Patient Quality, Safety & Outcomes Committee

Fri 23 February 2024, 09:00 - 11:00

Microsoft Teams

Agenda

0 min

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 13th December 2023

Attached *Chair*

1.4 PQSOC Minutes 13th December 2023 reviewed by RD & PB.pdf (10 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 Action Log PQSOC February 2024.pdf (3 pages)

0 min

2. ITEMS FOR APPROVAL/RECTIFICATION

2.1. Safeguarding Annual Report

Attached *Director of Nursing*

2.1 Safeguarding Annual Report 2022-23.pdf (15 pages)

0 min

3. ITEMS FOR DISCUSSION

3.1. Committee Risk Report

Attached *Director of Corporate Governance*

3.1 Committee Risk Report_PQSOC_Feb24.pdf (6 pages)
3.1 Appendix A - PQSOC Strategic Risk Register.pdf (1 pages)
3.1 Appendix B - PQSOC Dashboard and Risk Assessments.pdf (6 pages)
3.1 Appendix C - CRR 004 Service Delivery RGH Robot Operational Risk to a Page.pdf (1 pages)

3.2. Overview of Audit Recommendations Tracking

Attached *Director of Corporate Governance*

3.2 Internal & External Audit Recommendations Q3 2023-24 Cover Report.pdf (5 pages)

3.2 Appendix A PQSOC Live Recommendations.pdf (2 pages)

3.3. Focus on the Pillars of Quality to Include:

Attached *Director of Nursing/Medical Director/Director of Therapies & Health Science*

- Safeguarding
- Incident report and Health Safety and Security
- Patient Safety Incidents and Learning
- Patient and Staff feedback and Complaints and Concerns
- Patient Story
- Clinical Effectiveness
- Putting Things Right
- Quality and Engagement (Wales) Act Preparedness and Implementation
- Clinical Negligence Claims and Implementation

3.3 PQSOC Performance Report - February 2024.pdf (104 pages)

3.4. Q3 Quality Outcomes Framework

Attached *Director of Nursing*

3.4 QOF Quarter 3 Outcome and Performance Quality and Safety Draft Feb 2024.pdf (29 pages)

3.5. Maternity Services:

Attached *Director of Nursing*

3.5.1. Organisational Improvement and Action Plan

Attached *Director of Nursing*

3.5.1 Maternity Services Improvement Plan 2024-27 - SBAR for Execs.pdf (4 pages)
3.5.1a Appendix 1 - ABUHB Maternity Services Improvement Plan 2024-2027.pdf (11 pages)
3.5.1b ABUHB Maternity Services Improvement Plan - 2024-27.pdf (11 pages)

3.5.2. Implementation progress update on the configuration of midwifery-led units

Attached *Director of Nursing*

3.5.2 Evaluation of the Configuration of Midwife Led Birthing Units - ET 080224.pdf (7 pages)

3.6. Internal Audit Review - Medical Devices - Action Plan Update

Attached *Director of Therapies & Health Science*

3.6 Board and Committee Report - SBAR Medical Devices Governance - For PQSOC 23 Feb 2024 v3.pdf (7 pages)

0 min

4. ITEMS FOR INFORMATION

4.1. Children's Rights & Participation Forum

Attached *Director of Nursing*

4.1 v3 Childrens Rights and Participation Final.pdf (4 pages)

0 min

5. OTHER MATTERS

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting:

30th April 2024 - 09:30-12:30

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Wednesday 13th December 2023 9:30-12:00
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Louise Wright, Independent Member, Vice Chair Paul Deneen, Independent Member Helen Sweetland, Independent Member
IN ATTENDANCE	Nicola Prygodzicz, Chief Executive Jennifer Winslade, Director of Nursing Rani Dash, Director of Corporate Governance Peter Carr, Director of Therapies & Health Science James Calvert, Medical Director Michelle Jones, Head of Board Business Leeanne Lewis, Assistant Director of Quality & Patient Safety Moira Bevan- Head of Infection and Prevention Jayne Beasley- Head of Midwifery and Gynaecology Rhian Gard, Deputy Head of Internal Audit Lucy Windsor - Head of Corporate Risk & Assurance Paul Underwood - General Manager - Urgent Care Division Rhys Monk – Directorate Manager for Stroke, CoTE, Neurology & Nephrology David Hanks - Head of Service Planning Fern Cook, Committee Secretariat
APOLOGIES	None to note

PQSOC 1312/1	**Preliminary Matters**
PQSOC 1312/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 1312/1.2	**Apologies for Absence** Apologies for absence were noted.
PQSOC 1312/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
PQSOC 1312/1.4	**Minutes of the previous meeting**

	The minutes of the Patient Quality Safety and Outcomes Committee held on Wednesday 11th of October 2023 were agreed as a true and accurate record.
PQSOC 1312/1.5	**Committee Action Log- October 2023** The Committee received the action log. Members were content with progress made in relation to completed actions and against any outstanding actions.
PQSOC 1312/2	**Items for Approval/Ratification**
PQSOC 1312/2.1	**Annual Report: Putting Things Right Annual Report 2023** Jennifer Winslade (JW),Director of Nursing, provided the Committee with an overview of the Putting Things RightAnnual Report highlighing to the Committee that there was a need to maintain a focus on the performance of complaints. The following key points were highlighted: - • 80% of complaints submitted were resolved. • 75% of complaints were closed within 30 days of submission. • Investigating Officer Training was routinely provided across the Health Board. • PSOW provided training for the Health Board to ensure that effective partnership arrangements were in place. • Future Divisional work would be completed on the responsibility of Divisions owning Datix. • Sickness issues had impacted upon capacity. • Priorities for next year would include a focus on the learning from human and system errors. JW agreed to bring a report on human factors issues identified through PTR to the next Committee Meeting. **Action: Jennifer Winslade, Dirctor of Nursing** ***The Committee approved the report and noted the key priorities for next year.***
PQSOC 1312/3	**Items for Discussion**
PQSOC 1312/3.1	**Never Events Review: Theatres** James Calvert (JC), Medical Director, provided the Committee with an overview of the Never Events review recently completed in Theatres.

	JC informed the Committee that the review had been completed with the support of ABCi, and that the focus of the review was: • wrong site injections, and • retained swabs. Members noted that there were occasional operational pressures within Theatres that had impacted upon the ability to consistently deliver a safe process. JC informed Members that an action from a recent Serious Incident meeting was for the Orthopaedic and Radiology Governance Leads to work with the Anaesthetist team to standardise processes where possible across all Theatres. Pippa Britton (PB), Chair, questioned whether there was a procurement need for a system within Theatres. JC advised that the preference was for a system, as the data would be stored in one place. It was highlighted to Members that a process had been established called "Quiet for the Count" to allow the swab count to be completed uninterrupted. Paul Deneen (PD), Independent Member, questioned if there were specific human factors that needed to be addressed. JC confirmed that training was a key consideration. ***The Committee received the updated of the review and was assured by the information provided.***
PQSOC 1312/3.2	**Committee Annual Programme of Business 2023/24** Rani Dash (RD), Director of Corporate Governance, provided the Committee with the workplan for the current year and noted that the workplan for 2024/24 would be developed shortly. Paul Deneen (PD), Independent Member, expressed that the work plan was well structured, helped with the planning of the committee, and supported when there was an audit of the Committee's work. PD requested that next year's plans included a focus on dentistry services. RD advised the commissioning for quality framework was in development and this would pull through the work of the external service providers, however, would ensure dentistry was also reference. ***The Committee received the information provided and noted the items for the next Committee meeting.***

PQSOC 1312/3.3	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provide the Committee with a summary of the Risk Register highlighting that the pharmacy robot had been included previously. ***The Committee were assured by the information provided.*** *Lucy Windsor left the meeting*
PQSOC 1312/3.4	**Clinical Audit Activity Report** Leeanne Lewis, Assistant Director of Quality & Patient Safety, provided the Committee with an overview of the Clinical Audit Activity report. The following key points were highlighted: - • A large number of improvements had been made and the standardised reporting for this Committee had been reviewed and streamlined in light of this. • At the CSEG meeting the focus was to look at the action plan to discuss what measures would need to be put in place. • The standardised tool had been set up which would allow a better position on quality to be reported upon. • The Clinical Audit plan had been created, and it was highlighted that not all audit reports were reported to CSEG, and this would be reviewed moving forwards. • The AMAT systems also included ward assurance, ward accreditation and local audits. Pippa Britton (PB), Chair, sought confirmation if all audit information was on the new AMAT system and was advised that the approach involved working alongside National Clinical Audit and the use of the standard audit tool. To support this work, it was noted that the process had changed, and Clinical Leads were engaged to agree the action that needed to be captured within the AMAT. It was highlighted to Members that training for the system had been completed, but there was still work to be undertaken in terms of its full potential to be realised. Helen Sweetland (HS), Independent Member, queried the funding for the system that was due to end in early 2024 and was advised that confirmation of funding was still awaited.

	Paul Deneen (PD), Independent Member, questioned whether there were any areas of concerns in terms of the funding for the system. LL advised that there were plans in place to secure funding. The Committee requested that the Finance & Performance Committee be asked to seek assurance that there were robust processes in place for the management of contracts that were scheduled to end to ensure that the quality aspect of such work would not be lost. **Action: Rani Dash, Director of Corporate Governance** ***The Committee was assured with the update provided and sought action in respect of assurance on the management of contracts scheduled to end.*** *Paul Underwood left the meeting*
PQSOC 1312/3.5	**Stoke Improvement Plan, including the response to HIW National Review of Patient Flow (Stroke Pathway)** *Rhys Monk and David Hanks Joined the meeting.* Peter Carr (PC), Director of Therapies & Health Science, supported by Rhys Monk (RM), Directorate Manager for Stroke, CoTE, Neurology & Nephrology and David Hanks (DH), Head of Service Planning, provided the Committee with an update on the Improvement Plan for Stroke Pathways. PC advised the Committee that the Stroke pathway had been struggling since the move to the Grange University Hospital, and to improve patient care an improvement plan had been established and key to the development of this, was the engagement with GIRFT. PC provided an update on the progress made in addressing the HIW report and the 53 recommendations within, of which 9 recommendations related to Stroke. He advised that the Executive Committee had also received an update on the Stroke Improvement Plan. RM provided the Committee with an update on the progress made in addressing the action plan and the following key points were highlighted: - • 20 recommendations were from GIRFT. • 6 recommendations had been completed. • 6 recommendations were currently in progress. • 3 recommendations were ongoing with some challenges. • 5 recommendations had not started and would require strategic support from the Health Board.

	Pippa Britton (PB), Chair, questioned if there was a pathway through ED that allowed patients to attend the ward straight away. PC advised this had been explored, but some Stroke patients would require Resus support through ED. PC assured the Committee that when Stroke patient were ED patients, they would still have access to stroke support. Louise Wright (LW), Independent Member, asked what the barriers were for targets not being met. PC advised that various models had been trialled and that once funding was available, the preferred approach would be to strengthen the Rehab pathway and for the service to operate 7 days a week. ***The Committee received the report and was assured by the information provided.*** *Rhys Monk and David Hanks Left the meeting*
PQSOC 1312/3.6	**Patient Quality and Safety Outcomes Performance Report, December 2023** Jennifer Winslade (JW),Director of Nursing, supported by Leeanne Lewis (LW) Assistant Director of Quality & Patient Safety, Moira Bevan (MB), Head of Infection and Prevention, Peter Carr, (PC), Director of Therapies & Health Science, provided an overview of the patient quality safety outcomes performance report for December. The following key points were highlighted: - • **Positive medicine stories** had been shared throughout the year and a learning framework had been created. The communication team were supporting the development of this information on SharePoint for staff to access. It was agreed that the video of the positive medicine story would be shared with the Committee. **Action: Fern Cook, Committee Secretariat** • **Equality, Diversity, Inclusion,** Independent Living Skills (ILS) internships were at Nevill Hall Hospital and a story was shared as to how the workplace had made adjustments to enable a member of staff to stay in their profession. • **Infection Prevention and Control,** cases had placed pressure on the organisation, due to the increase in CDifficile (CDiff). MB provided the Committee with the approaches deployed to resolve this matter and the following was noted:- o A decline in the number of cases was noted from November.

- CDiff cases in November had been reviewed and as a result a collaborative and faculty meeting to support with the prevention of CDiff had taken place.
- Welsh Government had created a strategy to address this.
- Hospital cleaning on isolated areas had been revised.

Paul Deneen (PD), Independent Member, asked whether leaflets were available to the public on CDiff and if these needed to be updated. MB advised that the leaflets had been updated and were available to patients and families.

The following was also noted:

- **National Reportable Incidents,** 8 incidents had been recorded.
- **Duty of Candour Triggers**, 102 incidents of triggering duty had been reported. Of these, 83 had conducted in person. It was noted that there was a needed to continue to keep the Duty of Candour tiggers at this level.
- **Mortality,** Since the Grange University Hospital had opened it was recorded that the mortality rate had reduced despite the higher number of unwell patients. The Committee was advised that there was learning from death framework to better understand this.
- **Falls,** It was noted that the Health Board was consistent with the approach to the management of falls. It was reported that 20 patients had fallen in October and of these 2 patients had 2 falls and 9 had 3 or more falls. It was also noted that the Mental & LD Health Division recorded higher than average numbers of falls. PC assured the Committee that work was ongoing to address this.
- **End of Life,**
  - The Committee was advised that Jenny Winslade had been appointed as Chair of the End-of-Life Care Board.
  - The Committee noted that the End-of-Life Board was looking as to how a quality statement could be implemented and noted that positive representation from the palliative care champions was in place. Although, more needed to be done to better engage Clinical Leads in supporting this at ward level.
  - Bereavement standards were recorded as red, and the Committee was assured that work was being undertaken to secure improvements and

	that feedback from staff and relatives had been reviewed in respect of bereavement support and this was informing the approach. ○ The Committee was advised that the Learning from Death Framework would be brought to the next Committee meeting. **Action: Jennifer Winslade, Director of Nursing & Leeanne Lewis, Assistant Director of Quality & Patient Safety** ***The Committee received the report for assurance and was content with the information provided.*** *Moria Bevan left the meeting*
PQSOC 1312/3.7	**Birth Outcomes and Maternity Care Assurance Report, as requested by the Litigation Group** Jayne Beasley (JB), Head of Midwifery and Gynaecology, provided the Committee with assurance on the ongoing work in this area. The Committee noted the following key points: - • There was a higher number of babies born at the end of 34 weeks when compared to the national average. • The Health Board was improving the outcomes for premature babies and examples of how this was addressed was provided. • A dashboard was to be created to allow the Maternity Unit to have real time evaluation of care. • HEI cases- The Committee noted an increase of cases in 2022 and JB provided the committee with assurance that each case was reviewed, and it was noted from the review there was no Hypoxic Ischaemic Encephalopathy 3 (HIE3) cases. It was noted that the findings from this confirmed that the babies affected either had an infection with some babies having heart abnormalities. The Committee was informed that the Maternity Unit had undertaken the following actions to improve: ○ Introduced a Lead Midwife for foetal surveillance. ○ Embedded weekly Continuous Cardiotocography (CTG) training in collaboration with the Welsh risk pool and other Health Boards. ○ Moving forwards a new training package based on how to provide foetal surveillance training which would be considered on a monthly basis to allow all staff members to be trained. ○ PROMPT Wales Training compliance had increased to 81%. This was enabled through a

	lead Consultant Obstetric and Anaesthetic Lead being engaged. ***The Committee received the report and was assured with the information of the work being completed within the Maternity Unit.*** *Jayne Beasley left the meeting*
PQSOC 1312/3.7	**Committee Annual Self-Assessment Results** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Annual Self-Assessment Results and noted that the actions would be taken forward within an overarching action plan being submitted to the Board. ***The Committee were content with the information provided.***
PQSOC 1312/4	**Items for Information**
PQSOC 1312/4.1	**WHSSC QPS Committee Annual Report** The Committee received the report for Information.
PQSOC 1312/4.2	**Overview of Internal and External Audit Recommendation Tracking** The Committee received the report for information.
PQSOC 1312/5	**Other Matters**
PQSOC 1312/5.1	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** The Committee requested that the Finance & Performance Committee be asked to seek assurance that there were robust processes in place for the management of contracts that were scheduled to end to ensure that the quality aspect of such work would not be lost.
PQSOC 1312/5.2	**Any Other Urgent Business** There was no urgent business.
PQSOC 1312/5.3	**Date of the Next Meeting:** Wednesday 7th February 2024

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
26th July 2023	**PQSOC 2607/3.1**	**Patient Quality and Safety Outcomes Performance Report, July 2023** The End-of-Life Board report be brought to a future Committee meeting.	**Director of Nursing**	February 2024	Director of Nursing provided an update at the December 2023 Committee Meeting. Complete
13th December 2023	**PQSOC 1312/2.1**	**Annual Report: Putting Things Right (PTR) Annual Report 2023** Report on human factors issues identified through PTR to the next Committee Meeting	**Director of Nursing**	April 2024	
13th December 2023	**PQSOC 1312/3.4**	**Clinical Audit Activity Report** The Committee requested that the Finance & Performance Committee be asked to seek assurance that there were	**Director of Corporate Governance**	December 2023	Action has been transferred to F&PC. Action log and forward work plan for F & PC Committee has been updated to reflect that item will be added to the February F&PC agenda.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		robust processes in place for the management of contracts that were scheduled to end to ensure that the quality aspect of such work would not be lost.			Complete
13th December 2023	**PQSOC 1312/3.6**	**Patient Quality and Safety Outcomes Performance Report, December 2023** Video of a positive medicine story to be share with the Committee via email.	**Committee Secretariat**	December 2023	Video shared following meeting on 13.12.23 Complete
13th December 2023	**PQSOC 1312/3.6**	**Patient Quality and Safety Outcomes Performance Report, December 2023** Learning from Death Framework to be brought to a future Committee meeting.	**Director of Nursing/ Medical Director**	April 2024	

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

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.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Safeguarding Annual Report 2022/23

Introduction

NHS organisations have a statutory duty to ensure processes are in place to safeguard those at risk, as outlined by: -

- Health and Care Standards for Safeguarding Children and Adults at Risk (Welsh Government and NHS Wales, 2015)
- Social Services and Well-being (Wales) Act (SSWBA) (Welsh Government, 2014)
- Violence Against Women and Domestic Abuse (VAWDASV) Act (2015) (Welsh Government, 2015)

This Annual Report will demonstrate compliance with legislation and inform the Aneurin Bevan University Health Board (ABUHB) of the Safeguarding activity during the period 2022 to 2023. In doing so, the report aims to:

- Provide assurance to the Board that the organisation is fulfilling its statutory obligations.
- Assure external organisations, partners and regulatory bodies that the there is effective work in progress to prevent abuse and reduce harm to vulnerable service users.
- To inform the Board, its workforce, partners and regulatory bodies of the activities and function of the Safeguarding & Vulnerabilities Team.
- Demonstrate that governance and assurance arrangements within Safeguarding are robust.
- Identify and describe the key risks that were managed during the year, as well as any highlighting current risks and their management.
- Provides a summary of some the key activities undertaken throughout the year, both locally and nationally.
- Set out priorities and areas identified for improvement in relation to safeguarding activity for implementation during 2023/2024.

Local Partnership Arrangements

The Aneurin Bevan University Health Board Safeguarding Team are statutory members of both the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV Partnership Board, as well as supporting work at a range of sub groups and committees.

The Gwent Joint Children and Adult Safeguarding Board is a multi-agency partnership board responsible for making sure safeguarding is at the core of all services provided across the region. It is supported in its work by a number of sub groups that manage the core business and other more specific pieces of work which deliver on the strategic priorities set each year.

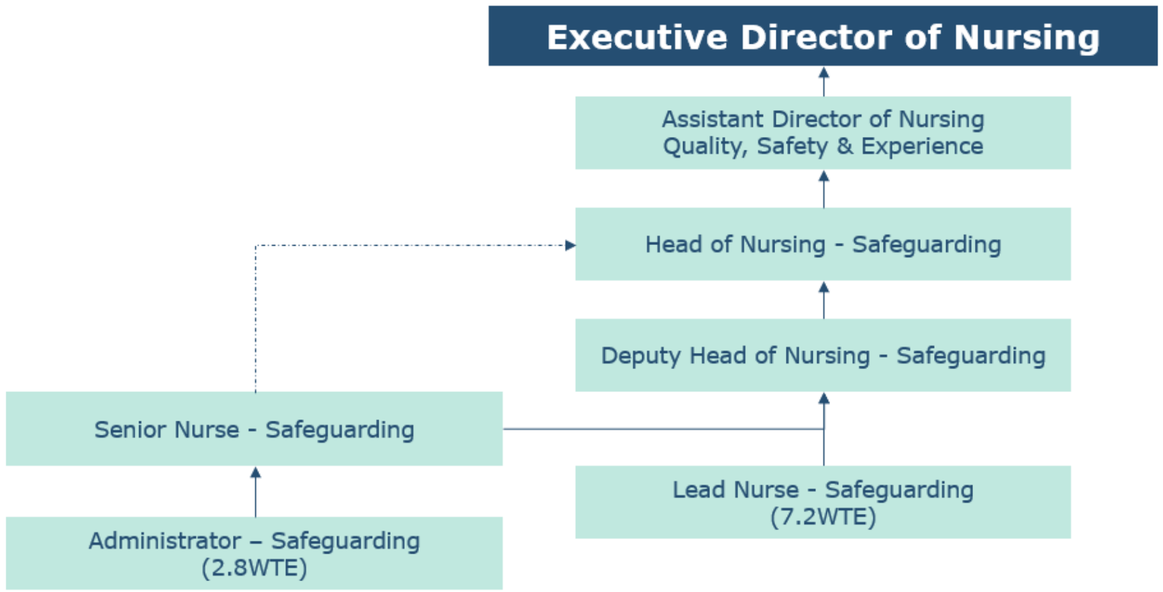
VAWDASV Partnership Board is a multi-agency collaboration working together across Gwent to prevent violence against women, domestic abuse and sexual violence, with the objective of improving the outcomes for individuals experiencing or at risk of harm, along with those of their families and support networks.

Staffing and Governance

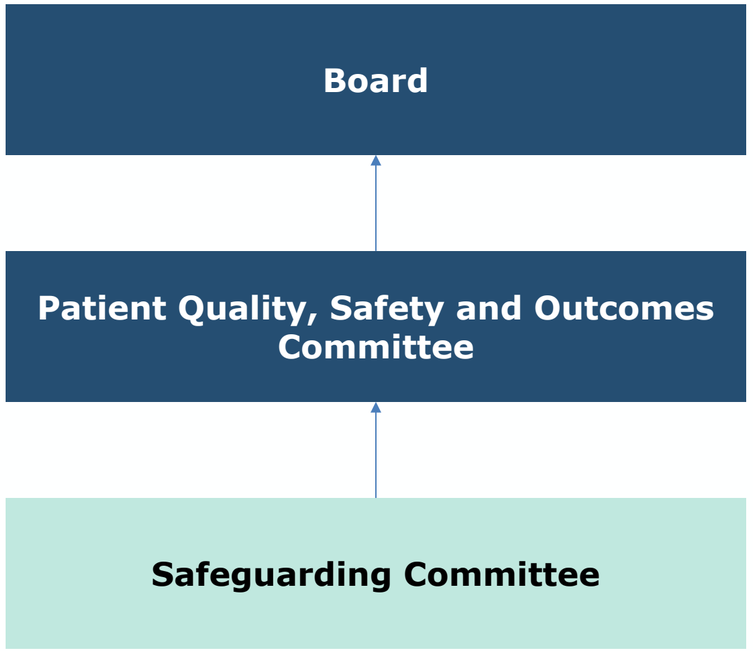
ABUHB is accountable for ensuring that its own safeguarding structure and processes meet the needs of the service. Safeguarding within ABUHB is underpinned by a clear and robust structure, with the Chief Executive accountable for safeguarding and responsibility for executive leadership delegated to the Director of Nursing, supported by the Assistant Director of Nursing – Quality & Safety. A Head of Safeguarding, supported by a Deputy, is in place to provide strategic assurance for Safeguarding, as well as being the representative on Partnership Boards.

As strategic lead, the Head of Safeguarding has delegated responsibility for development of appropriate systems including development and implementation of policy, provision and monitoring of training, support with operationalisation of safeguarding practice and ensuring there is a process for monitoring both quality and effectiveness of safeguarding, across the organisation.

As of 31 March 2023, the Safeguarding Team is fully established.



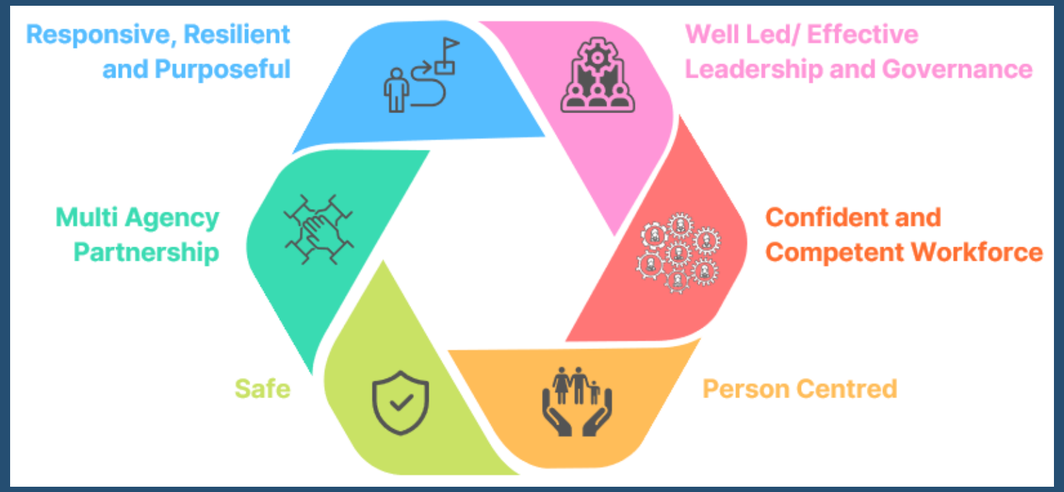
The Safeguarding Committee is a formally constituted Committee within the Heath Boards governance structure and reports to Patient Quality and Safety Outcomes Committee, having delegated authority to oversee and monitor the Safeguarding of Adults, Children and Young People.



This committee sets out the Health Board's Safeguarding Strategy and sets objectives to encourage continuous improvement, as well as compliance with national and local policies. It is further tasked with responsibility to develop and implement systems for quality monitoring that are robust, auditable and effective, as well as raising the awareness of safeguarding agenda.

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix is a quality assurance tool that all Health Boards and Trusts in Wales submit to the NHS Wales National Safeguarding Team on a yearly basis, used by Health Boards to measure the effectiveness of Safeguarding using self-assessment, identifying strengths and areas for future focus. This tool has 6 standards and a total of 43 indicators across the categories of:



The most recent Safeguarding Maturity Matrix completed and evaluated highlighted three areas of non-compliance, fourteen areas of partial compliance and twenty five areas of full compliance.

Non-compliance related to the following indicators: -

- Evidence that safeguarding training compliance is able to be monitored for new starters, existing staff, bank & agency staff, independent contractors and volunteers.
- Evidence that feedback from people who use services is used to monitor and improve the quality of services.
- There is evidence that colleagues, including bank & agency staff, independent contractors and volunteers have the training and skills to recognise when children or adults are at risk are in need of additional support and can make appropriate referrals internally and externally.

Partial compliance related to the following indicators: -

- **Leadership/Staffing:** this focussed on the vacancies within the team and a need to undertake more work in relation to succession planning.
- **Training:** there is not strong evidence that training is delivered to all staff, compliance is monitored and that training contains all relevant subject matter, including learning from reviews and audit.
- **Audit/Evaluation:** there is not strong evidence that audit is undertaken routinely to ensure that policies are adhered to and that learning is embedded in practice.
- **Policy/Procedures:** there are areas of policy and procedure which required strengthening, in particular with regard to practitioner concerns.

In response to these areas for development, the following was identified:

- **Leadership/Staffing:** the Safeguarding Team was fully established from December 2022 and staff development/progression/succession planning forms a core part of appraisal.
- **Training:** a full review of training, compliance and content begun in Q4 2022/23, and training dates are scheduled and advertised throughout the 2023/24 reporting period
- **Audit/Evaluation:** an audit is scheduled for Q2 2023/24. In addition, work is planned by the Safeguarding Board to gather feedback.
- **Policy/Procedure:** the particular highlighted concern has been addressed, but future policy review will be based upon changes in legislation, learning from reviews/audit and feedback from staff/service users.

Audit

No formal audit of safeguarding arrangements was undertaken in 2022/23. An Audit is scheduled for Q2 2023/24.

Activity for Safeguarding Children and Adults

A Corporate Safeguarding Hub was launched in January 2021, offering a single point of contact for advice and support to both the Health Board and for external partners. The function of this hub is supported by expert safeguarding practitioners who triage, assess, coordinate, and monitor cases relating to individuals at risk known to the Health Board.

Safeguarding Children

In 2022/23 there have been 1932 cases where a strategy discussion has been held across the five boroughs. Whilst there is not a full data set for 2021/22 to utilise for comparison, there were 451 strategy discussion for the five-month period for which there is data available. This therefore indicates an increase in activity of 78%.

Whilst some of the increases in activity can be put down to better resourcing within Local Authority Safeguarding Teams and better training/awareness in relation to safeguarding, this does not account for such a sharp rise in activity.

In 2023/24 the Corporate Safeguarding Team will continue to work with partner agencies, both responsively in regards of individual cases but also proactively, via the Safeguarding Board, to ensure the increase in activity is fully understood.

The effectiveness of our safeguarding hub in contributing to the safety planning for children at risk, enables staff to better support children, young people and their families at an early stage, as a result of engagement in multi-agency discussion.

Child Protection Medicals (CPM)

Child Protection Medicals are examinations to look for signs that a child or young person has been neglected or abused.

Throughout 2021/2022 the number of CPM were consistent, averaging 75 per quarter. Unfortunately, the data for 2022/23 has been corrupted, but discussions with the Lead Clinician for the CPM process has indicated that the volume of work remains roughly the same.

Review of some the CPM undertaken has revealed that the complexity of cases has increased, particularly in relation to radiology, family complaints and some unusual presentations.

The radiology concerns have related to some differences in opinions between radiologists within ABUHB and those in other Health Boards. This is subject to ongoing work on a national basis, to look at how processes can be standardised throughout Wales.

In regard of the unusual presentations, this relates to some very young babies being seen with physical injuries. Whilst no formal comparator work has yet been undertaken, initial discussions suggest that this is unique to our area, so further consideration to this will need to be given in 2023/24.

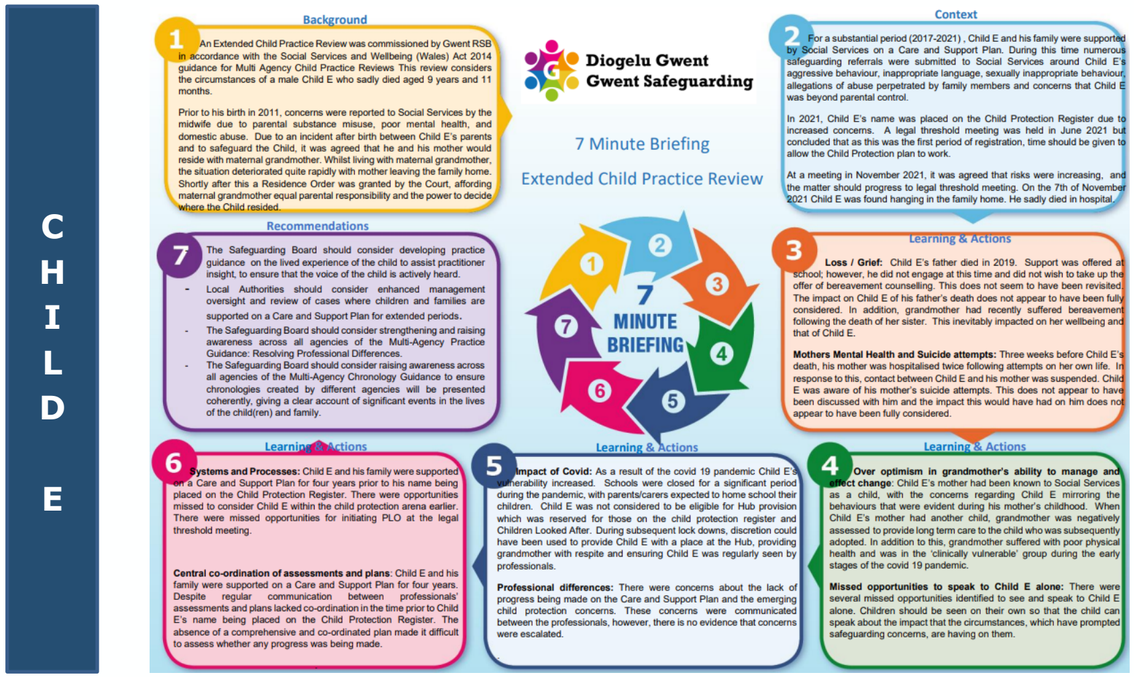
According to policy a CPM should be conducted within 24 hours of request being accepted. In the reporting year all children were seen within the set timeframe.

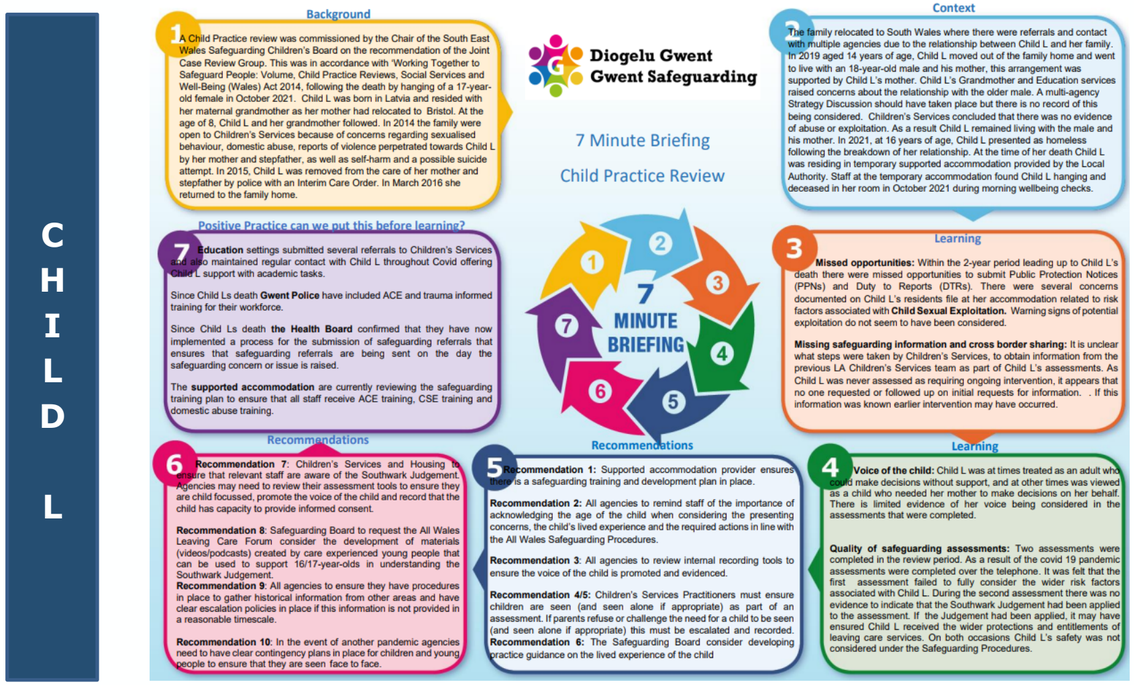
Child Practice Reviews

In 2022/23 there were two Child Practice Reviews published by Gwent Safeguarding Board and learning from these has been disseminated via the Safeguarding Committee.

The first of these reviews, Child E, relates to a child who died following having been found hanging in 2021. Child E had been known to services following a particularly complex first ten years of their life. Within the review there were no specific areas where it was identified that there had been any oversights or that there were any specific areas for improvement in relation to ABUHB provided or contracted services. However, some of the wider learning points regarding effective models of both safeguarding and management supervision for staff working with complex cases provided some useful learning internally.

Child L, the second of these reviews, relates to a sixteen-year-old who died having been found hanging in 2021. This young person had been known to services for some time, due to a history of domestic abuse and physical abuse. Within the review there were no specific areas where it was identified that there had been any oversights or that there were any specific areas for improvement in relation to ABUHB provided or contracted services. However, some of the wider learning points regarding effective models of both safeguarding and management supervision for staff working with complex cases provided some useful learning internally. Of particular note were issues related to cross border sharing of information and the risks associated with not seeing at risk individuals face to face during the pandemic.





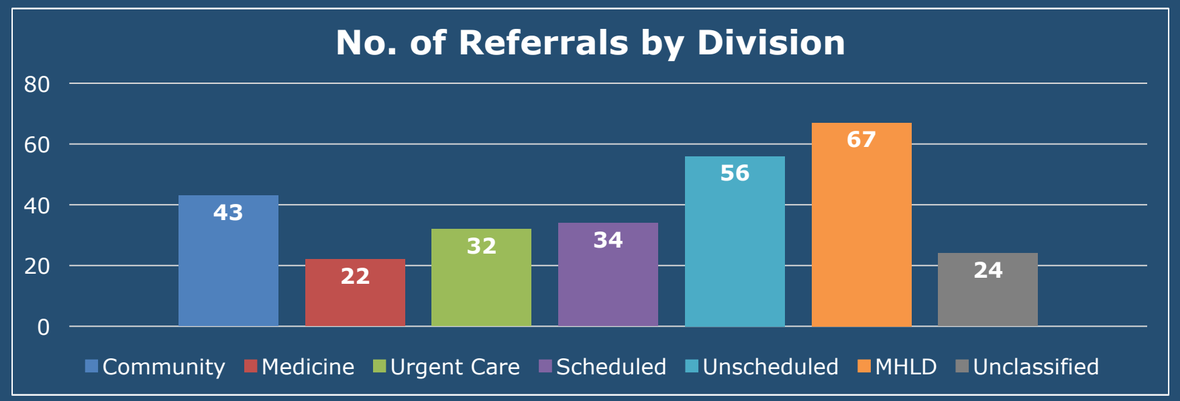
Safeguarding Adults

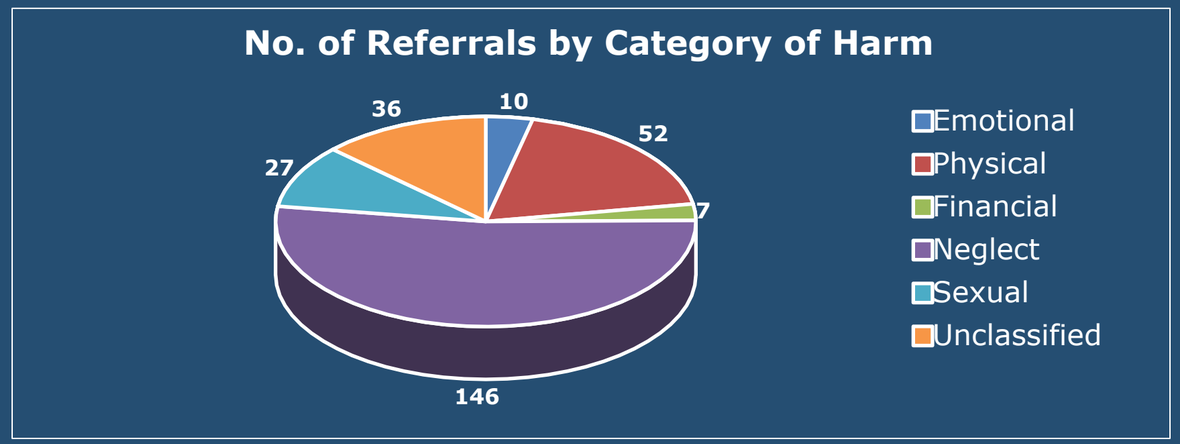
The adult safeguarding function of the Corporate Safeguarding Team receive Duty to Reports from Divisions enabling assessment and multi-agency referral for adults at risk.

These include cases that pertain to possible safeguarding risk that the Health Board may have contributed to, and cases where external parties (individuals or organisations) are contributors.

In 2022/23 there were 278 Duty to Reports received by Corporate Safeguarding. This is consistent with a gradual increase since 2019, with 231 in 2019/20, 24 in 2020/21 and 261 for 2022/23.

The following show the referrals broken down by Division and Category of Harm.





The information provided by Division is reported for information purposes only and is not utilised for comparison, as often the Division reporting will be reporting a concern that is not related to the care and treatment that they are delivering.

When reviewing the data categorised by type of harm, it is clear that Neglect is by far the most prevalent. This category includes allegation of neglect with sub themes including poor discharge, pressure ulcers and medication errors.

On closer analysis of the data relating to physical harm, it is noted that a bulk of these incidents are patient upon patient assaults, which on investigation have nearly always been unavoidable.

Of significant concern is the number reported in relation to sexual assaults. This has been brought in to sharp focus by a UK wide report which draws attention to people experiencing sexual assault when at there most vulnerable. Extensive work is planned in 2023/24 to look at this issue in much more detail.

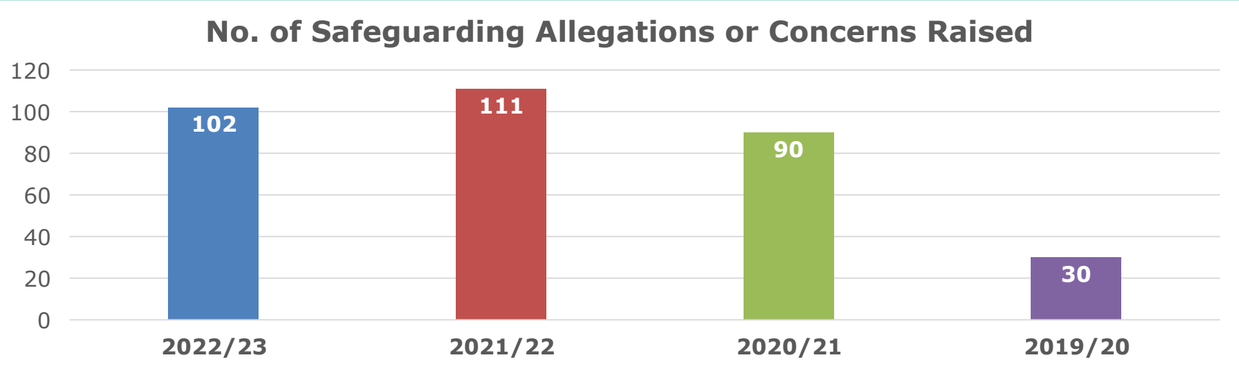
As the total figures reported are much higher than we would hope for, it is important to view them in terms of the outcomes of the safeguarding action that followed the DTR. Of the 278 DTR reported, 250 resulted in no further action, as a result of ABUHB having put in place adequate safeguards to protect patients from harm, with 18 resulting in requests for further action. Unfortunately, at the time of this report, 10 cases remained open and were with the Police for consideration of further action.

Adult Practice Reviews

In the period 2022/23 there were no Adult Practice Reviews published by the Gwent Safeguarding Board.

Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

Section 5 of Wales Safeguarding Procedures provides a framework for how to respond appropriately to safeguarding concerns about people whose paid or voluntary work brings them into contact with children or adults at risk.



Of the 102 referrals in to the process in 2022/23, only 10 were substantiated, with 10 proceeding to criminal investigation.

When reviewing this report it is important to recognise that the process in place means that staff are considered under this process, regardless of whether the allegation made against them relates to their work for ABUHB or is related to an incident or occurrence within their private lives.

Domestic Abuse

Domestic Abuse is "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality" (Welsh Government, 2015).

The Corporate Safeguarding Team are involved in work to support victims of domestic abuse who are at high risk, through supporting the Multi Agency Risk Assessment Conferences (MARAC). These are multi-disciplinary meetings where cases pertaining to victims who are at risk of serious harm or homicide are discussed, and actions made to safeguard them.

In 2022-2023, due to staffing challenges ABUHB's Corporate Safeguarding Team were unable to commit to attend MARAC', but were still able to support the process through submission of reports. Further to this. They also ensure that all health-related actions are co-ordinated and sent to appropriate practitioners for implementation.

Safeguarding Supervision

Safeguarding supervision is a key part of the Corporate Safeguarding Teams role. It ensures all staff are competent to carry out their responsibilities in safeguarding and feel supported and able to develop by reflection.

Supervision provides a restorative and reflective space for staff to discuss cases and reflect on what went well and what could be done better. It also helps to alert the Corporate Safeguarding Team around the themes being seen by the frontline in ABUHB.

ABUHB staff have access to supervision in several ways. This includes immediate telephone supervision, debriefs, individual supervision and group supervision.

Child Safeguarding Supervision

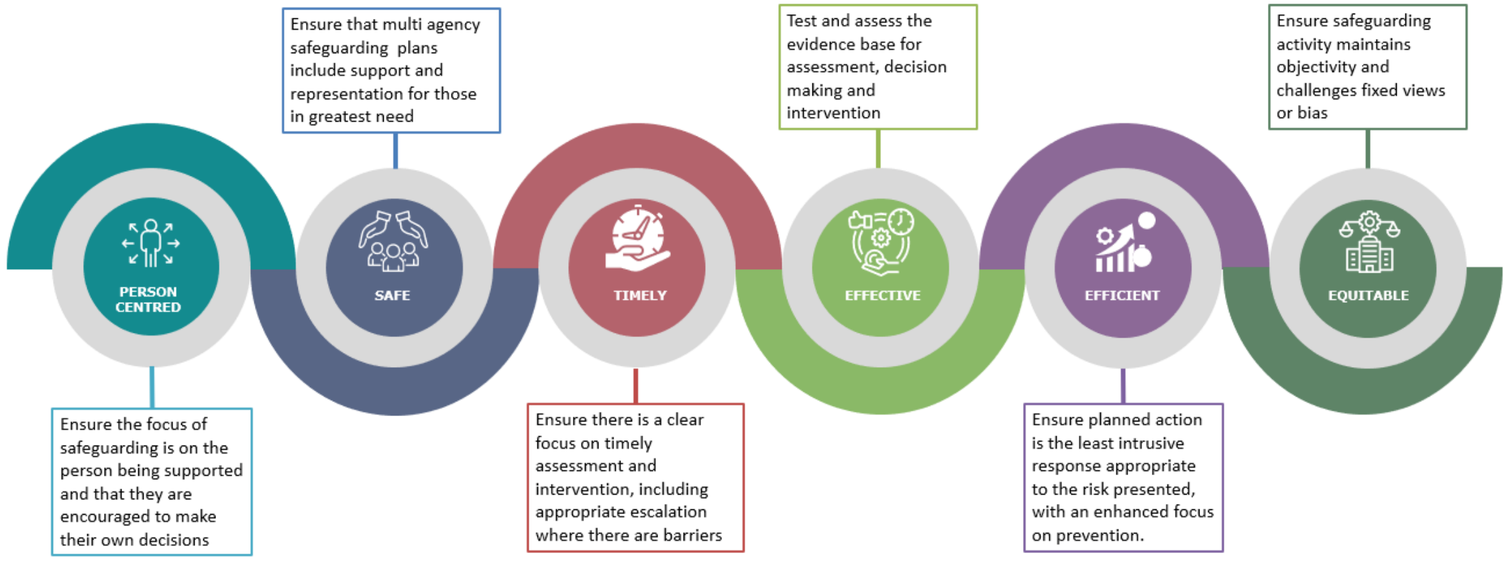
Regular supervision continues for child specific specialities including Health Visitors, School Nurses, Child Adolescent Mental Health (CAMHS) Practitioners, Community Paediatric Nurses, Children with Learning Disability Nurses, Sexual Health Outreach, Acute Paediatric Nurses, Health Care Support Workers, Neonatal Intensive Care Nurses and the Neonatal Intensive Care Liaison Team and Midwives.

The Corporate Safeguarding Team has recognised the importance of ensuring that Health Board staff are able to speak to subject matter experts regarding cases and incidents they are involved with. They are recommended to receive supervision (from the Safeguarding Supervision policy) twice per year.

Electronic reporting of safeguarding supervision began in January 2022, providing a very short comparator period. However 11 safeguarding supervision sessions were held in this period. In the reporting period for 2022/23, a total of 77 sessions were held, which evidences approximately a 75% increase in delivered sessions.

Adult Safeguarding Supervision

Adult safeguarding supervision is still in its infancy and at this current time there are no scheduled supervision sessions in place. However, since development of the Safeguarding Hub in 2021, there is always a member of Adult Safeguarding staff on duty who is available to offer support and advice on individual cases.



Domestic Homicide Reviews

In 2022-23 the Corporate Safeguarding Team supported two Domestic Homicide Reviews (DHR's), which are yet to be published.

Whilst he reviews are ongoing, some initial learning has been addressed through conversations with practitioners and has also been incorporated in to Level 3 Safeguarding Training. This related to "professional curiosity" and encouraging clinical staff supporting patients with addiction to "check in" with those supporting them and enquire about their safety and wellbeing.

The learning from these reviews will inform future interventions, as a Health Board, to better identify and service users who are victims of domestic abuse, as well as those who are supporting them.

Independent Domestic Violence Advocate (IDVA)

During 2021-22 a pilot was introduced to employ an experienced Independent Domestic Violence Advocate (IDVA) in the Mental Health and Learning Disabilities (MHLD) division. This aimed to improve the awareness, assessment, signposting and referral for patients experiencing domestic abuse (including coercive control) whilst in contact with mental health services.

It was decided in quarter 4 of 2021-22 the pilot in MH/LD would cease and the IDVA would transfer to the Urgent Care Directorate, based in ED, GUH. The impact of the IDVA in ED will be reported in the 2023/24 Annual Report.

The IDVA Service is commissioned Gwent Wide and is currently hosted by Newport City Council, though funding is provided by the five Gwent Local Authorities, ABUHB and the OPCC.

Throughout the reporting period of 2022/23 the IDVA service available to health was based in the Grange University Hospital, though this supports patients and staff across the whole ABUHB inpatient and urgent care footprint. Unfortunately, as this is an externally hosted service, no verified data is available for the reporting period. As such, a priority for 2023/24 will be to ensure a review of this service and to ensure that activity data is made available on a routine basis.

Training

Safeguarding training is a key part of the Corporate Safeguarding Teams role. Safeguarding training is mandatory in ABUHB and compliance is expected to meet Welsh Governments national target of 85%. Training is provided through e-learning and face-to-face teaching methods.

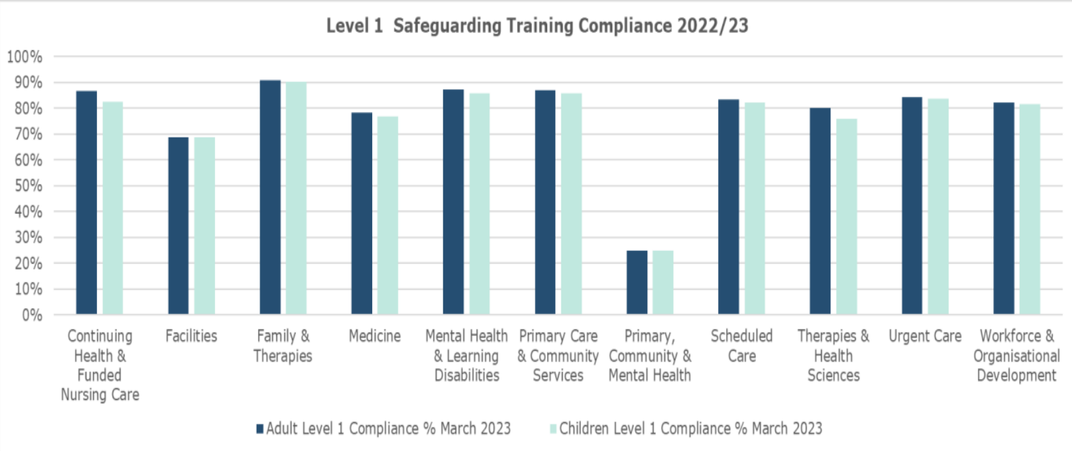
Safeguarding training compliance has been an area of service provision that was challenging to maintain throughout the time period due to reduced staffing. Planning to improve this situation was confirmed with a Senior Nurse for Safeguarding Education and Training starting employment in December 2022. At that point no face to face level 3 training was being provided.

Level 1 Safeguarding Training

Level 1 safeguarding training is mandatory for all professionals who work within ABUHB. It ensures that all staff can recognise safeguarding concerns for adults and children and are able to take appropriate action to safeguard.

Safeguarding Level 1 training compliance for adults was 84% and Safeguarding Level 1 training compliance for children was 83% on March 31st 2023.

These figures are both improved on last year. The compliance figures demonstrate only minor improvements are required to reach the 85% target. The graph below shows level 1 compliance for both adult and children by division.



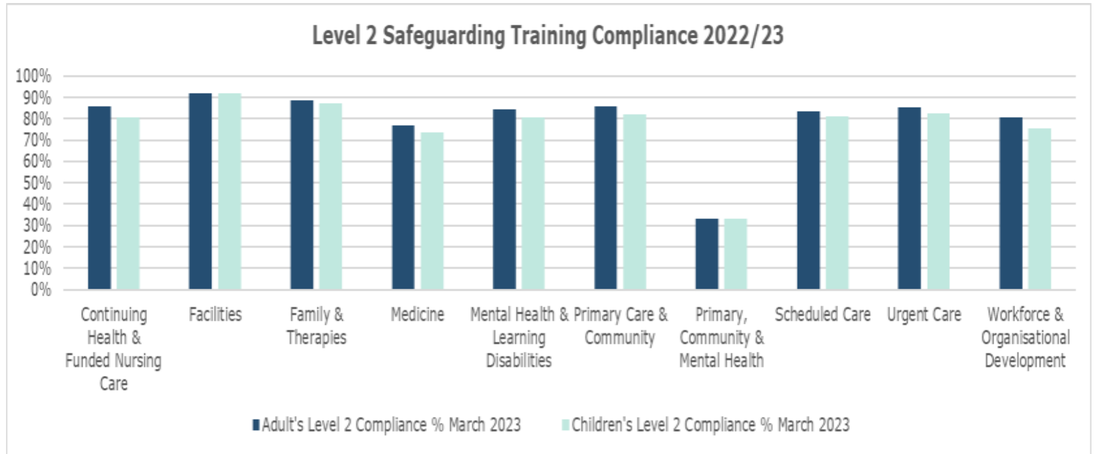
Level 2 Safeguarding Training

Level 2 safeguarding training is mandatory for professionals who work within ABUHB and have any contact with patients. They should be able to recognise and act on safeguarding concerns by making referrals and advocating for adults and children.

Safeguarding Level 2 training compliance for adults is 84% and Safeguarding Level 1 training compliance for children is 81%. This is the first time that Level 2 training compliance is being reported via ESR so presents the baseline data for future comparison.

The compliance figures demonstrate there has been a significant increase on the compliance percentage from 2021-2022 where adults were at 71% and children at 67%. The compliance figures demonstrate only minor improvements are required to reach the 85% target. The graph below shows level 2 compliance for both adult and children by division.

The graph below shows level 2 compliance for both adult and children by division.



Level 3 Safeguarding Training

Level 3 safeguarding training is for professionals who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a children or adults with safeguarding concerns.

Level 3 safeguarding training for children and adults is accessed through a 1 full day training course (7.5 hours) which provides the 'building blocks' to Level 3 competency. Additionally, level 3 members of staff are requested to complete a safeguarding competency booklet that demonstrates how they have been involved in the planning, evaluating and reflection of safeguarding over a 3-year period.

Reporting against Level 3 Safeguarding Adults and Children training is not yet complete. When agreeing the target completion date of Quarter 2 2021-2022 it was hoped that this could be achieved by using the approach of bulk aligning roles and titles on ESR. This was the approach taken for Level 2 and allows large numbers of staff to be assigned a competency at any time. An example of this is Health Visiting which would require Level 3 Safeguarding Children but not Level 3 Safeguarding Adults. Contact has been made with ESR and discussions on how this can be achieved have been commenced. Once achieved the Corporate Safeguarding Team will then be able to support in the identification and alignment of staff.

Domestic Abuse Training

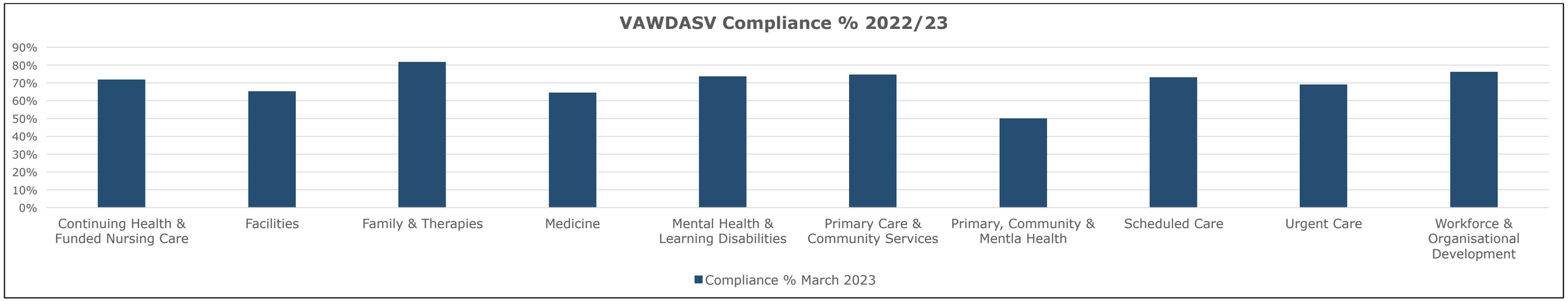
Ask and Act training aims to ensure that professionals are trained to provide an effective response to anyone affected by any form of gender-based violence, domestic abuse, and sexual violence.

Ask and Act training is grouped similarly to standard safeguarding training using level 1, 2 and 3 to indicate the responsibility and learning requirement of the participants. Level 1 being the most basic and is mandatory for all ABUHB staff, and level 3 being for those who actively work with victims and are likely to identify, assess and refer.

In 2022/23 74% of eligible staff at ABUHB were trained to Level 1 in Ask and Act. Which is a decrease from 2021/22's compliance of 78%.

Level 2 Ask and Act training there have been challenges to extracting compliance data due to ESR reporting which will be added to the Training Needs Analysis of 2023/24.

The graph below shows level 1 compliance for both adult and children by division.



Review of Priorities for 2022/23

1	There is a need to address the rising rates of Allegations/ Concerns about Practitioners or those in a Position of Trust. A Section 5 Standard Operation Procedure, Toolkit and Training package will be created, launched and communicated across the Health Board to ensure robust and consistent management of these safeguarding concerns.	A Standard Operating procedure can be found on the Safeguarding pages of ABUHB Intranet.
2	There have been increases in the number of Duty to Report referrals received from the Unscheduled Care Division. There will be close work between the Corporate Safeguarding Team and the Division to ensure incidents and risks are co-managed, and safeguarding supervision and safeguarding training packages are in place, are being accessed by staff and compliance is regularly monitored. A pilot of an evidence-based safeguarding proforma will be rolled out in the Emergency and Assessment departments to help guide the initial assessment, triage and referral process for adults at risk.	This relates to work in the Urgent Care Division, where a new referral pathway has been rolled out. Whilst improvements are noted, further work will be required in the next reporting period to ensure that the level of improvement is maintained.
3	There has been an increase in the number of Duty to Reports received regarding patient-on-patient assaults in ABUHB. It is important this trend is understood and interventions can be put in place to prevent harm to adults at risk whilst they are in the Health Board's care. Close work with the Divisions who report higher levels of patient-on-patient assault will be required to look at incident monitoring and themes, and to use the Safeguarding Committee and Operational Groups to create an approach that can be piloted in the Health Board.	Considerable work has been undertaken in partnership with the MHLD Division to understand these incidents and to ensure that proactive safeguarding care plans are in place to try to reduce both frequency and impact of these incidents. It is noted that prevention of these incidents is unlikely, as they often cannot be predicted and any control measures need to be balance with patient's rights. However, it is noted that prevention and management plans have reduced the impact rather than the frequency.
4	Safeguarding supervision for adult specific practitioners was piloted in 2021 for District Nurses. The pilot has been challenging to evaluate as there was poor attendance due to the pandemic. There needs to be a continued focus on safeguarding supervision for adult practitioners in 2022-'23 with wider roll-out focused in safeguarding 'high impact' areas, such as Unscheduled Care and Mental Health & Learning Disabilities Divisions.	It was agreed that the initial focus should be on increasing the take up of Level 3 Adult Safeguarding Training, prior to trying to embed formal Safeguarding Supervision across the Adult workforce. It should be noted that the target audience for this supervision is potentially 4000 staff members across the organisation. However a programme of Safeguarding Supervision for the Band 7 Nurses and above in the Complex Care has been prioritised and will be launched in 2023/24.
5	The pilot of an Independent Domestic Violence Advocate in the Mental Health & Learning Disabilities Division had some success in 2021-'22. However, it was recognised the referrals and training numbers did not match the levels seen in comparative Health Boards such as Cardiff and Vale UHB, and with the levels of domestic abuse reported across the Health Board. Consequently, the IDVA service will be re-piloted in the Unscheduled Care Division to ascertain if the impact is higher. This will be thoroughly evaluated in 2022-'23.	The IDVA Service is fully embedded within ABUHB and has secured long term funding. Therefore, this pilot has now been completed.
6	Compliance for Level 1 and 2 Safeguarding Children and Adults Training and Level 1 'Ask and Act' training has improved in the reporting year. However minor improvements are needed to meet the 85% target. A training needs analysis will be produced to better understand and address the challenges in achieving target compliance in 2022/23. Bespoke training for Divisions where compliance is low will be introduced.	The training needs analysis has been completed and informed the current training offer. It should be noted that the training offered is of prescribed frequency, content and time, so there is little scope for innovation in regard of delivery

Review of Priorities for 2022/23

7	Level 3 Safeguarding Children and Adults Training compliance is not yet able to be reported. This needs to be addressed in 2022/'23 with a complete mapping exercise of the roles that require Level 3 training to be completed. The current 'building blocks' approach to Level 3 safeguarding training also requires review, as compliance with the 'Safeguarding Competency Booklet' is challenging to monitor.		The mapping exercise is completed and staff requiring training have been identified. Challenges with ESR are yet to be overcome in regard of mandating this training to identified cohorts in a measurable way.
8	Current ongoing Domestic Homicide Reviews that ABUHB are involved in have demonstrated there is work needed to better understand and address routine inquiry and support offered to older adults who are victims' of domestic abuse. Engagement in local and national multi-agency VAWDASV groups is required to ensure that the Health Board is included in plans and pilots for this specific area of concern.		There is ongoing delivery of Ask and Act Training, alongside more localised education regarding routine enquiry. However, Ask and Act compliance is currently not able to be monitored or reported on.
9	Suicide and self-harm for children and young people has been identified as a theme in multiple Child Practice Reviews. It is important that the Health Board is included in local and national workstreams that are ongoing next year, to ensure that a preventative approach to suicide and self-harm is promoted across all divisions. 'High impact' areas such as the Child and Adolescent Mental Health Service, School Nursing and Emergency Departments must be particularly involved in planning and piloting of new approaches.		The ABUHB Public health team have been heavily involved in the national and regional work in respect of Suicide Prevention.
10	ABUHB is piloting a new version of the Safeguarding Maturity Matrix in 2022- 2023. It is important actions from the new quality assurance tool are incorporated into the annual Workplan and Safeguarding Strategy.		The findings of the Safeguarding Maturity matrix have influenced the objectives set out in this annual report.
11	Impending changes to the Mental Capacity Act legislation has faced significant delays in UK Government. Work needs to continue regarding the Act and the proposed changes that look set to be launched in Autumn 2022. The Mental Capacity Act must remain on the Workplan for 2022-2023 to ensure it remains in focus and risks are addressed as they arise.		Whilst impending changes to the MCA must remain on the workplan, the UK Government has announced that the proposed replacement for Deprivation of Liberty safeguards (DoLs) called Liberty Protection Safeguards is postponed, and the publication of a new MCA code of practice on hold. DoLs remains the legal safeguarding framework. Compliance with the Mental Capacity Act 2005 and the DoLs framework remains a statutory duty and education and training to support the organisation to meet its statutory duty remains a clear priority for all LHB's.

Conclusion

In conclusion, 2022/23 was a challenging year for the Corporate Safeguarding Team, impacted by the challenges of staff vacancies for a large part of the reporting period.

Despite the challenges, successes have been secured:

- Continued involvement in national pilots and workstreams relating to the Safeguarding Maturity Matrix and the Single Unified Safeguarding Review.
- Understanding the challenges of delivering effective safeguarding training to an evolving and agile workforce.
- Delivering and quality assuring safeguarding supervision
- Full implementation of the Safeguarding Hub model
- Embedding of an Independent Domestic Violence Advocate based in urgent care
- Publication of Standard Operating Procedure to manage professional concerns

ABUHB is committed to ensuring the safeguarding of children and adults is a priority and continues to improve in 2023/24, tackling both existing and new challenges, many of which will be from hidden harms faced by victims and survivors, who will need safeguarding in different ways to those we have known before.

Work will continue with the community and partners to ensure the development and adaptation according to need, with patients at the heart of everything that we do.

Priorities for 2023/24

ABUHB acknowledges that there is further work required to improve the safeguarding of children and adults at risk. It is important as Health Board that we continue to adapt and enhance the services we offer to meet the needs of contemporary society.

The priorities for ABUHB in 2023/24 are:

Priority 1:
Level 3 Safeguarding Training is not yet mandated via ESR and therefore is unable to be monitored at either an operational or strategic level. Therefore, ongoing work will be needed to ensure that this is remedied, to able better monitoring of compliance.

Priority 2:
Divisional Reporting to Safeguarding Committee is not yet established as standard practice. As the bulk of the operational work relating to safeguarding takes place at an operational level, divisions need to be able to demonstrate an awareness of themes, trends and risk. As such, the Corporate Safeguarding Team will work with Divisional leadership Teams to ensure that a mechanism is in place for reporting to committee.

Priority 3:
Feedback from partners has highlighted some delays in referrals being made to local authorities where a child in urgent care may present with a need that meets the threshold for referral to safeguarding. Work will be undertaken to ascertain how IT can be utilised to minimise the impact on staff and enable more timely referral, this will be the subject of monitoring to ensuring improvement and to monitor quality.

Priority 4:
ABUHB has a statutory duty to engage with local multi agency work focussed on reduction of serious violence. As such, the Safeguarding Team will work internally with Public Health and externally with partners to ensure that we are first recording/ reporting appropriate data and then to utilise this to direct strategies to reduce violence.

Priority 5:
To undertake a thematic review of PRUDiC to understand any themes and ensure that these drive improvements both internally and externally to our organisation.

Priority 6:
To work with partners regionally to understand the variance in reporting of skeletal surveys that form part of the Child protection Medical Process, looking at how peer support and review may facilitate consistency.

Priority 7:
To engage with the partners regarding the review and recommissioning of the IDVA service, to ensure that it meets the needs of the ABUHB population and that the way in which it meets these can be evidenced both quantitively and qualitatively.

Priority 8:
To review internally the way in which reports of sexual harassment and sexual harm are reported and managed, both in respect of individual cases and wider thematic learning.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

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

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

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 December 2023 was that the Committee Strategic Risk Register included **three** high-level strategic risks and **four** sub-risks. Since then, the Board approved changes to the Strategic Risk Register at its meeting in January 2024. Two of the approved changes are related to the delegated responsibility of the PQSO Committee. These changes are outlined below.

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 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 inclusion of a new high-level strategic risk **SRR 010,** compromising **one** sub-risk which will be monitored by the PQSO 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.*

As at February 2024, the PQSO Committee Strategic Risk Register contains **four** high-level strategic risks comprising **four** 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 February 2024 for the **four** strategic sub-risks delegated to the PQSO Committee. The 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. While the risks have been updated to include enhancement of control and assurances there has been no change in the risk score or level.

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

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 003B **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	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 the limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	**Extreme** **(20)**	**N**

SRR 005 **Theme** Service Delivery **Appetite** Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	**High (12)**	**Y**
SRR 008 **Theme** Transformation & Partnership Working **Appetite** Open Score 16 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**High (8)**	**Y**
SRR 010 **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**Extreme (20)**	**N**

Over the coming weeks, a deep dive into sub-risks outside of appetite will be conducted, to provide assurance to the Committee at its next meeting that additional controls are being implemented to reduce the risk to within appetite level. Where risks fall within the appetite level, work with risk owners will continue to assess and refine controls and assurances, with a focus on the financial context and its impact on individual strategic risks, as well as horizon scanning for potential new risks that could impede delivery of the Health Boards' objectives.

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 PQSOC will ensure 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 **Theme** Service Delivery **Appetite** Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to the current Pharmacy layout/robot at RGH being over 18 years old and not fit for purpose.	**Extreme** **(20)**	**N**

Throughout February, meetings with Executive Directors have been scheduled to proactively identify and document any high-level operational risks in the Corporate Risk Register (CRR). These risks will be owned by the Executive Team, as they require a level of ownership that surpasses an individual Executive Director's capacity. The identified risks will typically span across two or more divisions or require resources and plans beyond a division's capability or capacity to implement.

Collaboration with the Mental Health and Learning Disabilities Division is ongoing; meetings with directorates and the divisional leadership team have already taken place. The meetings were held to provide risk management training and to start developing risk registers that accurately reflect potential risks. This initiative has been supported by the recently approved Risk Management Framework and Policy.

The training has focused on differentiating between issues and risks to ensure that issues are being actively managed, and potential risks are being controlled appropriately. Any gaps identified in the control environment are being addressed through appropriate action. Additionally, the processes in place for reporting and escalating risks through the Division are being streamlined and implemented as per the escalation process set out in the Risk Management Framework.

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

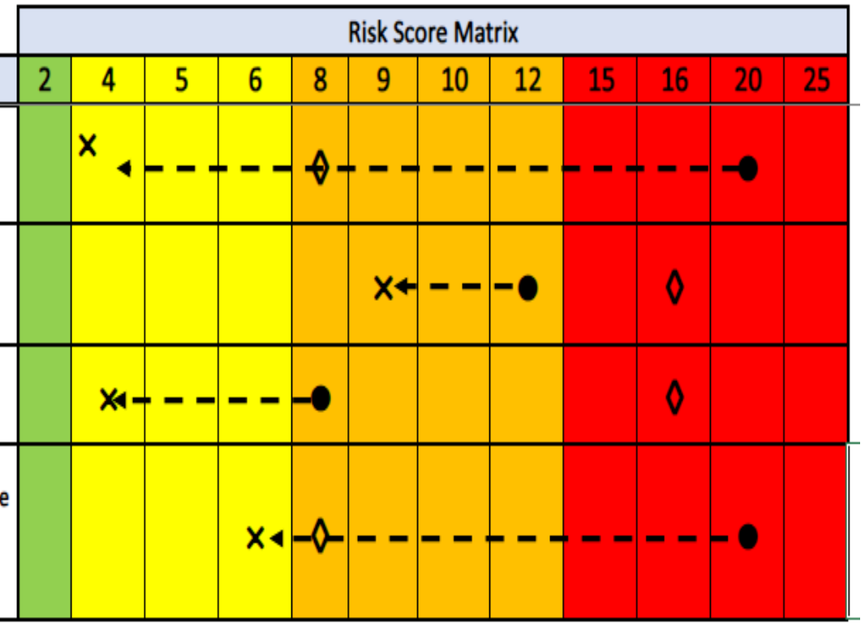
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees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

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

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 003	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Chief Operating Officer	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	b)Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	•Harm or injury to patients and/or staff •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.	Medium	2	2	4	Low	12/01/2024	12/02/2024
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	12/01/2024	12/04/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.	Medium	2	2	4	Low	11/01/2024	11/04/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Satey of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	4	4	16	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	11/01/2024	11/02/2024

Patient Quality, Safety & Outcomes Strategic Risk Dashboard

Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix
SRR 003	Chief Operating Officer	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	b) Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	
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	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.

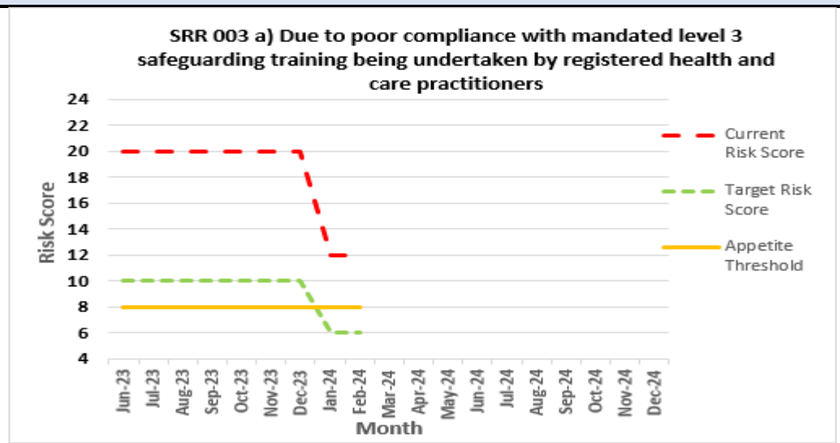
Key	
	Current Score
	Target Score
	Appetite Threshold
	Current to Target

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	**b) Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.**			
Impact	➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Unlikely)*
Last Reviewed	12 January 2024	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*
Next Review Due	12 February 2024			

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

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

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• CAMHS now have a team of healthcare support workers, at band 4 (our BOOST team), who are in the process of being trained, prior to being ready to be available over 7days to directly support young people who are in hospital because of a delayed discharge. • CAMHS have an agreement with adult Mental Health Services in place, enabling us to access a 'holding bed 'situated in the Extra Care area at Ty-Cyfanol ward, at YYF. This allows us to support young people experiencing suspected serious mental illness for up to 72 hours, whilst a gatekeeping assessment is carried out by our colleagues at the tier 4 in-patient unit. • Our Emergency Liaison Team are present at GUH on a daily basis, assessing young people at the point of need. • Windmill farm therapeutic residential home, a partnership project between CAMHS and social services, is now open and can accommodate young people struggling with complex mental distress that are environmental and not organic. There are 4 places at the home, and we have	• Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: • Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. • Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. • Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Senior Management Team meetings to track progress against the action plan. • Twice-daily X-Site flow meetings to provide a position report **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee • Regular reporting to the Mental Health Act Monitoring Committee • Reporting to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections of Mental Health Wards across all sites	**Gaps in Assurance** Development of CAMHS Crisis Hub Project build. **Action to Address Gaps in Assurance** The CAMHS Crisis Hub Project development is ongoing – tenders for contracts were return 20th December 2023 within identified capital budget constraints. Tenders are currently with Quantity Surveyors Faithful & Gould for a two-week review to check for omissions or anomalies. Tenders have all identified estimated completion of the CAMHs Crisis Hub by August 2024. CAMHS Crisis Hub Project Team meet monthly – update reports are provided to the CAMHS	**Reasonable Assurance**

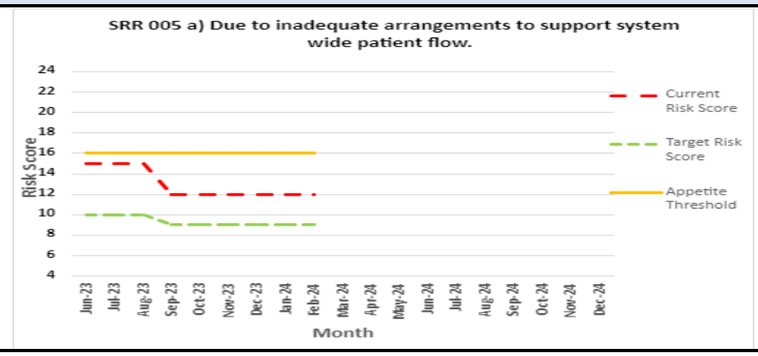
already successfully placed, supported, and transitioned several young people who may previously have required an out of county placement. • BOOST team manager in place. • Crisis Outreach Team are the designated team who manage and co-ordinate admission to the holding bed. • Standard Operational Policy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

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	**a) Due to inadequate arrangements to support system-wide patient flow**			
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3 *(Minor)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due	12 April 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.



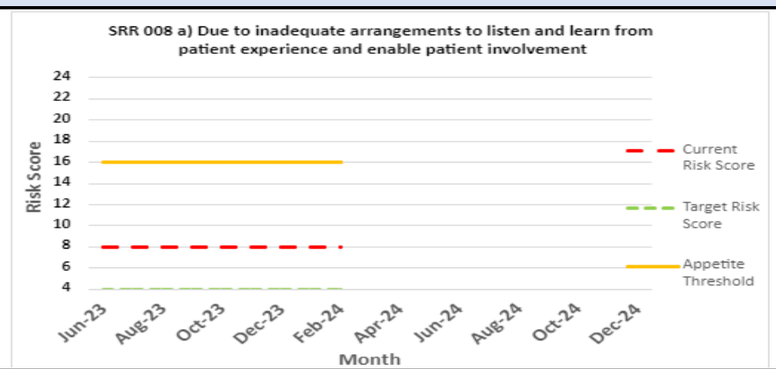
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. • Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: • Focus • Processing power • Capacity • Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. • Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. • Improve regional acceptance of flow processes with neighbouring Health Boards. • Industrial Action – command and control structures across gold, silver and bronze to ensure service continuity and patient safety throughout any medical strikes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** 1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 008)	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**			
Strategic Threat	**a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	11 January 2024	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*
Next Review Due	11 April 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.



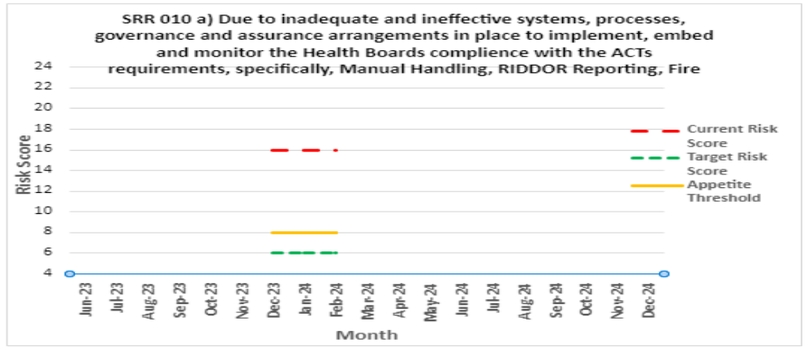
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence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

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; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments; ➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage			
Lead Director	Director of Therapies & Health Science	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**4** (*Likely*) **x**	**2** (*Unlikely*) **x**
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*
Date Reviewed	11 January 2024	**Overall Risk Rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*
Date of Next Review	11 February 2024			

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

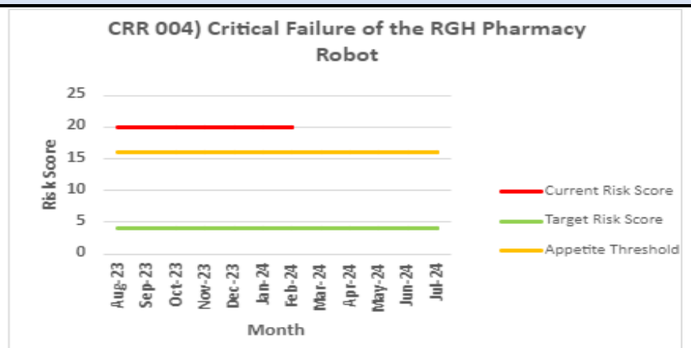
Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**

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. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee) • Develop and Implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Board Training /development • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	**Gaps in Assurance** • Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	**Negative Assurance**

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.			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	➢ Unintended patient harm from missed doses of medicines due to the disruption in supply. ➢ Impact on patient flow through our hospitals due to the delay in supplying medicines at discharge; reduced ability to process TTHs ➢ Reduced clinical pharmacy service at ward level to support local procurement teams at each pharmacy department, with redistribution of staff to departments with functioning robots to focus on medicines supply. A reduced clinical service will lead to a reduction in medicines reconciliation and reduction in the identification of prescribing errors leading to further patient harm. ➢ Further deterioration in staff morale leading to further vacancies.			**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.
Lead Director	**Medical Director**	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	**Patient Quality, Safety & Outcomes Committee**	**Likelihood**	**5** *(Almost Certain)* *x*	**1** *(Rare)* x
Initial Date of Assessment	**01 July 2023**	**Impact**	**4** *(Major)*	**4** *(Major)*
Last Reviewed	**12 February 2024**	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• GUH and YYF staff are trained to complete 'critical low' supplies for bulk items that fall below set PAR levels for onsite Omnicell's before top-up trigger from RGH. • Automated daily reports to sites are in place to trigger supply to maintain critical levels of stock across hospital sites in between centralised top-up from RGH. • A contingency plan is in place and 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: • **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. • **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. • **Long Term** - Replacement of the Robot. Executive Committee has agreed RGH robot as a priority from Capital monies in the 2024/25 program. Project delivery anticipated in Q2/Q3 of 24/25.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Check critical levels of stock reported daily. • The operational status of the Robot is monitored at the Pharmacy, Divisional Senior Leadership Team, and at Divisional Assurance meetings. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Operational status of the robot and service delivery monitored by the Executive Committee through the Corporate Risk Register Report • Management of the risk is monitored by the PQSO Committee • Recorded and updated on Datix. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Not applicable	**Gaps in Assurance** • Reporting on the number of medication incidents or patient harm related to a critical failure. **Action to Address Gaps in Assurance** • Ensure that any medication-related DATIX reports are reviewed at the point of robot failure to determine the impact. • Ensure that the impact on staff is assessed following any critical failure, lessons learned, and contingency plan updated where necessary.	**Reasonable**

Agenda Item:3.3

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Recommendations Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This is the first iteration of this report presented to the Patient Quality, Safety, and Outcomes (PQSO) Committee.

The purpose is to provide greater transparency 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 constructively evaluate the effectiveness of governance and risk management, using a risk-based approach to delivering improvement. It also aims 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 Corporate Governance Directorate records and tracks 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.

This report aims to enhance transparency and oversight of audit findings. It provides the Committee with the current status of recommendations covered by the PQSOC agenda. As of the end of Quarter 3 (October – December) reporting for the year 2023/24, there are **32** active recommendations across **eight** Audit Reports owned by the Clinical Executives. The list of these reports is provided below:

- Health and Safety (2017/18)
- 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 **32** recommendations by 'Year,' 'Executive Lead,' and 'Priority Rating. The colour coding within the tables is explained below. Further detail regarding the **32** 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					
Audit Year	**Lead Director**				**Total**
	Director of Nursing			**Medical Director**	**Director of Therapies & Health Science**	
2017/18	-			-	**4**	**4**
2021/22	-			**1**		**1**
2022/23	**1***	**7**	**7**	**4**	**-**	**1**	**20**
2023/24	**1**	**4**	**2**	**-**	**-**	**7**
Total	**26**			**1**	**5**	**32**

*Denotes one external audit recommendation. The remaining 31 are internal audit recommendations.

Asesiad / Assessment

The Audit Risk and Assurance Committee has reviewed the Audit Recommendation Tracker for the reporting period of Quarter 3, 2023/24 (October - December) and approved its closing position. As per the report, there are currently **32** live recommendations owned by Clinical Executives. The status of these recommendations is categorised into two sections: 'overdue' and 'not yet due'. Overdue accounts for all recommendations that have passed their original or revised implementation date, and 'Not Yet Due' are all recommendations that have an original or agreed (by the Audit Risk and Assurance Committee) implementation date that has not yet been reached and is still within the agreed implementation period.

As of 31 December 2023, **0** of the 32 recommendations are overdue. However, it's important to note that 17 out of the 32 recommendations have surpassed their original deadline as specified in the final reports. The Audit Risk and Assurance Committee has approved a new date for these recommendations, which places them in the category of 'Not Yet Due'.

Table 3 represents all **32** recommendations **'Not Yet Due'.**

Table 3

Number of Recommendations by Lead Director				
Audit Year	**Lead Director**			**Total**
	Director of Nursing	**Medical Director**	**Director of Therapies & Health Science**	
2017/18	-	-	**4**	**4**
2021/22	-	**1**		**1**
2022/23	**1*** **7** **7** **4**	**-**	**1**	**20**
2023/24	**1** **4** **2**	**-**	**-**	**7**
Total	**26**	**1**	**5**	**32**

For information, there are **0** overdue recommendations for the Audit Year 2023-24.

Argymhelliad / Recommendation

- **NOTE** the position of the 32 audit recommendations

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. 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 Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	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 Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Final Report Deadline Status	Revised Deadline Status	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?
Internal	2017	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R1 The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	31/03/2024	Overdue	Not Yet Due	**March 2023** - A programme of respiratory protection equipment (RPE) inspections has been developed and commenced in October 2022. The plan to inspect all in-patient clinical areas by March 2023 is approximately 95% complete. The inspections conducted by the Corporate Health and Safety Department are recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. A programme of health and safety environmental inspections will commence in May 2023 and will target clinical areas. The programme will be carried out over a two-year cycle, commencing with the older estate or those that have been subject to significant change i.e. Royal Gwent Hospital and Nevill Hall Hospital. The inspections will be conducted by the Corporate Health and Safety Department and recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. The Corporate Health and Safety Department are also planning the development of self-assessment inspection tools for wards and departments to complete their own localised health and safety monitoring. This will support a programme of health and safety monitoring across the Health Board.	There are no identified barriers to implementing the revitalised plan of health and safety monitoring. Resources that were not previously available within the Corporate Health and Safety Department have now been established to ensure a sustainable system of monitoring.	The risk will reduce as the programme of health and safety monitoring is implemented.	August 2023: Notes of the Health and Safety Committee. Inspection reports via AMaT.
Internal	2017	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R2 The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	31/03/2024	Overdue	Not Yet Due	**March 2023** - The Corporate Health and Safety Department have engaged with Divisions to ensure risks are recorded, monitoring and managed using the Datix system. This has improved the quality of health and safety risks on the system. The Corporate Health and Safety Department are reviewing all high risks (risk rating of 12 or above) recorded on the Datix system and where necessary support local managers to mitigate the risk. The programme of health and safety environmental inspections will support the identification and review of health and safety risks across the Health Board. Health and safety risks will be regularly reported to the ABUHB Health and Safety Committee to enable active monitoring. A revitalised education programme of health and safety risk assessment training has been approved and commenced in 2023. The register of risk assessors within the organisation has been reviewed and areas needing support will be prioritised for attendance at the risk assessment training.	The primary barrier to implementation would be lack of engagement from the areas / Divisions. Implementation of the new risk module in Datix Cymru could present a potential barrier.	The risk associated with the lack of health and safety risks will be reduced as areas engage with the risk assessment training and complete or update risks on the Datix system.	August 2023: Notes of the Health and Safety Committee. Risk Assessment Training
Internal	2017	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record 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	31/03/2024	Overdue	Not Yet Due	January 2024: Please see assurance report for full details. Nov 2022: This recommendation is monitored regularly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assets however, further work is required to physically tag the equipment and ensure compliance and traceability.	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.
Internal	2017	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	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. • Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment. Aug 2023: • New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.	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.	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.
Internal	2021.2	Medicines Managment	Reasonable	Medical Director	Medium	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	31/12/2023	Overdue	Not Yet Due	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
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Medium	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	29/02/2024	Overdue	Not Yet Due	January 2024: The development of an All Wales SOP on the management of HSE reports has stalled, therefore the Health Board have developed a Draft SOP which is currently awaiting approval August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the national meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the divisions.			
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Low	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	January 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. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	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					
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	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					

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	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					
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	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.	01/04/2024		Not yet due					
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	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.	01/04/2024		Not yet due					
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	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.	01/04/2024		Not yet due					
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	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					
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	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 specialty, 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	31/03/2024	Overdue	Not Yet Due	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			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	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 that exceptions are regularly escalated / reported following the commencement of workstream monitoring by the Dementia Programme Manager	01/07/2024		Not yet due					
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	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	31/01/2024	Overdue	Not Yet Due	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.			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	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	31/01/2024	Overdue	Not Yet Due	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
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	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	28/02/2024	Overdue	Not Yet Due				
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	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	28/02/2024	Overdue	Not Yet Due	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.	
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	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	28/02/2024	Overdue	Not Yet Due	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.			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	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	28/02/2024	Overdue	Not Yet Due	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.
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	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	28/02/2024	Overdue	Not Yet Due	Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvements 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 improvements in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	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	28/02/2024	Overdue	Not Yet Due				
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	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		Not Yet Due					
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	All investigation evidence should be attached to the complaint Datix record for ease of referance in the event of queries.	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		Not Yet Due					
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Low	Complex complaint cases which under the regulations are permitted an investigation period of up to six months should be excluded from the 30 day breach statistics.	Welsh Government are currently reviewing PTR regulations.	31/01/2024		Not Yet Due					
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	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		Not Yet Due					
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	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 follows OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability framework between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023		Not Yet Due					
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	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		Not Yet Due					
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	Actions to review the current structure throughout the Health Board mapped to the end to end process. Where gaps in or additional resourse requirements are identified these should be implemented to meet the requirements of the Health Board.	Review of all QPS resourses being undertaken via an OCP.	31/12/2023		Not Yet Due					
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	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	31/12/2023	Overdue	Not Yet Due	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. 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. Additonally, 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			

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

FEBRUARY 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 with Divisions to embed in patient experience and feedback
  - Working on recording of compliments
  - Big conversation on bereavement in March
  - PALs team receiving positive feedback
- 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

Responding to Relative Feedback: Visiting Times

A relative spoke to one of the PALS Team to express concern that they did not see staff enter their relative's room when they were **visiting**.

The relative said she would 'like to think' that this may be because staff wanted to give them time together, but that it 'would be nice to know' that. She stated that she may not be the only relative to think this and **suggested a notice** be available about respecting visiting times.

'Respecting Your Visiting Times' poster developed. Supported by Divisional Nurses.

Relative informed of the actions taken as 'listening and learning' and she was **delighted** stating 'I am very impressed'.

Welsh translation awaited and then for dissemination across all ward areas.

Respecting Your Visiting Times

We recognise that visiting times are important to people, their relatives, and friends.

During visiting hours, our staff will try not to interrupt your visits. However, they may need to enter a room or ward to provide clinical care, either for the person you are visiting or other people on the ward.

Please be assured, that whilst staff may not come into a person's room or ward during visiting times, they will be available for you to talk to should you wish to discuss anything with them.

If you would like to discuss anything about your care or the care of the person you are visiting, please do not hesitate to speak to a member of staff.

If you do not feel able to speak to the ward team, please contact the Patient Advice and Liaison Service (PALS) either by email abb.pals@wales.nhs.uk or by telephone 01633 493753.

Yours sincerely

Ward Manager

abuhb.nhs.wales

Person Centred Care: Listening and Learning from Feedback

Volunteer to Career Case Study

Earlier this year we received a referral from the Domestic Violence Team who thought volunteering may support a young lady who had been a victim of Domestic violence and give her a sense of purpose.
This volunteer commenced at YAB and thoroughly enjoyed it but wanted more. The team arranged for her to volunteer additionally in a local care home to gain further experience.

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

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

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

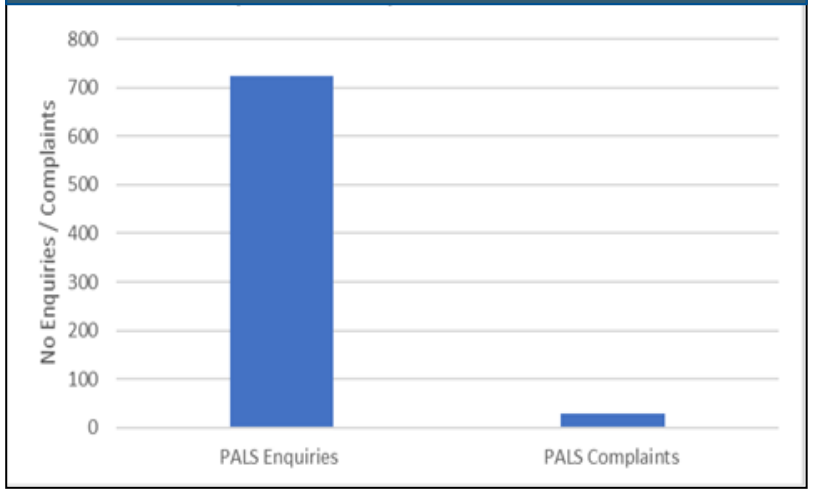
Patient Advice and Liaison Service (PALS)

Launched on 06/11/23

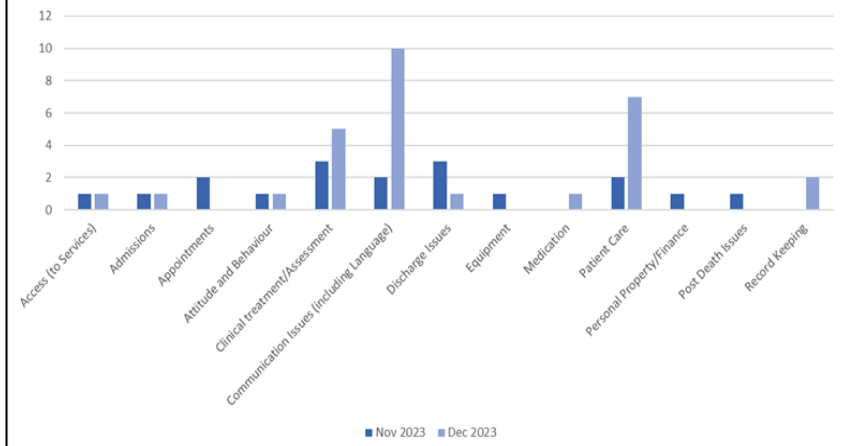
December 2023

- PSO / PALS **Enquires: 725**
- PALS **Complaints** (managed / being managed through Early Resolution): **29**
- Complaints **Escalated** to PTR: **0**
- **Compliments** relating to PALS: **3**

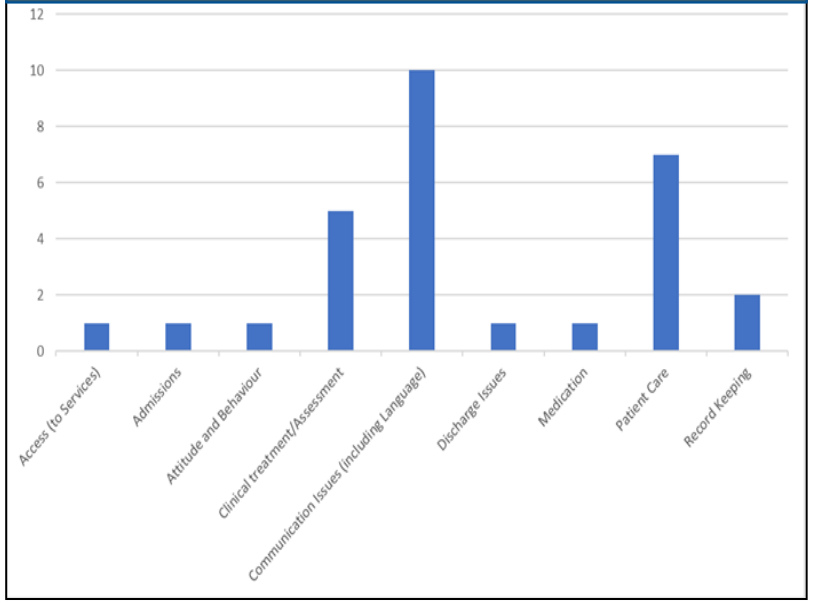
PALS Enquiries/Complaints December 2023



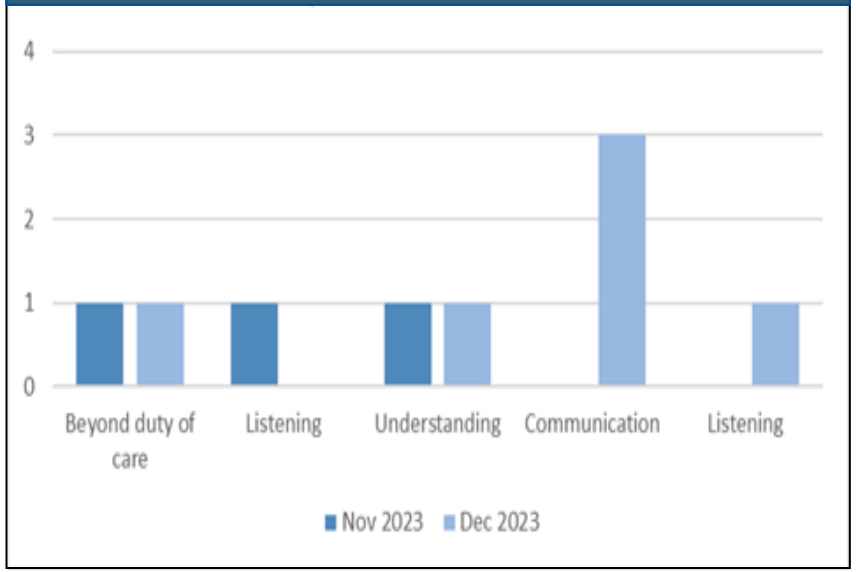
PALS Complaint Theme Comparison November / December 2023



PALS Early Resolution Themes – December 2023



Compliment Themes logged via PALS November / December 2023



Bereavement

- Inaugural **Bereavement Collaborative** held- action plan in progress
- Interviews for **Bereavement Clinical Lead** 22 January 2024
- **Drop in** Sessions for people/staff to talk about bereavement experience
- Additions to **PTR** Letters relating to CAD/bereavement- opportunities to discuss experience and inform new model. People are starting to contact
- **Big Conversation** – 20 March 20 2024

NHS Performance Framework: **Feedback from Welsh Government**

Overall, we welcome the honest assessment of your RAG status and recognise that action has already been taken to ensure Executive oversight and responsibility across respective portfolios with the Health Board. We are already seeing evidence of this through engagement at the last Health Board Leads meeting and a series of activities which have been planned for early 2024.

Key Volunteer Highlights During 2023

Our volunteers have provided **7602** unpaid volunteer hours.	Our Welcomer volunteers at NHH and YYF have supported over **2516** 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.	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 created a 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** and **The Bevan Commission** have published a national case study on our Volunteer to Career model.	**Volunteer Long Service** **25** completed **50 hours**. **18** completed **100 hours**. **12** completed **200 hours**. **6** completed **300 hours**. **4** completed **400 hours**. **1** completed **500 hours**. **1** completed **800 hours**.	In 2023, the Volunteer Service has won a **Volunteer Award** and have been finalists in **3** other awards.

Volunteering Case Study

(Welsh Language)

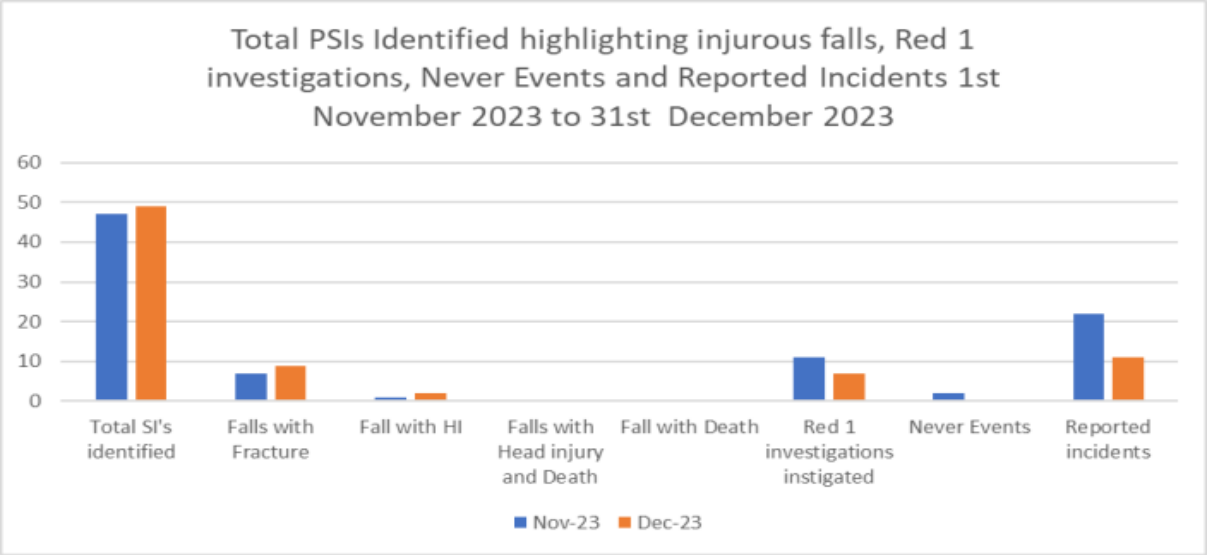
"This was my first visit with 'I' whose first language is Welsh, and she was delighted that I spoke Welsh. She was very grateful for her care as she was only able to move a little. Spoke about her childhood and where she is from originally. Spoke about her child and her family circumstances. Very humorous and humble despite her circumstances. She is looking forward to going home."

The volunteer was visiting the patient's childhood home village the same weekend and intended to take pictures to share with her at her visit the following week.

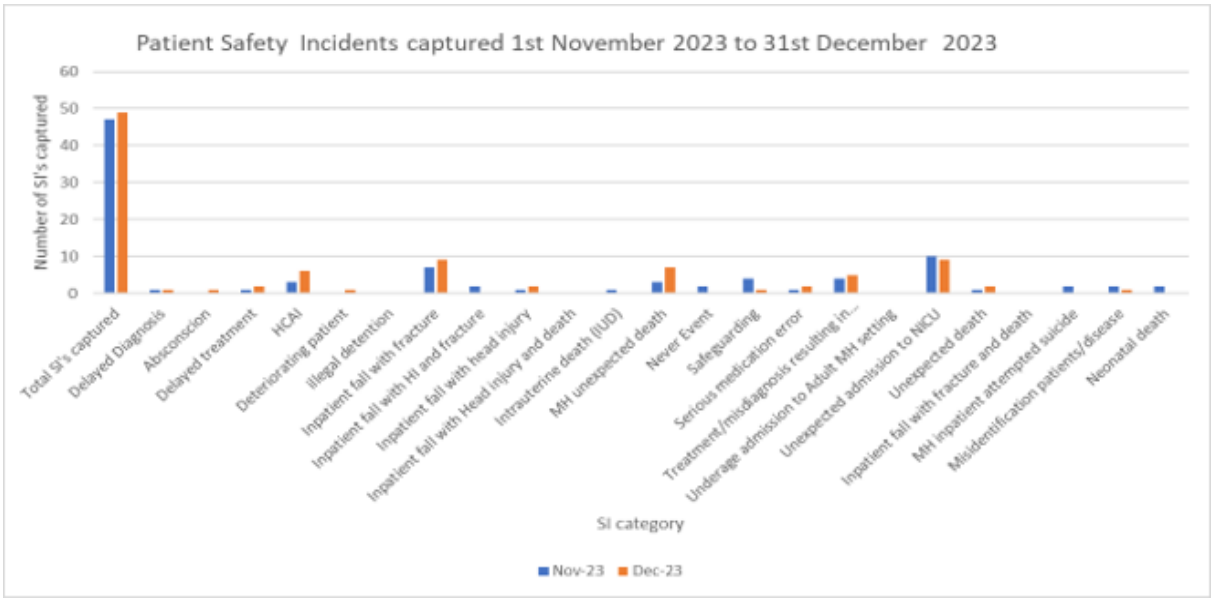

6 Pillars of Quality
1
Patient and staff experience and stories
2
Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
3
Complaints, Concerns and Compliments
4
Health, Safety and Security
5
Infection Control and Prevention
6
Safeguarding

Section 2

Patient Safety Incidents



A total of 96 serious incidents were identified during November and December 47 and 49 respectively. MH Unexpected Death, Unexpected Admission to NICU and Inpatient fall with # were the top themes.



Early Warning Notifications

There were 14 EWNs reported to WG during this period, 9 in November and 5 in December. Themes include varied safeguarding issues and a Reg 28 re: ambulance handover delays.

Missed Fractures

Update; In conjunction with Medicine, ED is reviewing the documentation used for elderly patients to help guide and support trauma assessments. NOF pathway is also being reviewed. A report is being produced by one of the ED trainees.

Anticoagulation Incidents

Update; Reporting of incidents around prescribing, administration and monitoring is being encouraged. SCD, UC & Med sent HAT data and asked for learning and improvement ideas re anticoagulant prescribing.

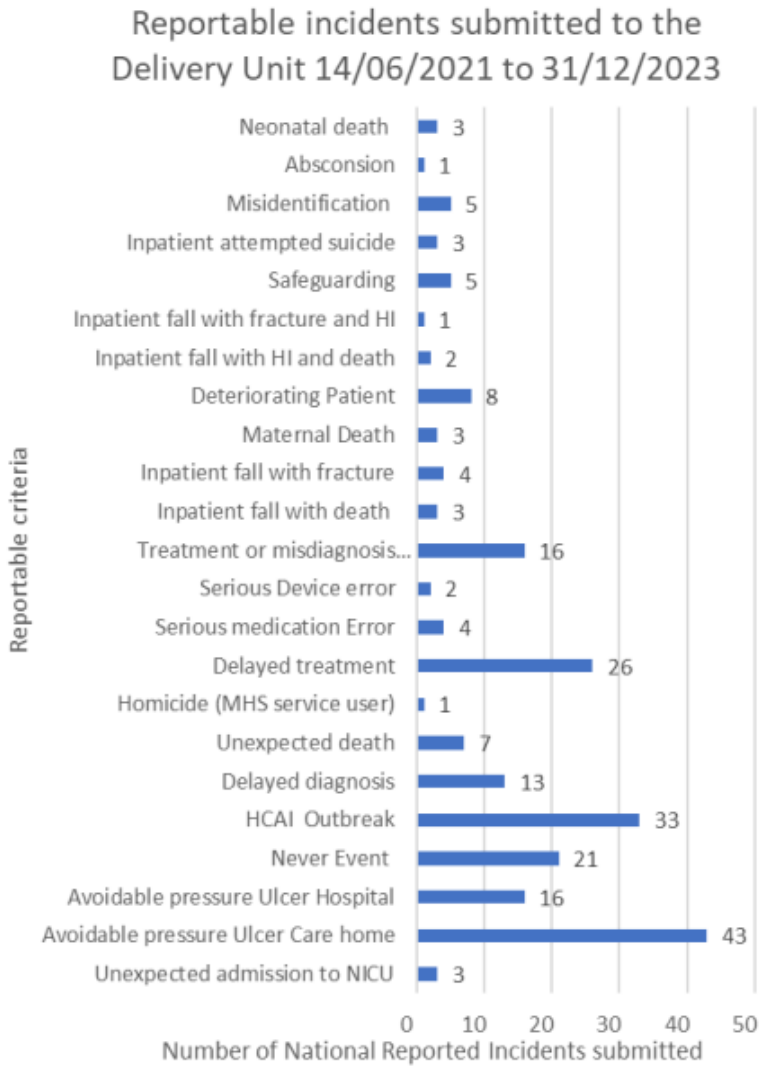
OCP/PSI Team

The PSI team is reviewing SI report templates, safety huddles and IO training. The types of SIs are increasingly complex and cross divisional/organisational posing challenges in identifying suitable IOs.

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 Varying processes across Corporate and Divisions Lack of organisational learning shared	Presentation of all Serious incidents to weekly Executive Huddle for decision regarding level of investigation.	Head of Putting Things Right	Ongoing
		Weekly pre- Executive Huddle meeting to form a decision panel.	Assistant Director of Nursing	Complete
		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. Outcomes to be communicated.	Assistant Director of Nursing	Complete January 2024
		QPSOG to be reconfigured in line with the Learning Framework.	Assistant Director of Nursing/Assistant Director for Quality and Patient Safety	Ongoing

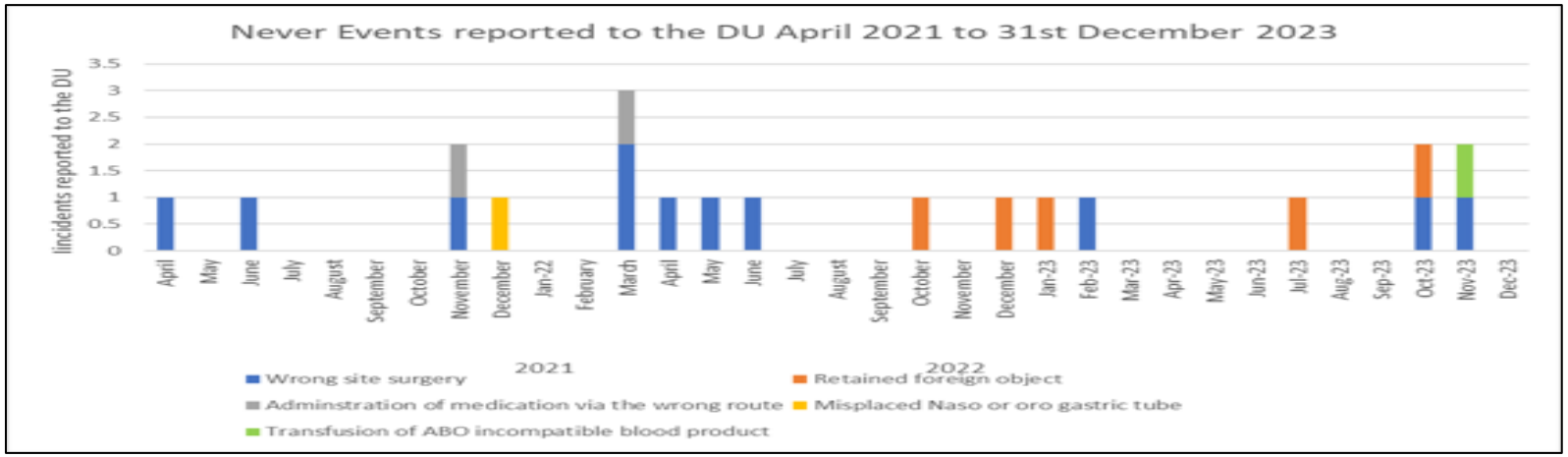
National Reportable Incidents



- The Health Board saw an increase in November in NRI'S to 22, with a return to 11 in December.
- There were no themes. However, two Never Events were reported during November. One Transfusion of ABO incompatible Blood products on an acute medical ward and One wrong site surgery in Endoscopy.

Learning from NRIs	Improvement
A patient was referred via pre-hospital streaming with a history of haematemesis, dizziness and light headedness. The Flow centre referral guidelines for patients with GI bleeding were not followed and there was variance from the normal process for referral for patients with GI bleeding.	Review of on-call rotas Review of documentation standards Education when placing 2222 call to define location.
Delay in recognising a deteriorating patient and update on head injury. Non-qualified staff accompanying seriously compromised patients to other clinical locations.	Patients with a compromised GCS are accompanied for procedures by suitably qualified personnel equipped with safety equipment in the event of a clinical emergency.
Unexpected Death in a lady 8 weeks post-partum/difficulties with contact/communication. Limited sharing of all care documentation amongst primary and secondary care services.	If the patient has complex needs, they would benefit psychologically and physically from a more flexible, proactive, supportive approach to enable them to build trust with her professional teams. This would have encouraged transparent discussions of the patient's plans and expectations.
A 5-year-old child was admitted to Hospital for a planned Adenotonsillectomy, insertion of myringotomy grommets and an examination under anaesthesia (EUA) of their ear. When the child returned to the ward, a small gauze (6x1cm) swab used in the procedure was identified.	National Safety Standards for Invasive Procedures 2 (NatSSIPs 2) now being used in the organisation.

Never Events



- There has been 2 Never Events reported November and December 2023 – A wrong side block and transfusion of ABO incompatible products.
- A report has been presented at Dec PQSOC outlining the Improvement Programme for Theatres.
- A full investigation is underway into the administration of the blood product.

Issue	Remedial Action	Who	When
Recent data illustrates that the most common type of Never Event within ABUHB theatres over the past 5 years is 'Retained Foreign Objects' (these included retained swabs) and 'Wrong Site Surgery' (in particular, wrong sided Anaesthetic blocks). Need to embed learning from Never Events within organisational culture.	Key safety themes identifies 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.	Corporate PTR & Divisional Governance	Complete
	A number of existing resources and programmes of work are already in place to ensure that the highest standards are maintained. These include: A Theatre Safety Team and programme of work, a team of Theatre Practice Educators to foster continuous learning and high standards of care and a Human Factors training programme led by one of the Anaesthetics Team which commenced as a test of change, with the potential to identify and support the programme of improvement required, and expand as needed.	ABUHB QPS Team Divisional QPS leads ABCi	Complete
	The existing Theatre Safety Programme was reviewed in 2023 alongside the ABUHB Quality and Patient Safety work programme. Priorities expanded to include: reducing Never Event incidents within Theatres, Building Quality Improvement capability within Theatres, Embedding Human Factors within the Theatres Safety Culture Programme, Involvement in the Safe Care Collaborative – Acute Workstream, Theatre Safety workstream within Theatre Maximisation Programme, and National Safety Standards for Invasive Procedures (NatSSIPS 2).	ABUHB QPS Team Divisional QPS leads ABCi	Ongoing monitoring
	Appointment of a Theatres Improvement Advisor post- work with multidisciplinary teams across Theatres and wider to deliver the programme of work. Start date 8th January.	Scheduled Care Triumvirate and ABCi	Ongoing
	Human Factors Programme Lead supporting work around safety culture. Working with OD and ABCi to develop the use of a Safety Culture Survey to be tested in theatres.	Human Factors Lead	Complete

Duty of Candour

Incidents Affecting Patients

Since 1 April 2023 there have been **20,807** incidents affecting patients reported on the Datix Cymru system.

At the time of preparing this presentation there are currently **1,385** incidents whereby the field '***Following the Initial/Management review, what level of adverse outcome was considered?***' has not been completed.

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

Division / Service	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Total
Complex & Long Term Care	4	1	5	6	0	5	4	1	2	5	0	33
Estates & Facilities	1	0	1	1	0	3	1	1	1	0	0	9
F&T	2	0	2	0	1	12	29	35	82	131	38	332
Nursing Director	4	1	1	3	4	5	3	2	0	4	0	27
Planning, Performance & ICT	2	1	0	1	1	1	1	3	1	0	1	12
Primary Care & Community Division	24	18	35	26	30	38	36	49	72	162	40	530
Medicine	4	4	17	2	7	4	14	38	73	107	51	321
Scheduled Surgical & Critical Care	0	1	0	1	2	0	1	3	0	17	14	39
Workforce & OD	0	0	1	0	1	0	0	0	2	1	0	5
Director of Public Health	0	0	0	0	0	1	1	0	2	1	0	5
Medical Director	0	0	0	0	0	1	1	0	0	0	0	2
Clinical Support Services	0	0	0	0	0	0	0	2	2	16	3	23
Chief Executive / Non Executive	0	0	0	0	0	0	0	0	1	0	1	2
Mental Health & Learning Disabilities	0	0	0	0	0	0	0	0	3	16	8	27
Urgent Care	0	0	0	0	0	0	0	0	3	3	12	18
Total	**41**	**26**	**62**	**40**	**46**	**70**	**91**	**134**	**244**	**463**	**168**	**1385**

Duty of Candour

Triggers

Since 1 April 2023 there have been **161** incidents that have triggered the Duty of Candour. *This figure is based on the initial/management review field recorded as Moderate or above.*

Division / Service	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Total
Complex & Long Term Care	1	0	1	0	1	1	0	1	1	0	0	6
F&T	2	3	3	1	1	1	2	3	3	3	0	22
Mental Health & Learning Disabilities	2	1	1	1	0	2	1	2	1	0	0	11
Planning, Performance & ICT	1	0	0	0	0	0	0	0	0	0	0	1
Primary Care & Community Division	6	4	3	2	2	2	4	4	6	3	0	36
Scheduled Surgical & Critical Care	3	1	4	6	3	2	4	0	0	0	0	23
Medicine	4	4	2	3	2	1	4	2	5	8	1	36
Clinical Support Services	1	0	0	3	0	0	0	2	0	0	0	6
Urgent Care	0	2	0	3	1	2	3	0	3	1	1	16
Estates & Facilities	0	0	0	0	0	1	0	0	1	0	0	2
ABCi	0	0	0	0	0	0	1	0	0	0	0	1
Nursing Director	0	0	0	0	0	0	0	1	0	0	0	1
Total	**20**	**15**	**14**	**19**	**10**	**12**	**19**	**15**	**20**	**15**	**2**	**161**

The field within Datix '**Date NHS Body first became aware that DoC was triggered**' has been populated **368** times.

35 of these incidents relate to no harm and **142** relate to low harm. This highlights that users are retrospectively changing the initial/management review.

Duty of Candour

Triggers

Of the **161** incidents triggering the duty **124 (77%)** have conducted the 'in person' initial notification.

22 records highlight that the date of 'in person' initial notification occurred prior to the Health Board becoming aware that DoC was triggered. **This needs validation**.

98 (79%) of the 'in person' initial notifications were carried out within 30 working days. **3 incidents** were significantly more than this target.

90 records highlight that a date of written notification has been sent.

32 (35%) of the written notifications were sent five or more days following the 'in person' initial notification

There are currently **130 incidents** that have not completed the final response. **101** of these are where the Health Board became aware that the DoC had triggered prior to January 2024.

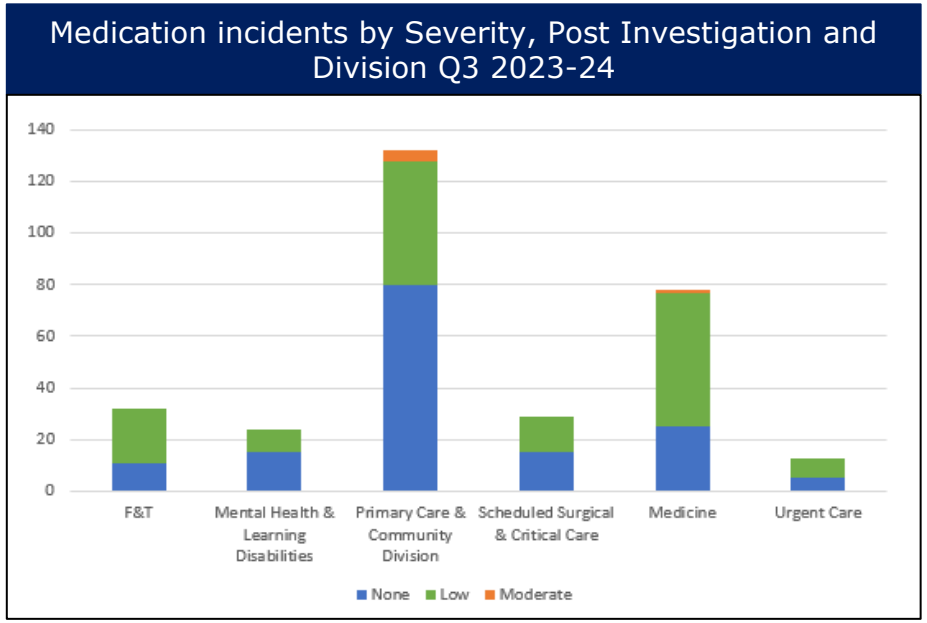
Finally, there are currently **83** records where the field '*Severity of Incident Post Investigation*' has been recorded as **Moderate or above**, however, the field '*Following the Initial/Management review, what level of adverse outcome was considered?*' is recorded as **no or low harm**.

These incidents will need review to identify whether the duty of candour should be triggered.

Medication Safety Group (MSG)

	Q4	Q1	Q2	Q3
None	208	188	194	187
Low	98	88	128	197
Moderate	35	21	60	77
Severe	5	7	7	8
Catastrophic	0	0	0	0
Total	**346**	**304**	**389**	**469**

"Reporters View on Levels of Harm"

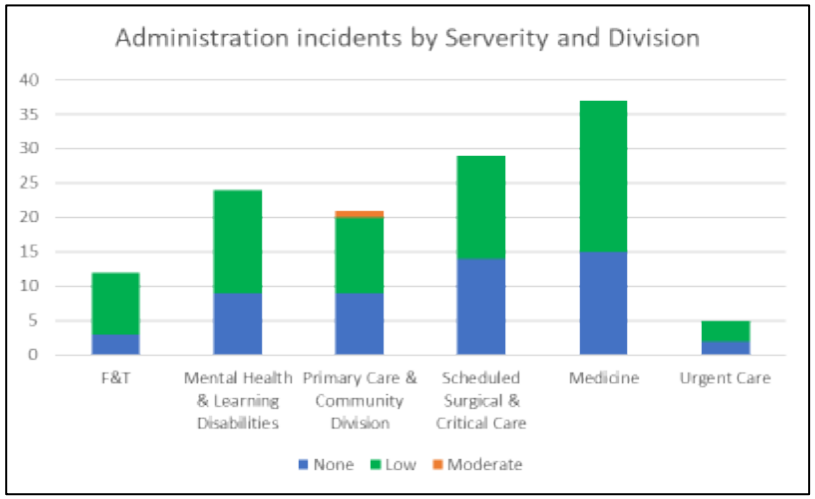


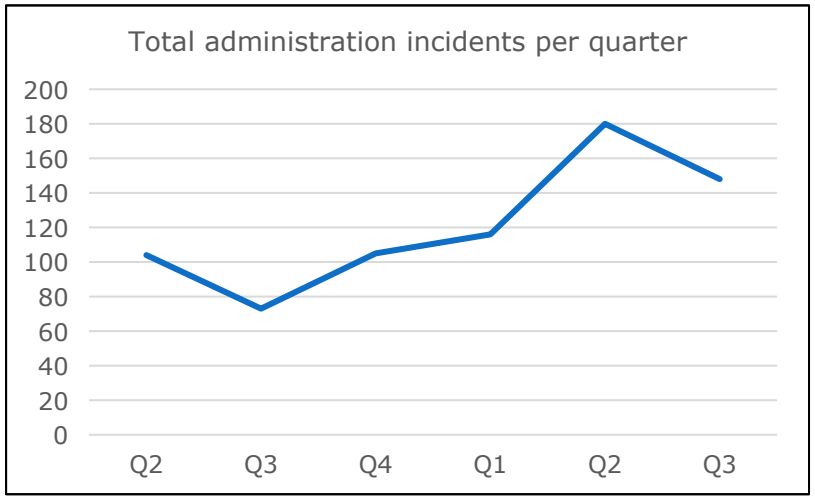
- Data for Q3 was scrutinised in terms of type of incidents, themes and areas of concern.
- Total 469 incident reported Oct to Dec 2023 based on "reporters view on level of harm". Total 319 incidents reviewed and investigated.

Focused Outcomes:

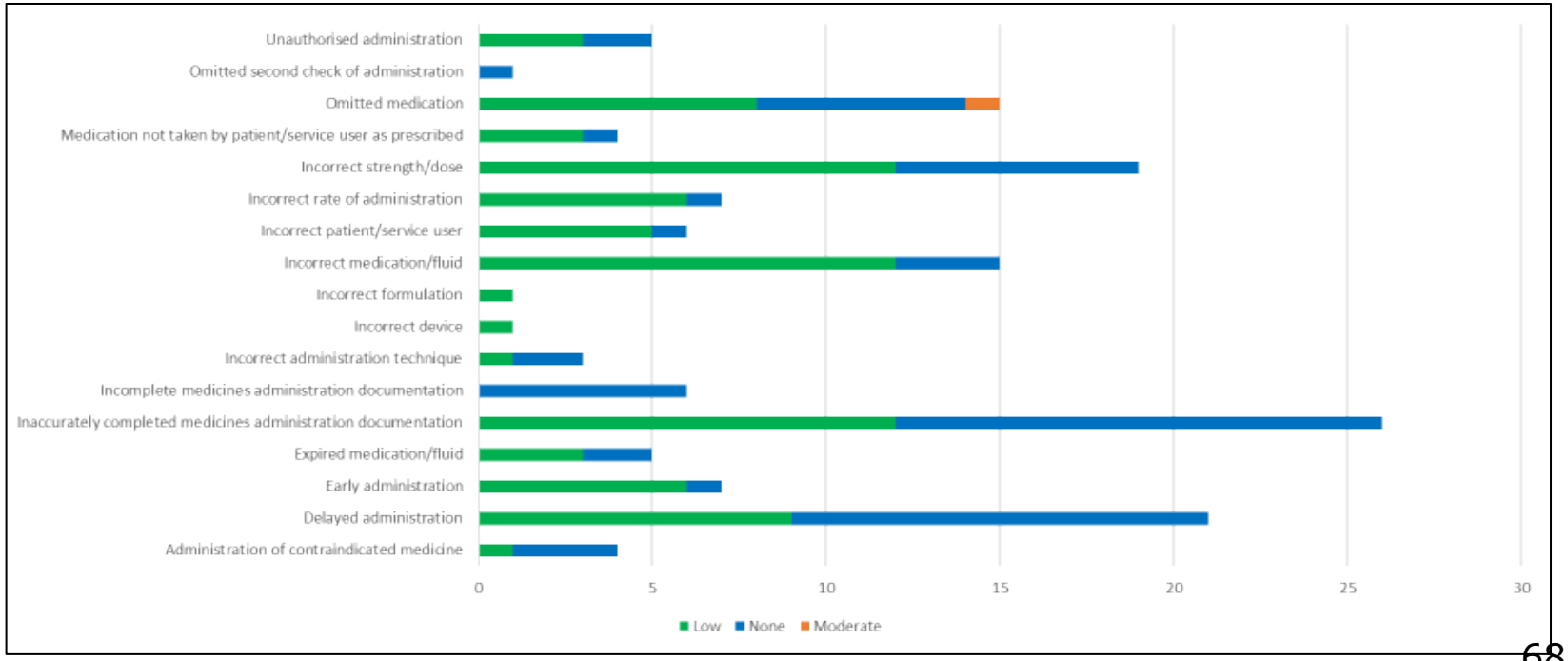
- Corporate action plan for anticoagulant incident review to include scoping activities such as pharmacy intervention report, thematic review, SOP update.
- Ongoing work to deliver on recommendations for Time Critical Medication e.g., patient information posters in admission areas.
- Continue to work with DICE to highlight areas requiring support with VRIII/ insulin training
- Monitor medication reconciliation incidents to identify any new learning for sharing
- Work with risk team to improve timely processing of incidents.

MSG: Administration Incidents





Medication administration incidents by Sub-Category



Medication Safety Group (MSG)

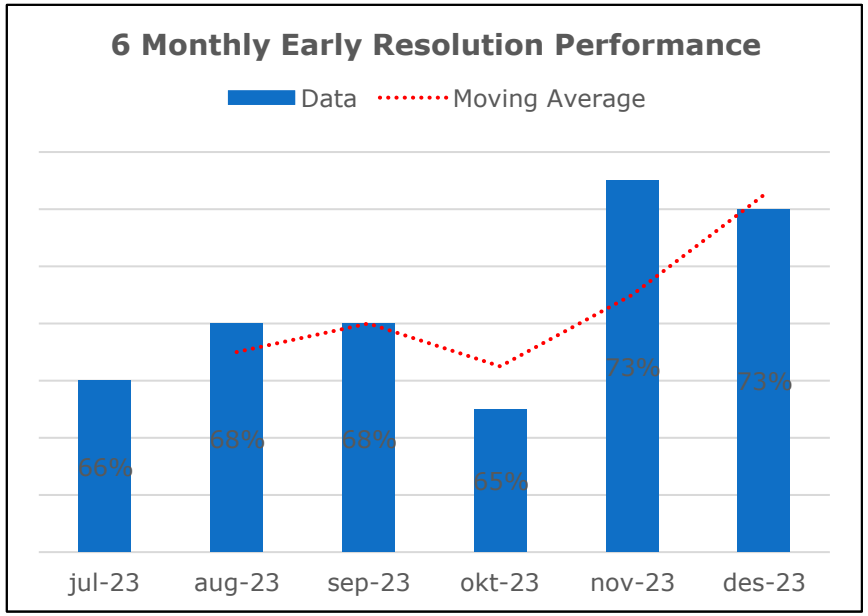
Posters developed by All Wales Medication Safety Network as part of recommendations from Time Critical Medication workstream. These are available bilingual (Welsh) and will be displayed in waiting and admission areas.

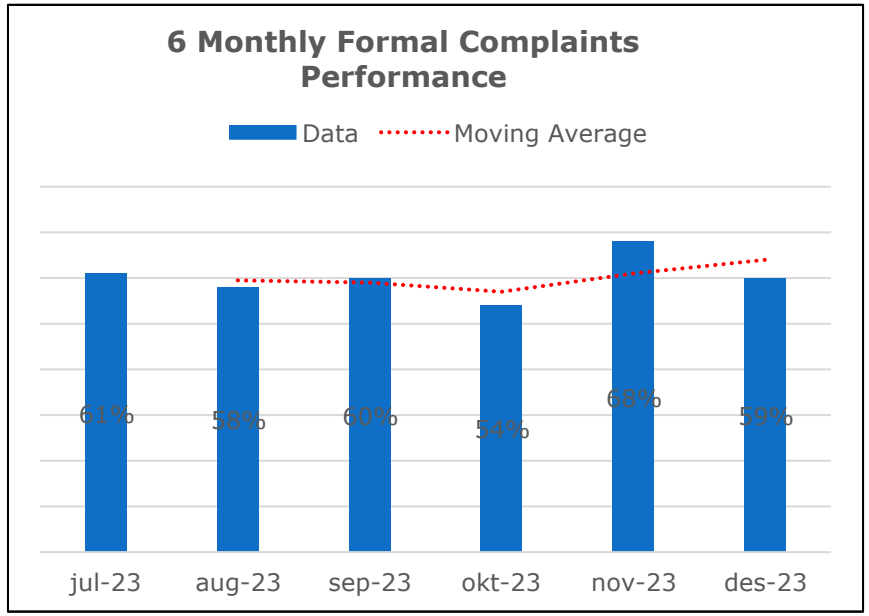
These prompts should support a reduction in incidents where patients miss doses of time critical medication which can contribute to deterioration while they are waiting to be seen e.g., Parkinson's medication, insulin.

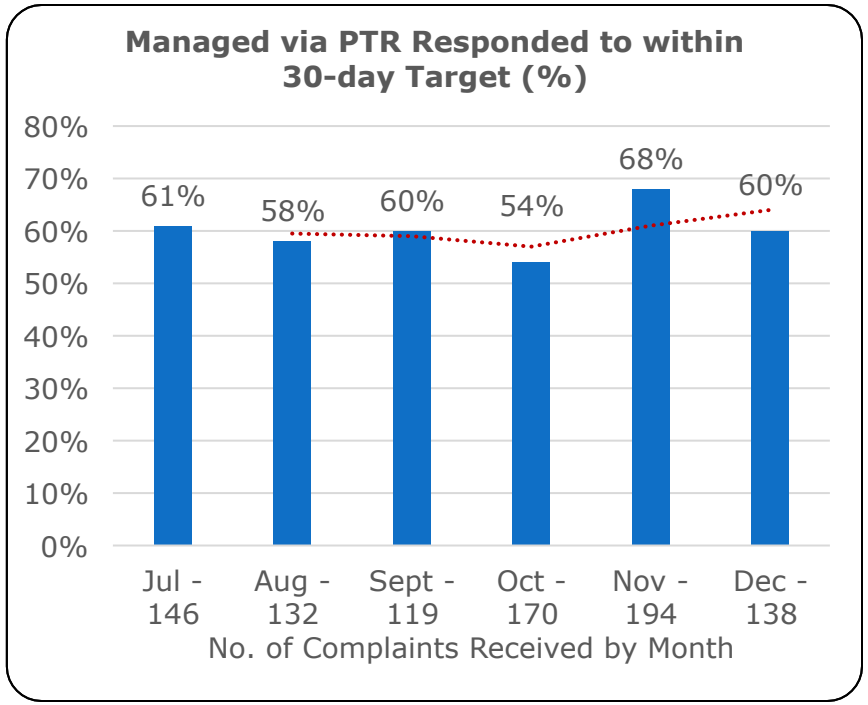
MSG action plan

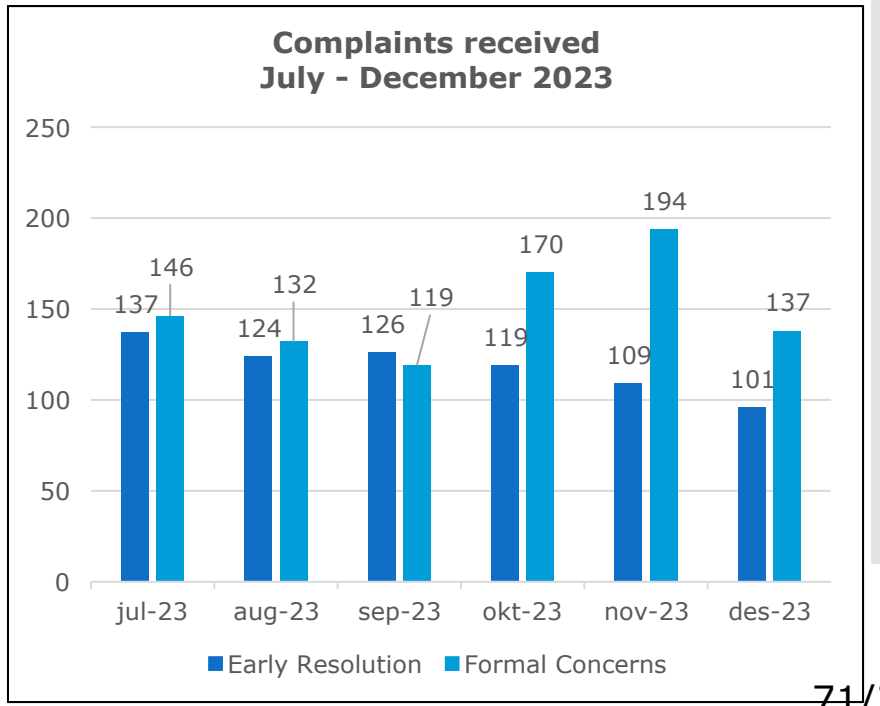
Issue	Cause	Remedial Action	Who	When
Increase in medication administration incidents	Multifactorial – scoping activity to look at contributory factors – likelihood lack of self-check/ second check.	Develop action plan following scoping.	MSG	MSG April 2024
Primary care feeding back on issues from secondary care e.g., lack of documentation/ information when patients initiated on DOAC.	Multifactorial – workshop had December 2023 to scope. Findings being taken to a corporate meeting looking anticoagulant thematic review	Action plan developed, will require sign off at MSG.	MSG/ dedicated MDT	MSG April 2024
Insulin incidents consistently occurring across all divisions.	Contributory factors include lack of knowledge, complexity of dosing regimens and extensive preparations of insulin available.	Action plan with MSG/ DICE and work with the division for local remedial work e.g., focused training on VRIII and insulin, sign posting to new SharePoint page with lots of info.	MSG/ DICE/ DQPS leads	Ongoing

Complaints Nov – Dec 2023

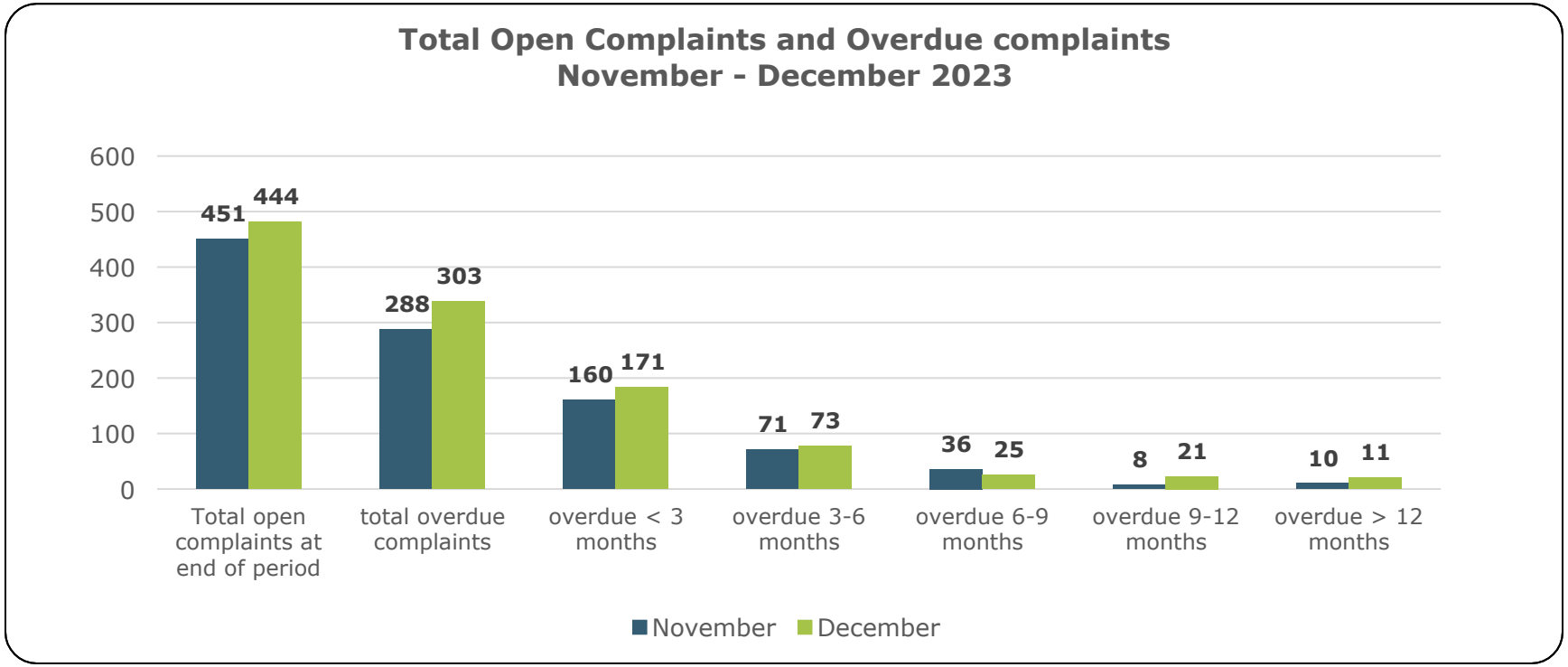








Complaints Nov – Dec 2023



The total overdue complaints were on a downward trajectory. However, there has been a slight upturn in overdue concerns across November and December.

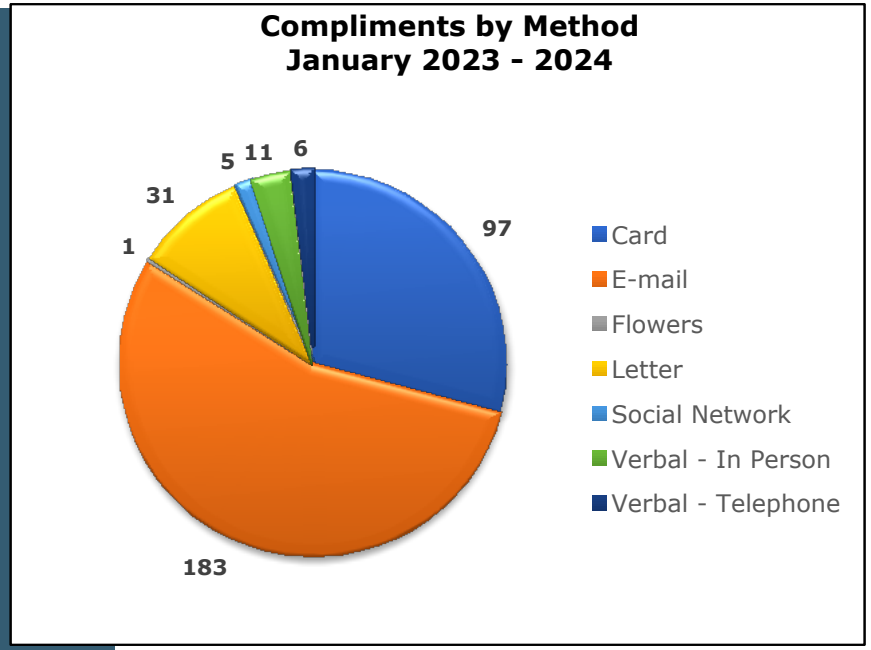
Focussed meetings between PTR and QPS teams are to be reinstated to ensure emphasis remains on tackling overdue complaints particularly those >12 months. With each >12 complaint requiring active monitoring and a "plan to completion".

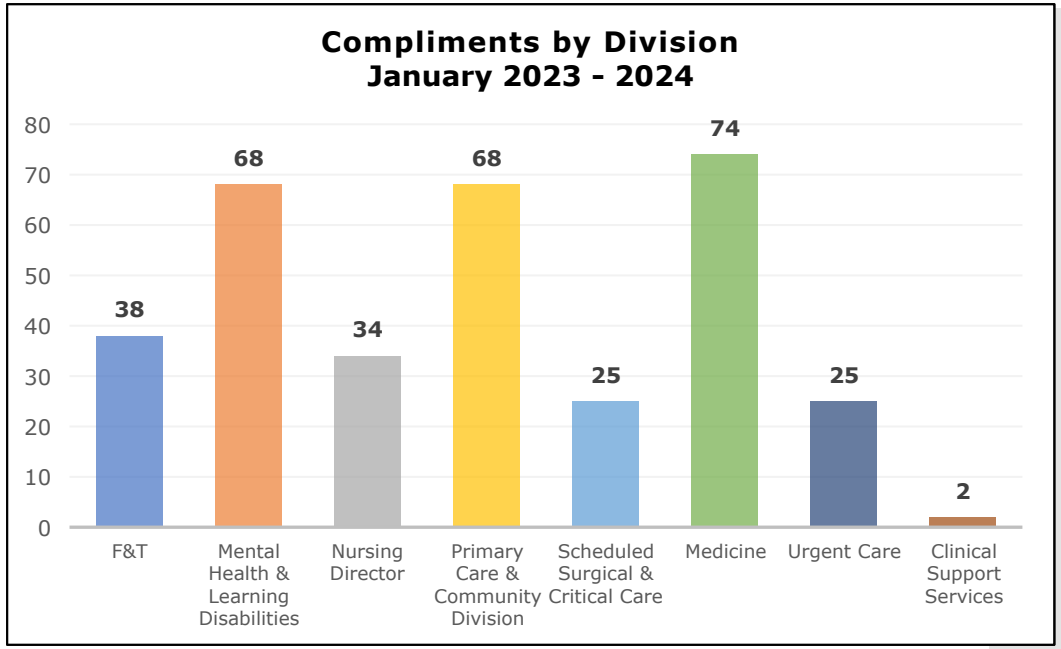
The PTR team and Senior QPS Manager will be embracing the "**Fresh Eyes**" ethos as utilised in NHS England's Quality, Service Improvement and Redesign tools to assess bottlenecks/ obstacles to finalising investigations/responses and how to overcome them through a new perspective/lens.

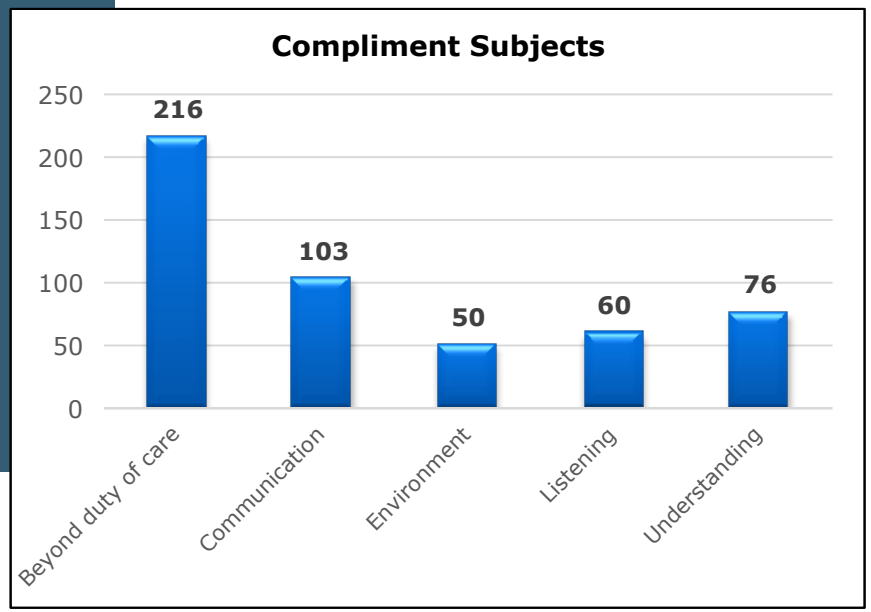
Compliance with the 30-working day target was positive across the November-December period in relation to the volume of complaints received and those being successfully managed and completed under PTR with formal responses.

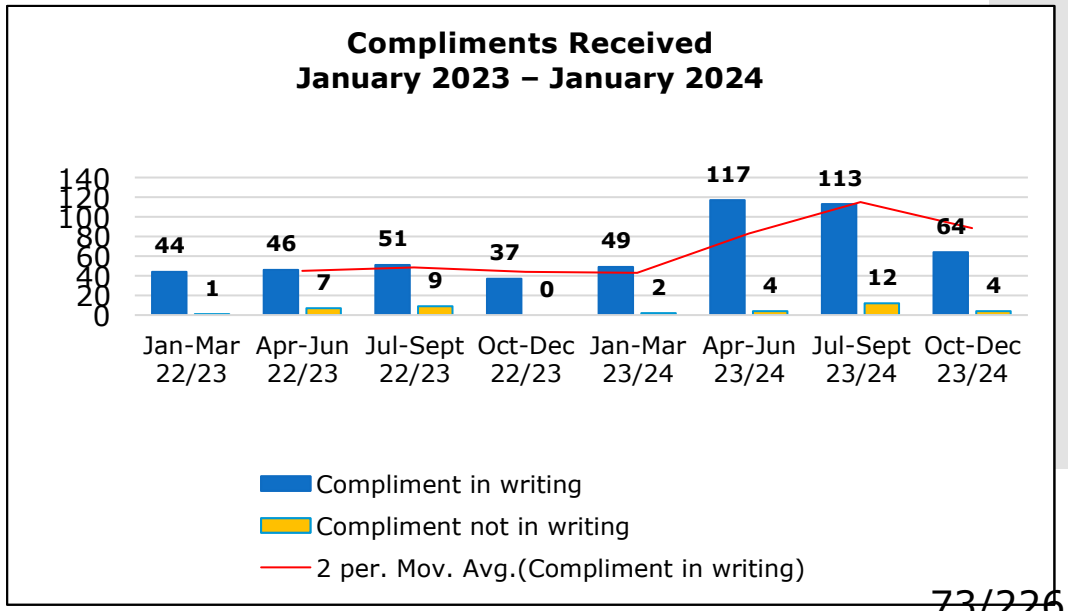
Compliments

Compliment recording has continued an upward trajectory across 2023. The majority of compliments are received via email and relate to staff going beyond the duty of care.









Successes

Issue	Cause	Remedial Action	Who	When
PTR publish an Annual Report each year outlining Concerns, PSOW, Redress and Patient Safety incidents.	This report shows progress and major workstreams being undertaken by the PTR Team.	Ratification of Annual Report.	Executive Board.	Completed December 2023
A new complaints form has been devised using Microsoft forms	Reducing patient email traffic, ensuring correct and detailed demographics from the outset of patient and family engagement with the Health Board and generally providing a more consistent, uniform approach to how the Health Board receives complaints, akin to our counterparts in other HBs across Wales.	The form will be uploaded and fully functional on the patient facing website by the end of January.	Senior Quality Patient Safety Manager	December 2023
MS/MP Concern logging	MS/MP concerns are currently not logged to Datix and are held independently by Corporate Governance.	Discussions have been held between Corporate Governance and PTR regarding data validation of historic cases and logging to Datix in future.	Corporate Business Manager & Senior Quality Patient Safety Manager	December 2023

Claims, Redress, Inquests,

November – December 2023

- The Health Board had 2 Regulation 28 Reports – issued by Coroner – assurance for prevention of future deaths
- **Graeme Hughes, Snr Coroner SW Central**
  - Ambulance handover delays – Tri party ABUHB / WAST / Minister for Health Welsh Government
- **Caroline Saunders, Snr Coroner for Gwent**
  - Delegation of nursing duties to family of inpatient

- Both reports responded to via CEO
- Both available to public via Chief Coroner website
- 2nd report also sent to HIW

Health, Safety & Security

Health and Safety Executive Engagement

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

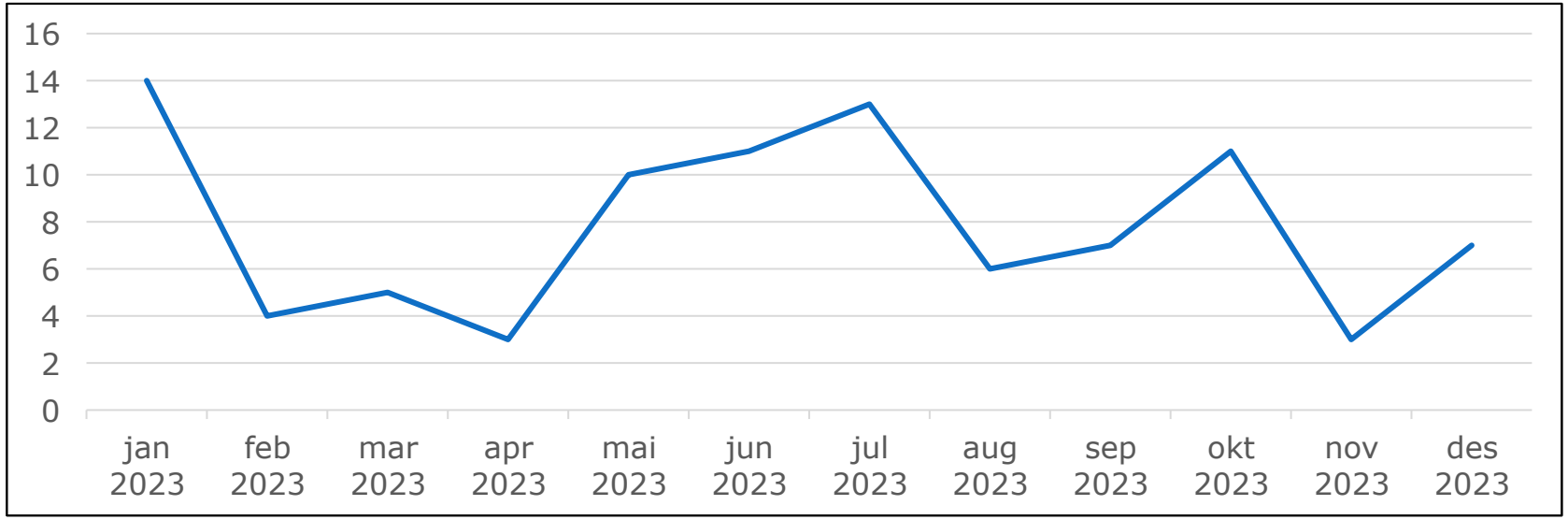
This follows the HSE investigation of a patient fall at Nevill Hall Hospital, which occurred in 2019.

The Health Board has the option to provide written submissions on matters they wish the HSE to take into account when making their enforcement decision.

Health, Safety & Security

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period January 2023 to December 2023 the Health Board have reported **94 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).



65% 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 December 2023 training compliance for the Health Board was reported as:

Health & Safety – 86%
Violence & Aggression – 85%
Fire Safety – 82%
Manual Handling – 54%

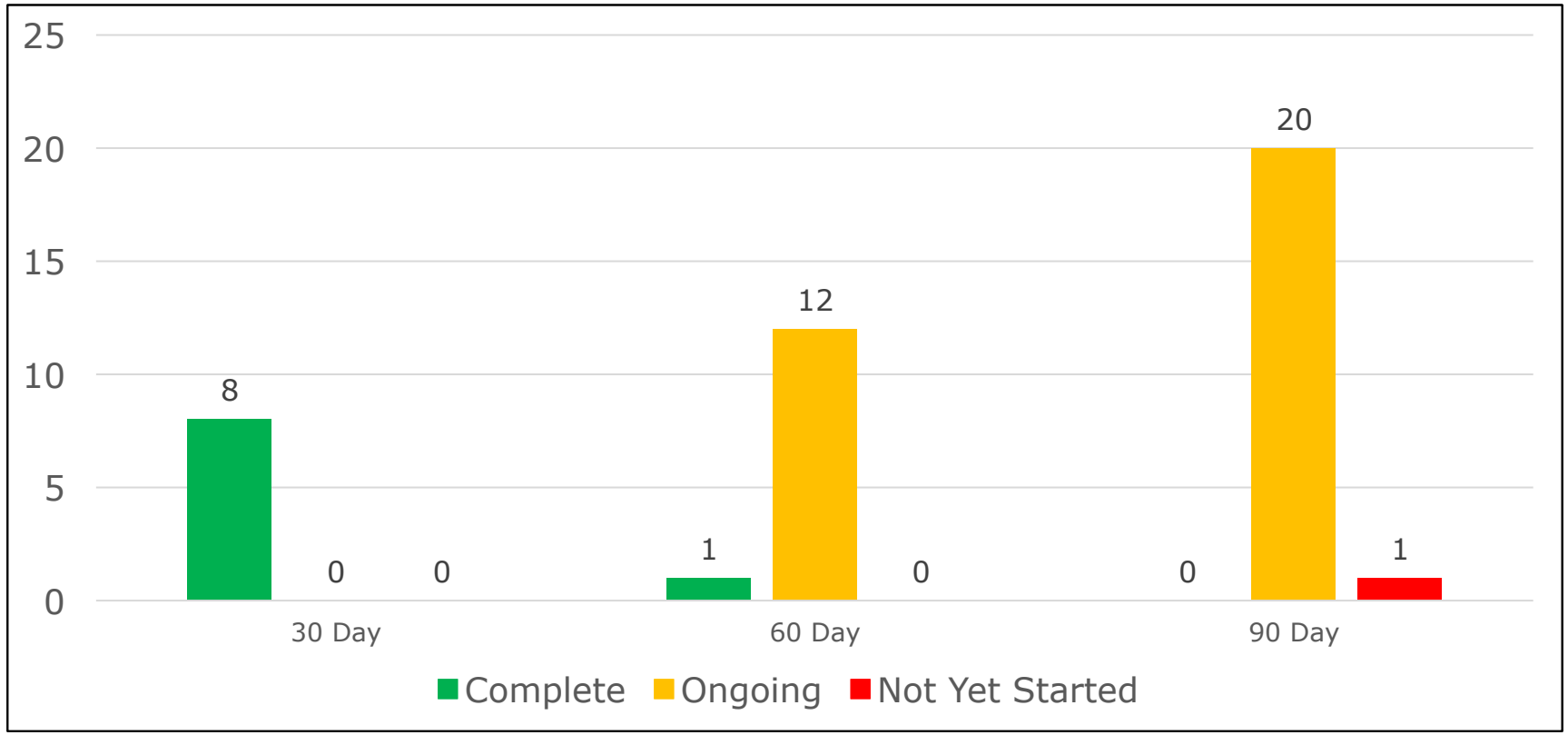
There has been **no change** in the compliance with Health & Safety, Violence & Aggression and Fire Safety training compared with the previous report.

Manual handling training has **decreased by 1%** from the previous report.

Health, Safety & Security

Health and Safety Improvement Plan 2023/24

The chart below provides the current position of the 30, 60, 90 day actions within the improvement plan:



Health, Safety & Security

Health and Safety Improvement Plan 2023/24

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

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

COVID-19 Investigations

November and December 2023

	Wave 1 (27/02/2020 – 26/07/2020)	Wave 2 (27/07/2020 – 16/05/2021)	Wave 3 (17/08/2021 – 19/12/2021)	Wave 4 (20/12/2021 – 30/04/2022)**
Total Incidents	316	1170	321	1042
Investigations Not Started	0	254	0	115
Under Investigation	0	10	0	24
Downgraded/ Recatergorised	31	71	177	286
Referred to Scrutiny Panel	0	284	0	164
Completed Investigations	285	728	144	453
Check +/-	0	0	0	0
Deaths	147	386	52	118

Wave 1: **100% complete**

Wave 2: 92% complete

Wave 3: **100% complete**

Wave 4: 86% complete

Overall: 94% complete*

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

Highlights:

- Team performance tracking on trajectory to complete programme on time with staff resource in post. Remaining cases will be completed by the mid February 2024 ahead of final MDT.
- NNCP site visit positive; assurance regarding governance, completion rates, processes provided
- Weekly MDT panels scheduled. Final MDT 20th February 2024
- NNCP CIVICA user experience survey live however no responses thus far for ABUHB
- Incoming enquiries from patients and/or relatives extremely low
- No queries post investigation outcome responses (except existing complaints pre programme)
- No support requests to Llais
- No escalation of cases to AB Scrutiny Panel or legal
- QPSOG updated with learning feedback. Completed QPs learning meetings with Scheduled and unscheduled care divisions. Presented in unscheduled care QPS divisional forum.

Challenges:

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

Mitigating Actions:

- Pushing case completion pace for remaining cases and on track to complete mid February
- Staff meetings undertaken regarding redeployment
- Working with divisional colleagues to access records

Escalated risk concerns

Section 3

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:** • Missing Persons Policy - currently out for Health Board consultation
60 Day Actions	**16 Completed**	**Outstanding 2 actions:** • Strengthening OOHs arrangements • Safe staffing in-patient SBAR to Execs
90 Day Actions	**2 Completed**	**Outstanding 2 actions:** • Commissioning Arrangements • 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.

Health Inspectorate Wales

Inspections and National Reviews

Talygarn Unit, County Hospital (Inspection)
Date of Inspection: **5-7 February 2024**
Immediate Improvement Notice Received: **8 February 2024**
Immediate Improvement Response to be submitted: **20 February 2024**

Community Mental Health Team (Inspection)
Date of Inspection: **16 – 17 January 2024** ***(CANCELLED)***

How are healthcare, education and children's services supporting the mental health needs of children and young people in Wales (Joint National Review)
Review Scheduled: **2024**
Self Assessment Submitted: **22 January 2024**

DNACPR (National Review)
Date of Inspection: **27 – 29 November 2023**
Immediate Improvement Notice Received: **20 December 2023**
Immediate Improvement Response Submitted: **22 January 2024**

Framework for Speaking up Safely in the NHS

- Soft launch of the internal raising concerns bespoke email address.
- Collate the data that HR have from their internal raising concerns bespoke email address (which will then the decommissioned) we also have wellbeing survey data to use as baseline.
- Transition from internal system to external.
- External Employee Assistance Programme and Speaking Up service will start on 1 March 2024.
- Steering Group: Set up an ABUHB Stakeholder Group 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.

PSOW

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

ABUHB Improvement Plan

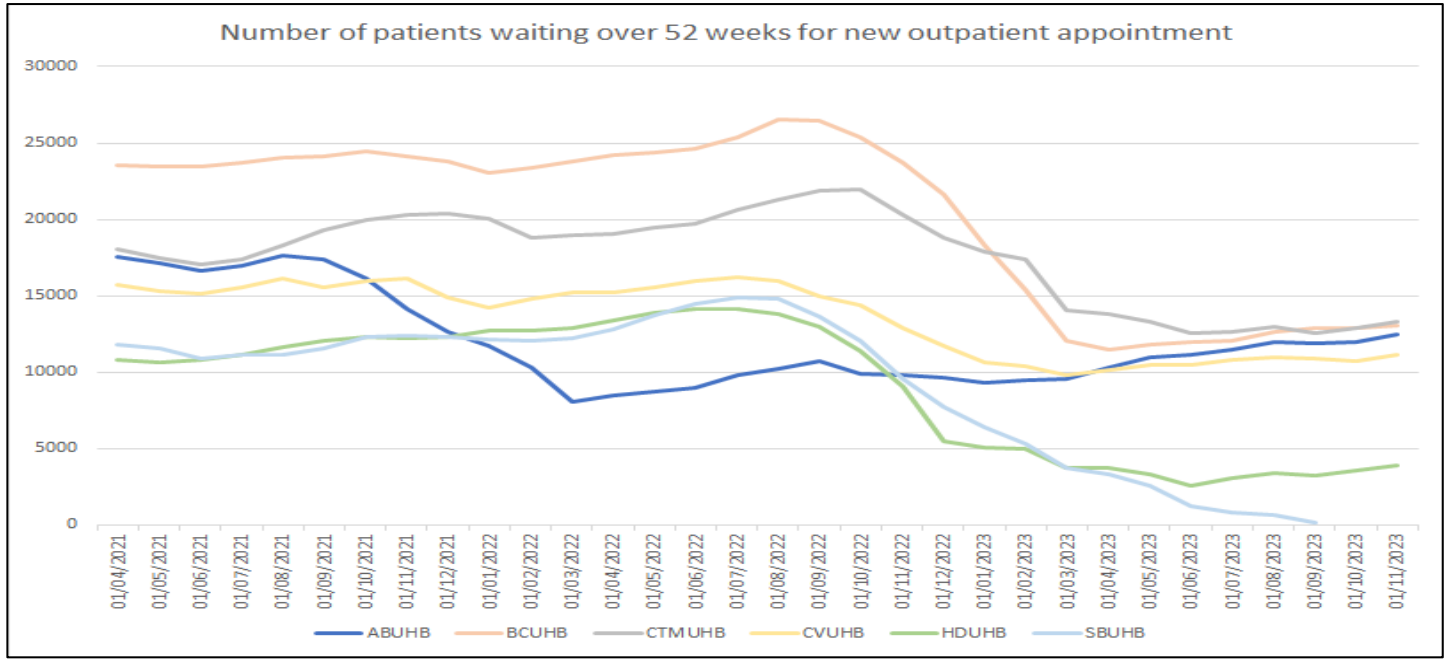
Recommendation	ABUHB Action	Responsible Officer	Timescale
Review the resources available to complaints teams in their Health Board	This will be addressed through implementation of the review of the QPS Resources.	Executive Director of Nursing and Assistant Director Quality Patient Safety	February 2024
Consider the option to provide staff investigating complaints with information regarding seeking independent medical advice, on a case-by-case basis where appropriate.	Incorporate into future IO Training sessions specific to Complaints and PSOW	Senior Concerns Manager and Senior Quality	March 2024
Ensure that lessons learned from the PSOW's findings and recommendations are included in the Health Board's annual report on the Duty of Candour and Quality	These will be incorporated into the inaugural Report on Duty of Candour and Quality	Head of Quality & Patient Safety	April 2024
Improve complaint handling	Education work to commence across QPS/Complaint teams regarding quantitative and qualitative complaint management.	Senior Quality, Patient, Safety Manager & Concerns Manager	April 2024

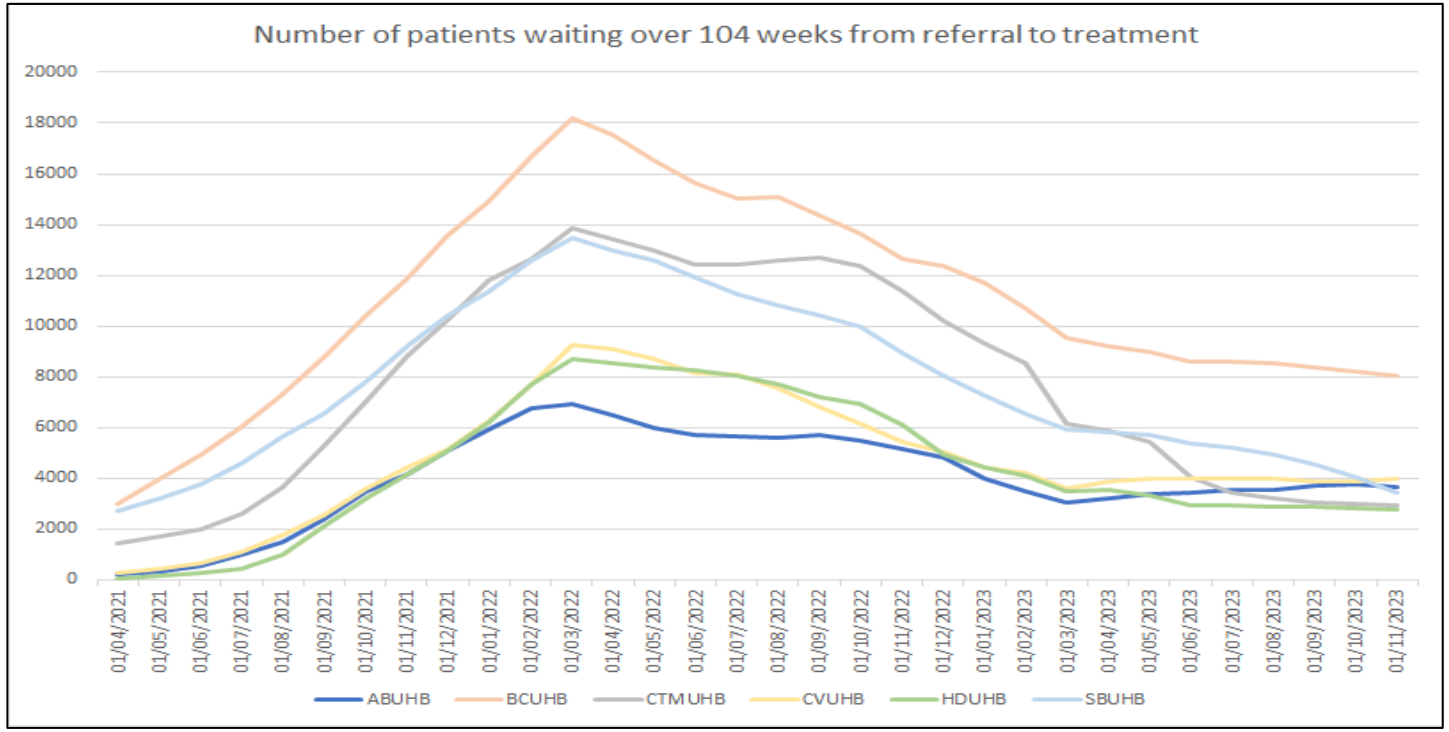
Llais Gwent Region Visits

Ysbyty Ystrad Fawr
(Ty Cyfannol/Anwylfan/Oakdale Wards)
Report Publication Date: **29 January 2024**
Llais Visiting Summary - YYF - Ty Cyfannol Ward *(hyperlink)*
Llais Visiting Summary - YYF - Anwylfan Ward *(hyperlink)*
Llais Visiting Summary - Oakdale Ward *(hyperlink)*

Ysbyty Aneurin Bevan
(Ebbw/Sirhowy Wards)
Date of Inspection: **November 2023**
Draft Report Received: **7 February 2024**
No. of Actions Identified: **Sirhowy Ward – 4 Ebbw Ward - 3**
Improvement Plan Response Due: **20 March 2024**

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

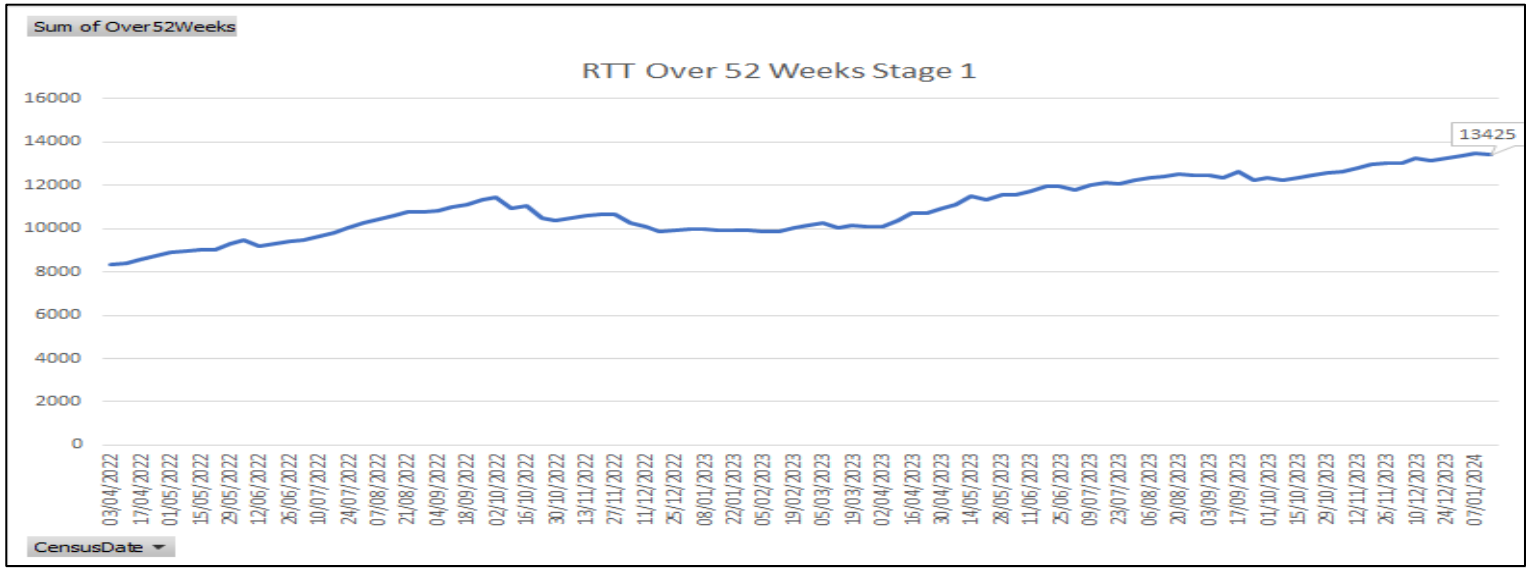




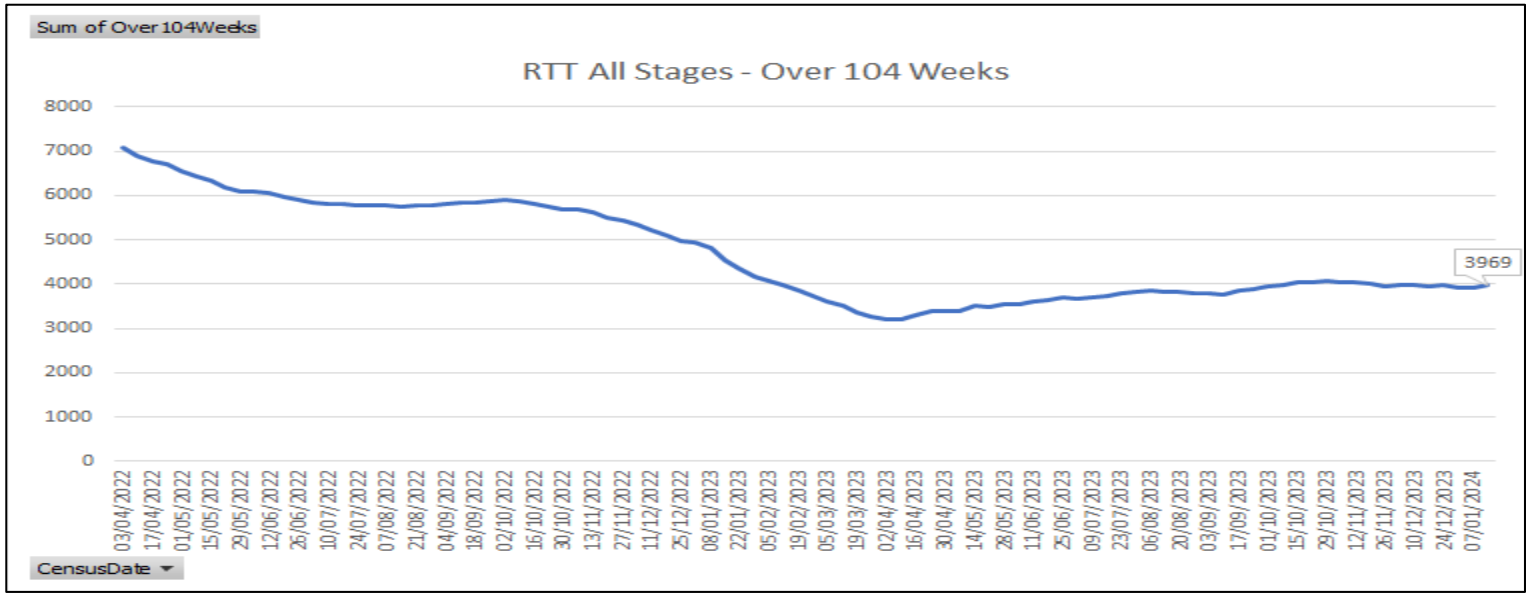
Planned Care

RTT Weekly Snapshot *(reportable activity only)*

RTT – Stage 1 (New Outpatients) Over 52 Weeks



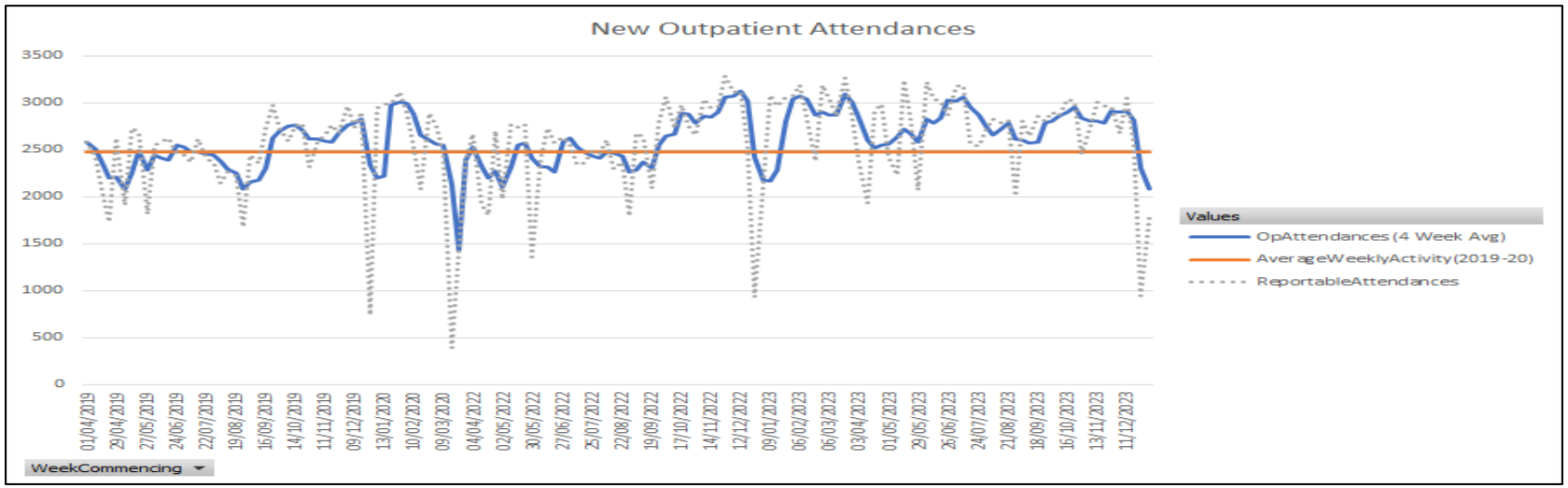
RTT – All Stages Over 104 Weeks



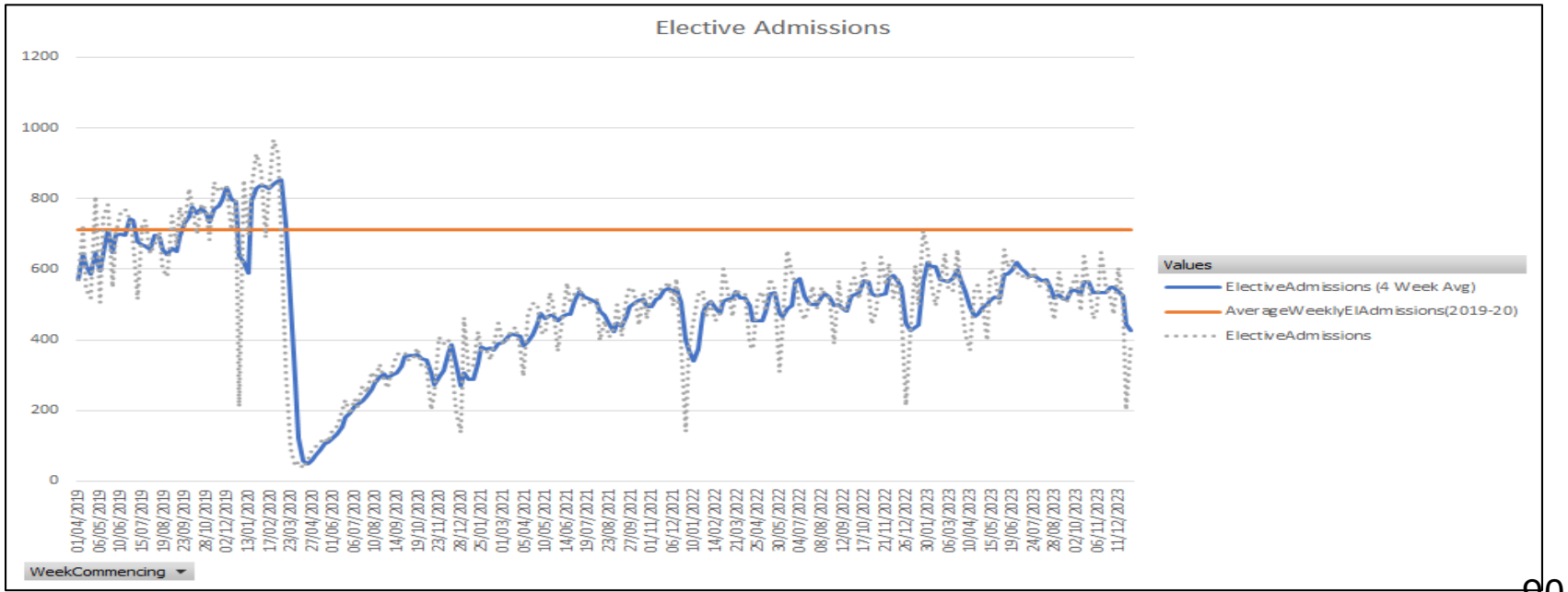
Planned Care

Activity Summary

New Outpatient Attendances (RTT Specialties Only)



Elective Admissions (Surgical Specialties Only)



Planned Care

Performance Overview – Actual (Waiting List Snapshot 15/01/24) against Model Forecast

Outpatients

Over 52 Weeks Stage1(Current Week)	Change Stage 1 Over 52 Weeks (past 5 weeks)	Model Forecast Over 52 Weeks St 1 (Current Month)
13425	186	9951
		3474

Over 104 Weeks Stage1 (Current Week)	Change Stage 1 Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks St 1 (Current Month)
2167	153	40
		2127

Division/specialty	Over 52 Weeks Stage1 (CurrentWeek)	Model Forecast Over 52 Weeks St 1 (CurrentMonth)	Variance Against Model New Over 52 Weeks	% Var Againt Model St 1 52W	% Var Againt Model St 1 52W Status	Change Stage 1 Over 52 Weeks (past 5 weeks)
⊞Clinical Support Services	1		1			-3
⊞Family and Therapies	113		113			30
⊞Medicine	16		16			11
⊟Scheduled Care						
Dermatology	2		2			2
Ear Nose & Throat	4120	4255	-135	-3%		81
General Surgery	10		10			7
Maxillo-Facial	868	120	748	623%		-72
Ophthalmology	5308	4198	1110	26%		74
Orthodontics	75		75			-8
Trauma & Orthopaedic	1910	152	1758	1157%		70
Urology	1002	1226	-224	-18%		-5
Grand Total	13425	9951	3474	35%		187

Stage 4 Treatments

Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks (Current Month)
1166	-117	246
		920

Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)	Model Forecast Over 156 Weeks (Current Month)
47	-60	7
		40

Division/specialty	Over 104 Weeks All Stages (Current Week)	Model Forecast Over 104 Weeks (CurrentMonth)	Variance Against Model Over 104 Weeks	% Var Against St 4 104 Weeks Status	Change Over 104 Weeks (past 5 weeks)
⊟Medicine					
Gastroenterology	1		1		1
⊟Scheduled Care					
Ear Nose & Throat	219	37	182		7
General Surgery	115		115		-6
Maxillo-Facial	2	0	2		-7
Ophthalmology	84	0	84		-18
Trauma & Orthopaedic	645	209	436		-87
Urology	101	0	101		-6
Grand Total	1167	246	921		-116

Planned Care Recovery Programme

Exec Lead:	Hannah Evans	SRO:	Rich Morgan-Evans

Programme Objective

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

What Went Well this Period

- **Health Pathways-** pathways are in development. Comms plan is being implemented. Aim to go live in March '24
- **Patient Access and Activation-** Plans for Keeping Well service (/Single Point of Contact) being established following confirmation of funding from WG.
- **Outpatients** – WG part-funded RGH OP Treatment Unit until March 2024, business case drafted for full funding of the unit.
- **Diagnostics** – Endoscopy Unit at RGH opened on 6/11/23. Continuing to engage in regional diagnostic developments e.g. CDH, Path and Endoscopy although concerns around how regional diagnostic programme is being managed.
- **Theatres** – Embedding new dashboard through scheduling meetings and performance reporting. Draft data pack from GIRFT shared, working through data quality issues.
- **Planned Care Academy** –3 workstreams are progressing objectives (e.g. draft training plan has been developed)

Key Milestones and Deliverables for the Next Period

- **Health Pathways** – Continue progress towards March go-live date and mitigate associated risks (capacity due to industrial action and programme manager gap). Agree specialties for for phase 2 priority pathway development.
- **Patient Access and Activation** – submit plans to WG for funding to develop a Single Point of Contact service
- **Outpatients** – focus on increased virtual/video/group activity. Implement plans to reduce 100% past target FUs.
- **Theatres** – finalise GIRFT data pack and work through in-depth data analysis.
- **Planned Care Academy** – progress plans for delivery of training modules.

Key Risks

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

Clinical Effectiveness

Section 4

Aneurin Bevan University Health Board NPID Data

Audit Title:	Annual National Pregnancy in Diabetes Audit 2021 and 2022, England and Wales published 2023 (NPID)	Clinical Lead: Dr Anurag Pinto
Rationale:	The audit will answer the following three key questions: • were women with diabetes adequately prepared for pregnancy? • were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother? • did any adverse outcomes occur?	
Objectives:	Purpose - report on the demographics, patterns of care and pregnancy outcomes for women with diabetes in England and Wales. 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. Recommended targets for pre-pregnancy and antenatal glucose control. Women with type 1 diabetes are offered continuous glucose monitoring (CGM) based on strong evidence that use of CGM technology improves maternal glucose and reduces obstetric and neonatal complications.	
	Presented to Clinical Standards and Effectiveness Group – November 2023	
Findings:	• 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 Folic acid pre pregnancy don't have this info for both sites- and 100% from 1st contact in both sites	

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.

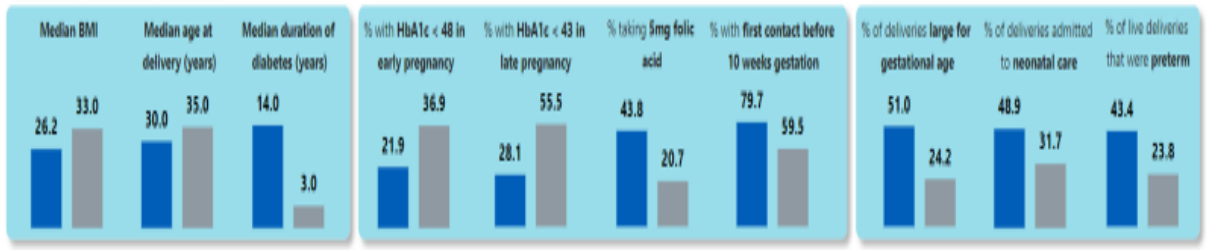
Median BMI	Median age at delivery (years)	Median duration of diabetes (years)	% with HbA1c < 48 in early pregnancy	% with HbA1c < 43 in late pregnancy	% taking 5mg folic acid	% with first contact before 10 weeks gestation	% of deliveries large for gestational age	% of deliveries admitted to neonatal 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.

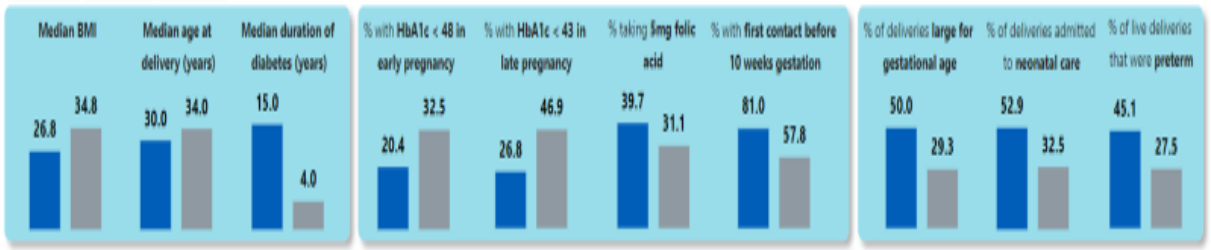
National Pregnancy in Diabetes Audit 2021 and 2022
Aneurin Bevan University Health Board Performance

Diabetes type: 1 | 2

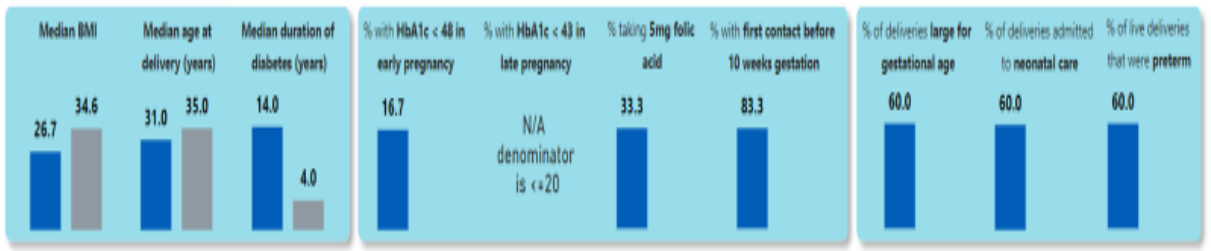
National results:



Wales results:



Aneurin Bevan University Health Board results: by Type of Diabetes



Aneurin Bevan University Health Board NPID Results

NPID 2023 report demonstrates:

- 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. Only capturing 50% of the data relating to use of Folic Acid and HbA1c <48 in 1st and 3rd trimesters.

Measures relating to HbA1c:

- 48 in early pregnancy and HbA1c <43 in late pregnancy, folic acid and first contact before 10 weeks' gestation
- Lacking data for the Health Board. Clinical Lead (Dr Pinto) has analysed the data. Variation between sites, NHH HbA1c <48 - one third in 1st trimester. For 2022 late pregnancy HbA1c <48 75% and <43 42% and 67% taking Folic Acid 5mg pre pregnancy.
- Info not avaible for both sites- 100% from 1st contact in both sites. Data capture needs to be improved.

Dr Pinto working with Peri-Prem Cymru (national project to reduce morbidity in pre-term birth). Health Board has higher rates of pre-term birth deaths (pre 37 weeks' gestation) which needs investigation. 35-37 weeks' gestation has lower rates of deaths than <34 weeks, 25% born less than 34 weeks and 44% less 37 weeks with 51% SCBU admissions in 2022. Missing data relating to term normal deliveries impacts the pre-term data.

Assurance Level and Risk Level

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

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

Has this audit been placed on a Risk Register	Yes/No/ Not Applicable

Key Success and Concerns

Report Successes:	
1	Above national average for early contact in T1DM
2	Local audit shows better early and 3rd trimester HbA1C and outcomes for babies (reassurance)
3	All women are using the FreeStyle Libre System Dexcom

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

Recommendations

Report 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.	The service uses FreeStyle Libre System 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.	ABUHB guideline is due to be updated - will incorporate the new targets (AMP+LP) with input from Lead Clinicians (LPP and DE)

Are Health Board services in line with the report recommendations? YES/NO

If YES, no actions are required

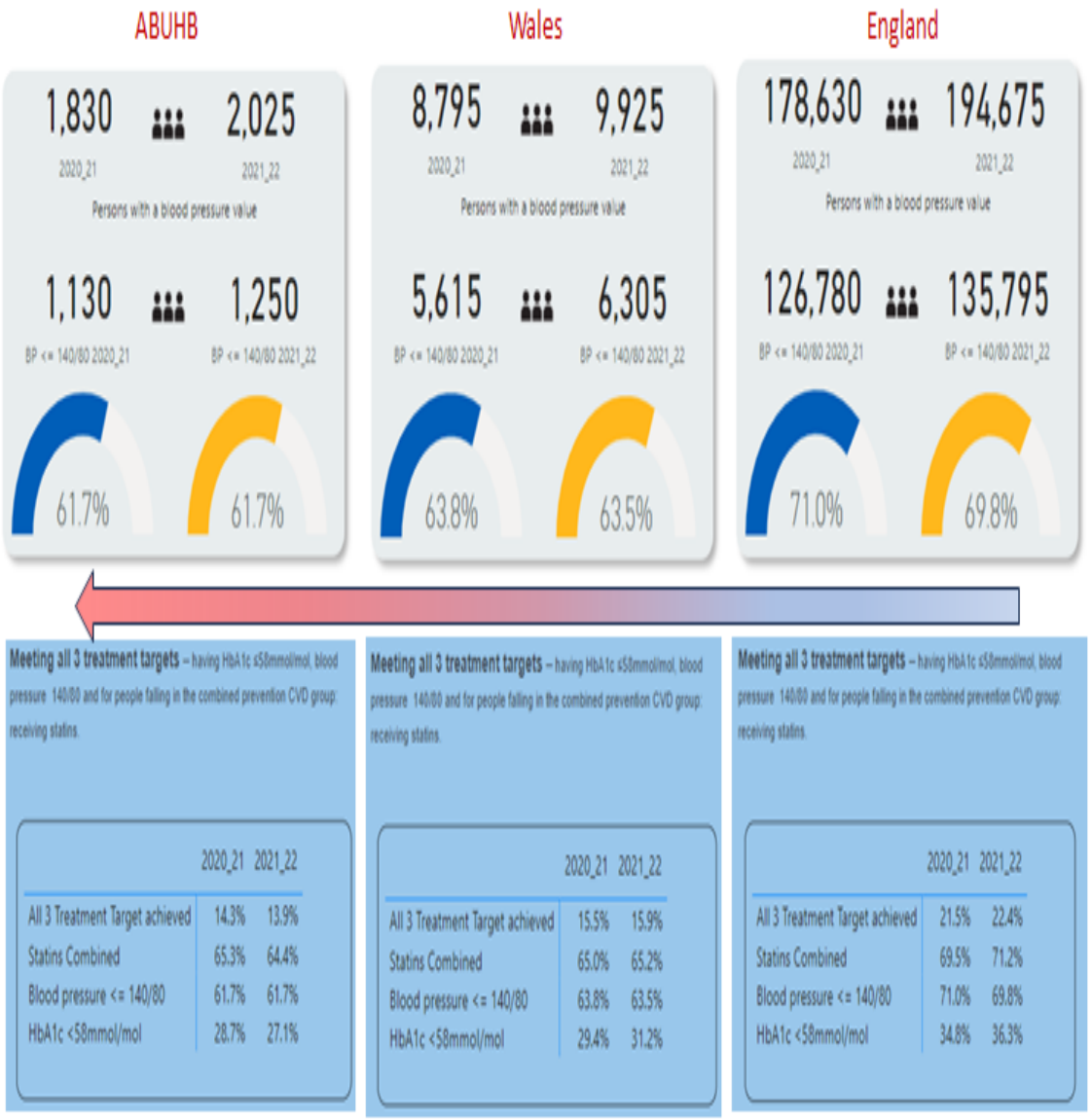
Action Plan

	Clinical Lead Recommendations:	Actions:	Responsible:	Due Date:	Progress:
1	Reduce the volume of pre-term births for ladies with diabetes	Audit completed and data presented at the December 2023 Clinical Governance meeting. Next step is to work upstream and find ways to prevent preterm births. Responsibility to oversee directed to clinical leads (Gareth Edwards- CD, Jyothi Singh - Obstetric lead, Jayne Beasley- Head of Midwifery).	Mrs Anurag Pinto	31/03/2024	New
2	Incorporate new NICE Guidelines	GL updated - submitted to CEF team for ratification- Jan 2024.	Mrs Anurag Pinto	31/03/2024	New
3	Improve cross site working to reduce variation (aspiring to involve Primary Care)	1st meeting has taken place, further quarterly meetings planned.	Mrs Anurag Pinto	31/03/2024	New
4	QPS support to ensure accurate data and maximise the volume entered	Clinical Lead working with Audit Team - Data for 2023 is being entered into NPID database in the next 4 weeks.	Mrs Anurag Pinto	31/03/2024	New

Audit Title:	National Diabetes Audit (NDA) 2021-22, Report 1: Care Processes and Treatment Targets	Clinical Lead: Dr Clifford Jones – presented by Dr Heather Griffiths
Rationale:	Measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. Collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.	
Objectives:	Report details the findings and recommendations relating to diabetes care process completion, treatment target achievement and structured education. Local level data made available to services in a timely manner that can help drive improvements in the quality of diabetes care locally.	
	Presented the Clinical Standards and Effectiveness Group – November 2023	
Findings:	• Care Processes for the Health Board for both Type 1 and Type 2 Diabetes have 2021/2022 have improved in 7 of the 8 areas since 2020/2021. Smoking status being the only one to decline, however in both periods, this is a very small decline. • The Health Board is performing better than the Wales average in 7 out of 8 measures for Type 1, with the smoking status being slightly lower for the Health Board, in Type 1 Diabetes only, Type 2 Diabetes the Health Board is performing better than the Welsh average in all 8 Care processes. • In both Type 1 and Type 2 diabetes, the Health Board and Wales is under performing compared to England.	

Type 1 Diabetes Receiving ALL 8 Care Processes:	
England	35.2%
Wales	15.7%
ABUHB	19.7%

Type 2 Diabetes Receiving ALL 8 Care Processes:	
England	47.9%
Wales	30.2%
ABUHB	32.5%



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%

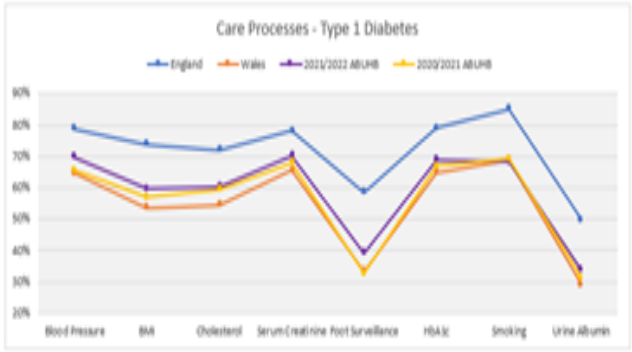
Meeting all 3 treatment targets – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

	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%

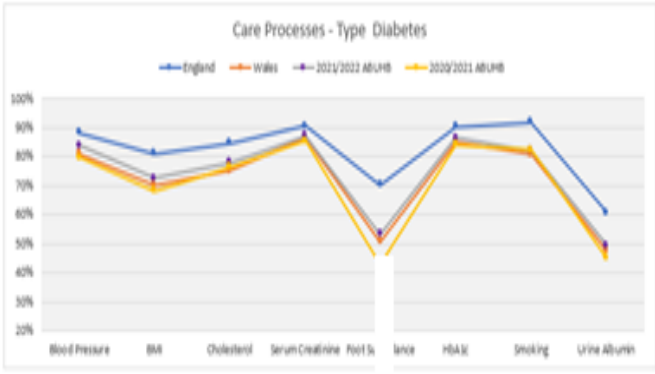
Treatment Targets across Wales and England have improved slightly from 2020/2021 to 2021/2022, however the Health Board is performing lower than the rest of the UK and has slightly declined in the latter year.

Aneurin Bevan University Health Board Results

Type 1 Diabetes	England	Wales	2021/2022 ABUHB	2020/2021 ABUHB
Blood Pressure	78.7%	64.7%	69.7%	65.4%
BMI	73.8%	53.5%	59.7%	56.9%
Cholesterol	72.0%	54.5%	60.4%	59.4%
Serum Creatinine	78.2%	65.6%	70.2%	67.9%
Foot Surveillance	58.5%	33.3%	39.1%	32.6%
HbA1c	78.9%	64.8%	68.8%	66.8%
Smoking	85.1%	68.8%	68.2%	69.0%
Urine Albumin	49.8%	29.0%	33.9%	31.4%



Type 2 Diabetes	England	Wales	2021/2022 ABUHB	2020/2021 ABUHB
Blood Pressure	88.30%	81.2%	83.9%	79.7%
BMI	81.00%	70.3%	72.7%	68.3%
Cholesterol	84.60%	75.3%	77.9%	76.6%
Serum Creatinine	90.60%	86.5%	87.3%	85.4%
Foot Surveillance	70.20%	50.9%	53.3%	43.1%
HbA1c	90.40%	85.3%	86.6%	84.1%
Smoking	91.80%	80.8%	82.2%	82.5%
Urine Albumin	60.70%	47.8%	49.5%	45.1%



Assurance Level and Risk Level

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

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

Has this audit been placed on a Risk Register	~~Yes~~/No/~~Not Applicable~~

Key Success and Concerns

Report Successes:	
1	Care Processes for the Health Board for both Type 1 and Type 2 Diabetes have 2021/2022 have improved in 7 of the 8 areas since 2020/2021.
2	The Health Board is performing better than the Wales average in 7 out of 8 measures for Type 1, with the smoking status being slightly lower for the Health Board, in Type 1 Diabetes only, Type 2 Diabetes the Health Board is performing better than the Welsh average in all 8 Care processes.

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

Action Plan

Clinical Lead Recommendations:		Actions:	Responsible:	Due Date:	Progress:
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.	Dr Clifford Jones/Dr Heather Griffiths	31/03/2024	New
2	Commissioners of care should continue to work with providers in restoring and then further improving pre-pandemic care process completion levels.	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.	Dr Clifford Jones/Dr Heather Griffiths	31/03/2024	New
3	Commissioners of care should continue to work with providers in restoring and then further improving pre-pandemic care process completion levels.	GP practices to help support social prescribing to help reduce obesity via engagement with link works/community connectors.	Dr Clifford Jones/Dr Heather Griffiths	31/03/2024	New
4	All 3 above recommendations:	GP/primary care needs to work with the All-Wales Diabetes Prevention Programme to reduce the progression of prediabetes to diabetes where available. Being undertaken by GP practices based in defined NCN areas of Caerphilly and Blaenau Gwent.	Dr Clifford Jones/Dr Heather Griffiths	31/03/2024	New

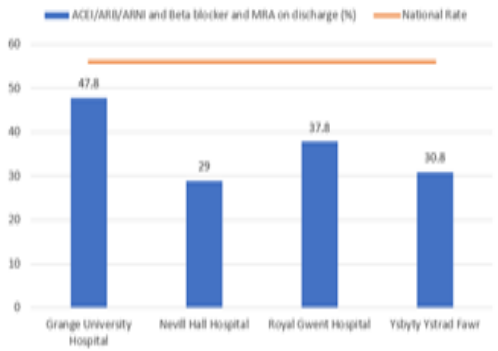
Are Health Board services in line with the report recommendations? YES/NO
If YES, no actions are required

Audit Title:	National Heart Failure Audit (NHFA) 2023 Summary Report (2021/22 data) Published June 2023	Clinical Lead:	Linda Edmunds Consultant Nurse, Cardiac Rehabilitation
Rationale:	This report summarises the key findings from the National Heart Failure Audit (NHFA), part of the National Cardiac Audit Programme (NCAP). It focuses on several quality improvement (QI) metrics that aim to drive up standards of care and achieve better patient outcomes during an admission to hospital.		
Objectives:	The report is based on 2021/22, emergence from the first year of the COVID-19 pandemic. As a result, there continued to be a marked reduction in the number of submissions to the audit in the 2021/22 reporting cycle.		
Presented at Clinical Standards and Effectiveness Group 21st September 2023			

Aneurin Bevan University Health Board Results

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

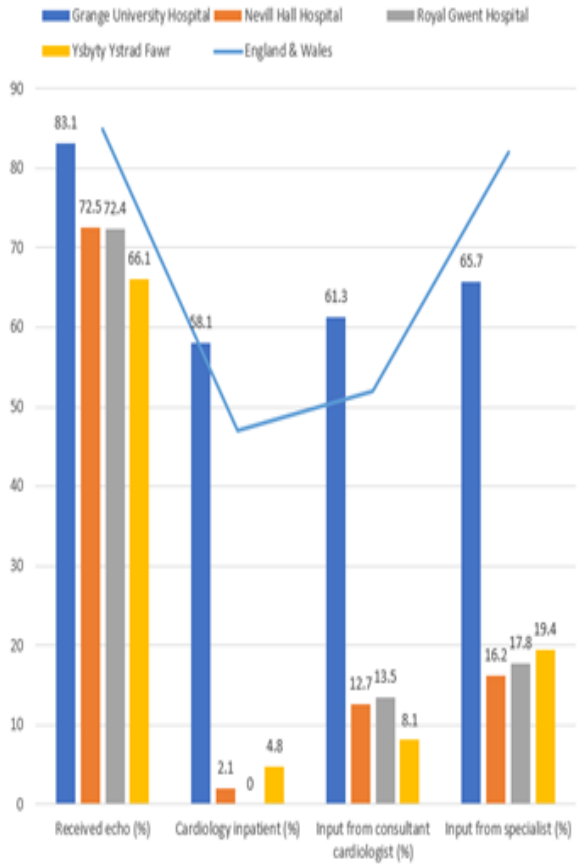
The National Average rate for discharge on three disease modifying therapy drugs is 56% and all sites within the Health Board are beneath this rate with considerable variation across the Health Board and compared to the rest of Wales, the Health Board has some of the lowest rates, 4 sites within the bottom 7 of 16 hospitals.

Key Message 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.

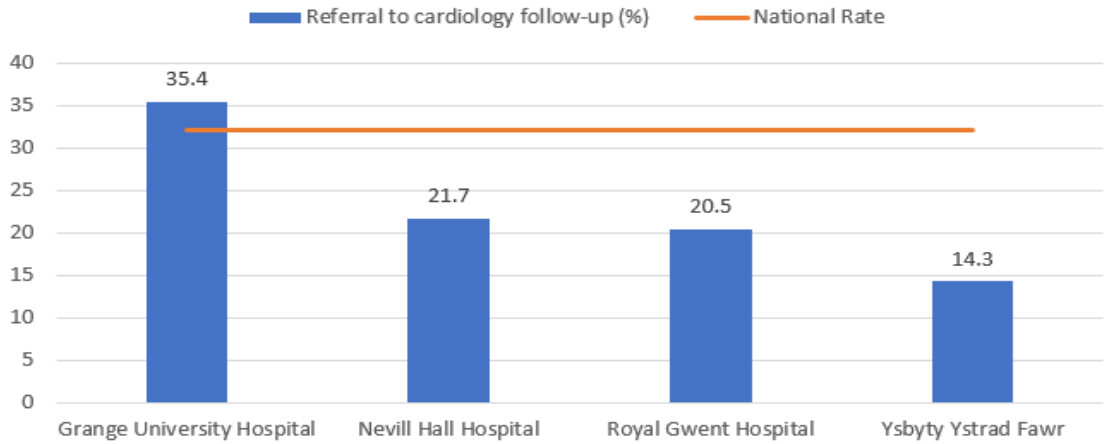
Patients in the main sites are more likely to be seen by a consultant cardiologist/specialist. Within the Health Board Nevill Hall Hospital (NNH) and the Royal Gwent Hospital (RGH) provide Echo at a similar rate (72.5% & 72.4% respectively), with Ysbyty Ystrad Fawr (YYF) rate 66.1%.

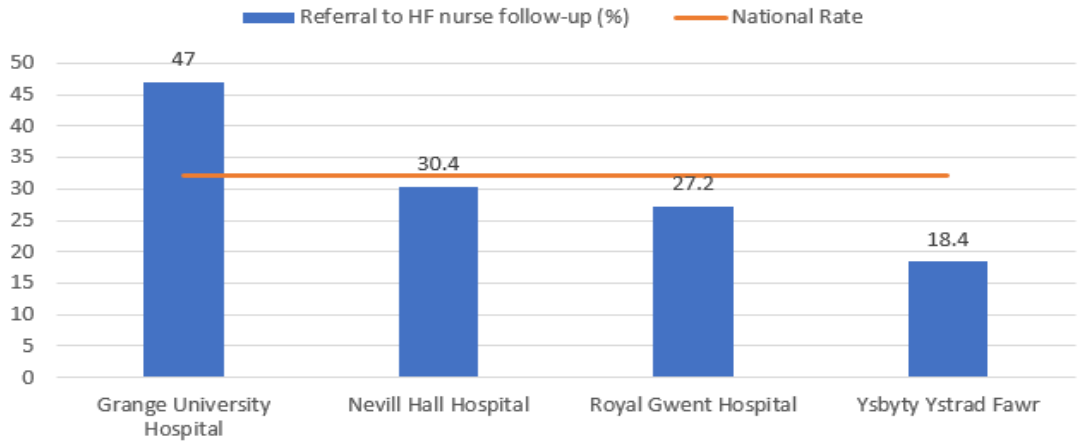
The Health Board is consistent with eh message of patients are more likely to receive and Echo if admitted to a cardiology ward, with those having specialist care on other wards more likely to receive Echo.



Key message 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 Level and Risk Level

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

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

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

Key Success and Concerns

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

Concerns:	
1	Rates of medication on discharge

Action Plan

Recommendations:	Actions:	Lead	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.	Health Board Echo rates have improved since the reduction due to the pandemic and with outsourcing the Health Board can deliver a prompter service. Inpatient heart failure service has commenced gradually throughout the sites. GUH to join next year, (seeing patients within 24 hours of referral). 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	New
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

	Clinical Lead Recommendations:	Actions:	Responsible:	Due Date:	Progress:
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	New
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
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	31/03/2024	New
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. All patients are offered face to face, or telephone follow up and patients under heart failure nurse have access to the MDT.	Mrs Linda Edmunds	31/03/2024	New

Are Health Board services in line with the report recommendations? YES/NO

If YES, no actions are required

For Information

Section 5

Person Centred Care:

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Deteriorating Patient **(PALS)**	Family of deteriorating patient contacted PALS Team for second opinion.	PALS Officer contacted the clinical team to express families concern. Second opinion of treatment plan/regime provided, and family satisfied.	Family anxiety around deteriorating relative alleviated through second opinion and new treatment plan devised. Patient very happy with intervention.	Call For Concern working group established by Deputy Medical Director to address requests for second opinions and PALS support.
Reasonable Adjustments **(PALS)**	Patient contacted PALS team about long waiting times at clinic appointments exacerbating pain from long waits.	PALS Officer contacted booking team and clinical lead and patient will now be offered first appointment.	Allocation of first appointment means the patient will spend less time sat in waiting room alleviating discomfort.	Continue to monitor the PALS themes monthly to determine reasonable adjustments.
Care Closer to Home **(PALS)**	Patient wife contacted PALS regarding her husband being so far from home and unable to visit and husband unable to see his dog. (patient was on stroke pathway in YYF but lived in Chepstow).	PALS Officer contacted YYF team to discuss care plan for patient and when he would be ready for general rehab. PALS Officer contacted Chepstow team to ensure they were aware of the situation. Patient added to transfer list once stroke pathway rehab had finished.	Patient was transferred to Chepstow to be near his wife and dog and continue with general rehabilitation.	Wife fed back that she is 'over the moon' and has shared that her husband is doing much better since being closer to home and having daily visits from his wife and dog.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Discharge **(PALS)**	Wife of patient rang the PALS Team in a very distressed state because she was told her husband was to be discharged imminently (following a potential unsafe discharge previously). Wife called as she was still awaiting social services to assess her home and she was adamant she was unable to meet his needs at home at this present time. Husband had been discharged and readmitted a few days prior.	PALS officer contacted ward sister, senior and divisional nurse and asked for them to look into the discharge and also link in with social services. Ward team spoke to wife and talked to her step by step through the next process.	The wife reported that this intervention had 'lifted a massive weight' off wife's shoulders. PALS have been checking in with her as there are some other issues (separate from this concern) that they are still offering support with. Wife is aware that if she has any concerns around health care or if anything like this happens again, she can contact the PALS team, alleviating her anxiety.	Patient to be transferred to YAB. Despite anxieties about the transfer, after discussion she now feels confident about YAB and knows she can always contact PALS. Volunteer co-ordinator to be approached to ask if one of the volunteers in YAB could visit the patient in future as his wife wants him to have someone to talk to when he's at that hospital, due to potential loneliness in single bays.
Mental Health Management **(PALS)**	Complaint forwarded from PTR. Patient suffers with mental health and Schizophrenia. Rehab ward had refused to admit patient due failed trial. Mum concerned about possible discharge to community and lack of rehab options.	PALS Officer liaised with Adferiad and Pillmawr ward to arrange a meeting between staff, patient, and family. A plan was agreed by all which was agreeable with patient and Mum.	Patient and family feel comfortable with plan and patient has a clear understanding of pathway if they engage / disengage. Clear communication channels have been opened with the ability to maintain going forward. Family feel supported and listened to.	Patient will have day patient trials on Pilmawr ward. If successful they will then be admitted for rehab once a bed becomes available. Mum and patient both feel this is a desirable outcome. This complaint was able to be resolved through Early Resolution.
Spiritual / Pastoral Care **(Chaplaincy)**	Core to pastoral care is patient engagement and supportive listening. Through this 1 to 1 pastoral care offered to patient's, concerns are sometimes expressed. Most concerns are relating to communication and quality of care.	Concerns are shared with ward staff and escalated to ward manager / sisters where the concern is serious. On-gong support is provided to the patient. Where patients continue to be unhappy about issues, further escalation is offered.	Patient feeds back to chaplain. Sense of reassurance from patient.	Continued support and monitoring of situation.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Preparing People for Treatment. **(Cancer Services)**	Cancer patient panel fed back that they would have benefited from more information on how to prepare for treatment and the impact the treatment would have on their life.	Getting ready for treatment programme being developed • Training for staff • Webpage/resources • What matters to you conversation	Good initial feedback from patients and staff. The programme means patients will be helped to self-manage and be better prepared for treatment	Full pilot launching March 2024.
Volunteer Concerns following Visits. **(Volunteering)**	A volunteer had expressed concern about the 'welcome' they received on a ward. However, this concern was reported late meaning that volunteer concerns were not acted upon in a timely manner.	The Volunteer Manager has now added '*Did anything concern you'* to the Volunteer visiting feedback form.	Addressing volunteer concerns immediately will ensure the wellbeing of volunteers and ensure concerns are addressed immediately.	Monitoring of any concerns will take place after each recorded visit.
Reasonable Adjustments **(Complaint Response)**	Patient had complained through PTR that reasonable adjustments were not made during an outpatient appointment. Patient is Deaf.	Clinical team contacted Equalities, Diversity and Inclusion Team. Training provided and team made aware of the adjustments that are available to them e.g. Sign Live. Patient offered opportunity to discuss their concerns further with Head of Patient Experience and Involvement. Contact has been made with patient and visit will be made to discuss this patient experience further.	Listening and Learning from this patients experience will be used to improve accessibility to NHS healthcare for those with sensory impairment. At the visit patient will be asked if they are interested in becoming an 'Expert by Experience' on the organisations Disability Forum.	Patient feedback will be used to improve accessibility and ensure staff are trained to recognise and respond to those requiring reasonable adjustments.
Patient Safety Bedside Boards **(Dementia)**	Relative told us that there is a need to see 'at a glance' that someone has dementia when in hospital.	Bedside Boards introduced. Impact evaluation taken during October 2023. Feedback report produced, series of recommendation and actions developed. Liaison with Communications team to discuss the development of information videos. Staff briefing document to be produced. Additional pen and magnetic pen holders to be scoped, secure funding then procured for each board.	Bedside Boards can provide immediately information about patient needs/risks, including dementia.	Second impact evaluation to measure improvement planned for April 2024. Ongoing bedside board implementation and impact evaluation to take place through the Dementia Hospital steering group.

Person Centred Care:

Listening and Learning from Feedback

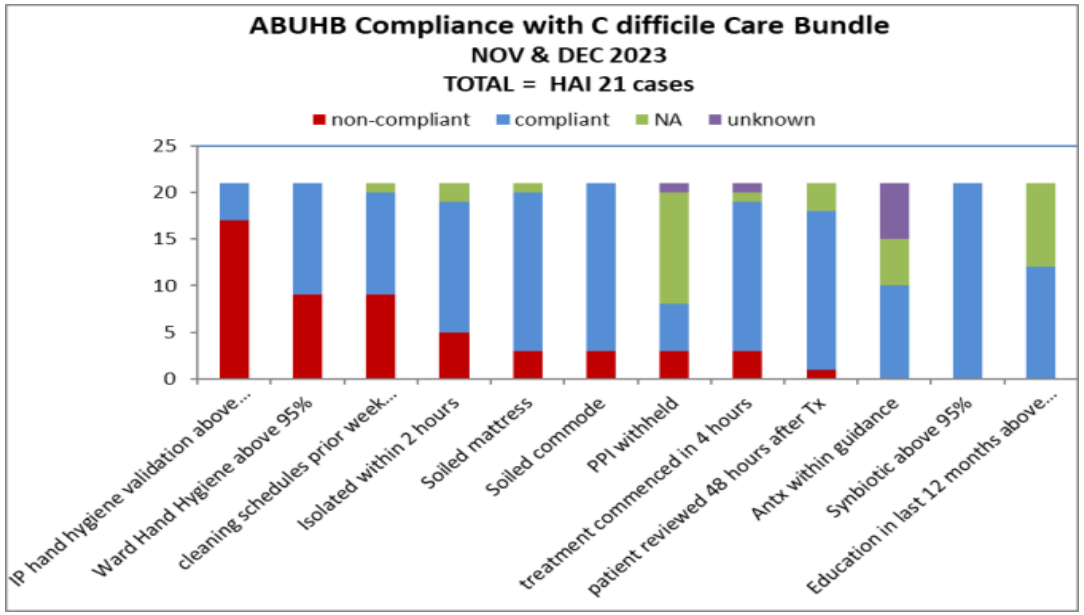
Theme	Feedback	Action Taken	Impact	Next Steps
Patient Identification and Clinical Coding **(Dementia)**	Feedback from public engagement and staff ward improvement as well as the National Audit of Dementia. People felt that having a better way of identifying people with dementia whilst attending or staying in hospital would help support approached to care as well as inform future service/ care needs.	A small group has been formed to review the use of Clinical Workstation Coding to help identify patients on admission through to discharge. A draft flow chart, coding instruction and communication briefing plan will be developed.	The impact will be measured through National Audit Dementia local group as well as Dementia Hospital Steering Group	Ongoing. Evaluation of actions though subgroups.
Meaningful Engagement and Activity **(Dementia)**	Patients on wards have expressed boredom, loneliness and isolation.	An evaluation of the previous Meaningful Engagement and activity in hospital programme was used to support an NHS Charities Together (NHSCT) charitable funds bid which was successful to extend programme to care homes, people's own homes and prison health care units in Gwent. A Steering group has been developed to consider and agree implementation of this programme. This includes: scoping of Care homes in Gwent, prison health care units, resources required and current provision available. Training and development and impact on patient care, staff confidence and competence.	The programme will have a series of measurements which will help us identify the impact of patient care and experience. It is anticipated that meaningful engagement/activity will be integral to care planning.	NHSCT funding has allowed for the appointment of band 6 Practice Educator and Band 3 Activity Co-ordinator for 18-month secondment, supporting the wider health and social care workforce to implement meaningful engagement strategies. Continuous review of action plan and project progression though steering group. Reporting template to NHSCT and Regional Dementia Board.

Welsh Government targets

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

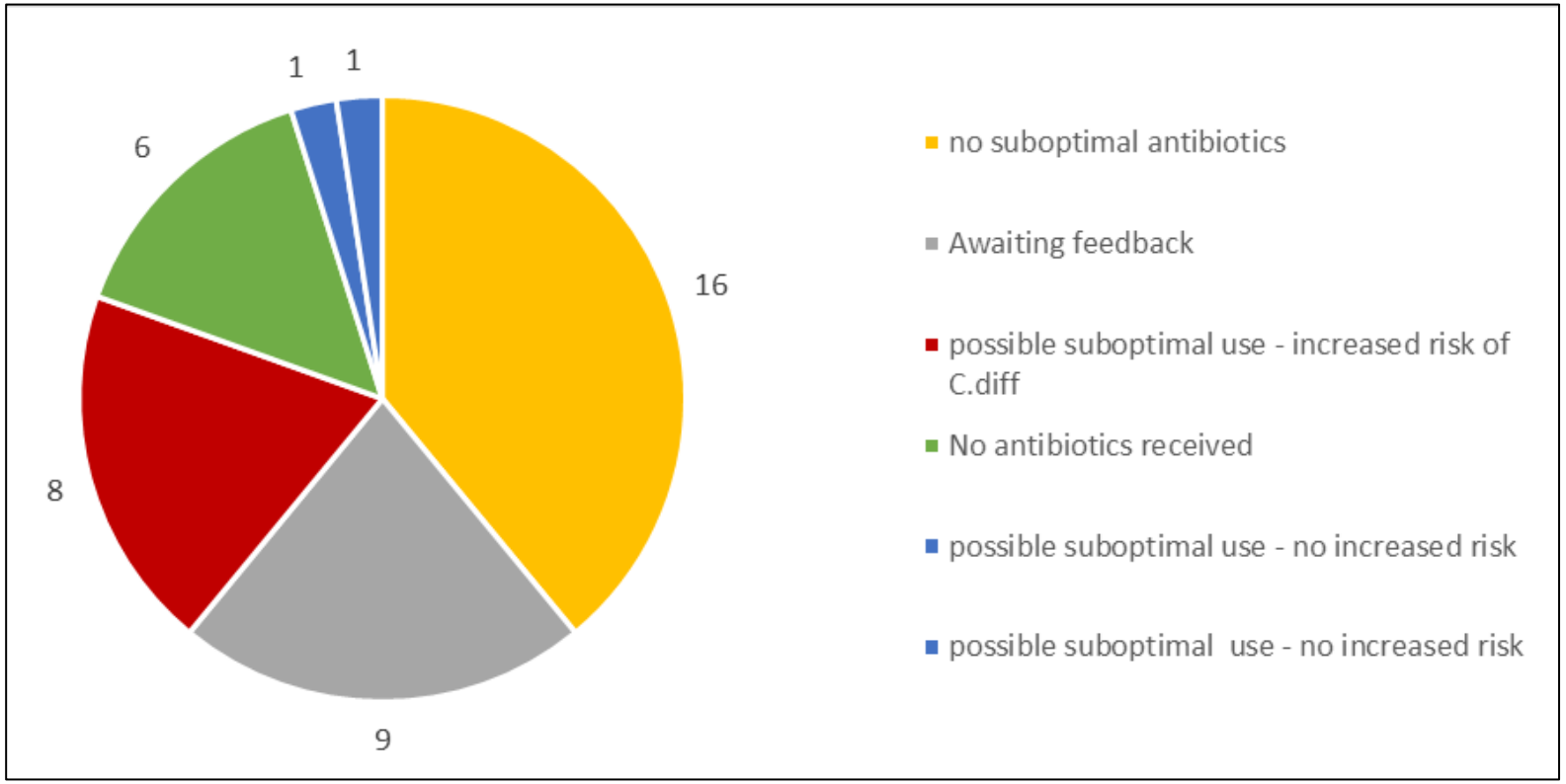
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	36.71	1.11	18.02	60.29	23.58	4
Betsi Cadwaladr UHB	39.17	1.14	23.65	79.66	24.22	5.49
Cardiff and Vale UHB	21.1	2.11	31.39	72.02	24.27	4.22
Cwm Taf Morgannwg UHB	30.77	2.07	29.59	86.98	27.52	4.14
Hywel Dda UHB	47.13	3.07	26.3	106.55	26.3	7.85
Powys THB	18.01	0	1	2	0	0
Swansea Bay UHB	62.64	1.7	37.11	69.11	23.49	6.47
Velindre NHST						
Wales	37.75	1.72	25.7	74.78	23.93	5

C difficile



- Two wards identified increased incidents
- QI programme within Medicine ongoing
- Cubicle assessment visible in hub at RGH/NHH for timely isolation

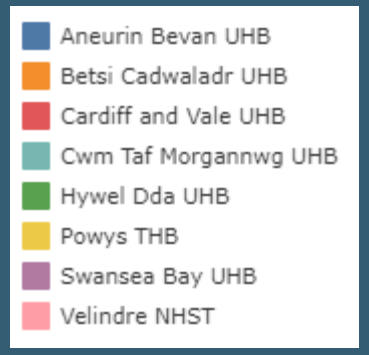
C. difficile antibiotic root cause analyses November & December 2023

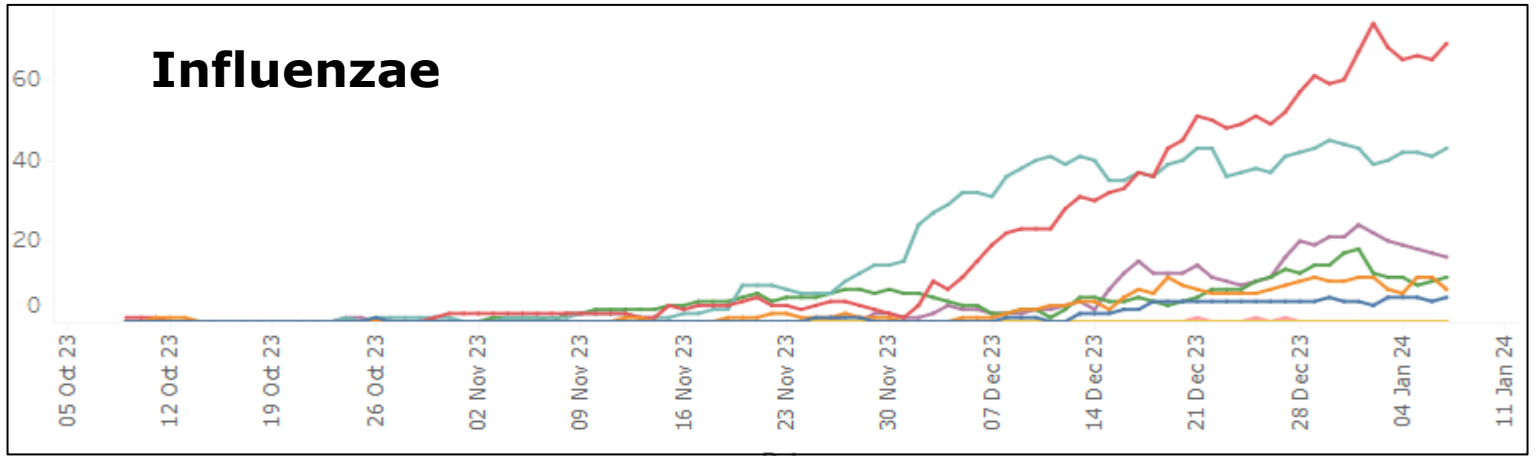


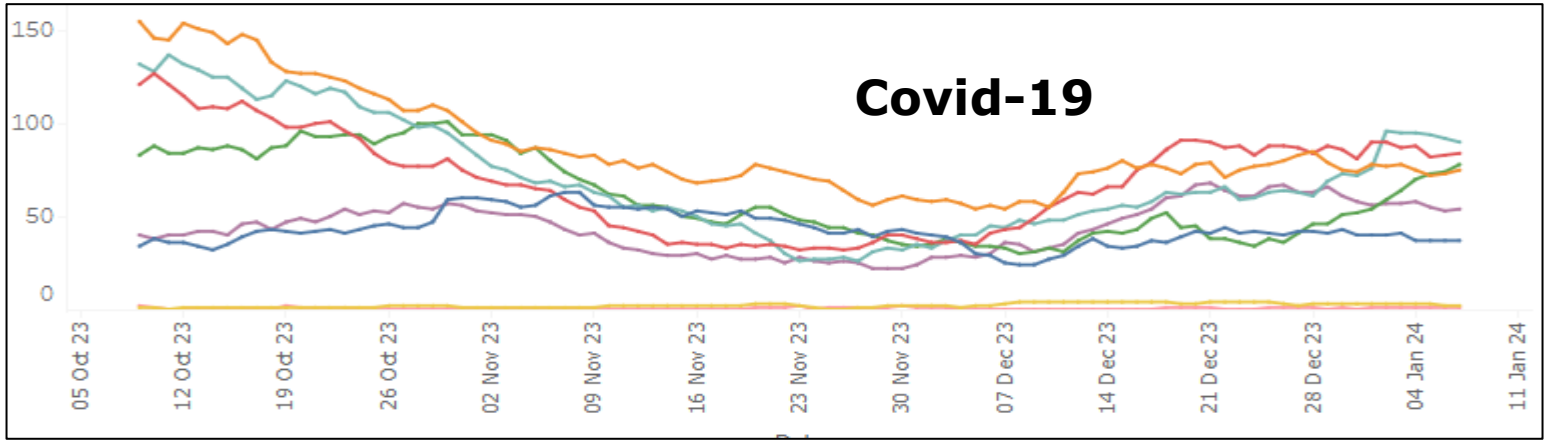
The majority of RCAs where feedback is awaited are from primary care. Returns are being encouraged by one of the Primary Care Clinical Directors.

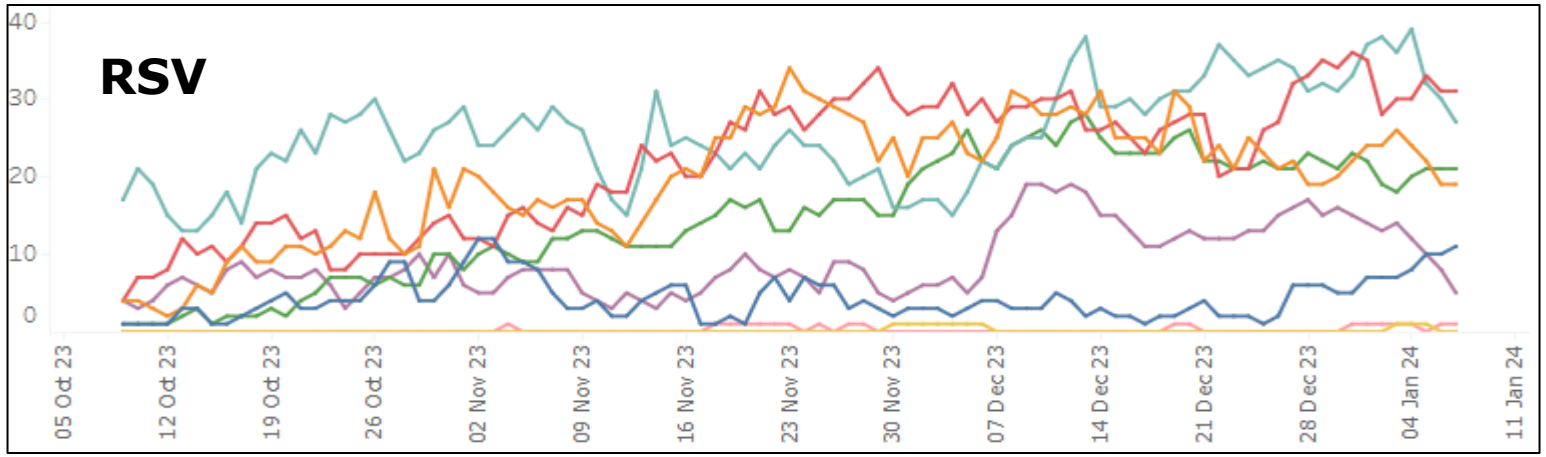
All of the suboptimal use involved use of Tazocin or co-amoxiclav, in either GUH or RGH with the exception of one case in NHH. This will be investigated in further detail by the Lead Antimicrobial Pharmacist for Secondary Care.

Respiratory Infections





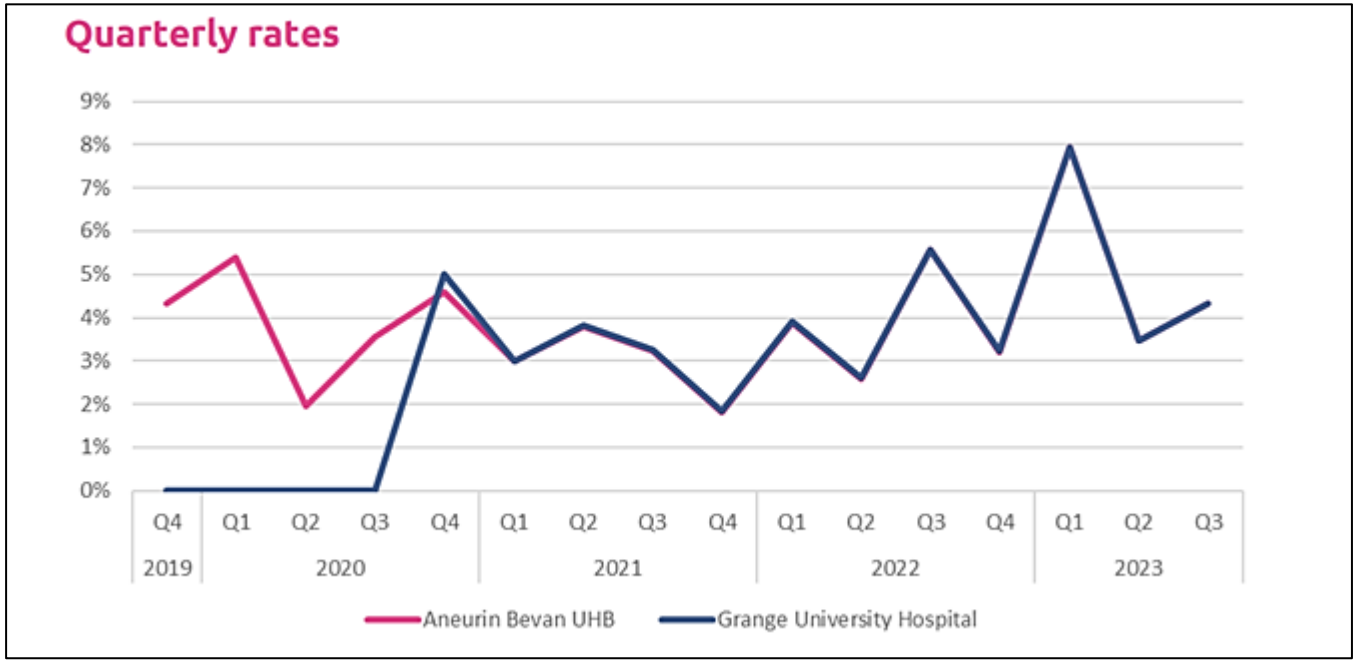




National Reportable Incidents & Significant Incidents

Issue	Cause	Remedial Action	Who	When
5 ward closures due to Covid-19 infection	Correct use of appropriate PPE Visitors attending with symptoms Shared facilities Limited isolation facilities Staff risk assessment – working with symptoms if well enough	• Patients to wear masks whilst mobilising & using toilet. • Encouraged ventilation throughout the ward. • Cleaning with Actichlor solution 1000ppm focusing on frequently touched points • Minimised staff transfer between wards • Implemented Step down guidance for positive patients • Visiting restricted & visitors informed they were visiting an area with known Covid • Reviewed Covid safety measures	Ward Managers Senior Nurses Facilities Infection Prevention Team	Immediately
2 ward closures due to C difficile infection. Genomic sequencing confirmed the same strain	D3E – high risk patient due to chemo & recent bowel surgery Ruperra – delayed isolation & sub optimal cleaning	• Improve hand hygiene • Environmental cleaning • Prompt isolation	Ward Managers Facilities	Completed at time & ongoing
Two patients underwent thyroid surgery at Royal Gwent Hospital Theatres (Theatre 14) on 26.10.2023 both had swabs sent from their surgical site infection and both grew *Streptococcus disgalactiae*.	• Small theatre environment • Use of masks for all theatre personnel within the theatre suite and surrounding clinical area • Thoroughfare of theatre staff accessing the suite during a procedure	• Review staff risk assessment for respiratory infections • Staff wellbeing included in theatre WHO risk assessment • Cleaned vents in theatres • Consider type of procedure being undertaken due to small environment	Theatre Personnel Consultant	Completed

Caesarean Section Surgical Site Infection



Issue	Cause	Remedial Action	Who	When
Increase of wound infection following c-section Q1 2023 – 7.9% Q2 returned to a rate of 3.5% Q3 – slight increase to 4.3% See graph below	• Over reporting • Endogenous infection	Task & Finish group established Deep Dive of Q1 cases – estimated rate to be 5.9% Training & education for maternity staff Theatre observation Reviewed information given to mothers to be Reviewed SOP inline with One Together pathway Link with Public Health Wales to amend the report	Maternity personnel Infection Prevention Directorate Manager Governance Lead	Completed & ongoing

Decontamination

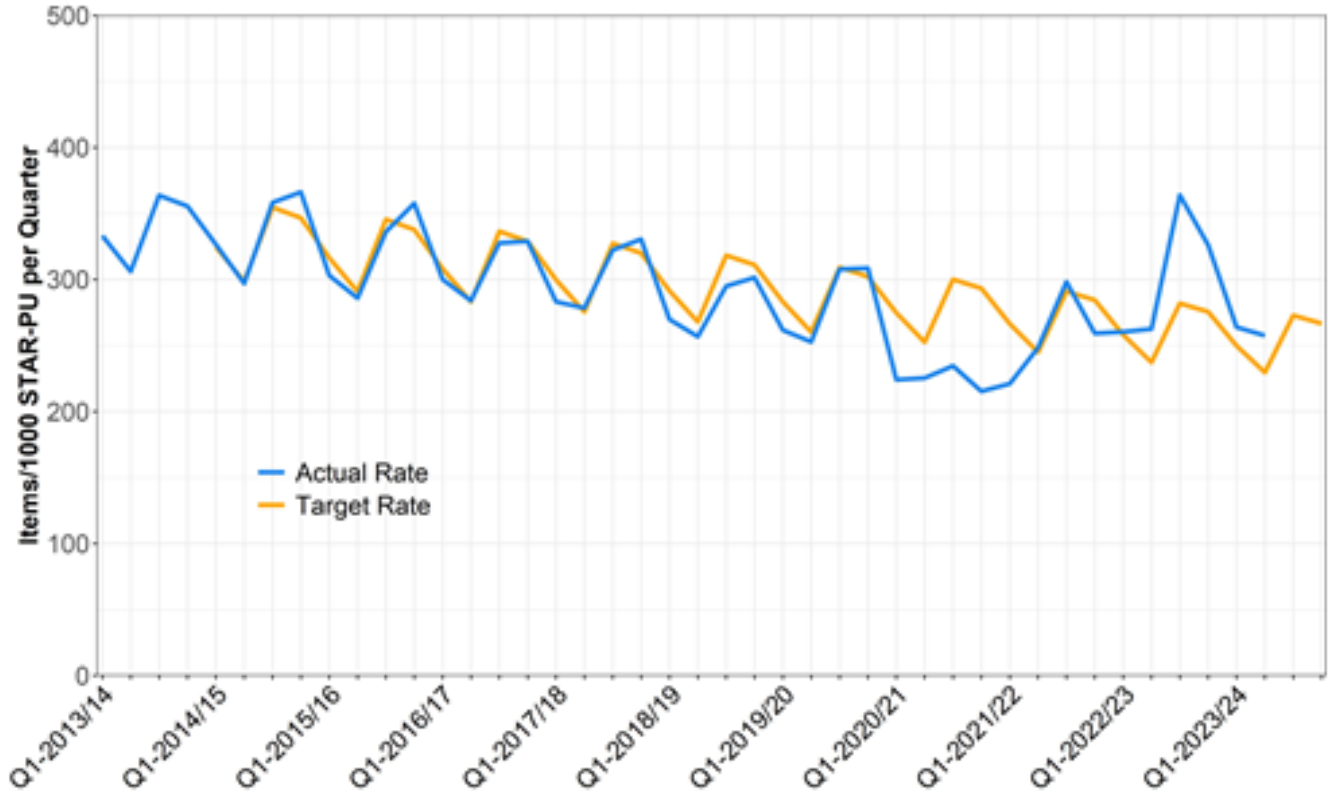
Issue	Cause	Remedial Action	Who	When
Community Dental Service washers and autoclaves have not been serviced / tested for at least 8 months.	Lack of works and estates trained staff to undertake the role and their focus on other decontamination testing, eg HSDU.	Conversation with the All Wales Authorised Engineer (Decontamination) AE(D) for awareness. Further delay in undertaking annual testing until January.	Work and estates trained staff. Competent Person (D) & Authorised Person (D).	January February 2024
Delay in HSDU taking over the decontamination of endoscopy scopes at the Royal Gwent Hospital. Continued use of endoscopy directorate staff as trained on the endoscope washers disinfectors (EWD)	Delay in receiving the interim portacabin dec ontamination facility from Torbay. Further delay with asbestos found in electrical board.	HSDU staff trained and undertaking manual wash but endoscopy trained staff operate the Wassenburg EWDs. Asbesto issue has been addressed by works.	HSDU Works completed Nov / Dec 2023	Interim Building going live January 15th
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D)	Identified issues showing little progress since 2022 year audit, including works and estates input, electronic track & trace (IT), report governance.	Updated action plan by Directorate stipulating responsibilities and must dos. Action plan review by Directorate	Directorate manager & Senior Nurse	December – immediate April for financial & IT aspects
AP(D) role not fully functioning from a governance aspect.	Lack of AP(D)s and decontamination trained staff. Currently under review and progress toward AP(D)	Decontamination manager continues to support AP(D)with joint report review and submission.	General Manager Facilities / Works & Estates	Ongoing Review complete Marach 2024
Risk of losing automated decon process for US probes. Poor decon process for US probes within Critical care.	Trophon 1s HPV probe disinfector are obsolete. Compliance issue within Critical care	Replacement programme within Ultrasound. Decon lead within critical care actioning interim 3 stage wipe and retraining for Trophon 2s	Ultrasound Lead Critical Care decon lead	January 2024 January 2024

Welsh Government targets

Antimicrobial prescribing: primary care

- ABUHB is unlikely to meet the primary care reduction goal, especially given the target period falls in high-prescribing winter Q4.

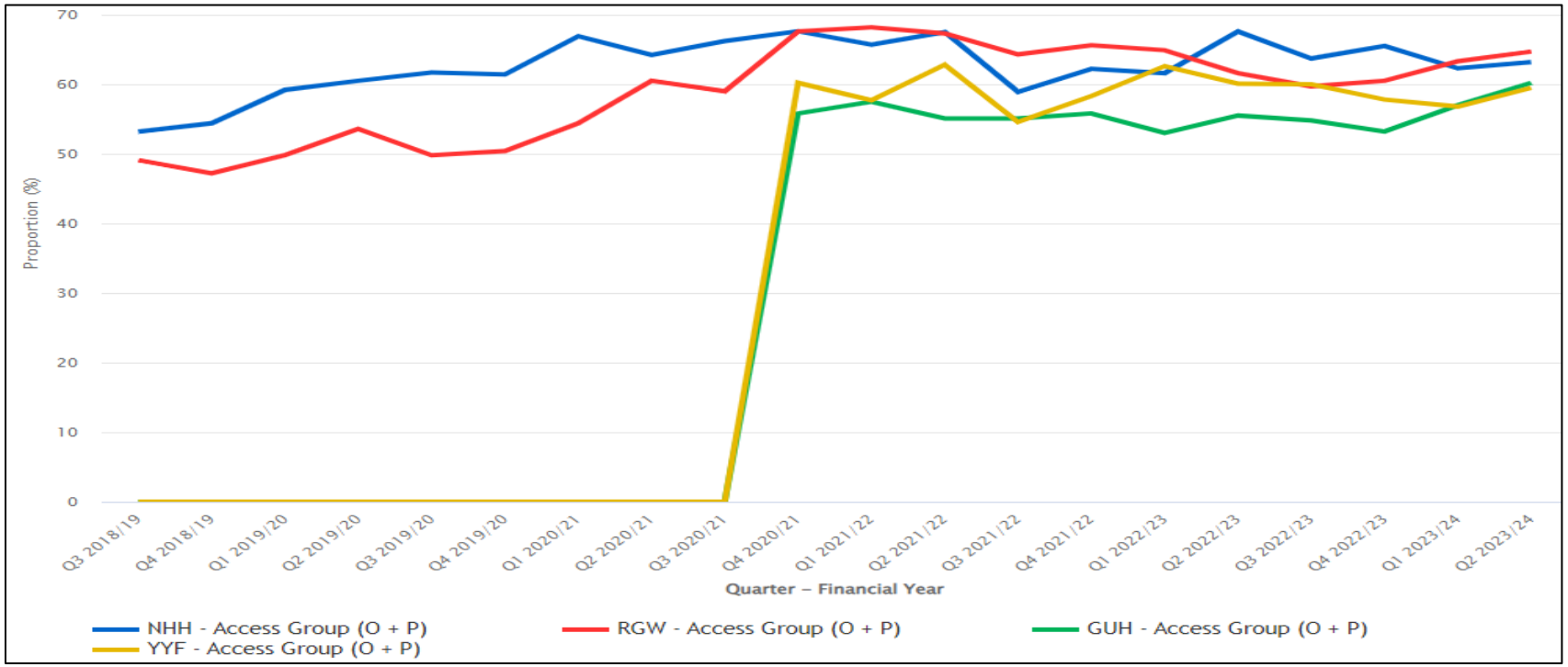
- Torfaen, Blaenau Gwent & Caerphilly are the highest prescribing localities in Wales. Audit & feedback cycles are ongoing with high prescribing practices. Recruitment is underway to an additional 0.4WTE pharmacist post to accelerate this workstream, but this will not deliver results in time for FYE.



Welsh Government Targets

Antimicrobial prescribing: secondary care

All 4 secondary care sites have achieved the secondary care target of using 55% or more antimicrobials in the lower-risk 'access' group of antibiotics (mean 61.9% in 23/24 Q2).



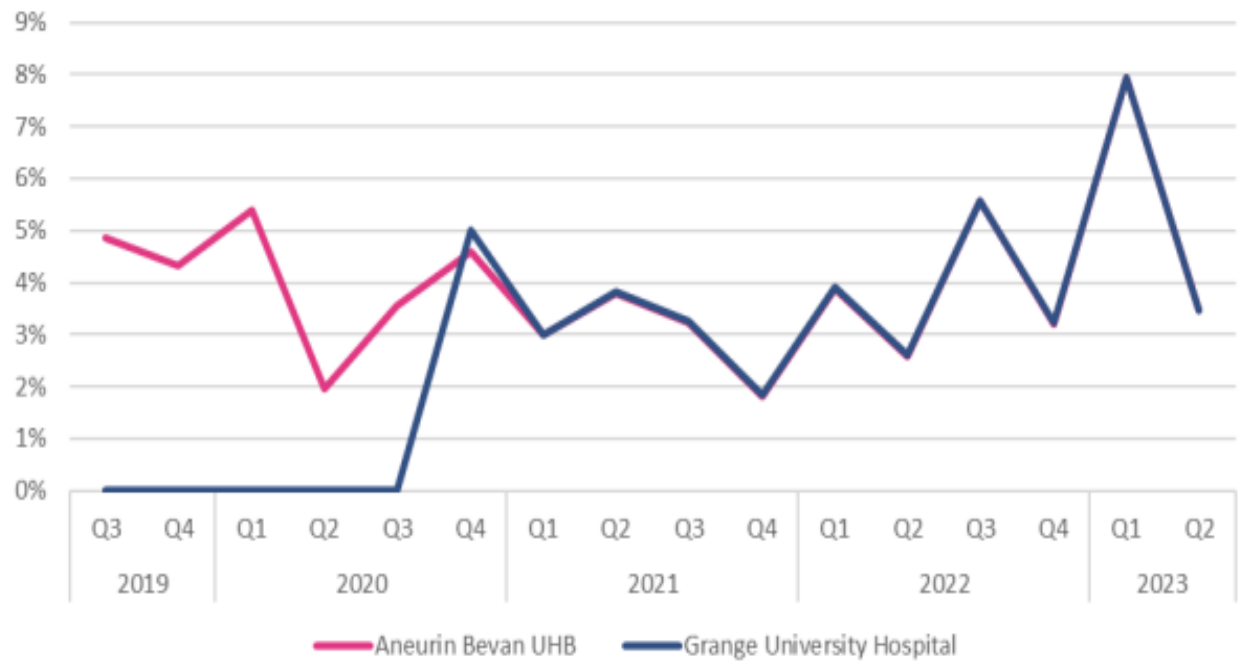
Completion of Start Smart Focus audits to measure prescribing quality is poor. An alternative approach has been discussed in the Antimicrobial Working Group and will be supported by the Medical Director.

Maternity SSI Rates

Rates

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

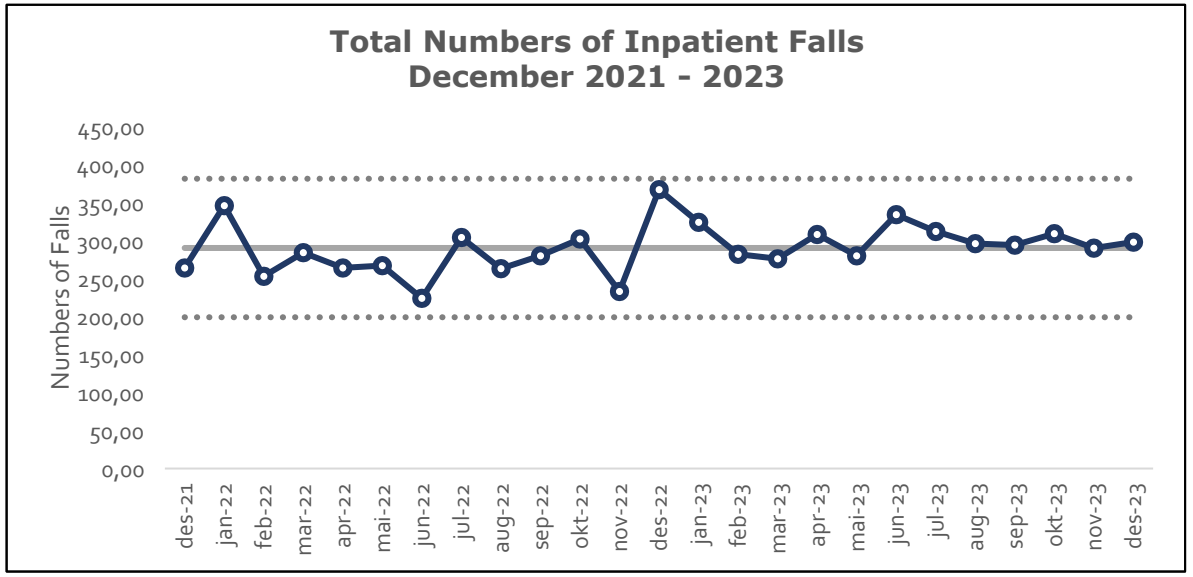
Quarterly rates



Action for Service

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

Total Numbers of Inpatient Falls



February 2024 - Context

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

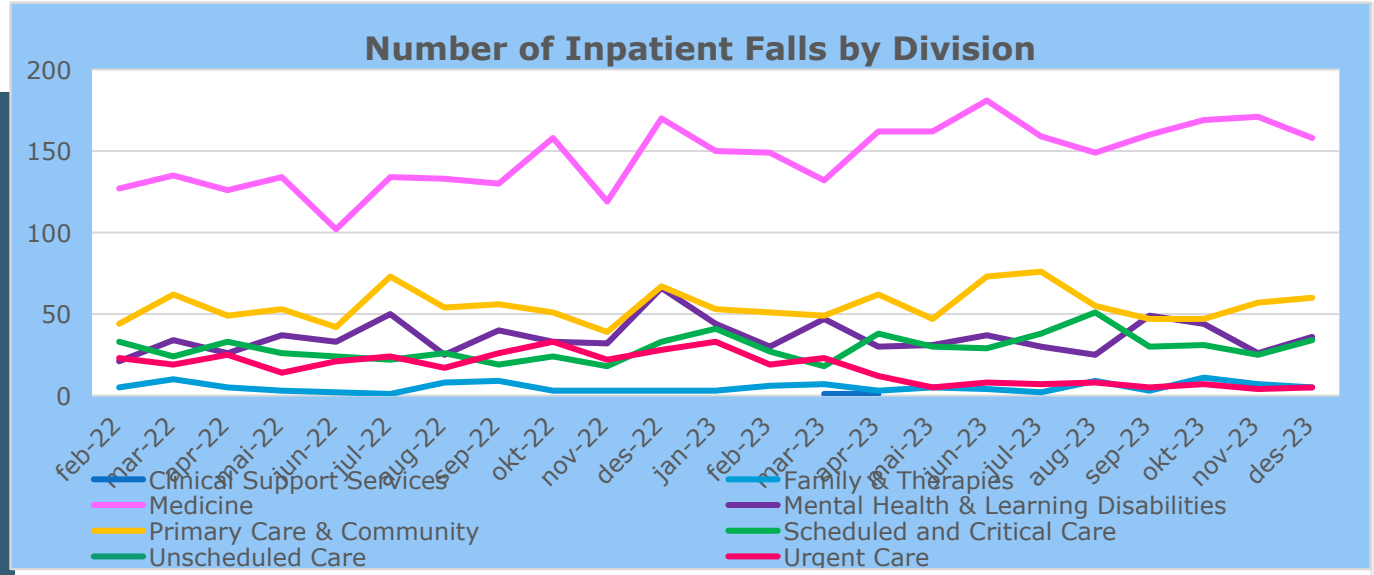
The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period December 2021-2023.

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

With the information available for 2024 11 patients have experienced more than 2 falls. 10 patients have experienced 3 falls with the 11th Patient haven fallen 4 times. The areas in which these falls have occurred relate to Medicine, Mental Health and Learning Disabilities and Primary and Community Care,

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the year 2023 incident reporting numbers have demonstrated consecutive months in which there is close alignment to the mean average value for the given data period at 282 • Except for June 2023 the numbers of falls incidents have remained on a steady trajectory along the centreline.	June 2023 represents the second highest value for reported incidents in the given data period at 334. 2023 has seen significantly less variation above or below the mean average value as compared to 2022.

Inpatient Falls Data by Division



February 2024 - Context

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

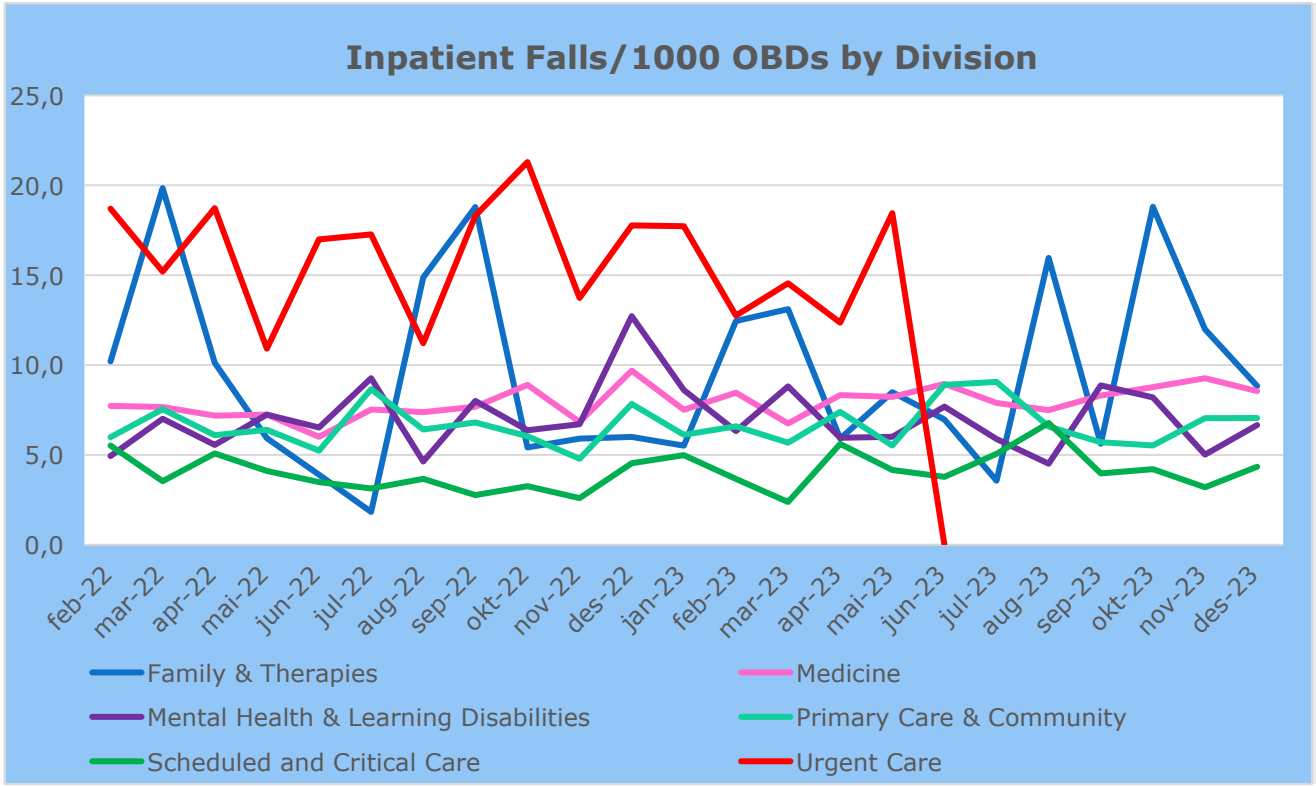
As expected, the highest numbers of falls remain linked with those ward that are populated by our frailer and older patients.

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

Definitions	What the chart tells us	Key Variation for 2023
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	The information provided represents that per Division for the total numbers of inpatients falls for the period February 2022 to December 2023.	**Medicine** • Peak value seen in June 2023 (181) with a significant downwards trajectory to August (149). **Scheduled and Critical Care** • Following a peak in August 2023 (51) the numbers of incidents have decreased with a trajectory of minimal variation.. **Clinical Support Services** • Incidents of falls were recorded for March, April & June 2023 when inpatients were attending for diagnostics. **Mental Health & Learning Disabilities** • September 2023 saw the highest numbers of falls incidents (49) with a subsequent downwards trend to the second lowest value in November (26). **Primary Care and Community** • Following a peak in falls incidents during June & July (73 & 76 respectively) a downwards trajectory was seen for subsequent months with a marginal increase in December 2023.

Inpatient Falls Data

by Division



February 2024 - Context

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

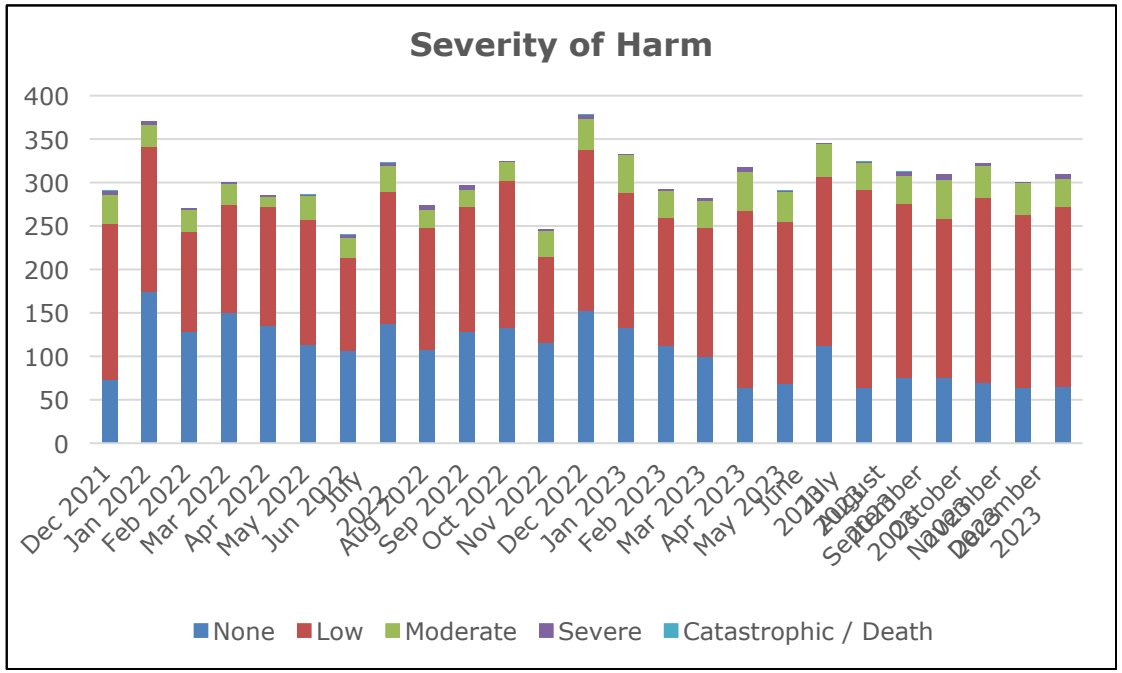
It is important to consider these values in the context of numbers of patients in hospital within a given service.

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.

Definitions	What the chart tells us	Key Variation Highlights 2023
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	The information provided represents Inpatients Falls per 1000 Occupied Bed Days (OBD's) per Division for the period February 2022 to December 2023. For 2023 three out of five Divisions saw a value aligned to or below the National Average of 6.6	**Mental Health & Learning Disabilities OBD** • Lowest value seen in August 2023 for the total data. **Families and Therapies OBD** • Values have seen two peaks in August and October with subsequent significant downward trajectories.

Inpatient Falls Data

Severity of Harm



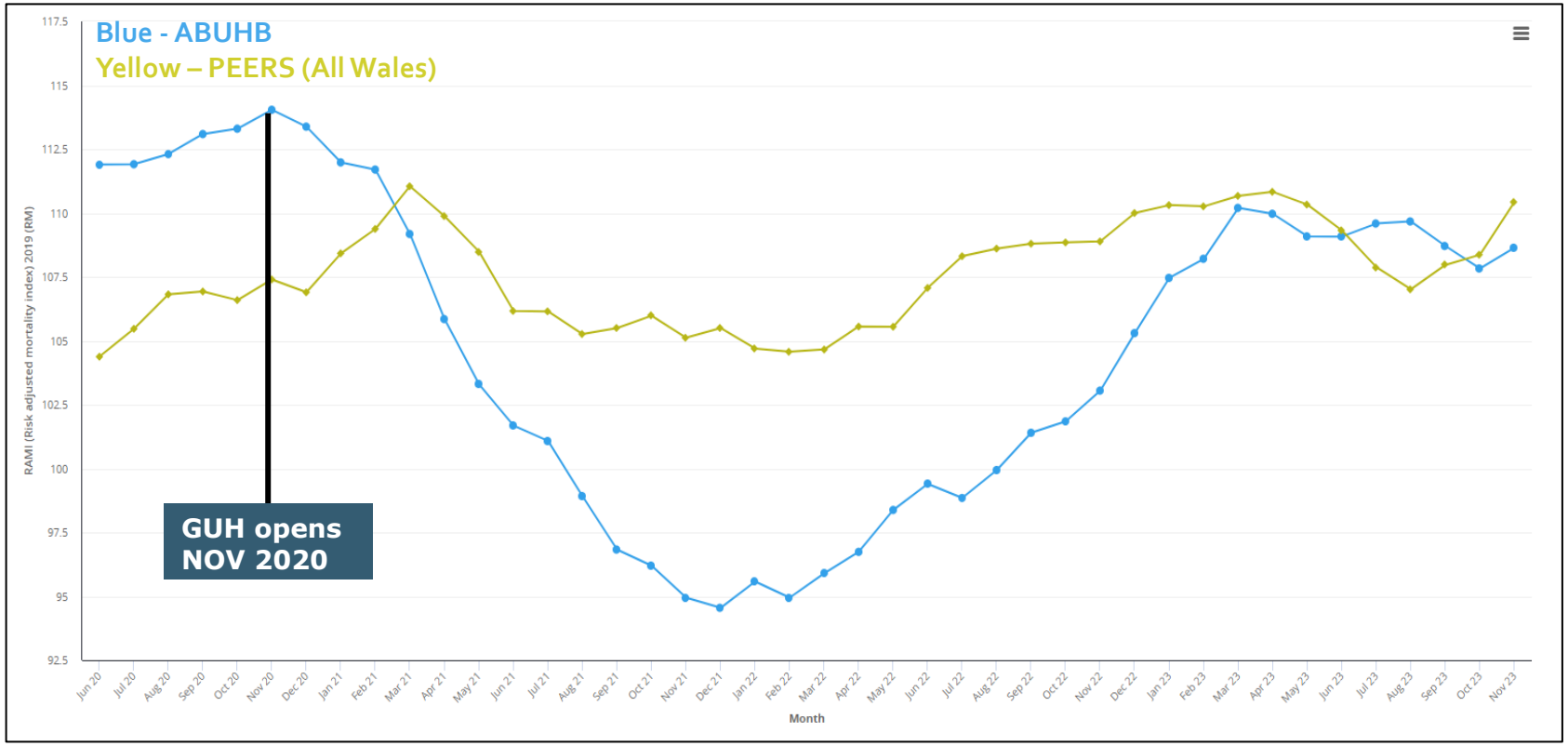
February 2024 - Context

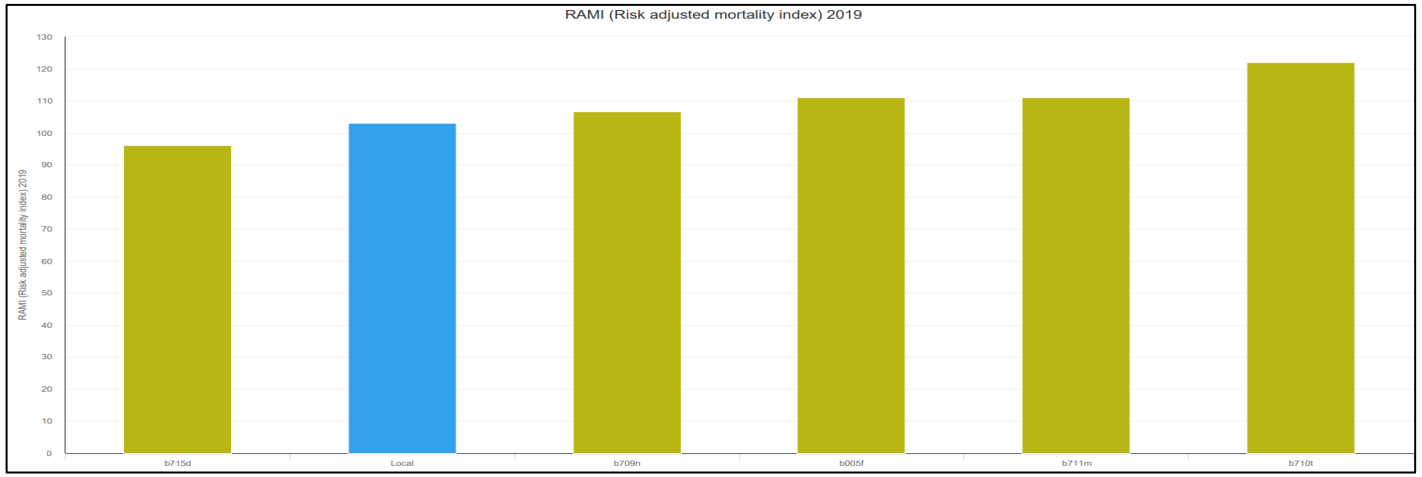
The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period December 2021- 2023.

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

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported the severity of harm is categorised as follows for the period December 2021-23 • 35% No harm • 54% - low harm • 10% - Moderate harm • 0.9% Severe harm • 0.1% Catastrophic	No incidents were reported as catastrophic at the time of the reporting the view of harm for the months since the last report.

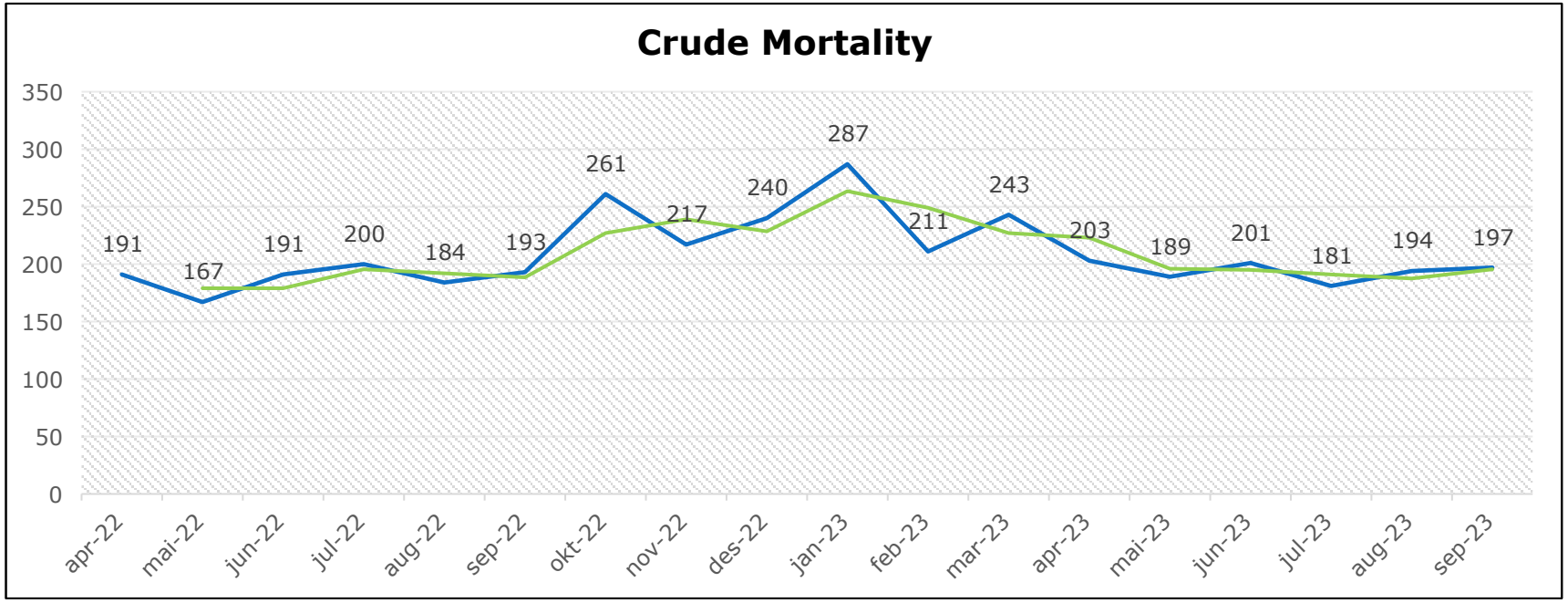
RAMI (Risk adjusted mortality index)

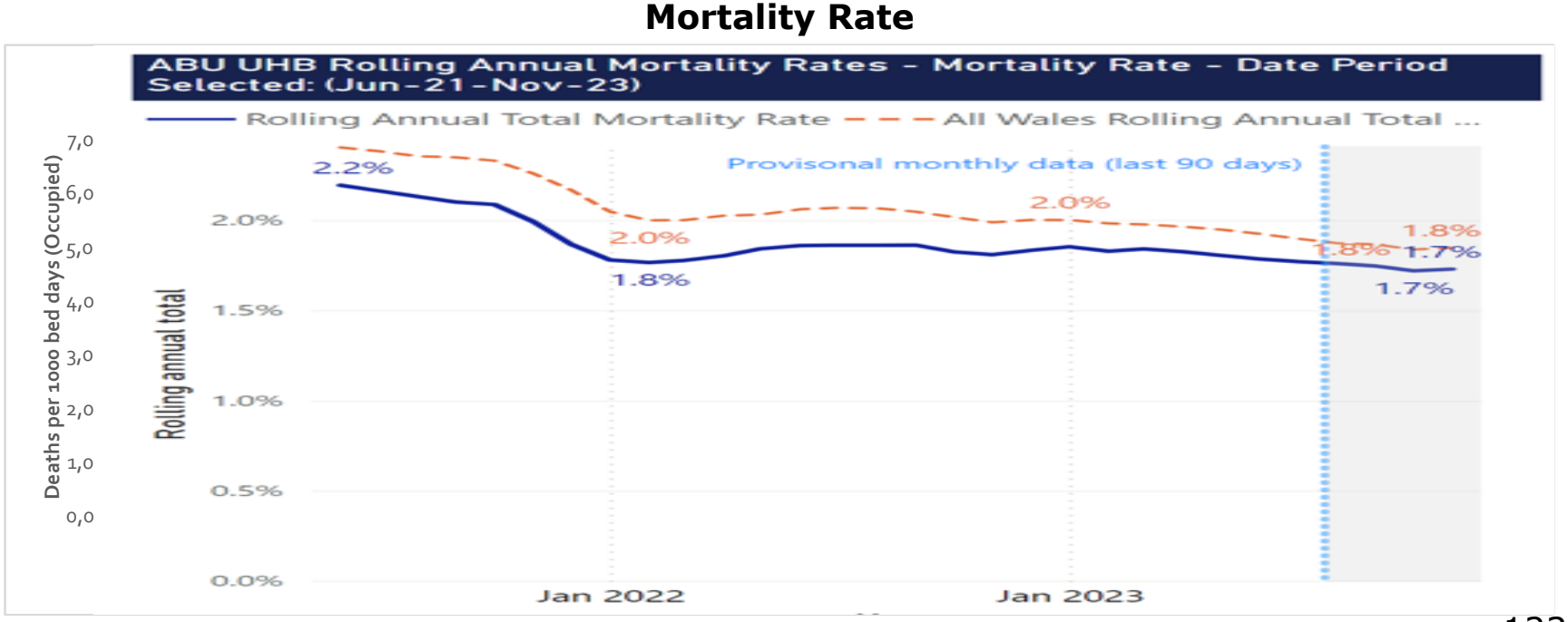




Currently performing 2nd of 6 within All Wales peer group

Crude Mortality in Hospital





Actions

Issue	Cause	Remedial Action	Who	When
Understanding mortality data and how we implement learning from mortality	Need for understanding what is reported to PQSOC and to Board for mortality. England produce a Learning from Death framework which standardises a mortality report.	Initial work on learning from Death Framework underway and progressing to drafting stage, this will include the learning for the Medical Examiner service and the mortality review screening panel. Visited Bristol as an Exemplar site for mortality to consider their end to end mortality process and how we can introduce similar for the Health Board. This will include processes for MHLD deaths and robust SOP for suicide.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistently of mortality reporting and data	Producing a mortality framework that will look at crude mortality and other mortality indictors that are attributable to Divisions and Directorates, linking in with Clinicians to understand mortality outliers. We will consider how we compare with our peers. All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Dedicated resource to review and utilise CHKS data	Information Manager now in post and meeting regularly with CHKS	Information Manager	Complete
	Understanding, interpreting and interrogating CHKS data to formulate a clinical outcomes report	Information Manager and QPS team meeting with Divisions to identify what is currently reported, to progress Clinical Outcomes around Mortality Outliers. CHKS wish list produced to request additional information.	Information Manager and QPS Team	On-going
	Developing governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	QPS Team and Information Manager	On-going
	Process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review	QPS Team and Information Manager	On-going

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.

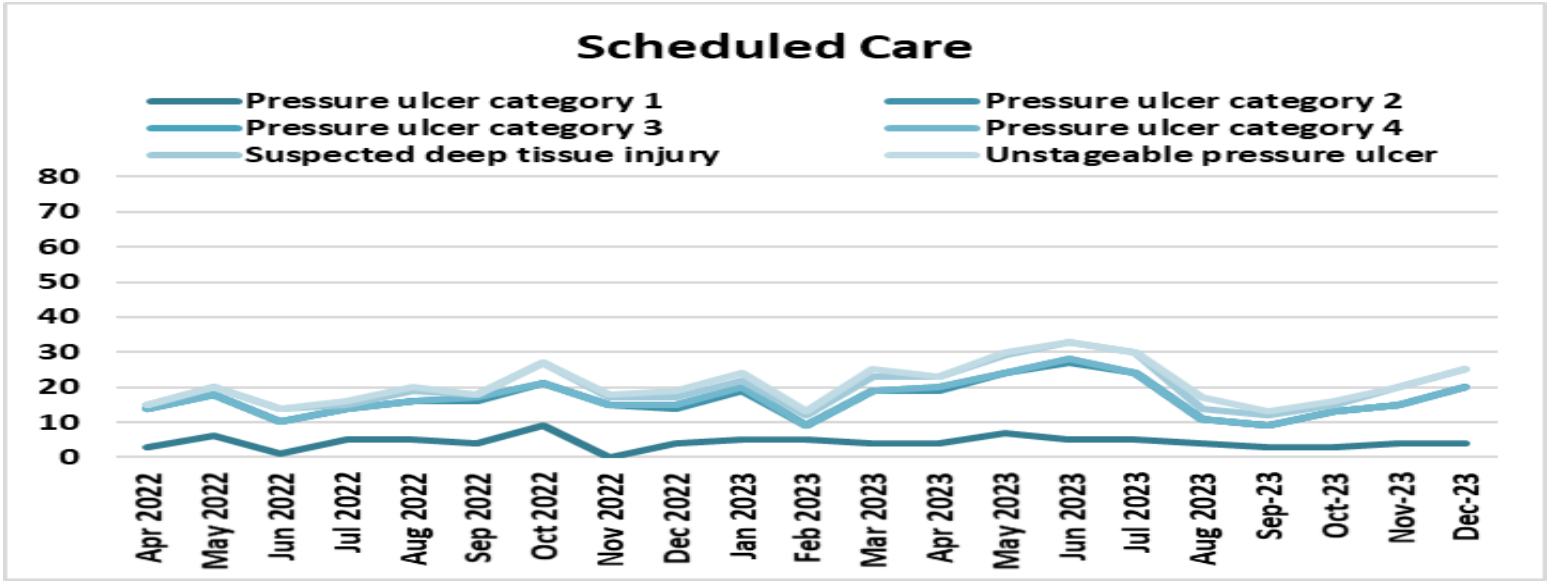
The Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers. With the success of the previous pressure ulcer prevention and reduction collaborative in July 2018, the Pressure Ulcer 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*.

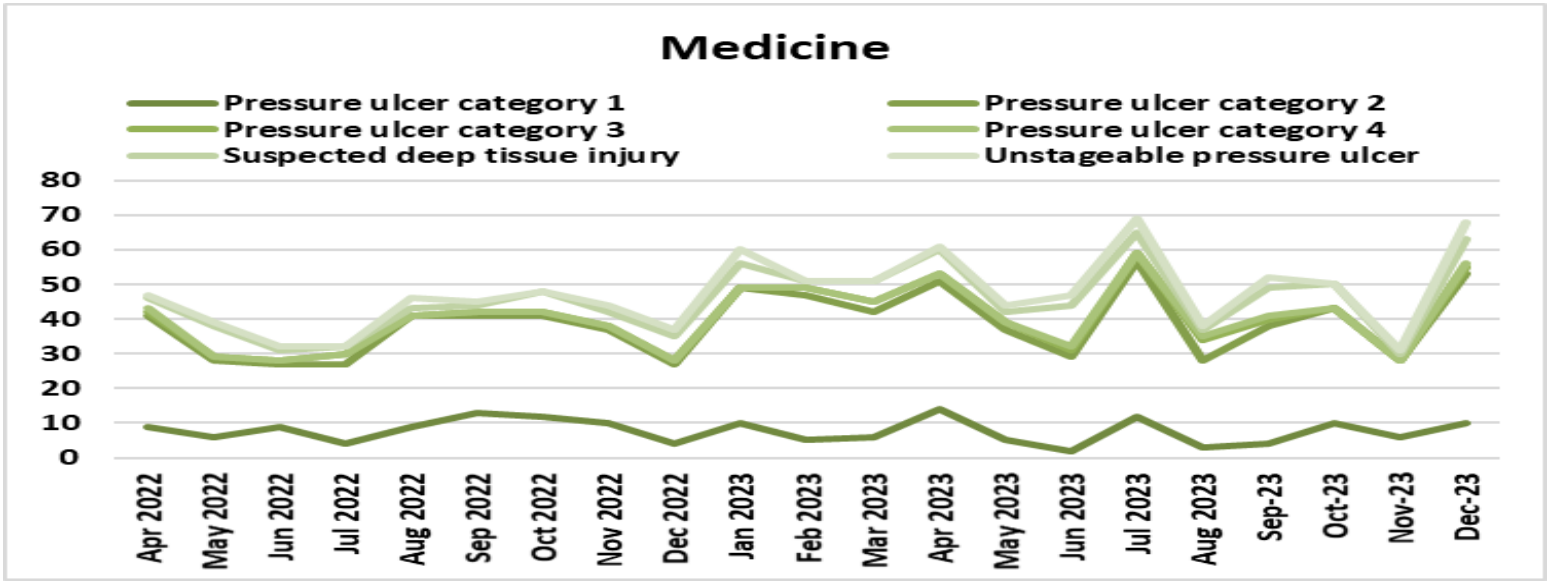
Aim of the Faculty

- 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

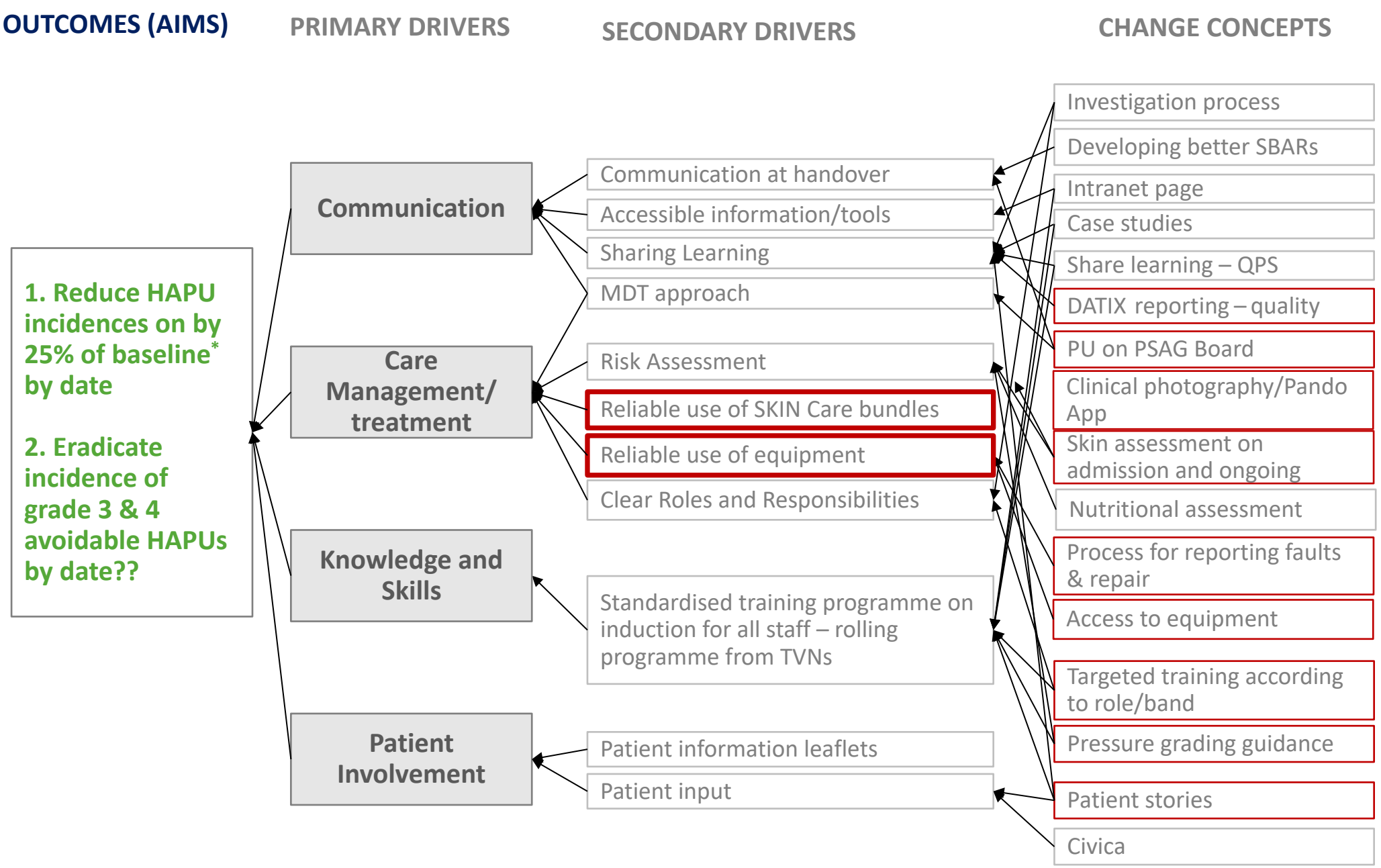




Pressure Ulcer Faculty 2023

Aims and Progress

- Upward trend noted in November and December 2023
- 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
- Date of commencement of Pressure Ulcer Pilot February 2024


OUTCOMES (AIMS)
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE CONCEPTS
1. Reduce HAPU incidences on by 25% of baseline* by date
2. Eradicate incidence of grade 3 & 4 avoidable HAPUs by date??
Communication
Care Management/ treatment
Knowledge and Skills
Patient Involvement
Communication at handover
Accessible information/tools
Sharing Learning
MDT approach
Risk Assessment
Reliable use of SKIN Care bundles
Reliable use of equipment
Clear Roles and Responsibilities
Standardised training programme on induction for all staff – rolling programme from TVNs
Patient information leaflets
Patient input
Investigation process
Developing better SBARs
Intranet page
Case studies
Share learning – QPS
DATIX reporting – quality
PU on PSAG Board
Clinical photography/Pando App
Skin assessment on admission and ongoing
Nutritional assessment
Process for reporting faults & repair
Access to equipment
Targeted training according to role/band
Pressure grading guidance
Patient stories
Civica

Quality Strategy Implementation Plan

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

Quality pillars as defined in the Quality Strategy:

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

Quality Strategy Update

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

COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Retention of FTC staff	High FTC resource & high risk of losing resource prior to 31 March 2024.	Requested 3 Month extension (to 30 June 2024) for critical resource to secure programme completion. Senior COVID-19 investigations manager contract until July 2024 Redeployment meeting completed Discussions undertaken with divisions to support release for seconded staff.	COVID-19 Investigation Team (CIT)	On going
Investigation resource to undertake live wave in line with Duty of Candour	Out of scope of the NNCP framework.	Actions with IP&C Agreed this will form continue in line with National patient safety reporting of HCAI	IP&C	On going
General record keeping & access to information	Clinical notes sparse for COVID-19 identification & management.	N/A		
	Locating pertinent notes due to non-chronological back scans.	N/A		
	Mental Health notes in off-site storage facilities.	Liaising with Health Records colleagues. Improvement has been noted Information relating to investigation in medical notes very limited.	COVID-19 Investigation Team (CIT)	On going

Safeguarding

Training and Development

- ABUHB is required to provide Safeguarding Training in relation to Children and Adults in line with National Standards. The current compliance is:

Level	Adult	Children
1	79.%	85%
2	88%	86%

- Safeguarding Level 3 training package recommenced in April 2023. Both adults and children's training packages are currently evaluating well.
- Following work on ESR, Adult Safeguarding Level 3 Training will need to be delivered to approximately 4000 staff within ABUHB.
- Adult Safeguarding Supervision will be a priority for 2024/25, to supplement the Level 3 Training.

Safeguarding Activity

There has been a marked increase in regard of requests to attend formal meetings/conferences in regard of:

- **Adult Safeguarding**
- **Child Protection**
- **Section 5 – Practitioner Concerns**

The Corporate Safeguarding Team are working with statutory partners to try to understand the increase in activity and to determine if it is indictive of increased risk within the Gwent area or is related to better staff understanding of Safeguarding Processes across statutory agencies.

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

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 – Nov-Dec 2023	Number of closed incidents/complaints – Nov-Dec 2023	Total number of incidents/ complaints not closed and to be reported on/during the next reporting period -	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	7	1 of the 7 Unavoidable	6 of the 7 (There is 1 HAPU's still open from Sep/Oct) (There are 2 HAPU's still open from July/Aug) (There are 3 HAPU's still open from May/June)	1 of the 1 closed	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	5	3 of the 5	2 of the 5 (There are 5 injurious falls still open from Sep/Oct) (There are 4 Injurious falls still open from May & June) (There are 3 injurious falls still open from July/August)	0 of the 3 closed	0
Medication errors never events	0	0	0	0	0
Any complaints about nursing care	21	1 of the 21	20 (13 complaints remain open from August-end of October 2023)	0 of the one closed (but high B&A usage)	Not known at this time
Infiltration/ extravasation injuries	1	0	0	0	0

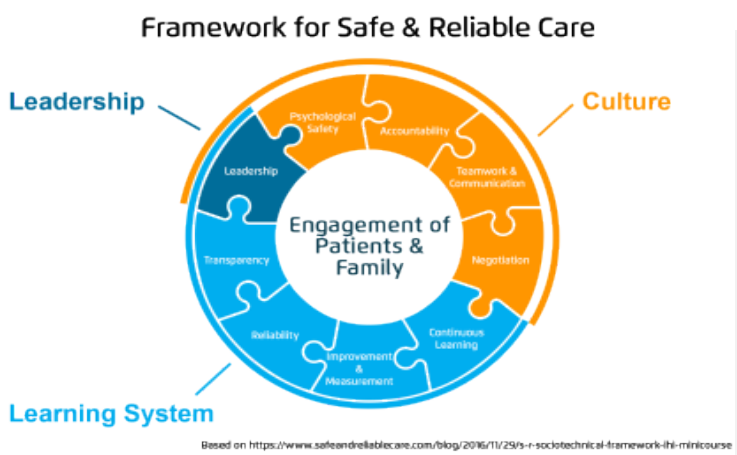
Nursing Staffing Levels Wales Act 2016

Issue	Cause	Remedial Actions	Who	When
Senior nurses are not always made aware of the requirement to complete the NSLWA questions in the complaints in Datix	1) In Complaints feedback, PTR teams are not always initiating the drop-down box "is this complaint wholly or partially to do with nursing". 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 and senior nurses	Divisional Nurses Nurse Staffing Programme Lead	January 2024
Fewer injurious falls than previous 2 months, however, there is a delay in closing falls datix	waiting for presentation to Falls Panel	Staff to be reminded to close Datix following presentation at Falls Panel	Divisional Nurses Senior Nurses	January 2024
We are likely to see a reduction in reporting of injuries moderate and above	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 teams and QPS teams	October 2023
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.

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.	Compliant
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	29-Sep-23	This project is kindly being lead by Peggy Edwards, we have a working group at ABUHB and are meeting approximately 8 weekly. Work is still on-going.	In-progress
PSA016 Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	15-Dec-23	Work underway. The ABUHB policy for AKI and treatment of hyperkalaemia has been revised and has recently been the intranet. ABUHB should be declare compliance with this alert this month (Jan 24).	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.	In-progress
PSA017 Identified Safety Risks with the Euroking Maternity System. Compliance deadline: 28/06/2024	28-06-24	This PSA is kindly being led by Peggy Edwards. It is important to note that ABUH does not use this system. However, all organisations need to review actions 5 and 6 which Peggy is currently reviewing. .	In-progress



Safe Care Collaborative Update

November – December 2023

Organisational Update: Stage-Action Period 8

- **Learning Session 4, Nov 28-29th** – First local Learning Session of the ABUHB Deteriorating Patients Collaborative – focussing on Safety Culture, Sharing Learning and listening to unheard voices (bereaved family & jnr dr). Day 2 held virtually
- ***ABUHB Deteriorating Patients Collaborative –** Draft driver diagram based on SCC participant feedback. Focussing on reducing harm from acute and chronic deterioration, through development of Safety Culture
- **Leadership programme of work** – schedule of executive Safety Walkarounds – 2 visits took place during Nov/Dec. Programme set up until March 2024.
- **Quality Outcomes Framework**– Working to refine QOF in conjunction with Public Health. Prep of Q3 report
- **QI Skills Development**– Improvement in Practice training initiated with Improvement Cymru for staff from Primary Care, Mental Health and Collaborative work. Quality Coach Course being developed for New Year.
- **OCP - QPSQI Teams together - Nursing Directorate**
- **Improvement Advisor – Theatres** appointed

Team Update:

Storyboards - Monmouthshire Team were invited to present their project at Spotlight Session at National SCC LS4

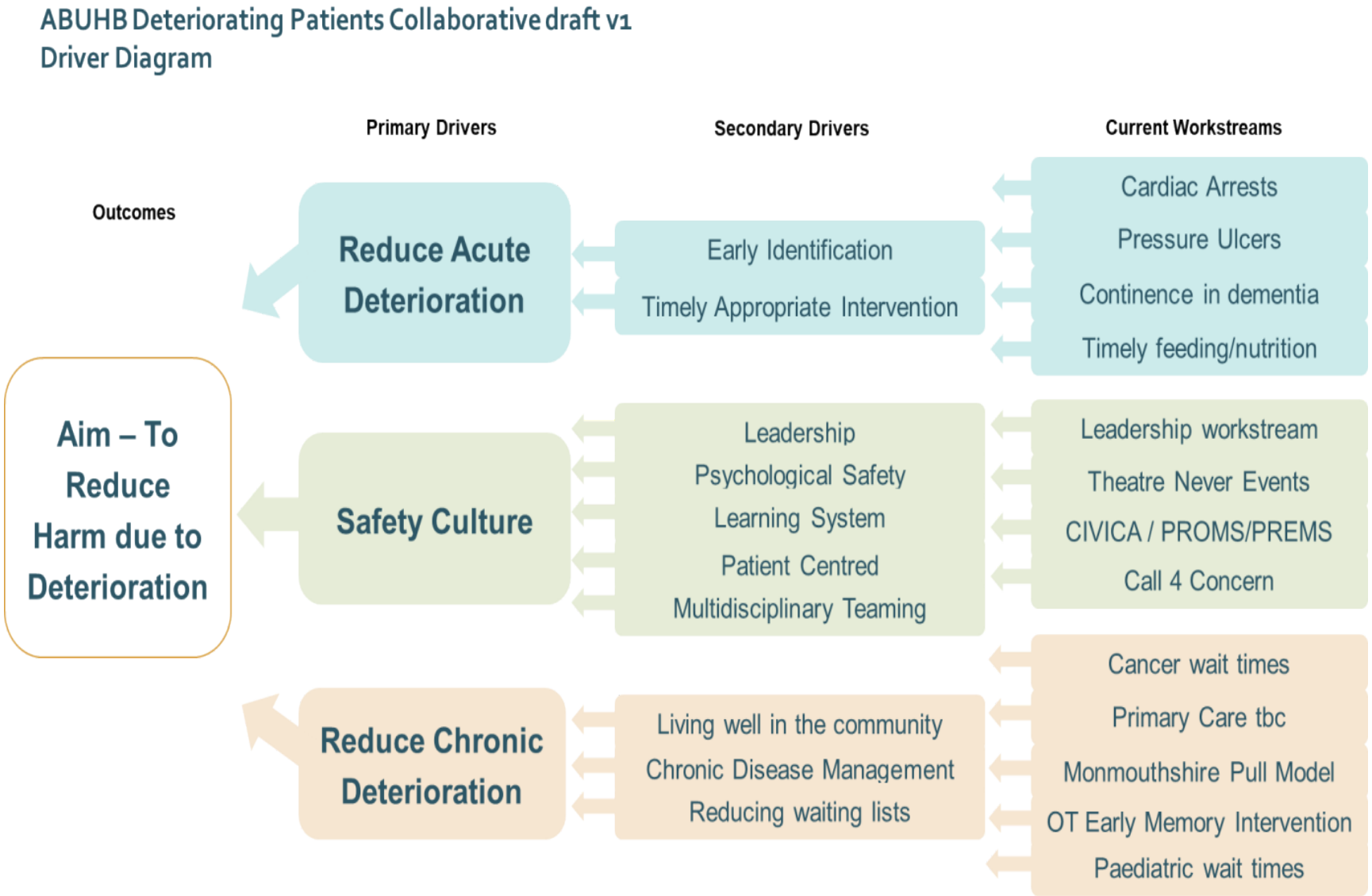
Project Outcomes

- **Ward C0** -270 days with only one crash call
- **Monmouthshire** – Reduction in Package of Care hours for medically optimised patients. ALOS reduction but recent increase being explored.
- **AMU** – Increase in the number of observations each week. Focussing on Response arm of work
- **OT Early Intervention** – 30-60 minute saving for each patient 3 month evaluation via telephone rather than face to face now adopted as common practice

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

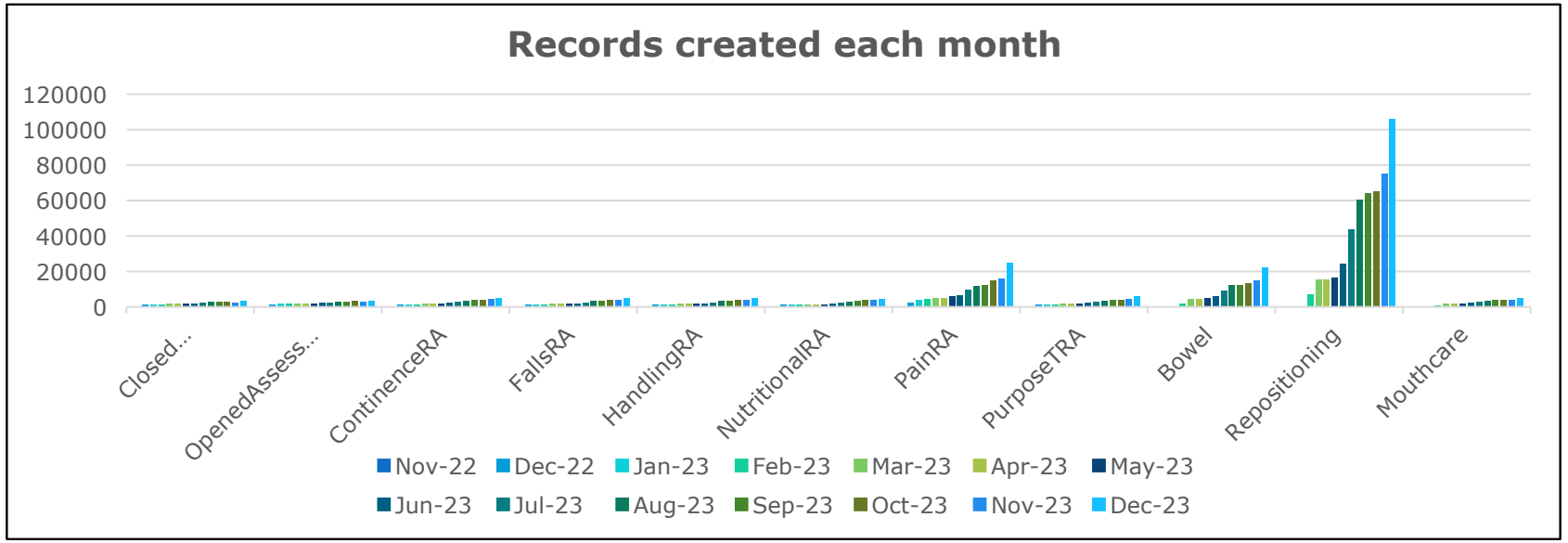
Score	IHI - Stage of Project Scoring
0.5	Intent to participate
1.0	Forming team
1.5	Project plan begun
2	Activity but no changes
2.5	Changes tested but no improvement
3	Modest improvement
3.5	Improvement
4	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable improvement

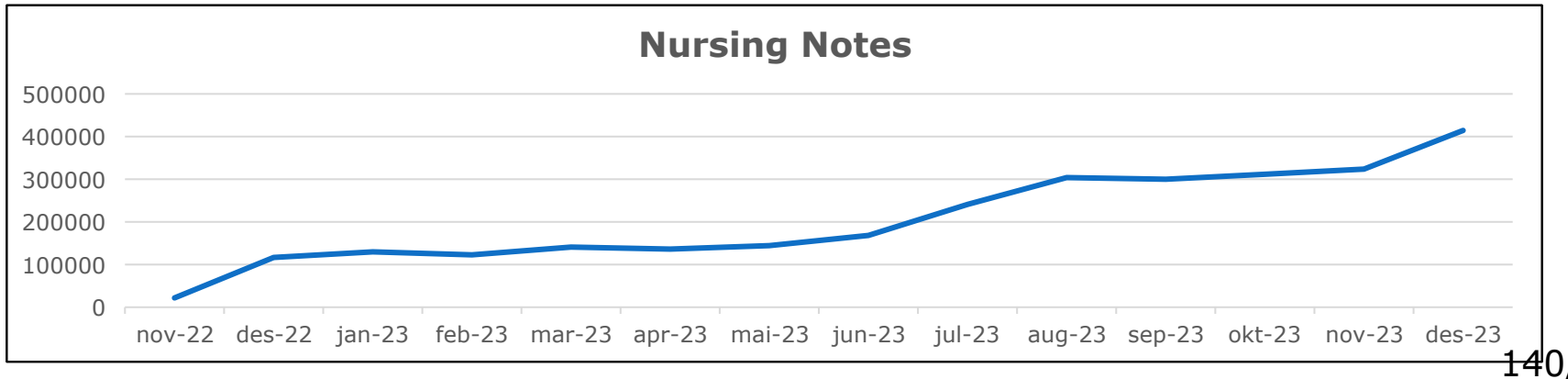
*ABUHB Deteriorating Patients Collaborative – Driver Diagram



Welsh Nursing Care Record

- NHH now live (33 ward across three sites).
- YYF implementation delayed by a week due to strike action, to start W/C 22 January 2024. Plan now is in place for all in-patient setting to complete July '24.
- Paediatric CNS now in post



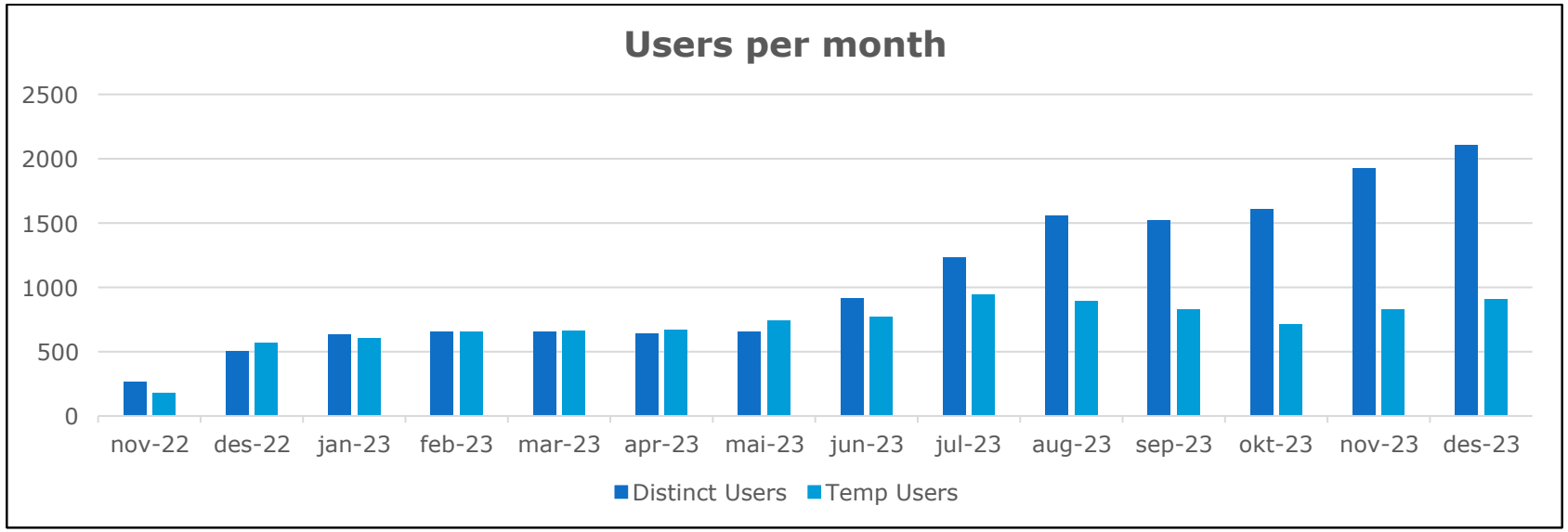


Welsh Nursing Care Record

V2.3 released provided an opportunity to cull all accounts again.

However this 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

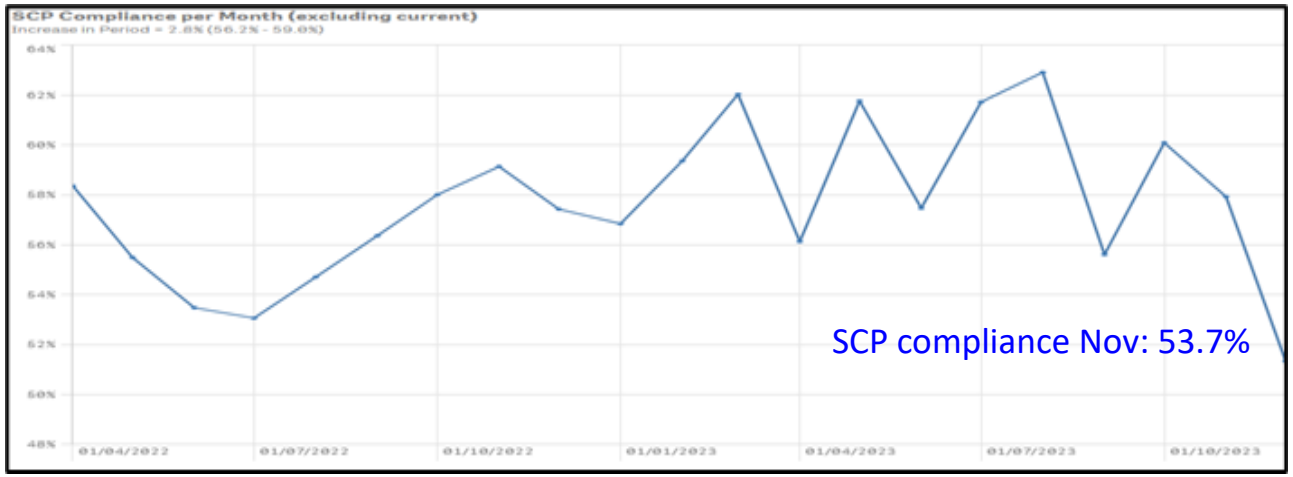


Welsh Nursing Care Record

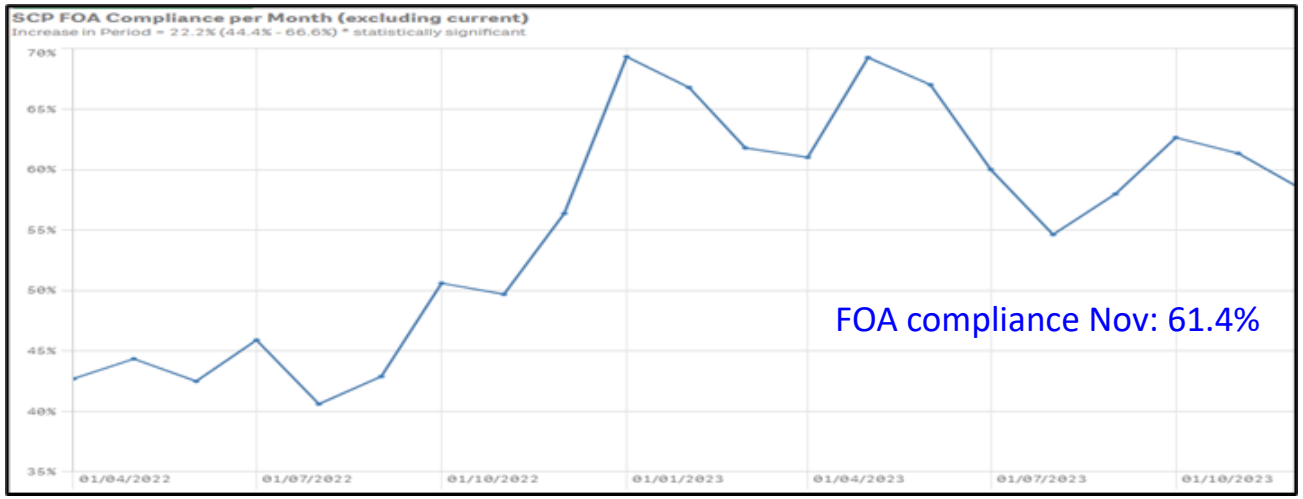
Issue	Cause	Remedial Action	Who	When
Delay in getting a WNCR record started on one ward (one ward resolved) remains an issue	One ward have issues where the patient pathway on WPAS is not completed for semi-elective patients	Training has been provided to support WPAS pathway selection when booking patients	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) WCP provided for all nursing staff	DHCW	Q3
Not currently providing qualitative data to ward managers	Dashboard output from data warehouse not yet available	Requirements gathering ongoing and mechanisms to provide dashboard being explored – *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 Review of what data items recorded in multiple areas e.g. observations	Digitisation Nursing Documents Group	Q2
CNIO availability to support further roll out	CNIO also Clinical Safety Officer for health board	Planning and prioritisation of CSO activity	Directors of Digital	Q3
Night staff / Bank / HCSW Nadex access	Lack of use of Nadex accounts users do not have active accounts when ward areas go live	Ward managers processing accounts Engagement with Bank to ensure access Out of hours support from Service desk	Directors of Digital / Ward Managers	Ongoing

Cancer – 62 Day Performance

SCP Compliance: November 2023



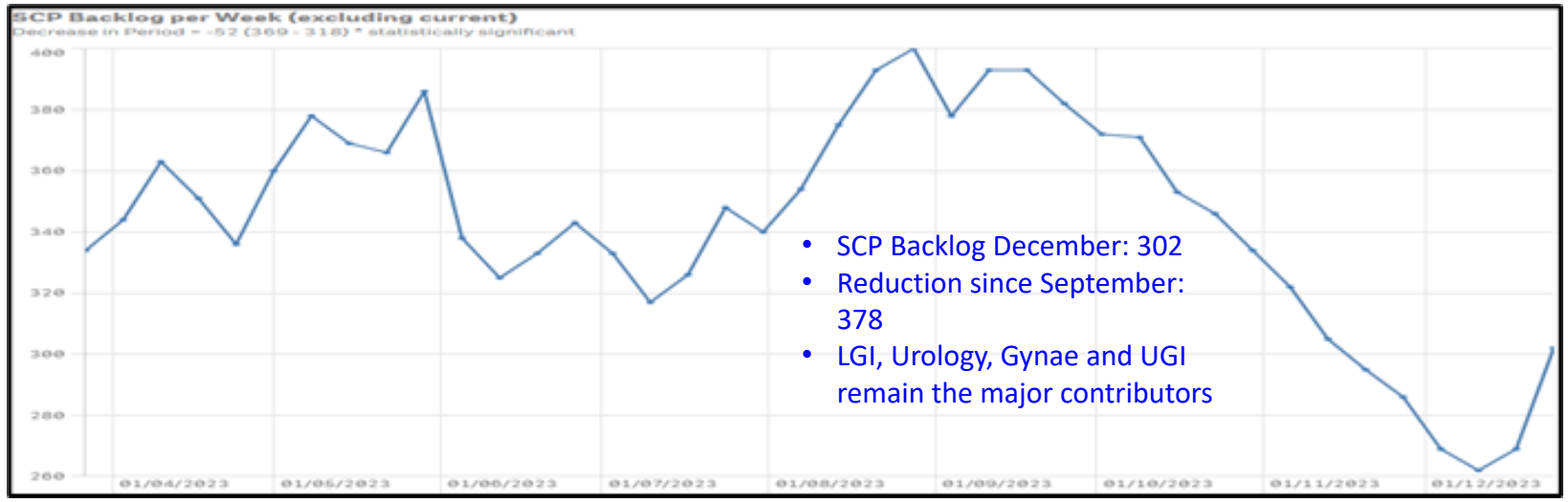
Compliance in November was reported by the deadline date but prior to all available, in target, treatments thus, misrepresenting performance. Upon receiving all results it was evident that performance would have been **58.1%**. Prompt action was taken to rectify the results delay to reduce the chance of this occurring in the future



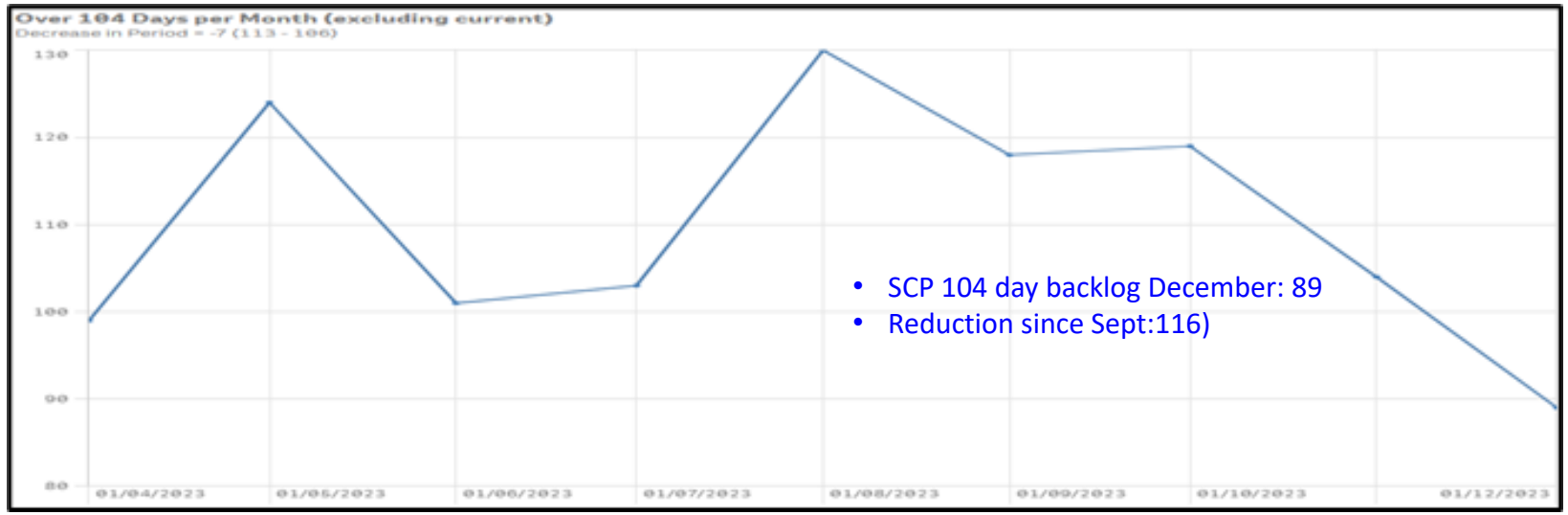
14 day compliance continued to improve since September, however, a small deterioration can be seen in December.

Cancer Backlog

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

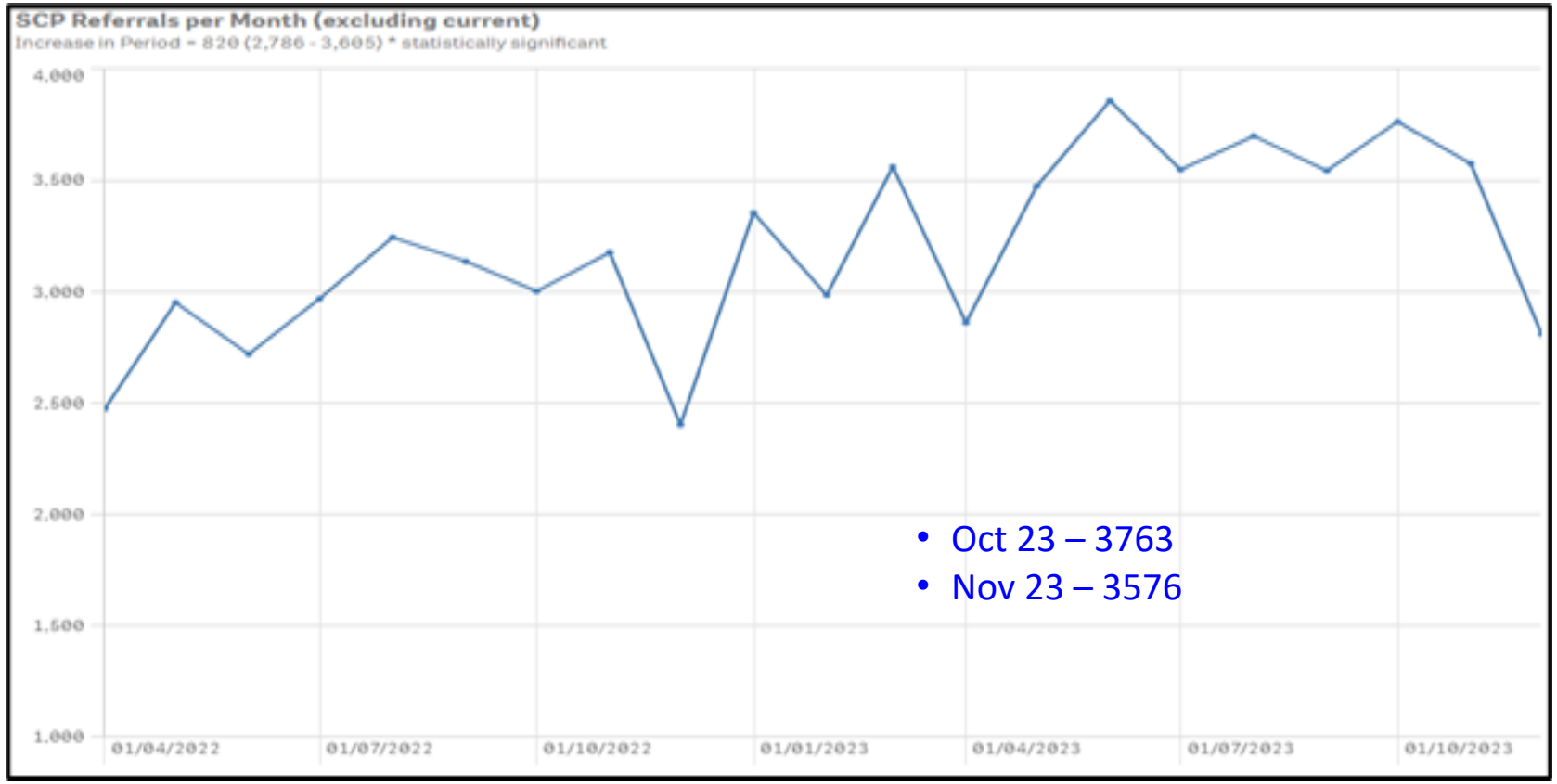


- SCP Backlog December: 302
- Reduction since September: 378
- LGI, Urology, Gynae and UGI remain the major contributors



- SCP 104 day backlog December: 89
- Reduction since Sept:116)

SCP Demand



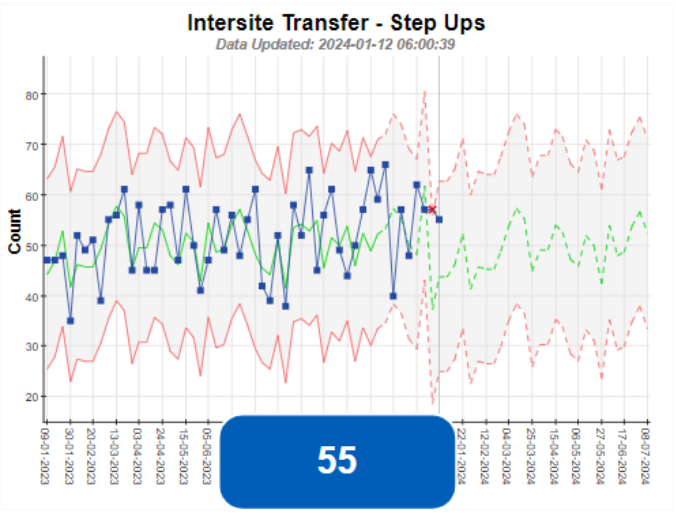
Demand remains high. However, there was an inevitable seasonal decrease in December although, ~400 more than December 2022.

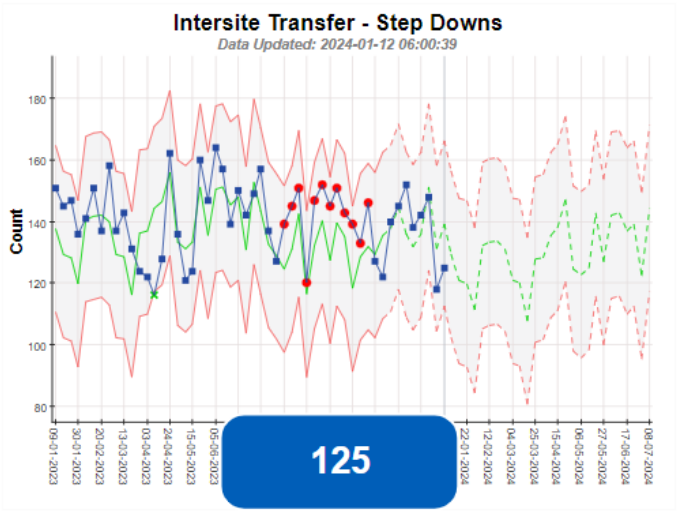
Risks

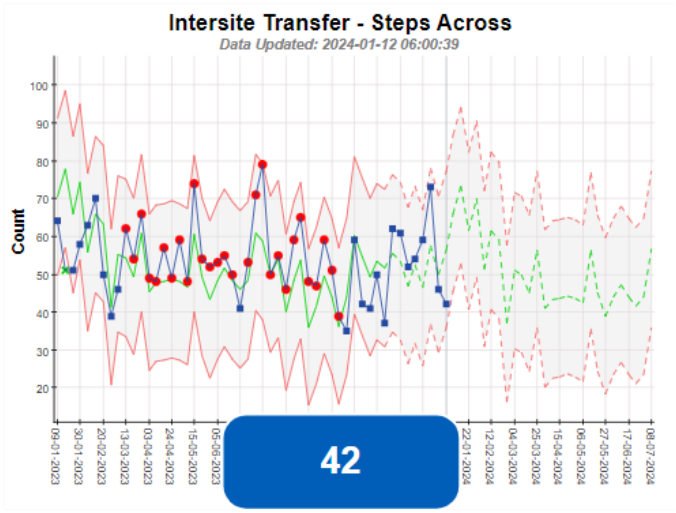
Issue	Cause	Remedial Action	Who	When
Loss of Urology clinic and surgical capacity at key holiday times, including half terms	Overlapping and/or simultaneous annual leave taken (medical staff)	The policy has been developed and supported by the Medical Director. The service plans to introduce it following the impending junior doctor industrial action	General Manager	End of Q4 2023/24
Cancer pathways not meeting 62 day SCP compliance (exception is skin)	Referral demand Lack of sufficient timely access to diagnostic capacity Delays in turn around times for reporting investigation/treatment results	Task and Finish groups planned in Q4 2023/24 to begin pathway improvement programme. The programme will incorporate learning from Toyota training and inclusion of National Optimal Pathway mapping against milestones	Macmillan National Optimal Pathway Manager Divisional General Managers	Progress will be ongoing. Anticipate incremental improvement by the end of Q2 2024/25
Loss of OPA, Endoscopy and Theatre capacity in January and the ongoing effect into February/March 2024	Junior doctor 72 hour industrial action (IA) during week commencing 15 January 2024	Services will mitigate as much loss as possible during IA. Potential WLI activity post IA to reduce the effect of lost capacity	Divisional General Managers & Clinical Directors	End of Q4 2023/24
Loss of breast OPA capacity	Breast Unit move to YYF in January 2024	Service plan to limit the loss if capacity by providing additional clinics post move	Directorate Manager	Q4 2023/24

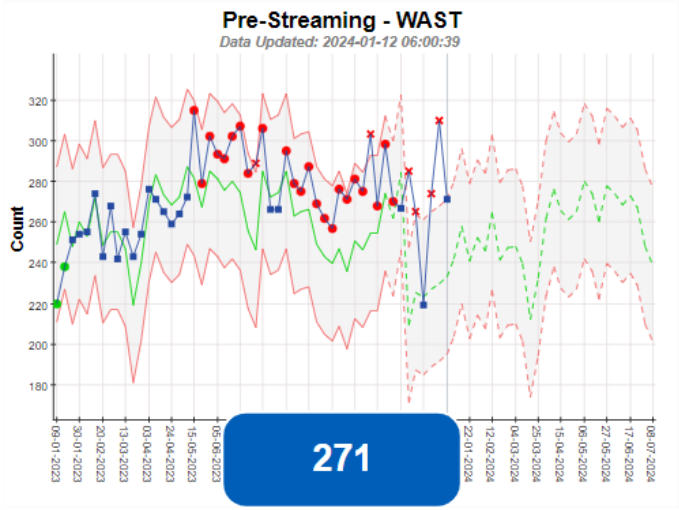
Goal 2: Signposting people with urgent care needs to the right place, first time

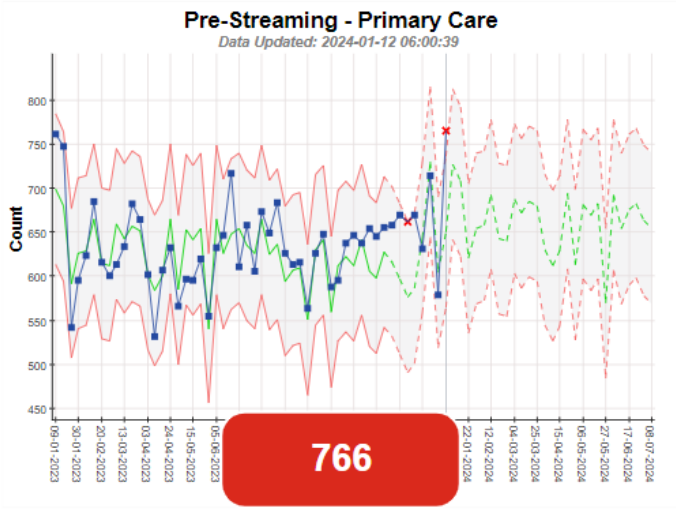
Flow Centre





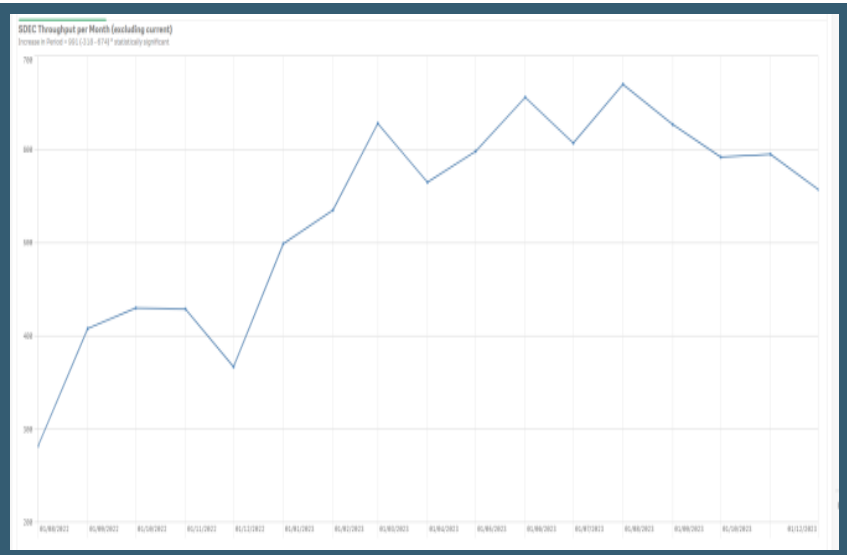


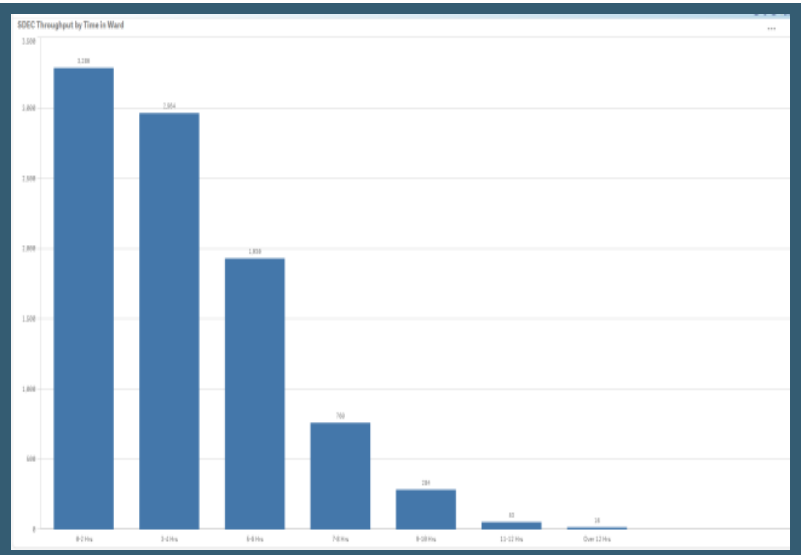


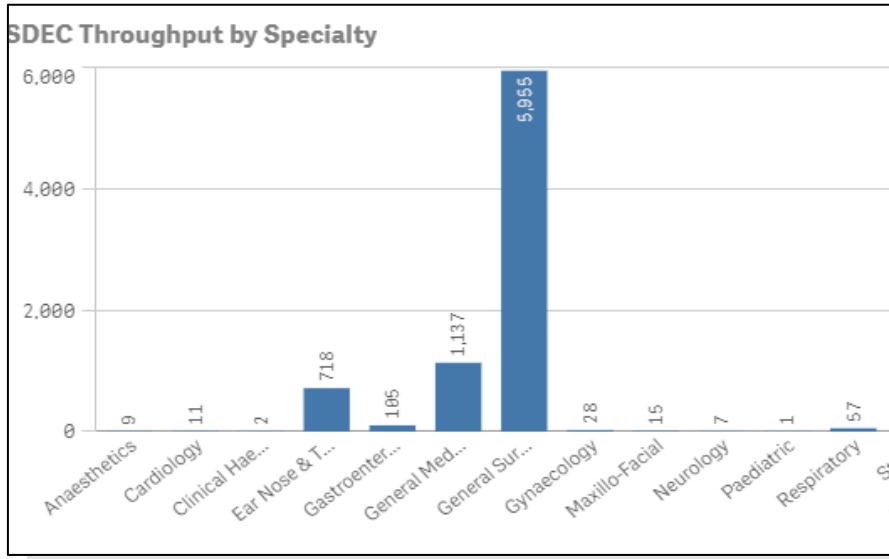


- **Step Ups** around 60/week in recent weeks
- **Step Downs** had been 120-150/week
- **WAST Pre-Streaming** has continued around 250-300/week
- **PC Pre-Streaming** has been more variable in December after a consistent increase in demand
- Others operating as normal

SDEC GUH at a Glance 8/8/22 – 11/01/24







9293 Patients seen

Average 37 Patients per day

693 Next day Returners

Median time 3:55 hours

7613 patients Discharged Same Day (82%)

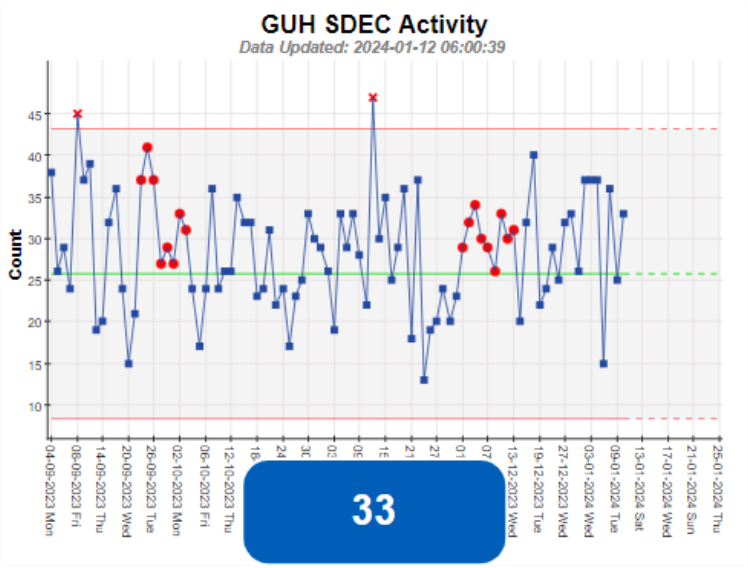
1562 Admissions

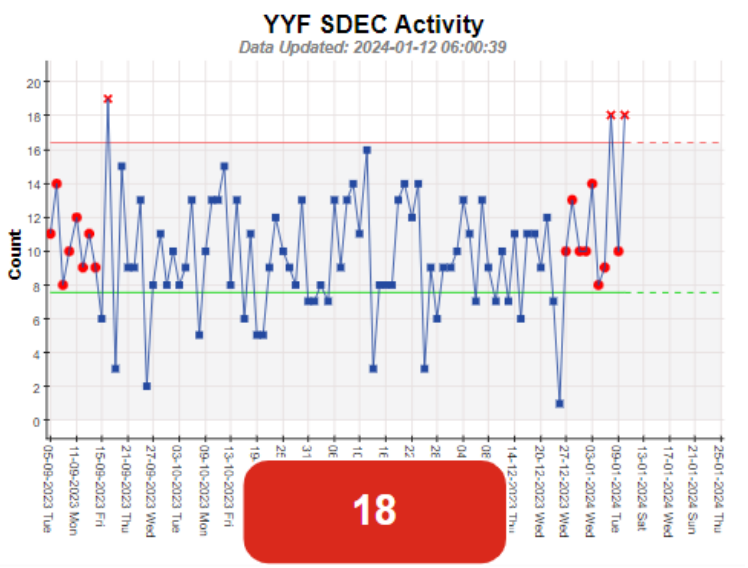
Progress Summary:

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

Goal 3: Clinically safe alternatives to admissions to hospital

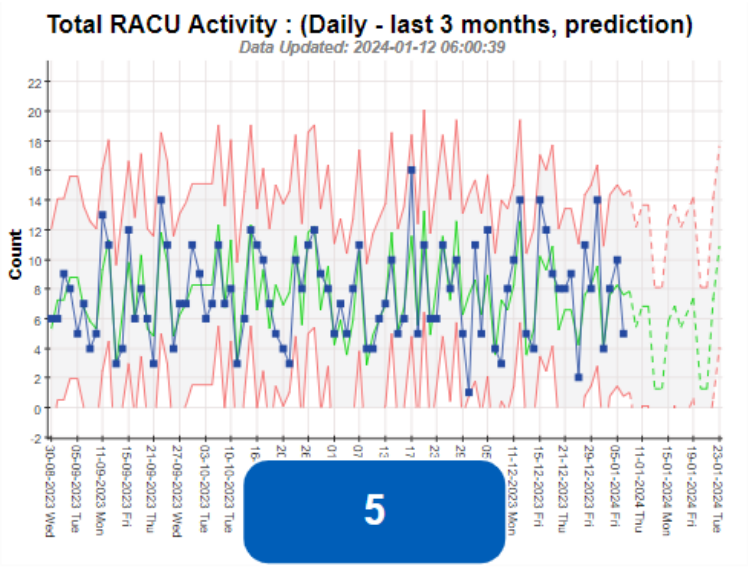
Alternatives to Admission

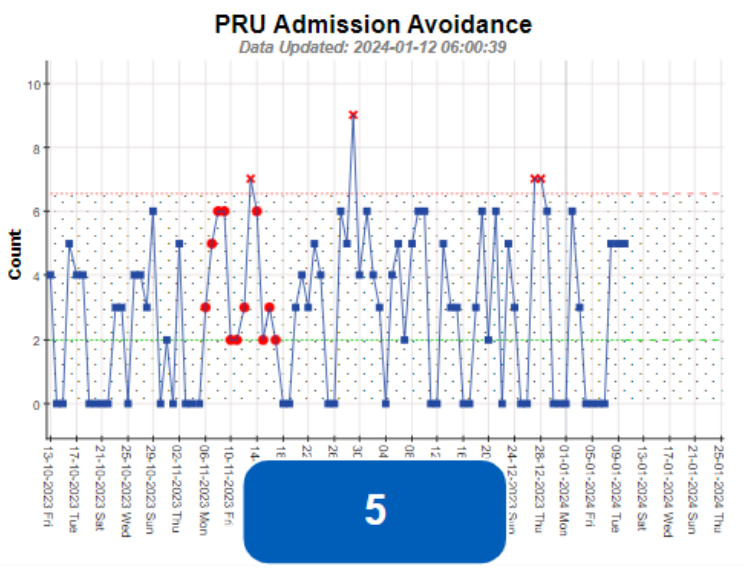




Data Updates & Forecasting:

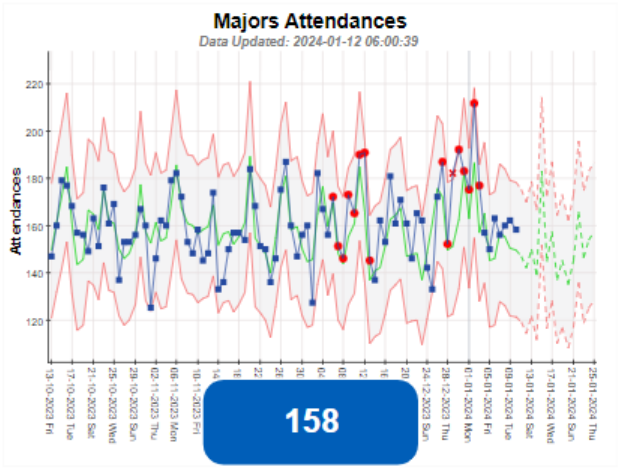
- **GUH SDEC** has been seeing around 20-40 patients/day
- **YYF SDEC** has been slightly higher than normal between 8 and 18/day recently

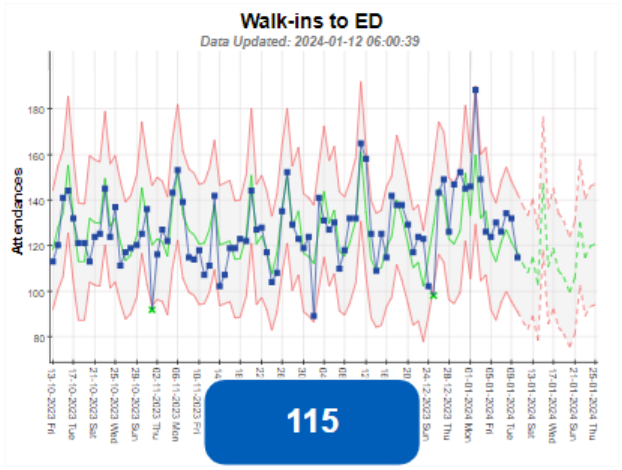


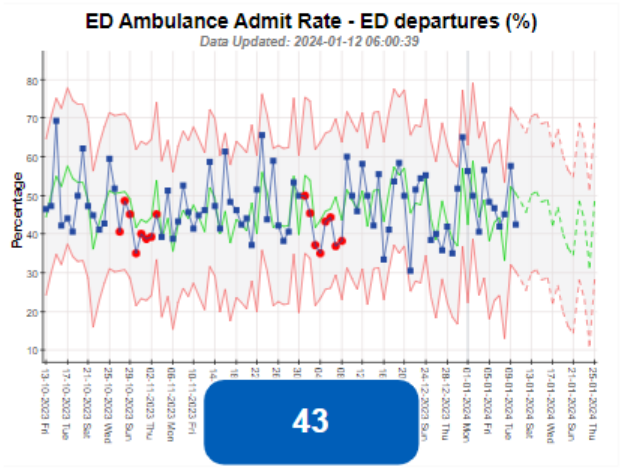


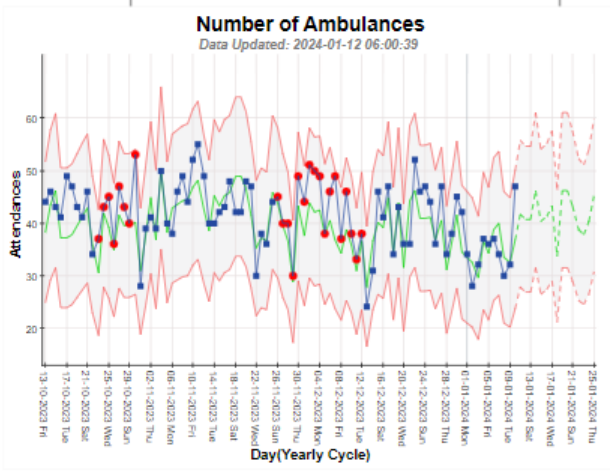
GUH ED Activity

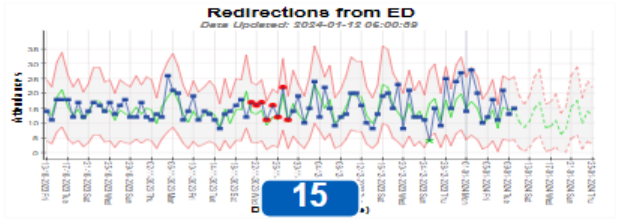
Ambulances	47
Admitted	18

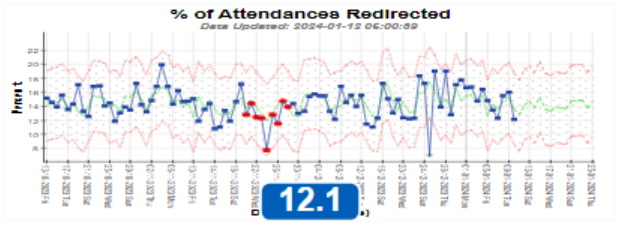


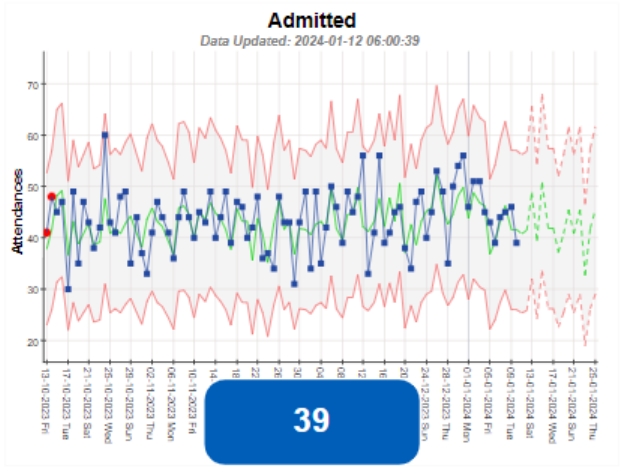


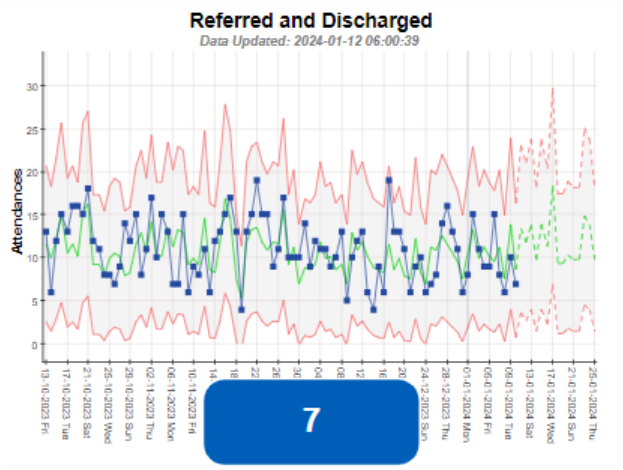


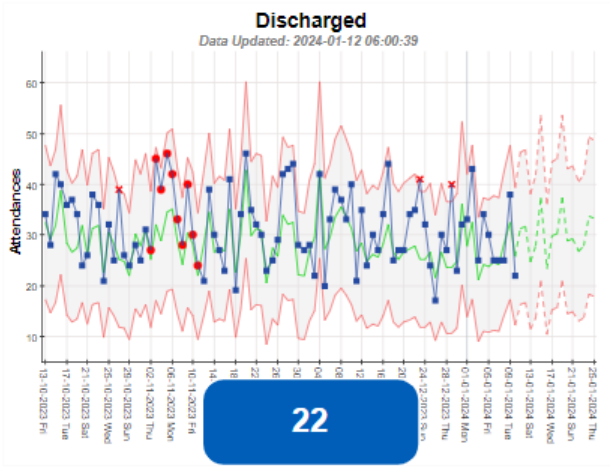




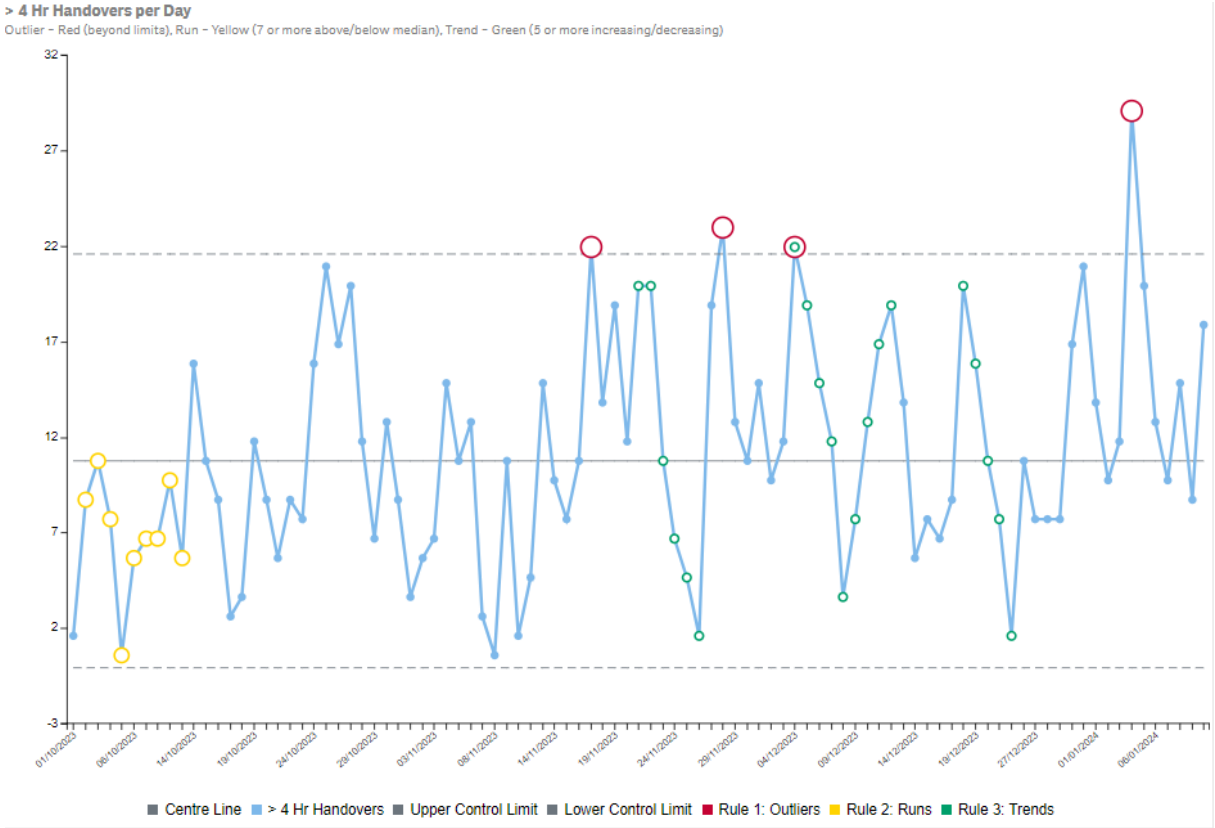


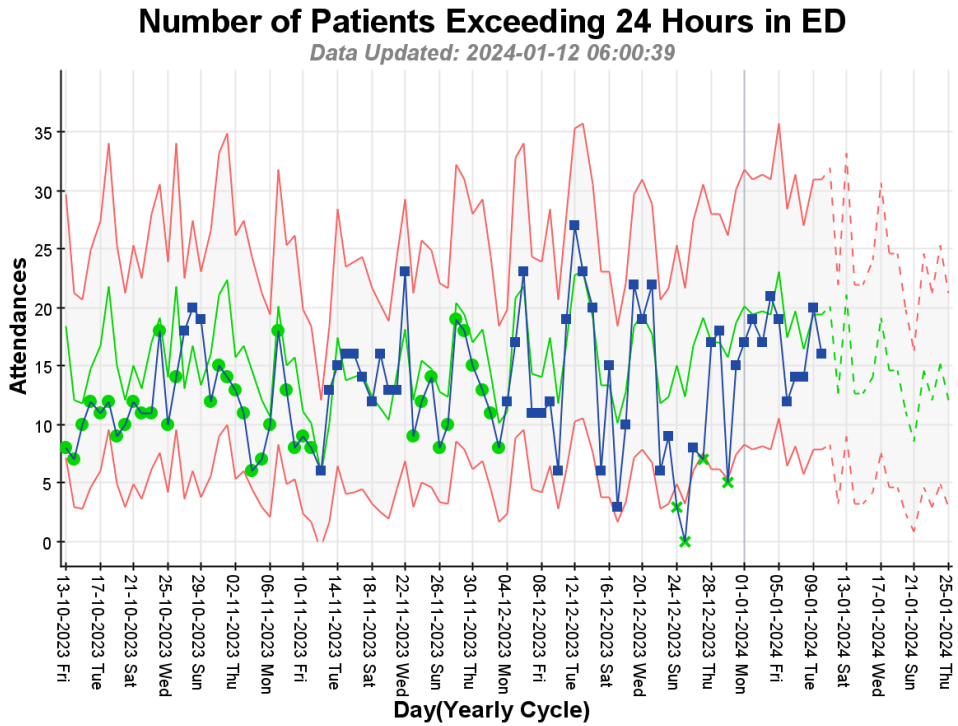






Goal 4: Rapid response in physical or mental health crisis





Data Updates & Forecasting:

- **Around 12 patients a day** waiting over 4 hours for ambulance handovers at GUH
- **Around 13 patients a day** spending over 24 hours in ED

Urgent & Emergency Care

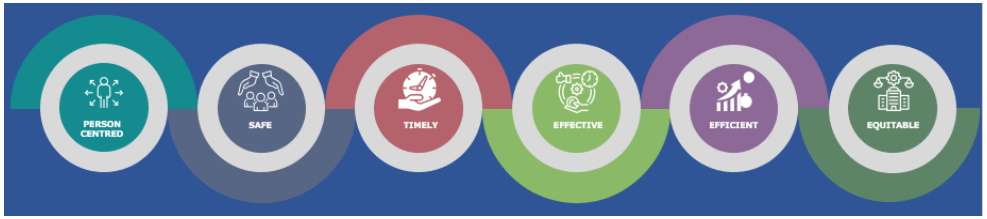
Issue	Cause	Remedial Action	Who	When
Medical Staffing: Medical Staffing to support the Emergency Department (Demand & Capacity modelling showing deficit for demand)	• Increased activity	• Locum processes in place and reviewed weekly with management team and monthly within Directorate • Ongoing recruitment • Demand & Capacity modelling completed	General Manager / Divisional Director / Divisional Management Team	Ongoing
	• Vacancies	• Regular review of medical rotas to match demand within financial envelope are in place with site leads.		
	• Implementation of different models of care	• Explore alternative roles e.g. Physicians Assistants, ANPs etc.		
Nurse Staffing: Vacancies with increased number of patients causing additional staffing pressures and associated governance and costs.	• National shortage of registered nurses • Emergency Department Establishment was increased following the move to the GUH • Challenging place to work due to increased attendances, increased acuity, environmental challenges, inadequate flow	• Recruitments drives for Registered Nurses and HCSWs • Student streamlining • Recruitment of internationally trained nurses • Robust sickness management • Practice Educators working clinically alongside junior staffing • Senior Nurse Point of Contact (POC) • Block-booking of staff secured and robust processes in place to manage roster • Progress alternative roles	Divisional Nurse / Divisional Management Team	Ongoing
Patient Flow: Congestion within the ED (and Assessment Units). Increased presentations / Long lengths of stay / Ambulance delays	• Increased demand • Poor patient flow • Pathways of Care • Increased Delayed Discharges of Care	• Red Line (24/4) in place from 15 May 2023 to support ambulance offloads and long waits in ED (Now 24/2) • Escalation plan in place to support movement of patients • Comprehensive review of available spaces with Capital Planning colleagues at GUH (Main Wait, Sub-wait and SDEC) • Full Capacity Protocol (FCP) in place • Expansion of ED Main Wait business case approved by board and being progressed with WAG • SDEC in GUH open. Predominantly scheduled care utilising but medicine usage now increasing along with other pathways such as ED direct referrals and WAST direct access • Acute Release Area (ARA) commissioned from 8 January 2024 which can support 6 patients outside of ED to facilitate timely handover of ambulances	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

Questions

Aneurin Bevan University Health Board

Quality Strategy

Quality Outcomes Framework



2023/24

Quarter Three

The Quality Outcomes Framework (QOF) was approved by the Patient, Quality, and Safety Operating Committee (PQSOC) in Quarter 1. It was acknowledged this would become an iterative framework that was under constant development throughout year one. The goals, expectations and ambitions were set out in the Quality Delivery Plan. This has been implemented to comply with the Duty of Quality and Duty of Candour as part of the Health and Engagement Act (Wales).

The reporting of the new QOF recognises the development of some of the measures as we bring online new ways of reporting and capturing what is important for our patients. This process will continue to be refined by working with planning and the digital, data and technology team.

The table below sets out the proportion of measures that were expected to be reported versus what has been included in this report. These measures are being reviewed and the reporting is being aligned to mirror the Performance report produced for the Board with the use of 'iconography'. This will ensure the measures in the QOF from part of our Quality Management System.

Priority	Measures Reported	Expected to be able to report for Q2
Person Centred	4 out of 7	5 out of 7
Safe	16 out of 20	18 out of 20
Timely	17 out of 21	17 out of 21
Effective	5 out of 13	6 out of 13
Efficient	8 out of 11	9 out of 11
Equitable	2 out of 4	1 out of 4

The timing and format of the report is under review for Q3 and Q4. An interim report with continue between quarters. Working collaboratively will allow standardised reporting quality metrics and enable a quantitative data to inform insight to intelligence.

In summary, during Quarter 3 the Health Board delivered:

- ✓ Review of the Serious Incident Policy
- ✓ Introduction of PALS
- ✓ Increase in early resolution of complaints
- ✓ Maintained RAMI and Crude Mortality Scores
- ✓ Improved provision of Safeguarding training
- ✓ Improved cancer programme outcomes through adoption of Quality Improvement methodology.

The actions to improve the position and risk level have been included in our plans set out later in this document.

Structure
This report is structured across four sections as follows:

2. OUTCOMES FRAMEWORK & PERFORMANCE SUMMARY

The vision set out in the Quality Outcome Framework 2023-2024 is to:

> Drive continuous improvement in the delivery of healthcare services by focusing on measurable outcomes.

In order to achieve this vision, the Strategy focuses on developing and delivering our services around the six domains of quality:

- Person-centred care
- Safe care
- Timely care
- Efficient care
- Effective care
- Equitable care.

The Quality Outcomes Framework is updated quarterly and, depending on data availability, the latest data is reported for each indicator. For the 2023/24 the Quality Outcomes Framework was reviewed and, where appropriate, aligned with the 6 Domains of Quality. The timescales for indicators vary according to the data source. The 'New Measure' category is used where the indicator is in development but has been recognised as important to include and measure.

The Outcomes Framework for the first iteration will stand alone and will be produced for Board, the Executive and PQSOC, the proposed indicators have been drawn from existing Service Ward, and National Reporting benchmarking against best practice.

Quality Priority 1- PERSON CENTRED and opportunities to improve patient safety.

Delivering **PERSON CENTRED** care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities are key to ensuring improved health outcomes and to improve patient safety.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 1 - Person Centred	Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	*New Measure*	*New Measure*	Q3 2023.24	81.0%	*Improved*	Y	Overall satisfaction score as 75% (benchmark is 85%). It should be noted that currently survey completion is small scale
		Balance of complaints received and closed by grade score	Q2 2003	269/271	Q3 2023	498	Improved	Y	The number of complaints received and managed through PTR was 498 and 329 were managed via Early Resolution. The number of
		Compliments - Themes identified for improvement	*New Measure*	*New Measure*	Q2 2023		*New Measure*	N	Communication, and recording of information
		Reduction in the complaints backlog	Q1 2023	400	Q2 2023	380	No Change	Y	The backlog has seen a continued decrease with focused work to improve the baseline position established in June 2022
	Increased patient, public and staff involvement.	Increase in number of responses in Civica	*New Measure*	*New Measure*	Q3 2024	282	*New Measure*	Y	Q3 282. (Q1/2 466).Total 728 reponses. CIVICA is live on all inpatient wards.
	Learning from complaints is implemented	Qualitative feedback use of the learning section in Datix						N	In development
		Increase in the number of actions plans completed						N	Work commenced to collect this data

Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations.

The Aneurin Bevan University Health Board introduced the CIVICA Citizen Experience platform across the organisation in February 2023. An organisational hierarchy has been developed across all Divisions. This is to ensure patients can provide anonymous feedback which can be recorded (and retrieved) across several levels, including down to Ward, Team/Department, and service location.

Increased patient, public and staff involvement.

There has been a graduated roll-out to support staff training in CIVICA resulting in **728** Person Centred Care (PCC) Surveys completed to date. This is a new measure and adoption, and completion is expected to significantly increase over the next two quarters. CIVCA is being included in Ward Accreditation and highlighted through Divisional Reporting showing the following measures.:

- Satisfaction Score,
- Heat Map,
- Comment Analysis (Themes),
- Comment Reports,
- Listening and Learning,
- You said, we did.

The KPI's for Primary and Community have been structured in to 8 core questions, and to ensure a whole system approach to provide feedback the National ED and COVID surveys are now active.

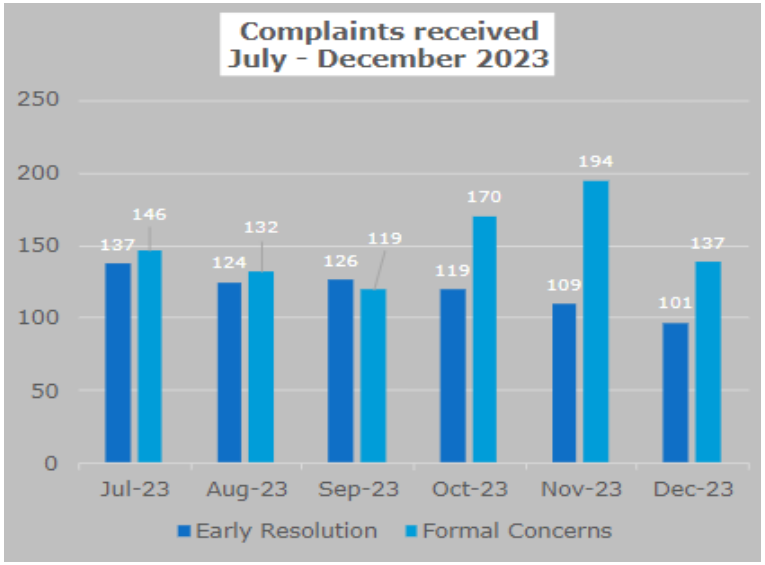
Satisfaction Score Health Board Wide **01/03/23 – 31/12/23**
81%

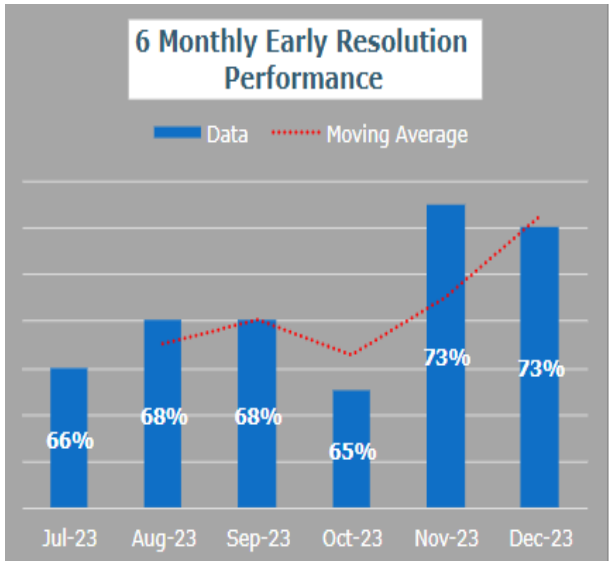
For Q3, 728 surveys having been completed, these have indicated an overall satisfaction score as 81% (benchmark is 85%), which combines Q1-3. Civica is live on all inpatient wards, however not all have received feedback, therefore it should be noted that currently survey completion is small scale. CIVICA is being embedded with patient experience feedback. A minimum number of surveys per month will be built into Ward Accreditation systems. Summary to date:

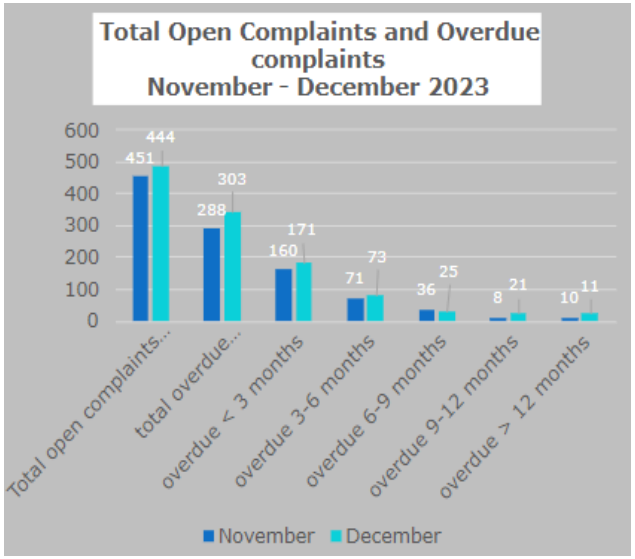
Q1&2 446 responses - 75% overall satisfaction

Q3 282 responses – 87% overall satisfaction

The number of complaints received and managed through PTR in Q3 was **498** and **329** were managed via Early Resolution. There has been an increase in the number of complaints managed by early resolution. The number of complaints opened and closed remains comparable.







Since the introduction on the Patient Liaison Service (PALS) there were no cases escalated to PTR for December 2023. Total activity for one month:

PSO / PALS Enquires: 725

PALS Complaints (managed / being managed through Early Resolution): 29

Complaints Escalated to PTR: 0

Compliments relating to PALS: 3

Reviewing the complaints and identifying themes and impact is important for continuous learning and change, themes will form part of the patients experience feedback.

Quality Priority 2- Safe Care.

Provide **SAFE** care through reducing harm, preventing errors, and delivering consistently safe care through increased visibility and insight from multiple sources of patient safety information.

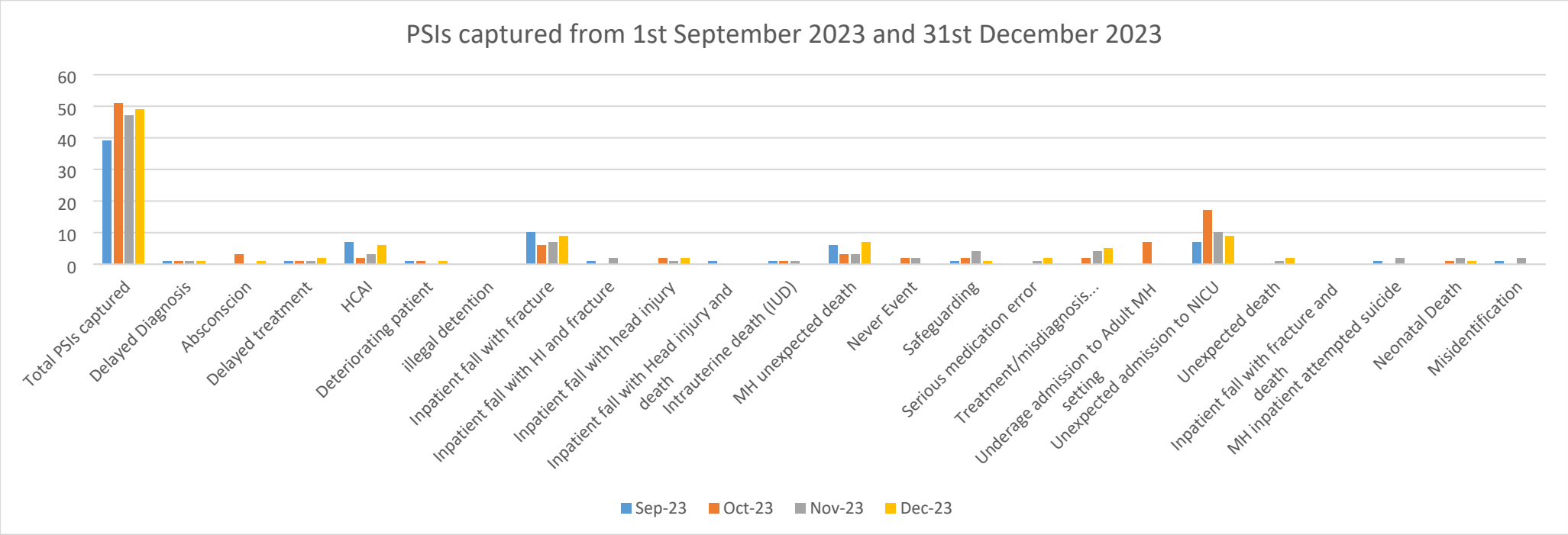
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 2 Safe Care	Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category.	Q2 2023	61	Q3 2023.24	68	Increased	Y	As of 31st December 2023 the PSI team were managing 68 live Serious Incident investigations (moderate/severe), with 48 in meeting stages, and so an upward trend in SI investigation numbers
		Reduction in the number of National Reportable Incidents	Q2 2023	173	Q3 2023.24	223	No Data	Y	The Health Board saw an increase in November in NRI'S to 22, with a return to 11 in December.
		Reduction in the number of Never Events	Q2 2023	1	Q3 2023.24	4	Increased	Y	There has been 2 Never Events reported November and December 2023 - A wrong side block and transfusion of ABO incompatible products.
		Improvement in the time to respond and close incidents	Q1 2023	70 days	Q2 2023	70 days	No Change	Y	There has been increasing trend over the past year for the time taken to close incidents, and an increase in the number of incidents reported in line with an increased use of the DATIX stem
		Decrease in the number of reportable IPAC incidents	Q1 2023	47/week	Q2 2023	29/week	Decreased	Y	Numbers have been lower since April in line with seasonal trends. Around 41% occur in RGH, and 21% in NHH
		The number of incidents with no harm themes identified						N	
		Increase in the compliance of Health and Safety Statutory and Mandatory Training	Q1 2023	84%	Q2 2023	86%	Improved	Y	There has been an increase in all the health and safety areas compared with the previous report
	Improved clinical outcomes,	Decrease in the time to complete safety alerts	Q2 2023	4 days	Q2 2023	4 days	No Change	Y	The average time to report has stabilised however the data is highly variable with regular peaks above four days
		Improvement in the severity of harm following a fall in hospital	Q1 2023	10%	Q2 2023	10%	No Change	Y	The number remains in line with Q1 however the variation has decreased
		Decrease in the number of Falls by 10,000 occupied IP Bed days	Q1 2023	10	Q2 2023	9	No Change	N	Compared to the previous period the number have stabilised following a period of reduction
		Decrease in the number of falls treated in ED which have had a previous admission - reattendance	No Data	No Data			No Data	Y	
		Improved RAMI Scores	Q2 2023	98	Q3 2023.24	114	Increased	Y	There has been a significant decrease in RAMI until December 2021 before gradually increasing in line with the rest of Wales but continued to be below the Welsh average. Q1 110, Q2 showed a decrase. The time lag of coding is 3 months so RAMI appears to increase for Q3, but this could be inaccurate until coding is recorded.
		Improved Crude mortality by hospital	Q1 2023	4.3	Q2 2023	4.3	No Change	Y	Over the past year ABUHB has seen an improvement in the Deaths by 1000 bed days measure and notably in the first quarter
		Decrease in the number of HA pressure ulcers by grade	Q1 2023	20%	Q2 2023	20%	No Change	Y	The number remains in line with Q1 however the variation has decreased
		Decrease in the number of HA pressure ulcers	Q1 2023	21/week	Q2 2023	23/week	No Change	Y	There has been a small increase in the last Quarter
		Decrease in the severity of medication incidents	Q1 2023	304	Q2 2023	389	Severe category consistent	Y	Total 304 incident reported April to June 2023. Sever incidents total of 7 for Q1 and Q2.
		Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	Q2 2023	28	Q3 2023.24	23	Decreased	Y	23 incidents to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 65% of these cases were reported within the legal timeframes within the legislation. This is an increase of 2% from the previous report.
		Reviewed Cardiac Arrest calls by 10,000 bed days	No Data	No Data			No Data	Y	
		Decrease in Hospital Acquired Venous Thrombosis incidents	Q3 2022	54	Q2 2023	49	Improved	Y	Q1
		Increase in the number of PREM Audit and actions						N	

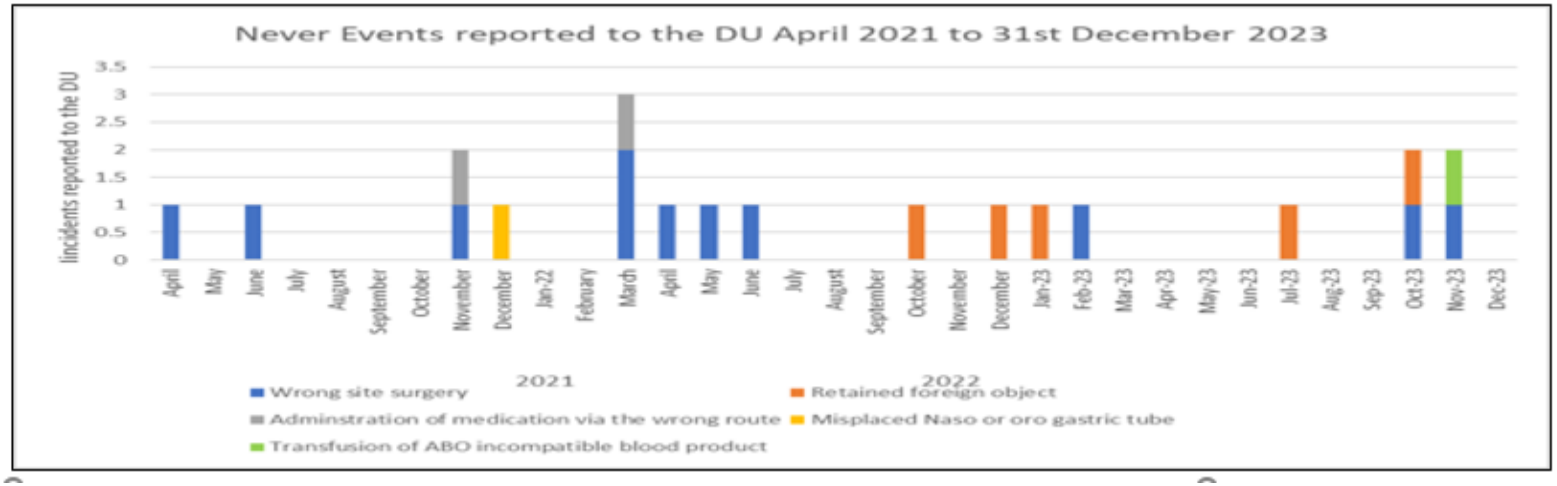
Fewer repetitive incidents in the priority areas and across the Health Board

Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events

As of the 12th September 2023 the Corporate Patient Safety Incident (PSI) Team were managing **55 live Red 1 SI's, with 26 in meeting stages**. Discussion with the NHS Executive highlighted an issue with the Health Board potentially under reporting under the New Framework. The NHS Wales National Incident Reporting Policy was introduced June 2021.During May 2023 *'NHS Wales National Policy on Patient Safety Incident Reporting & Management',* was launched, this document merged the Policy and Guidance into one.

In November 2023 the Health Board's Serious Incident policy was updated to map to the National Policy, receiving approval from PQSOC and the Executive team 'Patient Safety Incident Reporting and Management Policy (Duty of Candour: Moderate/Severe Harm)'. As of 31st December 2023, the PSI team were managing **68 live Serious Incident investigations (moderate/severe), with 48 in meeting stages,** and so an upward trend in SI investigation numbers.

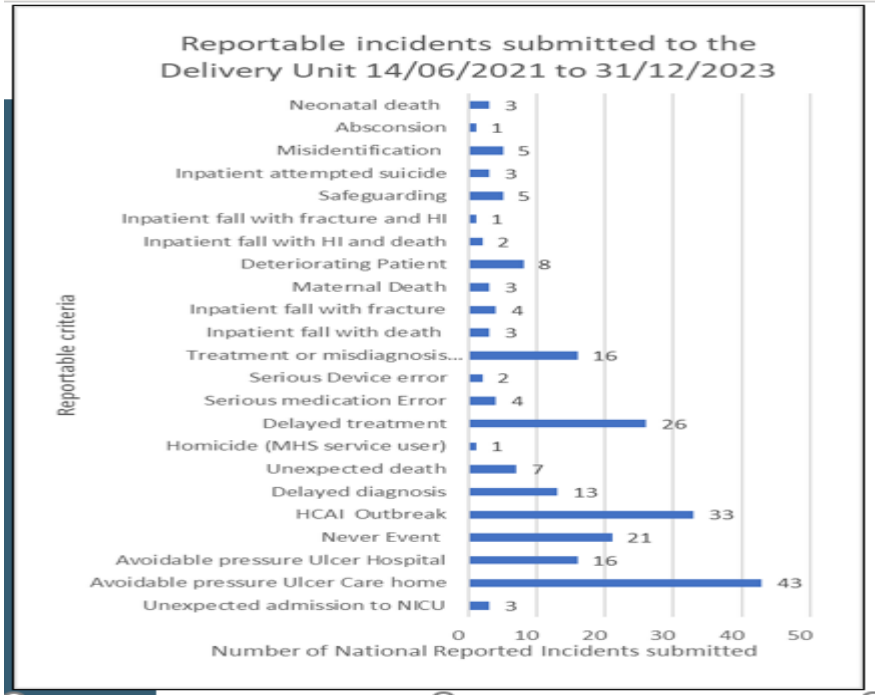




There were **4 Never Events** reported during Q3.

- Two Never Events were reported during October. One retained foreign object in Obstetrics and one wrong site surgery within Dermatology.
- There has been 2 Never Events reported in November – a wrong site block and transfusion of of ABO incompatible products.

A focussed approach to preventing Never Events continues across the organisation. A report presented at December's QPSOC, outlined the Improvement Programme for Theatres.



45 incidents have been reported to the NHS Executive for Q3 2023. There has been a marked increase since the summer, when the Health Board were advised to review their reporting criteria. 12 being reported during October. There were no particular themes. However, two Never Events were reported during October. One retained foreign object in Obstetrics and one wrong site surgery within Dermatology. The Health Board saw an increase in November in NRI'S to 22, with a return to 11 in December. There were no themes. However, two Never Events were reported during November. One Transfusion of ABO incompatible Blood products on an acute medical ward and One wrong site surgery in Endoscopy.

Decrease in the number of reportable IPAC incidents

There have been around 29 infection incidents recorded each week. Numbers have been much lower since April. Around 41% occur in RGH, and 21% in NHH. 74% of infection incidents occur in Medicine settings. The vast majority of these are considered to be "Low" level of harm. Respiratory infections are also being recorded as part of winter planning.

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

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	36.71	1.11	18.02	60.29	23.58	4
Betsi Cadwaladr UHB	39.17	1.14	23.65	79.66	24.22	5.49
Cardiff and Vale UHB	21.1	2.11	31.39	72.02	24.27	4.22
Cwm Taf Morgannwg UHB	30.77	2.07	29.59	86.98	27.52	4.14
Hywel Dda UHB	47.13	3.07	26.3	106.55	26.3	7.85
Powys THB	18.01	0	1	2	0	0
Swansea Bay UHB	62.64	1.7	37.11	69.11	23.49	6.47
Velindre NHST						
Wales	37.75	1.72	25.7	74.78	23.93	5

Increase in the compliance of Health and Safety Statutory and Mandatory Training

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

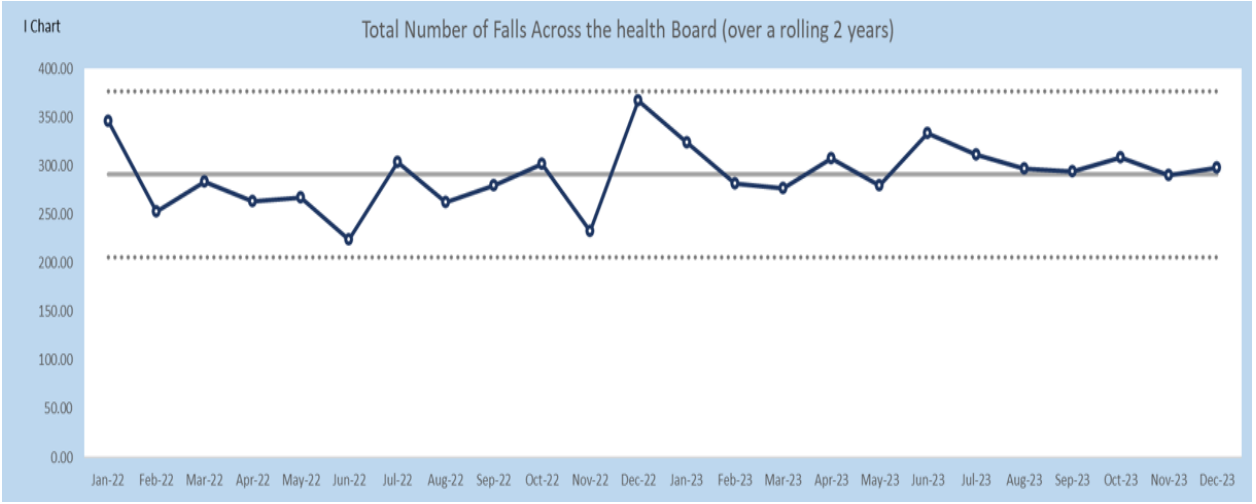
Training	End of May	End of August	End of December
Health & Safety	84%	86%	86%
Violence & Aggression	82%	84%	85%
Fire Safety	79%	81%	82%
Manual Handling	52%	56%	54%

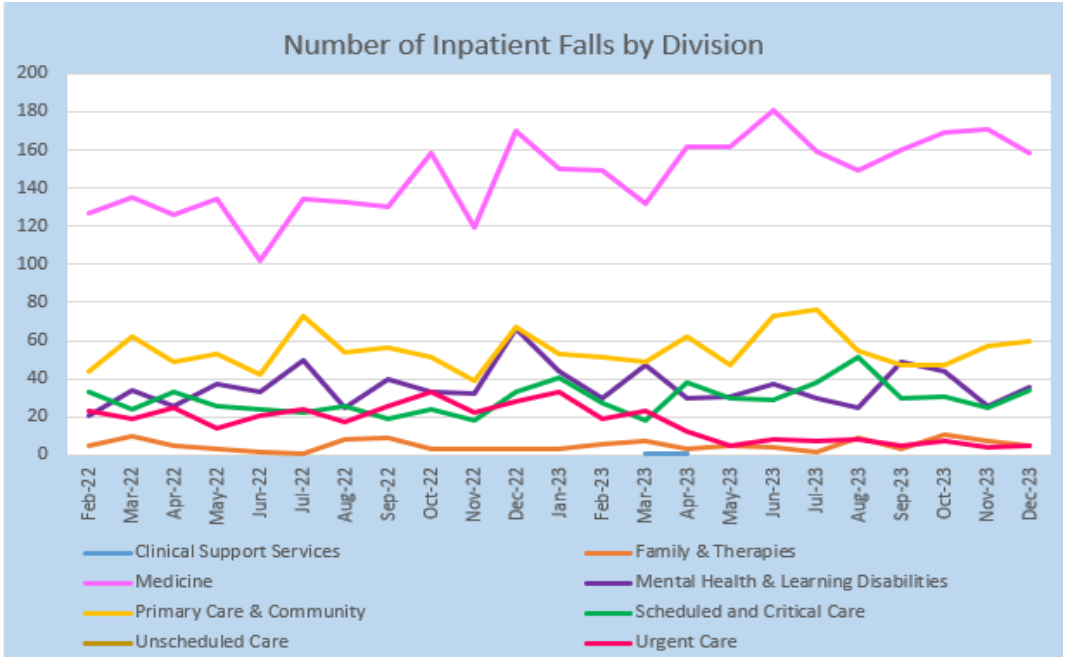
There has been an increase in all the health and safety areas compared with the previous report. A review of all health and safety training strategies is being undertaken to ensure an increase in compliance and active engagement with the Divisions to implement the training model is happening.

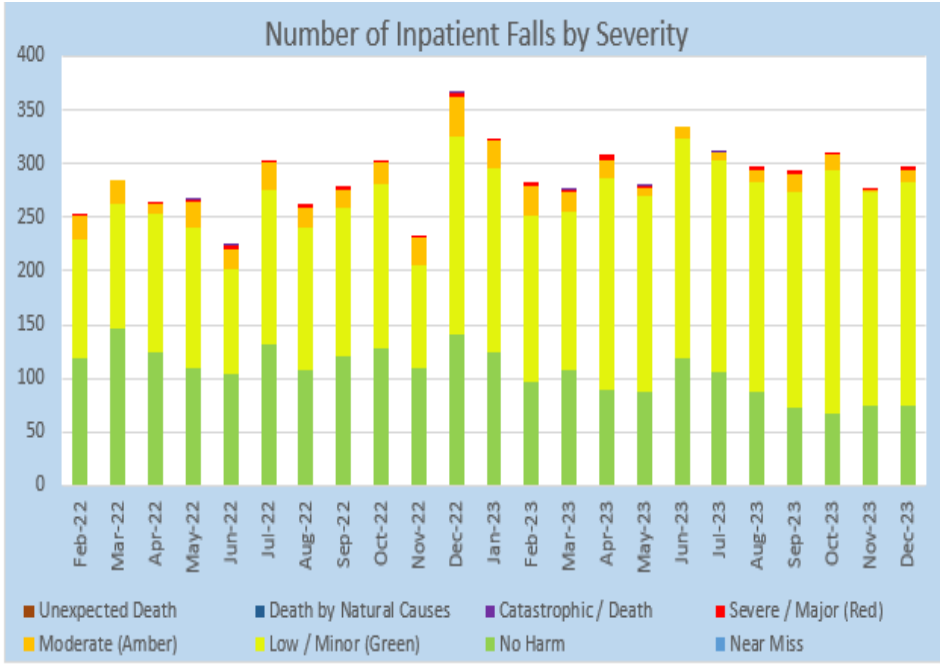
Falls

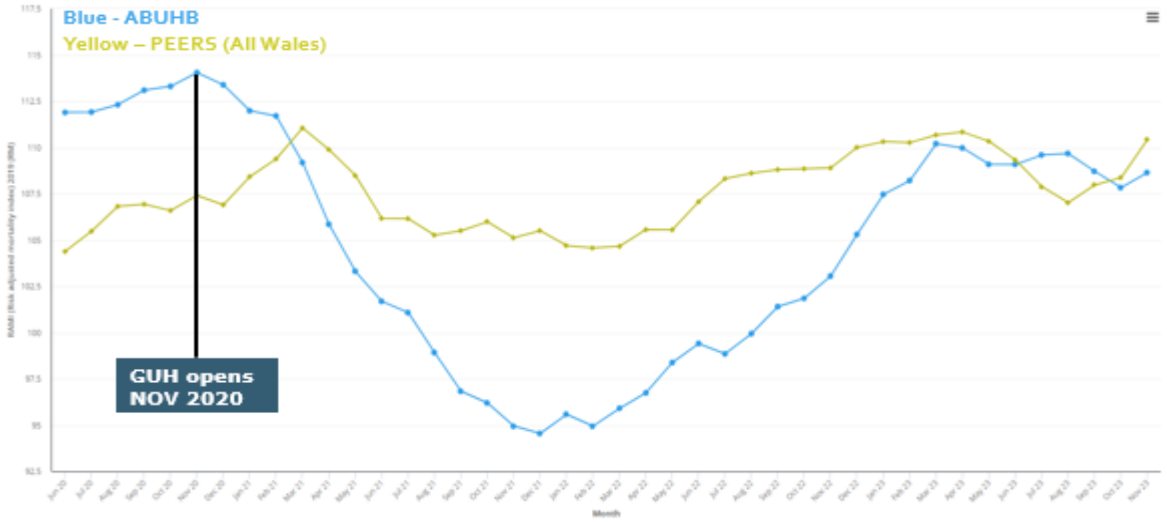
Falls analysis of data associated with Inpatient falls management continues to be monitored over a two-year rolling period to provide assurance. This approach identifies any changing trajectories or statistical variation in the number of falls incidents. The mean average value for the total number of falls per quarter remains consistent.

For Q3 there was a decrease in the number of falls. This year there has been a return to closer alignment to the mean average value, with a downwards trajectory for July and August 2023.







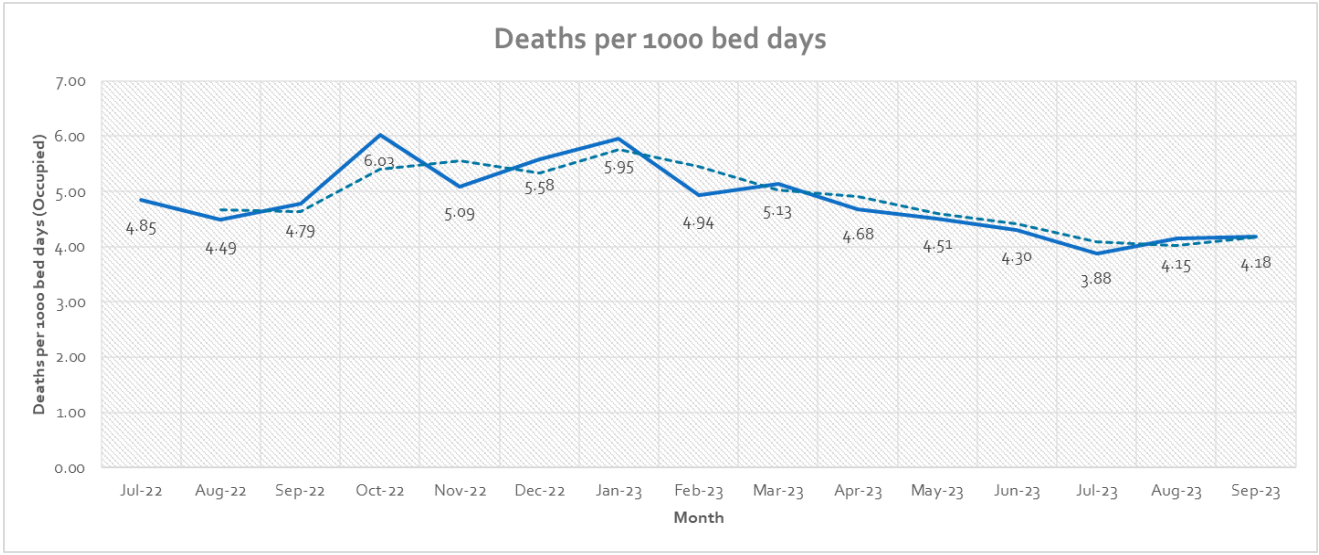


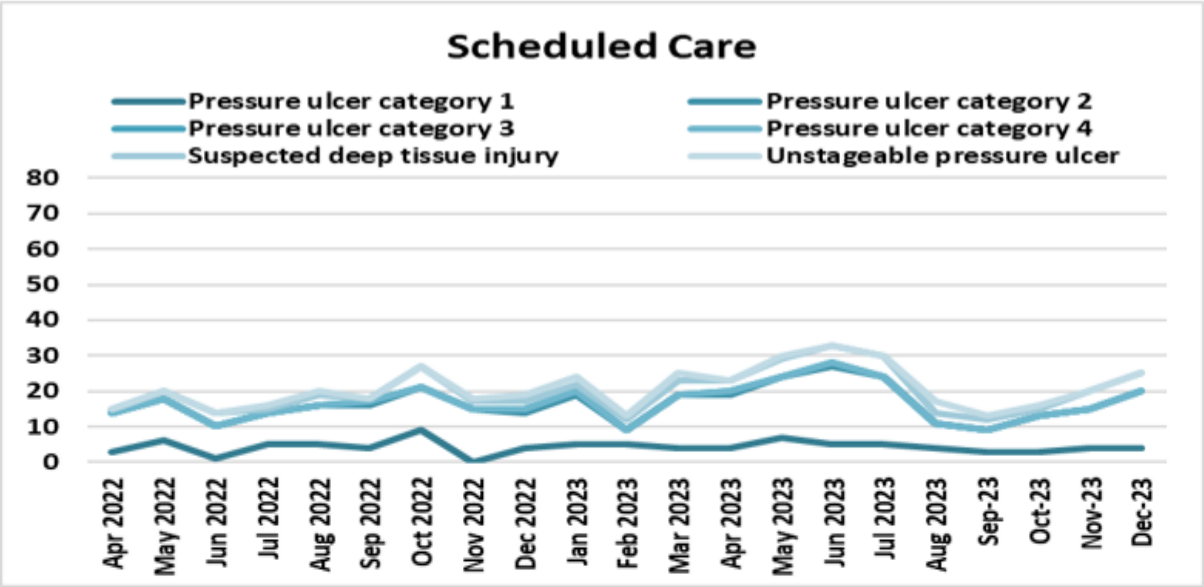
Risk Adjusted Mortality Index (RAMI)

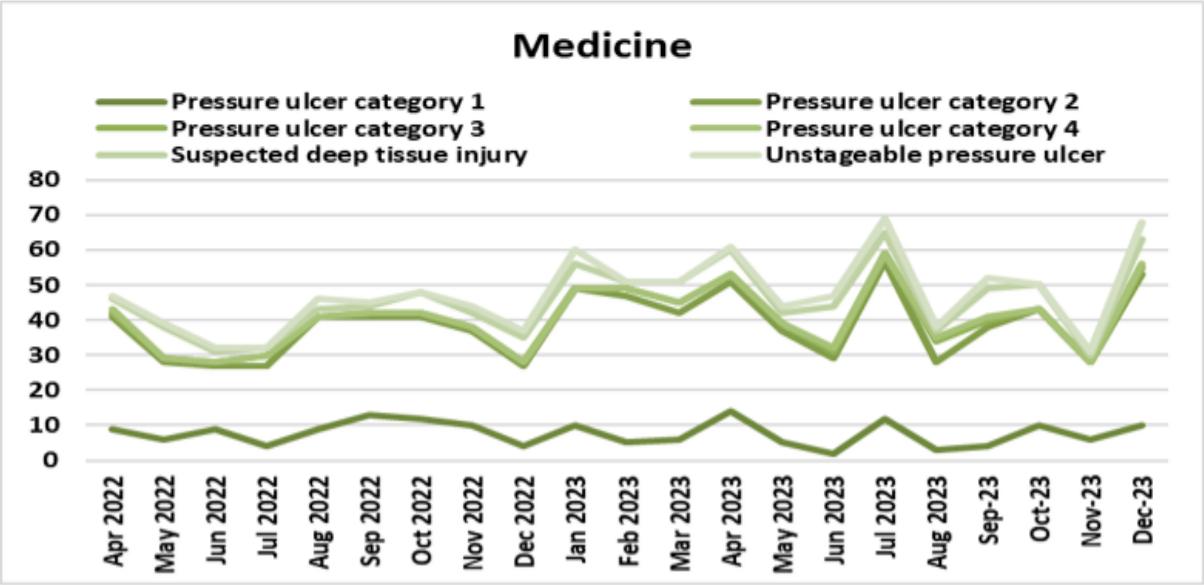
RAMI is used to assess whether inpatient mortality across all medical and surgical patients deviates from the expected, taking risk factors into considerations. Since the opening of the Grange University Hospital, there has been a significant decrease in RAMI until December 2021 before gradually increasing in line with the rest of Wales but has continued to be below the Welsh average. To date, the Health Board is performing 2nd of 6 within its peer group.

Crude Mortality

The review of mortality rates supports understanding of many questions about the causes, consequences, correlates, and measurement of mortality in a complex environment: Over the past year ABUHB has seen an improvement in the Deaths by 1000 bed days measure and notably in the first quarter.







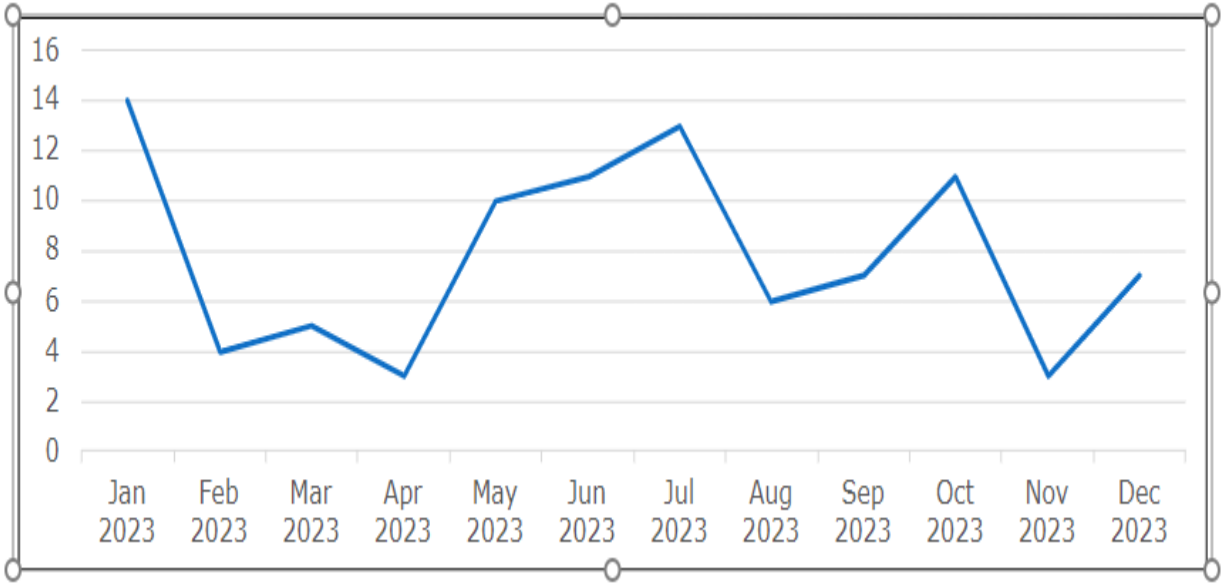
Health Acquired Pressure Ulcers

Following the COVID-19 Pandemic, the Health board reported increased numbers of unstageable and grade 3 & 4 Health Acquired Pressure Ulcers (HAPU's).
Reported Health Acquired Pressure Damage occurs at a rate of around 23/week. Around 20% are considered Moderate or Severe based on the reporter's view. 34% of these occurred at GUH and 52% in eLGHs.

With the success of the previous pressure ulcer prevention and reduction collaborative, 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 ABCi. The Aim of the Faculty is to:
Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty and eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty

There has been an upward trend noted in November and December 2023, which has resulted in the TVNs developing a pre-recorded PowerPoint teaching package. PDSA cycles are in progress and a diagram has been updated. Date of commencement of Pressure Ulcer Pilot is February 2024.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations



During the period January 2023 to December 2023 the Health Board have reported **94 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 60% of these cases were reported within the legal timeframes within the legislation. 65% of these cases were reported within the legal timeframe within the legislation.

Medication Incidents

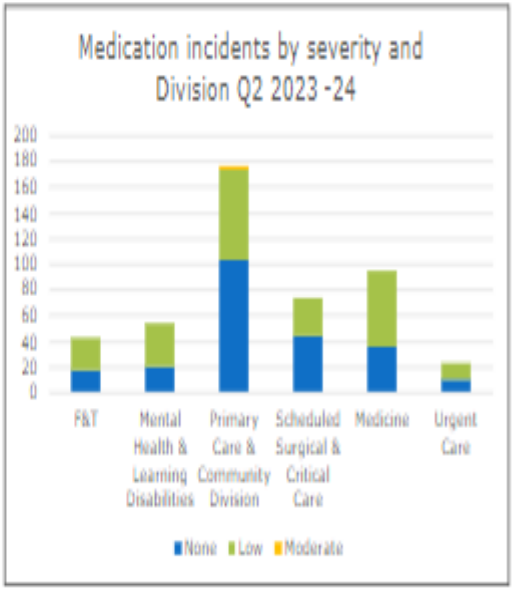
A total of **304** incidents were reported from April to June 2023 and a total of **389** incidents were reported July to September 2023. Q3 incidents will be discussed at Medicines Safety Group in February.

There are around **25 medication incidents** recorded each week.Around **37% occur** in 'Other' sites outside of the main ABUHB hospital sites. A large portion of the incidents in PC&C were Medication Supply Errors.

There Number of incidents reported as severe remains consistent.

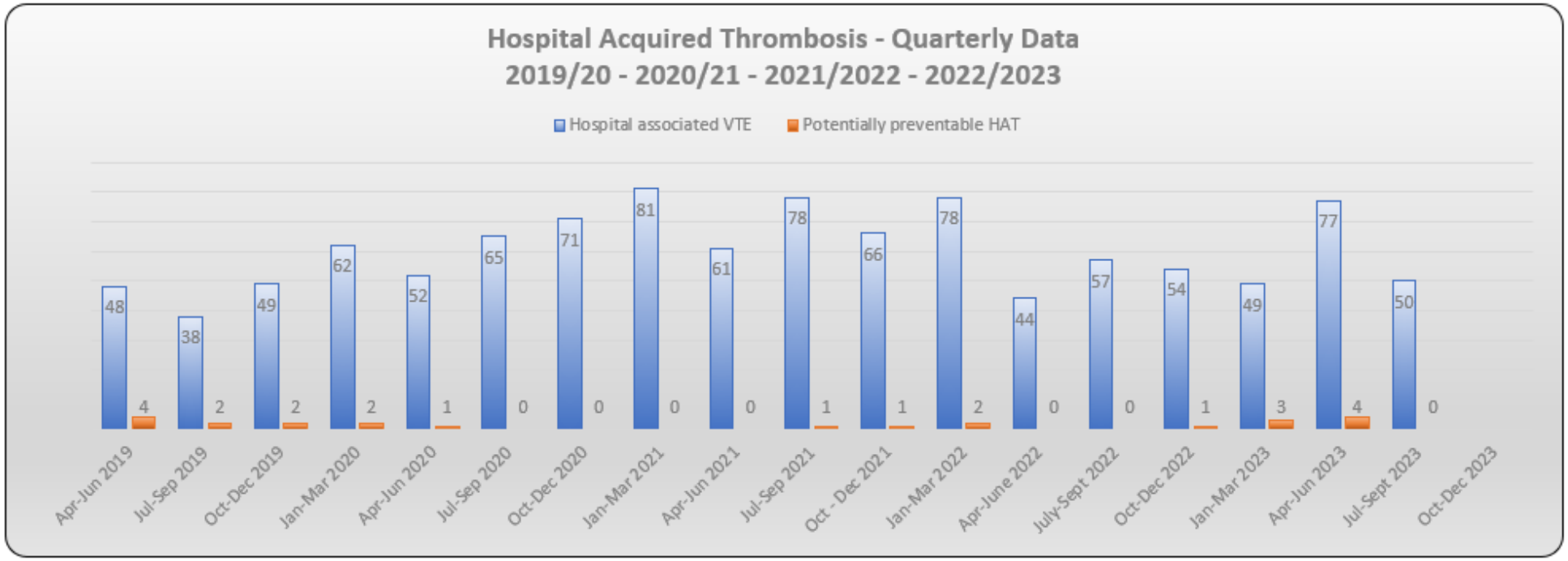
	Q3	Q4	Q1	Q2
None	226	208	188	194
Low	95	98	88	128
Moderate	32	35	21	60
Severe	7	5	7	7
Catastrophic	0	0	0	0
Total	360	346	304	389

"Reporters View on Levels of Harm"



Health Acquired Venus Thrombosis

The last available data is Q2 2023. There number of HAT's in ABUHB remain consistent. However, over Q3 and 4 of 2022.23 and Q1 2023 there has been an increase in the number of preventable incidents. There is a focused programme of work with Scheduled Care and Trauma and Orthopaedics who have seen the highest prevalence and an increasing trend.



Quality Priority 3- Timely Care

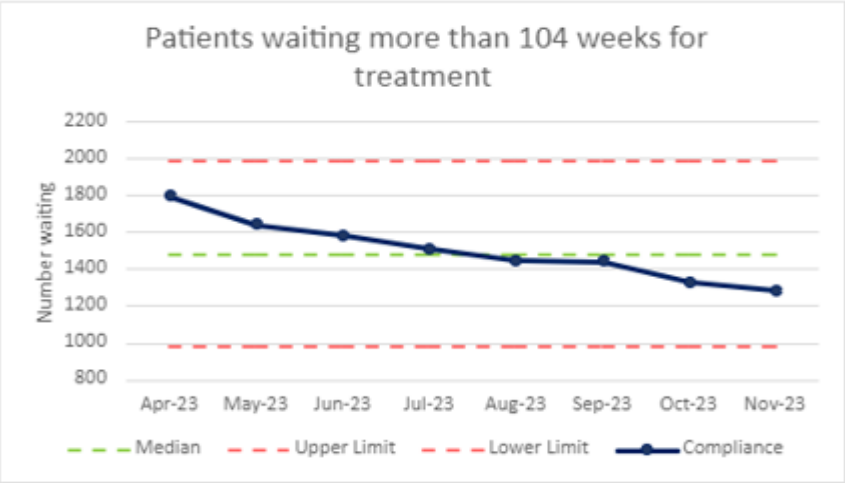
Provide **TIMELY** care, through ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time**.**

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 3 Timely	Maximising and individuals time and outcomes	Decrease in the time from admission to surgery for emergency admissions	Q3 2023	30 hours	Q4 2023	34 hours	No change	Y	Average time to theatre from Arrival/Admission continues generally around 30 hours aside from a period in October/November of 32-42 hours.
		Decrease in the time from surgery to discharge	Q3 2023	2.6 hours	Q4 2023	3 hours	No Change	Y	Average time from leaving theatre to discharge has been mostly stable around 3 hours
		Decrease in time spent on a waiting lists	Q2 2023	34.16			Improved	Y	Improving trend for our longest wating patients, ahead of plan for those waiting 156 weeks, emerging issues in ENT and Ortho spines with Divisional actions plans
		Decrease in the number of handovers >1 hour, monthly	Q3 2023	1169	Q4 2023	1314	Improved	Y	Improved indicator value through implementation of change programme over the summer
		Decrease in the time for patients to be seen by first clinician	Q3 2023	4.2 hours	Q4 2023	3.8 hours	Deteriorated	Y	Trend has stabilised since Q2. Was improved in November but returned to normal in December.
		Decrease in the time for bed allocation from request	Q3 2023	7.5 hours	Q4 2023	8.4 hours	Deteriorated	Y	Increase from September to November
		Decrease in ED waits >12hrs, weekly	Q3 2023	261	Q4 2023	261	No Change	Y	No change
		Increase in discharges before midday;	Q3 2023	32%	Q4 2023	32%	Improved	Y	Improving indicator value, expected to see further improvement in Q3
		Decrease in the number of patients with a LoS over 21days	Q3 2023	563	Q4 2023	550	Improved	Y	>21 days Occupancy is below normal trends by around 40 patients
		Time from Flow Centre call to discharge/ admission from assessment?					No Data	Y	
		Number of emergency admissions in hospital over 7 days	Q3 2023	354	Q4 2023	354	No Change	Y	7-21 days Occupancy is has continued at normal levels
		Decrease in the time from request to step up/down to a different site					No Data	Y	
		Decrease Overnight bed moves and patient transfers	Q3 2023	37.90%	Q4 2023	38.70%	Deteriorated	Y	Gradual increase since Q2 against the overal improving trend since 2021.
		Reducing time spent in hospital					No Data	Y	
	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Q3 2023	59.20%	Q4 2023	60.80%	Improved	Y	Deterioration in indicator value from 58.2% (Mar 23) to 56.2% (Jun 23)
		Increase in 5 year cancer survival rates	Q2 2023	0.54			Improved	New	Indicator value is similar and has been sustained. Next update scheduled Sept 23 (provisional)

Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	Jun-23	82.30%			Deteriorated	New	Deterioration in metrics, however IMTP target remains achieved.
	Decrease in neurodevelopmental (SCAN) waiting list	Jun-23	36.20%			Deteriorated	New	Indicator has deteriorated from 42.2 (Feb 23) to 36.2% (Jun 23)
Improved mental health resilience in adults	Increase in life satisfaction among working age adults	2021/22	73.50%			Improved	New	""New Indicator"" Increase in value between 2020/21 and 21/23
	Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	-	-				New	""Measure will be available from July and will be included within the next quarterly report""
	Increase in life satisfaction among older people	2021/22	84.20%			Improved	New	""New Indicator"" Improvement within indicator from 75% to 84.2%, surpassing the all Wales average of 82.4%.

IMTP data for Q3 is currently being updated and reported to Board in March 2024. Data is up to the end of November.

Maximising an Individuals Time and Outcomes



The Health Board has made good progress towards eliminating waits of over 156 weeks for all stages, with 136 patients waiting at the end of November 2023 compared to the March 2023 position of 653.
Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,284 at the end of November 2023.

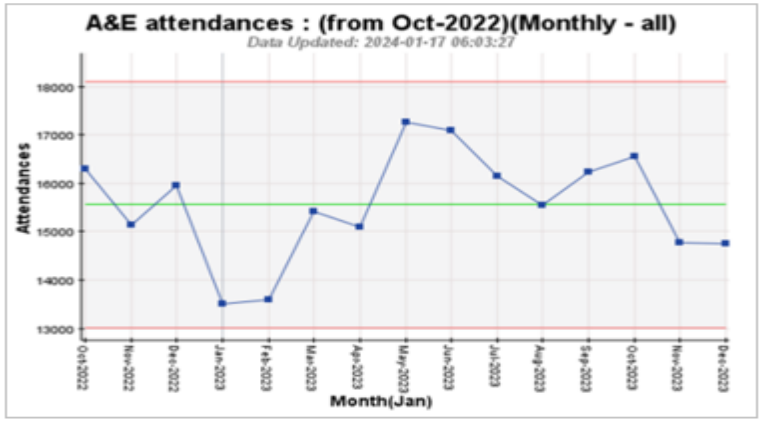
With regards to outpatients, at the end of November 2023, there were 1,938 patients waiting over 104 weeks for a first outpatient appointment compared to 1000 at the end of April 23. There is mixed progress across specialities with ENT, Ophthalmology and Orthopaedics currently behind trajectory.

The number of patients waiting over 52 weeks for a first outpatient appointment has been maintained at 12,824 as of November 2023.

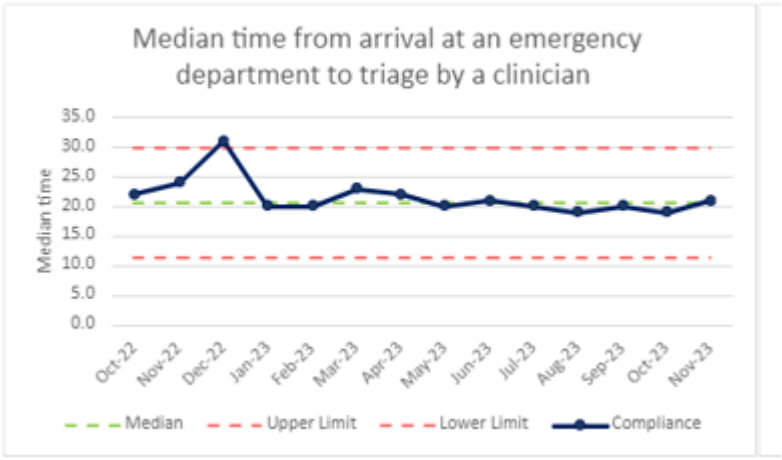
The outpatient transformation programme is focussing on its outpatient Did Not Attend (DNA) plan. Additionally, the programme is continuing to work alongside finance and divisional teams, with a particular focus to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment.

Maximising an Individual's Time- Urgent Care

Urgent Care services continue be under significant pressure both nationally, regionally, and locally, making delivering timely care challenging. There has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.

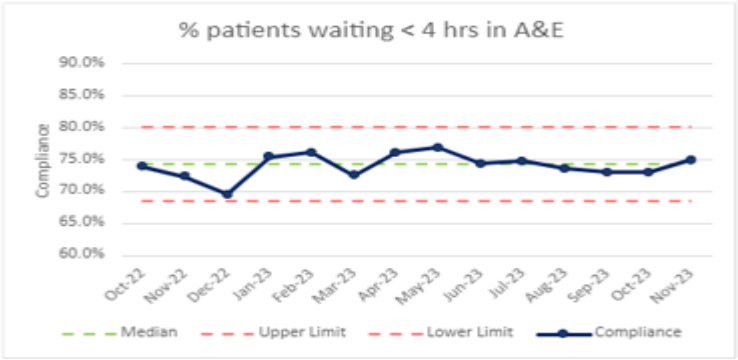


Time from arrival to triage by a clinician

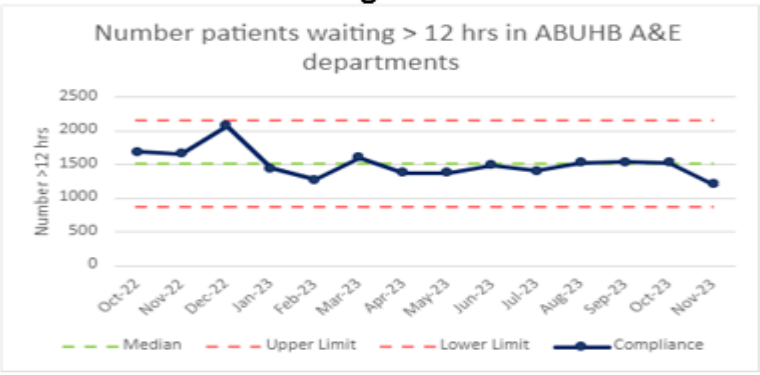


During December there have been on average 475 daily attendances to the Emergency Department or a Minor Injury Unit. Despite the extreme pressures upon the urgent care system, the performance measures of patients waiting less than 4 hours in ED has improved from 73% in November 23 to 75% in December 23 and remains above the all-Wales average of 69%. The most recent national performance data reports that whilst the 95% target for 4 hour ED waits has not been met, the Health Board's performance is the second highest in Wales. Patients waiting over 12 hours in Emergency Departments was reported at 1,205 in December 23, which is a significant decrease against the baseline of 1,606 (March 23) and has achieved and surpassed the national target of 1,689.

Patients waiting <4hrs in A&E

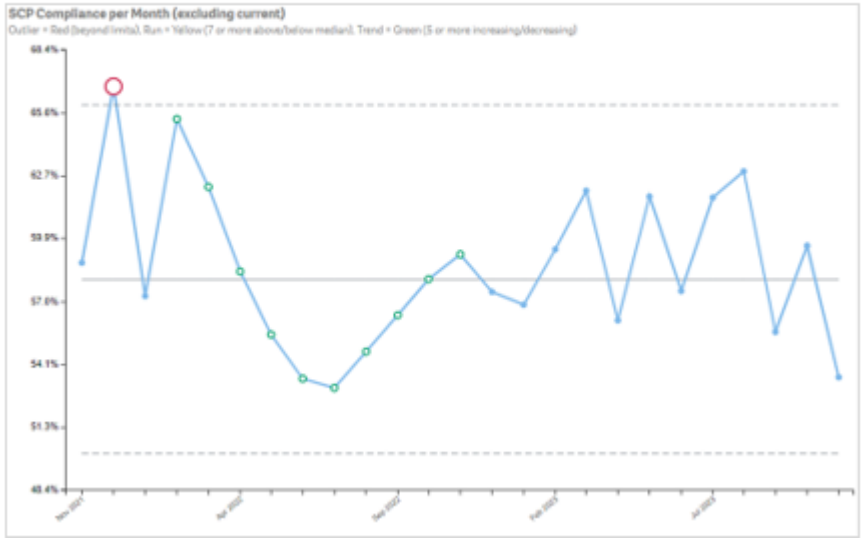


Patients waiting >12hrs in A&E



Maximising cancer outcomes

SCP Cancer Compliance per Month



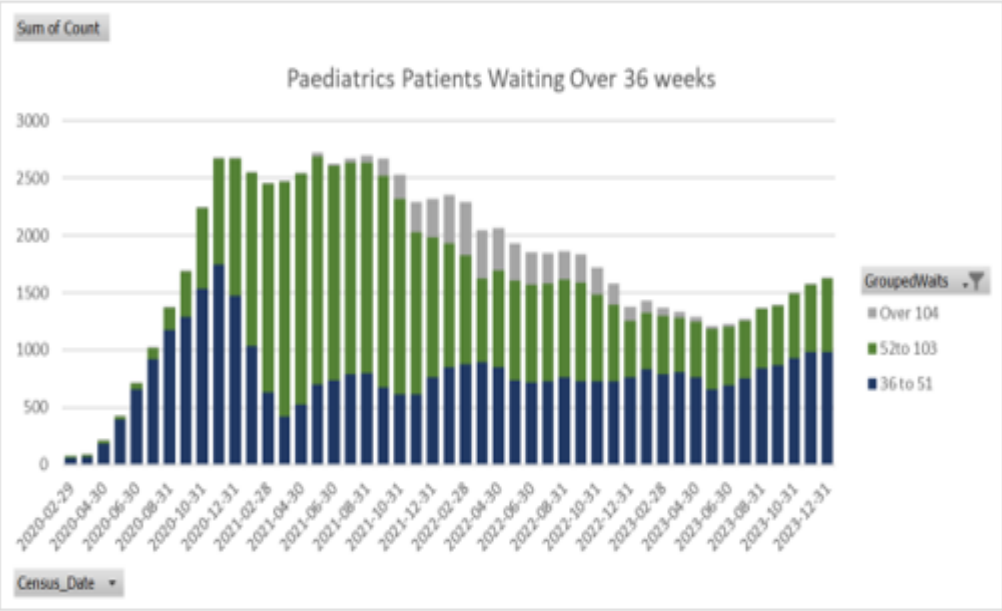
Backlog of cancer patients waiting over 62 days

Compliance against the 62-day target for definitive cancer treatment has decreased from 58.4% (October 2023) to 53.7% at the end of November 2023. This is behind the performance ambition set in the IMTP. Drivers for this are the increase in demand alongside the focus on the over 62 day waits, which will affect compliance. Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.

Increased demand is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres. Additionally, the number of SCP treatments undertaken has increased by 9% over the last 12 months and is continuing to increase month by month (Dec 22 - Nov 23 = 4,407 Single Cancer Pathway treatments compared to Dec 21 – Nov 22 = 4,042 SCP treatments).

Despite the pressures of increased demand and capacity challenges, the number of SCP backlogs has reduced by 21% since the beginning of the quarter, with 303 waiting over 62 days at the end of December 2023 compared to 384 at the end of September 2023.

Improve Mental Health Resilience in Children and Young adults



Progress within the 'Improve Mental health Resilience in Children and Young Adults' outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks.

The number of children on the Health Board's waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of December 2023, there were 185 children waiting over 52 weeks for a new outpatient appointment. There are a number of contributing factors to the waiting list including nurse capacity, bed capacity, Anaesthetics support and theatre availability.

There continues to be focused efforts to improve care and access for paediatric patients through service improvements such as an expert referral triage team and advice letters as an alternative to consultation to support waiting times. This focuses on the efficiency by turning the tap off at the top end and managing demand.

A robust ND recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0 -18 years pathway by separating the cohorts of 0 - 5 years and the 5 - 18 years. A new pathway has been approved for those aged 0-5 years on the waiting list waiting for an ASD assessment. This will begin to have an impact once the new team is in place following recruitment, that should commence August 2023. For the children and young people on the 5-18 years waiting list, an ND recovery team has been put in place to support with the longest waiters and support the core ND team. Focus will also be on the ND screening of new referrals with completed supporting information.

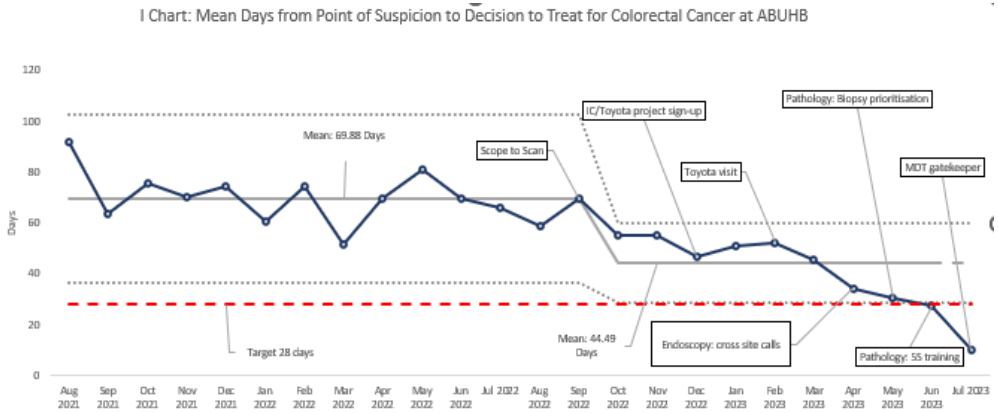
Quality Priority 4- Effective Care

Quality 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	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 4 Effective	Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation plans by area						N	New measure reporting from Q3
		Insert ward accreditation measures - to be confirmed						N	New Measure from Q3
	Increased understanding of variation to focus Improvements	Increase in the SMART action plans with accountability in National Clinical Audit						N	New Measure from Q4
		Increase in the numbers of wards participating in accreditation (Audits via AMaT)						N	New Measure from Q5
		Increase in the actionable audit recommendations by National Clinical Audits						N	New Measure from Q6
	Improvement is part of the AB way	Staff Survey - increase in the score for staff being able to raise concerns						N	New Measure from Q7
		Compliance the number of incidents triggering Duty of Candor within 5 days	No Data	No Data			No Data	Y	T&F group working on data and validation
		QI projects outcomes (Non SCC)	Q1 2023		Q2 2023			Y	Narrative report
		Outcomes of the SCP teams	Q1 2023		Q2 2023			Y	Narrative report
	Improving Good Health in Pregnancy	Decrease in low birth weight rates	2021	5.10%	2022	6.10%	Deteriorated	New	Increase in indicator between 2021 and 2022. In line with the All Wales average.
		Decrease in stillbirths	2021	3.9	2022	4.5	Deteriorated	New	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	59.20%	56.50%	Q4 2022/23	58.90%	Improved	New	Indicator value has improved by 4.2% between Quarter 3 and Quarter 4.
		Increase of eligible children measured and weighed at 8 weeks	62.50%	35.00%	Q4 2022/23	39.70%	Improved	New	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average.

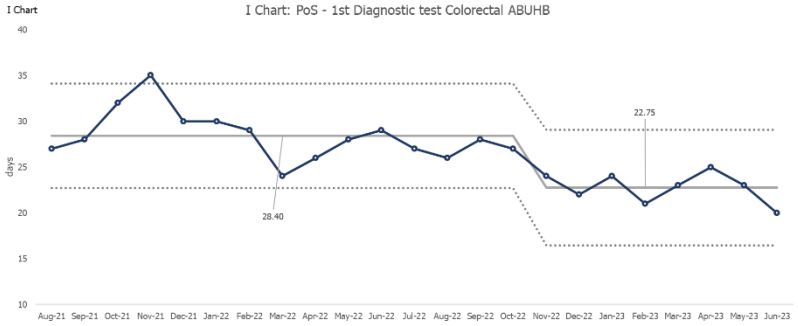
QI projects outcomes (Non-Safe Care Collaborative) - ABUHB Colo-rectal Suspected Cancer Pathway Improvement Work

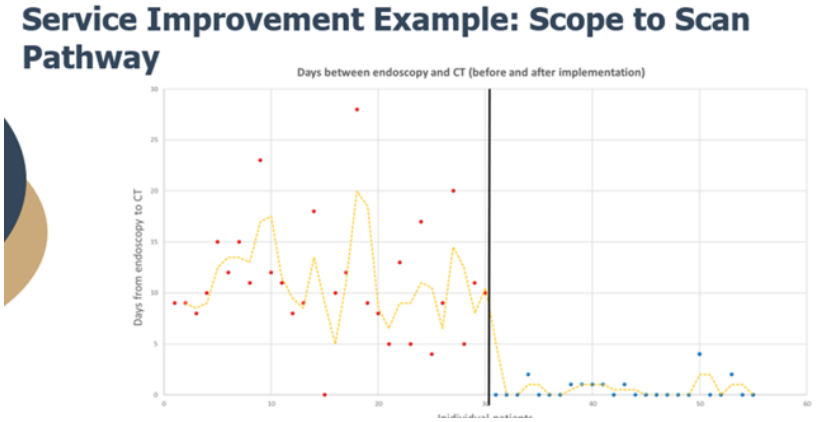
Health Board is working with the Wales Cancer Network and Improvement Cymru to work with Cancer MDTs across Wales to facilitate and enable improvement to the Suspected Cancer Pathway with a focus on the first 28 days. A Go Look Go See visit to understand the current system followed by a 3-day training programme at Toyotas engine plant in Deeside to focus on improvement work. The people on the training were asked to extract lessons learnt from Toyota into the health setting and their day-to-day work. With this work the persons experience/ story has always been considered in any conversation around reducing the days waiting.



A follow up coaching visit from Toyota was undertaken to hear about improvement changes and ideas. Improvement Cymru provided coaching support to enable application of new knowledge and learning.

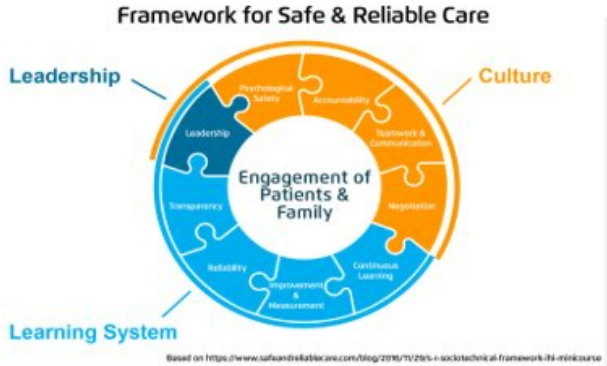
The chart shows an overall improvement in a person's journey from **70 days** to a new mean **of 44 days**. The second graph shows an overall improvement in days from a median **of 17 to 12 days** wait between POS to 1st appointment. This appointment can be outpatients or at endoscopy/ straight to test. Work in Endoscopy has included introducing cross site calls each day to coordinate phone calls to book appointments and further work is being undertaken on standardising the calls to ensure people are booked in for the earliest possible appointment available. Further standardisation of all processes is being undertaken to ensure people are booked in within the 2-week target.





Work in Radiology (Pre Toyota) correlates with improvements being made to the Colo-rectal pathway – The Endoscopist can now send an e-referral for same day CT staging scans, whereas previously biopsy results were awaited before arranging these scans. Endoscopies complete all safety and pre scan preparations allowing the staging CT to take place on the same day and MRI within the 72 hrs of the referral. This has helped reducing waiting times to the overall pathway by between **15-20 days**.

Outcomes of the Safe Care Partnership Teams



Safe Care Collaborative Update

November – December 2023

Organisational Update: Stage-Action Period 8

- **Learning Session 4, Nov 28-29th** – First local Learning Session of the ABUHB Deteriorating Patients Collaborative – focussing on Safety Culture, Sharing Learning and listening to unheard voices (bereaved family & jnr dr). Day 2 held virtually
- ***ABUHB Deteriorating Patients Collaborative** – Draft driver diagram based on SCC participant feedback. Focussing on reducing harm from acute and chronic deterioration, through development of Safety Culture
- **Leadership programme of work** – schedule of executive Safety Walkarounds – 2 visits took place during Nov/Dec. Programme set up until March 2024.
- **Quality Outcomes Framework**– Working to refine QOF in conjunction with Public Health. Prep of Q3 report
- **QI Skills Development**– Improvement in Practice training initiated with Improvement Cymru for staff from Primary Care, Mental Health and Collaborative work. Quality Coach Course being developed for New Year.
- **OCP - QPSQI Teams together - Nursing Directorate**
- **Improvement Advisor – Theatres** appointed

Team Update:

Storyboards - Monmouthshire Team were invited to present their project at Spotlight Session at National SCC LS4

Project Outcomes

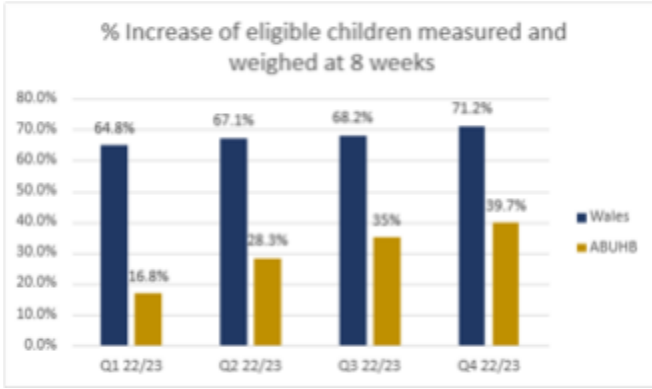
- **Ward C0** -270 days with only one crash call
- **Monmouthshire** – Reduction in Package of Care hours for medically optimised patients. ALOS reduction but recent increase being explored.
- **AMU** – Increase in the number of observations each week. Focussing on Response arm of work
- **OT Early Intervention** – 30-60 minute saving for each patient 3 month evaluation via telephone rather than face to face now adopted as common practice

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

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

Optimising a child's long-term potential

Following the impacts of the Covid-19 pandemic in 2020, the number of Healthy Child Wales Programme contacts have recovered to numbers seen prior to the pandemic. There has been an improvement in one indicator of the outcome 'Optimising a child's long term potential' with an increase from the last reported position **of 28.3%** (Q2 2022/23) to **35%** in the increase of eligible children measured and weighted at 8 weeks as part of the Healthy Wales Child programme.



Health Visiting Improvement and Sustainability Board

In response to increasing challenges and concerns from managers and staff regarding the health visiting service this Board was established in November 2023. The group is chaired by Jenny Winslade Executive Director of Nursing and its members include managers, staff ,staff reps and key stakeholders. The group has agreed a draft Improvement Plan which incorporates 5 key workstreams:

- Service Redesign
- Workforce
- Governance
- Well Being
- Communication and Engagement

Each workstream has an identified lead and working group who are identifying key priorities. The workstream leads will provide progress reports to the Board which will meet quarterly.

Quality Priority 5- Efficient

Quality 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	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept partial)		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value			
Priority 5 Efficient	Patient experiences are visible and acted on	Decrease in the number of open personal injury claims	Q2 2023	71	Q3 2023	76	Increased	Y	Q1 71 Over 100 submissions of evidence/learning/assurance No Financial Penalties at July WRP Committee
		Decrease in the number of open clinical negligence claims	Q2 2023	637	Q3 2023	657	Increased	Y	Q1 615 No Financial Penalties at July WRP Committee
		Decrease in the number of open Coroner inquests	Q2 2023	216	Q3 2023	188	Decreased	Y	Q1 205. Decrease in Q3
		Decrease in the DNA's and CNA'S	Q1 2023	6.10%	Q2 2023	5.40%	Decreased	Y	The current rate has reduced from 6.1% (2,762) in March 2023 to 5.4% (2,354) in June 2023 the programme is continuing to work alongside finance and divisional teams, with a particular focus next quarter to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment
		Response time to Public Services Ombudsman for Wales(PSOW)	No Data	No Data	Q2 2023		No Data	Y	
		Number of INNUS's being completed	Q2 2022	518	Q3 2022	457		Y	Remained constant over the year with a small decrease between Q2 and Q3
		Decrease in the number of outliers by Specialty	New Measure					N	New Measure
		Decrease in the number of medically fit for discharge patients	Q1 2023	280	Q2 2023	280	No change	Y	In the past year there has been a decreasing trend in the numbers from 320 to 286, this has now stabilised over the last quarter to 280
		Decrease in the number of patients cancelled on the day of surgery	Q1 2023	130	Q2 2023	110	Decreased	Y	There has been a decreasing trend in the numbers cancelled in the day of surgery the numbers over the past quarter remain circa 110 per week
		Decrease in the % of hospital as a place of death	Q1 2023	4%	Q2 2023	2.50%	Decreased	Y	There has been a notable decrease in the % of hospital as a place of death in the past quarter outside of normal season trends from 3.2% to 2.75%
	Improve care at the end of life	Increase in compliance of issuing of Medical Certificates within 5 days	No Data	No Data	Q2 2023		No Data	Y	

Claims, Redress & Inquests

Quarters 1 and 2 focused on learning through the Welsh Risk Pool Learning Advisory Panel, ABUHB focus on all aged cases > 6 months and returned over 100 submissions of evidence/learning/assurance. Data has been collected for Q1-3 to look at trends. There has been a small increase in the number of personal injury claims, from **71 to 76.** There has been a slight decrease in the number of open inquests which has decreased from **216 to 188.**

	Q1 2023	Q2 2023	Q3 2023	Trend
Decrease in the number of open personal injury claims	71	71	76	Increase
Decrease in the number of open clinical negligence claims	615	637	657	Increase
Decrease in the number of open Coroner inquests	205	216	188	Decrease

In October the Patient Safety Investigation Team transferred to Legal Services. There have been time out sessions reviewing systems and looking at how to improve and simply processes.

Quality Priority 6 Equitable

Quality Priority 6 - Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position (Sept		Change over the last time period	Expected for Q2 reporting	Latest findings
			Latest data	Indicator value	Latest data	Indicator value			
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the access to Safeguarding Training	Q2 2022	Level 1 Adult 84.07% Children 83.05% Level 2 Adult 84.57% Children 82.03%	Q3 2023.24	Level 1 Adult 79% Children 85% Level 2 Adult 88% Children 86%	N/A	N	Compliance remains within tolerance of 85%
		Narrowing of the life expectancy Gap across our Health Board	Q4 2020	Women 20 years Men 13 years	Q4 2020	Women 20 years Men 13 years	N/A	Y	The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities
		Timely closure of Safeguarding incidents		Measure in development		4 Child Practice Reviews 1 Adult Practice Review 5 Domestic Homicide Reviews		N	
		Decrease in the incidents of violence and aggression towards staff						N	

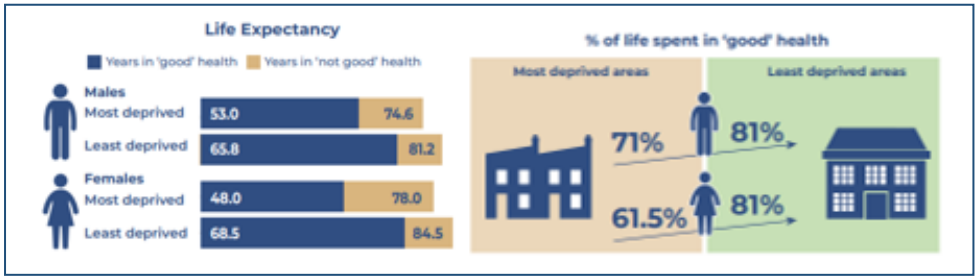
Increase in the access to Safeguarding Training

The Health Board is required to provide Safeguarding Training in relation to Children and Adults in line with national standards. The current compliance levels are in line with expected levels. The Safeguarding offer has been expanded during Q1-Q3 2023 with Safeguarding level 3 training package commencing in April 2023. Both adults and children's training packages are currently evaluating well, reporting will commence in Q3.

At this current time the uptake/compliance of Level 1 and 2 Safeguarding Training remains at very similar levels. Level 3 Safeguarding Training continues to be available, though sessions are not fully booked. Work has been completed with the ESR Team, so managers will be able to monitor compliance from Q1 2024/25.

Level	Adult	Children
1	79.%	85%
2	88%	86%

Narrowing of the life expectancy Gap across our Health Board



As an organisation our mission is to improve population health, and, through doing this, reduce the health inequalities experienced by our communities. The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities. The consequences of inequality that mean a greater number of citizens require our services; this measure is expected to be next reported in 2024.

Quality Outcomes and Performance Summary

The outcome measures are being refined as part of the first year of the Duty of Quality and implementation of the quality strategy. Overall, the indicators show that the Health Board is making some progress in key areas. This first iteration has provided a good starting point to understand the quality of our services and the experiences of our patients. The QOF has been replicated for Q3 and will continue for Q4.

The new financial year and year two of the implementation plan will see the reporting structure being developed with the data, digital and technology team. This will enable automated reporting and the facilitate the development of a dashboard. The reporting format will mirror the new style Performance report for the Board following the iconography style of reporting. This will be a progressive step in building our quality management system, whilst still working in collaboration with planning and quality improvement.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Maternity Services Improvement Plan 2024-27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jayne Beasley - Head of Midwifery

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to advise on the Maternity Improvement Plan which aims to determine how Aneurin Bevan University Health Board maternity service will achieve high quality maternity care and details their approach to providing individualised care, reductions in health inequalities, improves, innovates and develops to meet the needs of those who access the service and those who work in it.

Cefndir / Background

Aneurin Bevan University Board maternity services serves a diverse population with high levels of socio-economic deprivation across a wide geographical area. Maternal deprivation is linked to disparities in health with 29.5% of Aneurin Bevan births being from the most deprived areas. In conjunction with levels of deprivation there is an increase in the complexity of women and babies, increasing births via caesarean section, rising rates of obesity, smoking, perinatal mental health and low levels of breast feeding are evident. Midwives are key to providing education, information and targeted intervention to increase life chances for babies and improve health outcomes and birth experience for women.

A number of key strategic reports have been developed to drive change to improve health, health outcomes and reduce inequalities, and to ensure safe practice is at the heart of health care. It is with these reports in mind that the maternity improvement plan has been developed.

- Maternity Care in Wales a 5-year vision 2019
- Healthier Wales 2018
- The maternity and neonatal safety programme 2022
- CNO priorities 2022-2024
- Nursing, Midwifery, SCPHN workforce strategy 2023-2026
- ABUHB IMTP
- Anti-Racist Wales by 2030 action plan Welsh Government
- 5 Year vision for breastfeeding

Asesiad / Assessment

The improvement plan details how care will be delivered through a number of key themes. Focussing on women babies and families through the life course, pregnancy, birth and the postnatal period, and on those that are working to provide care. The improvement plan includes a multidisciplinary review and this has been compiled into a priority plan, around improvement work, including timeframes covering a 3-year period 2024-2027.

Improvements and high-quality care will be delivered through several key themes:-

1) The Population – Women, Families and Babies
With a commitment to delivering improvements in antenatal care through targeted public health intervention, supporting choice, continuity and building.

2) Safe Effective Care
Maternity services will ensure a robust governance structure where continuous learning is in place to aid improved outcomes and multidisciplinary teams are work within a safe supportive working environment.

3) Workforce
We will commit to a positive work environment where a positive learning culture is fostered, whereby multi professional teams train and work in a culturally safe environment.

4) The Future of the Service
Maternity service will be involved in innovation improvement, research and development to ensure safe effective high-quality care.

Within these key themes are a number of work streams. The following table articulates a number of actions under specific work streams.

Workstream	No. of Actions
Antenatal Care	9
Public Health	7
Infant Feeding	8
Patient Experience	4
Governance	7

Bereavement care	4
Infection prevention	6
Training	8
Intrapartum care and birth	5
Culture	11
Staff development	5
Workforce	8
Digital technology	4
Pathways of care	4
Environment	2
Research and Development	3
Total	**95**

A number of these workstreams are already in progress for 2024 and form part of maternity services IMTP.

Argymhelliad / Recommendation

The Executive Team is asked to note the ongoing work to implement and embed improvements within maternity services.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 7.1 Workforce Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Workforce and Culture Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

ABUHB MATERNITY SERVICES IMPROVEMENT PLAN 2024-2027

WOMEN, FAMILIES AND BABIES

There will be a commitment to informed choice, respect and compassion in care provision for women and their families. Decision making, which places women, families and babies at the centre of care provision is paramount to building trusting relationships and empowering parents. Choice and personalised care will be provided according to women's need and wishes. Health promotion will be embedded through care to improve outcomes.

Maternity services will work in partnership with women and families, care will be personalised to provide women with choice and the ability to make informed decisions regarding their care.
We will commit to: -

- Providing choice
- for place of birth
- Providing excellent experience for women families and babies
- Supporting women to make informed choices, based on good quality information and the best available evidence.
- Improve women's health through public health messaging
- Safer pregnancy campaign
- Ensuring a positive care experience
- Improving equity of access and a reduction in health inequalities
- Working in co-production with other health professionals
- Acting on and seeking out feedback
- Working in line with maternity network re midwifery led care standards

Ante-Natal Care

Measurement of Success	Timescale Quarter	Year
Direct access to maternity service with 80% of women who will have been booked for their pregnancy by 10/40.	4	2024
100% of women are sign posted to Healthier together website.	2	2024

Early access to specialist antenatal care for women with underlying health conditions.	2	2024
Care will be delivered through a trauma informed model.	1	2024
Development and implementation of the Midwife led diabetes pathway for women with gestational diabetes.	1	2026
Increase scan capacity to ensure that all at risk women receive USS in line with GAP and GROW.	4	2025
100% of women are supported to write their birth plan.	1	2024
Adoption of the All-Wales Family Engagement Framework.	4	2024
Increase options for outpatient induction at all LGH sites.	4	2024
Public Health		
Measurement of Success	**Timescale Quarter**	**Year**
95% midwives will have completed MECC training.	3	2024
Encourage women to maintain a healthy lifestyle and offer all women who smoke specialist smoking cessation support, good quality health information prevention and promotion will be delivered via push notification and digital learning library.	1	2024
Delivery of brief advice/intervention by midwives to all pregnant women with a BMI of 25+ and weight management support for those women with a BMI 30-35. Specialist one to one support for those with a BMI greater than 35.	4	2025
Weight Management postnatal support groups.	4	2025
100% recording of CO2 monitoring.	4	2024
100% of eligible women offered/signposted vaccination.	3	2024
Increase volunteer service within black and Asian communities and learning from experience.	3	2025

Infant Feeding		
Measurement of Success	**Timescale Quarter**	**Year**
100% of women who feel that they require support after birth are offered a debrief - Women will have access to a consultant midwife or to the perinatal mental health service where their needs are more complex.	3	2024
All mothers and babies who are able will be kept together and ensuring skin to skin contact following birth.	4	2024
100% Women who wish to breast feed offered support to breast feed/ express within an hour of birth.	2	2024
Implementation of 3 tiers of support for infant feeding support There will be peer support groups in all areas and a champion team of midwives with additional skills in breastfeeding.	4	2025
5 midwives complete train the trainer BFI course.	4	2025
100% of women with GDM are offered support to harvest breast milk.	4	2024
Achieve Baby friendly accreditation.	3	2026
Establishment of Tongue Tie pathway with audit.	1	2025
Patient Experience		
Measurement of Success	**Timescale Quarter**	**Year**
Adoption of CIVICA across the service, measurement of patient experience through patient reported outcome measures.	4	2024
Inform all parents of babies who have died that a review will take place with feedback.	1	2024
Collaboration of maternity and neonatal voice partnership with a focus on health inequalities and ensuring that the voices of people with protected characteristics are represented. This will be achieved through formal MNVPs, BABI roadshow and the maternity volunteer service.	4	2025

The 30-day response times for formal concerns to increase to 80%, with majority of concerns responded to informally within 48 hours.	4	2024

SAFE & EFFECTIVE CARE

We will aim to deliver multi professional, timely, equitable, high-quality evidence-based care using continuous improvement as well as learning from concerns, incidents, trend's themes, experience and feedback.

Maternity services will ensure a robust governance structure where continuous learning is in place to aid improved outcomes and multidisciplinary teams are work within a safe supportive working environment. We will commit to: -

- Transparent governance system, with identification of themes and trends
- Evidence based learning culture
- A reduction in avoidable harm
- Standardised guidelines policies and processes
- Risk assessment during pregnancy
- Monitoring and fetal wellbeing
- MDT training incorporating human factors

Governance

Measurement of Success	Timescale Quarter	Year
Implementation of combined maternity and neonatal dashboard with accurate data reporting of real time clinical outcome measures.	4	2024
Thematic analysis of ATTAIN data and monthly shared learning through MDT perinatal meeting, reduction in term admissions.	4	2024
Dedicated governance team with allocated sessional time lead midwife, governance lead midwife, consultant and admin support.	3	2024
All investigators trained to undertake their roles.	4	2026

All adverse outcomes investigated sensitively within time frames and in collaboration with families.	3	2024
Adoption of the All-Wales Meows chart.	4	
Daily emergency equipment checks and fridge temperature compliance 100%.	1	2024
Bereavement		
Measurement of Success	**Timescale Quarter**	**Year**
MDT PMRT review for 100% of all stillbirths and all babies who died in the Health Board, to include external review.	4	2025
Ensure all women whose baby died unexpectedly are offered a post-mortem.	2	2024
90% MBRRACE reporting within 7 days.	1	2024
Adoption of the Bereavement care pathway.	4	2026
Infection Prevention		
Measurement of Success	**Timescale Quarter**	**Year**
WHO surgical safety lists completed for all surgical events.	2	2024
Reduction in SSI 4.5%.	4	2025
Implementation of caesarean section reducing SSI SOP.	1	2024
Cleaning hand hygiene audit 100% compliance.	1	2024
100% women informed hygiene and wound care.	2	2024
85% staff completed ICP training & ANTT.	4	2024
Training		

Measurement of Success	Timescale Quarter	Year
95% MDT Prompt training.	3	2024
Adoption of IFS standards with monthly MDT IFS training target 95% compliance.	3	2024
All midwifery staff working in intrapartum care trained in neonatal life support.	3	2024
80% community staff completed Level 3 safeguarding for community staff.	4	2025
85% all staff completed level 2 safeguarding.	3	2024
All midwives working in HDU undertaken critical care prompt.	3	2024
25% midwives able to undertake NIPE.	1	2026
All maternity staff receive perinatal mental health training.	3	2024
Labour and birth		
Measurement of Success	**Timescale Quarter**	**Year**
Optimisation of the pre term infant through commitment to Periprem and reduction in premature births.	3	2025
Induction of labour pathway to improve information, communication and reduce delays in transfer to labour ward.	4	2024
100% of women who have low risk for complications in labour are enabled to consider birth in any setting.	2	2024
There will be an additional option for pool birth in the alongside midwife led unit.	4	2024
Embed All Wales guidelines to include All Wales Normal labour pathway and the All-Wales Transfer Policy, through cascade training, teaching aids and training videos.	2	2025

OUR PEOPLE

We will continue to invest in our teams, enabling flexibility, developing skilled midwifery staff and leaders of the profession. There will be workforce planning and evidence-based tools to determine staff and appropriate skill mix to meet the needs of the population. Midwives will have continued professional development and specialist roles to develop practice. Support workers will be trained and supported to contribute to care.

Women are listened to and are central to care, listening to their experience will inform service change and delivery. This starts with prioritising staff wellbeing fostering a safe and caring culture within the work place. Maternity staff will feel valued and will work together to improve health and wellbeing.

We will commit to a positive work environment where a positive learning culture is fostered, whereby multi professional teams train and work in a culturally safe environment. Birth rate plus is the current tool utilised to assess appropriate midwifery staffing levels. In April 2023 an updated report concluded the following levels of staffing for The Grange University Hospital, community and outpatient services, Band 3-7 plus specialist midwives and management of 269.47 wte.

To note:

- The service has a 94/6% registered to non-registered staff which could be increased to 90/10% split for postnatal care
- There was a negative variance of – 0.51wte with traditional birth rate plus calculation this increased to 7 wte if calculating additional care provision for training student supervision and births outside of guideline
- Specialist and management roles should account for 26.7 wte the service has 18.6 a deficit of 8.1 wte
- There will be a sustainable workforce with appropriate staffing at all levels.

This will be evidenced by: -

- Psychological safe culture
- Emphasis on a positive health and wellbeing culture
- Create a culture that allows people to speak up
- Visible compassionate leadership
- Provide a positive learning environment
- Ensure staff health and wellbeing is embedded
- Health board values and behaviours
- Develop of new roles, flexible working patterns and career succession opportunity’s

Culture

Measurement of Success	Timescale Quarter	Year
Cultural competency accreditation.	4	2025
Implementation of Swartz huddles.	3	2024
Undertake a yearly psychological safety survey.	4	2026
95% maternity staff undertake civility saves lives training.	3	2024
Human factors incorporated into mandated training.	3	2024
4 hours mandated Clinical supervision for all midwives.	1	2024
Safeguarding supervision embedded into practice.	1	2025
Wellbeing peer supporters across all areas of the service.	1	2024
Refresh and revisit - Caring for you campaign.	2	2024
Succession planning and coaching sessions for all grades.	3	2026
Support flexible working arrangements.	1	2024
Development		
Measurement of Success	**Timescale Quarter**	**Year**
Band 7 and 8 development and support for leadership academy.	1	2024
100% preceptor midwives to undergo Once for Wales preceptorship programme.	3	2024
85% staff have a meaningful PADR, regular catch ups.	3	2024
100% staff have an exit interview.	4	2024

100% midwives have undertaken Student Supervision and Assessment training.	2	2025
Workforce		
Measurement of Success	**Timescale Quarter**	**Year**
Birth rate plus compliance.	1	2024
Workforce review of band 3 and 4 maternity support workers and skill mix to align with 90/10% skill mix split of registrants to non-registrants.	2	2025
Adoption of safe care to ensure maternity services aligns with health board re ward staffing levels.	3	2025
A review of the management structure to include Director of midwife consultant midwife and specialist midwifery team, to include succession planning.	4	2024
Review Band 6 to band 7 development into specialist roles.	2	2025
Supporting midwives with educational development BSc MSc.	1	2024
Improve recruitment experience, engagement in local community and schools, living the life of a midwife. Also encouraging a diverse workforce and dynamic future midwifery team through Living the Life of a midwife, attending open days and careers events and road shows	1	2024
Positive publicity and promotion of maternity services to reassure women and families like encouraging staff to submit abstracts for conferences, sharing good news stories etc.	1	2024

OUR FUTURE

Long term sustainable service will be achieved through transformation and quality improvement work. There will be an investment in technology to improve information, education and clinical care and outcomes.

Maternity service will be involved in innovation improvement, research and development to ensure safe effective high-quality care. We will commit to reduce the environmental impact of climate change to reduce emissions. We have an active maternity research service with dedicated research midwives and multiple open randomised control trials and observational studies. We will further embed research within maternity services and midwifery practice, to give all midwives the opportunity to participate in research and subsequently improve outcomes from women and families

We will endeavour to commit to: -

- Digital solutions to support staff to undertake their role
- Ensuring safe working environments
- Wellbeing hubs
- Data collection systems for visible timely learning
- Research and development
- Quality improvement programs
- Improve accuracy of information

Digital

Measurement of Success	Timescale Quarter	Year
Maternity records will be digitalised and embedded into practice.	4	2024
Bespoke reports will be available via Badgernet and real time accessible data collection.	4	2024
Digitalised central process for recording training.	1	2024
Implementation of safe care.	1	2024

Pathways of Care		
Measurement of Success	**Timescale Quarter**	**Year**
Improve assessment and triaging of women through the maternity triage unit use implement ISBOTS.	2	2025
Introduction of PLGF to reduce length of stay for women and experience for women with pre-eclampsia.	4	2026
Development of community HUBS in LGH in line with care closer to home for increase public health awareness.	2	2025
Review environmental footprint at GUH to support patient flow and discharge.	4	2024
Environment		
Measurement of Success	**Timescale Quarter**	**Year**
Ensure safer working environments through nitrous oxide destruction.	4	2024
Audit Entonox within the environment.	2	2024
Research & Development		
Measurement of Success	**Timescale Quarter**	**Year**
Dedication to research projects in collaboration with R&D.	1	2024
Quality improvement programmes embedded through service to address patient flow and pathway.	4	2024
Monthly QI and research forums embedded in practise and QI training incorporated into mandatory training study days.	4	2024

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

ABUHB Maternity Services

Improvement Plan

2024-2027

Supporting healthy pregnancies, improving maternity care and health outcomes

Important note: We recognise that not all pregnant people will identify as women. When referencing pregnant women throughout this document, this is intended to be inclusive of pregnant and birthing people of all genders.

Foreword

Pregnancy and birth are life changing events for women and their families. Evidence based, person centred, safe and high-quality care during pregnancy, birth and following birth can have a positive impact on the health and life chances of women and babies as well as the healthy development of children throughout life. This can help to reduce the impact of inequalities which can have long term health consequences for families, securing the best possible outcomes for mothers' babies and communities.

This document sets out the vision for achieving high quality maternity care in Aneurin Bevan University Health Board and details our approach to ensuring maternity service provides individualised care, reduces inequalities, improves, innovates and develops to meet the needs of those who access our services and those who work in it.

The Maternity Plan aligns to: -

01 Maternity Care in Wales 5-year Vision 2019

02 Health Wales 2018

03 The Maternity & Neonatal Safety Programme 2022

04 CNO priorities 2022-2024

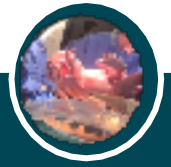
05 Nursing, Midwifery, SCPHN Workforce Strategy 2023-2026

06 ABUHB IMTP

07 Anti-Racist Wales by 2030 Action Plan, Welsh Government

Introduction

Aneurin Bevan University Health Board Maternity Service provides care during pregnancy, birth and the postnatal period for approximately 6000 women and their families per year. All 4 choices for birth are offered, to include home, freestanding birth unit, alongside midwife led unit and obstetric unit, whilst outpatient services are provided in the Local General Hospitals in line with care close to home.



GRANGE UNIVERSITY HOSPITAL

- Obstetric Unit
- Triage
- High Dependency
- Bereavement Room
- Antenatal & Postnatal Ward
- Midwife Led Unit
- Elective and Emergency Theatres
- Induction Ward

YSBYTY YSTRAD FAWR YSBYTY ANEURIN BEVAN

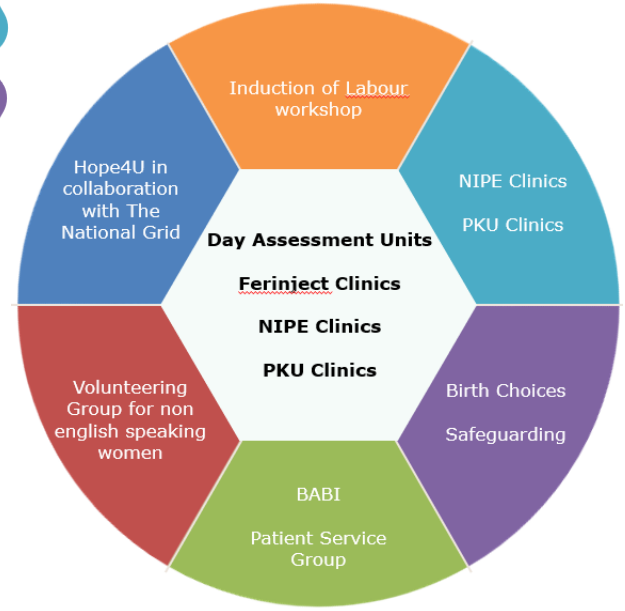
- Midwife Led Birthing Unit
- Outpatient Services

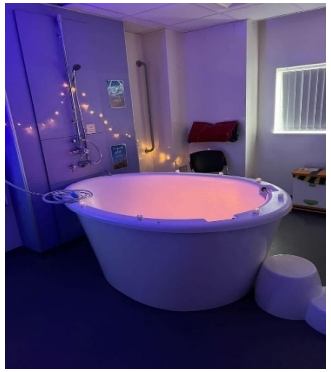
ROYAL GWENT COUNTY NEVILL HALL HOSPITALs

- Outpatient Services
- Community Hubs

What do we provide at ABUHB	Which Hospital site is this offered
Routine Antenatal Clinics	NHH, RGH, County, YAB, YYF
Fetal Medicine Clinics	NHH, RGH
Haematology Clinics	NHH, RGH,
Diabetes Clinics	NHH, RGH, YYF
Sonography Clinics	NHH, RGH, County, YAB, YYF
Epilepsy Clinics	NHH, RGH,
Weight Management Clinics	NHH, RGH, YYF, YAB, County
Perinatal Mental Health Clinics	YYF
Asthma Clinic	RGH
Obstetric Anaesthetic clinic	RGH, NHH
Substance Misuse Clinics	NHH, RGH
Smoking Cessation	NHH, RGH, County, YAB, YYF
Debrief rewind service	Virtual and Face-to-Face
Glucose Tolerance Test (GTT) & Anti D clinics	NHH, RGH, County, YAB, YYF
Maternal Medicine Clinics	NNH, RGH, YYF
FGM Clinic	RGH

Outpatient Services





Acute Services

Emergency Theatres

Elective Theatres

High Dependency Unit

Triage

Alongside Birth Centre

Induction of Labour Ward

Antenatal Ward

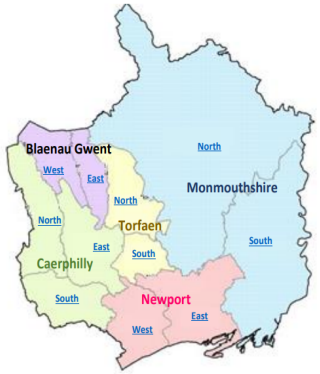
Postnatal Ward

Post-op Ward

Free Standing Birth Centre and POD

Population

The total population in the Health Board catchment areas is 591,396 people. Those eligible to access Maternity Care ages: -

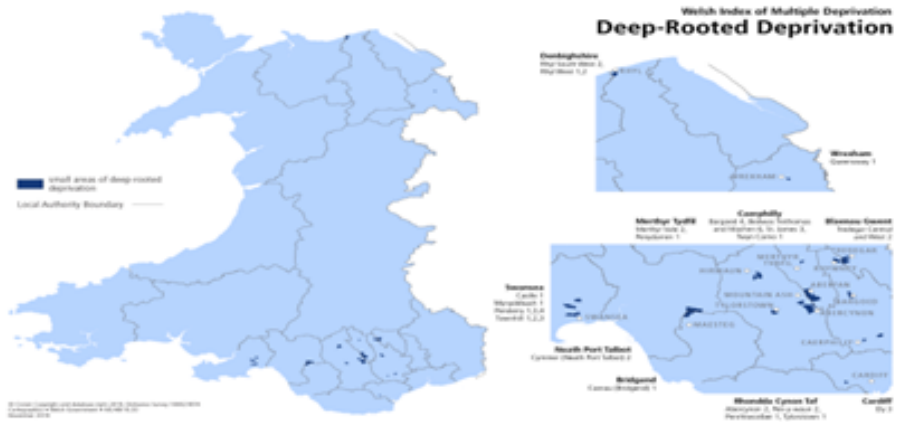


Age 16-25 = 53,384
Age 25-44 = 84,234

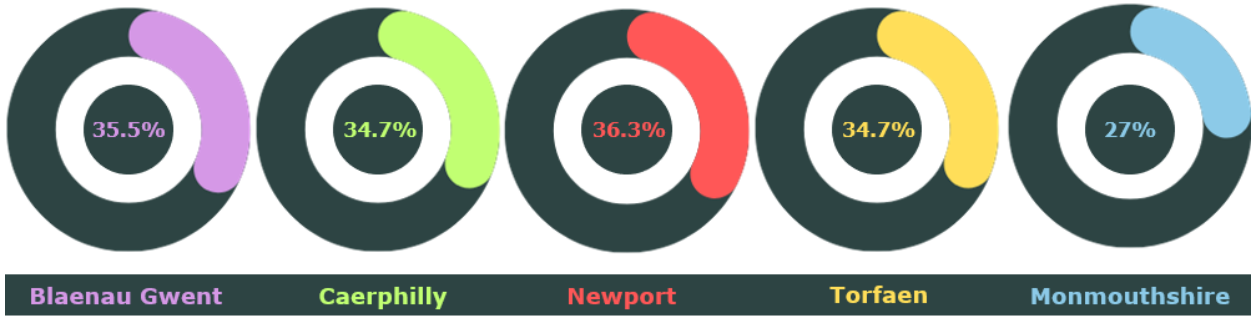
Caerphilly	170,615	169,546	178,782	177,610	177,277	176,735	176,805	175,999	176,130
Blaenau Gwent	72,666	70,000	68,812	67,829	67,566	67,382	67,219	66,989	67,014
Torfaen	90,961	90,912	91,190	90,638	91,130	91,685	92,337	92,454	92,860
Monmouthshire	80,209	84,984	91,508	91,791	91,834	91,370	92,456	93,163	93,886
Newport	135,479	137,642	145,785	153,234	155,222	156,773	158,438	159,687	161,506

Deprivation

Aneurin Bevan University Board serves a diverse population with high levels of socio-economic deprivation across a wide geographical area. Maternal deprivation is linked to disparities in health and an increased risk of adverse maternal and perinatal outcomes. 29.5% of Aneurin Bevan births are from the most deprived areas compared to a UK average of 20%.



Areas shown on the map with deep deprivation in our catchment locality.



Deprivation is linked to: -

- Substance and alcohol misuse
- Raised safeguarding problem
- Increased BMI, and poor nutrition
- Mental Health problems

Risk Factor	Preconceptions+	In Pregnancy	
		Early	Late
Tobacco Smoke	✓	✓	
Bacterial Vaginosis		✓	
Young Maternal Age	✓	These factors can only be impacted preconception	
Birth Interval	✓		
Periodontal Infections	✓	✓	
Sexually Transmitted Infections	✓	Little evidence on intervention available	
Low/High BMI	✓		
Nutrient Deficiency	✓	✓	
+ Preconception intervention includes postnatal interventions within an inter-pregnancy period			

Midwives are key to providing intervention over the life course.

Maternity Services has specialist midwives in place to support families to provide safe and effective care. With their professional knowledge and guidance, they encourage and improve wellbeing before, during and after pregnancy, relating to all public health indicators.

- Public Health Lead Midwife & Lead for Substance Misuse
- Perinatal Mental Health Lead Midwife
- Safeguarding Lead Midwife
- Breastfeeding Midwife

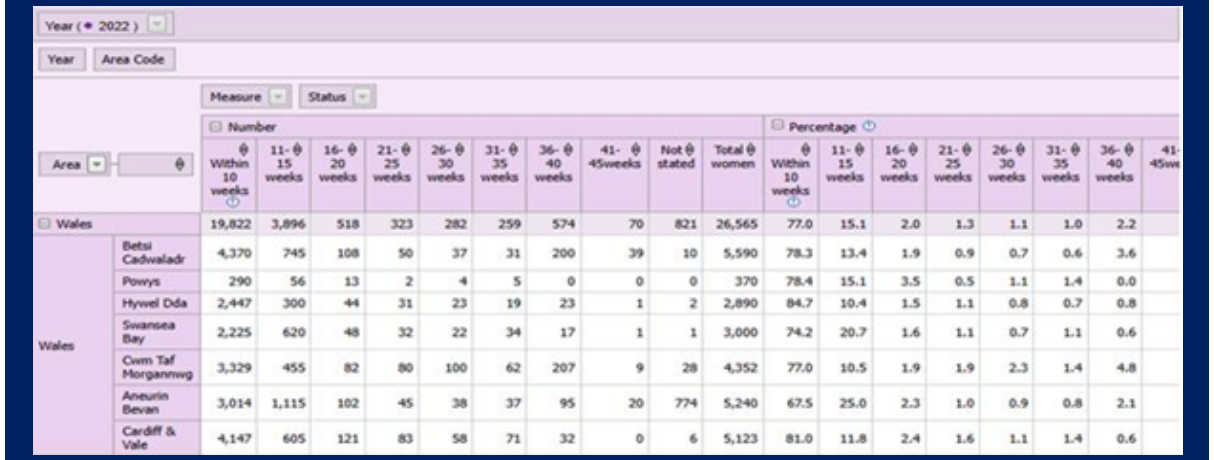
Public Health Data ABUHB 2022

Smoking	15.1%
Body Mass Index >35	14.4%
Alcohol Substance Misuse	0.6%
Mental Health – Referral for PNMH	4.5%
Low Birth Weight Babies	6.1%
Breastfeeding	10 days: 47% 6 months: 17%

Summary of Statistics from Antenatal Care

Initial Assessment/Bookings

The percentage of pregnant women receiving their initial assessment by their 10th completed week of gestation decreased by four percentage points in 2022, falling from 71.5% to 67.5%. The percentage was lower for women in the youngest and oldest age groups.



Year (2022)

Year | Area Code

Measure | Status

Area		Number										Percentage							
		Within 10 weeks	11-15 weeks	16-20 weeks	21-25 weeks	26-30 weeks	31-35 weeks	36-40 weeks	41-45weeks	Not stated	Total women	Within 10 weeks	11-15 weeks	16-20 weeks	21-25 weeks	26-30 weeks	31-35 weeks	36-40 weeks	41-45we
Wales		19,822	3,896	518	323	282	259	574	70	821	26,565	77.0	15.1	2.0	1.3	1.1	1.0	2.2	
Wales	Betsi Cadwaladr	4,370	745	108	50	37	31	200	39	10	5,590	78.3	13.4	1.9	0.9	0.7	0.6	3.6	
	Powys	290	56	13	2	4	5	0	0	0	370	78.4	15.1	3.5	0.5	1.1	1.4	0.0	
	Hywel Dda	2,447	300	44	31	23	19	23	1	2	2,890	84.7	10.4	1.5	1.1	0.8	0.7	0.8	
	Swansea Bay	2,225	620	48	32	22	34	17	1	1	3,000	74.2	20.7	1.6	1.1	0.7	1.1	0.6	
	Cwm Taf Morgannwg	3,329	455	82	80	100	62	207	9	28	4,352	77.0	10.5	1.9	1.9	2.3	1.4	4.8	
	Aneurin Bevan	3,014	1,115	102	45	38	37	95	20	774	5,240	67.5	25.0	2.3	1.0	0.9	0.8	2.1	
	Cardiff & Vale	4,147	605	121	83	58	71	32	0	6	5,123	81.0	11.8	2.4	1.6	1.1	1.4	0.6	

Obesity

Close to a third of pregnant women were classed as obese by their BMI score at initial assessment. This proportion has increased every year since data was first collected in 2016 and was similar for all age groups between 20 to 24 and 45 or older.

The percentage of obese pregnant women at initial assessment from Black or White ethnic backgrounds was close to double the percentage of obese pregnant from Asian backgrounds. Just over a quarter of all women gained the recommended amount of weight during pregnancy, based on their BMI group at initial assessment.

Percentage of Women with a BMI of 30+ at initial assessment, by individual Health Board 2022

Measure | BMI Group

Area		Number						Percentage					
		BMI 10 <= 18.5	BMI 18.5 < 25	BMI 25 < 30	BMI 30+	Not stated	Total women	BMI 10 <= 18.5	BMI 18.5 < 25	BMI 25 < 30	BMI 30+	Not stated	Total women
Wales		491	8,704	6,625	7,132	589	23,541	2.1	37.9	28.9	31.1	2.5	
Wales	Betsi Cadwaladr	121	1,951	1,400	1,555	58	5,085	2.4	38.8	27.8	30.9	1.1	
	Powys	4	141	103	93	0	341	1.2	41.3	30.2	27.3	0.0	
	Hywel Dda	63	1,018	765	778	112	2,736	2.4	38.8	29.2	29.6	4.1	
	Swansea Bay	52	1,049	798	854	62	2,815	1.9	38.1	29.0	31.0	2.2	
	Cwm Taf Morgannwg	56	1,167	1,011	1,372	161	3,767	1.6	32.4	28.0	38.0	4.3	
	Aneurin Bevan	89	1,518	1,156	1,244	70	4,077	2.2	37.9	28.8	31.0	1.7	
	Cardiff & Vale	106	1,860	1,392	1,236	126	4,720	2.3	40.5	30.3	26.9	2.7	

Smoking

The percentage of pregnant women recorded as smokers at initial assessment and birth decreased slightly in 2022 to their lowest levels on record. Just over a quarter 'stopped smoking' between their initial assessment and birth, also the highest on record. However, during COVID 19 smoking data has been self-reported rather than tested through a carbon monoxide test, from 2022/2023 onwards carbon monoxide monitoring has been reinstated.

Smoking rates at both initial assessment and birth decreased as the mother's age group increased. Rates were also markedly higher in mothers from White and Mixed ethnic backgrounds, with very few mothers from Black or Asian backgrounds recorded as smokers.

Summary of Statistics from Antenatal Care

Smoking

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Number and percentage of women who 'stopped smoking' during pregnancy, by health board providing the service 2022

Area		Number				Percentage			
		Mental health condition reported	Mental health condition not reported	Not stated	Total women	Mental health condition reported	Mental health condition not reported	Not stated	Total women
Wales		4,808	11,119	696	16,623	30.2	69.8	4.2	.
Wales	Betsi Cadwaladr	.	.	.	.	.	.	.	.
	Powys	95	266	9	370	26.3	73.7	2.4	.
	Hywel Dda	795	1,885	210	2,890	29.7	70.3	7.3	.
	Abertawe Bro Morgannwg	.	.	.	.	.	.	.	.
	Swansea Bay	1,123	1,778	99	3,000	38.7	61.3	3.3	.
	Cwm Taf	.	.	.	.	.	.	.	.
	Cwm Taf Morgannwg	.	.	.	.	.	.	.	.
	Aneurin Bevan	1,212	3,693	335	5,240	24.7	75.3	6.4	.
	Cardiff & Vale	1,583	3,497	43	5,123	31.2	68.8	0.8	.

Mental Health

Three out of ten pregnant women reported a mental health condition at initial assessment. Younger pregnant women were more likely to report a mental health condition than older pregnant women.

The percentage of pregnant women from Mixed ethnic backgrounds and White ethnic backgrounds reporting a mental health condition was more than three times higher than pregnant women from Black or Asian ethnic backgrounds.

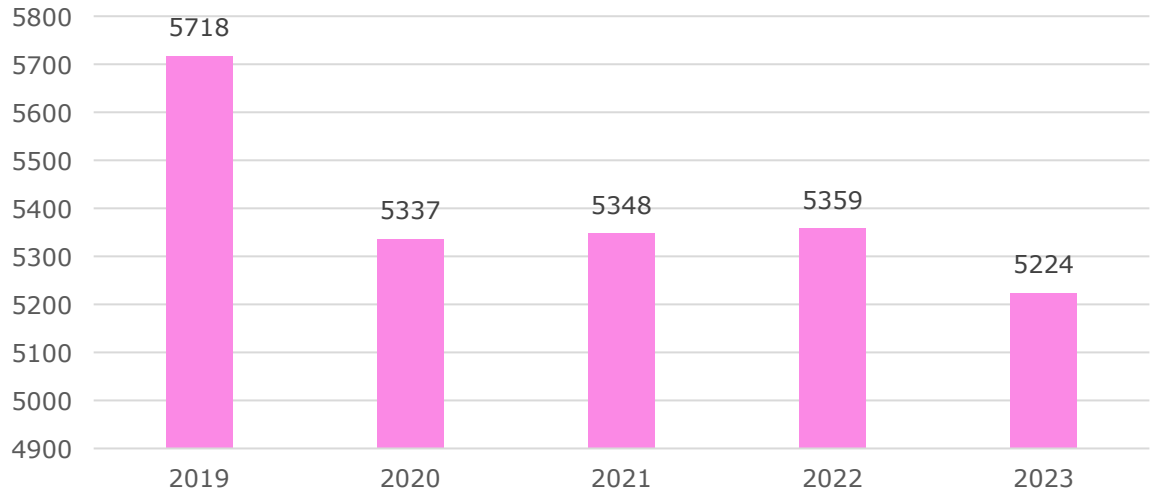
Number and percentage of women at initial assessment who had reported a mental health condition, by Health Board providing the service 2022

Area		Number				Percentage			
		Mental health condition reported	Mental health condition not reported	Not stated	Total women	Mental health condition reported	Mental health condition not reported	Not stated	Total women
Wales		4,808	11,119	696	16,623	30.2	69.8	4.2	.
Wales	Betsi Cadwaladr	.	.	.	.	.	.	.	.
	Powys	95	266	9	370	26.3	73.7	2.4	.
	Hywel Dda	795	1,885	210	2,890	29.7	70.3	7.3	.
	Abertawe Bro Morgannwg	.	.	.	.	.	.	.	.
	Swansea Bay	1,123	1,778	99	3,000	38.7	61.3	3.3	.
	Cwm Taf	.	.	.	.	.	.	.	.
	Cwm Taf Morgannwg	.	.	.	.	.	.	.	.
	Aneurin Bevan	1,212	3,693	335	5,240	24.7	75.3	6.4	.
	Cardiff & Vale	1,583	3,497	43	5,123	31.2	68.8	0.8	.

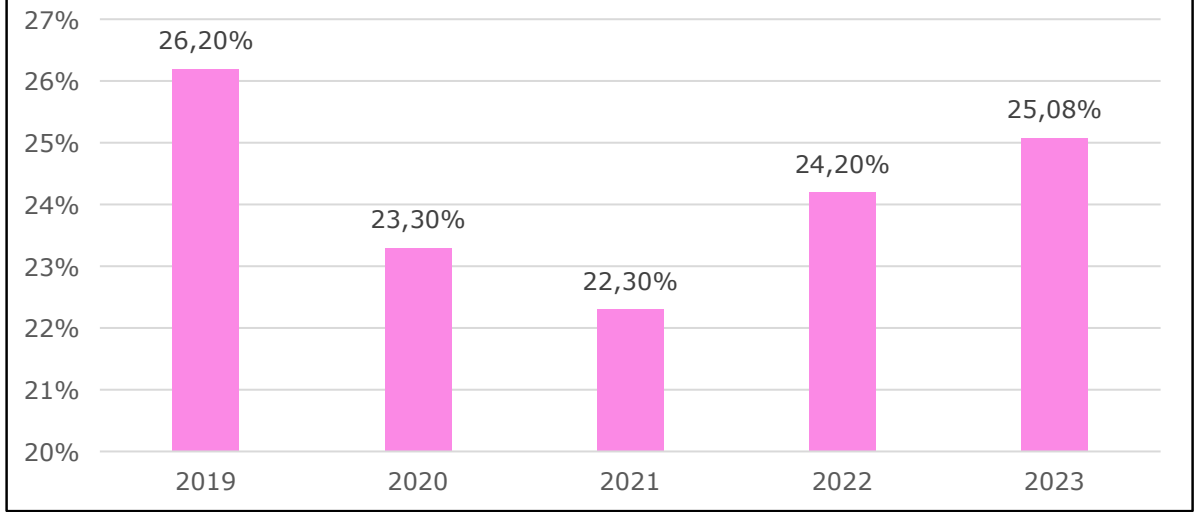
Summary of Statistics for Labour and Births

- Fewer than half of labours began spontaneously in 2022, continuing the longer-term downward trend.
- An epidural was administered in just under a quarter of all births.
- A third of babies were born via caesarean section, the highest percentage on record. One in five born via emergency caesarean section and close to one in seven arrived via elective caesarean section.
- The number of live births decreased, in 2022, there were 15% fewer singleton live births and 39% fewer multiple (twins and triplets) births than there were ten years prior.
- 9 out of 10 births were from White ethnic backgrounds, a decrease by 2 percentage points from five years ago. Percentage of births from Black and Asian ethnic backgrounds has increased by 0.8 and 0.6 percentage points respectively, over the same period.
- The percentage of younger mothers birthing in the year continued to fall, and just over half of all mothers birthing in the year were aged 30 or older. There were more mothers birthing aged between 35 and 39 than there were aged 20 to 24 for the second year in a row.
- Close to one in fifty births were at home in 2022, the lowest proportion of home births since 2002.
- Close to one in twelve births arrived pre-term. This proportion has been largely unchanged for the past seven years.
- The percentage of low birthweight babies increased slightly to 6.1%. While there are year-to-year variations, this percentage has been on a marginal upward trend over the past eight years. A slightly higher percentage of female babies had low birthweights than males.
- The average birthweight for a singleton birth was a little more than one kilogram heavier than a multiple birth. Just over half of births at gestations between 32 and 36 completed weeks had low birthweight, compared to 3% of births at gestations between 37 and 41 completed weeks.
- While it is expected that a higher percentage of births from women of Asian ethnic backgrounds would have low birthweight compared to other ethnic groups, the percentage of low birthweight babies from Asian backgrounds increased to its highest rate on record, while rates for all other ethnic groups remained broadly in line with longer-term trends.

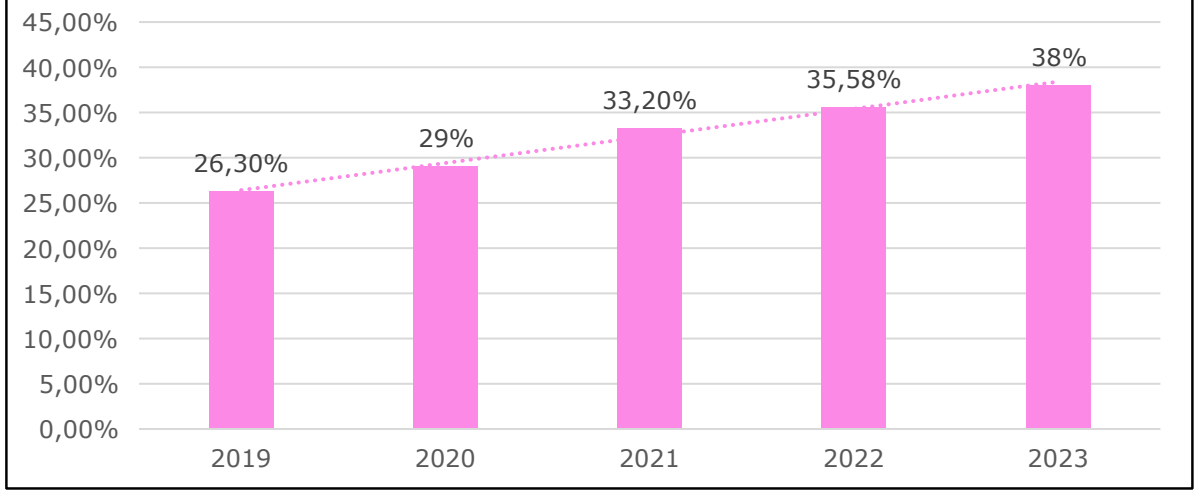
Total Births 2019 - 2023



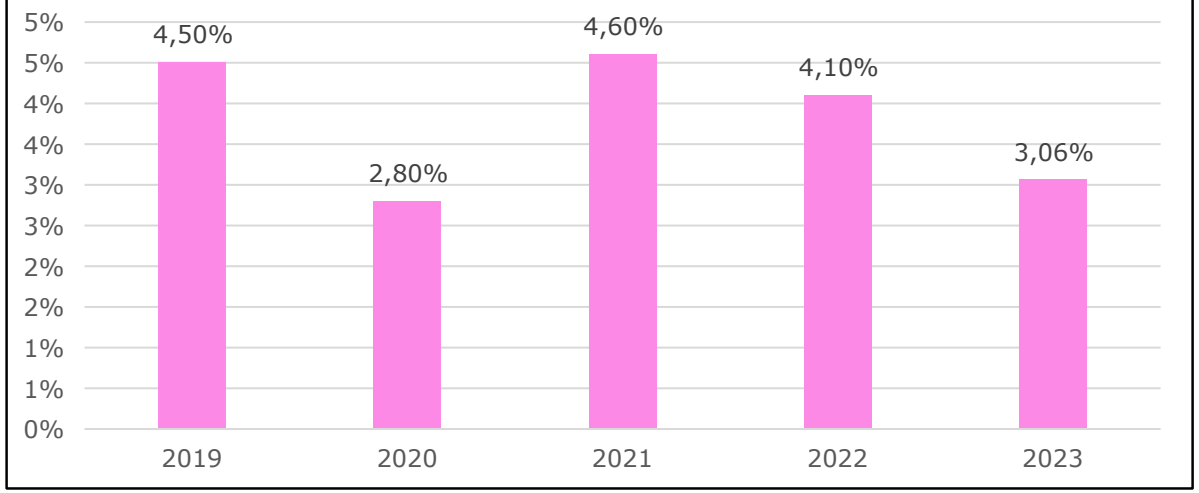
Total % of IOL's 2019 - 2023



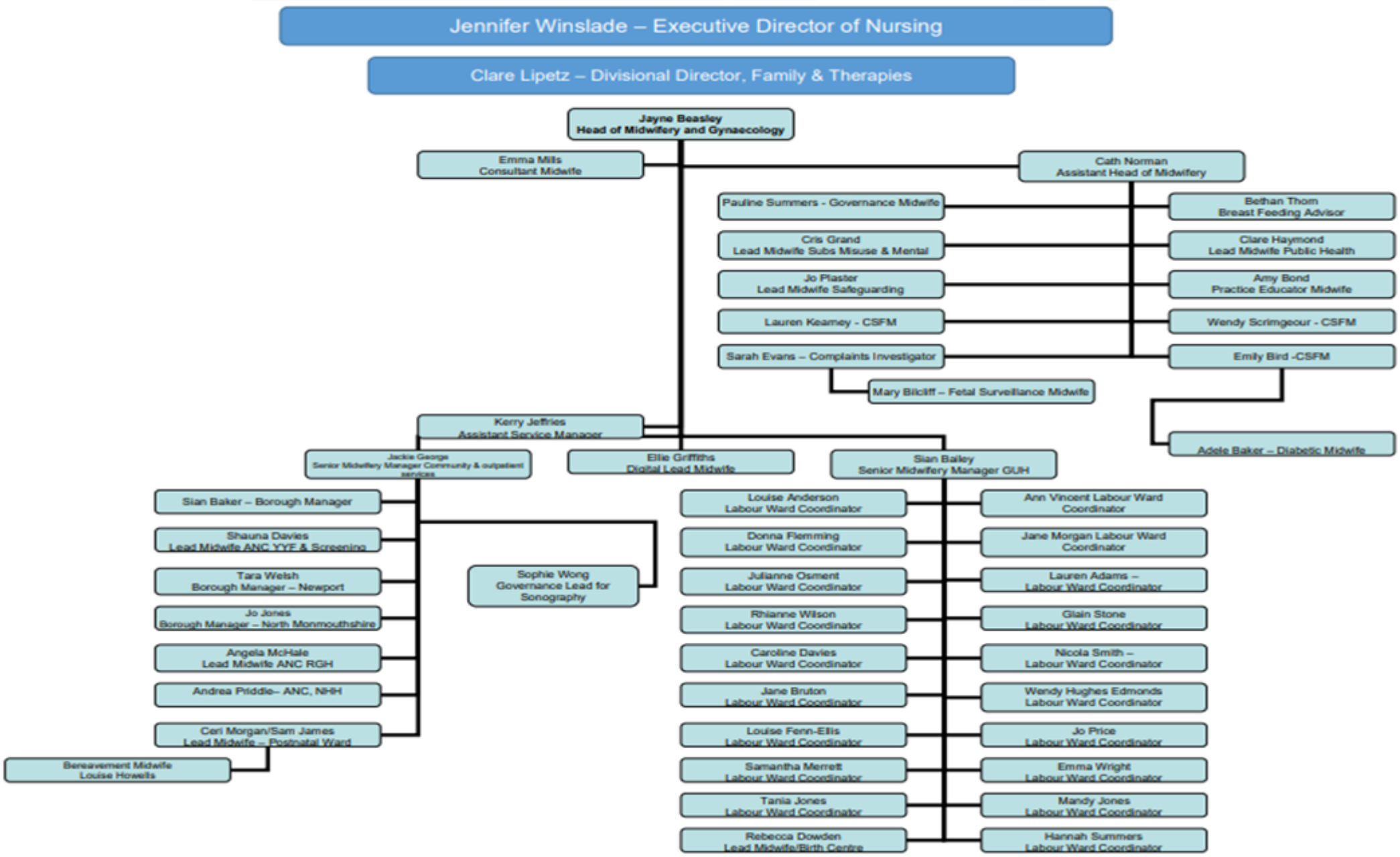
C Section Rates 2019 - 2023



Total % of IOL's 2019 - 2023



Our Structure



Delivering the Vision, our Aims…

We believe that every child deserves the opportunity to have the very best start in life. Early childhood experiences, including before birth, are key to ensuring improved health outcomes, better learning, access to good work and a fulfilled life. To deliver this priority, we will challenge traditional practices, introduce new ways of working and forge greater alliances with local authorities and the third sector.

GOOD HEALTH IN PREGNANCY

- Increase in successful births to healthy babies including reduction in miscarriages, premature births and low birth rates

MIDWIFERY AND NEONATAL SERVICES

- Promoting and encouraging normal births wherever safe and practical and reduce use of induction of labour and caesarean intervention

HEALTHY CHILD WALES PROGRAMMES

- Improved access to breastfeeding and nutrition support
- Establishing fully integrated working between midwifery, health visiting, school nursing and Flying Start teams

CHILDHOOD IMMUNISATION

- Improved uptake and compliance with national measures to achieve population immunity

Women, Families and Babies

There will be a commitment to informed choice, respect and compassion in care provision for women and their families. Decision making, which places women, families and babies at the centre of care provision is paramount to building trusting relationships and empowering parents. Choice and personalised care will be provided according to women's need and wishes. Health promotion will be embedded through care to improve outcomes.

Safe and Effective Care

We will aim to deliver multi professional, timely, equitable, high-quality evidence-based care using continuous improvement as well as learning from concerns, incidents, trend's themes, experience and feedback.

Our People

We will continue to invest in our teams, enabling flexibility, developing skilled midwifery staff and leaders of the profession. There will be workforce planning and evidence-based tools to determine staff and appropriate skill mix to meet the needs of the population. Midwives will have continued professional development and specialist roles to develop practice. Support workers will be trained and supported to contribute to care.

Women are listened to and are central to care, listening to their experience will inform service change and delivery. This starts with prioritising staff wellbeing fostering a safe and caring culture within the work place. Maternity staff will feel valued and will work together to improve health and wellbeing.

Our Future

Long term sustainable service will be achieved through transformation and quality improvement work. There will be an investment in technology to improve information, education and clinical care and outcomes.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Evaluation of the Configuration of Midwife Led Birthing Units
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jayne Beasley - Head of Midwifery

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to advise on the evaluation in respect of the reconfigured Midwife led birthing units within the Health Board.

The service instigated agreed temporary changes in May 2022 as a direct result of significant staffing challenges to ensure safe staffing levels across the Health Board. The subsequent completion of an independent review of the community-led midwife birthing services and following a comprehensive public engagement exercise in September 2023 Board approval was given to support the permanent service reconfiguration.

Cefndir / Background

Despite evidence to support the safety of midwife led births, there has been under-utilisation of the free-standing midwife led units in Aneurin Bevan University Health Board compared to the initial clinical futures modelling, with most women choosing to birth in the alongside midwifery led unit at the Grange University Hospital. In the context of this trend and as a result of significant challenges in securing midwives across the service, temporary changes to the midwifery-led units were instigated May 2022, to include:

- Temporary closure of the birthing units at Nevill Hall (NHH) and Royal Gwent (RGH) Hospitals.

- Maintenance of home births and births at Ysybty Aneurin Bevan (YAB) birthing pod with a risk assessment to be undertaken on a case-by-case basis.
- Conversion of Ysbyty Ystrad Fawr (YYF) to be staffed 9-5 operating as a POD overnight (instead of staffed 24/7).
- Incentivised bank pay.

In addition, an independent review of the Community Midwife Led Services at Aneurin Bevan University Health Board was commissioned to consider the current provision and to identify the most effective long-term staffing model for Free Standing Midwife Unit (FMU) birth and Midwife Led Care, considering the geographical area and within a framework of safe and good quality care, whilst maintaining the principle of choice.

Details of the review and recommendations were set out in a paper brought to Board in January 2023. In summary four options for future service configuration were set out as follows:

1. Retaining the existing temporary arrangements as the permanent model
2. Reverting to the arrangements in place before the temporary change
3. A 'hybrid' model whereby the units at RGH and NHH remained closed, but with extended facilities at YYF
4. A more radical long-term option consisting of the existing units at the Grange University Hospital (GUH), supported by community services and home birth options

The preferred option was option 1; to make permanent the current temporary arrangements as set out above, supported by the full consultant-led obstetric unit and alongside midwifery-led unit at GUH.

Whilst accepting the case for this preferred option, the Health Board recognised the need for a comprehensive communication and public engagement exercise prior to any final decision regarding a permanent change, which also included a staff engagement exercise.

It was concluded that the proposed permanent arrangements constitute the best balance between local accessibility and service safety / sustainability, maintaining all birth options around Gwent and surrounding areas and minimising the incidence of additional travelling requirements.

In September 2023 following board approval the changes, as per option 1, were made permanent.

Asesiad / Assessment

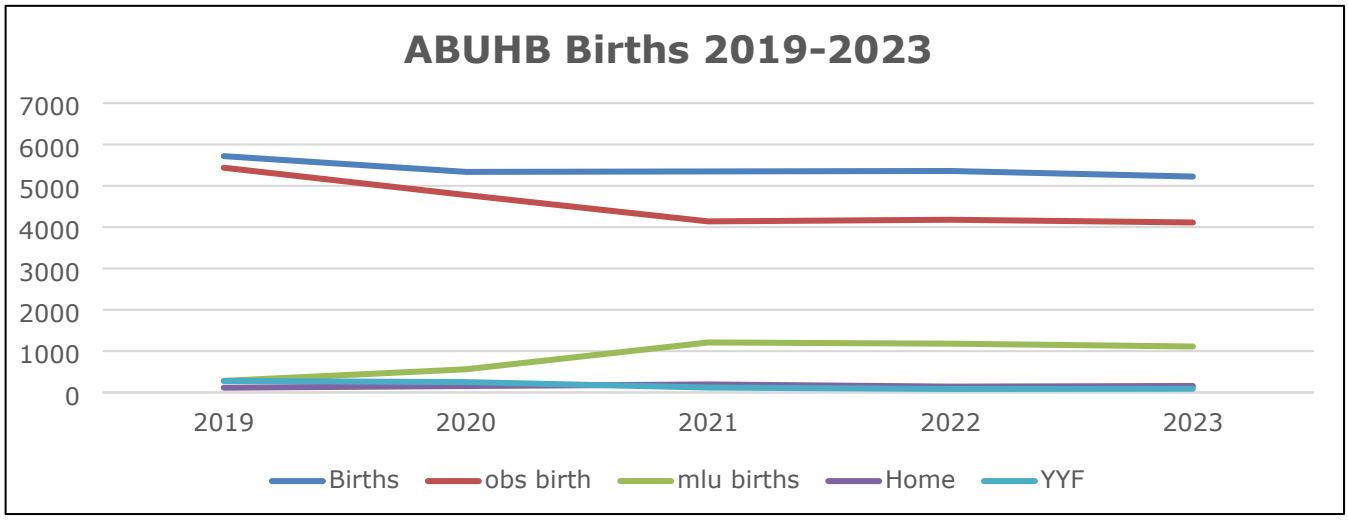
Since May 2022 the service has operated the freestanding birthing units in alignment with:

- Closure of NHH and RGH birthing units
- YAB operating as POD
- YYF staffed 9-5 operating as a POD overnight

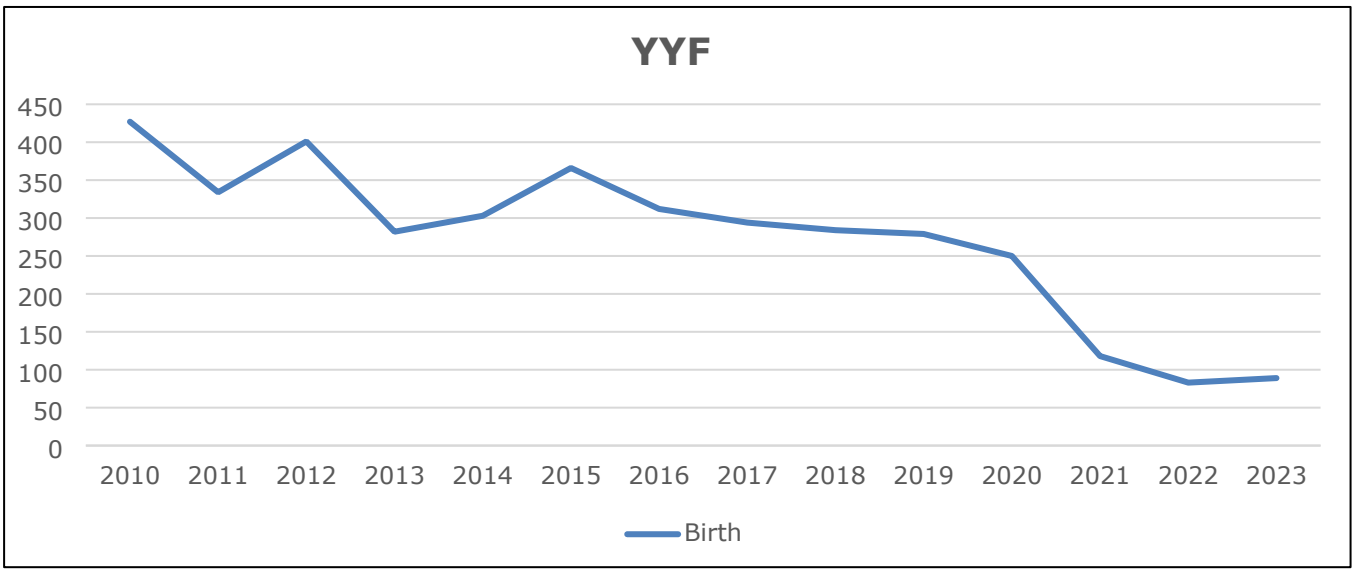
This model was made permanent September 2023.

Births

The current model of care provides four places for birth, to include home, freestanding, alongside birthing unit and an obstetric unit birth.



- Overall, the fall in birth rate is in line with the national picture.
- Decrease in obstetric led birth: expected as a consequence of the amalgamation of services to GUH.
- Overall increase in MLU births from 2021: reflection of better reporting of births in the alongside midwife led units. 840 births in 2021, 931 births in 2022 and 890 births in 2023.
- Static home births
- No overall increase in births at GUH though normal variation has been noted, in keeping with booking numbers.
- Reduction in options for water birth – costing for transfer of pool to GUH agreed
- Overall fall in YYF births – now appears stable 80-100 per year.
- Static births for YAB



Outcomes

- Families living near to GUH, YAB and YYF continue to have birth options closer to home.
- 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.
- No informal or formal concerns raised regarding inability to birth in RGH/NHH
- No informal or formal concerns regarding changes to YYF
- No increase in unexpected/unplanned births before arrival
- Incidents reported between 2022 and 2024 in relation to birth at the midwife led units:

- One woman contacted the birthing unit at GUH and advised to attend, however attended YYF. This lady attended in advanced labour, could not gain access to the unit at YYF as she attended out of hours and birthed in the car park.

  On investigation it was noted that the Midwife had not confirmed which birthing unit the lady was requesting to attend. This incident was discussed with midwives at the birth unit in GUH and learning initiated to ensure the exact place of birth is confirmed when women contact the unit, to ensure a midwife is in attendance. No further incidents reported since.

- A woman attended YYF in advanced labour, this was not the planned place of birth, due to the quick nature of the birth it was unsafe to transfer her. She was identified as having group B strep and required transfer with her baby after birth, no harm occurred.

- A women presented to MIU in advanced labour and proceeded to birth, midwife called to attend, no harm occurred.

- A woman attended RGH with pain and was noted to be premature gestation. There was a discussion with GUH regarding transfer however 999 ambulance was not called. Consequently, the birth of a premature baby occurred at RGH.

  As a consequence of this incident advice was shared with the LGH A&E/ MAU departments to inform them that pregnant women with pain should be considered to be in labour and transferred to GUH immediately.

Transfer Rates YYF

National average transfer rate from free standing birth unit is 36-45% for first time mothers and 9-12% for women who are having subsequent births. Increase noted in August 2022, but overall in line with national picture.

Finances

There has been no financial change since the reconfiguration of the midwife led birthing units. Royal Gwent and Nevill Hall birth units were never staffed 24/7 and operated as a birthing pod. Women only attended in labour and the on-call midwife would attend. These areas have been retained as antenatal postnatal hubs for provision of community care, antenatal education and parentcraft, YOGA, assessment, neonatal checks and clinics, baby weights, heel prick clinics and baby massage. Collaborative work is ongoing with health visiting services.

YYF is no longer staffed overnight which has seen a reduction in variable pay.

2021/22 total pay costs circa 1.4 including bank pay 75k.
2022/23 total pay costs circa 1.36 including bank pay 30k.

Staffing

The service has actively and successfully recruited during 2023 which has resulted in a significant decrease in vacant posts. Additionally, 2 new midwives have joined the community midwifery team.

2023	Head Count	WTE	Comment
Streamlining 2023	20	16.4	29 commissioned offered FT hours - commenced October 9th 2023
Band 5 M/W	8	8	3 to commence January 2024
Band 6	2	2	Start date October 2023 YYF and March 2024 Abergavenny community
Band 7	3	3.8	Start date October 2023 and January 2024
Band 4	1	1	Commenced December 23
HCSW		6.4	
Total registrant recruitment		29.2	
Increased Hours registrants		1.56	

Vacancies remaining		
Midwives Band 5/6	3	Interviewed 9 m/w - Jan 24- filled vacancies await start date
Band 7	1	Out to Trac
RGN	1.36	To readvertise
HCSW	1.6	To readvertise
Total registrant vacancies remaining	5.36	Anticipated that these hours will be filled by March 2024

- Staffing levels improved across all areas
- Maternity leave: 12.8 WTE
- Sickness: 6.01%, short term sickness has increased at GUH
- Community Midwives report improved work life balance
- Improved continuity and time for safeguarding cases
- Community midwives increase in hours as a result of 10-hour shift introduction
- No issues raised regarding reconfiguration of Midwife led birthing unit
- Escalation utilised when acuity elevated in GUH, monitored by senior team

No concerns have been raised in relation to the increase of community midwives into GUH to support.

Argymhelliad / Recommendation

The Executive Team is asked to note the evaluation of the reconfiguration of the midwife led units which offers a sustainable option for birth for women and families, offering a suitable and effective working environment for community midwives.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 7.1 Workforce Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Workforce and Culture Choose an item. Choose an item.

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal Audit Review – Medical Devices – Action Plan Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr Director of Therapies & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis Assistant Director for Quality and Patient Safety Richard Stubbs Risk Manager, Quality and Patient Safety

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper outlines the risks associated with the current governance arrangements for the management of medical devices and equipment within the Health Board.

In 2017/2018, the Health Board was provided with limited assurance following an internal audit that was undertaken. This position remained the same in June 2022, following an update on findings for the high priority level recommendations, with an acknowledgement that the risks outlined were continuing to be managed by the Medical Device Committee (MDC). NHS Wales Shared Services Partnership's (NWSSP) Audit and Assurance Services are currently undertaking a new Internal Audit on Medical Equipment & Devices. The report is expected in January 2024.

The Health Board has been challenged in achieving compliance with the two high level 2017/2018 Audit recommendations relating to the presence of a medical

devices and equipment register and its functions relating to the physical tracking of devices, and to assurance of safe medical device user training levels. The Health Board can demonstrate a baseline level compliance with many of the described sub-factors, however, there have been barriers to timely mitigation of key residual risks that support moving to a structured corporate framework for governance of medical devices and equipment devices in line with models adopted in other exemplar organisations.

The Executive lead for medical devices and equipment is the Clinical Executive Director of Therapies and Health Science. However, the management of devices, which often sits within a dedicated clinical engineering department in organisations of comparable size, is being shared across multiple stakeholders.

The MDC, chaired by an Assistant Director of Therapies and Health Science, was re-established in 2019. The Medical Director's Quality and Patient Safety (QPS) Risk Management team oversees regulatory compliance concerning medical devices and its clinical intersect. There is also a Medical Electronics / Electronics and Biomedical Engineering (EBME) department managed by Facilities that undertake the operational tasks of medical equipment lifecycle management.

The current internal audit in progress will aid a concurrent scoping exercise under the MDC to understand the wider gaps in assurance which will better define the existing structures in place around health technology governance, in particular relating to medical devices and equipment. Part of this work involves comparing these against the governance and device management arrangements in exemplar institutions. The combined results will inform discussion on possible approaches towards mitigating the gaps identified.

Cefndir / Background

Health Technology sits at the interface between high -end science and medicine. It encompasses medical devices and equipment that are both systemic and essential in healthcare delivery.

Safe, effective and appropriate use of Health Technology requires multi-professional expertise with systematic centralised oversight. This requires high level-professionally assured leadership interlocked with appropriate operational structures to connect the expertise base with the clinical workstream[1].

Health Technology poses a multitude of risks that require expert control. Protection of the public is assured through appropriate training and Regulation of the professionals involved. These individuals have the credentialled clinical and engineering skills to understand, apply and follow best practice, relevant standards and guidance, and comply with pertinent legislation.

In model health organisations the key aspects of health technology governance are typically coordinated through Healthcare Science led services, such as Clinical Engineering. This forms a strong direct connection with Senior management. As this is divided across many directorates within the Health Board, a robust governance process needs to be defined, as demonstrated by the collective approach covering key elements, which is supported through the MDC.

Within the Health Board's current governance arrangements, the QPS team's Risk Manager provides professional leadership and advice on best practice to all areas and departments of the Health Board. This ensures nominated staff take responsibility for key devices and equipment and working in close liaison with pan organisation service leads, directorate and divisional managers to progressively reduce patient risk. This activity includes keeping the Health Board up to date with current medical device Legislation, regulations, guidance, and best practice to assure appropriate compliance.

The EBME department coordinates the technical services covering lifecycle management of electronic patient connected medical devices and equipment, including standardisation, commissioning, maintenance, repair and disposal, plus provision of specialist advice and control of the equipment register.

Whilst governance arrangements are reported through the MDC, this disjointed approach to managing medical devices and equipment needs to be streamlined to enable compliance with the audit standards. These are founded on the current Medicines and Healthcare products Regulatory Agency (MHRA) guidance on Managing Medical Devices[2]. This guidance extends the diligence of long-established principles first laid out in 1982-1991[3], and reiterated in 1998[4], 1999[5], 2000[6], 2004[7], 2006[8], and 2014-2021[9]. These underpin the professional credentialling and assurance has been supported across all four UK nations through the development of the government led national Healthcare Science agenda.

There is a risk that gaps in overall governance could reduce the level of public protection, which results in a lack of assurance to Board, owing to not having in place the appropriate set of professionally registered and credentialed staff. Previous Audits have illustrated some of the Health Board's current challenges, particularly with respect to medical devices training and tracking medical devices. In order to deliver a plan for improvement, the MDC Workplan was produced to highlight the risks identified in the Audit and to propose actions to be taken in order to mitigate against potential weaknesses in the system. The actions were mapped against the healthcare standards. However, progress on the plan has been met with a number of challenges: one fundamental barrier is the existing organisation structure and what can be practicably achieved within its constraints.

On completion of the outstanding mitigation work in respect of the 2017/2018 Audit:

- Work is in progress to assure that within the medical devices and equipment register, lists of medical devices and equipment located in our wards and departments are up-to-date and accurate that is anticipated to be completed in March 2024.
- Work is in progress to identify competency needs and compliances at ward and department level for assured rostering of fully trained staff according to clinical function need that is anticipated to be completed in May 2024.

Asesiad / Assessment

There is a need to carry out a full gap analysis. The MDC is currently lacking a comprehensive register indicating the divisions of responsibility in the governance of medical devices and equipment. Governance is shared between the relevant clinical, scientific & technical, information technology, and financial services. In partnership, they underwrite safe, accurate, effective use and best value

deployment of medical devices and equipment. Such a register is needed to fully support compliance with the Health Board's quality and patient safety agenda and to give the MDC clear sight of the governance arrangements.

The Health Board does not have a critical mass of senior Clinical Engineering specialised Healthcare Scientists, that are present in other similar organisations, to advance its medical devices and equipment risk mitigation workplan at pace.

Responsibility for the governance of medical devices and equipment is managed by the QPS team, who report to the Clinical Executives. The internal audit report findings and responsibility for identified actions sit with the Director of Therapies and Health Science. Whilst the service is managed by the Medical Director's team. The Assistant Directors attached to both Directors ensure there is a connection to the operational workstreams: both clinical and science & engineering knowledge and skills go Handin hand-- in the governance needs. The current gold standard leading textbook[1] on a systematic approach to Healthcare Technology Management points to the MDC as being at the hub with the responsible Executive Director as the Health Board senior accountability connection. In this Health Board, the two foci of the Medical Director and the Director of Therapies and Health Sciences each have roles to play in this.

To date, the Medical Director's QPS Risk Management team has bridged important gaps to cover the service within its current expertise. However, there is a need to better align roles and responsibilities for complete governance and assurance. It is challenging to address the current risks highlighted by internal audit as the current position cannot be sustainably prioritised over other risks within the Medical Director's team's portfolio within the currently available resources.

A Working Party, under the MDC that could be overseen by QPS Risk Management, is being proposed, drawing its members from the departments, services and specialties involved in the current setup. The Working Party would:

- Produce a comprehensive assessment of current divisions and developments of responsibility operating in Aneurin Bevan University Health Board.
- Describe how the organisation may comprehensively address each key theme and recommendation of the current MHRA guidance, 'Managing Medical Devices', identifying any gaps.

However, with current service pressures and demands and winter pressures it will be challenging to ask more from operational teams to prioritise rapid pursuit of this.

The QPS Risk Manager would have the expertise to analyse gaps and make suggestions for addressing them based on published guidance and best practice.

The function and membership of the MDC should be reviewed in light of recent changes to the quality and patient safety arrangements

Ideally, the future medical devices governance system should operate with services accredited to a recognised quality management system (QMS), such as BS70000, ISO55000, ISO13485 or ISO9001. This approach has been successfully implemented in other centres.

As part of a review of the governance structures, a systemic gap assessment coupled with sense check- against exemplar organisations could be carried out. This would identify a comprehensive set of activities that the Health Board should reinforce and yield proven options for improving overall governance arrangements. Nationally, there are well established models for covering all the wider requirements, elements of which could be adopted where the Health Board is not performing effectively.
Argymhelliad / Recommendation The Committee is asked to note the report for assurance The Committee will be updated on activities to fully map governance gaps and to review emerging options, based on best practice in exemplar organisations, towards their mitigation, to balance the patient quality and safety risks with business continuity needs. Any specific requests for direct support will flow from the work of the MDC's Working Party.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care 3.4 Information Governance and Communications Technology
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Research, Innovation, Improvement, Value
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	References: [1] 'Healthcare Technology Management - A Systematic Approach', Hegarty F, Amoore J, Blackett P, McCarthy J, Scott R; CRC Press, 2017 {Chapter 5} [2] Managing Medical -Devices Guidance for health and social care organisations, MHRA, 2014, Revs 2015, 2021 [3] Health Equipment Information 98 – Management of Medical Equipment and Devices, Department of Health, 1982 Revs 1984, 1991 [4] MDA DB 9801 Device Bulletin Medical Devices and Equipment Management for Hospital and Community based- Organisations, Medical Devices Agency, 1998 [5] The Management of Medical Equipment in NHS Acute Trusts in England, National Audit Office 1999 [6] Controls Assurance Standard - Medical Devices Management, NHS Executive, 2000 [7] Better equipped to care? Follow up- report on managing medical equipment, Audit Scotland, 2004 [8] DB2006(05) Device Bulletin Managing Medical Devices -Guidance for health and social care services organisations, Department of Health, 2006 [9] SHTN 00-04 Guidance on Management of Medical Devices and Equipment in Scotland's Health and Social Care Services, NSS Health Facilities Scotland, 2020, Rev 2021
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities;

	and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	23 February 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Children's Rights and Participation
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Kavitha Pasunuru- Assistant Director, Families and Therapies Division
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rebecca Stanton- Regional Children and Families Transformation Lead

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This briefing to the PQSOC is because Children's Rights needs to be a focal point of our work with Children and Families through all aspects of healthcare within Aneurin Bevan University Health Board. The Children's Rights and Participation Forum strives to keep Children's rights on the agenda of services, supporting information sharing and examples of good practice.

Cefndir / Background

The Forum's work is an important subject for Aneurin Bevan University Health Board to keep appraised of, and in Wales, there are currently the following National policies and legislation in place underpinned by the UNCRC;

Rights of Children and Young People (Wales) Measure 2011,
Social Services and Well-being (Wales) Act 2014,
Well-being of Future Generations (Wales) Act 2015.

All of these policies establish duties on public authorities that contribute towards the realisation of Children's rights.

Asesiad / Assessment

There is currently a regular group that takes place every quarter to ensure Aneurin Bevan University Health Board keeps the subject of Children and Young People's rights firmly at the front of people's minds. The Children & Young People's Rights & Participation meeting has a mix of representatives from various areas across Aneurin Bevan University Health Board, but the membership is still being built in order to raise the awareness of Children's Rights and how this can be implemented within daily practice.

Rebecca Stanton the Regional Children and Families Transformation Lead has worked closely with the Children's Commissioner's office and Welsh Government to develop a training package for Children and Young People's Rights that will eventually be functional for Aneurin Bevan University Health Board ESR system.

The Family and Therapies Division have been successful in the past with involving Young People in the recruitment of staff but will look to continue to build on this further and to identify any further opportunities across Aneurin Bevan University Health Board.

There is a Children & Young People's Rights & Participation Forum on the 20th of February (the first of 2024) where the group will review and refresh the priorities for the next few months and beyond. Kavitha Pasunuru, Assistant Director for Families and Therapies Division (Chair) and Rebecca Stanton, Regional Children and Families Lead (supporting the meeting) have recently implemented a new system where departments share 'highlight reports' prior to the meeting so there is written evidence of the activity and in order to invite areas to share and reflect on their outcomes.

Kavitha and Rebecca have successfully setup a coproduction group with families focussing on the area of Neurodiversity, and Children's Rights has underpinned the work carried out. This group has recently won the NHS Wales award for this coproduction work and is keen to build on this achievement.

The Children & Young People's Rights Group are still developing a plan around rewards for young people who partake in activities such as the recruitment of staff because the members of the Children and Young People's Rights and Participation Group recognise that young people's time is valuable and should be renumerated fairly.

Argymhelliad / Recommendation

- For Information – i.e. does not require discussion and is for noting purposes only

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	6.2 Peoples Rights Governance, Leadership & Accountability Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Getting it right first time for children and young people
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities;

	and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.