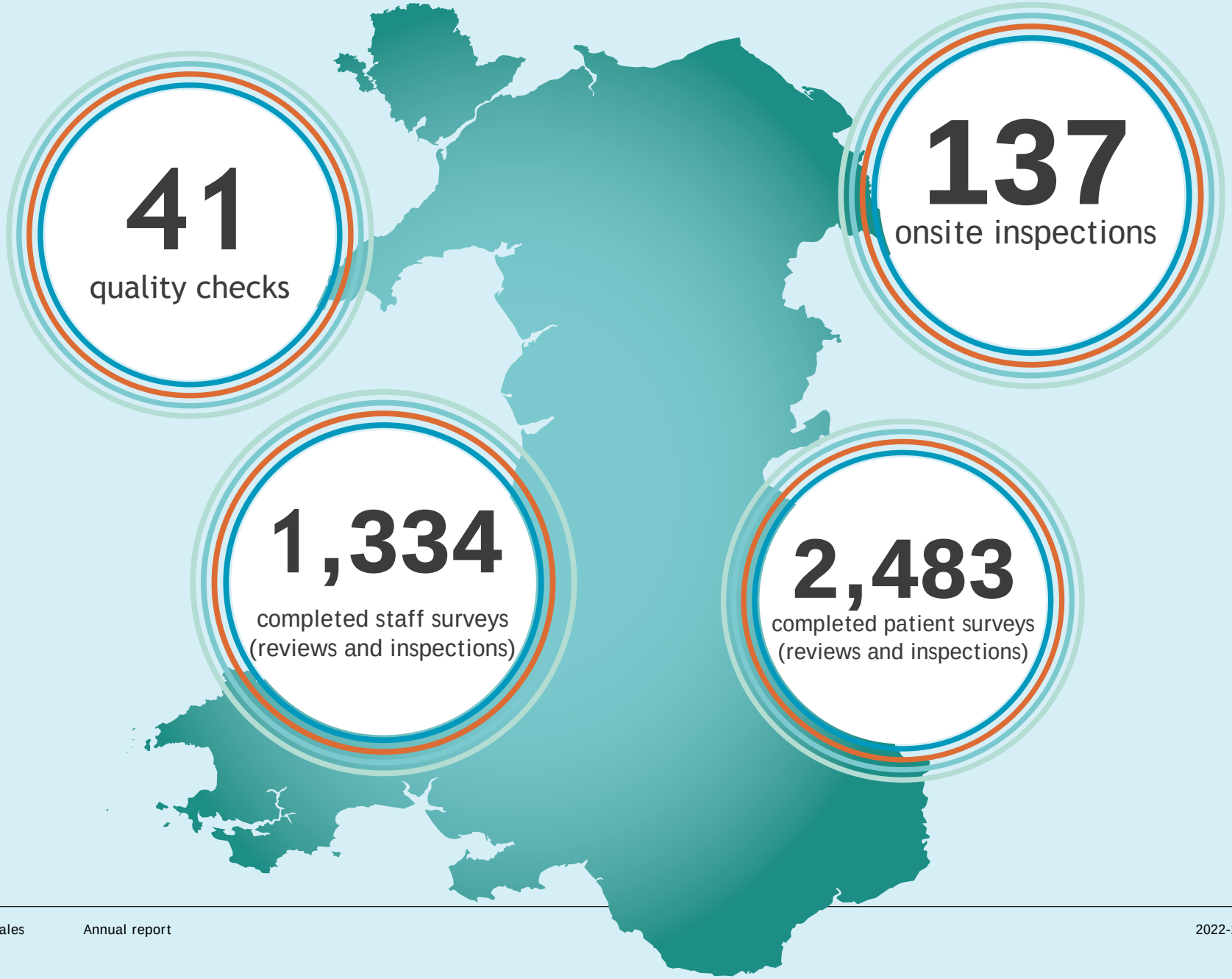
Now, more than ever, healthcare in Wales needs continued innovation, and a vision and understanding of what works and what does not. We have a clear role in illustrating, through our work, what good quality looks like within services and where we find issues with quality we will continue to shine a light on these, pushing services to put them right.

If you have any questions, comments, ideas, or feedback on our work, please do get in touch with us – we would love to hear from you.

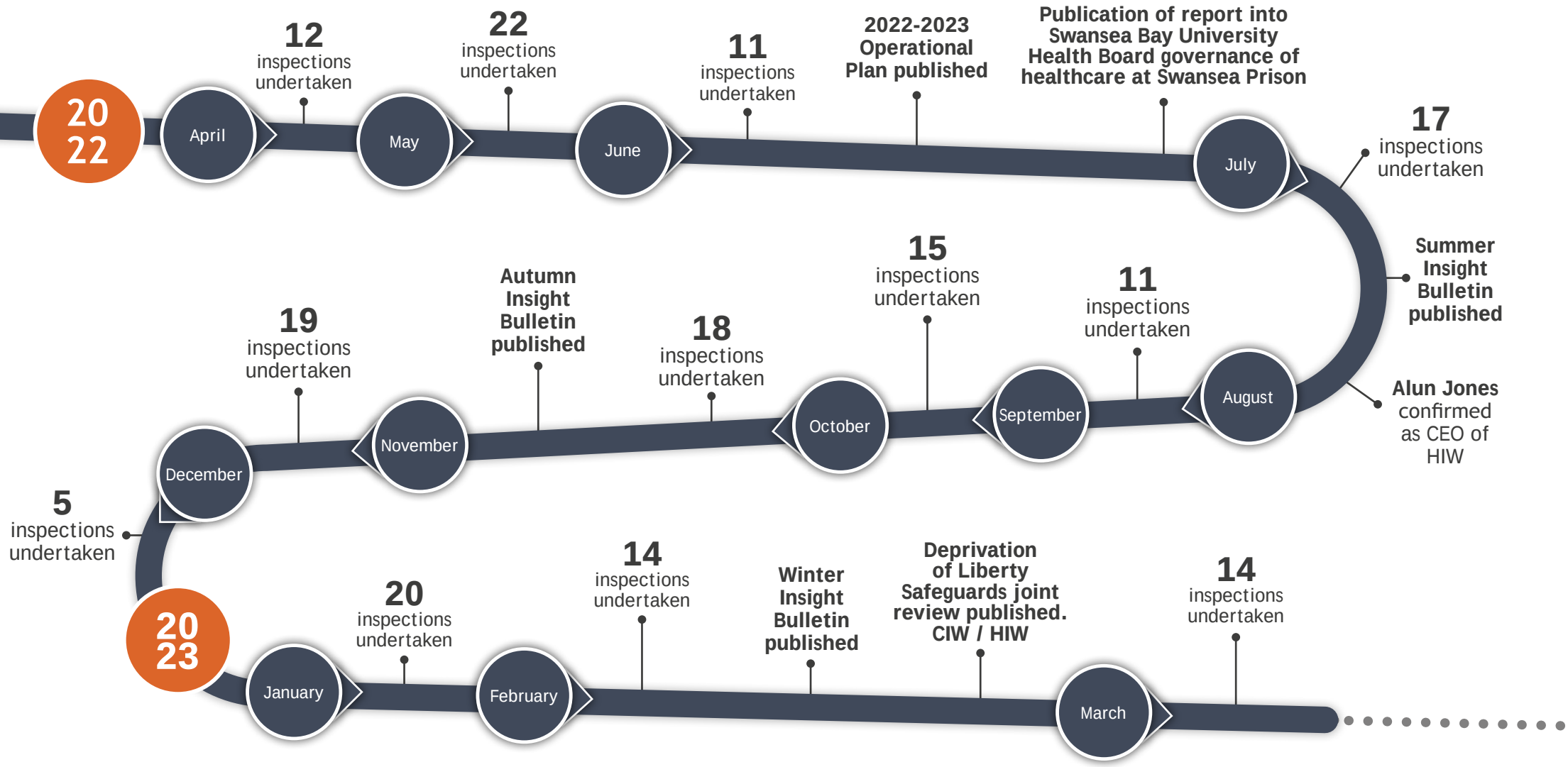
*Alun Jones*

Chief Executive
Healthcare Inspectorate Wales

# HIW in Numbers


41
quality checks
137
onsite inspections
1,334
completed staff surveys
(reviews and inspections)
2,483
completed patient surveys
(reviews and inspections)

## Timeline of our work



# Engagement and Collaboration

# Engagement

**Speaking and listening to people who use healthcare services and who work within healthcare services is a key priority for us, and something that we are also committed to improving on. By listening to people who use and work in services, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.**

Across our inspection, quality check and review work, 4,677 people gave us their views on the care they had received, or the service they were working within.

Of the 4,677 separate responses, 4,107 related to our inspection activity and 570 related to our review work.

We heard from:

- **2,633 patients overall**
- **1,826 staff overall**
- **99 Carers / family members**

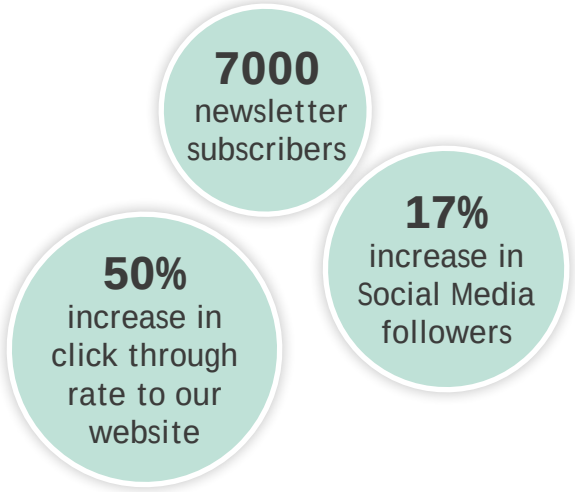
During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey. When we are able to speak to patients in person during onsite visits, we gather views directly. We are also now using videos on our social media channels to help explain and promote our work.

In February 2022, we launched on LinkedIn and in our first year we have reached 7k users. This channel is providing a useful additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. We have seen a 50% increase in people clicking through to our website from our social media posts. We aim to post varied and interesting content across all three social media channels, posting 1.5k times during the year and seeing a 17% increase in our followers.

This is not our only means of engagement, in the spring of 2022, we launched our new Insight Bulletin. This is a quarterly update which we issue electronically to over 7000 subscribers on our mailing list. Within this we summarise our work from the quarter, and in summer 2022, added a new Learning and Insight section to the bulletin, providing us with a central area to share themes and learning emerging from our work.

We implemented a new approach to report writing in April 2022 which involves publishing a public summary and a full detailed report for the setting. We also updated our report writing style, removing duplication, and making the content easier to read.

In early 2022, we launched our HIW Stakeholder Advisory Group. Membership of the group is made up of a wide range of organisations who work with and represent people with protected characteristics. We are immensely proud of this group and it has continued to strengthen during the year. The group has influenced the way in which we ask patients for feedback during inspections and reviews and has challenged us to think more critically about the way in which our work is both designed and delivered so that we are able to capture as diverse a range of views as possible. The group is one of the ways in which we are working towards our strategic priority of better understanding the quality of healthcare being delivered to people and communities as they access, use and move between healthcare services.



## Collaboration

**We place considerable importance on collaboration and joint working with other organisations. The added insight and expertise we can draw on when we collaborate with others increases the impact of our work. The provision of healthcare is complex and sharing intelligence with partners enables us to gain insight and experiences that, with our organisational resources alone, we would not be able to achieve.**

During 2022-2023, we hosted two Healthcare Summits, attended by regulatory and improvement bodies for healthcare across Wales. Healthcare Summit meetings take place bi-annually to enable discussion between audit, inspection, regulation, and improvement bodies.

They provide an interactive forum for sharing intelligence on the quality and safety of healthcare services provided by NHS Wales. The meetings enable us to foster close working relationships, and share intelligence between participating organisations as we all play our respective roles in driving healthcare improvement in Wales.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW). In February 2023 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The Safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care.

Since 2019, we have been part of Joint Inspections of Child Protection Arrangements (JICPA), working alongside Care Inspectorate Wales (CIW) plus Estyn; Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation) to carry out this work.

In 2022-2023, we continued this work and published our findings of a review of the multi-agency arrangements in Denbighshire for responding to cases of abuse and neglect.

The report outlines our findings about the effectiveness of partnership working and the work of individual agencies in Denbighshire.

In common with many areas across Wales, we found the challenges in recruitment and retention of staff across key agencies in Denbighshire was impacting on the arrangements for safeguarding children. This is made more difficult by the high levels of demand and increasing complexity of children's needs.

We found there are systems and relationships in place to facilitate effective partnership working where a child is at risk of harm. Partners are working to a shared ethos of safeguarding children at different levels of vulnerability. Organisational leaders have a shared vision with a positive approach to regional safeguarding arrangements.

This clear strategic commitment has resulted in the commissioning of a sufficient range of effective local services to support children and families.

# Assurance and Inspection Findings NHS Services

# Acute Hospital Inspections

## In 2022 – 2023, we carried out 19 acute hospital inspections across Wales.

We visited all Health Boards and Trusts where inpatient care is provided.

Our work showed that in general, the demand for inpatient beds and having enough staff to manage the high number of patients was a significant challenge.

The numbers show that we did more of our work in unscheduled care areas compared to scheduled care. The reason we did this was because of the complexity and overall higher risk level in these areas. Across these pieces of work, we needed to use our Immediate Assurance process in 58% of the inspections (11 out of 19). This is a highly concerning figure and demonstrates that at present, acute inpatient healthcare carries the highest level of risk in services across Wales. This figure is currently higher than we found in our inspections of mental health services, an area of healthcare which historically tends to see very high levels of patient risk. This latest finding indicates that mental health services are tackling the risks they face more successfully and strongly suggests that within inpatient acute care, more needs to be done to tackle risk, and quickly.

In the previous year, we introduced our Service of Concern process for the NHS. In 2022 – 2023, we considered 13 NHS services through this process which involves increased scrutiny of the issues identified through inspection and intelligence. In May 2022, we designated the Emergency Department at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as being a Service Requiring Significant Improvement (SRSI) which is a service with the most significant levels of risk.

Our findings on a national level, from our assurance and inspection activity were:

Huge demand for services continues

Compliance with mandatory training remains mixed and in general, across Wales, there are challenges in ensuring the workforce keep this up to date

The quality of the discharge planning process needs to be improved

Reducing risks within the inpatient environment is something that needs to be improved on. For example, we continue to find medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

In 2021-2022, our work found evidence of significant pressures in the emergency care system. In 2022-2023, our overall summary is the same and if anything, pressures have increased. These pressures mean that we have seen overcrowded emergency departments, delays in ambulance handover of patients, long waits for triage and long waits for treatment to start. This of course, is not the finding in all instances, but the cases where we saw delay represent the majority rather than the minority. The challenge for staff working at the front line within these emergency and urgent care areas is enormous and the impact on them is equally huge.

The challenge within planned care areas differs in that there are huge challenges in getting patients discharged to more appropriate placements, or back home with support. There are often delays in this due to shortages in social care staff and social workers to assess discharge needs. Patients frequently stay in hospital beds for a long time after they are medically fit to leave because of the unavailability of support services.

When patients are able to be seen and treated by emergency and urgent care services, then admitted and cared for as inpatients, and discharged as soon as they are medically fit, the outcomes for them are far more positive then when they are delayed at each stage of their journey. The delays being experienced lead to adverse patient outcomes in the form of deconditioning, higher risk of hospital acquired infections, loss of social networks and, the initial assessment of support needs on discharge no longer being accurate and needing to be repeated due to a change in condition.

This year, once again, we found that in planned care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care, there were fewer areas requiring improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

The case studies demonstrate two of our pieces of work from 2022-2023 relating to acute hospitals in the NHS. This work, challenged services and health boards to look for different ways of doing things when outcomes for patients could be improved.

CASE STUDY

## National Review of Patient Flow a journey through the stroke pathway

**Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. Our national review of Patient Flow continued during 2022 – 2023 to explore this.**

At a time when the NHS in Wales has continued to deal with significant pressure, staff shortages and huge demand for beds, the review explored the challenge of trying to provide timely care to confirmed stroke patients when resources are under such demand.

In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. National reviews are deep dive pieces of work which enable us to explore a service, care pathway, or department in depth.

During the period from April 2022 to the end of March 2023, we gathered evidence about the care and treatment provided to patients on the stroke pathway across Wales, undertaking nine site visits in total. The site visits involved our review team consulting with health boards in Wales including the Welsh Ambulance Service Trust (WAST), reviewing the processes in place from calling an ambulance to arrival at an emergency department, to admission when patients were receiving inpatient care and through to discharge.

The review found a high demand for inpatient beds and complexities involved in discharging medically fit patients from hospitals which led to the acute hospital system in Wales operating under extreme pressure. Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections or deterioration whilst awaiting discharge. The bottleneck at the point of discharge has a knock-on impact on emergency departments, ambulance response times, inpatient care, planned admissions and overall staff wellbeing.

CASE STUDY

## Inspection of Maternity Services, Glangwili Hospital, Hywel Dda University Health Board

**HIW completed an unannounced, onsite inspection of the maternity unit across three consecutive days in November 2022, this included the antenatal and postnatal wards, the midwifery led unit, the labour ward and the triage assessment area. Inspectors found the maternity care provided had improved since HIW's previous inspection in 2019, but there were still some areas which required attention.**

We found staff were committed to providing a high standard of care to patients. There were many examples where the inspection team witnessed staff being compassionate, kind and friendly to patients and their families. Most patients we spoke to told us they were happy and receiving good care at the hospital. Inspectors also noted that there were good arrangements in place to provide patients and families with bereavement support. We considered the quality of management and leadership, and the culture of the workforce, to be very good.

Staff were encouraged and supported to become involved in quality improvement projects to enhance the care provided, and to aid their ongoing development. Staff were positive about the support and leadership they received and described a positive culture around reporting and learning from incidents. Inspectors noted that the leadership team were visible, supportive, and very engaged with the staff. There was dedicated and passionate leadership displayed by the Head of Midwifery, who was described as energetic, approachable, supportive and visible. There was also a focus on staff wellbeing, including good welfare support and team building activities. Improvement had also been made to collaborate with other health boards effectively.

Some women on the post-natal ward indicated that when they required pain relief, it was not always given in a timely manner, or they were not given an explanation as to why they could not receive the medication. The health board must ensure that there is efficient, safe, and timely administration of pain relief for patients.

Inspectors evidenced improvements had been made regarding security measures to ensure babies were safe and fully protected within the hospital. However, on the first night of the inspection, inspectors noted that the cupboards containing patient records were unlocked and the doors were open. Inspectors immediately raised this with senior management and the cupboard doors were subsequently locked. Management must ensure staff are locking medication fridges and cupboards containing patient records when not in use. We also found that not all staff were compliant with mandatory training and that management needed to ensure rotas are reviewed to ensure there is sufficient resourcing.

Some staff we spoke with raised a concern in relation to the variance of responsiveness of consultants to an emergency when requested by junior doctors and midwives. This was also echoed by comments made in the staff survey we undertook.

We found that there had been significant improvements made since our previous inspection in 2019. There were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was achieved through a rolling programme of audit and an established governance structure, which enabled key/ nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Ongoing improvements need to focus on staff compliance with the clinical room processes, such as medication fridges being consistently locked when not in use and cupboards containing patient records being always locked.

## General Practice

**During 2022-2023 we carried out 20 pieces of assurance work to GP practices across Wales. nine of these used our remote Quality Check methodology and 11 were onsite inspections. We needed to use our immediate assurance process in 30% of these inspections (6 out of 20 pieces of work).**

This inspection year marked our first using our newly refreshed General Medical Practice (GP) methodology. The updated methodology considers the wider primary care landscape including referrals and signposting to other services.

GP practices are under significant pressure and are facing unprecedented demand. Long wait times at Emergency Departments and on long waiting lists for treatment are increasing the pressure on GP services. We used our immediate assurance process, reflecting high risk to patients, on more occasions during 2022 – 2023 compared to the previous year.

We found a range of issues such as:

- Incomplete safeguarding records and poor follow up of concerns
- Checks of emergency equipment and drugs not completed
- No DBS checks on staff including administrative and reception staff
- Medicines not safely stored
- Medication fridge temperature checks not completed
- Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control
- Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles, some of which were dated 2006.

**20** pieces of assurance work

**11** Onsite Inspections

**9** Quality Checks

Our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but around a quarter of patients tell us they struggle to access an urgent appointment.

Difficulty in accessing GP appointments was one of three clear themes to come out of our HIW Concerns service during 2022-2023.

The effects of delayed appointments on patients encompass physical health, emotional well-being, and overall healthcare experiences.

Delayed access to medical care can lead to worsened health conditions. Conditions that could have been treated effectively with timely intervention might deteriorate, resulting in prolonged suffering, increased complications, and potential long-term consequences. Chronic conditions may worsen, requiring more complex interventions and leading to avoidable hospitalisations.

Patients who struggle to obtain appointments often experience heightened anxiety and stress. The uncertainty of not knowing when they can see a doctor can exacerbate existing mental health conditions or trigger new ones. This emotional toll can further impact their ability to cope with health issues and make informed decisions about their care.

Frustrated by the inability to secure timely appointments, some patients may resort to using emergency services for non-urgent issues. This strains emergency departments and diverts resources away from patients with genuine emergencies.

It is crucial that leaders within this area consider the repeated concern from patients who are unable to access the service and consider what else can be done to alleviate the pressure on GP services.

# Mental Health

**We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.**

During 2022 – 2023 we undertook 20 pieces of work to mental health care services across Wales. Out of these, 16 were onsite inspections to inpatient units, 3 inspections of Community Mental Health Teams (CMHT's) and one larger piece of review work to Cwm Taf Morgannwg Mental Health service. Across these 20 pieces of work, we used our immediate assurance process on seven occasions, this represents 35% of the work where issues found at inspection and review carried the most immediate risk to patients.

A positive area across the majority of our inspections was the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving.

Patients who are in an acute and/or challenging phase of their illness may require a degree of effective observation to ensure that their safety and the safety of others is protected. Staff must deliver a holistic plan of care in the least

restrictive way, balancing this with a risk-based approach. In four of our visits to hospitals, within health boards, we identified a lack of managing aggression/physical intervention training for staff, including bank staff. This is a significant issue because well trained staff decrease the incidents of patients and staff being injured during a restraint.

We found that patient records did not always evidence episodes of patient restraint accurately, and observational charts were not always being kept up to date.

There was also lack of staff training and guidance in this area, and during one inspection, a complete lack of any patient engagement for extended periods of time.

We found little improvement to the following areas, despite raising these in 2021-2022:

- workforce challenges – issues with recruitment and retention of staff
- medicines management – a range of issues with the storage, administration and audit
- patient observations – lack of effective recording, training of staff and the timely review of policies/procedures
- patient information – lack of information available for patients on key topics
- risk assessments and care planning documentation – including risk assessments not completed and lack of a timely review
- environment of care – a lack of audits and the management of environmental ligature risks
- governance - a lack of audit and oversight of key areas including training.

Difficulty accessing mental health services was a key theme to emerge from our HIW Concerns team which hears directly from members of the public. We repeatedly heard of the difficulty in getting support from mental health services and of the poor outcomes for patients who have not received the level of support that was needed.

The inability to access mental health services can lead to the deterioration of mental health conditions. Individuals grappling with anxiety, depression, bipolar disorder, or other mental health issues may experience worsening symptoms in the absence of proper care and support. This deterioration can impact all aspects of life, from work and relationships to physical health.

Without timely intervention, individuals facing mental health challenges are at a higher risk of experiencing crisis. Delayed access to mental health services can extend recovery times for individuals dealing with mental health disorders. Early intervention is often crucial in managing and alleviating symptoms. Protracted delays in receiving treatment may prolong suffering and hinder the individual's ability to regain stability and functioning. Mental health challenges affect not only the individual but also their families and communities.

CASE STUDY

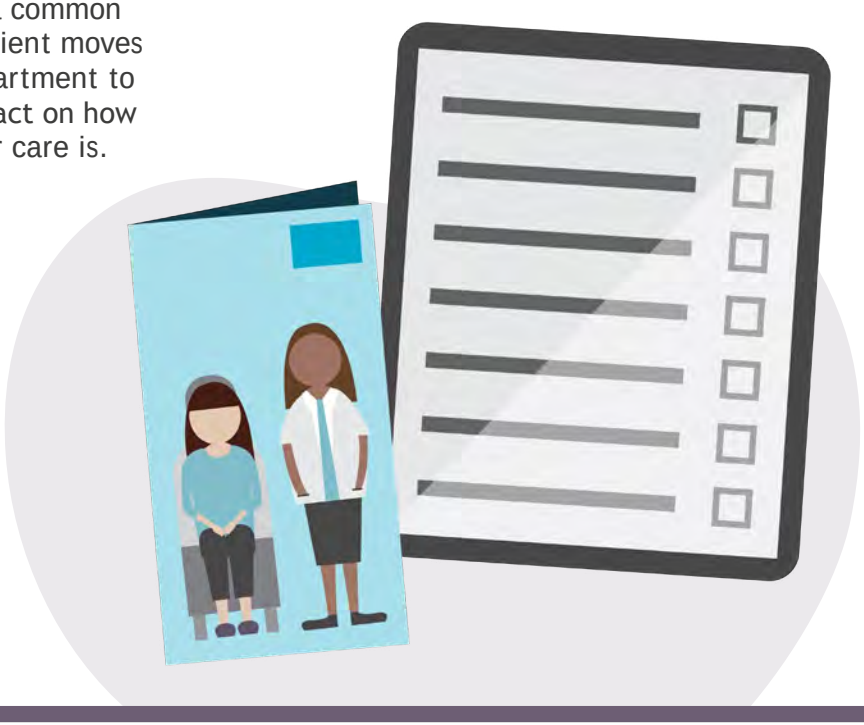
# Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

**We reviewed the discharge arrangements for adult inpatients on mental health wards in Cwm Taf Morgannwg University Health Board (CTMUHB) from adult (18-65) inpatient mental health units. The decision to undertake the review was made as a result of intelligence indicating significant concerns about the health board's mental health services. This included serious incidents, issues identified through previous HIW inspections, and concerns reported to HIW by patients, the public and staff whistle-blowers.**

The review focussed on the quality and safety of discharge arrangements for adults discharged from inpatient mental health units into the community. The review considered the relevant policies and procedures in place, an evaluation of patient records, and information gained through interviews with a range of staff who worked within the health board's mental health services.

As a result of the review, HIW made 40 recommendations for improvement. Some patient safety concerns were of such significance, the health board was issued with an immediate assurance letter, following which, it was required to submit an immediate improvement plan to HIW.

We found evidence of highly complex systems which made the delivery of timely and effective patient care more challenging. As with our National Review of Patient Flow, a common thread was that at the point a patient moves from the care of one team or department to another, there is a significant impact on how timely and well co-ordinated their care is.



## Learning Disability Services

**HIW undertook three inspections of facilities providing learning disability services. Within these inspections, we noted a range of positive findings including, staff interacting and engaging with patients appropriately and patients being treated with respect and dignity. In addition, there was a range of suitable community-based activities available for the patient group. However, we did find that staffing numbers were not always at a level which met patient needs.**

Although this was a small number of inspection visits, we did find issues of concern in one of the three services inspected. There were risks to patient safety within this unit due to ligature risks not being managed appropriately.

**3**
Onsite Inspections

## Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

**Medical ionising radiation is used in many healthcare settings, including dental practices and widely within hospital care. It is used to diagnose injuries and illnesses as well as being a form of treatment, for example x-rays and radiotherapy treatment.**

It is a highly technical area of healthcare, that used carefully and in accordance with the regulations has huge benefits but there is potential for harm if it is not used safely.

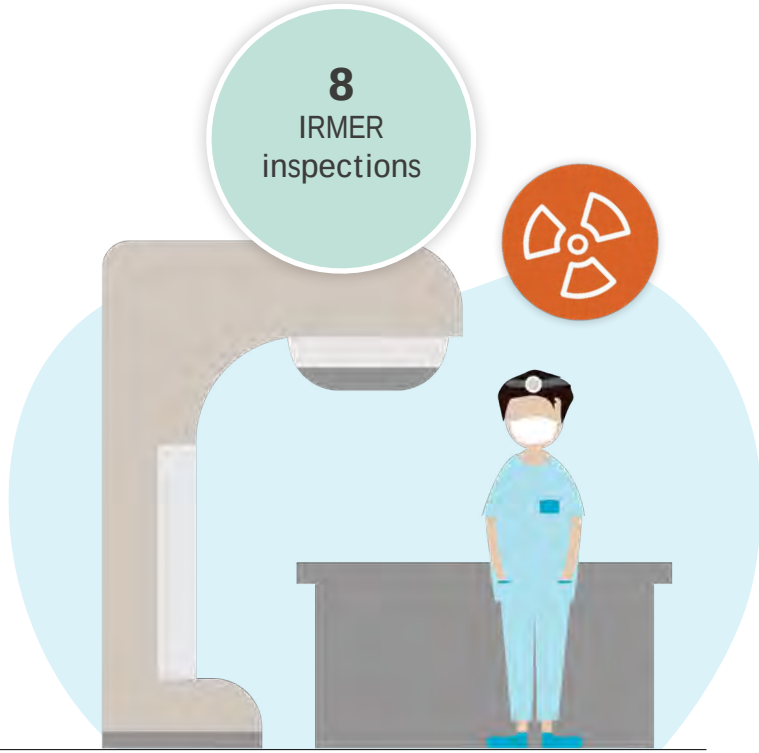
HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation and they set out the responsibilities of those undertaking the procedures which use ionising radiation. Within the regulations, these individuals are called duty holders and will comprise of the employer, referrer, IR(ME)R practitioner and operator. Their responsibilities are to meet safety standards and ensure radiation protection, for example, minimising unintended, excessive, or incorrect medical exposures.

During 2022-2023 HIW completed eight IR(ME)R inspections, covering the three modalities of medical exposures. These inspections also covered both NHS and independent hospitals.

HIW was assisted in these inspections by a member of the Medical Exposures Group (MEG), which is part of the UK Health Security Agency (UKHSA), acting in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. Radiology areas were good at letting patients know of waiting times and any delays in being seen, patients told us they appreciated this. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R. There was a need to improve the written procedures governing the use of ionising radiation and required against the regulations in this area.

We heard from some staff who felt there were insufficient numbers of them to do their job well and to achieve a good work-life balance. We also heard that they did not always feel listened to by management when they raised this. Although more generally, staff told us they felt very well supported in their work by senior management and the wider organisation.



## Dental Practices

**During 2022-2023, we undertook 74 pieces of assurance work to dental practices across Wales. Out of these, 44 pieces of work were conducted onsite at the practices, where a HIW team including a qualified dentist working as HIW dental peer reviewer, spent time examining the practices, policies and procedures which governed the way each practice was run. We also conducted 30 quality checks which are our remote method of seeking assurance, first developed at the height of the COVID-19 pandemic. The composition of work represented a huge shift back to our teams carrying out onsite inspection work. The 44 onsite pieces of work in 2022-2023 compares to just 9 undertaken onsite in 2021-2022.**

Difficulty in accessing dental appointments and securing a regular dentist was one of three key themes to emerge from our HIW Concerns service this year. Securing timely access to dental care is a critical component of overall health and well-being, yet the difficulty in obtaining dental appointments has become a pressing concern with far-reaching consequences. Factors such as limited availability of dental providers, high demand for services, and changes to dental contracts have all impacted patients' ability to access timely dental care and treatment.

Evidence clearly identifies that delayed or infrequent dental appointments can lead to the progression of oral health issues. What might initially be a minor dental concern could develop into a more complex problem, requiring more invasive and costly treatments. Oral health is closely interconnected with overall health. Dental issues such as gum disease have been linked to systemic conditions like heart disease, diabetes, and respiratory problems.

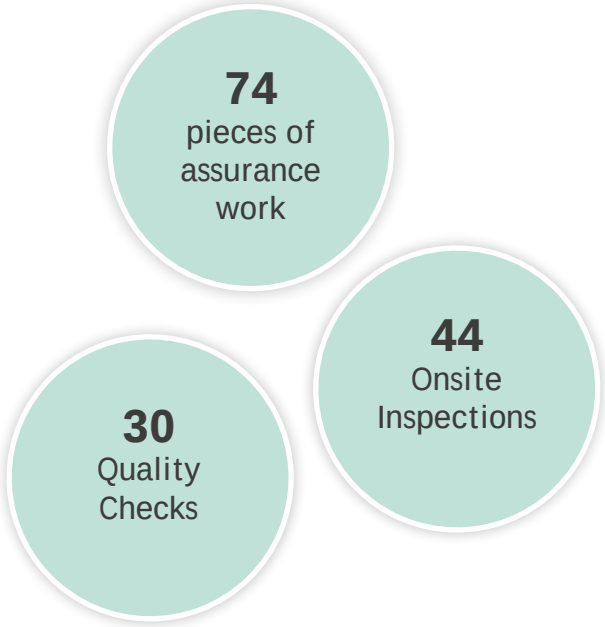
Delayed access to dental care can result in prolonged discomfort and pain for patients. Toothaches, gum sensitivity, and other oral pain can significantly impact daily life, affecting eating, speaking, and even sleeping. The physical discomfort can also contribute to emotional stress and reduced quality of life.

Frustration over delayed dental appointments can lead some patients to seek relief through emergency dental services or hospital emergency departments. This not only strains healthcare resources but often also results in only temporary measures rather than comprehensive treatment.

Regular dental appointments provide opportunities for oral health education and preventive guidance. When patients are unable to access these appointments, they miss out on valuable information about maintaining proper oral hygiene, which can further contribute to deteriorating oral health.

Across all 74 pieces of work, we used our Immediate Assurance process on 6 occasions. This means that in 8% of our work to dental practices in 2022-2023, we came across concerns which had the highest level of risk to patient safety and therefore needed action to be taken and assurance of this action provided to HIW within 48 hours.

We also made a substantial number of recommendations for improvement. The key themes emerging from our dental inspections are described below:



**We identified a number of key themes through our dental inspection and assurance activity:**

**Environmental:**

- A poor standard of cleanliness in decontamination areas. In some practices HIW Inspectors uncovered ineffective decontamination processes, including inadequate cleaning of instruments and ineffective use of 'dirty/clean' pathways.
- We reported inappropriate storage of items in clinic and decontamination rooms such as food and cleaning materials, including high numbers of clinical fridges containing non-clinical items such as food and out of date medication. Practices should ensure there are procedures in place to reduce the risk of contamination and to support good standards of infection prevention and control.
- There were numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency and quality of care and treatment that is provided to patients, and they are a quality improvement tool, which can provide many benefits and support better practice.
- A number of practices did not have a system in place which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date and fire drills were not being carried out and evidenced. Risk assessments are an important management tool, which help to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.
- During some inspections, we highlighted the poor maintenance of first-aid kits, emergency drugs and resuscitation equipment – some included out of date items posing a significant risk to patients.

**Staffing**:

- The majority of dental practices needed to improve their documentation when recording staff training and evidencing that all staff had completed mandatory training sessions.
- Annual appraisals, clinical supervision and staff meetings were often overlooked. We recognise these aspects have been challenging to maintain at times during the COVID-19 pandemic, but practices must continue to prioritise this to support their staff.

**General:**

- Through our assurance work, inspectors did note practices had out of date or incorrect information on informative literature including patient care leaflets. Practices should conduct regular audits of materials to ensure the information available to patients and staff is relevant and accurate.

# Assurance and Inspection Findings Independent Healthcare

**HIW's role in the independent healthcare sector in Wales is to register and regulate independent healthcare services. The independent healthcare sector encompasses a huge variety of services, from acute hospitals, mental health hospitals, to independent clinics and laser services. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry.**

Independent healthcare services must register with HIW, and once they are successfully registered, they will be subject to ongoing regulation which is done through inspections and checks that providers are meeting the requirements of their registration, complying with the relevant regulations and providing a safe service.

During 2022 – 2023, HIW registered 53 independent healthcare providers. This number included new dental practices and new laser clinics. In total, we had 21 additional services registered with us by the end of the year.

Once registered, any changes a service intends to make to their conditions of registration, requires an application to vary what they are registered to provide. An application to vary a registration will not automatically be approved. Each application involves scrutiny by HIW as to the appropriateness of the proposed changes. During 2022-2023, HIW processed and approved a total of 24 registration variations.

In addition to this, all independent healthcare services have a manager who goes through a registration process to enable them to run a service. In 2022-2023, HIW processed and approved 88 new managers of independent healthcare services.

Registration activity:

**53** new providers registered

**24** variations of registration approved

**88** new registered managers approved

During the 2022-2023 period, we responded to intelligence which suggested there were 24 unregistered providers, across a range of different service types, operating services they were not registered to provide. We followed up each of these cases, requiring the provision of services was stopped until a registration with HIW had been successfully processed.

Where inspections or intelligence indicate serious concerns in registered services, we monitor them through our Service of Concern process. We monitored 26 independent healthcare services through this process during 2022-2023. Whilst not all of these were designated as a Service of Concern, they were all subject to increased scrutiny which triggered follow up assurance and inspection work as required.

In order to check that registered services are continuing to meet the requirements of their registration, and providing a safe, quality service to patients, HIW undertakes a programme of inspection work each year.

In 2022 – 2023, we undertook a total of 31 individual pieces of assurance work to independent healthcare settings. This figure can be broken down further into:


Eight inspections to independent mental health services and 74 dental practice inspections were completed. These are discussed elsewhere in the report.

Our Immediate Assurance process was used in two of seven inspections to independent clinics, a rate of 29%. Improvements required included carrying out a health and safety risk assessment; ensuring evidence of cleaning schedules is recorded, and improving infection, prevention and control arrangements. Recommendations were also made at some independent clinics to improve the feedback process with patients, ensuring that feedback is actively sought and reviewed, and ensuring that complaints procedures are up to date and readily available in the event patients need to use them.

We carried out one inspection to a non-acute independent hospital. This was to PCP Cardiff, a drug and alcohol detoxification and rehabilitation service providing residential treatment on a private basis. Patients receiving treatment there were very complimentary of the staff and the care they were receiving. We found that the service was not adequately managing the risk of ligature and needed to improve medicines management procedures. We issued a non-compliance notice, requiring remedial action within 48 hours of our inspection in order to rectify this. The service was receptive to our findings and complied with the urgent improvements required.

## Hospices

**Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured.**

During 2022 – 2023, we completed:

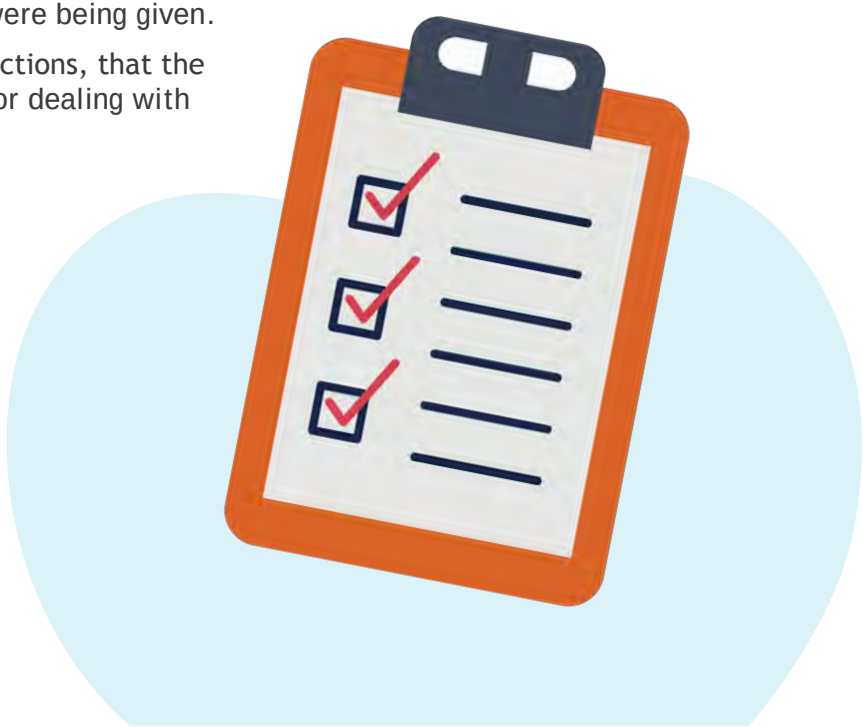
**3**

Onsite inspections to hospices in Wales comprising both adult only hospices and one hospice providing care to children. All three are provided by the independent healthcare sector.

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Without exception, we found evidence of positive interactions between staff, patients and their families and carers. The care provided was tailored and clearly person centred. Care plans were updated regularly and evidenced changes in condition and any treatment changes. Families and carers who provided us with feedback were very positive about the experience of care being provided, and the support they were being given.

We did find across all three inspections, that the equipment and medication kits for dealing with medical emergencies needed to be better maintained and kept updated. These kits are used in for example, an adverse reaction to medication. All three services were highly receptive to our findings and have addressed this.



# Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

**During the year 2022-2023, we conducted 19 onsite inspections to laser and IPL registered providers across Wales.**

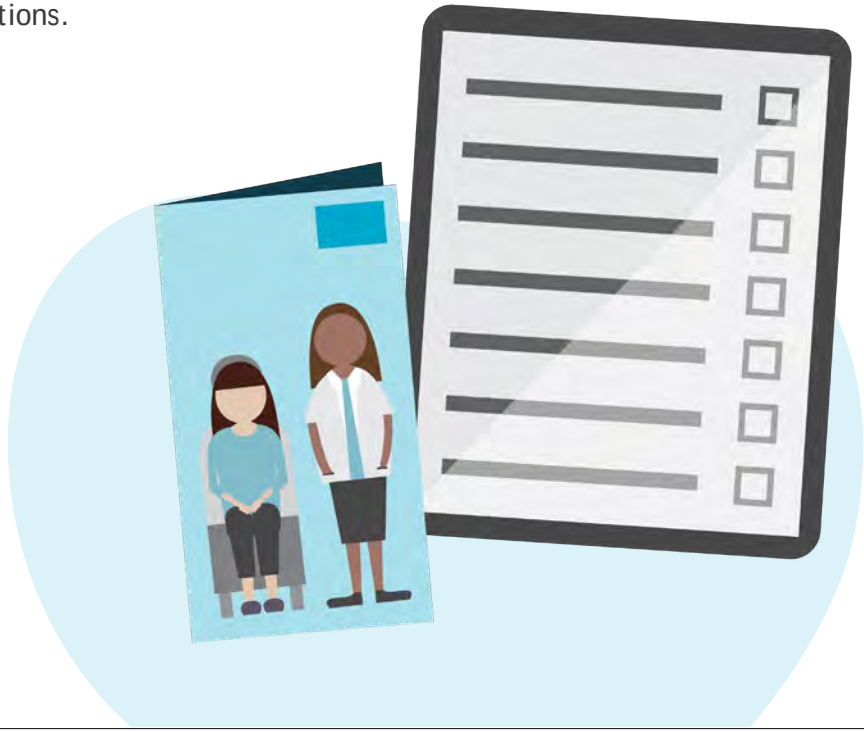
From these 19 inspections we identified non-compliance with relevant regulations in six cases. This means that in 32% of these inspections, we found laser and IPL providers were not meeting all the requirements they need to comply with in order to meet the requirements of their registration. The issues we found required us to use our Immediate Assurance process and request urgent action.

These included, using machines which they were not registered to use, treating patients outside of the age range they were licensed to treat and having no first aider.

The regulations under which laser and IPL providers are required to operated are specific and require them to comply with a number of areas in order to demonstrate their fitness to provide these services. We found a number of areas where we were repeatedly making recommendations for improvement through these inspections. In general, these related to the governance arrangements for these services. Good governance helps to ensure services are safe for the public to receive. Laser and IPL providers should therefore ensure they are familiar with their responsibilities against the regulations. The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

In a number of cases we found that the correct documentation, such as written policies and procedures were not available, or were not kept up to date. Staff training records and recruitment records also needed improving in some cases. The provision of a first aider, appropriately trained first aiders and an up to date first aid kit were also recommendations made in a number of these inspections.

**19**
onsite
inspections



# Findings from Concerns, Investigations and Notifications

Three key themes have come through our concerns:

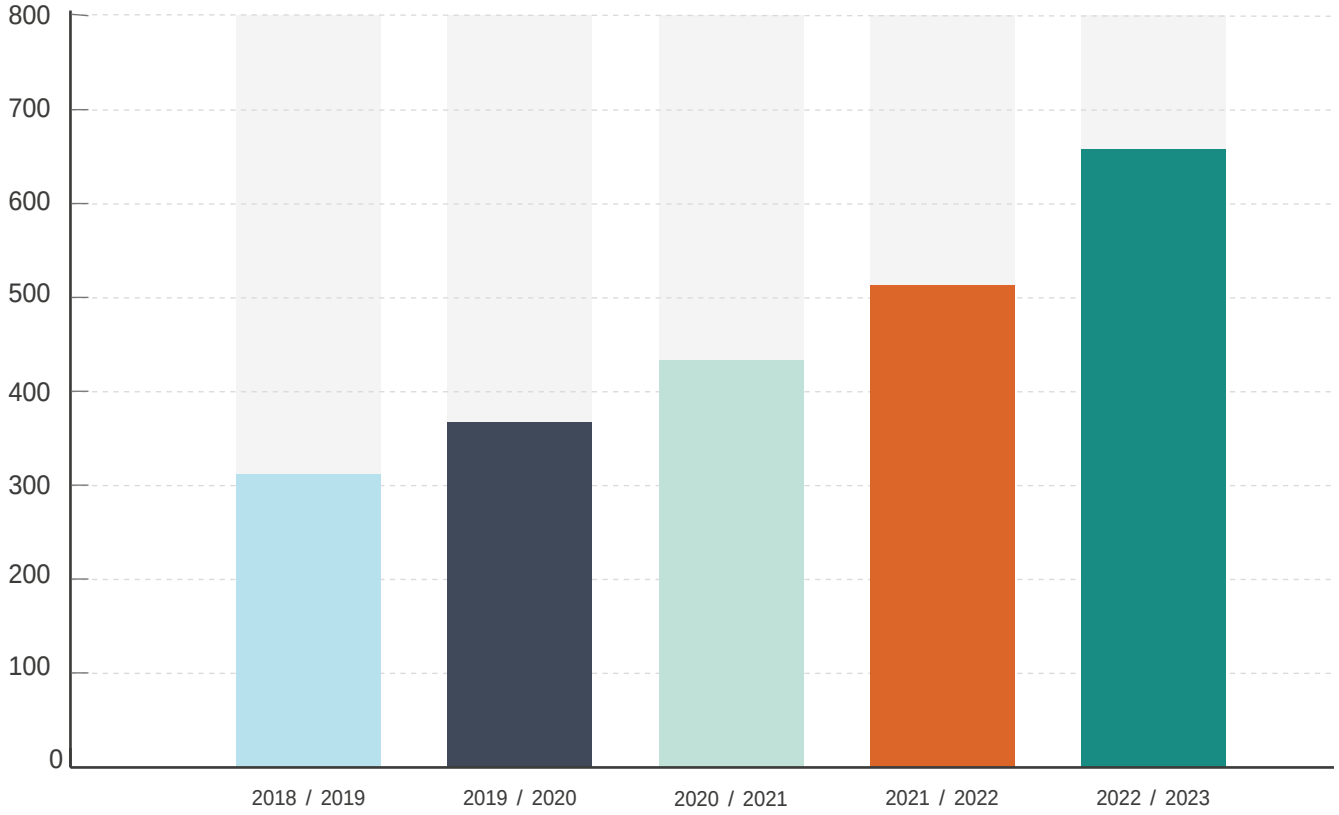
- Access to GP appointments
- Access to dental appointments / care and treatment
- Mental Health appointments and access to services

Complaints play a crucial role in identifying issues and fostering improvement within the healthcare sector. Feedback, often conveyed through complaints, provides valuable insights into areas of concern, inefficiencies, and lapses in quality. These grievances shed light on both systemic and individual problems, ranging from administrative processes to clinical care standards. By addressing and analysing complaints, healthcare organisations can pinpoint recurring patterns, root causes, and potential risks.

The concerns we receive provide an important opportunity to identify problems within a healthcare service. The intelligence received from these concerns enables an evaluation of risks to be identified and conceptualised. Consequently, HIW places significant importance on the intelligence received from concerns and uses it to drive its inspection and assurance activities.

As an organisation HIW is committed to managing concerns fairly, efficiently, and effectively. In total we received 659 concerns from 1st of April 2022 to 31st of March 2023. This represents an increase of 145 concerns compared to the previous year which equates to a 28% increase in the number of concerns received. Over the last 5 years we have seen a 111% increase in the number of concerns received.

The last 5 years of numbers of concerns

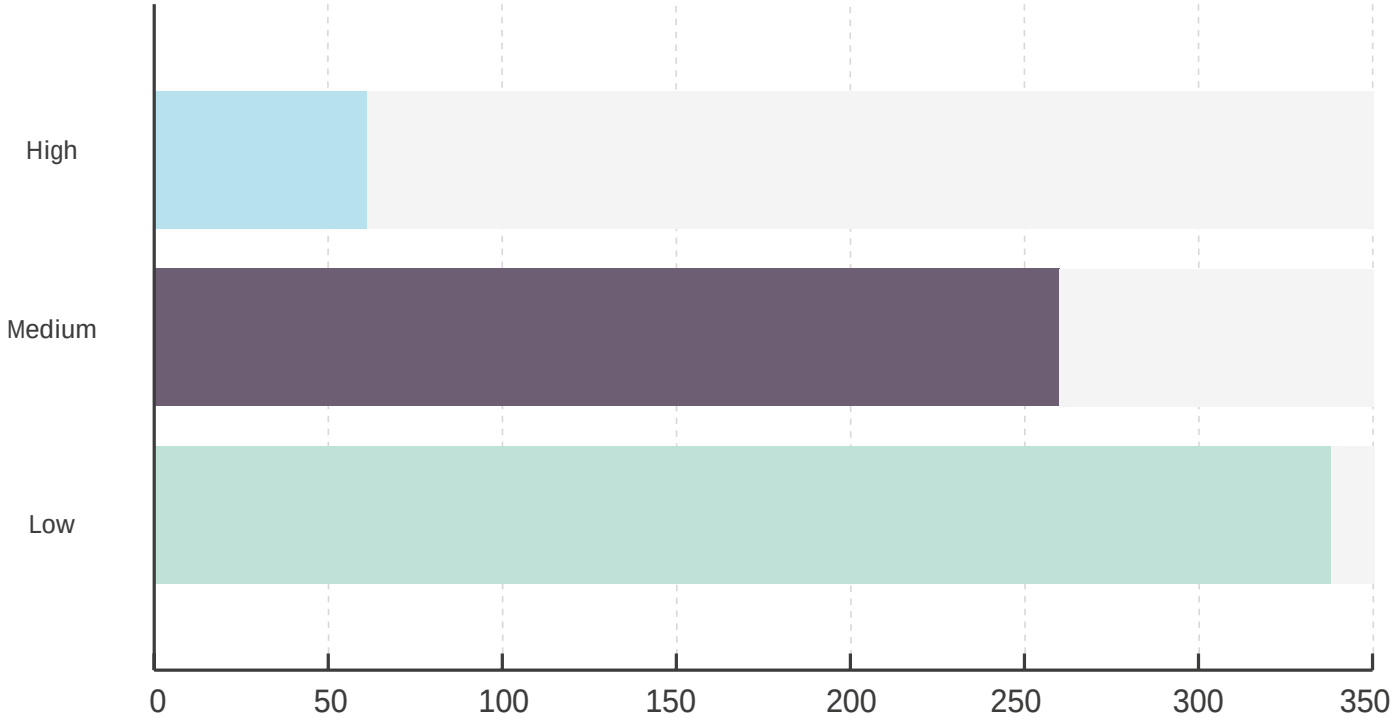


High-risk concerns require immediate action and response within 2 working days, either by HIW or another agency. Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days. Low-risk concerns are those concerns that are generally dealt with by way of signposting towards NHS Putting Things Right processes or the respective local complaints process for independent health providers, with responses being be actioned within 7 working days

The number of high risks concerns received has increased considerably over recent years.

We have experienced a **258%** increase in the number of high-risk concerns received compared with 2021-2022

## Risk level of concerns received



HIW responds immediately to all high-risk concerns. This can be in the form of immediate escalation to the health boards / trusts or independent healthcare settings. In addition, some high-risk concerns require the immediate intervention via safeguarding structures or the police.

## Abbreviations

**ABUHB**
Aneurin Bevan University Health Board (UHB)

**BCUHB**
Betsi Cadwaladr UHB

**CVUHB**
Cardiff and Vale UHB

**CTMUHB**
Cwm Taf Morgannwg UHB

**HDdUHB**
Hywel Dda UHB

**IHC Settings**
Independent Healthcare Settings

**PTHB**
Powys Teaching Health Board

**SBUHB**
Swansea Bay UHB

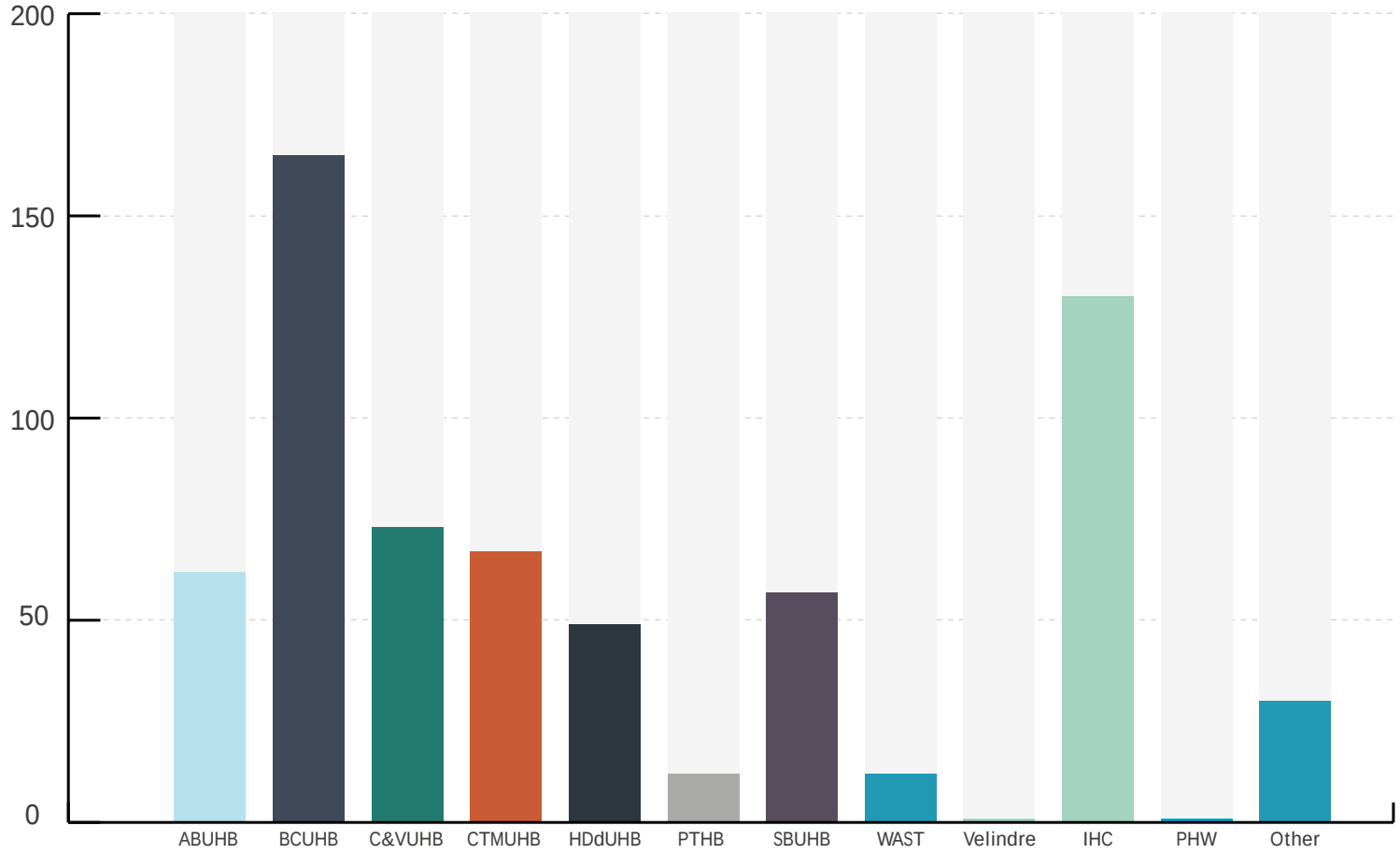
**PHW**
Public Health Wales

**Velindre**
Velindre University NHS Trust Welsh

**WAST**
Ambulance Services NHS Trust

**IHC**
Independent Healthcare

### Location of concerns



## Whistleblowing Concerns

**25** received for 2019-2020

**100** received for 2020-2021

**61** received for 2021-2022

**133** received for 2022-2023, an **85% increase compared** to previous year.

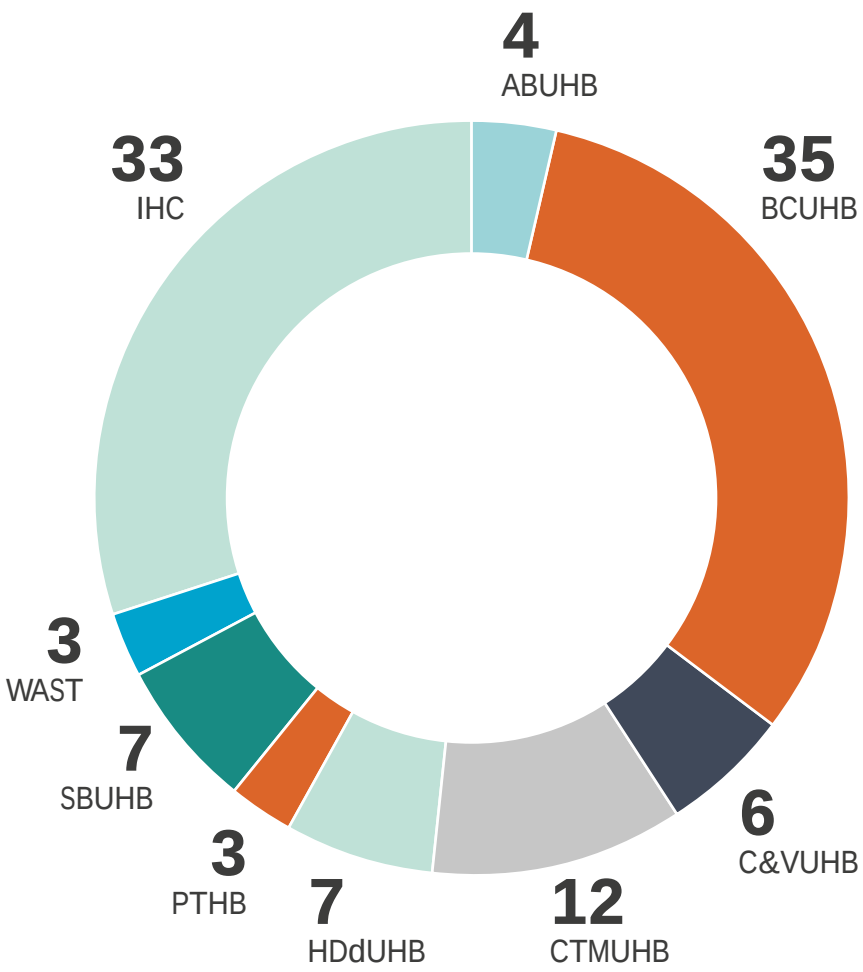
## What is whistleblowing?

Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality, or risk in the organisation. These concerns can affect patients, the public, other staff, or the organisation itself.

Whistleblowing applies to raising a concern within the organisation as well as externally, such as to a regulator like HIW. HIW has a special role for people who are thinking about "blowing the whistle" about concerns they have about wrongdoing in healthcare in Wales. HIW is a "prescribed body" under the whistleblowing laws, so employees, former employees, temporary agency staff or contractors who bring us concerns about their employer's activities can have some protection for their employment rights.

All healthcare professionals must follow their professional code of conduct and we would always recommend that they raise their concern within their own organisation first. However, if they feel unable to do this, or have already gone through this route, we will listen to the concern and explain how we can help. We may need to pass on the information they give us to another organisation or regulatory body if it is more appropriate for them to investigate the concern.

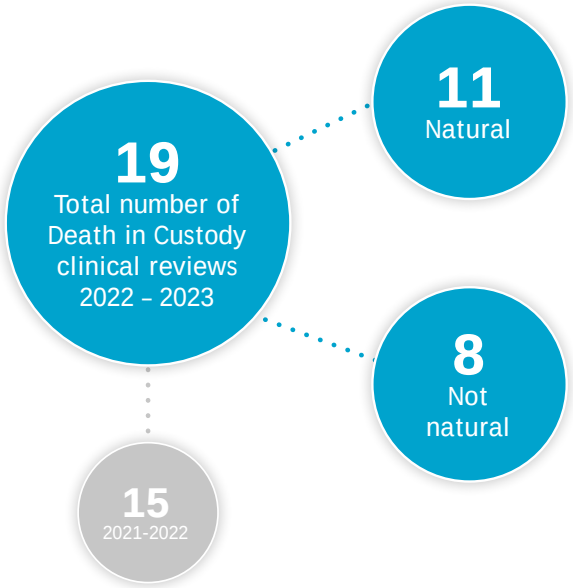
### Location of Whistleblower 22/23



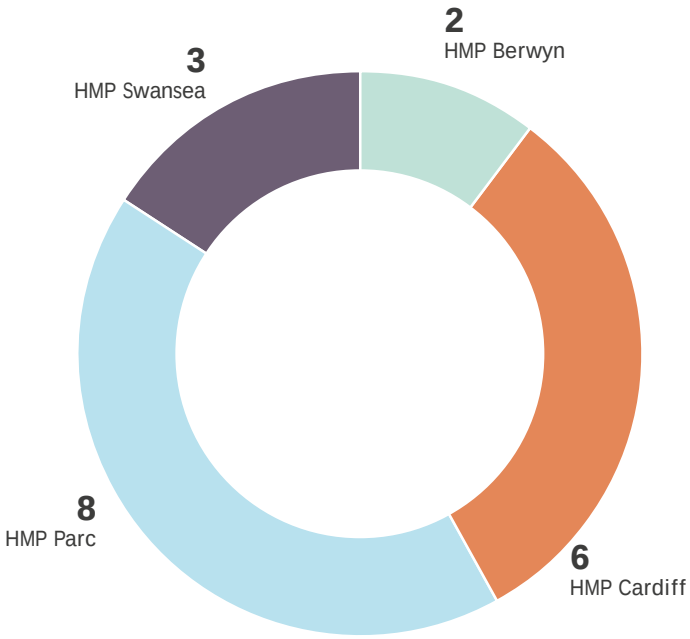
## Death in Custody

**Every death that takes place in a prison or other authorised location in Wales is subject to an examination by the Prisons and Probation Ombudsman (PPO). HIW assists these inquiries by conducting a clinical review of each death that occurs in a Welsh prison or other authorised location.**

The fundamental goal of our clinical reviews is to assess and evaluate the level of care and medical treatment given to inmates while they in a prison or other authorised location. We aim to evaluate whether the care and treatment provided was equitable to what a person in the community could expect to receive.




Location of death:




## Common Theme

**A common theme identified in our reviews is the failure of prison healthcare staff to record a full set of baseline observations (vital signs) during the very early healthcare screening appointment that prisoners will have on, or shortly after arrival.**

Having a comprehensive set of observations for a prisoner at the start of their incarceration is crucial. These measurements offer important insights into the body's functioning, helping healthcare professionals detect any changes. When a prisoner becomes unwell, regular clinical observations also need to be taken so that abnormalities can be spotted, and deterioration can be recognised and acted on. When this does not happen, there can be poor outcomes for patients.

## Notifications

**Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.**

The total number of regulatory notifications received in this reporting period is 1,847. This figure includes notifications against the following set of regulations:

- Independent Healthcare Regulations (IHC)
- Private Dentistry Regulations (DR)
- IRMER Regulations

A breakdown of the grand total shows the following number of notifications against each of the regulations:

**IHC Regulations**
**1,713**

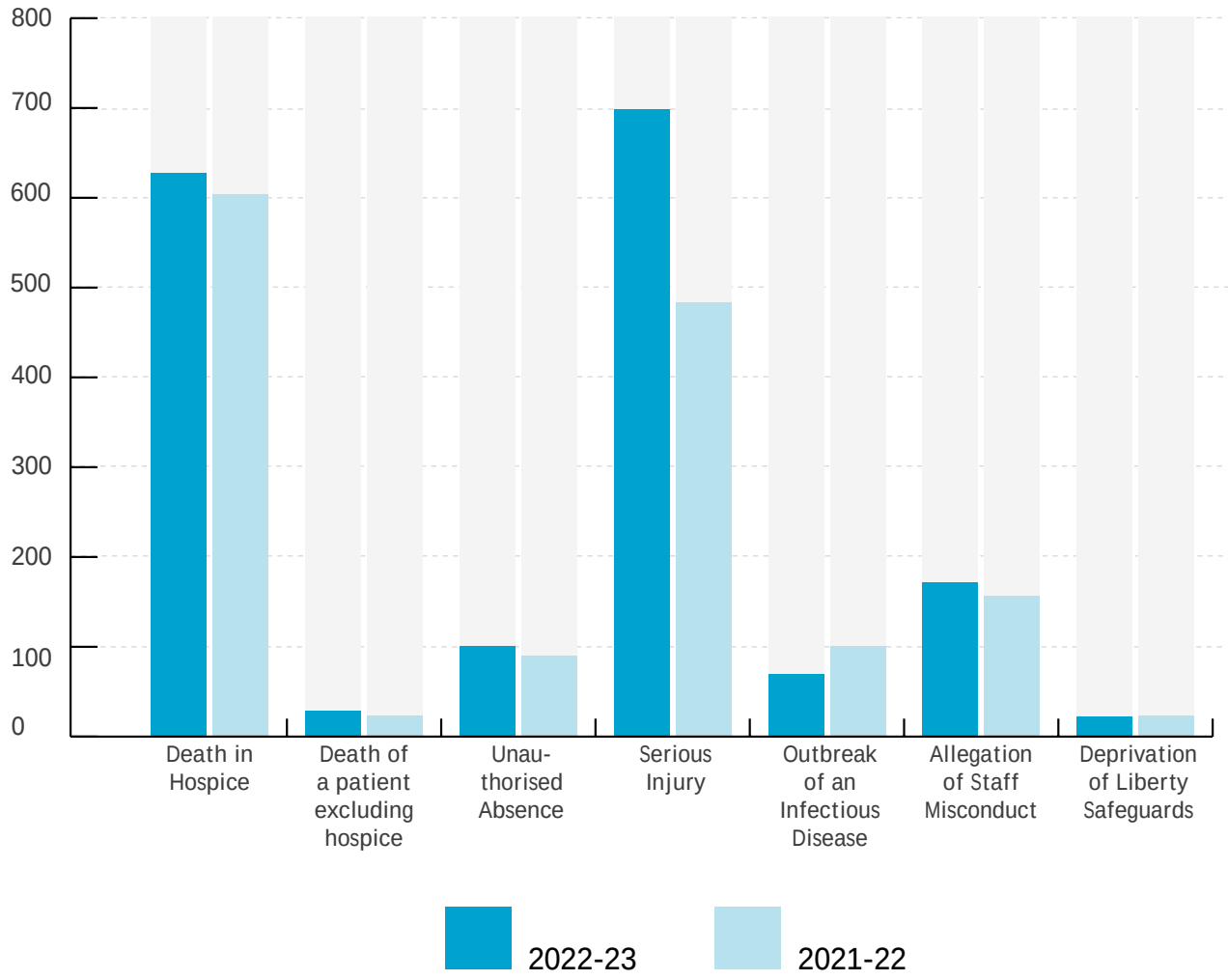
**Private Dental Regulations**
**32**

**IRMER Regulations**
**102**

Each regulation has its own reporting threshold. IHC Regulation 30/31 includes the following categories:

- **Death in Hospice**
- **Death of a patient excluding hospice**
- **Unauthorised Absence**
- **Serious Injury**
- **Outbreak of an Infectious Disease**
- **Allegation of Staff Misconduct**
- **Deprivation of Liberty Safeguards**

The graph shows a breakdown of the number of notifications received against each category and provides a comparison to the same reporting period last year.



## Private Dentistry Regulation

Includes the following categories,

**Serious Injury**

**Outbreak of Infectious Disease**

**Allegation of Staff Misconduct**

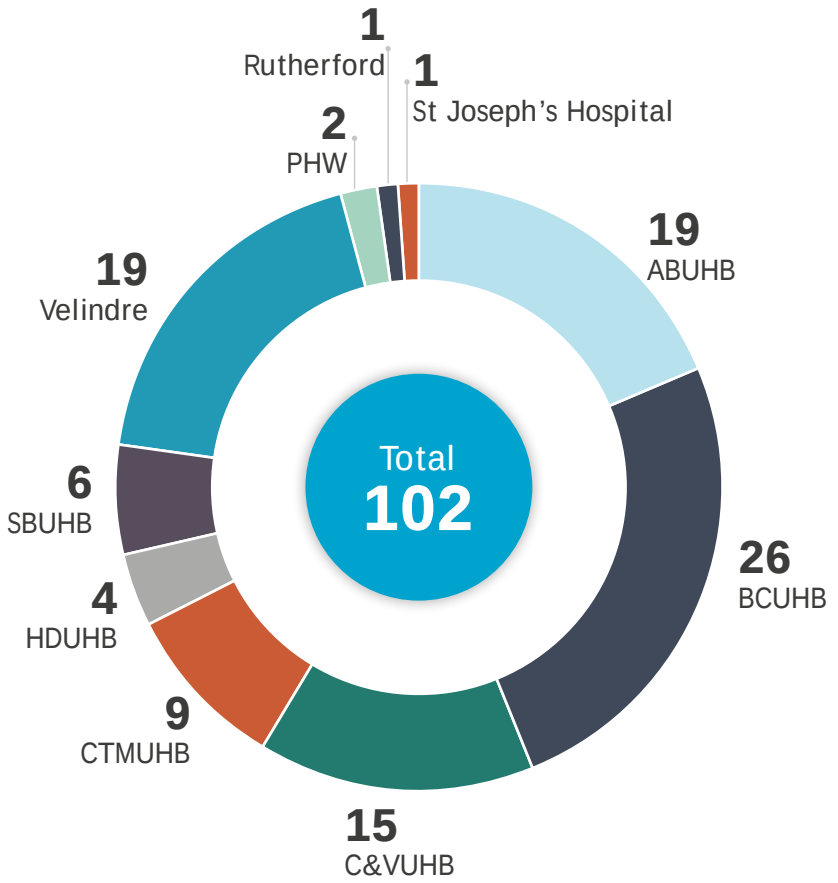
**Death of a Patient**

| Category | 2022-23 | 2021-22 |
|---|---|---|
| Serious Injury | 2 | 6 |
| Outbreak of an infectious disease | 30 | 147 |

There has been a significant reduction in the number of notifications received, mainly in the number of outbreaks of infectious diseases reported. This significant drop in the number of Outbreaks of infectious diseases is due to the COVID-19 pandemic.

## IRMER

The chart below shows a breakdown of the number of notifications received against the IRMER regulations for this reporting period.



## Safeguarding

**256**
Significant drop in the number of referrals received

**In 2021/2022 we received 404 referrals**

**128 NHS**

**125 Independent Healthcare**

**3 Other**

## NHS

| | Financial Abuse | Neglect | Physical Abuse | Psychological / Emotional Abuse | Sexual Abuse | Grand Total |
|---|---|---|---|---|---|---|
| Aneurin Bevan University Health Board | | 11 | 4 | | | 15 |
| Betsi Cadwaladr University Health Board | 2 | 25 | 13 | 2 | 3 | 45 |
| Cardiff and Vale University Health Board | | 2 | | | | 2 |
| Cwm Taf Morgannwg University Health Board | | 24 | 8 | 3 | | 35 |
| Powys Teaching Health Board | | 6 | 7 | | 4 | 17 |
| Swansea Bay University Health Board | | 7 | 2 | | | 9 |
| Welsh Ambulance Service NHS Trust | | 5 | | | | 5 |
| **Total** | **2** | **80** | **34** | **5** | **7** | **128** |

## Independent Healthcare

| | Financial Abuse | Neglect | Physical Abuse | Psychological / Emotional Abuse | Sexual Abuse | Grand Total |
|---|---|---|---|---|---|---|
| Aberbeeg Hospital | | | 1 | | | 1 |
| Aderyn | | | | | 1 | 1 |
| Cefn Carnau Hospital | | 3 | 7 | | | 10 |
| Coed Du Hall | | | 2 | | | 2 |
| Heatherwood Court Hospital | | 7 | 1 | 1 | 1 | 10 |
| Hillview Hospital | | 4 | 4 | 3 | | 11 |
| Llanarth Court | | 11 | 13 | 6 | 4 | 34 |
| New Hall | | | **1** | **2** | | **3** |
| Nuffield Health The Vale Hospital | | **1** | | | | **1** |
| Rushcliffe Independent Hospital (Aberavon) | | | **1** | | | **1** |
| St Peter's Hospital | | **5** | **11** | **3** | **1** | **20** |
| Ty Cwm Rhondda | | | | **2** | | **2** |
| Ty Grosvenor | **1** | **14** | **7** | | | **22** |
| Ty Gwyn Hall | **2** | | **4** | **1** | | **7** |
| **Total** | **3** | **38** | **51** | **17** | **6** | **125** |

Three of the referrals were in relation to settings not regulated or inspected by HIW.

# Second Opinion Appointed Doctor (SOAD) Service for Wales

**HIW operates the SOAD service for Wales, employing registered medical practitioners to approve some forms of treatment for patients who are detained under the Mental Health Act. Ultimately, the role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.**

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the amount of treatment which can be given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. Approved clinicians refer cases to HIW seeking a SOAD opinion. Case reviews are requested in the following circumstances:

- liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)
- patients under eighteen years of age, whether detained or informal, for whom electroconvulsive therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

**Total Number of SOAD cases dealt with by HIW in 2022 - 2023:**

694

**Medication:** 640 requests related to the certification of medication

**ECT**: 42 requests related to the certification of ECT

**Both:** 12 requests related to the certification of both medication and ECT

By comparison, during 2021-2022, HIW dealt with 759 requests for a SOAD review.

**Medication:** 640 requests related to the certification of medication

**ECT**: 42 requests related to the certification of ECT

**Both:** 36 requests related to medication and ECT

# Review of Treatment (Section 61)

**Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the seventh consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. There was a delay in the timeliness of the review of treatments in 2022-23, this was due to a vacant Lead SOAD position. However, all cases have now been reviewed with appropriate action taken where applicable.**

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.
- There were a few instances where T3 forms were being utilised instead of the appropriate CO forms, due to temporary methodology guidance implemented during the COVID Pandemic. These have now been rectified and refreshed guidance has been issued.

1 The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

# Our Resources

The table shows the number of full or part time posts in each team within HIW during 2022-2023.

| Team | Posts |
|---|---|
| Senior Executive | 3 |
| Inspection, Regulation and Concerns | 39 |
| Partnerships, Intelligence and Methodology | 14 |
| Clinical Advice (including SOAD service) | 6 |
| Corporate Services (including business support) | 18 |
| Strategy, Policy and Engagement | 7 |
| **Total** | **87** |

For 2022-2023 we had a budget of approximately £4.3m.

We have posts equivalent to approximately 87 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have 44 Patient Experience Reviewers and Experts by Experience.

# Finance

**The table shows how we used the financial resources available to us in the last financial year to deliver our work in 2022-2023.**

HIW staff continue to be our most important resource. A programme of learning and development opportunities has once again been designed and delivered in accordance with feedback from staff. We have refreshed our internal People Forum which provides a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development.

We have continued to recruit into specialist peer reviewer roles, and increased our pool of patient experience reviewers. This has strengthened our access to up to date clinical expertise and provided additional resource who can engage directly with patients during inspection work.

Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

| | £000'S |
|---|---|
| **HIW Total Budget £** | **£4,372,000** |

| **Expenditure** | |
|---|---|
| Staff costs | 4,176,468 |
| Travel and Subsistence | 26,225 |
| Learning & Development | 29,854 |
| Non staff costs | 80,210 |
| Translation | 59,834 |
| Reviewer costs | 405,761 |
| ICT Non CRM costs | 16,810 |
| Depreciation of assets | 8,000 |
| Total expenditure (a) £ | 4,803,162 |

| **Income** | |
|---|---|
| Total income from Independent Healthcare (b) £ | 528,239 |
| Total Net Expenditure (a-b) £ | 4,274,923 |

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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ISBN: **978-1-83577-212-6**

| | |
|---|---|
| Reporting Committee | Quality Patient Safety Committee (QPSC) |
| Chaired by | Carolyn Donoghue |
| Lead Executive Director | Director of Nursing & Quality |
| Date of Meeting | 19 February 2024 |

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

1.0 MENTAL HEALTH UPDATE (INCLUDING NEUROPSYCHIATRY PATIENT SOTRY)

Members received a comprehensive presentation and an update on developments within Mental Health. The presentation delivered by David Roberts (DR) provided updates on the following key areas;

- Mental Health Strategy
- Secure Services
- CAMHS
- Eating Disorders
- Mother & Baby Unit (MBU)
- Neuropsychiatry

The Interim Business Manager for the Wales Neuropsychiatry Service provided members with a presentation containing an outline of the Neuropsychiatry service in Wales and it was noted that the sustainability of the service was highlighted as a risk on the CRAF.

Members received an informative patient story about a gentleman who had sustained a serious brain injury at the age of 59 and how a technique called "Rich Pictures" was used to obtain his thoughts and feedback. Members noted the challenges that the patient faced at the outset and how the Neuropsychiatry service helped the patient and his family to obtain much needed support. The patient story highlighted the positive impact that the Neuropsychiatry services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales. Some queries were raised on the new WKN risks which included Interventional Radiology and the Financial risk and growth within the Integrated Commissioning Plan (ICP).

In terms of interventional radiology, it was noted that this was not a WHSSC commissioned service, but it has an impact on renal service provision as there is

a need to often access urgent treatments for patients following complications from kidney biopsies, urgent and elective vascular access procedures. Members were assured that all Chief Executives were currently aware of the issues and significant work was underway to address the sustainability of the service. Members of the committee asked for this to be highlighted to the JC.

## 3.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

### 3.1 Cancer & Blood

Members received an update of the quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

The All-Wales Lymphoma Panel (AWLP) service was removed from the WHSSC escalation process in November 2023 due to implementation of the agreed action plan and an improvement in immunohistochemistry turnaround times.

The Burns service has been de-escalated from Level 3 to Level 2 due to the capital case having been approved by Welsh Government. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.

Plastic Surgery outreach in BCUHB remains in Welsh Government escalation/special measures framework and the next escalation meeting is due to take place in March 2024. WHSSC is contributing to the Welsh Government escalation arrangements and continue to attend the Task and Finish Group as an advisor. There has been some progress on some of the Commissioning and operational arrangements.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continued to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB but there has been some improvement. The service will remain in escalation level 2 to ensure this continued improvement. The Health Board shared the plastic surgery delivery plan and trajectory at the escalation meeting in October 2023.

An update on the BCUHB plastics surgery and the harms review was provided. The interim report found no evidence of patient harm but once completed, the report will the shared with WHSSC QPSC after it has been through BCUHB QPSC. Members requested that this be highlighted to the JC.

### 3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio and noted that two new risks for the portfolio had been added to the Risk Register since the last report.

The first risk relates to waiting times for patients from BCUHB and North Powys awaiting obesity surgery procedures in Salford Royal Hospital. The waiting times were unlikely to reduce in the short to medium term. Since writing the report, a pathway has been agreed and the pathway is open for patients to travel to south Wales to access treatment at the Welsh Institute of Metabolic and Obesity Surgery (WIMOS).

The second risk relates to a cyber-security attack on the Trauma Audit Research Network Database (TARN) which resulted in the database being taken offline. A sustainable long-term solution for this data collection which will support the ability of the Network to benchmark performance is delayed. TARN has issued a standardised spreadsheet for interim data collection, but this will not be sufficient to undertake national benchmarking and WHSSC will be unable to monitor performance against the business case. A letter has been written to NHS England and this has been escalated and a response is awaited. There is also clinical concern as the data is also used for clinical audit.

Both cardiac services remain in escalation level 2. In terms of CVUHB the planned repatriation of cardiothoracic surgery to UHW has been delayed until April 2024. An escalation focused review meeting with the Health Board was convened on in January 2024, at which progress against those outstanding escalation actions was noted with a follow up meeting arranged for March 2024.

Swansea Bay Cardiac Surgery Service continues to make progress against its planned escalation actions as assessed by means of its performance dashboard. A report providing an update on the status of the remaining actions was delayed as a result of the HB reconvening its Gold Command meetings and the need for the report to be subject to internal governance and oversight. NJ provided members with assurance that the Gold command meetings were not as a result of cardiac surgery – the Gold command was instigated in response to very high levels of emergency pressures across the Health Board during December 2023 and January 2024.

### 3.3 Neurosciences

Members noted one new risk and one increased risk relating to neurosurgery waiting times in both south Wales and north Wales. Both are being managed through the Performance Management Framework and were being closely monitored.

Concerns with the Deep Brain Stimulation (DBS) service in Bristol were highlighted. Concerns had been raised around communication with referring clinicians and patients but there had been no engagement and no improvement despite repeated efforts. As a result, expressions of interest were requested for a new provider to support the south Wales gatekeeper.

The ALAC service review around Micro Processor Knee (MPK) was also highlighted, and it was noted that this will be fed into Individual Patient Funding Requests (IPFR) as part of the outcomes work.

3.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio. The risks largely mirror the services in escalation, and it was acknowledged that the volume of risks and escalation issues within the portfolio are concerning and make this a complex and challenging area.

Members were informed that the Paediatric Cardiac Surgery service in University Hospital Bristol had shown improved performance against waiting times. There had been a notable decrease in the number of children breaching their recommended treatment date and the length of time patients were waiting beyond their recommended treatment date had also decreased. The risk was reduced, and the service de-escalated to Level 2 in January 2024.

There remain three services in escalation Level 3 and one in escalation Level 4. Three of the services (Paediatric Surgery, PICU and Neonatal Intensive Care) are at Level 3 and are provided by Cardiff and Vale University Health Board. The escalation continues to be managed as a 'Triple Escalation'. Due to the complexity of managing all three escalations together there are two Executive Leads from the Health Board and two Executive Leads from WHSSC involved.

Neonatal Care

Members were informed that an escalation meeting took place this morning and WHSSC will consider the next steps following this meeting.

Paediatric Surgery

Members received an update following the Joint Committee workshop that was held in November 2023 in which Paediatric Surgery was discussed. Members were informed that a commitment was made by the HB to deliver against a target of zero paediatric patients waiting over 52 weeks by the end of March 2024. This was to be delivered to through a hybrid model of additional lists within the Health Board and continued outsourcing to Nuffield. There is evidence of improvement and there is a high confidence rating that the service will deliver. Joint Committee also agreed with a recommendation in the ICP 2024/25 that the 52 week is maintained now that the backlog is reduced.

Paediatric Intensive Care

Financial support has been provided to the HB to support winter pressures by increasing the workforce to support the unit. Despite previous assurance received from the Health Board regarding pressure area concerns WHSSC has been notified that a Joint Review of Child Protection Arrangements (JIGPA) that was undertaken in December 2023 has highlighted concerns which need to be

readdressed. A letter has been received from the CVUHB Director of Nursing on the 9th February outlining the request for the Acute Child Health Directorate to undertake a retrospective audit of the care of thirty children in PICU since September. The results of this audit will be shared with WHSSC on completion and brought back to the QPS committee. Assurance has also been given that the CVUHB Executive Team are sighted on the concerns and work needed to review the cases.

The Committee were informed that since writing the report a letter had been received from the DoN in CVUHB and this provided detail of the actions that they were taking. It was agreed to highlight these continued concerns to JC in the QPSC Chairs Report and await an update on the further actions currently being undertaken.

Wales Fertility Institute
Despite the service remaining in escalation Level 4 there has been some recent progress with securing a new Person Responsible (PR). The HB have nominated a number of staff to sit the HFEA exams ; this will enable each site Neath and Cardiff to have their own PR, with staff ready to step up should they become unavailable to fulfil the statutory requirements of the role of PR. The PR had been a single point of failure and the intention to have more than one PR will help mitigate this risk in the future.

3.5 Mental Health
The Mental Health and Vulnerable Groups update was provided during the presentation.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register and since the report had been written a letter of assurance had been received outlining measures for the sustainability for the service going forward. They will be appointing a local consultant, and it is likely that on the basis of this letter of assurance the risks will be reduced at the next commissioning team meeting.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary
Members noted the content of the report and the three Paediatric services in escalation Level 3 were noted and were discussed in detail above under the Women and Children's Report.

A copy of each of the services in escalation is attached to the report at Appendix 1.

4.2 CRAF Risk Assurance Framework

Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

One new organisational risk was highlighted and this related to the formation of the new JCC and the business continuity risk associated with this. The mitigations required will be critical as we are close to the go live date for the new JCC and a lot of the detail was still unclear. Members requested for this to be highlighted as a matter of concern to the JC.

4.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period July 2023 to January 2024 was presented to the committee.

4.4 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.5 Service Improvement and Innovation

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

Members noted the content of the report, the summary of activities, aims and key points of learning and sharing. The report demonstrated the positive work that had been achieved and undertaken by clinicians. Members also noted the comprehensive update following the WHSSC QPSC development day.

4.6 Duty of Quality

Members received a report providing the steps taken by the organisation to meet the requirements of the Duty of Quality Act and to consider the revised templates to support the reporting mechanisms in accordance with the Act. Members noted that the report and the template was developed following the work undertaken in the Development Day.

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee November 2023,
- Oversight and Escalation Framework – NHS Wales Organisations; and
- QPSC Distribution List.

6.0 ANY OTHER BUSINESS

| | |
|---|---|
| There was no other business. | |
| Key risks and issues/matters of concern and any mitigating actions<br>Key risks are highlighted in the narrative above and summarised below;<br>The Interventional Radiology risk and impact on the renal service provision.<br>The outstanding Harms review and BCUHB plastics.<br>The pressure issues and Paediatric Intensive Care and general concerns with paediatric services CVUHB<br>Approval of proposed templates to meet Duty of Quality Act<br>The Business Continuity Risk on the CRAF<br><br>Members continued to express 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<br>Attached (*Appendix 1*) | |
| Matters requiring Committee level consideration and/or approval<br>None | |
| Matters referred to other Committees<br>As above. | |
| Confirmed minutes for the meeting are available upon request | |
| Date of Next Scheduled Meeting | TBC |

**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: 23/10/23**

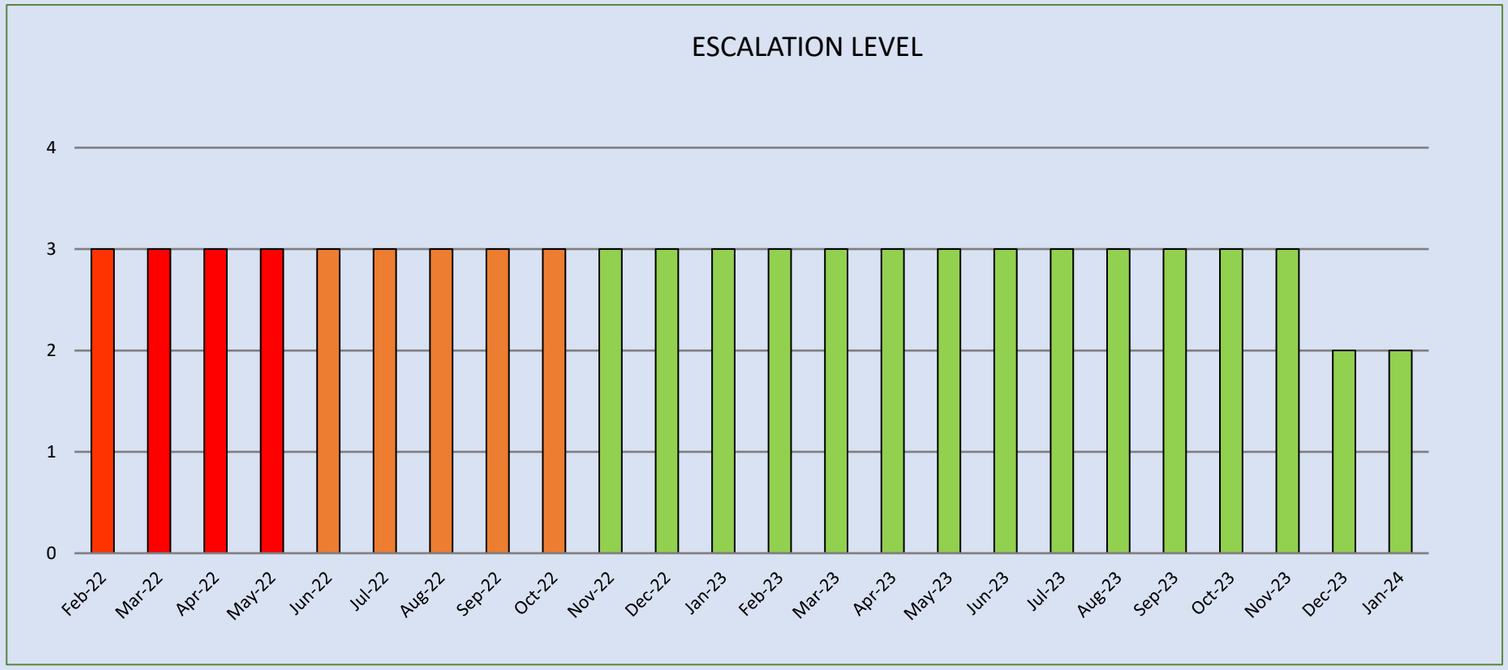
# Service in Escalation: Burns

**Current Escalation Level 2**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↓ December 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** |
| **December 2023 – WHSSC escalation** | **2** |

**Rationale for Escalation Status :**
De-escalated to 2.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is Autumn 2024.

**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.<br>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.<br>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 capital programme has commenced and is due to complete by October 2024. In view of this, the level of escalation has been reduced from level 3 to level 2. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete. Level 2 escalation has been maintained in case issues or risks arise during the implementation of the capital development. | 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.**

**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 & 19/12/23**
**Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23**

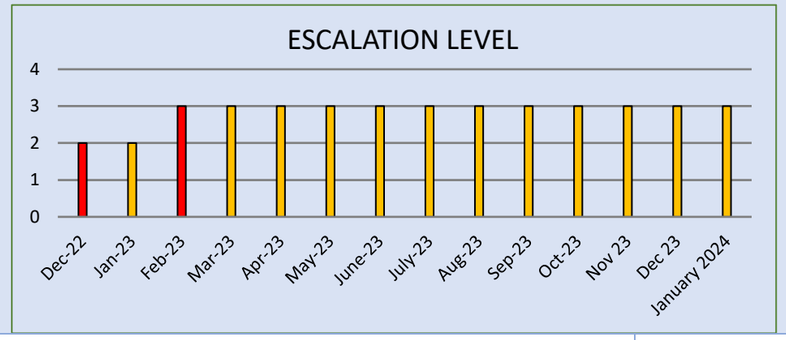
# Service in Escalation: Paediatric Surgery

**Current Escalation Level 3**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↔ January 2024 |
| ↔ | 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:**

**High –** Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The service has committed to deliver a 52-week inpatient waiting list position by year end. The delivery of this is against a robust plan of increasing day case surgery and outsourcing 37 cases to Nuffield. Monitoring progress on a monthly basis and the >52 weeks position is improving as set out in the trajectories.

**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 | Completed 23/10/23 |
| Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives. | DOP and DON | 23 January 2023 | |

**Issues/Risks:**
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – A number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

**Executive Director Lead: Nicola Johnson**
**Commissioning Lead: Kimberley Meringolo**
**Commissioning Team: Women and Children**

**Date of Escalation Meetings: 10/10/23 & 19/12/23**
**Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23**

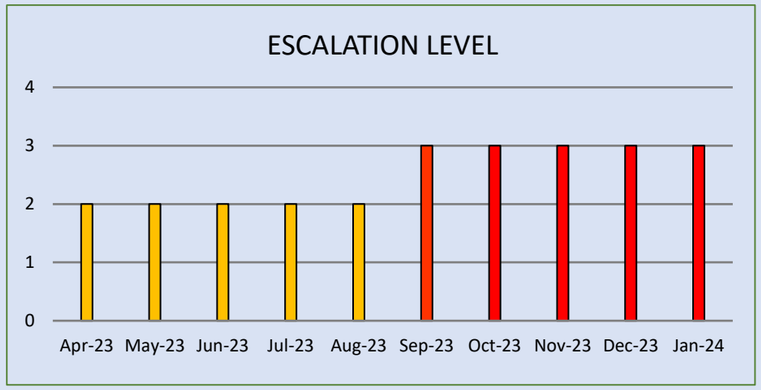
# Service in Escalation: Paediatric Intensive Care

**Current Escalation Level 3**

Escalation Trend Level

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↔ January 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **April 2023** | **2** |
| **September 2023 – Increased level from 2 to 3** | **3** |

**Rationale for Escalation Status :**

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

**Background Information:**

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of 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. WHSSC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Further work is required on the Pressure area concerns following a JIGPA review undertaken in December 2023.

**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 | 23 January 2024 | |
| Requested action plan to be developed against the escalation objectives. | Senior Planning Manager | 31 October 2023 | Completed 19/12/23 |
| Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee. | Director of Nursing | Ongoing | |
| Special Executive to Executive meeting scheduled with provider | Director of Planning | 23 October 2023 | Completed |

**Issues/Risks:**

**Executive Director Lead: Nicola Johnson**
**Commissioning Lead: Kimberley Meringolo**
**Commissioning Team: Women and Children**

**Date of Escalation Meetings: 10/10/23 & 19/12/23**
**Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23**

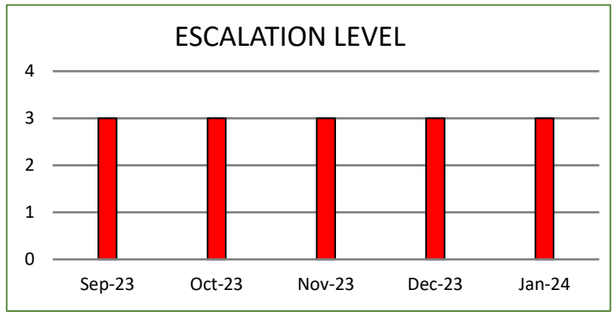
# Service in Escalation: Neonatal Intensive Care Unit

**Current Escalation Level 3**

Escalation Trend Level

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↔ January 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **September 2023** | **3** |

**Rationale for Escalation Status :**

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

**Background Information:**

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

**WHSSC assurance and confidence level in developments:**

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion.

**Actions:**

| Action | WHSSC Lead | Action Due Date | Completion Date |
|---|---|---|---|
| Develop agreed objectives for escalation | Planning Manager | 31 October 2023 | Completed 19/12/23 |
| Health Board to develop detailed action plan against the agreed objectives | Planning Manager | 14 November 2023 | Completed 19/12/23 |
| Special Executive to Executive meeting scheduled with provider | Director of Planning | Date currently being agreed | |

**Issues/Risks:**

**Executive Director Lead: Nicola Johnson**
**Commissioning Lead: Kimberley Meringolo**
**Commissioning Team: Women and Children**

**Date of Escalation Meetings: 14/12/23**
**Date Last Reviewed by Quality & Patient Safety Committee: 23/10/2023**

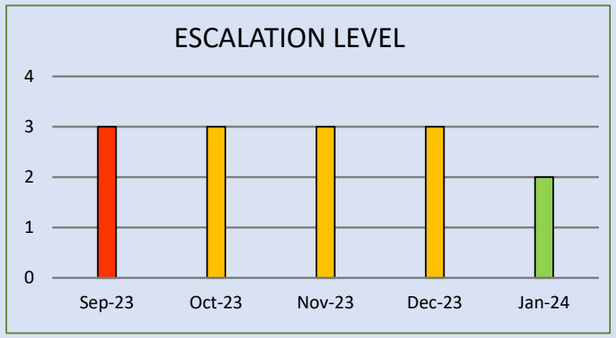
# Service in Escalation: Paediatric Cardiac Surgery

**Current Escalation Level 2**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↓ January 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **September 2023** | **3** |
| **January 2024** | **2** |

**Rationale for Escalation Status :**

A number of waiting were breaching the recommended date for treatment as set by the Joint Cardiac Committee. The period of time people were breaching was far in excess

**Background Information:**

Paediatric Cardiac surgery was placed in escalation level 3 due to the number of patients waiting in for surgery and those breaching their target date by over 200 days. Formal escalation meetings were established in September 2023 with Executive leadership from both the Trust and WHSSC.

**WHSSC assurance and confidence level in developments:**

High – Service de-escalated to level 2, robust reporting mechanisms have been established and the waiting list position has improved. There are currently only two patients that are breaching their recommended surgery date.

**Actions:**

| Action | WHSSC Lead | Action Due Date | Completion Date |
|---|---|---|---|
| Escalation meeting to discuss progress and trajectories | Director of Nursing & Quality | 14 December 2023 | Completed 14 December 2023 |

**Issues/Risks:**

**Executive Director Lead: Iolo Doull**
**Commissioning Lead: Dominique Gray-Williams**
**Commissioning Team: Women and Children**
**Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23**
**Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23**

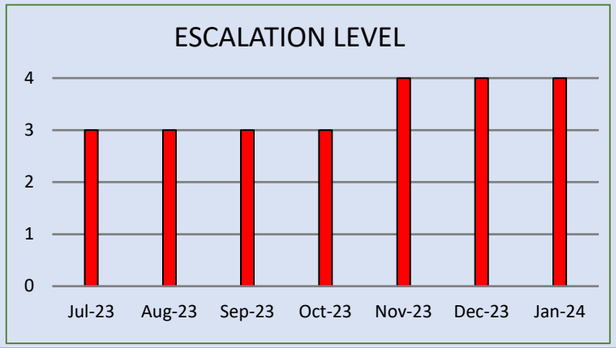
# Service in Escalation: Wales Fertility Institute

**Current Escalation Level 4**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↑ November 2023 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **July 2023 – WHSSC escalation** | **3** |
| **November 2023 – WHSSC escalation** | **4** |

**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 submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission.
The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Neath Port Talbot are due to be inspected in March 2024 and Cardiff in January 2024.
A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board.
The Directorate Manger and Associate Directorate managers have left and being replaced with a clinical manager.
The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. This review is due to be completed by the end of January and identify if any outsourcing is required.

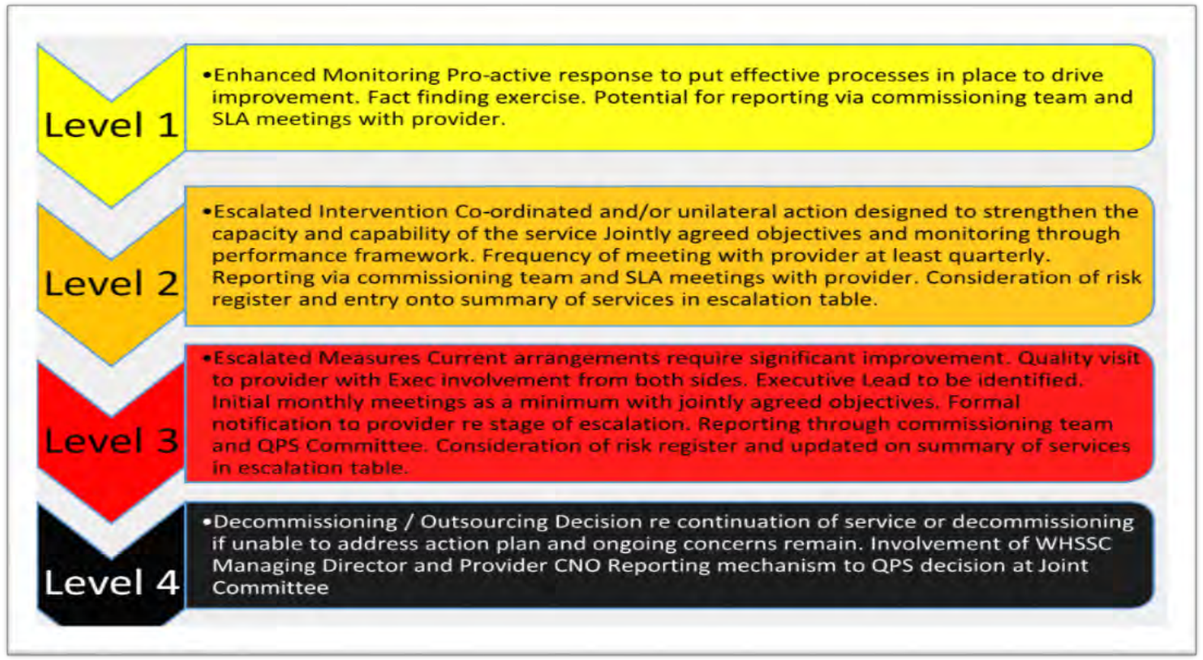
**Actions:**

| 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, 10th October 2023, 7th December 2023 | Assistant Specialised Planner | Monthly | Ongoing |
| Quality visit, this has been temporarily paused due to increase in escalation level to escalation level 4 | 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 | 19/09/2023 | 19/09/2023 |
| Regular Executive to executive meetings 16th November 2023, 21st November 2023, 1st December 2023, 7th December 2023, 21st December 2023 | Executive lead SBUHB/ Medical Director WHSSC | 16th November | Ongoing |

**Issues/Risks:** There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

| | |
|---|---|
| Level 1 ENHANCED MONITORING | Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes:<br>• 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.<br>• Continued intervention is required at level 1 and a review date agreed.<br>• Escalation to Level 2 if further intervention is required<br>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<br>• Provider performance meetings<br>• Triangulation of data with other quality indicators<br>• Advice from external advisors<br>• Monitoring of any action plans<br>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:<br>• 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.<br>• 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.<br>Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum:<br>• Chair (WHSSC Executive Lead)<br>• Associate Medical Director - Commissioning Team<br>• Senior Planning Lead – Commissioning Team<br>• WHSSC Head of Quality<br>Executive Lead from provider Health Board/Trust<br>• Clinical representative from provider Health Board/Trust<br>• Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary.<br>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<br>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.<br>The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue:<br>1. De-commissioning of the service<br>2. Outsourcing from an alternative provider. This may be permanent or temporary<br>3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider.<br>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.<br>At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales. |




SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing /