Patient, Quality, Safety Outcomes Committee

Mon 20 January 2025, 09:30 - 12:30

Microsoft Teams

Agenda

1. PRELIMINARY MATTERS

PQSOC Agenda 20th January 2025.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on Tuesday 12th November 2024

Attached *Chair*

1.4 PQSOC Minutes 12th November 2024.docx Reviewed BC & PB.pdf (13 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 Action Log January.pdf (3 pages)

2. ITEMS FOR DISCUSSION

2.1. Committee Risk Report

Attached *Director of Corporate Governance*

2.1 PQSO Committee Risk and Assurance Report. Jan 2025.pdf (5 pages)
2.1 Appendix A PQSOC Strategic Risk Assessments and Dashboard.pdf (7 pages)

2.2. Mental Health Act Monitoring Report

Attached *Chief Operating Officer*

2.2 MHA Update Report Q2 2024-25 .pdf (24 pages)

2.3. Quality Performance Report

Attached *Director of Nursing*

2.3 Quality Outcomes Framework - Q1 to Q3 2024-25 Cover Report.pdf (6 pages)
2.3 Appendix 1 - Quality Outcomes Framework - Q1 to Q3 2024-25 - FINAL (002).pdf (91 pages)

2.4. Maternity Services: Organisational Improvement and Action Plan

Attached *Director of Nursing*

2.4 Maternity Services Improvement Plan 2024-27 - Update for PQSOC - January 2025.pdf (8 pages)

2.5. Learning from Death Report

Attached *Medical Director*

2.5 Learning from Death PQSOC Jan 2025.pdf (7 pages)
2.5 Learning from death report Jan to June 2024 .pdf (57 pages)

2.6. Pharmacy and Medicines Management Annual Report

Attached *Medical Director*

2.6 Pharmacy MM Annual Report 2023-24 Cover Report .pdf (4 pages)
2.6 Appendix 1 - Pharmacy Med Mgt Annual report 23-24.pdf (66 pages)

2.7. Radiation Protection Committee Annual Report

Attached *Director of Allied Health Professions and Health Science*

2.7 23-24 Radiation Protection Committee (RPC) report December 2024.pdf (16 pages)
2.7 Appendix 1 - ABUHB Ionising Radiation Policy.pdf (29 pages)
2.7 Appendix 2 - RPC Terms of Reference.pdf (2 pages)
2.7 Appendix 3 - Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced), 25th and 26th April 2023.pdf (41 pages)
2.7 Appendix 4 Documentation (Employer's Procedures) and document QA.pdf (16 pages)
2.7 Appendix 5 - Certificate of Registration.pdf.pdf (1 pages)
2.7 Appendix 6 - IRMER 2017 statutory instrument.pdf (36 pages)
2.7 Appendix 7 - Learning outcome presentation.pdf (19 pages)

2.8. Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Machen Ward).

Attached *Director of Nursing*

2.8 Nurse staffing Levels following the reconfiguration of Respiratory- GIM service.pdf (8 pages)
2.8 Appendix 1 - C4 Nurse Staffing Adult Re-calculation Nov 2024 - Copy.pdf (2 pages)
2.8 Appendix 2 - B4 Nurse Staffing Adult Re-calculation November 2024_.pdf (2 pages)
2.8 Appendix 3 - Ward 4.4 NHH repurpose November 2024 Nurse Staffing Adult Re-calculation Template - Copy.pdf (2 pages)

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2024/25

Attached *Director of Corporate Governance*

3.1 Committee Programme of Business 2024-25 Cover Report.pdf (4 pages)
3.1 Appendix 1 PQSOC FWP 2024 January Meeting.pdf (10 pages)

3.2. NHS Wales Joint Commissioning Committee's Quality Report

Attached *Director of Corporate Governance*

3.2 QPS Chairs Report.pdf (5 pages)
3.2 Appendix 1 -QPS - Escalation Report.pdf (5 pages)

4. OTHER MATTERS

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

Oral *Chair*

4.2. Any Other Urgent Business

Oral *Chair*

4.3. Date of the Next Meeting : Monday 31st March 2025

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN** **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE AGENDA	
Date and Time	**Monday 20th January 2025 at 09:30AM-12:30PM**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on Tuesday 12th November 2024	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR DISCUSSION**		
2.1	Committee Risk Report	Attached	Director of Corporate Governance
2.2	Mental Health Act Monitoring Report	Attached	Chief Operating Officer
2.3	Quality Performance Report	Attached	Director of Nursing
2.4	Maternity Services: Organisational Improvement and Action Plan	Attached	Director of Nursing
2.5	Learning from Death Report	Attached	Medical Director
2.6	Pharmacy and Medicines Management Annual Report	Attached	Medical Director
2.7	Radiation Protection Committee Annual Report	Attached	Director of Allied Health Professions and Health Science
2.8	Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Machen Ward).	Attached	Director of Nursing
3	**FOR INFORMATION**		

3.1	Review of Committee Programme of Business 2024/25	Attached	Director of Corporate Governance
3.2	NHS Wales Joint Commissioning Committee's Quality Report	Attached	Director of Corporate Governance
4	**OTHER MATTERS**		
4.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
4.2	Any Other Urgent Business	Oral	Chair
4.3	Date of the Next Meeting: • Monday 31st March 2025 at 9:30am		

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 12th November 2024, 12:30pm-3:30pm
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Helen Sweetland, Independent Member Paul Deneen, Independent Member Penny Jones, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Peter Carr, Director of Allied Health Professions & Health Science Nicola Prygodzicz, Chief Executive James Calvert, Medical Director Rani Dash, Director of Corporate Governance Leeanne Lewis, Assistant Director of Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing Tanya Strange, Head of Nursing Person Centred Care (Item 2.4) Grace Hargreaves, Assistant Quality & Patient Safety Assurance Lead (Item 2.4) Matthew Kvedaras, Assistant Quality & Patient Safety Assurance Lead (Item 2.4) Lloyd Hambridge, Divisional Director of Primary Care and Community Services (Item 2.2) Rachel Prangley, Interim Head of Primary Care (Item 2.2) Karen Hatch, Assistant Director of Therapies and Health Science (Item 2.5) Emma Mills, Consultant Midwife (Item 2.4) Christopher Morgan, Divisional Nurse (Item 2.4) Claire Lipetz, Consultant Gynaecologist, Divisional Director F&T (Item 2.4) Helen Morgan, Divisional Nurse (Item 2.4) Joanne Hook, Senior Nurse (Item 2.4) Kelly Downes, Deputy Director of Nursing Eleanor Edwards, Deputy Head of Safeguarding (Item 2.4) Helen Ronchetti, Deputy Head of Infection Prevention Service (Item 2.4) Scott Taylor, Head of Health, Safety & Fire (Item 2.6) Ceri Phillips, Consultant Pharmacist Star Moyo, Health Inclusion Service Senior Nurse

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	Lyn Puckett, Trade Union Representative Fern Cook, Committee Secretariat
OBSVERING	Sara Utley, Audit Wales Rhian Gard, NWSSP - Audit and Assurance Services Linda Joseph, Llais Cymru
APOLOGIES	None

PQSOC 1211/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 1211/02	**Apologies for Absence** The Chair noted the apologies for absence to record.
PQSOC 1211/03	**Declarations of Interest** There were no declarations of interest raised to record.
PQSOC 1211/04	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 2nd September 2024 were agreed as a true and accurate record of the meeting, subject to the following change: - • page 7 change from V Pack to VPAG. **Action: Committee Secretariat** The Committee **APPROVED** the minutes based on the change made.
PQSOC 1211/05	**Committee Action Log** The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions.
PQSOC 1211/06	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. Since September, the risk environment had remained relatively stable, with no changes in the risk score or exposure to the three strategic risks that the Committee monitors, with 3 risks reporting as a risk level of Moderate or High.

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	The Committee **NOTED** the delegated strategic risks and the work being undertaken to ensure the Committee was sighted on all risks that have the potential to impact patient quality and safety.
PQSOC 1211/07	**Primary Care Quality Report** Leanne Watkins (LW), Chief Operating Officer, provided the Committee with an overview of the 2023/24 Annual Quality Report advising that the report highlighted the contract reforms, training programs, performance metrics, and governance mechanism. The Committee was advised that the annual quality report covered the following area throughout 2023/24:- • General Dental Services • Urgent Access and Wait Times • Orthodontic Services • General Ophthalmic Services • General Medical Services • Enhanced and Supplementary Services • Community Pharmacy Services LW advised the Committee that the primary care academy had been an important element of safeguarding quality for the future of the delivery of the primary care services. Paul Deneen (PD), Independent Member, asked what the areas of focus would be for improvement over the next 12 months. LW advised the focus would be around sustainability within GP and dental practices and to have an outcome focus on quality that was valuable to patients. Lloyd Hambridge (LH), Divisional Director of Primary Care and Community Services, advised the Committee that the Health Board was using the primary care model set out by Welsh Government. LH highlighted to the Committee that the increase in employer contributions for national insurance had been raised as a concern by the independent contractors to Welsh Government advising this would have an impact on stainability. Helen Sweetland (HS), Independent Member, asked if the Health Board had enough ophthalmology services to serve the population in Gwent. LW advised there was an eye care plan with leaders being engaged and a working group to move things forward.

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	Pippa Britton (PB), Chair, asked what the challenges were for people not able to access primary care services. LH advised there were enhanced services available to the public that were homeless, refugees and assured the Committee this would be included within the annual report going forward. The Committee questioned why there was only a small section within the report on clusters. Rani Dash (RD), Director of Corporate Governance, advised that primary care sustainability and place-based care, including clusters, was reported through the Partnerships, Population Health and Planning Committee. The Committee thanked the Primary Care team for the amount of information within the report and the positive work that had been done throughout the year. The Committee **NOTED** the 2023/24 Annual Quality Report.
PQSOC 1211/08	**Quality Strategy – Quality Outcomes Framework** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Strategy, advising that, in April 2023, the Health Board launched its first Quality Strategy and Patient Experience & Involvement Strategy. As part of ensuring successful implementation of the Strategies, a Quality Outcomes Framework and implementation plan was developed. The Committee was advised that the Quality Outcomes Framework aimed to drive continuous improvement in healthcare services by focusing 7 key objectives. There was a 2 year implementation plan for the new quality framework which would be used from the next quarter. The Committee was advised that a SOP on deep dives was being developed to ensure that there was a clear understanding about what should be included, and the final document would be shared with the Committee for oversight at a future meeting. **Action: Director of Nursing.** Paul Deneen (PD), Independent Member, asked what the key issues were for moving the framework forward. JW advised the main issue was how the Health Board would embed the framework, ensuring the right culture around quality.

	Helen Sweetland (HS), Independent Member, asked if the Health Board had a system that provided an alert if an area required support. JW advised there was a dashboard for each division where they have the option to flag any incidents. The Committee was advised that the Health Board does focus on areas of concern in relation to not meeting the requirements for quality, noting there was a large amount of work being done to ensure that quality throughout the Health Board was within required standards. The Committee **NOTED** the Quality Outcomes Framework.
PQSOC 1211/09	**Quality Performance and Outcomes Report** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Performance and Outcomes report for quarter 2, advising that the Quality Report was mapped across 6 domains of quality and the 6 quality enablers and structured under the Health Board's 6 Pillars of Quality. Joanne Hook (JH), Senior Nurse, Emma Mills (EM), Consultant Midwife, and Tanya Strange (TS), Head of Nursing Person Centred Care, provided the Committee with an overview of the Diverse Cymru Cultural Competency Accreditation scheme advising that Maternity services and the patient experience team had won 2 sliver awards, and highlighted the support received from the volunteering team, with the aim of achieving a gold award next year. JW advised the Committee that the Mental Health and Learning Disabilities division remained in escalation due to quality, safety and governance concerns however, following improvements they had now moved from special measures to enhanced monitoring. The Committee was advised that urgent and emergency care were also in enhanced monitoring, and were assured that work was being undertaken to improve the position of ED and the flow of patients throughout the hospital, with a new operational framework due to be tested. Paul Deneen (PD), Independent Member, asked if the Health Board were content with the progress being made with both areas in enhanced monitoring. JW advised that great progress had been made but, acknowledged that there were still areas for improvement.

Helen Sweetland (HS), Independent Member, advised the Committee that she had chaired an appointment panel recently and there were 5 consultants appointed which would bring a range of different skill sets to the Health Board.

The Committee was advised that a hip and knee survey report had been completed in July 2024 by Llais, Gwent Region, with 3 recommendations highlighted and the Health Board submitting an improvement plan in September 2024. There had been 8 Health Inspectorate Wales immediate assurance letter responses.

Ceri Phillips (CP), Consultant Pharmacist, provided the Committee with an update on antimicrobial prescribing within the Health Board, advising they had received the primary care Welsh Government targets which aimed to reduce the prescribing within the next 5 years.

The Committee was advised that, to support the reduction in antimicrobial prescribing, the Health Board had started to reduce the time period over which antibiotics should be taken from 7days to 5days, assuring the Committee that 5days would still clear an infection and would reduce costs.

Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, and Matthew Kvedaras (MK), Assistant Quality & Patient Safety Assurance Lead, provided the Committee with an update on the Sepsis Progress report, advising that there was an awareness campaign targeted in ED and the children's assessment unit with posters displayed on how to spot sepsis if a child was unwell.

The Committee was advised that there bi weekly meetings were held within ED looking at good practice through quality improvement approach and how to spot patients with sepsis.

LL advised that they were looking at an education campaign to allow recognition of early sepsis within primary care to try to prevent patients needing to come into hospital.

The Committee was advised that the Health Board was reviewing the sepsis screening tool and was holding a workshop on 29th November 2024 to look at the objective for the next 2years.

Paul Deneen, (PD), Independent Member, asked what the issue was with reporting sepsis data. LL advised that the

Health Board was now using a different approach where they were trying to catch sepsis at all wards rather than just at ED and flagging early warning signs.

The Committee was advised that the UK Sepsis Trust had agreed for the Health Board to use their branding and were content to support with the sepsis education programme.

Eleanor Edwards (EE), Deputy Head of Safeguarding, provided the Committee with an overview on the General Practice and Child Protection Register programme, advising that it had been raised to safeguarding that Monmouthshire council and GP practices were not receiving updates to the child protection register.

The Safeguarding team had work to resolve the issues by providing GP practices with an up to date list each quarter and notifying the council of the relevant children's GP. Positive feedback had been received, with GPs being able to flag concerns with the Local Authority.

The Committee was advised the Health Board was now in the second stage of the pilot with Monmouthshire and were aiming to expand the approach to Gwent by 1st April 2025.

Pippa Britton (PB), Chair, asked if there was any support to children transitioning into adulthood. EE advised that there was a pilot in Newport on how services can support children going into adulthood and once the pilot was complete, it would be rolled out to all 5 local authority areas.

PD asked if schools was aware of the children on the child protection register. EE advised the schools were involved via local authority safeguarding leads.

Claire Lipetz (CL), Consultant Gynaecologist, Divisional Director F&T and Helen Morgan (HM), Divisional Nurse, provided the Committee with overview of the actions and learning taken from the death of a 9year old boy in December 2022 who had presented at the children's emergency unit in the Grange University Hospital. The child was diagnosed with Influenza A and discharged without a senior medical review and returned 4 days later with septic shock from a bowel infection.

The Committee was advised that the Health Board had created an action plan to take learning from the incident

with the following key areas being identified within the plan:-

- Ensuring a senior medical oversight;
- Strengthening communication and triage processes;
- Capacity management and adaption;
- Developing a system for re-presentation and safety netting;
- Importance of family engagement in care and feedback;
- Enhancing resuscitation, transfer and communication training.

James Calvert (JC), Medical Director, asked if the staff training was an extension of the learning from the case. CL advised that with this case, the staff that did the transfer of the patient would not usually do this as part of their practice. The training was therefore to allow them to have the knowledge if needed again.

The Committee was advised that there were serval recommendations that had come from the action plan with most of them being complete and the following 2 remaining amber:-

- Improved flow and dealing with increased demand (Amber)
- Develop Health Board Sepsis Awareness Improvement Programme (Amber)

HM assured the Committee that the Health Board was providing family members with information on the illness the child had been diagnosed with when returning home.

The Committee was assured that, based on the work that had been completed on the action plan and implementation of the recommendations, an incident like this would not happen again.

JW provided the Committee on an overview of the Ward and Team Accreditation that creates a structured system to continuously raise standards of care through effective goal setting, measurement, feedback and staff engagement which brings benefit to patients, staff and the organisation.

The Committee was advised that the Health Board had completed phase 1 which targeted 55 adult wards, 2 paediatric wards and all inpatient mental health and learning disability wards.

	JW advised that they had undertaken 10 independent reviews across 4 sites and of these 7 reviewed wards met the criteria for bronze level status. The Committee was advised that next steps were to progress with phase 2 and to recruit a data analyst to identify the organisational themes for learning. The Committee **NOTED** the progress of the quality performance report and took the report for assurance.
PQSOC 1211/10	**Falls and Bone Health Management Annual Report** Karen Hatch (KH), Assistant Director of Therapies and Health Science, provided the Committee with an overview of the Falls and Bone Health Annual report, advising that the report covers the data analysis, key activities, challenges and next steps in support of reducing falls incidents alongside improving bone health as an ongoing commitment in further enhancing the quality of patient care. The Committee noted the prevalence of falls within the UK, with one in three people over the age of 65 have one fall within a year resulting in over 50M falls per year. The Committee was assured that the Health Board reviews inpatient data at a ward level to allow the opportunity to highlight the areas of concern and work with the nursing and multidisciplinary teams to ensure they were taking learning from the incidents. KH advised the Committee that the Health Board was represented nationally across a number of forums and were ensuring they were following the national guidelines when lifting a patients following a fall, with a task and finish group set up to ensure staff know how to lift patients correctly. The Committee was advised that there had been a pilot for patients within the hospital setting to be allocated yellow wrist bands to identify which patients were at a high risk of falls and the aim was to spread and scale across all Health Board sites. The Committee noted that the Health Board had been working collaboratively with Welsh Ambulance and had attended a workshop on what the new changes were that relate to the new fall's framework.

	KH advised the Committee that there was a challenge around how the Health Board ensures all staff members were trained in relation to falls. To address this, a Falls Training Strategy was due to be completed by March 2025. Paul Deneen (PD), Independent Member, asked what information was shared with patients and their families on discharge in regards to preventing falls at home. KH advised a leaflet would be shared upon discharge, noting this was an area for improvement. Jennifer Winslade (JW), Director of Nursing, advised the information shared would be picked up as part of the integrated dicharge plan. Penny Jones (PJ), Independent Member, asked if the Health Board had targeted women in their menopause. KH advised they had started working with women in their menopause providing them with information of the risks. Helen Sweetland (HS), Independent Member, asked what service the fall assistants provide. KH advised they were trained as a first responder to support ambulance waiting times Pippa Britton (PB), Chair, thanked KH for the work that had gone into the report and the work undertaken throughout the year. The Committee **NOTED** the Falls and Bone Health Annual report.
PQSOC 1211/11	**Health and Safety Compliance Annual Report** Peter Carr (PC), Director of Allied Health Professions & Health Science, provided the Committee with an overview of the Health and Safety Compliance Annual Report 2023/24, advising that the report identified the opportunities and challenges for the Health Board in ensuring and sustaining compliance within Health and Safety legislation, including specific compliance improvement action delivered in this period. Scott Taylor (ST), Head of Health, Safety & Fire, advised the Committee that the Health, Safety and Fire plan was created to focus on the following 5 areas:- • Fire Safety • Health and Safety Training Provision • Manual Handling • Risk Management • Violence and Aggression

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	The Committee was advised that the Health and Safety statutory and mandatory training compliance had increased to 76% in 2023/24 but remained a challenge for the Health Board. ST advised the Committee that the Health and Safety risk assessment education programme had trained 295 employees to undertake risk assessments within the work place. The Committee was advised that the fire alarms system programme within the Health Board had commenced and work was ongoing to replace all alarms on the sites. PC assured the Committee that the alarm systems were working. ST advised the Committee that the fire barriers across the Health Board sites had been assessed and had identified that improvement was needed at Nevil Hall Hospital and Royal Gwent Hospital with work in progress to improve these areas. The Committee was advised that there were challenges around the compliance of the Health and Safety policies, assuring the Committee that there was a plan in place for 2024/25 to review the policies which were out of date. The Committee noted that a plan had been developed to improvement violence and aggression within the workplace, with a lead now recruited and were looking to adopt the approach of NHS England. The Health and Safety Committee had been reviewed with a new terms of reference and governance structure to monitor the improvements. The Committee was advised the annual plan was due to be presented to Board in November. The Committee requested that an update to be included within the cover report on further compliance performance since March 2024, before being submitted to the Board. **Action: Director of Allied Health Professions & Health Science** Pippa Britton (PB), Chair, requested that the performance report included a section on the continuous progress being made on the Health and Safety policy review. **Action: Director of Allied Health Professions & Health Science**

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	The Committee thanked PC & ST for the work that had been undertaken over the last 12 months. The Committee **NOTED** the annual report.
PQSOC 1211/12	**Review of Committee Programme of Business 2024/25** Review of Committee Programme of Business 2024/25 was provided to the Committee for information.
PQSOC 1211/13	**NHS Wales Joint Commissioning Committee's Quality Report** NHS Wales Joint Commissioning Committee's Quality Report was provided to the Committee for information.
PQSOC 1211/14	**Learning and Improvement Forum Minutes** Learning and Improvement Forum Minutes were provided to the Committee for information.
PQSOC 1211/15	**Nurse Staffing Levels (Wales) Act 3-year Report** Nurse Staffing Levels (Wales) Act 3-year Report were provided to the Committee for information.
PQSOC 1211/16	**Children and Young Peoples Board Minutes** Children and Young Peoples Board Minutes were provided to the Committee for information
PQSOC 1211/17	**Nurse Staffing Levels Spring Recalculations** Nurse Staffing Levels Spring Recalculations were provided to the Committee for information. Jennifer Winslade (JW), Director of Nursing, highlighted to the Committee that there would be a paper coming to the next Committee referencing the changes to macken ward now becoming an medicine ward. **Action: Director of Nursing**
PQSOC 1211/18	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no key risks or issues for reporting or escalation to the Board or other Committees.

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PQSOC 1211/19	**Any Other Urgent Business** There was no urgent business.
PQSOC 1211/20	**Date of the Next Meeting:** Monday 20th January 2025

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
November 2024	**PQSOC 1211/08**	**Quality Strategy – Quality Outcomes Framework** Final SOP on deep drives document to be shared with the Committee for oversight at a future meeting.	**Director of Nursing**	January 2025	**Complete** <u>November</u> SOP on Deep Dives has been added the Committee forward work plan.
November 2024	**PQSOC 1211/11**	**Health and Safety Compliance Annual Report** An update to be included within the cover report on further compliance performance since March 2024, before being submitted to the Board.	**Director of Allied Health Professions & Health Science**	November 2024	**Compete** <u>January</u> A cover report, including an update on compliance to be provided at the next meeting
November 2024	**PQSOC 1211/11**	**Health and Safety Compliance Annual Report** The performance report to include a section on the continuous progress being	**Director of Allied Health Professions & Health Science**	January 2025	**Complete** <u>January</u> The cover report will include a plan to improve

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		made on the Health and Safety policy review.			compliance with health and safety policies
November 2024	**PQSOC 1211/17**	**Nurse Staffing Levels Spring Recalculations** A paper to come to the next Committee referencing the changes to Machen ward now becoming an medicine ward.	**Director of Nursing**	Janaury 2025	**Complete** <u>January</u> included on the agenda under item 2.9. <u>November</u> Machen wards changes has been added the Committee forward work plan for January

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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

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

At the November 2024 meeting, it was reported that the risk environment had remained stable, and there were no changes to the risk scores for the monitored risks. This stability has continued into the current reporting period.

Asesiad / Assessment

Strategic Risk Register (SRR)

Table 1 below provides the current status of the three strategic risks. All three sub-risks have been reviewed and updated in line with best practices to ensure that the Committee has the latest information regarding controls and assurances.

The Committee Risk Dashboard and individual assessments are included in **Appendix A.**

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer **Theme** Service Delivery **Appetite** Open Score 17 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	**High** **3 x 4** **(12)**	**Y**
SRR 008 Director of Nursing **Theme** Transformation & Partnership Working **Appetite** Open Score 17 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Moderate** **2 x 4** **(8)**	**Y**
SRR 010 Director of Therapies & Health Science **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**High** **3 x 4** **(12)**	**N**

For **SRR 005** and **SRR 008**, the risks remain within the Health Board's risk appetite, providing assurance that they are being effectively mitigated. Work will continue with risk owners to ensure that the controls in place are sufficient in preventing the potential risk from occurring.

SRR 010, while its score has reduced from 16 (Extreme) to 12 (High) in recent months due to the implementation of the 30, 60, 90-day Improvement Plan, it continues to be managed outside the agreed risk appetite and remains a significant challenge. Key priorities for addressing this risk include:

- Enhancing education and awareness of health and safety responsibilities among managers and supervisors.
- Optimising resources within the Corporate Health and Safety Department to meet legislative requirements.
- Updating health and safety policies to ensure clarity and alignment with organisational procedures.
- Improving compliance with manual handling training to reduce staff and patient injuries.
- Strengthening fire safety training to improve staff competency and assurance.
- Upgrading aging fire alarm systems, particularly in critical locations like Nevill Hall and Royal Gwent Hospitals.
- Addressing fire barrier breaches at Nevill Hall Hospital and assessing those at the Royal Gwent Hospital.

Progress on the strategic health and safety risk will continue to be closely monitored and reported to the Executive Committee and the PQSOC, with a clear focus on managing risks to an acceptable level. These efforts aim to sustain the progress achieved thus far and ensure continued compliance with health, safety, and fire legislation.

Additionally, the scheduled Internal Audit of Health and Safety, planned for Quarter 4 of the 2024/25 Plan, will offer further insight. The findings of this audit will be presented to the Audit, Risk, and Assurance Committee and subsequently to PQSOC. This process will provide evidence for the Committee to determine whether the Health and Safety Improvement Plan is effectively delivering the intended outcomes and addressing identified risks.

As of the end of January 2025, the PQSO Committee Risk Register reflects **three** high-level risks and **three** corresponding sub-risks, underscoring the continued focus on strategic oversight and targeted mitigation efforts.

Argymhelliad / Recommendation

The Committee is requested to:

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

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

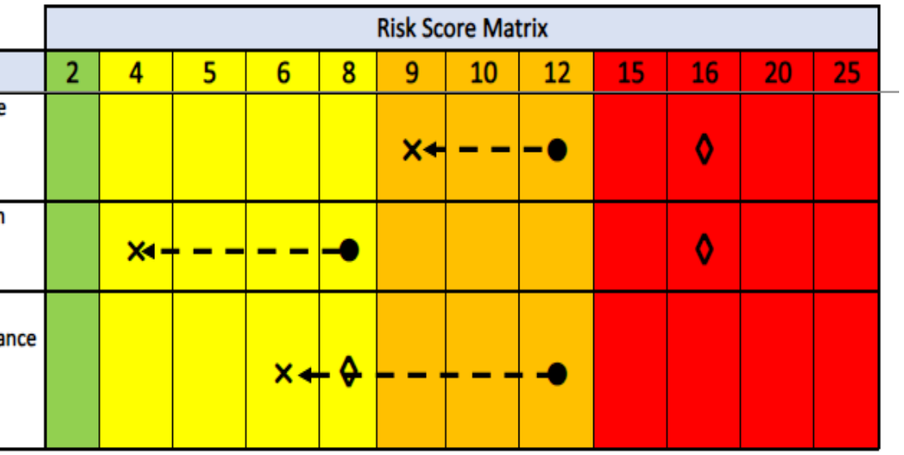
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk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

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

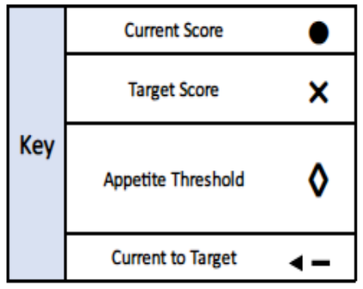
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

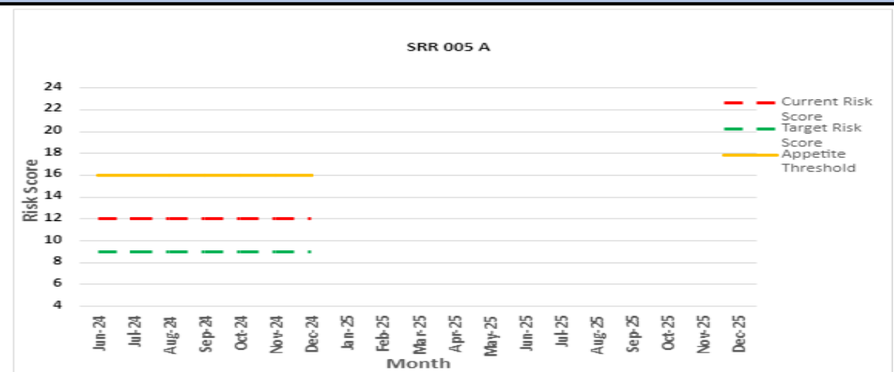
	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

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



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



RISK THEME	SERVICE DELIVERY					
SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**				**Publication Status**	**Public**
Strategic Threat	**A.** Due to inadequate arrangements to support system-wide patient flow				**Risk Appetite Level - Open** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	• Avoidable deaths or significant harm • Delays in releasing ambulances from hospital sites back into the community • Delayed discharges from acute and non-acute settings resulting in deteriorating patients; • Litigation & Financial Penalties • Reputational damage and loss of public confidence				**Risk Appetite Threshold – Open SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**3** *(Possible)* X	**3** *(Possible)* X		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Minor)*		
Last Reviewed	01 November 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*		
Next Review (Quarterly based on risk score)	01 February 2025					

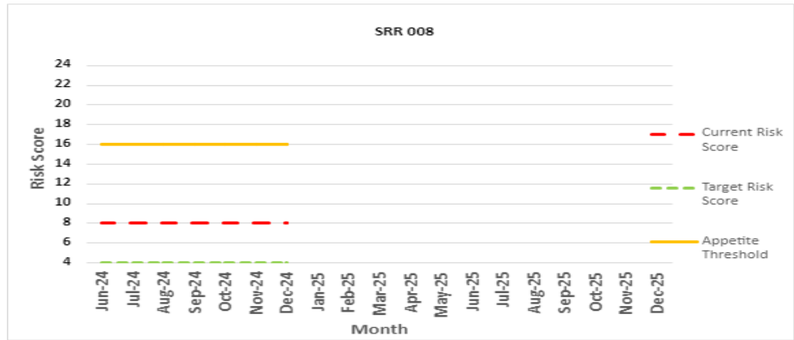
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Operational framework tested throughout November ’24. Framework in use. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.	• Opportunities to strengthen operational framework ahead of next winter 25/26. • Improve regional acceptance of flow processes with neighbouring Health Boards. • Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **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 Intra-Site Patient Transfers – **Reasonable Assurance accepted by the ARAC on 9th July 2024.** • External inspections/visits. • WG – IQPD meetings to review areas of focus. • Planned care recovery meetings with the NHS execs.	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements. • Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.

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

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

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

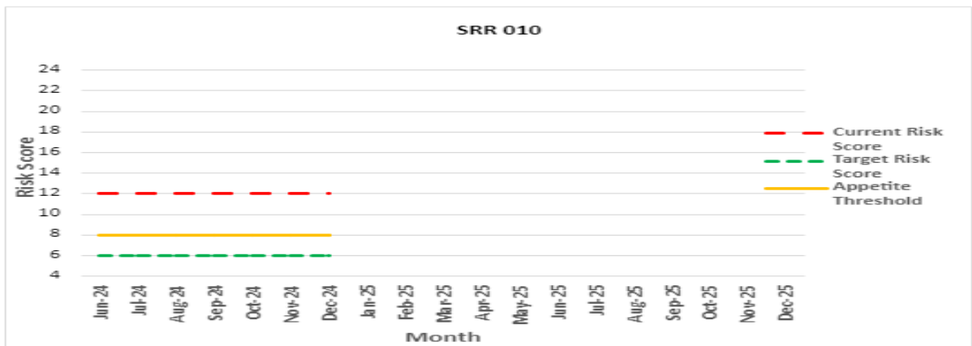


Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short,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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)* • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • LLais Reports • HIW inspections • Advocacy reports	• No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	• Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. • Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.

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

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

RISK THEME	COMPLIANCE AND SAFETY					
SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**				**Publication Status**	**Public**
Strategic Threat	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				**Risk Appetite Level - MINIMAL.** Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.	
Impact	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage				**Risk Appetite Threshold -** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.** **SUMMARY** The current risk level is **OUTSIDE** of target level and **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold. **Expected Date Target Score will be Achieved –**	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**3** (*Possible*) x	**2** (*Unlikely*) x		
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*		
Last Reviewed	01 November 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*		
Next Review (Quarterly based on risk score)	01 February 2025					

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Board IOSH Training/ development (completed 04 December 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Health and Safety compliance data extracted from ESR and Datix and reported	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Health & Safety Processes • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.		

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

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

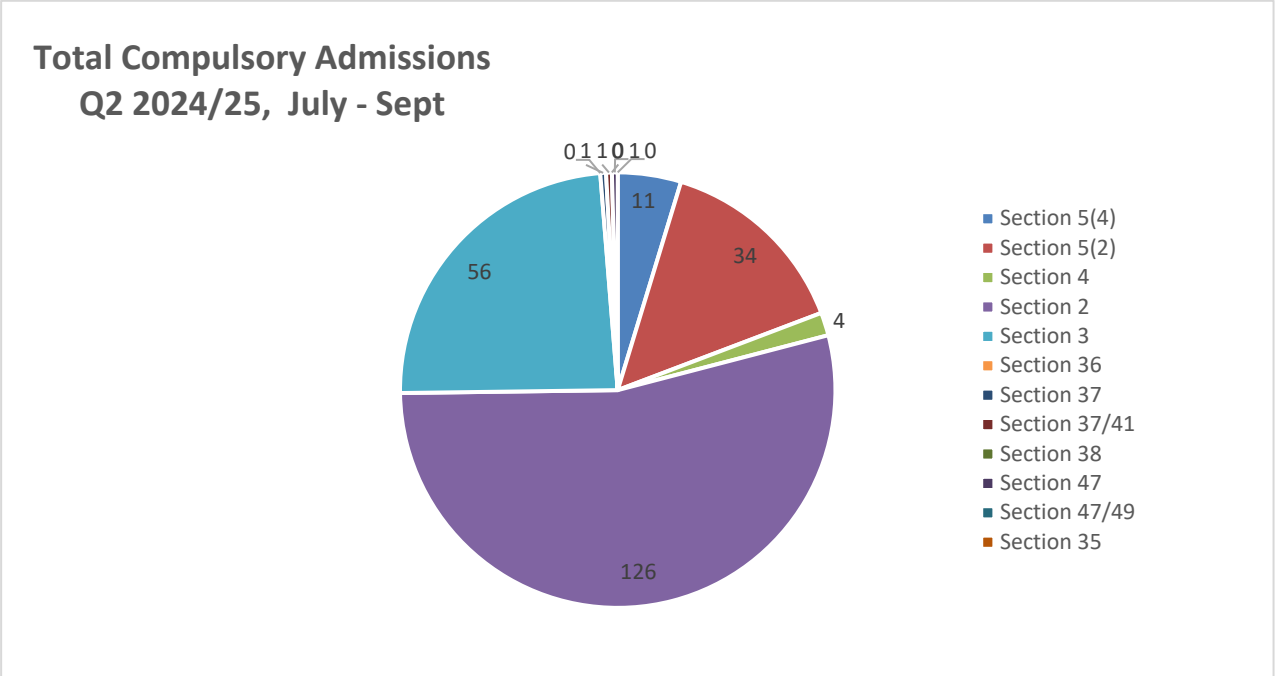
CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health Act Update Report Q2 2024-25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amelia James / Sarah Cadman

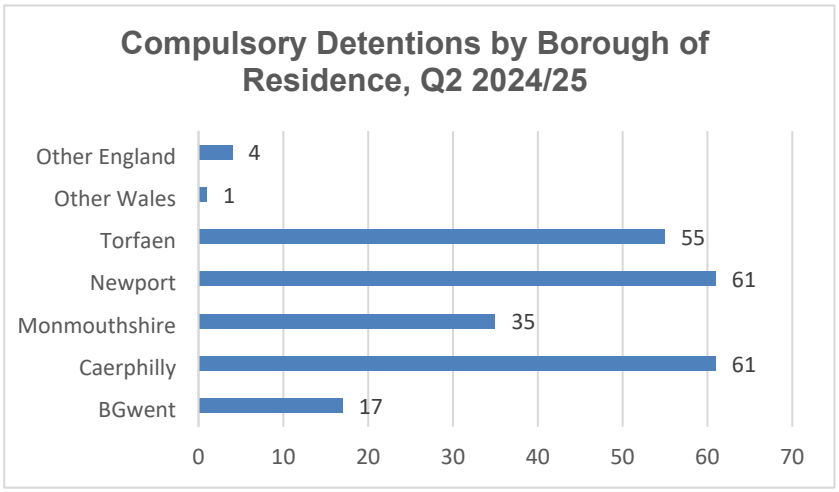
Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation The report provides activity information on the use of the Mental Health Act over Quarter 2, July – September 2024 and provides a comparison of activity over the previous quarter. Where available, other information sources will be used in order to highlight any trends, patterns or variation over time. The report is presented to provide assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act.
Cefndir / Background The report presents data for the second quarter of 2024/25 on the use of the Mental Health Act (MHA) across the Health Board. The data is currently collected and analysed manually through the Mental Health Act Administration Office. **1. In-Patient MHA Activity, Q2 2024/25**

Data on the use of compulsory admission under the MHA by quarter is shown below. The pie chart provides a high-level summary on the use of the Act by section across all ages/specialties in the Health Board.



A breakdown of all compulsory admissions by borough of residence of each patient is shown below. This shows that there is some variation in the number of detentions by borough in comparison to population size. Torfaen had the highest number of detentions per population.



Borough	Detentions Q2 2024/25	Population (000's)	Detentions per 1,000 population Q2 2024/25 (Previous Qtr.)
Caerphilly	61	176	**0.3 (0.4)**
Newport	61	163	**0.4 (0.5)**
Blaenau Gwent	17	67	**0.3 (0.2)**
Torfaen	55	93	**0.6 (0.6)**
Monmouthshire	35	94	**0.4 (0.3)**

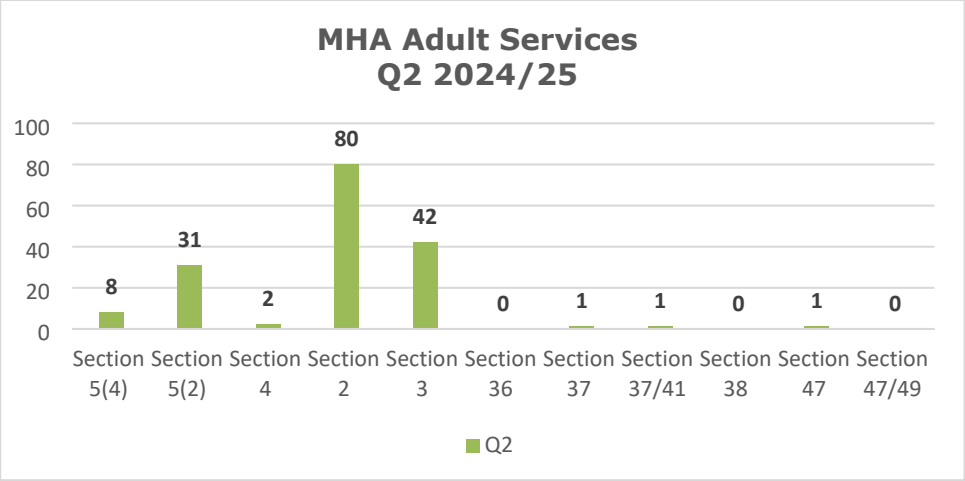
In comparison to the previous quarter, there has been a 5.5% decrease in the overall number of patients detained under the Act. Compared to the same quarter of last year (23/24) there has been a 14% increase.

Section	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 5(4)	11	17	17	15	11
Section 5(2)	24	29	40	41	34
Section 4	4	0	4	5	4
Section 2	122	100	113	133	126
Section 3	42	35*	45	49	56*
Section 35	0	0	0	1	0
Section 37	0	0	0	2	1
Section 37/41	2	0	2	1	1
Section 38	0	0	1	0	0
Section 47	0	1	0	1	1
Section 47/49	0	0	0	0	0
Section 48	0	0	0	0	0
Section 48/49	0	1	0	0	0
Total	**205**	**183**	**222**	**248**	**234**

*This figure includes a notional 37 detention. A notional 37 detention begins if a patient is still in hospital when their prison sentence ends.

- **MH Adult Compulsory Admissions Under the MHA (1983)**

A breakdown of all compulsory admissions to mental health wards of all adults under 65 years of age is shown in the chart and table below. It can be seen that just under half (48%) of all admissions are under Section 2 (Assessment) of the MHA, with 25% of detentions under section 3 (Treatment). 24% of all adult detentions were under Section 5 of the Act. There was an overall decrease (16%) in the number of detentions compared to the previous quarter.

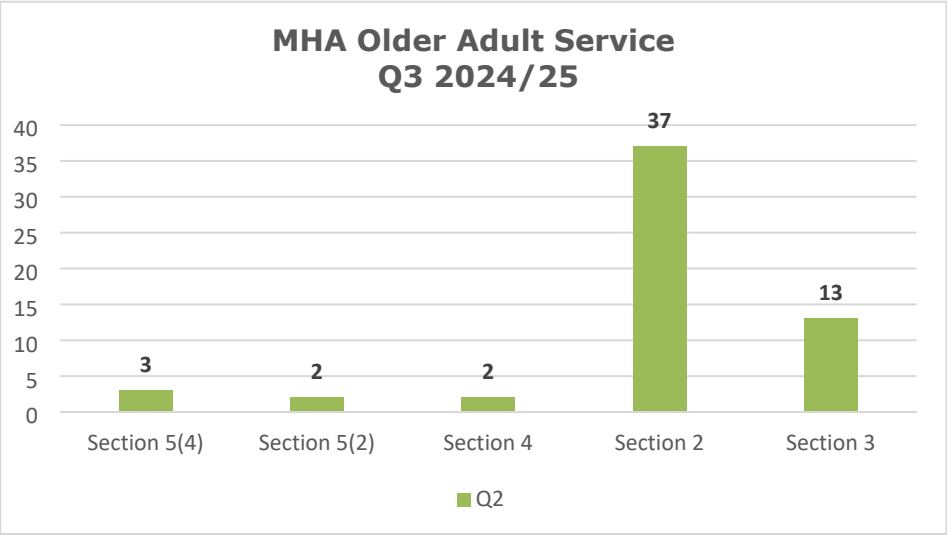


Section	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 5(4)	8	13	10	13	8
Section 5(2)	20	23	35	37	31
Section 4	2	0	2	4	2
Section 2	82	63	74	99	80
Section 3	31	22*	26	40	42*
Section 35	0	0	0	1	0
Section 36	0	0	0	0	0
Section 37	0	0	0	2	1
Section 37/41	2	2	2	1	1
Section 38	0	0	1	0	0
Section 47	0	0	0	1	1
Section 47/49	0	0	0	0	0
Section 48	0	1	0	0	0
Section 48/49	0	0	0	0	0
TOTAL	**145**	**124**	**150**	**198**	**166**

*This figure includes a notional 37 detention.

- **MH Older Adult Compulsory Admissions Under the MHA (1983)**

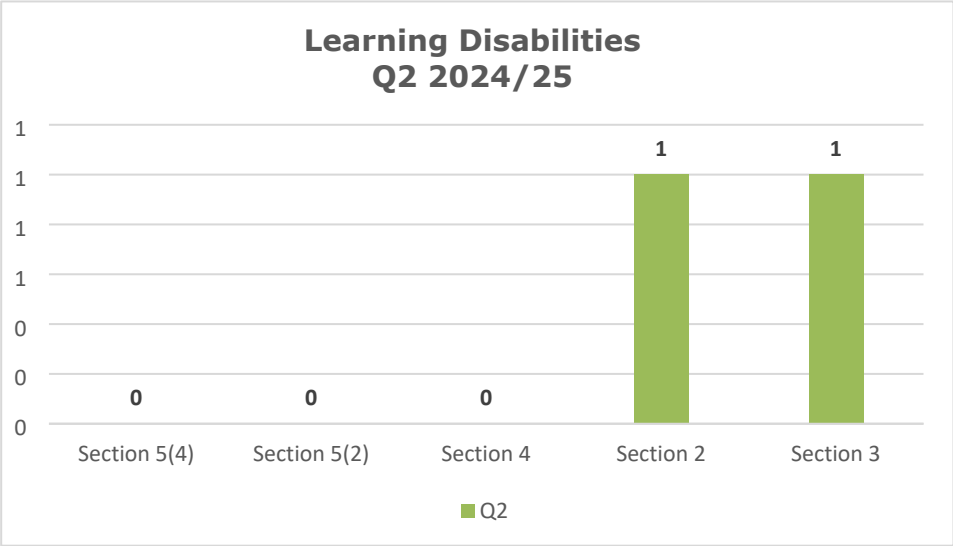
Within the older adult population patients admitted and detained, 88% were admitted under Sections 2 or 3 of the MHA with 9% admitted under Section 5 provision and 4% under Section 4. There was a 19% increase in the number of detentions compared to the previous quarter.



Section	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 5(4)	3	3	5	2	3
Section 5(2)	3	4	3	4	2
Section 4	2	0	2	1	2
Section 2	35	32	37	32	37
Section 3	10	11	16	9	13
TOTAL	**53**	**50**	**63**	**48**	**57**

- **Learning Disability Compulsory Admissions Under the MHA (1983)**

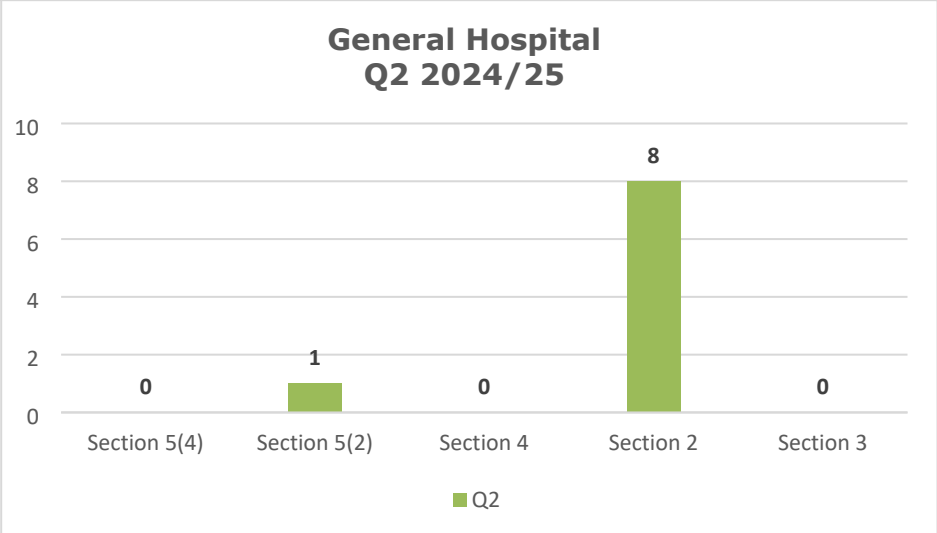
For individuals with a learning disability requiring admission under the MHA, 100% were admitted under Sections 2 or 3 of the MHA.



Section	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 5(4)	0	2	1	0	0
Section 5(2)	0	1	1	0	0
Section 4	0	0	0	0	0
Section 2	0	1	1	0	1
Section 3	0	1	1	0	1
TOTAL	**0**	**5**	**4**	**0**	**2**

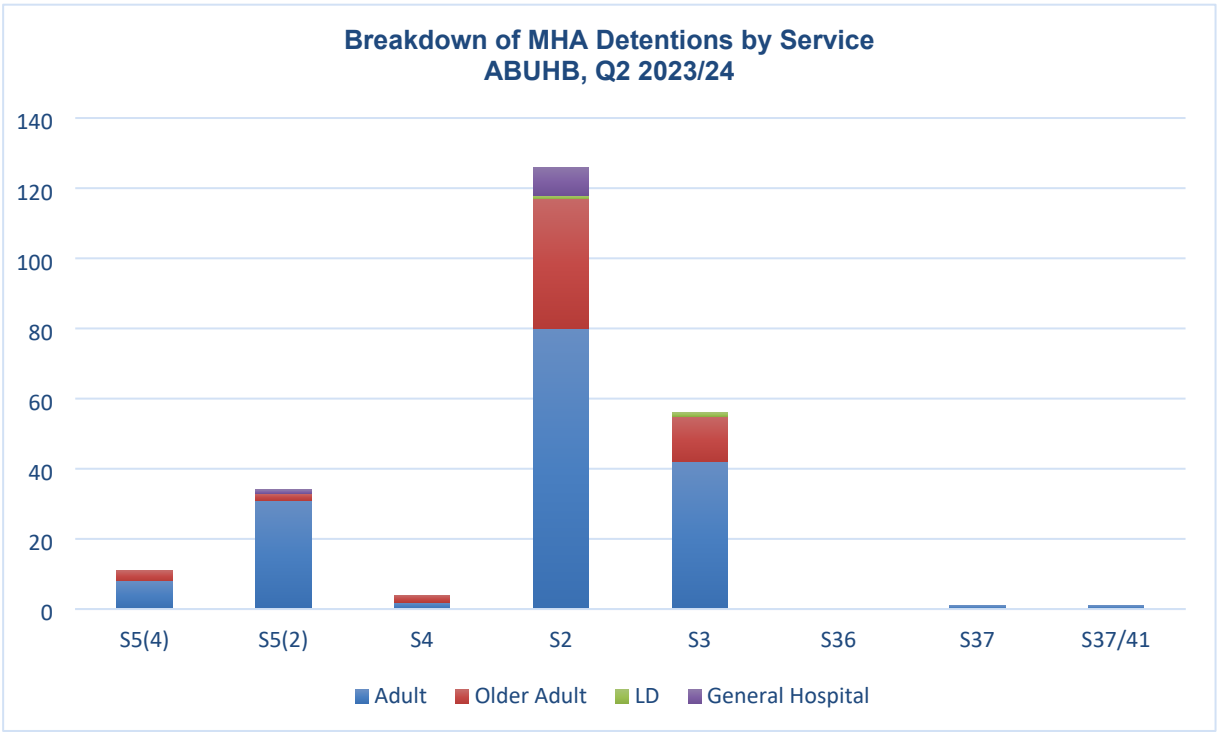
- **General Hospital Compulsory Admissions Under the MHA (1983)**

For patients detained under the MHA in a General Hospital setting, 89% were admitted under Section 2 of the MHA with 11% admitted under Section 5 provision.



Section	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 5(4)	0	0	0	0	0
Section 5(2)	2	1	1	0	1
Section 4	0	0	0	0	0
Section 2	5	4	1	2	8
Section 3	0	1	2	0	0
TOTAL	**7**	**6**	**4**	**2**	**9**

The below chart shows the total MHA detentions broken down by service for quarter 2, 2024/25.

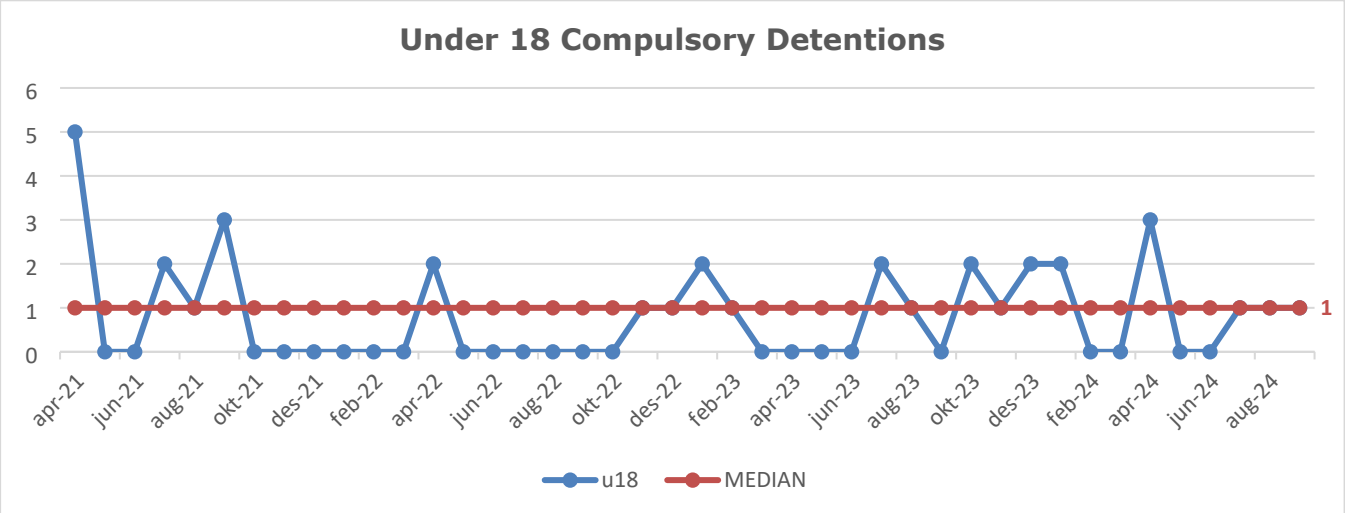


- **Total number of Under 18s Compulsory Detentions Under the MHA (1983)**

Within Aneurin Bevan there is no dedicated Children and Young Persons CAMHS inpatient provision. Access to emergency provision for a bed in Ty Cyfannol extra care area for up to 72 hours is provided locally for 16–17-year-olds, with younger patients normally being admitted to a paediatric ward if necessary.

The number of under 18 detentions taking place in quarter 2 stayed the same in comparison to quarter 1.

Under 18 years Detentions	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 5(4)	0	0	0	1	0
Section 5(2)	0	1	0	2	0
Section 2	2	3	1	0	3
Section 3	1	0	1	0	0
CTO	0	0	0	0	0
TOTAL	**3**	**4**	**2**	**3**	**3**



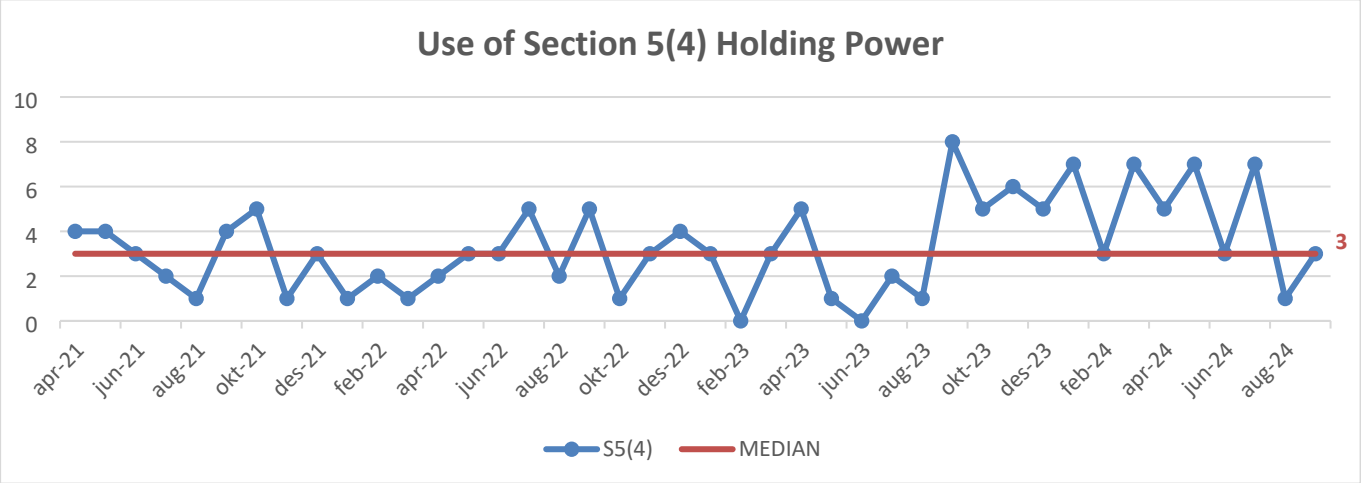
A higher number of admissions is a safety concern due to the limitations of the environment on a busy adult acute ward. Where there is an increase in Under 18 detentions under the MHA this is highlighted and escalated to the CAMHS and Adult senior lead nurses. Access to CAMHS specialist inpatient provision has also been escalated to Welsh Government previously. The MHA Administration Department monitors the trends on a regular basis.

2. Trend Analysis of the main compulsory admissions across all services from April 2021 to September 2024

This section briefly highlights any trends noted in the use of the Mental Health Act.

- **Use of Section 5 Holding Powers**

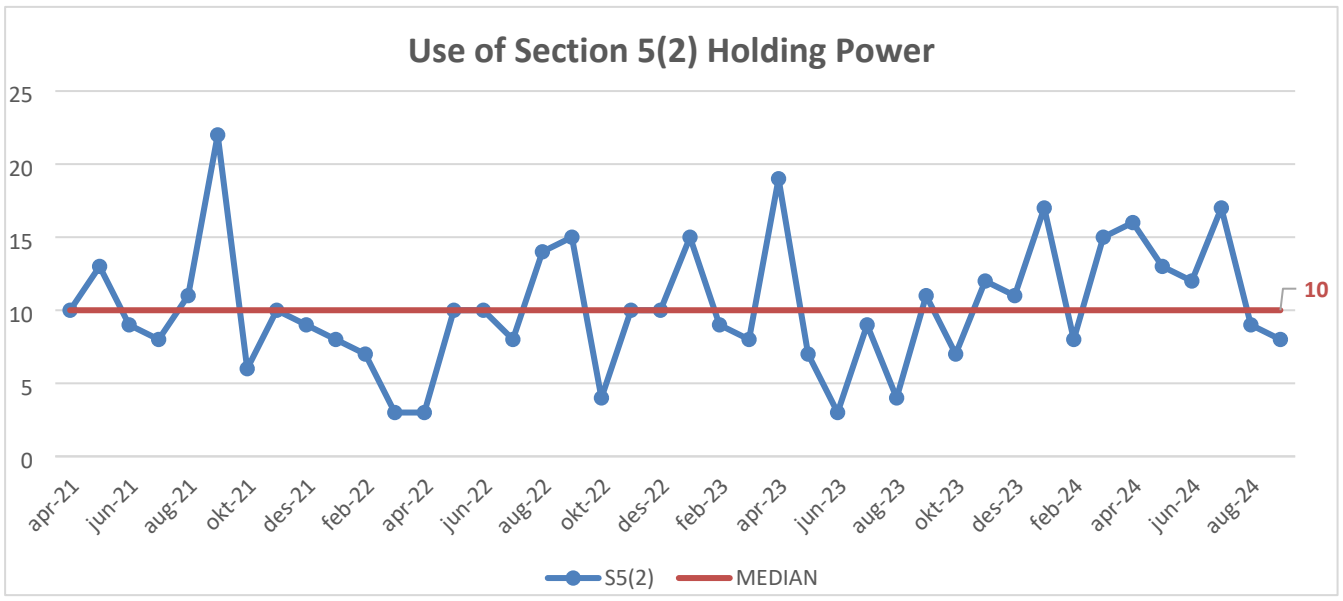
The use of Section 5(4) is intended as an emergency measure to detain informal patients for up to 6 hours to prevent an individual already receiving treatment from leaving hospital. There were 11 uses of this holding power over the quarter with 73% of these resulting in a doctor/approved clinician detaining the patient under Section 5(2) and 27% either ending or lapsing without further detention under the MHA.



Outcome of Section 5(4) – Q2 2024/25

Outcome	Total
Lapsed	2
Ended	1
Section 5(2)	8
Section 2	0
Section 3	0
Total	**11**

The use of Section 5(2) resulted in 44% of patients being detained under section 2, 9% being detained under section 3 and 47% ending or lapsing without further detention under the MHA.



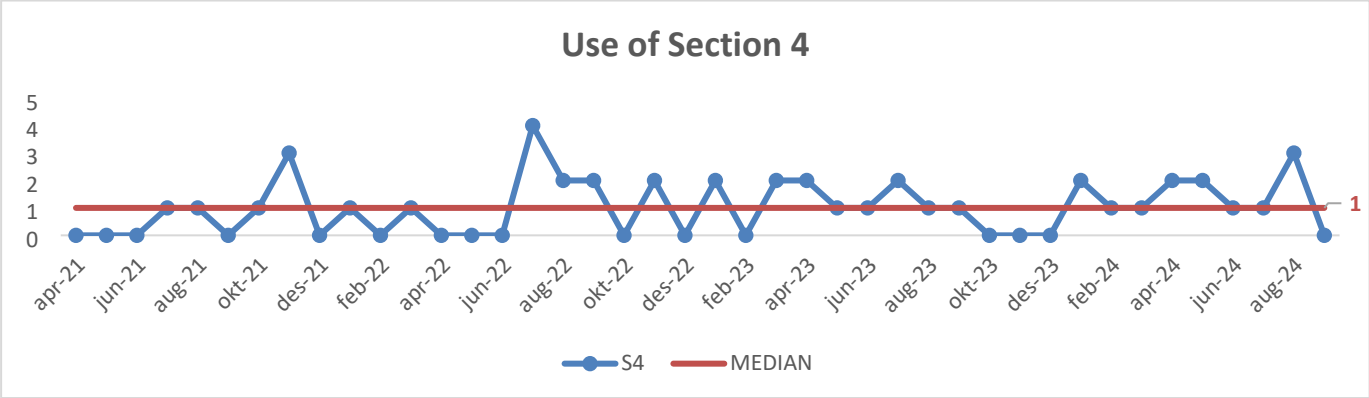
Outcome of Section 5(2) – Q2 2024/25

Outcome	Total
Lapsed	4
Ended	12
Section 2	15
Section 3	3
Total	**34**

- **Use of Section 4**

The use of Section 4 is a relatively rare event and data remains low. Section 4 will be used only in emergency situations where it is not possible to secure 2 doctors for a Section 2 assessment immediately and it is felt necessary for a person's protection to detain under a section of the MHA.

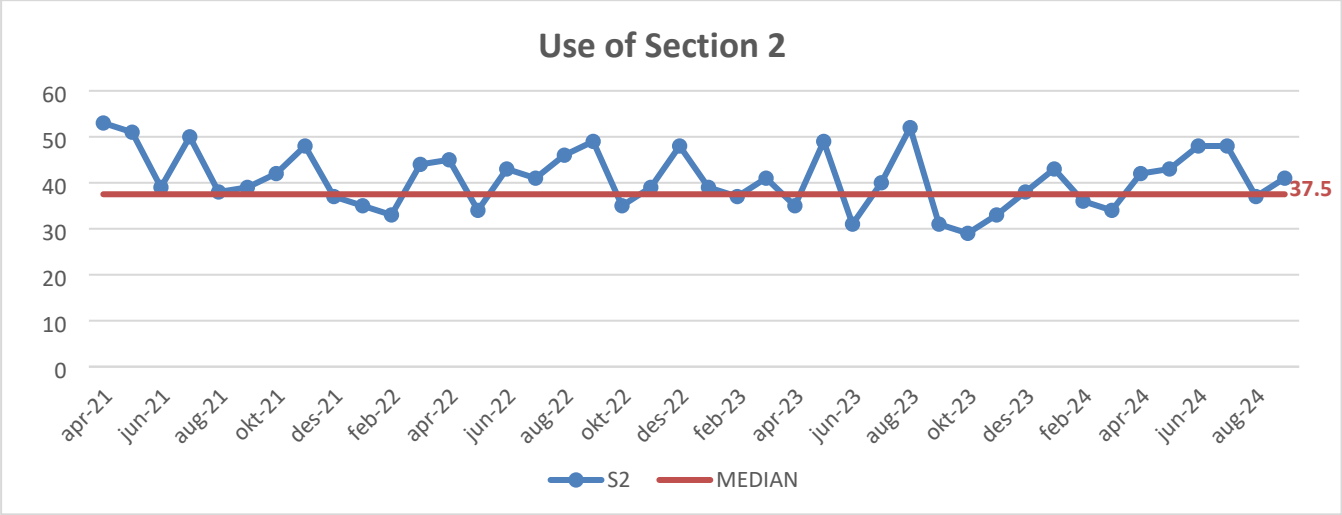
While the use of this provision is uncommon it can be an indicator of a problem in the availability of two doctors to undertake an assessment. Section 4 was used on 4 occasions this quarter (Q2). The chart below shows that the use of Section 4 has decreased by 20% in comparison to the previous quarter.



The main outcome of the use of Section 4 is that the individual will normally be placed on a Section 2 (admission for assessment), 100% of cases in this quarter.

All 4 uses of section 4 this quarter are proportionate and reasonable in the circumstances. The detail of each use has not been provided in this paper due to patient identifiable information.

- **Use of Section 2**



54% of all detained admissions were admitted under Section 2 during the quarter, with the number of admissions remaining fairly stable over the last two years.

Outcome of Section 2, Q2 2024/25

Outcome	**Total**
Expired	6
Regraded S3	22
Transferred	7
Died	1
Ended: 0-3 days	15
Ended: 4-14 days	28
Ended: 15-28 days	47
Total	**126**

A total of 126 detentions were made using Section 2, with 63% of these in adult mental health services, 29% in older adult, 6% in a general hospital setting and 1% in Learning Disabilities.

Of the total 126 patients detained under Section 2:

- 22 (17%) were regraded to Section 3
- 6 (6%) were transferred out of the Health Board during the Section 2

Of the remaining 98 detentions under Section 2, a breakdown of the length of admission of these individuals shows that:

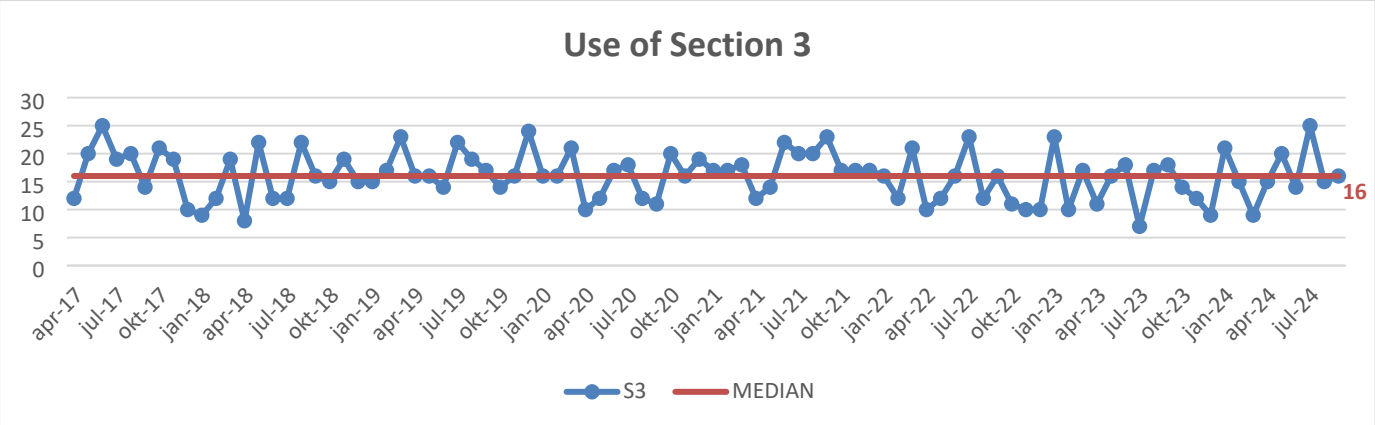
- 0-3 days 15 (12%) were detained between 0-3 days
- 4-14 days 28 (22%) were detained between 4-14 days
- 15-28 days 47 (37%), were detained between 15-28 days

Of this cohort, 6 (5%) detentions were allowed to lapse. This is a 14% decrease, compared to the last quarter. It is considered allowing a Section 2 to lapse as poor practice, as it raises the question whether the patient met the criteria to be discharged at an earlier stage of the detention. Where detentions are allowed to lapse the MHA Administration Department highlights this issue to the relevant medical and ward staff.

- **Use of Section 3**

20% of all detained admissions were admitted under Section 3 during the quarter. A total of 56 detentions were made using Section 3, with 75% of these in adult mental health, 23% in older adult mental health and 2% in Learning Disabilities.

The committee requested a longer timeframe to analyse use of Section 3 over time. The graph below shows use of s3 across the Health Board over 5 years. The graph shows that whilst there is some variance from month to month and quarter to quarter, use of s3 is consistently within expected controls over the last 5 years and continues to be into this year.



Of the total 56 patients detained under Section 3:

- 27 (48%) detentions remained as ongoing detentions as of 29.10.2024
- 23 (41%) detentions were ended as of 29.10.2024
- 6 (11%) detentions were regraded to CTO

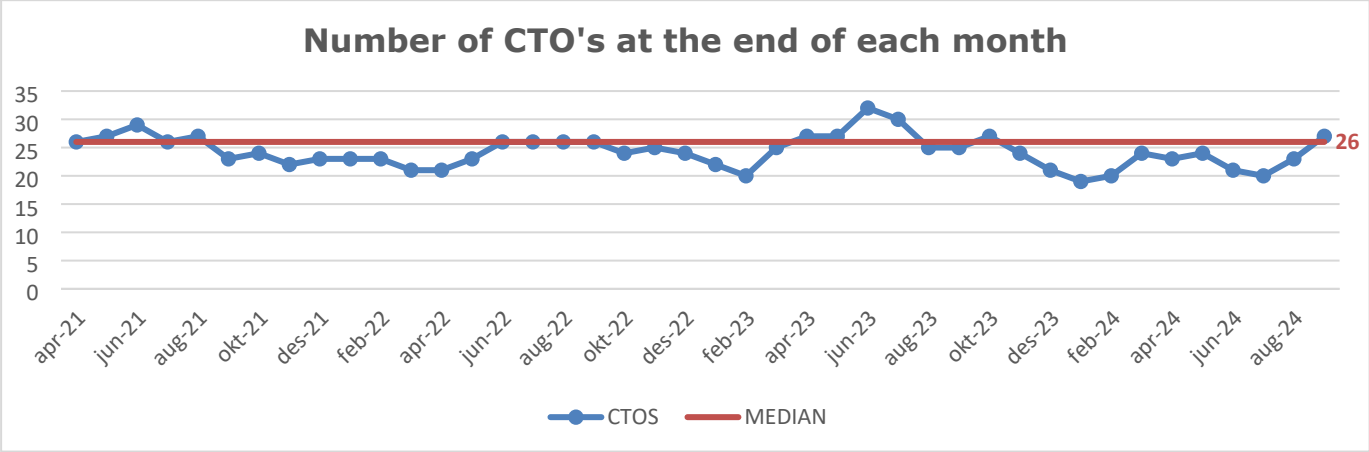
- **Renewal of In-patient Detentions under the MHA (1983)**

The table below shows that the number of renewals of inpatient detentions increased by 200% during the quarter (Q2) compared to the previous quarter.

Section	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Section 3 renewal	12	10	6	4	11
Section 37 renewal	1	0	0	0	1
Section 47 renewal	0	0	0	0	0
TOTAL	**13**	**10**	**6**	**4**	**12**

- **Use of Community Treatment Orders (CTOs)**

The number of Community Treatment Orders at the end of each month has increased by 29%, from 21 at the end of quarter 1 to 27 at the end of the current quarter (Q2).



A summary of the use / changes to CTOs is shown below

Community Treatment Orders (CTOs)

Section	Power	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
17A	CTOs made	2	8	7	6	9
	CTOs extended	4	7	3	6	3
	Recalled to hospital and not admitted	1	3	1	0	3
	Recalled to hospital and revoked	5	3	3	6	1
	Discharged from CTO	4	9	2	2	2

3. Unlawful Detentions/Failed Medical Scrutiny / Rectifiable Errors

A summary of unlawful detentions, section papers that failed medical scrutiny and section papers with rectifiable errors during the quarter is provided below.

- **Unlawful Detentions**

There were 2 unlawful detentions identified during the quarter. Where errors are identified the Mental Health Act Administration will immediately contact the ward/clinical team who will inform the patient, and the clinical team will determine the appropriate next steps such as undertaking a new assessment.

	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25

Unlawful Detentions	**1**	**0**	**0**	**2**	**2**

- Invalid Section 5(2) – Reason for admission to filled in
- Invalid Section 2 – Missing page of HO2

- **Failed Medical Scrutiny**

The Health Board has 14 days to undertake medical scrutiny of section papers. Where medical scrutiny identifies that further information is required the papers are returned to the doctor who completed the assessment highlighting what further information is required and returned within the 14-day period.

	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Failed Medical Scrutiny	**0**	**0**	**0**	**0**	**2**

- Invalid Section 5(2) – Additional information regarding why informal admission wasn't possible needed
- Invalid Section 2 – Additional information regarding risks to self and others needed.

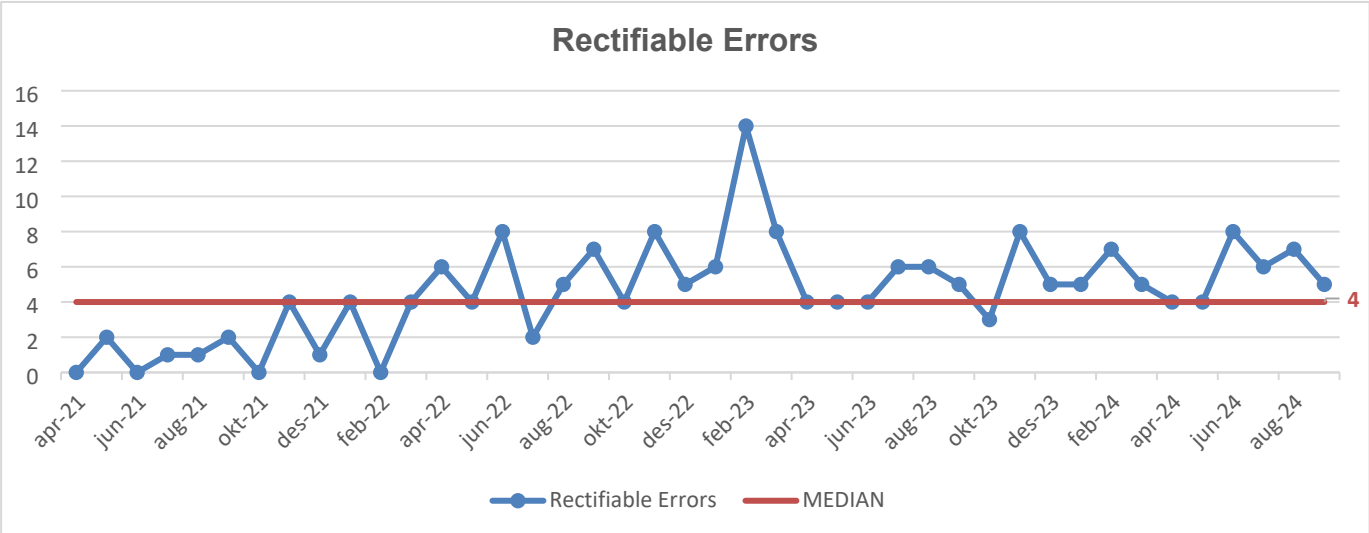
- **Rectifiable Errors on Documents**

Rectifiable errors are considered a 'slip of a pen'. Section 15 of the Mental Health Act allows for any documents containing rectifiable errors to be amended by the professional who completed the form within 14 days of the date the person was admitted onto a section. Common rectifiable errors include names not stated in full, misstating of places including hospitals and patients addresses, names or places being inconsistent, spelling errors, nearest relative address missing and deletions not being completed.

There has been a 13% increase in the number of rectifiable errors this quarter, demonstrating that there is still a need for continued awareness regarding the acceptance and scrutiny of documentation before it is received into the MHA Administration Department to ensures that documentation is as accurate as possible. This has been raised with the Senior Psychiatrists Committee for awareness, vigilance and action. Training around the scrutiny process is being conducted the MHA Administration Department.

	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Rectifiable errors on document	**17**	**16**	**17**	**16**	**18**

The chart below shows rectifiable errors. It can be seen that there was a significant reduction in rectifiable errors in 2021-22, with an increase in 2022-23. The first quarter of 2023-4 demonstrates a significant reduction, however this has increased during quarter 2 and stayed steady for the remainder of 2023-24. This has continued into 2024-25.



4. Use of Sections 135 and 136

- **Section 135**

There are data completeness issues with the compilation of Section 135 data. The table below therefore provides a summary of the available data.

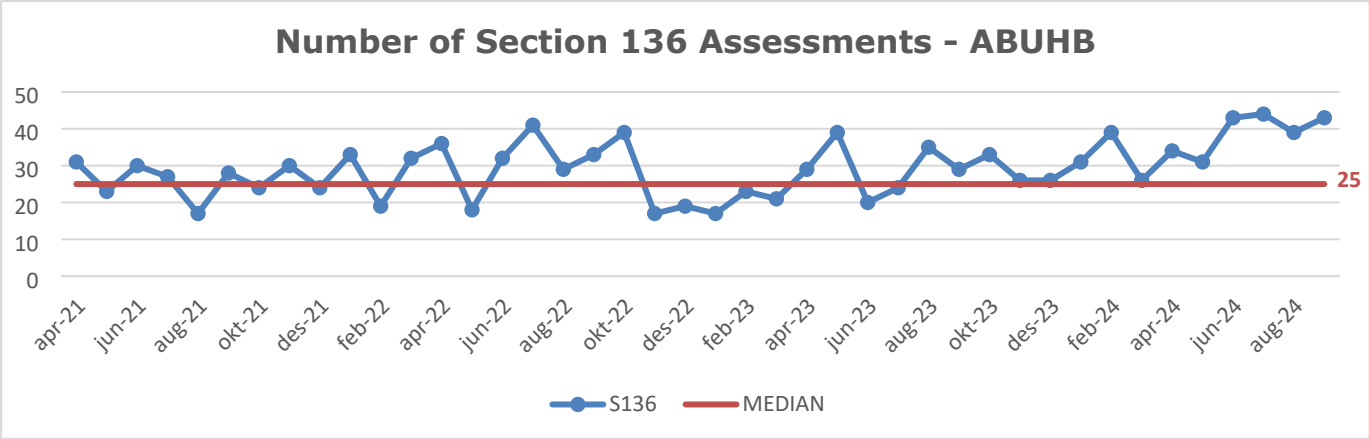
Use of Section 135, Q2 2024/25

Section 135 of the MHA	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Assessed and admitted informally	0	0	0	0	0
Assessed and discharged	0	0	0	0	0
Assessed and detained under Section 2	2	3	2	2	1
Assessed and detained under Section 3	0	4	0	0	0
Assessed and CTO Revoked	0	0	1	0	0
Other	0	0	0	0	0
Total	**2**	**7**	**3**	**2**	**1**

The MHA Administration department has confirmed that the above data is not complete and has been unable to capture the true activity information for the data periods due to not receiving all copies of executed Section 135 warrants. There are on-going inter-agency discussions between Health, Local Authorities and Gwent Police to ensure that all Section 135 activity is correct and is collected in a timely manner.

- **Section 136**

A breakdown on the number of 136 assessments undertaken at the 136 Suite (Place of Safety) at St Cadoc's Hospital is shown in the table below.

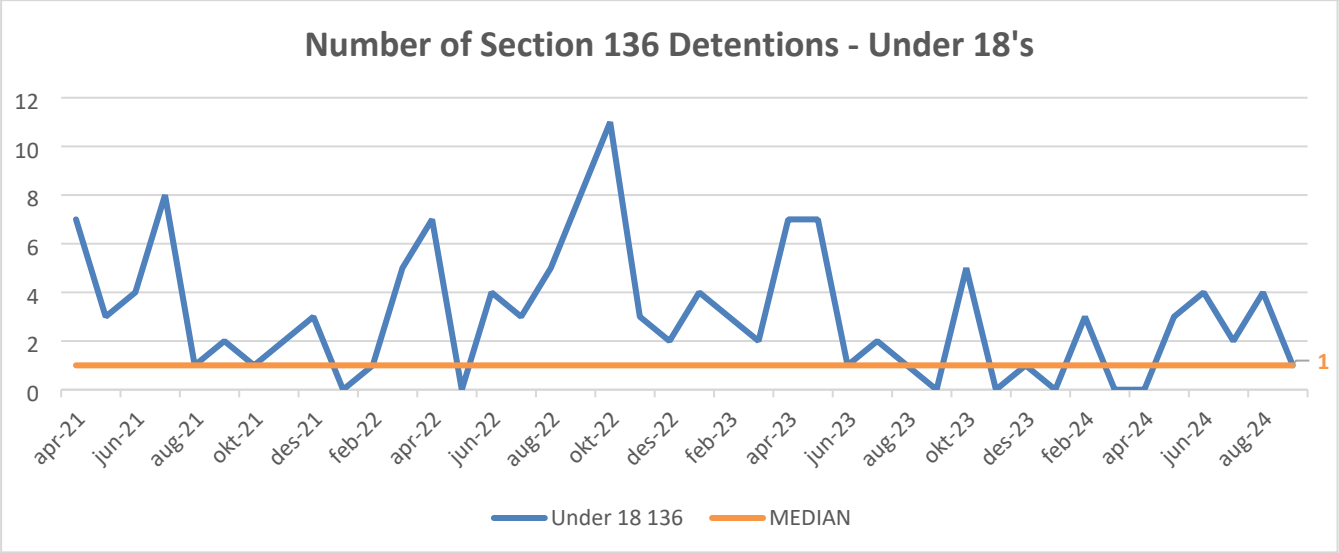


A breakdown of the outcome of 136 assessments is shown in the table below. A total of 126 assessments were undertaken. Of those assessed 35% were admitted, with 55% of those admitted being formally detained. 32% of individuals assessed were discharged with no follow up required, while 33% were discharged with a follow up plan in place.

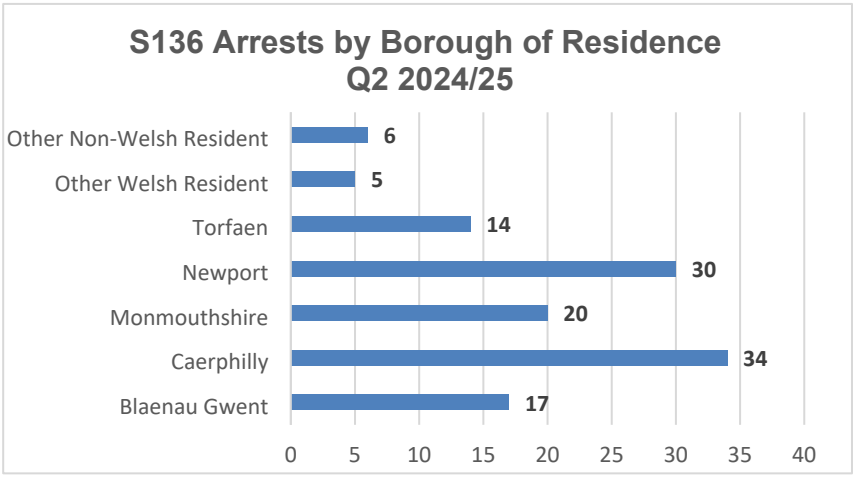
Use of Section 136, Q2 2024/25

Section 136 of the MHA	Q2 2023/24	Q2 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Assessed and admitted informally	17	12	24	19	20
Assessed and detained under Section 2	12	13	23	20	24
Assessed and detained under Section 3	0	0	2	0	0
Assessed and detained under Section 4	0	0	1	0	0
Discharged – no follow-up required	26	22	18	30	40
Assessed and Recalled under CTO	1	1	0	1	0
Discharged – with follow-up plan	32	36	27	37	41
Section 136 lapsed	1	1	4	1	1
TOTAL	**89**	**85**	**99**	**108**	**126**

A breakdown of the number of under 18's undergoing 136 assessment is shown in the graph below.



A breakdown of assessed patients by borough shows that Newport and Caerphilly had higher demand than other boroughs, together accounting for 51% of all assessments.



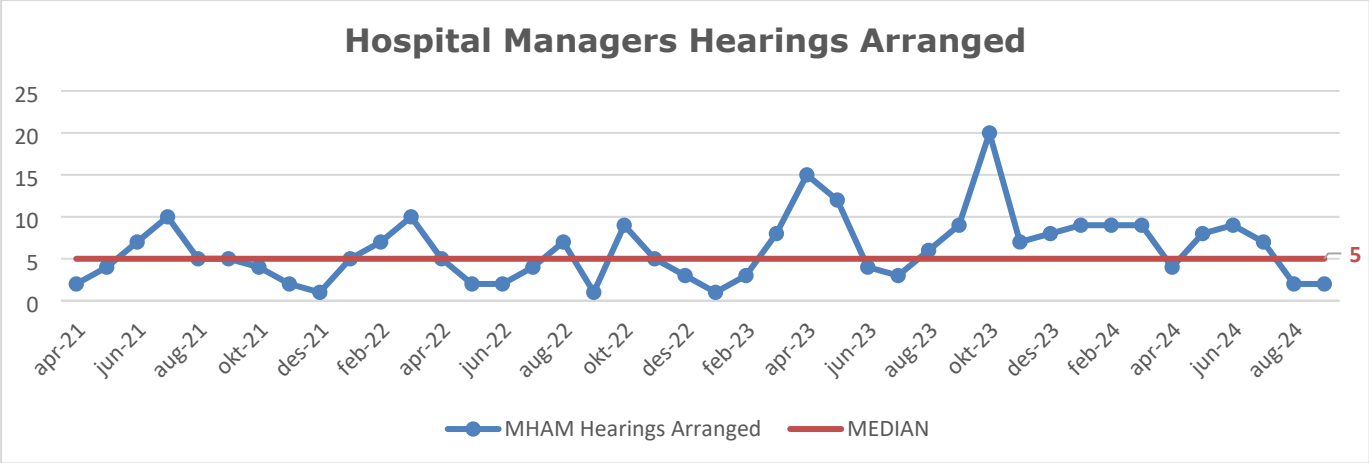
A breakdown of all 126 events shows that the majority of patients were female patients; alcohol and/or drugs being a related factor in 41% of all cases; 6% of cases were under the age of 18yrs. No assessments were undertaken at a police station.

Section 136 of the MHA	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
TOTAL	**N=89**	**N=85**	**N=96**	**N=108**	**N=126**
Gender:					
% Male	44%	55%	55%	52%	44%
% Female	56%	45%	45%	48%	56%
Place of Safety:					
% Hospital	98%	100%	98%	99%	100%
% Police Station	2%	0%	2%	1%	0%
% Under 18 Years	3%	7%	3%	6%	6%
Use of Illicit Substances:					
% Alcohol	30%	24%	17%	19%	26%
% Drugs	7%	2%	7%	7%	6%
% Both Alcohol and Drugs	2%	8%	9%	6%	9%

Where Assessment took place: % Hospital % Police Station	99% 0%	100% 0%	99% 0%	99% 0%	100% 0%
12 Hour extension required /granted	0%	0%	0%	2%	0%

5. Mental Health Act Managers Hearings

There has been a 48% decrease in the number of MHA Managers hearings arranged over the last quarter in comparison to the previous period. There were 3 hearings held during the quarter, a 57% decrease on last quarter and follows from a number of Associate Hospital Managers (AHM) either leaving the post or away from work at the current time. We have recently appointed 2 new AHMs and made offers to a further 3 applicants. The MHA office is working on a remedial plan to clear the backlog of cases.



A summary of activity and outcome of hearings is provided in the table below.

Mental Health Act Manager Review Hearings

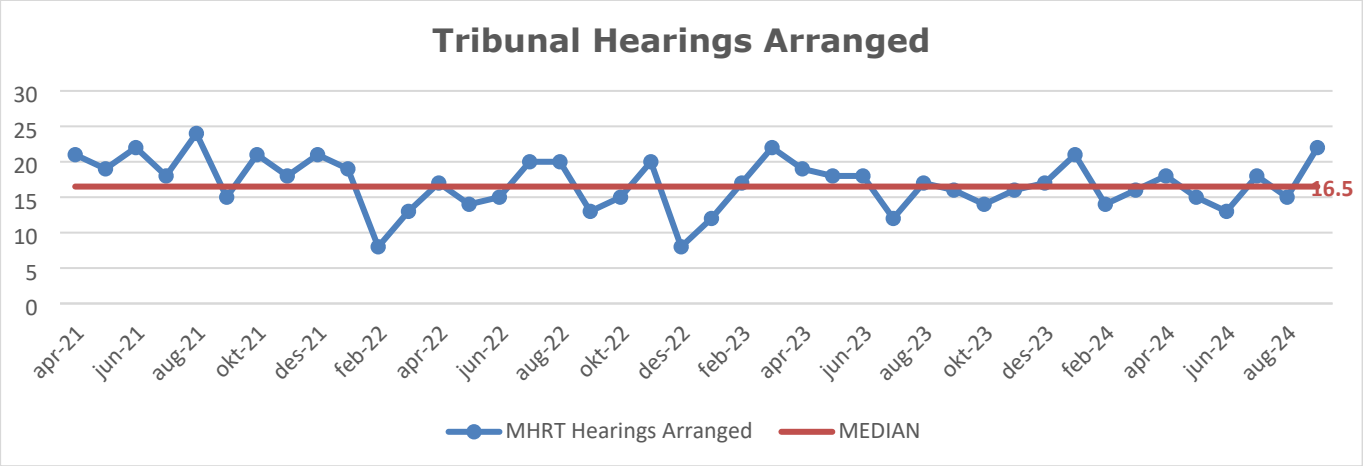
Hospital Manager Hearings	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Applications by patient – Inpatient	**1**	**1**	**0**	**0**	**1**
Applications by patient – CTO	**0**	**0**	**0**	**0**	**0**
Renewal Hearing Applications – Inpatient	**23**	**17**	**15**	**18**	**21**
Renewal Hearing Applications – CTO	**16**	**9**	**11**	**5**	**13**
Barring Hearings	**1**	**0**	**0**	**0**	**0**
Hearing cancelled before being heard	**14**	**16**	**13**	**14**	**8**
Hearing held - Patient Discharged by Hospital Managers	**0**	**0**	**0**	**0**	**0**

Hearing held – Section continued	**4**	**19**	**14**	**7**	**3**

6. Mental Health Review Tribunals

There continues to be a trend for patients to apply for a Tribunal hearing as opposed to Manager's hearings within the Health Board. The MHRT is a statutory independent body for hearing appeals against detention.

The chart below highlights the activity and outcomes of Tribunals arranged over the last two years. Overall, the number of hearings appears to be relatively consistent over the period of the last 12 months, with a 20% increase in the number of hearings arranged in Q2 in comparison to the previous quarter.



The activity and outcomes of arranged tribunals over the quarter is summarised in the table below.

Mental Health Review Tribunals Activity

MH Review Tribunal Hearings	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Applications by patient – Inpatient	**34**	**29**	**35**	**38**	**62**
Applications by patient – CTO	**0**	**2**	**3**	**2**	**2**
Renewal Hearing Applications – Inpatient	**6**	**13**	**7**	**4**	**8**
Renewal Hearing Applications – CTO	**3**	**6**	**2**	**3**	**2**
Referral by MOJ	**2**	**2**	**0**	**1**	**0**
Referral by Welsh Ministers	**1**	**0**	**1**	**0**	**0**
Outcomes: Hearing Cancelled before being heard	**25**	**31**	**33**	**23**	**32**

Outcomes: Patient Discharged by MHRT	**0**	**4**	**2**	**3**	**3**
Outcomes: Section Continued	**20**	**12**	**16**	**20**	**20**

This shows that a significant number of Tribunals continue to be cancelled before being heard. The reasons are that either the patient was discharged, or they withdrew before the Tribunal was held.

Asesiad / Assessment

This report is designed to provide information on trends and analysis of the use of the Mental Health Act and associated processes and to provide assurance to the Health Board that there are adequate governance arrangements in place to ensure the fair and lawful application of the act. The Mental Health and Learning Disabilities Division will continue to develop and refine the report using feedback provided.

Argymhelliad / Recommendation

The Committee is asked to receive the information provided on the use of the Mental Health Act.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 4. Dignified Care 7.1 Workforce 6.2 Peoples Rights
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Choose an item. Choose an item. Choose an item. Choose an item.

Strategic Equality Objectives 2020-24	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Mental Health Act (1983) Mental Health Act Code of Practice for Wales (Revised 2016)
Rhestr Termau: Glossary of Terms:	**Informal patient:** Someone who is being treated for mental disorder in hospital and who is not detained under the Act. **Detained patient:** A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital (e.g. on section 17 leave). **Section 135(1):** Provides the power to forcibly enter a property to look for and remove a person to a place of safety (usually a hospital) for a period of up to 36 hours for assessment, if it appears to a magistrate that there is reasonable cause to suspect that a person believed to be suffering from mental disorder; has been ill-treated, neglected or kept otherwise than under proper control or is living alone and unable to care for themselves. **Section 135(2):** Authorises forcible entry of a property to look for and remove a detained patient who is absent without leave (AWOL) from hospital if on information given, it appears to a magistrate that there is reasonable cause to believe that a patient already subject to a section is to be found on premises within the jurisdiction of the magistrate and admission to the premises has already been refused or a refusal of entry is predicted. **Section 136:** Under this section, if a police officer believes that a person in a public place is "suffering from mental disorder" and is in "immediate need of care and control", the police officer can take that person to a "place of safety" for a maximum of 24 hours (this can sometimes be extended for 12 hours) so that the person can be examined by a doctor and interviewed by an Approved Mental Health Professional (AMHP) and any necessary

	arrangements can be made for the person's treatment and care. **Section 5(4):** Allows a registered nurse to detain an informal patient of a patient lacking capacity for up to 6 hours. The person already has to be receiving treatment for mental disorder as an inpatient and is indicating that they wish to leave hospital and there has to be an immediate need to prevent this where a doctor or approved clinician is not available to complete a section 5(2) instead. This section is intended as an emergency measure. **Section 5(2):** This section provides the authority for a doctor or approved clinician to detain either an informal patient or a patient who lacks capacity for up to 72 hours. It is designed to provide the time required to complete an application for section 2 or section 3 if the person wishes to leave hospital before the necessary arrangements for these applications can be made. **Section 4:** Provides the power to forcibly admit and detain a person in hospital for up to 72 hours where it is of urgent necessity for the person to be admitted and detained under section 2 but only one doctor is available at the time to make a medical recommendation. **Section 2:** The detention period lasts for a period of up to 28 days to enable assessment or assessment followed by treatment for mental disorder to take place. Patients have the right of appeal to the Hospital Managers at any time and without limit to the number of appeals (at the discretion of the Hospital Managers) during the 28 days but they may only appeal to the Mental Health Review Tribunal within the first fourteen days of detention. Section 2 cannot be renewed but under certain circumstances, the 28-day period may be extended whilst an application is made to a county court to have another person appointed as nearest relative depending if certain grounds are met. **Section 3:** This admission is initially for a period of up to six months; if it runs its full course, the

	section may be renewed for a further six months and twelve-monthly periods thereafter. Patients may appeal to the Hospital Managers at any time during a period of detention but they can only appeal to the Mental Health Review Tribunal once in each period of detention. Where the patient has recently had a hearing (either MHRT or Managers), the chair of the Hospital Managers Power of Discharge Panel may refuse for the case to be considered unless there has been a significant change in the patient's circumstances or condition since that hearing. This prevents unnecessary hearings taking place which may distress the patient and impact on those involved in their care. **Section 37:** Section 37 provides for a court to sentence a person to hospital for treatment (or guardianship) for up to six months. The criteria and resulting admission work in the same way as a section 3 except for the appeal process. A section 37 patient has: • the right of appeal to the Crown Court or Court of Appeal to have the conviction quashed or a different sentence imposed. • the right to appeal to the Tribunal, but only in the second six months and then once in each subsequent period of detention. • the right of appeal to the Hospital Managers at any time and without limit to the number of appeals at the discretion of the Hospital Managers. **Section 38:** Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction. **Section 41:** Empowers the Crown Court, having made a hospital order under section 37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. **Section 47:** Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to

	and detained in a hospital to receive medical treatment for mental disorder. **Section 48:** Also known as a 'Transfer Direction'. Enables the Secretary of State, on the advice of two doctors, to remove a prisoner awaiting sentencing to hospital for treatment of a serious mental health problem. **Section 48/49:** As Section 48, but with special restrictions added for that transfer. **Section 49:** Also known as a 'Restriction Direction'. Enables the Secretary of State for Justice to add an order restricting the patient's discharge from hospital. **Section 17A, Community Treatment Order:** This allows for a patient to receive the care and treatment they need for their mental disorder in the community rather than in hospital. To be eligible for CTO the patient must have been detained on one of the treatment sections when the application for the CTO was made. Each time a period of section 17 leave is granted to a detained patient for more than 7 consecutive days, their RC must consider whether it would be appropriate for the patient to be subject to CTO rather than an inpatient on extended section 17 leave. The patient's responsible clinician may specify conditions to be applied by the CTO. The only limitation on conditions is that they are "necessary" or "appropriate" for: • ensuring the patient receives medical treatment • preventing the risk of harm to the patient's health or safety • protecting other persons. Once on a CTO, the patient may be recalled to hospital for up to 72 hours where the treatment rules under the Act apply during that period of recall.
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**	Choose an item.
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Outcomes Framework Quarter One – Three (Apr – Dec 2024)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Quality Outcomes Framework (QOF) report for Q1-Q3 2024/25 evaluates the Health Board's progress on quality and safety metrics. It aligns with ministerial priorities and emphasises patient experience, learning, and safety improvements.

Cefndir / Background

The Quality Outcomes Framework report for Q1-Q3 2024/25 provides an overview of the Health Board's performance against quality and safety metrics. It highlights achievements, areas of concern, and ongoing initiatives, aligned with ministerial priorities and the Duty of Quality.

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

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

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

Asesiad / Assessment

Areas of Achievement/ Improvement:

- **Patient and Staff Experience and Stories:** 86% positive emotional responses reported via the CIVICA feedback platform, exceeding the 85% benchmark. Introduction of patient participation panels, PALS, and bereavement services.
- **Incident Reporting:** Total falls incidents averaged 302 per month, with 99% categorised as no or low harm.
- **Risk-Adjusted Mortality Index (RAMI):** remained stable at 101.91, below the All-Wales peer average. Sharing incident data with divisional teams has improved education on medication safety.
- **Complaints, Concerns, and Compliments:** Ongoing improvements in complaints handling and incident investigations. Early Resolution: Achieved a 67% resolution rate for early complaints across Q1-Q3. Compliments: Regularly documented, with some wards actively logging positive feedback.
- **Health, Safety, and Security: RIDDOR Compliance:** Reporting compliance improved significantly to 86% in Q3. Training for Leaders: Part 1 of IOSH Safety for Executives and Directors completed for senior leaders. Violence Prevention: Development of a Health Board-wide Violence Prevention & Reduction Strategy.
- **Infection Control and Prevention:** Hand Hygiene and Environmental Cleaning: Continuous focus on compliance with infection control standards. Improvement Measures: Infection-specific faculty groups developed for Staph Aureus and C. difficile.
- **Safeguarding: Training Compliance**: Level 1 safeguarding training achieved 91.6% compliance.
- **Collaborative Work**: Integration with police and health alliances for mental health crisis management.
- **Sepsis Management:** Recognised improvements with workshops and task groups actively addressing patient deterioration.

- **Ward Accreditation**: Rolling out across several divisions, with the first wards formally accredited.
- **Theatres Safety Programme:** No Never Events reported since November 2023 in Theatres. The last reported in November were 3 Never Events, namely, one wrong site block, one incorrect transfusion and one wrong patient identification (near miss). There have been two events from April to December 2024, as discussed in the report, one within a non-theatre environment this is under review for early learning. Both events resulted in zero harm.
- **Bereavement Focus:** Increased focus on bereavement following a collaborative event.

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

Areas of Focus in Quarter Two:

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

- **Patient and Staff Experience and Stories:** Themes of dissatisfaction in complaints include communication issues and delays in discharge processes. The need for consistent engagement with staff feedback to support service improvements.
- **Incident Reporting:** Though most falls resulted in low harm, there is an ongoing upward trend in incidents. Moderate harm medicines incidents increased slightly in Q2, requiring further analysis and action. Crude mortality in hospital, while improving, requires closer scrutiny of trends and factors.
- **Complaints, Concerns, and Compliments: PTR Performance:** 30-day compliance for complaints averaged 55%, below the target of 75%. Themes of Concerns: Clinical treatment, communication, and attitude/ behaviour remain recurring issues.
- **Health, Safety, and Security: Training Compliance:** Manual handling training remains low at 69%. Fire Safety: Enforcement notices have been addressed, but broader compliance efforts are ongoing.
- **Infection Control and Prevention: Infection Rates:** C. difficile cases increased by 36%, with a rate of 50.05 per 100,000 population. Staph Aureus bloodstream infections rose by 63%. Pseudomonas cases increased by 77%. Ward Closures: 40 closures due to infections (C. difficile, COVID-19, Norovirus). Key measures: Enhanced cleaning, antimicrobial stewardship, and monitoring via dashboards. Focus on infection control through education, monitoring, and compliance with national policies.
- **Safeguarding: Incident Reviews:** Challenges in timely safeguarding incident reporting and follow-up require additional focus. Vulnerable

Populations: Efforts to embed Right Care Right Person for mental health and crisis situations are ongoing.

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

Learning and Improvement:

- Continuation of the Learning and Improvement Forum, implementation of the Listening and Learning Framework. Emphasis on the importance of shared learning platforms and forums.
- Workshops and Campaigns: Sepsis and deteriorating patient workshops identified barriers and set improvement strategies.
- "Big Conversation for Future Care Planning" event initiated public engagement on future healthcare planning.
- Patient and Staff Engagement: CIVICA feedback system highlighted recurring themes for improvement. Continuous emphasis on involving patients in service redesign and decision-making.

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

Argymhelliad / Recommendation

The Committee is requested to note the progress of the quality performance report and to take assurance from this report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults

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

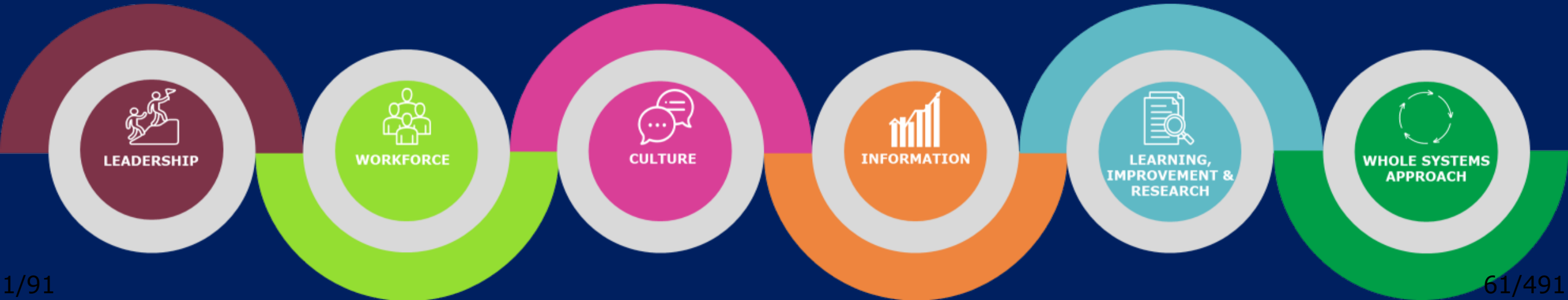
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Quality Outcomes Framework

Quarter One to Quarter Three: 2024/25



Overview

This is a combined report that includes the measures within quality outcomes framework (QOF) and an update of narrative, themes and learning. This provides the Board / Committee with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

This also covers the Health Board's quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy, ensuring that the Patient Experience and Involvement Strategy has been embedded throughout the report.

For quarter three the existing QOF indicators have been mapped where possible. Some of these indicators are still being refined. Work will continue with Digital, Data and Technology Directorate, with an ambition to produce automated reporting and enable reports to be standardised. The use of iconography will provide detail on trends.

This reports focuses on learning and improvement throughout quarter three 2024/25. It includes:

Quality and Safety Pillars
- Indicators mapped to the refined Quality Outcomes Framework, proposed for 2024/25
- Narrative on indicators
- Additional information is available in the report to provide assurance against these standards

Escalated Risk Concerns

Clinical Effectiveness

Information
- Learning and Improvement Forum highlights
- Additional indicators as defined as potential indicators are being mapped as part of the
- iterative process of refining the reporting of the QOF

QPS Update

- Continue to work with Digital, Data and Technology to enable automation of the Quality Outcomes Framework (QOF). The refinement includes a smaller number of metrics which demonstrate assurance and compliance. Ensure triangulation of data.
- The patient engagement and involvement strategy continues to progress the delivery of person-centred care, which included patient participation panels, PALS and bereavement services.
- Strengthened Divisional learning/reporting through Governance structures and standardised agendas. Supporting a culture of shared learning and a triangulated approach to quality, patient safety and experience. The listening and learning framework has been implemented, a learning and improvement forum and learning repository.
- The Learning and Improvement Forum meets to look at shared learning across the Health Board. Strengthening the learning and listening infrastructure.
- The Learning Repository is being utilised.
- Quality Improvement Strategy approved and implemented.
- Review alignment of Datix Management System in underway.
- The Safe Care Partnership (SCP) event, a collaboration between Improvement Cymru and Health Boards across Wales, aimed to shape the future of their work. Key initial findings included: a clearer definition of the work and importance of listening to and learning from patients and the public. There is a necessity of collecting and using meaningful measures that make a difference.

Patient Quality and Safety Learning and Improvement Forum Highlights

Good News:

- Theatre safety work has been accepted for presentation at the International Forum on Quality & Safety to be held in Quebec this year.
- Work on Sepsis was commended with the sharing of the good work. A scoping exercise had been undertaken and presented to QPSOC. A workshop linked to the deteriorating patients was scheduled to take place on the 29th of November 2024.
- The patient experience team were those to win awards in 2024 alongside Maternity services and the Lead Nurse for Dementia being the RCN Nurse of the year winner for the 'Care of the Older Person Award'.
- Latterly in 2024 the organisation has seen the launch of the 'Research Champions Programme' with the establishment of the first cohort of Health Board staff.
- The first cohort of staff training as 'Quality Improvement Coaches' had completed their training.

Patient Story:

A patient story was presented by Arts Therapies which demonstrated a positive outcome to a challenging journey. The story shared the proactive power of arts as an important means in supporting individuals in interpreting, expressing and resolving their emotions and thoughts to find resolutions.

Organisational Learning and Improvement:

- The Human Tissue Act (HTA) 2024 Annual report was presented with an overview presented of established goals for the coming 12 months which would be managed through the re-establishment of the Health Boards HTA Committee.
- Health and Safety presented positive progress in RIDDOR reporting with increased compliance for the given period increasing from 68.4% to 86.4%.
- Alongside the Health Boards plan to address violence and aggression the organisation is engaged in the National work.
- The first iteration of the 'QI is the AB way: QI Capability Strategy' was presented together with the 'Vision' for the Health Board as a learning organisation.
- The Quality Annual report summary was presented mapped to the six pillars and provided the insight into what has gone well and the challenges ahead with good progress on the 'Quality Outcomes Framework'. Examples of future and ongoing workstreams include sepsis, human factors and Infection prevention and control.
- A patient case story was presented aligned to the six pillars will be the basis of a multi professional, cross Divisional learning event in early 2025. The related report was commended by the coroner.
- A 'Big Conversation for Future Care' planning event was planned to invite the public to work with Health Care Professionals in raising awareness as to what the future may look like through a collaborative approach.

Good Practice

Section 1

Consent – Progress

Overview: A review conducted by Welsh Risk Pool assessed how well the Health Board obtained patient consent for examinations and treatments, ensuring patients are fully informed and involved in decision-making. The review was based on the Welsh Government's 2017 Guide to Consent and the 2018 updated Model Policy for Consent to Examination or Treatment. The review highlighted the importance of clear, informed consent processes to ensure patient safety and satisfaction.

Findings: Five consent forms were reviewed. Most patients signed their forms on the day of treatment, with some forms completed weeks in advance. However, there were issues with illegible signatures and missing clinician details.

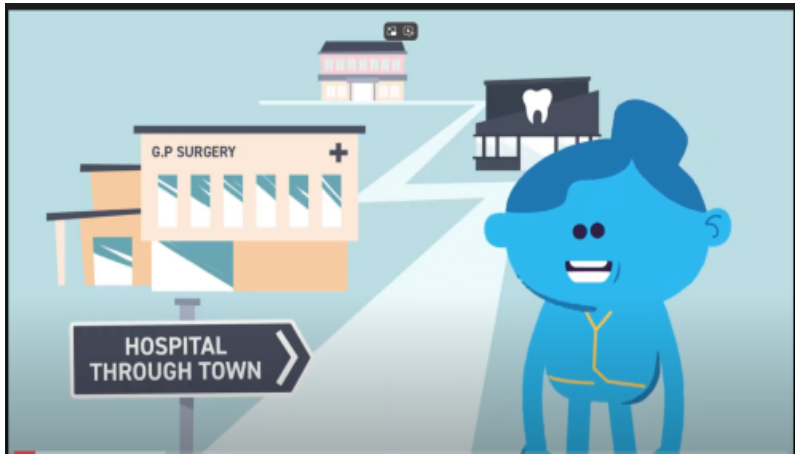
Recommendations: The Health Board is committed to making necessary improvements to enhance the quality of care provided to patients. All those made by WRP have been completed. These included:

- **Policy Review**: The Health Board Consent to Examination & Treatment Policy has been updated to reflect All-Wales guidance.
- **Compliance**: Health Board consent forms are compliant with All-Wales Forms.
- **Intranet Update**: The Intranet page includes new e-learning on consent in Wales.
- **Model Policy Adoption**: The All-Wales Model Policy for consent to examination or treatment for Adults, Children & Young People has been adopted.
- **Governance Process**: A governance process for developing locally produced patient information leaflets for consent is being implemented.
- **Audit Programme**: There is a Health Board audit programme for monitoring the consent process.
- **Continuous Monitoring**: Introduced processes to assess compliance with National and Local standards for obtaining patient consent.

Consent - Videos for the Public

The Clinical Executives are launching two new videos designed to help patients understand the process of obtaining informed consent for medical procedures. Created by a team of healthcare providers and risk management experts, these videos aim to ensure patients are fully aware of their rights and responsibilities when giving consent for examinations or treatments. One video is tailored for adults in primary and secondary care, while the other is specifically for obstetric and maternity services. Both videos are available in English and Welsh. The videos can be found on the intranet and will be added to the internet.

AB_CONSENT_ENGLISH_V03.mp4
AB_CONSENT_WELSH_v03.mp4



AB_CONSENT_ENGLISH_BEV v02.mp4
AB_CONSENT_WELSH_bev_V02.mp4

Our patients are at the heart of everything we do. We are committed to ensuring that patients feel informed, empowered, and secure in the knowledge that health is in the hands of a team dedicated to providing the best care while managing all potential risks.

A page dedicated to Informed Consent can be found on SharePoint.

Escalation

Section 2

Urgent and Emergency Care

- A new **operational framework** continues to be developed with ward visits across all sites undertaken in December, led by an Executive, to test its elements. These visits aimed to identify obstacles, assess framework embedding, and explore opportunities to simplify complex discharges with actions being progressed through January/February.

- **Weekly Safety Flow** cross-Divisional meetings continue to focus on reviewing and evolving practices and processes to improve outcomes, efficiencies, and patient experiences.

- **Additional ED Consultants** – coming on board from January and focus on rapid assessment.

- **Safe-to-Start meetings start on 13th January 2025** aim to empower specialties to take greater accountability for their demand, risk, and flow profiles to support first-floor services/risks, enhance the quality of care provided, and improve patient safety.

- A new **Transfer Lounge** is in train with increased capacity to be operationalised at the GUH in Feb/March 2025 to improve the timeliness of flow and generate an earlier bed capacity profile.

Improvement/Actions Progressed in the Last Quarter

NOVEMBER

Week 1
- ✓ ED SRATs/Consultant Recruitment Interviews
- ✓ Dual Pin implemented (joint compliance/SOP)
- ✓ Recruitment for TL staff
- ✓ Bed Modelling / Allocation

Week 2
- ✓ Gen Med Model implemented (SOP in place)

Week 3
- ✓ Ambulatory CEPOD operationalised

Week 4
- ✓ Machen utilisation

DECEMBER

Week 1
- ✓ Operational Framework/ward visits
- ✓ Fox Pod Model/plan Haematology Plan/Model
- ✓ Stroke pathway review/process to protect the HASU beds
- ✓ Medical Staffing Deep Dive

Week 2
- ✓ YYF MIU/UPCC
- ✓ Winter Respiratory support to 111/999

Week 3
- ✓ DVT Clinical Expansion/Model

Week 4
- ✓ ED short stay progressed

JANUARY

Week 1
- ✓ Operational Framework progress
- ✓ Enhanced on-call rota
- ✓ SDEC Flip/Model
- ✓ New Step Down Process/forms live

Week 2
- ✓ Optimal working of front door teams
- ✓ S2S Meeting/Ops Team Ways of Working reviewed

Week 3

Week 4
- ✓ Discharge Model 12hr model launched
- ✓ 2nd MRI – work starts

FEBRUARY

Week 1
- ✓ Transfer Lounge Modular arrives on site

Week 2

Week 3
- ✓ Discharge/Transfer Lounge GUH operational

Week 4

Mental Health & Learning Disability

- **Engagement and Workshops**: Workshops have concluded. The organisation development and communications plans are now focusing on ongoing development based on feedback received.
- **Learning Forums**: Part of the quality improvement programme is focusing on sharing and disseminating learning across the division. Participation in the national strategic programme for leadership exchange is also planned.
- **Continuous Improvement Plans**: Ongoing quality improvement work, including delivery of improvements identified during HIW inspections and evidenced by HIW return visits. Positive Report from HIW - received for the inpatient unit – Ty Lafant.
- **National MH & Wellbeing Strategy**: Engaged in all workstreams of the National Programme through the NSPB – National Board.
- **Patient Safety Incident Review**: Continuous review with the Executive Director of Nursing and COO, focusing on safeguarding and incident reporting. Fortnightly assurance meetings are part of enhanced monitoring.
- **Directorate Assurance Meetings**: Regular meetings for scrutiny of all aspects of QPS, led by the COO and supported by the Divisional nurse.
- **Right Care Right Person Integration**: Embedding with the new police and health alliance for mental health crisis management.
- **Clinical Risk Assessment Training**: All registered staff undertake WARRN training, delivered internally by dedicated trainers and supported by clinical staff.
- **Safeguarding Awareness and Training:** Our 6-monthly report shows bespoke training is well-received, with 91.6% compliance at Level 1.
- **Improved Discharge Plan**: Weekly POCD meetings with updated patient tracker information. Two patient flow coordinators with senior oversight are now in place.
- **Ongoing Quality Improvement Work**: Continuous work on patient search, observation policy and practice, safeguarding reporting, and escalation processes.

Challenges:

- **WCCIS Challenges:** Issues with the patient information system and user interface persist, requiring ongoing workarounds for validated data.
- **Waiting List Backlogs:** Strategies like validation, triage, and rule enforcement are in place, with fortnightly meetings to address capacity.
- **Recruitment and Retention:** Workforce and capacity remain challenges, but progress is being made with international nurse cohorts arriving in January and streamliners in March.

For Discussion

Section 3

Sepsis Progress Report – Update

National Drivers for Deteriorating Patient:

- The **Welsh Health Circular (WHC) /2024/035** – Standardising the management of acute deterioration provided an agreement on standardisation and use of Early Warning Scores (EWS). Following the release of this circular the Health Board has been working towards implementing the recommended EWS. These will support identification of acute deterioration for patients and suggest a point at which care needs to be escalated and to define a response to escalation triggers. As current practice varies, this introduces a potential risks to patient safety. A standardised, national approach using evidence-based tools will ensure clarity, minimise risk and support improved patient outcomes.

- **Safer Care Partnership** led by NHS Executive and Improvement Cymru, there is a National focused workstream on acute deterioration. This encompasses the WHC and the need for rolling out Martha's rule (Call for Concern), which the Health Board have been planning.

Local Implementation:

- **Working Group:** To implement the standardised National Early Warning Scores (NEWS2) the Health Board's Sepsis Working Group has divided into smaller task and finish groups. This will ensure delivery and compliance of the WHC. The groups will focus on digital, education, implementation, escalation, and audit. A driver diagram is being produced at the end of January to identify barriers and actions required for successful implementation of NEWS2. A key focus area will ensure the digital specifications are scoped to enable the switch over to NEWS2, which will take place as a workshop in the next few weeks.

- **Paediatrics:** Planning for the implementation of the National Paediatric Early Warning Score (PEWS) is underway, with a target launch in April. Discussions will be held to develop an education plan to ensure staff receive training on sepsis and the new EWS.

- **Maternity and Neonatal:** An implementation workshop for the All Wales Maternity Early Warning Scores (MEWS) and New-born Early Warning Track and Trigger 2 (NEWTT2) was hosted by the NHS Executive in December 2024. A follow-up meeting in January 2025 has been held, which established groups to support with the roll out of MEWS and NEWTT2 and identifying the key stakeholders to ensure successful implementation. Groups will include: digital, education, policy review, and measurement/audit. The digital template for BadgerNet will be available for NEWTT2 in June and MEWS in September, with the group working towards implementation once available.

These efforts aim to improve sepsis awareness, treatment, and outcomes across the Health Board.

Sepsis Progress Report – Progress

- **Scoping Exercise:** This has been undertaken to establish and review the health boards existing management of sepsis and review current practices and policies in order to align with National Institute for Health and Care Excellence (NICE) updated Sepsis guidance (2024) and the Academy of Medical Royal Colleges (AoMRC) guidance around appropriate antimicrobial usage when treating sepsis.

- During the scoping, a number of improvement initiatives are being undertaken within Divisions, which includes the launch of a sepsis specific project on C0 and a sepsis specific medical faculty group. This has highlighted further opportunities for improvement within the acute sector through reviewing incidents, complaints and exploring opportunities to learn and improve management of sepsis. Following the implementation of the EWS, the Medical Director's Quality and Patient Safety team are working collaboratively with specialities to develop sepsis expertise, scope performance targets and and provide support with improvement initiatives where required. This will include sharing learning amongst the specialities with an aim of improving the standard of sepsis recognition, response and management.

- **Sepsis Screening Tool:** There has been focused task and finish groups held to review the sepsis screening tool. This has led to an agreement to test the evidence-based Sepsis Trust UK tool. By quality improvement methodology and small tests of change (through PDSA cycles) within the acute sector this will be rolled out iteratively. Following implementation of the National EWS, the tool will be reviewed to ensure compliance and ensure the effective implementation is leading to improved outcomes for patients in adult, paediatric, and maternity/neonatal environments.

- **Primary and Community Care:** Scoping has commenced, with an initial presentation delivered to the Neighbourhood Care Network to gauge stakeholder buy-in.

- **Sepsis Workshop:** A workshop was hosted in November focusing on the deteriorating patient and sepsis. There was representation from multiple divisions, which explored key questions such as why patients deteriorate within the system and what barriers hinder effective responses. The collaborative discussions laid the groundwork for mapping out improvement strategies aimed at driving better outcomes for patients. In collaboration with the ABCi team a fishbone exercise was undertaken to look at barriers and consider how to improve how we identify and respond to patient deterioration across our wards. A follow-up workshop will be held after the implementation of the Welsh mandated EWS. Additionally, a Primary and Community Care focused workshop will be delivered in Quarter 4 2025 to capture barriers outside the acute setting. More info can be found here: Successful Workshop Held to Address Sepsis and Patient Deterioration

- **Awareness Campaigns:** A sepsis campaign was launched on 29th November 2024. Initially launched internally, the campaign aims to deliver sepsis awareness information to the public in January 2025. Content includes a new public-facing sepsis website, an internal staff pulse page, and resources/assets to drive awareness. Sepsis - Home

- **National:** The Health Board continues to be represented in national sepsis forums and actively contributes to the national direction for sepsis. The NHS Executive has recently employed an Early Warning Score Implementation Lead to provide oversight and guidance to health boards, ensuring alignment with the national mandate. This includes ensuring national available resources, such as eLearning material, is reviewed and provided for staff within our Health Board.

Nutrition & Hydration

- Steering Group re-established (Strategic). Senior clinical leadership led, comprising multi-disciplinary membership - first meeting scheduled 05/02/25.
- Two tactical sub-groups reporting to the steering group – one for food standards, and one for clinical standards.
- Steering group to report to Exec Team and PQSOC for assurance.

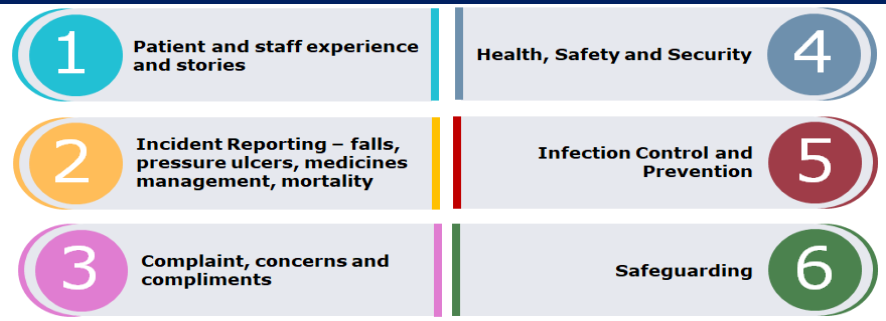
Examples of on-going and future work:

- Task and finish group established to produce an escalation policy for patients with nutrition and hydration needs not being met in a timely manner – this work is undertaken in response to several patient safety incidents. Policy ratification Q4 24/25.
- Task and finish group established to review and implement recommendations relating to fluid balance and hydration – this work undertaken in response to coronial Section 28 order
- Allergen management and menu development.
- Divisional patient catering groups established (Operational).
- Monitoring Health Board compliance with All Wales Standards for Hospital food and fluid provision (launching spring 2025).
- Reviewing Health Board nutrition and hydration audits and identify subsequent opportunities for quality improvement.


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

Section 4

Background



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

We must put the quality and safety of our health services above everything else. This strategy signals our intention to progress these six pillars of quality to establish our level of performance. The pillars will be our quality markers in our Quality Management System. Strengthening our Quality Management System helps us make sure our decision-making focuses on improving the quality of health services.

These measures of quality will allow standardised agendas for Divisions to report on quality measures.

PATIENT AND STAFF EXPERIENCE AND STORIES

Through the introduction of CIVICA – an electronic Citizen Feedback platform that will help people who are using our services to tell us what they think about their care. Providing feedback on our services will help us learn, make changes where we need to and celebrate what we do well. Staff will also be able to feedback on a regular basis, helping them to make improvements in their areas.

Analysis of patient experience data including complaints and compliments will provide a comprehensive picture of areas of positive performance and areas for improvement.

COMPLAINTS, CONCERNS AND COMPLIMENTS

Our commitment to patients is, wherever possible, to respond to their complaints timely and provide the information requested in an open and transparent way. Where it is not possible to provide immediate resolution, we commit to agree an appropriate investigation and to carry out that investigation to a high standard and on time. To ensure that all complainants have access to an investigating officer and are contact regularly.

INFECTION PREVENTION AND CONTROL

The Health Board is committed to zero tolerance of preventable Healthcare Associated Infections (HCAIs). Welsh Government sets reduction expectations for healthcare acquired infections which are achieved via collaboration from experts across healthcare. The Health Board are committed to providing clear programmes of work and evidence-based Policies which sets the expectation on the organisation. Our workforce will be skilled and trained to deliver against national, local and organisational objectives. We will monitor outcomes and reporting compliance/ learning through the Reducing Nosocomial Transmission Group (RNTG), Patient Safety Operational Group and Committee.

INCIDENT REPORTING

Through our 'Pillars of Quality' Programme, we will continue to focus on incident reporting as a key enabler of organisational learning and improvement. We will co-ordinate a comprehensive rolling Programme of quality improvement initiatives which strive to reduce avoidable harm with a focus on falls, pressure ulcers, deteriorating patients, mortality, end of life care, medicines management, discharge and safe transfers of care.

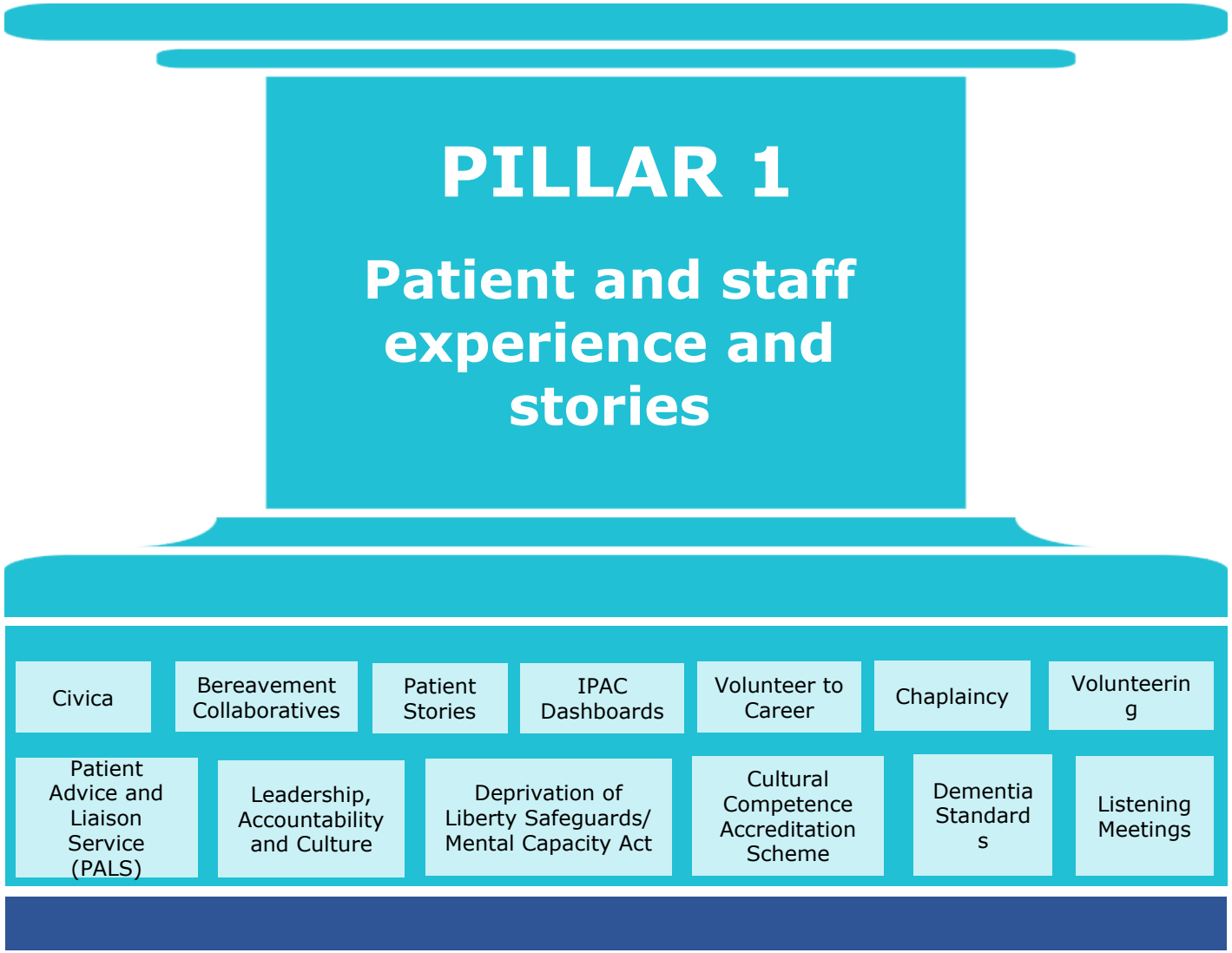
Our commitment to staff is to have a **just** culture, where staff feel safe to report concerns, incidents and near misses, knowing this will result in a timely, fair, comprehensive investigation. Our incident reporting system 'Datix' is a key component in providing insights to data gathering and learning actions.

HEALTH, SAFETY AND SECURITY

We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies and practices through our Health, Safety and Security Practitioners. We will conduct reviews of all sites and an annual snapshot of health and safety. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips and falls.

SAFEGUARDING

Safeguarding is everybody's responsibility. We will demonstrate reasonable steps to ensure the safety of children and adults at risk. The Health Board's Strategy and Policy sets the expectation of accessing services. The workforce will be skilled and trained to deliver national, local and organisational objectives. The Health Board will support and enable operationalisation through provision of tools and direct support from the corporate safeguarding team, as the workforce undertakes its duties in relation to safeguarding. We will monitor outcomes and report effectiveness through effective audit and clear governance processes.



QOF Metrics

Included in report:

- CIVICA data
  - Total new responses
  - Patient satisfaction % positive emotion trend, negative emotion trend

Developing metrics not yet reported:

- Staff culture – metric TBC
- Themes from patient stories – AI repository development

QOF Metric Pillar ONE - CIVICA data total new responses
Patient Experience Feedback April 2024 – December 2024

All Surveys

Number of Responses
Health Board Wide - 01/04/2024 to 31/12/2024
All Questions (Bereavement Survey/Arolwg Profedigaeth, Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , Emergency Department Survey, Health Visiting

5461
Responses

Export Options

Satisfaction Score
Health Board Wide - 01/04/2024 to 31/12/2024
All Questions (Bereavement Survey/Arolwg Profedigaeth, Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , Emergency Department Survey, National Nosocomial

90%
Satisfaction

Export Options

Person Centred Care (PCC) Survey

Number of Responses PCC
Health Board Wide - 01/04/2024 to 31/12/2024
All Questions (Person Centred Care - Standard)

4936
Responses

Export Options

Satisfaction Score PCC
Health Board Wide - 01/04/2024 to 31/12/2024
All Questions (Person Centred Care - Standard)

91%
Satisfaction

Export Options

Emergency Department (ED) Survey

Number of Responses ED
Urgent Care - 01/04/2024 to 31/12/2024
All Questions (Emergency Department Survey - Standard)

288
Responses

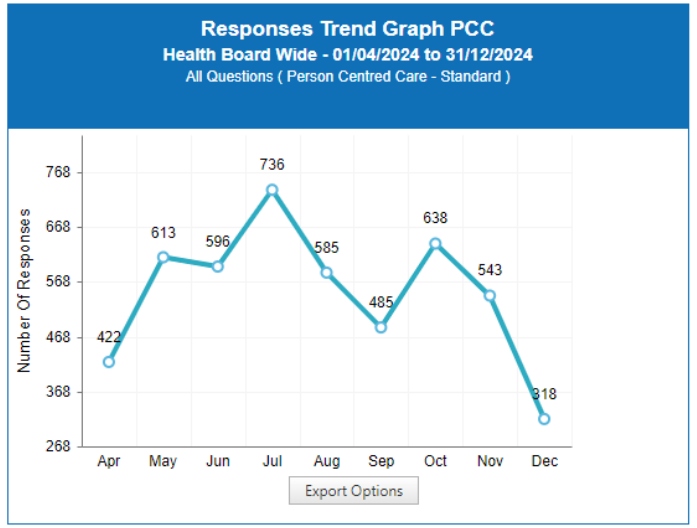
Export Options

Satisfaction Score ED
Urgent Care - 01/04/2024 to 31/12/2024
All Questions (Emergency Department Survey - Standard)

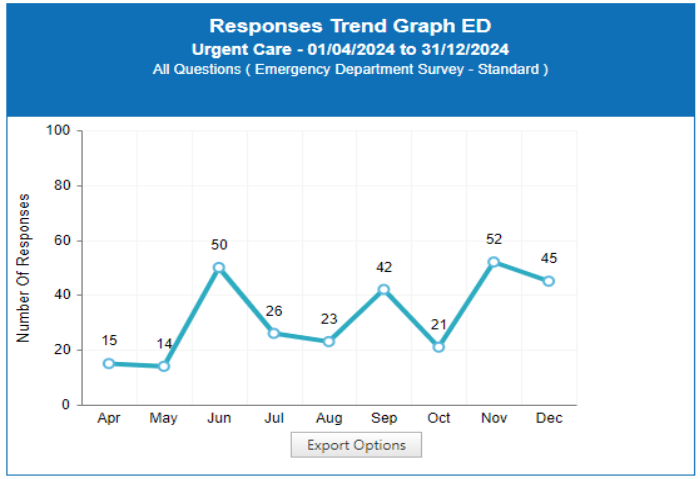
68%
Satisfaction

Export Options

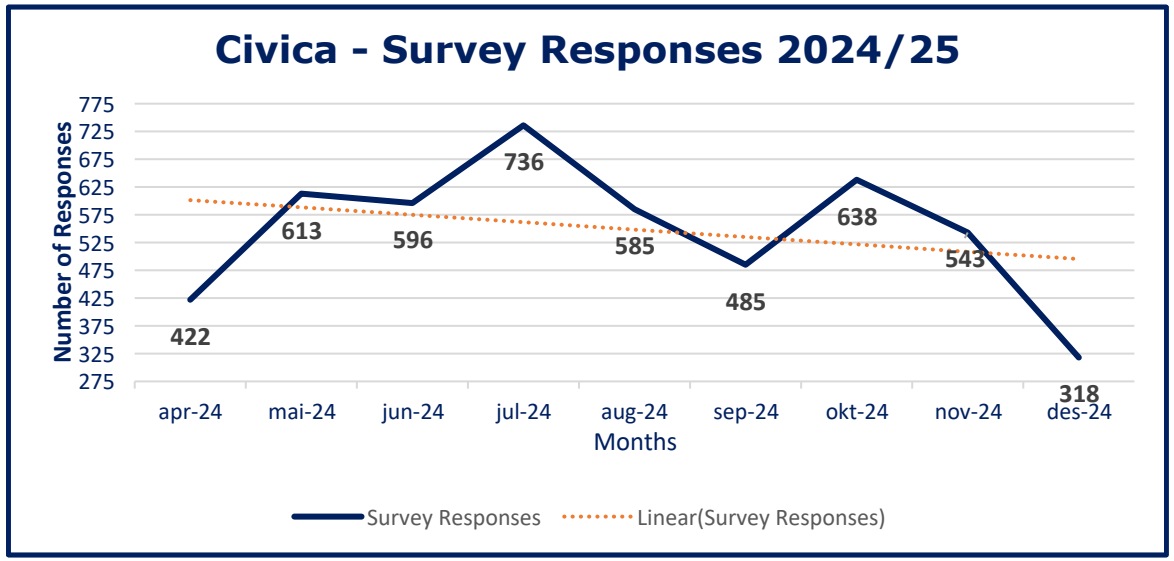
Response Trend PCC

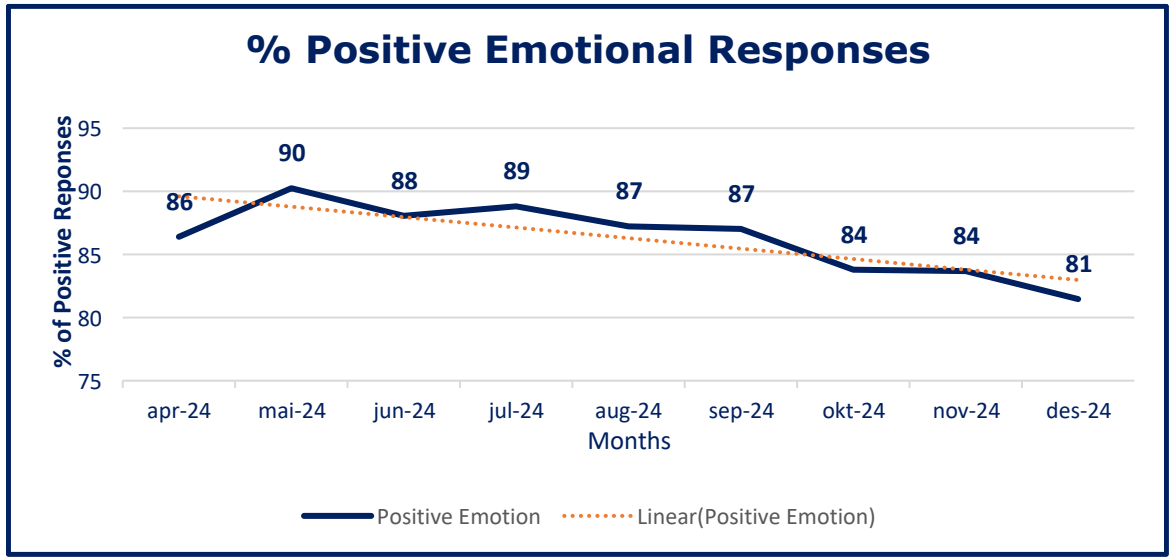


Response Trend ED



QOF Metric Pillar ONE - CIVICA Data Total Responses
Civica YTD – 2024/25





Quarter	Number of Responses	% Difference	
Q1	1631	-	
Q2	1806	11%	↑
Q3	1499	17%	↓

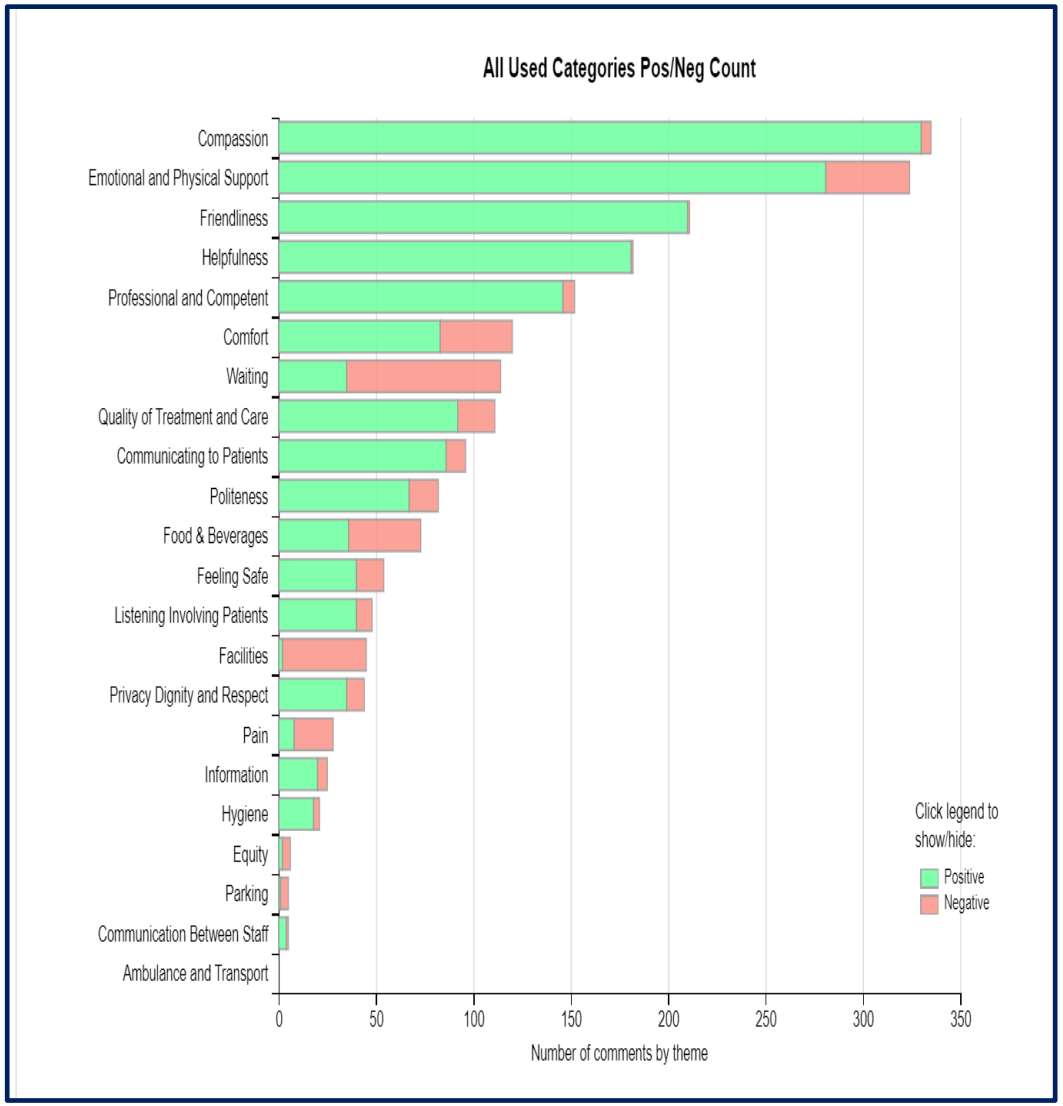
Total Responses YTD (2024/25)
4936

Quarter	Positive Emotional Responses	% Difference	
Q1	88%		
Q2	88%	1%	↓
Q3	83%	5%	↓

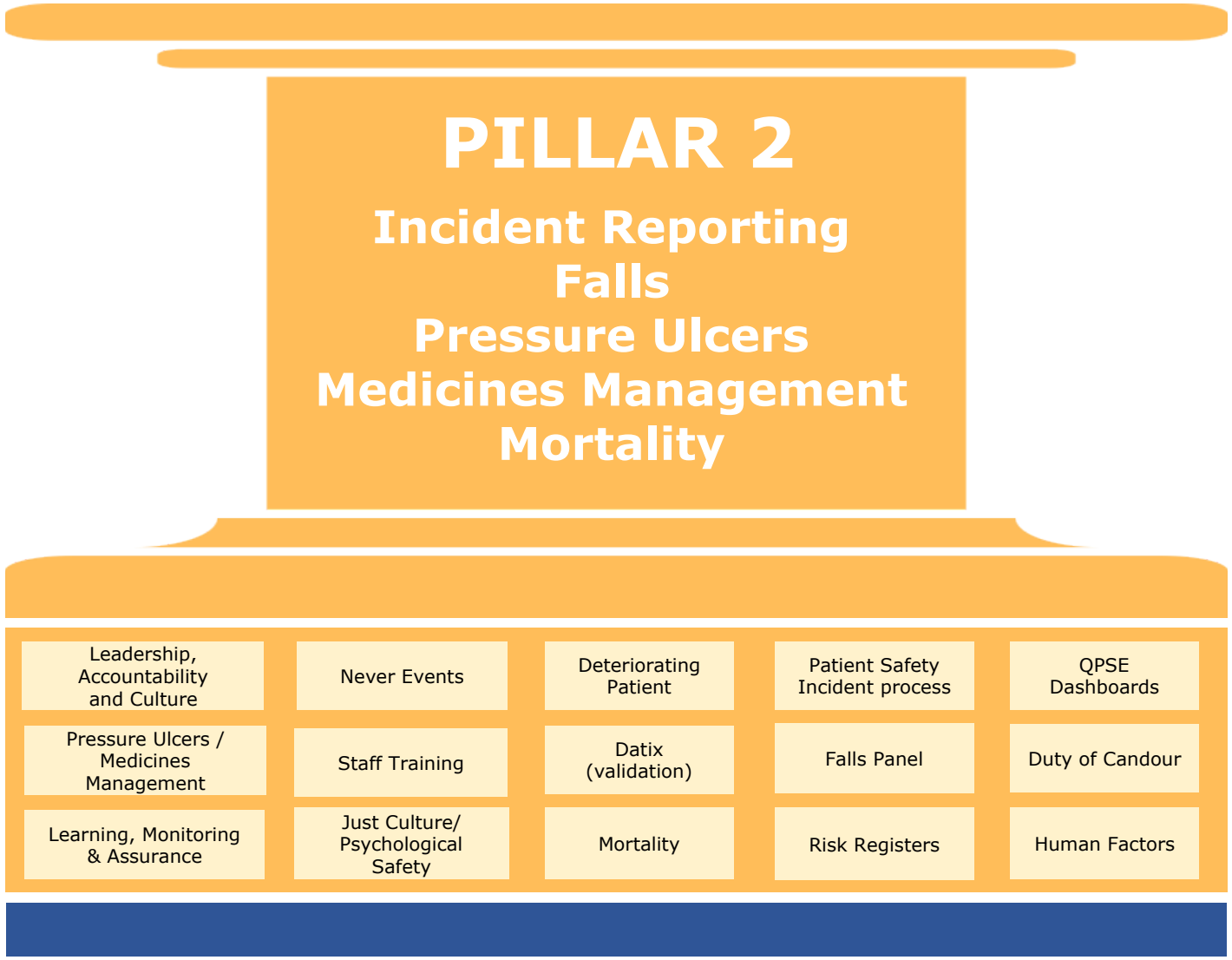
% Positive Emotional Response (2024/25)
86%

Average 86% is higher than 85% benchmark

QOF Metric Pillar ONE - CIVICA Data Patient Satisfaction, % Emotion Trend Civica Responses Q3 – 2024/25



What did we do well?	What could we have done better?
Top 3 – Positive Comments	**Top 3 – Negative Comments**
330 comments around **Compassion**	**60** comments around **Waiting**
281 comments around **Emotional and Physical Support**	**43** comments around **Emotional and Physical Support**
•210 comments around **Friendliness**	**37** comments around **Comfort**



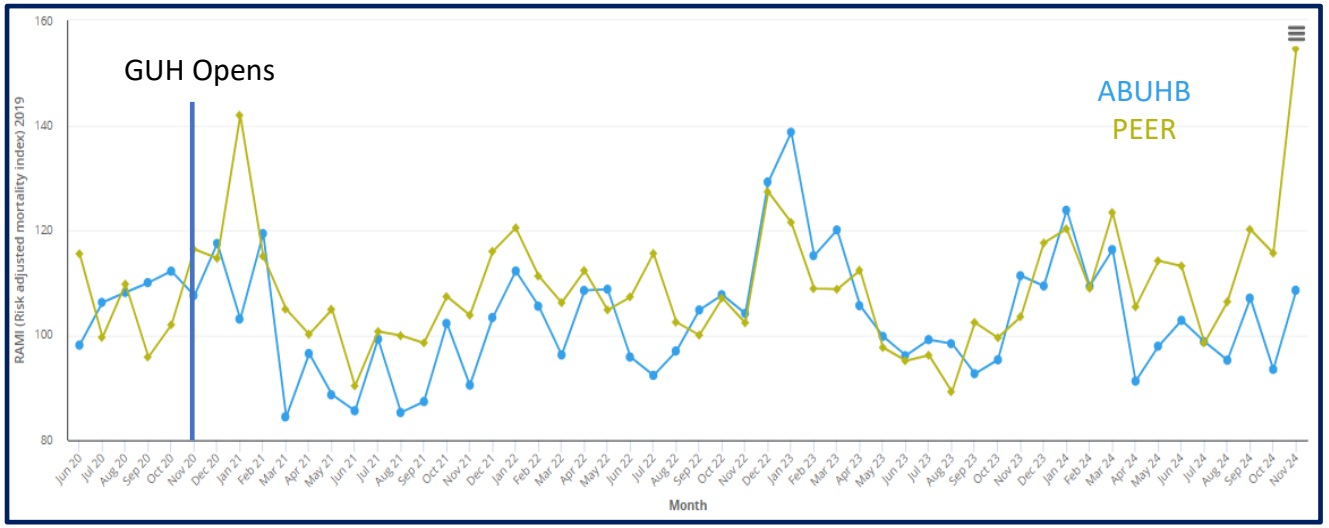
Proposed Metrics: -

- Mortality – Crude mortality and RAMI
- Incidents presented as – level of harm and closure date of incident
  - Global category of incident to ensure themes care captured – PUs, falls, HATs, medicines, H&S, RIDDOR
  - Trends in severe medicines incidents
- Nationally reportable incidents & compliance with closure timeframes
- Duty of candour – Datix numbers
- Thematic analysis of Patient Safety Incidents graded severe
- Thematic analysis of Regulation 28 reports
- Number of inquests that take place face to face (compared to the number completed on paper), ensuring meeting family needs

Developing Metrics: -

- Investigate the possibility of capturing incidents related to urgent care delays / flow in DATIX.

QOF Metric - Pillar Two Mortality
RAMI (Risk Adjusted Mortality Index)



RAMI has been consistent with All Wales peer organisations and remains below their levels. The Health Board's RAMI is 101.91 for Q3 2024/25.

The RAMI continues to fluctuate – more detail in provided in the Learning from Death report. For Q3 AB RAMI – 96.1 for October 2024. AB RAMI – 108.52 for November 2024. AB RAMI –December currently unavailable.

Currently performing 2nd of 6 within All Wales peer group

RAMI accounts for individual patient risk factors and comorbidities, enabling comparisons across different organisations. A RAMI less than 100 indicates the observed mortality is lower than the expected mortality rate for the population. Suggesting it is performing better than expected in terms of outcomes.

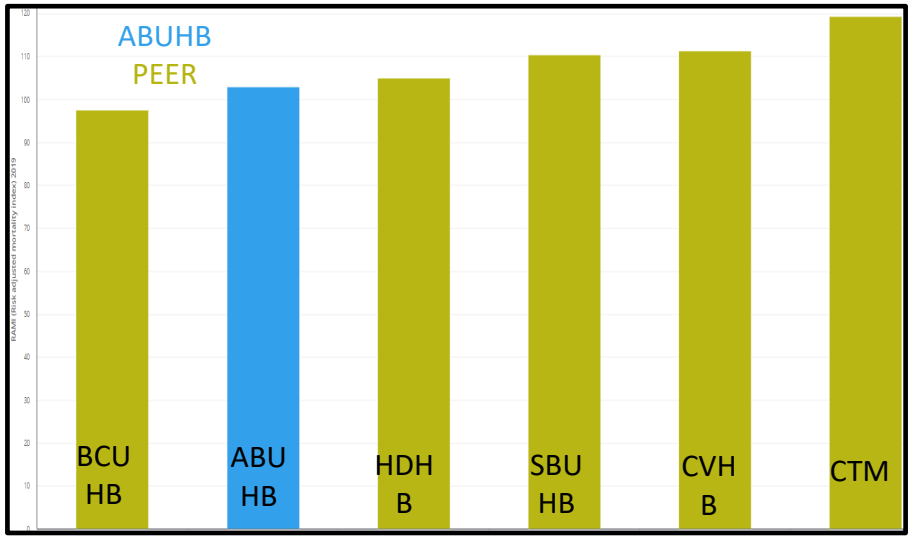
The accuracy of RAMI relies heavily on the completeness and precision of clinical coding. Completeness of coding is more accurate after 8 weeks, which often results in a decrease of RAMI.

The latest Learning From Death report has been produced and provides a deeper analysis of Mortality within the Health Board.

Quarter	RAMI	% Difference	
Q1	97.23	-	
Q2	100.35	3.12%	↓
Q3	100.09	0.26%	↑

An increasing RAMI as seen in Q2 is a decline and a lower RAMI is an improvement, as seen in Q3.

Chart displays RAMI for Quarter Three 2024/25

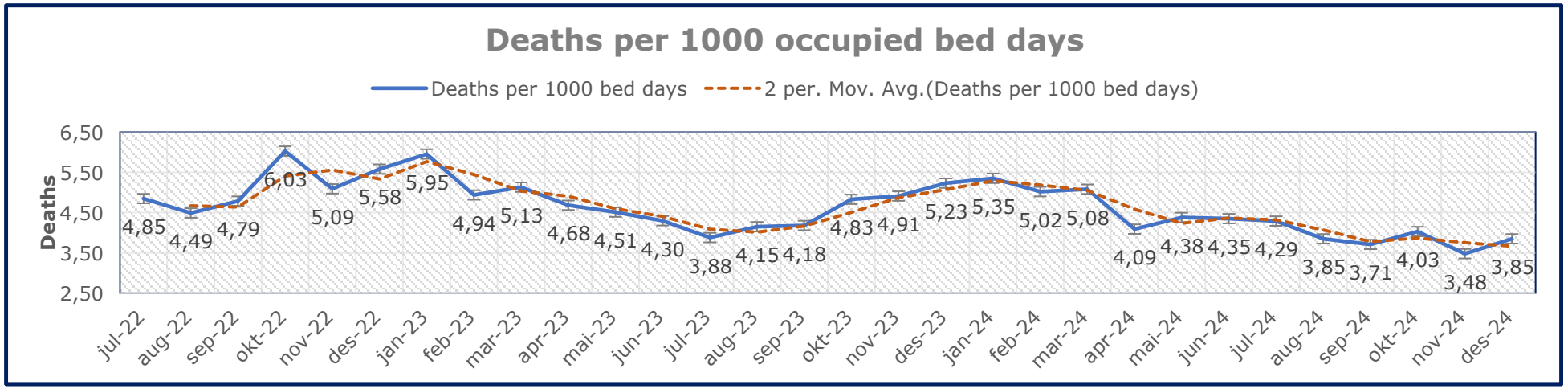


QOF Metric - Pillar Two Mortality: Crude Mortality in Hospital

Quarter	Crude Mortality in Hospital	% Difference	
Q1	232	-	
Q2	194	38%	↑
Q3	181	13%	↑

Crude Mortality (In Hospital) for December 2024 was the lowest since August 2024, at 168.
Crude Mortality (In Hospital) for Q3 2024 was an average of 181, compared to 184 for Q3 2023, and down from a Q2 2024 average of 194.

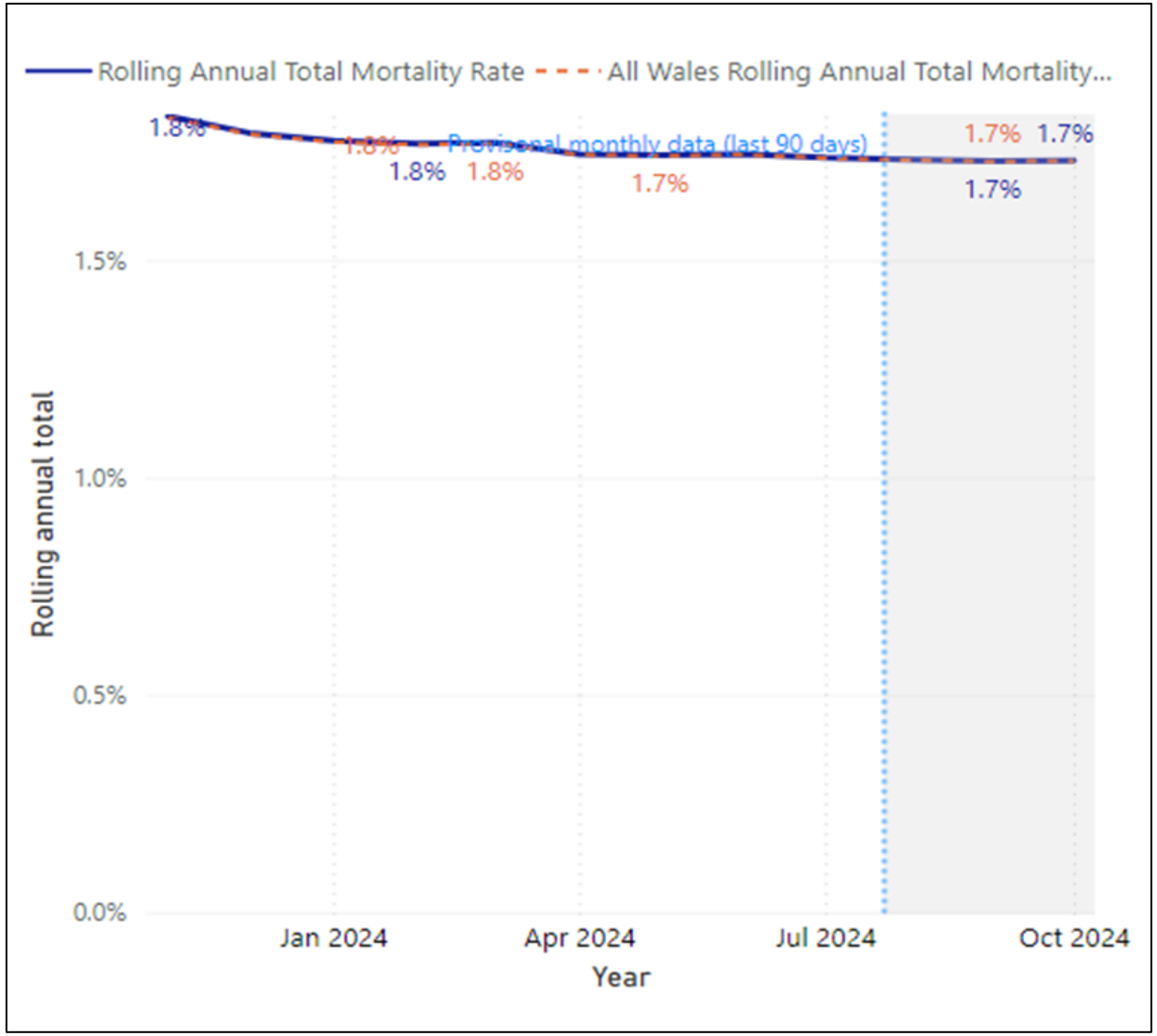
The Green arrow indicates an improvement with less deaths for both charts.



Quarter	Death per 1000 Bed Days	% Difference	
Q1	4.27	-	
Q2	3.96	0.31%	↑
Q3	3.78	0.18%	↑

Deaths per 1000 occupied bed days for December 2024 was 3.84.
Deaths per 1000 occupied bed days for Q3 2024 was an average of 3.78, compared to 4.99 for Q3 2023, and down from a Q2 2024 average 3.96.

QOF Metric - Pillar Two Mortality: Crude Mortality Rate



ABUHB	Mortality Rate
April 2024	1.41%
May 2024	1.47%
June 2024	1.55%
July 2024	1.44%
August 2024	1.37%
September 2024	1.45%
October 2024	1.35%

October 2024 is the latest data available due to the 8-week reporting cycle.
The Health Board's mortality rate has remained stable, showing a flat trend. Actual in-hospital deaths decreased during Q3 2024.

The Health Board's Learning From Death report presented at this month's Committee meeting demonstrates a blended approach to mortality that incorporates multiple sources of information; such as mortality reviews, national benchmarking, and national audits, in addition to RAMI.

The report supports adopting diverse methods to assess performance. This approach ensures quality improvement and assurance around mortality without relying solely on retrospective aggregated data like RAMI. Additional mortality indicators are included for reporting to enhance this process.

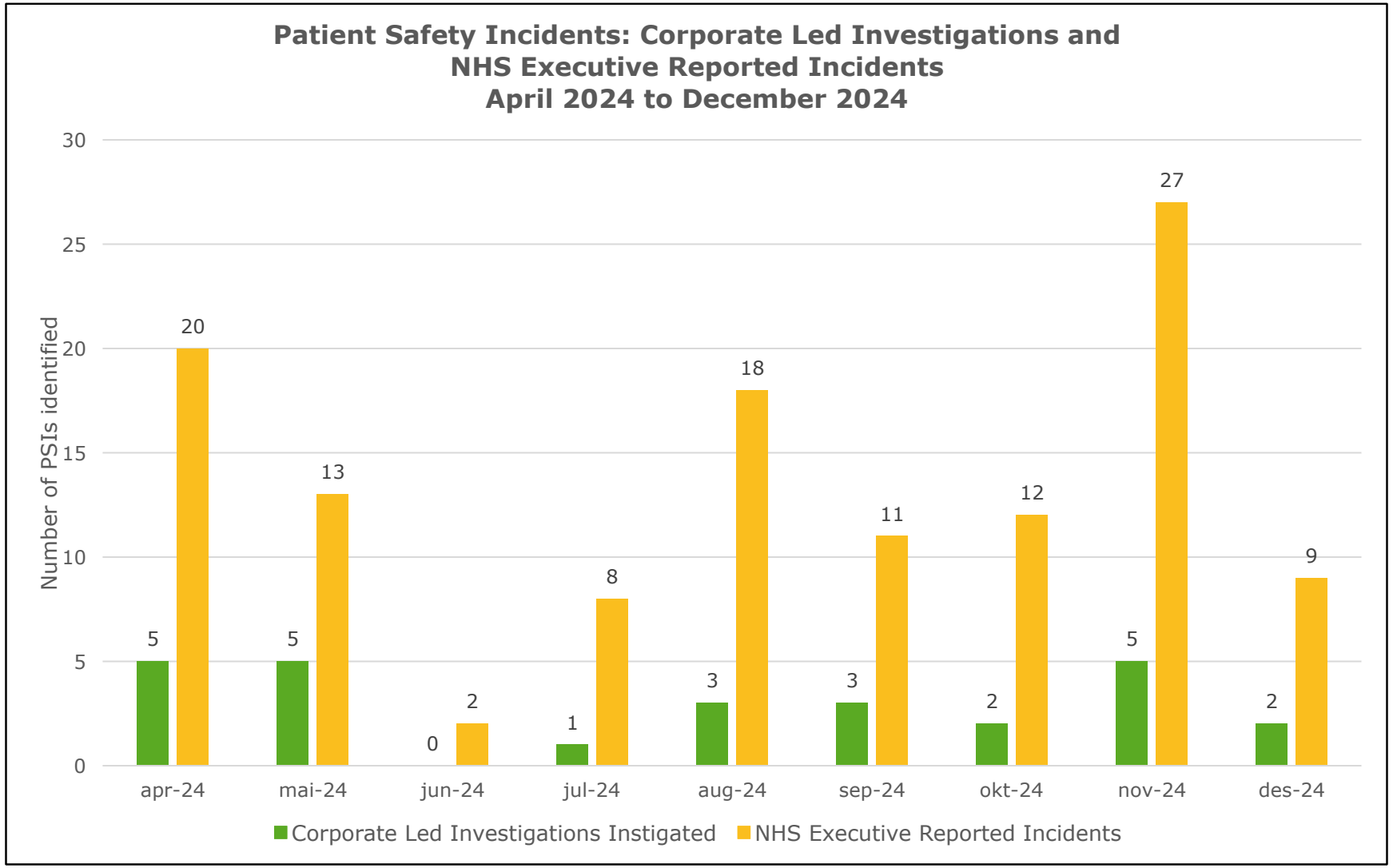
QOF Metric - Pillar Two: Post Investigation Harm Assessment and Closure Date of Incident Average Time to Close

The total numbers of incidents closed during April to December 2024 was 25,212. 381 of these had a Post Investigation Harm Assessment coded as Moderate or above.

The table below provides details on the closed incidents by Quarters 1, 2 and 3 of 24/25 by Post Investigation harm assessment for Moderate or above. The average time to closure is calculated in days.

Post Investigation Harm Assessment	Quarter 1 24/25	Average Time to Closure	Quarter 2 24/25	Average Time to Closure	Quarter 3 24/25	Average Time to Closure
Catastrophic / Death	22	143	26	76	42	85
Severe	14	299	14	281	15	293
Moderate	124	177	78	126	46	119
TOTAL	**160**	**183**	**118**	**133**	**103**	**130**

QOF Metric - Pillar Two: Patient Safety Incidents

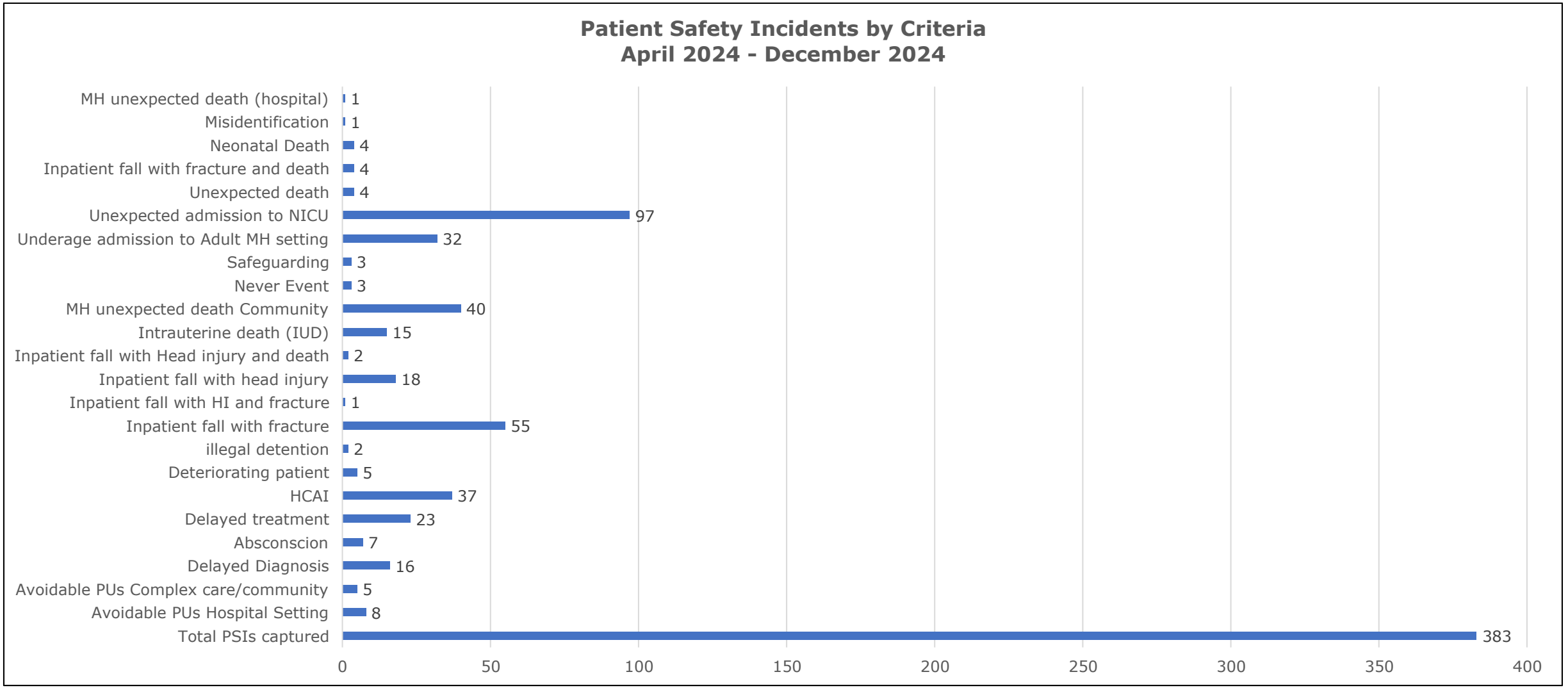


Quarter	PSI's Identified	% Difference
Q1	110	-
Q2	128	15% ↑
Q3	145	9% ↑

A total of 383 Patient Safety Incidents (PSIs) (moderate and above harm), that met the criteria for either Corporate or Divisional led Investigation, were identified between April and December 2024. This is lower compared to the same period of 2023, with 415 PSIs.

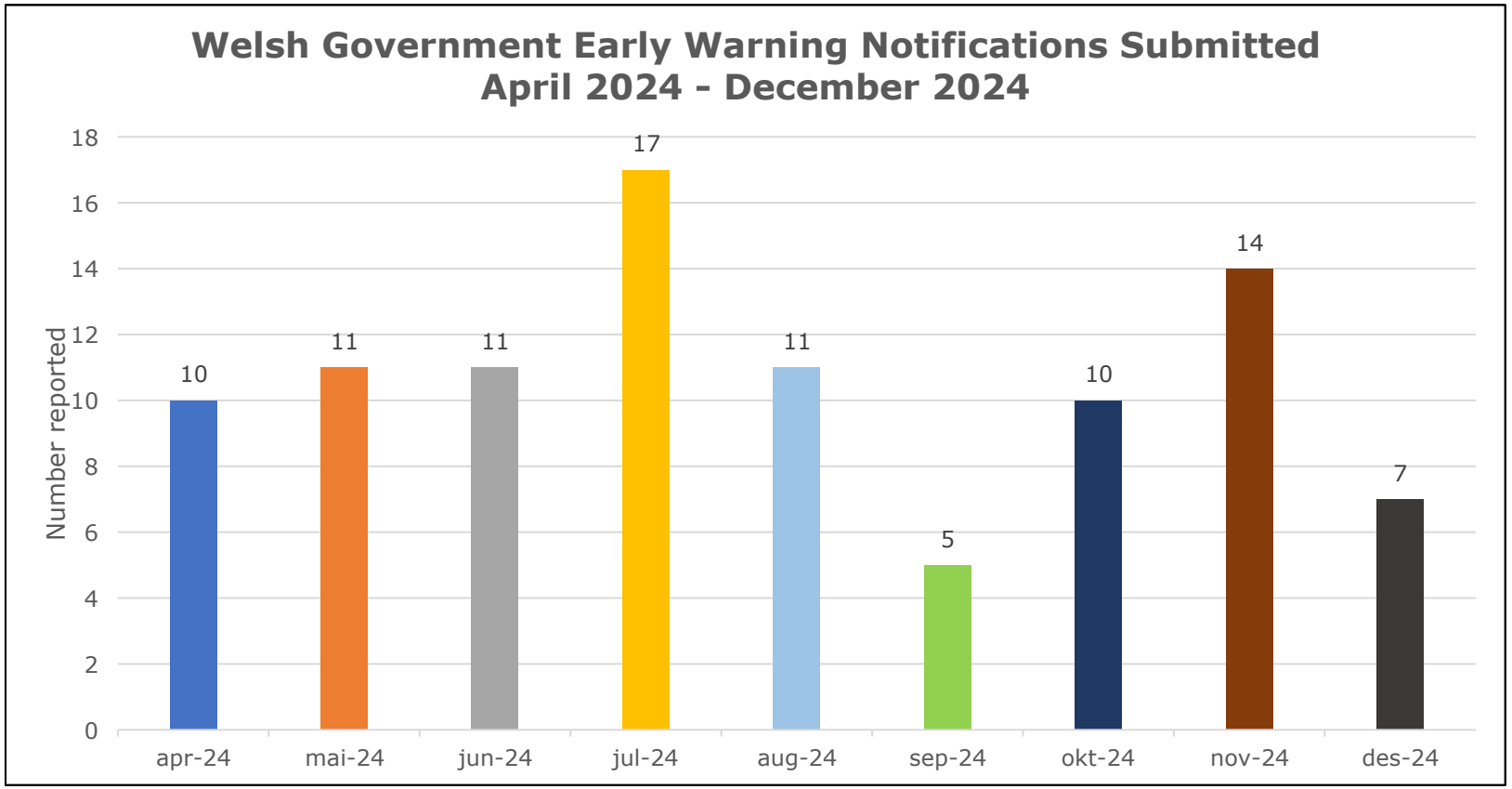
The PSI team continue to provide bespoke sessions to provide support and guidance with current investigations.

QOF Metric - Pillar Two: Patient Safety Incidents



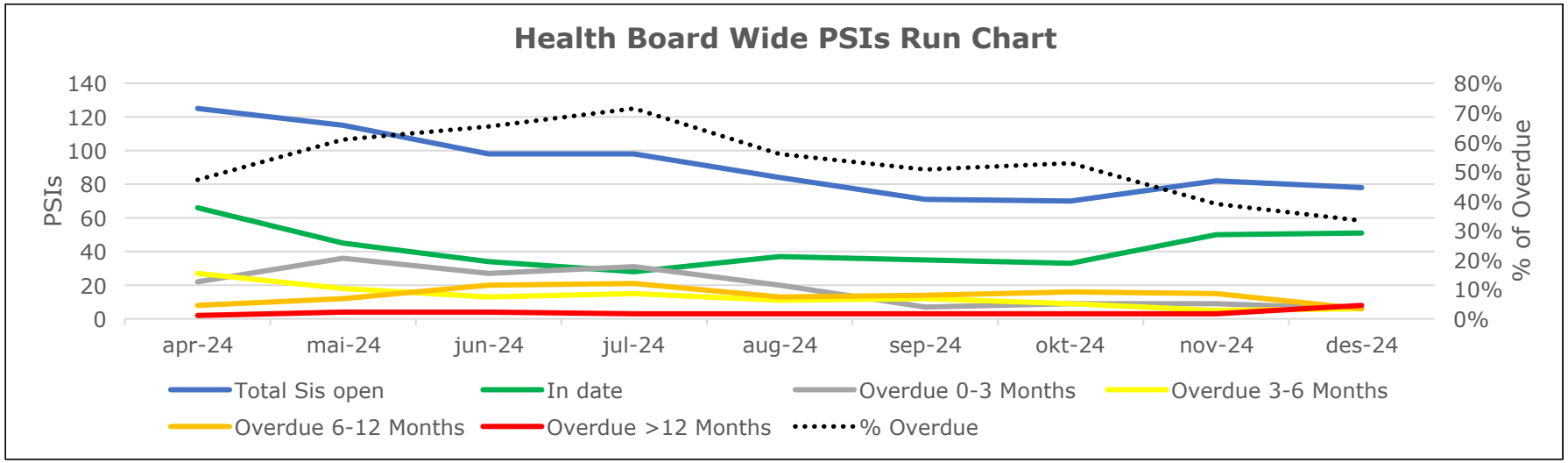
QOF Metric - Pillar Two: Patient Safety Incidents – Early Warning Notifications

There were 96 Early Warning Notifications (EWNs) reported to Welsh Government (WG) between April to December 2024. Themes included safeguarding concerns and patient absconsions. 79 EWNs were submitted for the same period in 2023.



Quarter	Early Warning Notifications	% Difference
Q1	32	-
Q2	33	3%
Q3	31	6%

QOF Metric - Pillar Two
Patient Safety Incidents - National Reportable Incidents



Quarter	PSIs	% Difference	
Q1	338	-	
Q2	253	28%	↓
Q3	230	9%	↓

Overdue NRIs decreased from 71% (July 2024) to 33% (December 2024) - a 38% improvement. There continues to be a focus on the management of the PSI process. Recommendations for improving compliance include robust progress monitoring and monthly reporting to divisional teams.

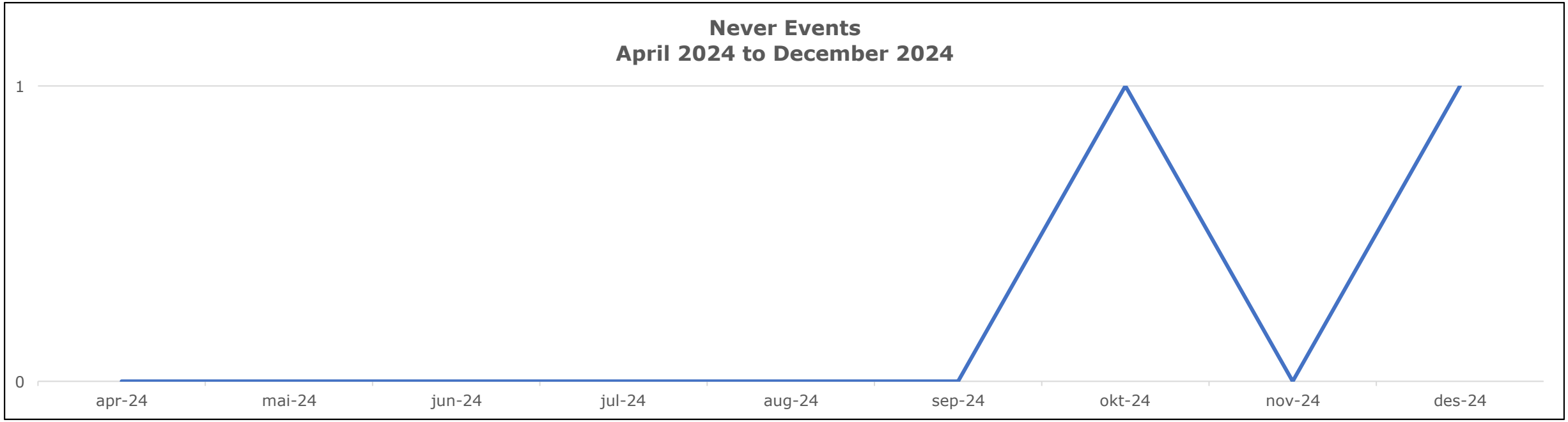
The PSI team provide additional training for Investigating Officers and have been running drop-in virtual training sessions for Investigating Officers to provide support and discuss any concerns. In addition the Corporate PSI Team will be delivering investigating officer training and offering bespoke support.

The PSI Team meet weekly with the Divisional Quality & Patient Safety (QPS) Teams to discuss PSIs, Medical Examiner Cases, and any incidents awaiting harm reviews. This initiative aims to help Divisions monitor their progress and ensure adherence to incident reporting standards.

Bespoke strategy meetings chaired by a clinical executive for complex and potentially challenging incidents, are proving to be successful in progressing investigations appropriately.

QOF Metric - Pillar Two: Patient Safety Incidents – Never Events

There have been two Never Events in Q3 - 1 in October and 1 in December. The first incident was classified as wrong site surgery in Dermatology day surgery and the second was a historic retained guidewire from a varicose vein procedure 14 years ago. In the first incident the patient had additional lesions removed that they weren't listed for, and the second incident was discovered when a patient had an unrelated hip x-ray undertaken in November 2024. Neither patient has come to any harm.



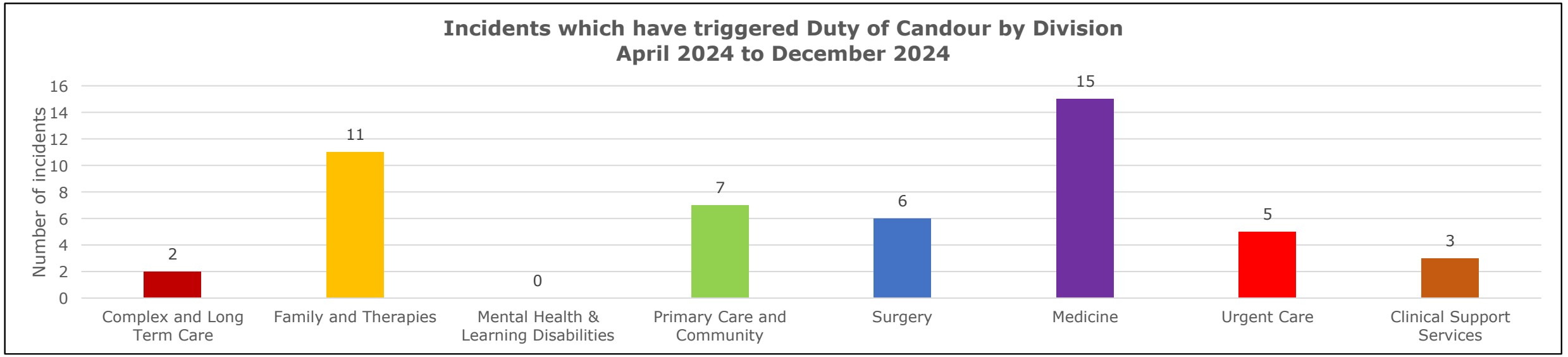
In respect of the second incident, a new investigation approach has been piloted through a multidisciplinary roundtable learning discussion, and an investigation has been conducted. This method has facilitated a prompt response to the incident and the immediate dissemination of key learnings to enhance patient safety. Both reports will undergo executive scrutiny and approval before being submitted and closed with the NHS Executive. All reports will be shared with patients and families.

QOF Metric - Pillar Two: Duty of Candour

Between April and December 2024 there were 19711 incidents affecting patients reported on the Datix Cymru system. This is in comparison to **23178** incidents for the same period in 2023.

There have been **49** incidents that have triggered Duty of Candour. *This figure is based on the question -* ***Was Healthcare provided a factor?***

These incidents involved inadequate supervision leading to a fall, post-operative complications, issues with communication around discharges, prescribing errors, and maternity incidents. All these incidents have triggered the Duty of Candour (DoC) process.

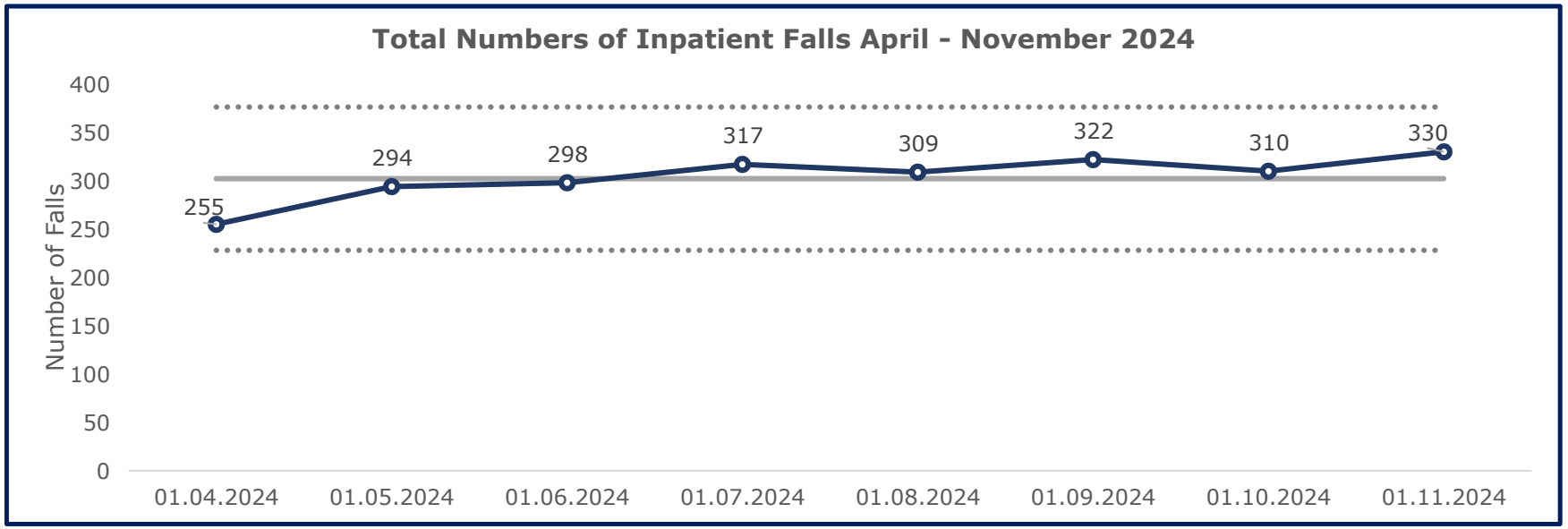


The way in which Duty of Candour is captured on RL Datix, has been refined for the 2024/25 reporting. In the 2023/24 period DoC was triggered when the management review had, been undertaken, and harm assessed at that time as moderate and above. Therefore, **151** incidents triggered for the same period in 23/24. The introduction of the question of 'was a healthcare a factor' focuses the investigator on the essence of DoC harm, in that it is the delivery or lack of delivery of healthcare that has led to the harm caused to the patient/
service user.

Patient Safety Incidents - Actions, Learning & Improvement

Issue	Proposed Action	Responsible Officer	Timescale
Timely IO availability/capacity to complete investigations/Lack of suitably trained IO's Clinical teams providing specialist opinions	Continue to work with Divisions PSI team to continue supporting Divisions through meetings and bespoke training To develop a PSI escalation process. Bespoke 1-2-1 training PSI team/chair to escalate any delays in clinical opinions	Head and Assistant Head of Patient Safety Corporate PSI and QPS Teams	January 2025
Complex investigations	Early contact with internal / external stakeholders If appropriate arrange a strategy meeting with key stakeholders The PSI team will coordinate meetings and link in with the relevant teams to feedback.	Corporate PSI and QPS Teams	Ongoing
Family engagement	Working with family members to review and improve the process Reporting template revised to prioritise patients' and families' questions in the Terms of Reference. This information is addressed first in the report, to ensure that this is prioritised Review PSI policy undertaken Roll out communication standards to ensure meaningful and regular engagement with patients and families.	Head and Assistant Head of Patient Safety Corporate PSI and QPS Teams	January 2025

QOF Metric - Pillar Two: Health Board Wide Inpatient Falls



Quarter	Inpatient Falls	% Difference	
Q1	282	-	
Q2	316	11.36%	↑
Q3	320	1.36%	↑

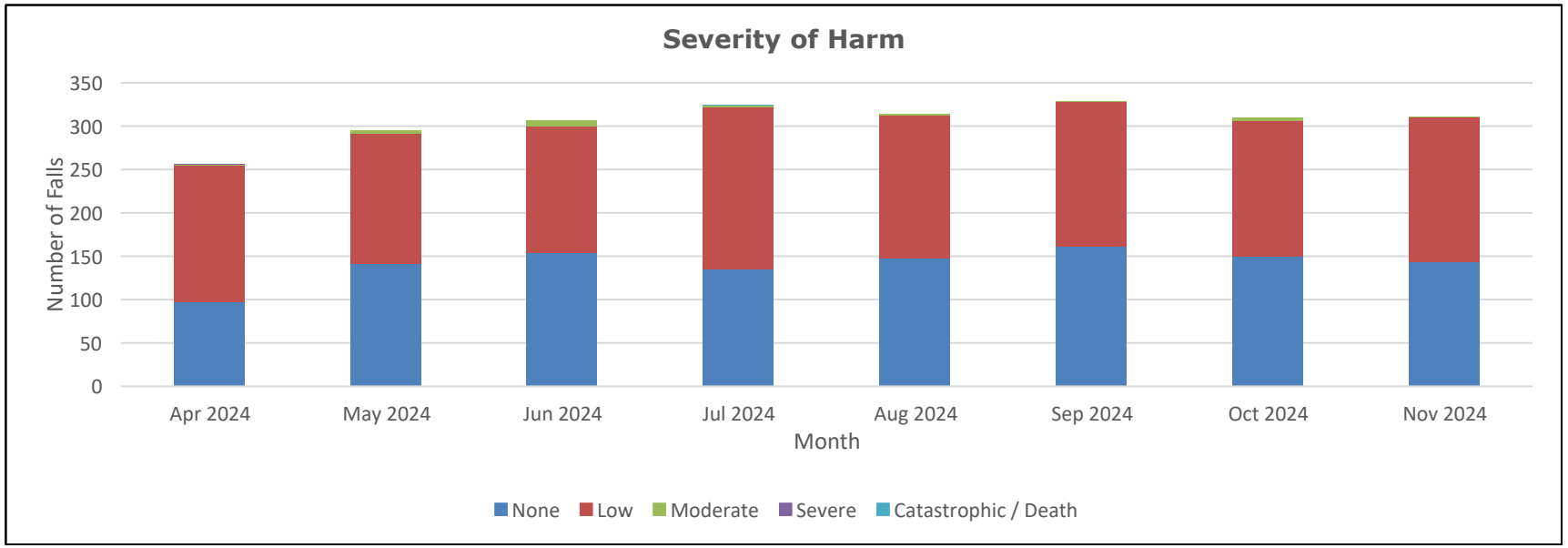
Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	For the given period of analysis, the mean average of fall incidents is 302 which represents a decrease since the last report in October 2024. Since April 2024 there has been a gradual upward trajectory with November being the highest number of reported falls incidents since April 2024.	

Q3 2024/25 - 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 April to December 2024. This period length for this data is selected to ensure the analysis is statistically valuable.

QOF Metric - Pillar Two: Health Board Wide Inpatient Falls Severity of Harm



Quarter	Inpatient Falls Severity of Harm (Severe or More)	% Difference	
Q1	1	-	
Q2	1	-	
Q3	0	100%	↓

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 3983. Of this figure the following is identified: • 99% No or low harm • 0.8% - Moderate harm • 0.1% Severe harm • 0.1% Catastrophic	The severity data is reflective of the identified level of harm recorded post investigation.

Q3 2024/25 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period November 2023/24.

Claims and Redress – 2024/25 Activity

Quarter	Clinical Negligence	% Difference
Q1	33	-
Q2	38	14.1% ↑
Q3	26	37.5% ↓

Clinical Negligence:

- 86 new clinical negligence matters received during Q1, Q2 and Q3.
- The total number of open clinical negligence matters as at the end of December 2024 is 395.

There was a slight increase in clinical negligence matters received during this quarter.

Quarter	Personal Injury	% Difference
Q1	12	-
Q2	13	8% ↑
Q3	4	105% ↓

Personal Injury:

- 29 new personal injury matters received during Q1, Q2 and Q3.
- 80 total number of open personal injury matters as at the end of December 2024.

Personal injury claims remained steady, and at a historic low, during this quarter.

Quarter	Redress	% Difference
Q1	6	-
Q2	9	40% ↑
Q3	12	28% ↑

Redress:

- 28 cases were taken through the Health Board's Redress Panel during Q1, Q2 and Q3.
- 10 Redress cases were settled during Q1, Q2 and Q3.

On average, each case settled through the Redress process will save the Health Board an estimated £30,000 in costs arising had those cases become clinical negligence claims.

Inquests – 2024/25 Q3 Activity

Inquests:

- 225 new inquests received during Q1, Q2 and Q3.
- During Q3, 105 new inquests were received.
- This represented an increase in the number of inquests received compared with Q2.
- 81 inquests were listed by the Coroner to be concluded within Q3.
- Of the 81 inquests listed, 18 inquests were held in person by the Coroner and where Health Board witnesses attended in person to give their evidence.
- Legal Services attended all 18 inquests in support of staff attending.

Quarter	Inquests	% Difference	
Q1	80	-	
Q2	55	37%	↓
Q3	105	64%	↑

Of the 81 inquests listed in this Quarter, 63 inquests were concluded in writing by the Coroner. This meant Health Board staff had prepared statements which were submitted to the Coroner, but those members of staff did not need to attend the inquest in person to give oral evidence.

Reg 28: Prevention of Future Deaths Reports:

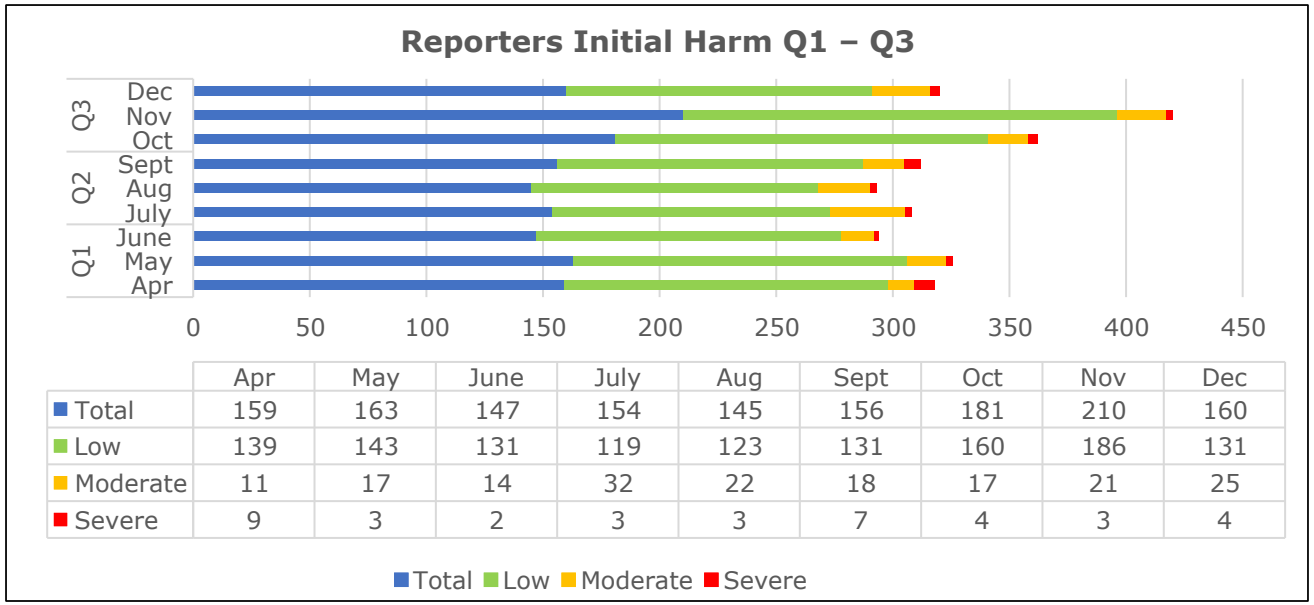
- Only 1 Regulation 28 report issued for Quarter Thee.
- The Coroner was concerned with a failure to complete and monitor fluid balances.

The Health Board provided the Coroner with a response within the required timescale, including details of actions taken to improve monitoring of patient fluid balance across the Health Board.

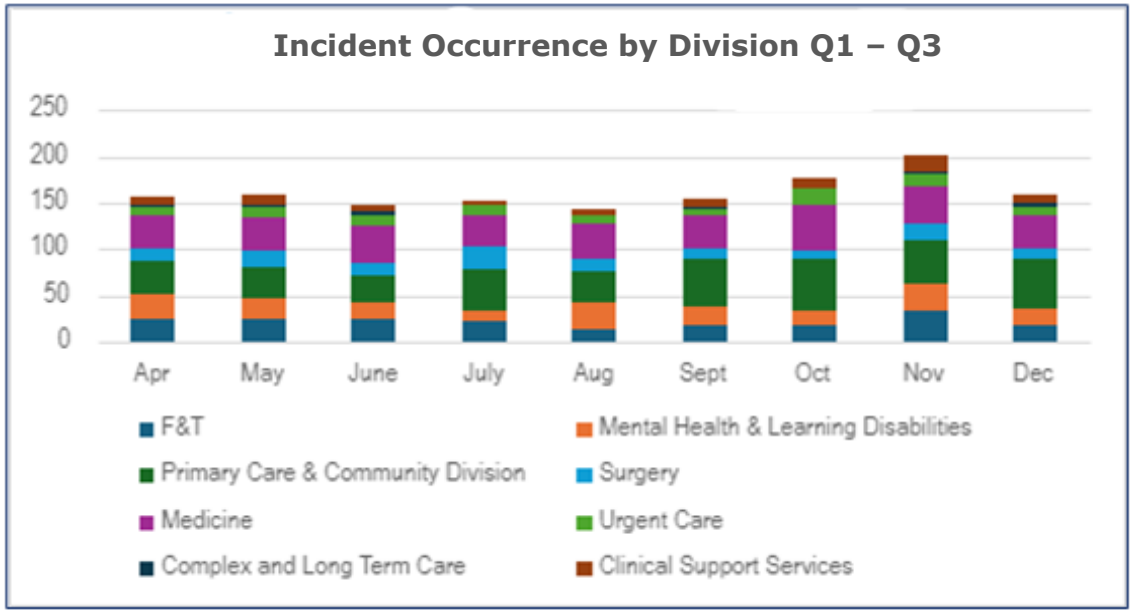
Coroner Update:

- The Coroner has appointed an Area Coroner, Rose Farmer.

QOF Metric - Pillar Two: Trends in Medication Incidents



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total	159	163	147	154	145	156	181	210	160
Low	139	143	131	119	123	131	160	186	131
Moderate	11	17	14	32	22	18	17	21	25
Severe	9	3	2	3	3	7	4	3	4



Quarter	Medication Safety Reports Initial Harm	% Difference	
Q1	19	-	
Q2	28	38%	↑
Q3	18	44%	↓

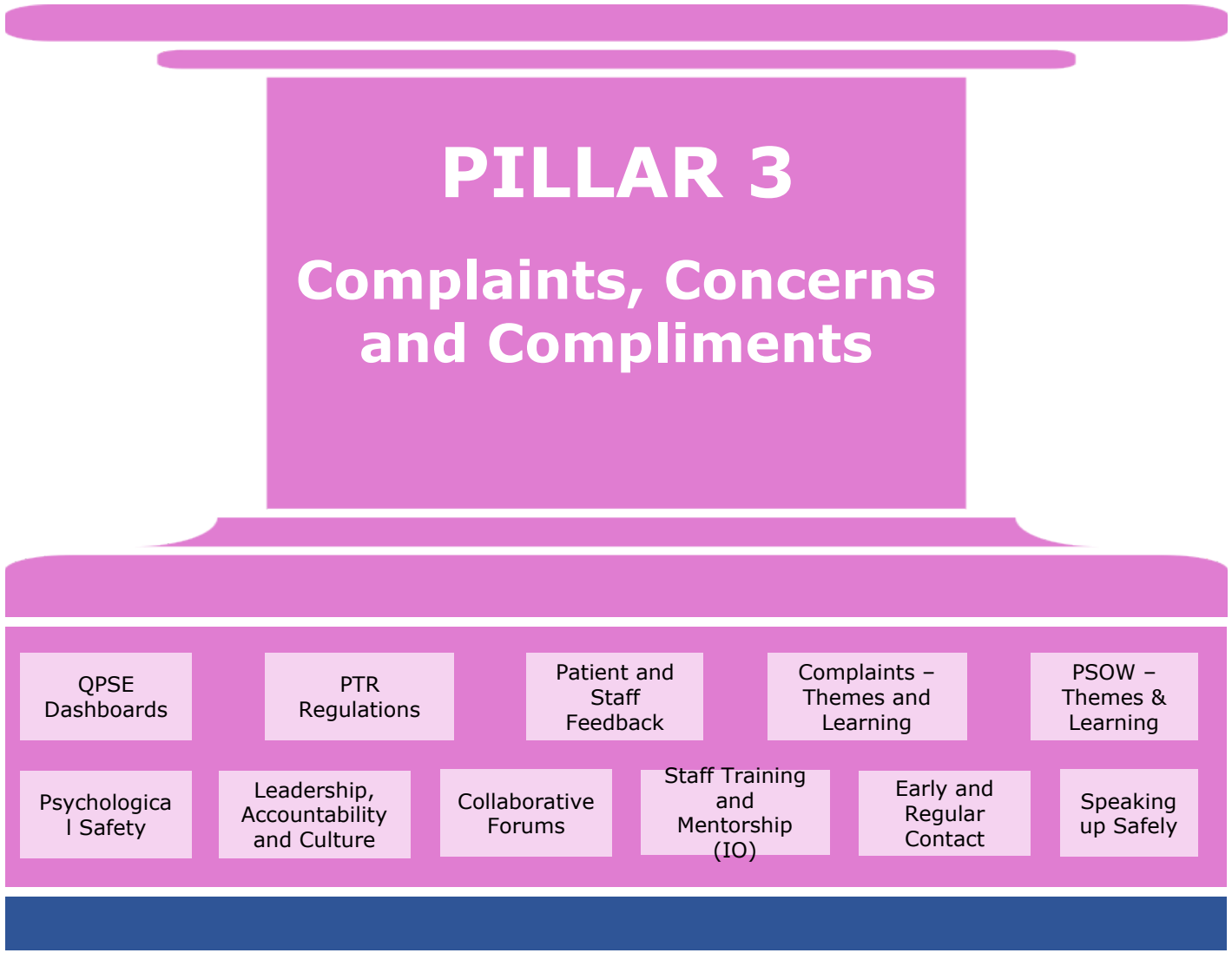
Key Insights:	**Total Incidents**: There is a slight decrease in the total number of incidents from Q1 to Q3. **Low Harm Incidents**: These incidents form the majority and show a similar decreasing trend. **Moderate Harm Incidents**: There is a noticeable increase in moderate harm incidents in Q2 compared to Q1 and Q3. **Severe Harm Incidents**: These are relatively low but show a significant drop from Q1 to Q3.
Monthly Trends:	**April to June**: There is a consistent number of incidents each month. **July to September**: There is a peak in incidents in August, followed by a drop in September. These charts help identify trends and areas that need attention, such as the spike in incidents in August and the increase in moderate harm incidents in Q2. This information can guide targeted actions to improve medication safety.

Medication Safety

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

What have we achieved:

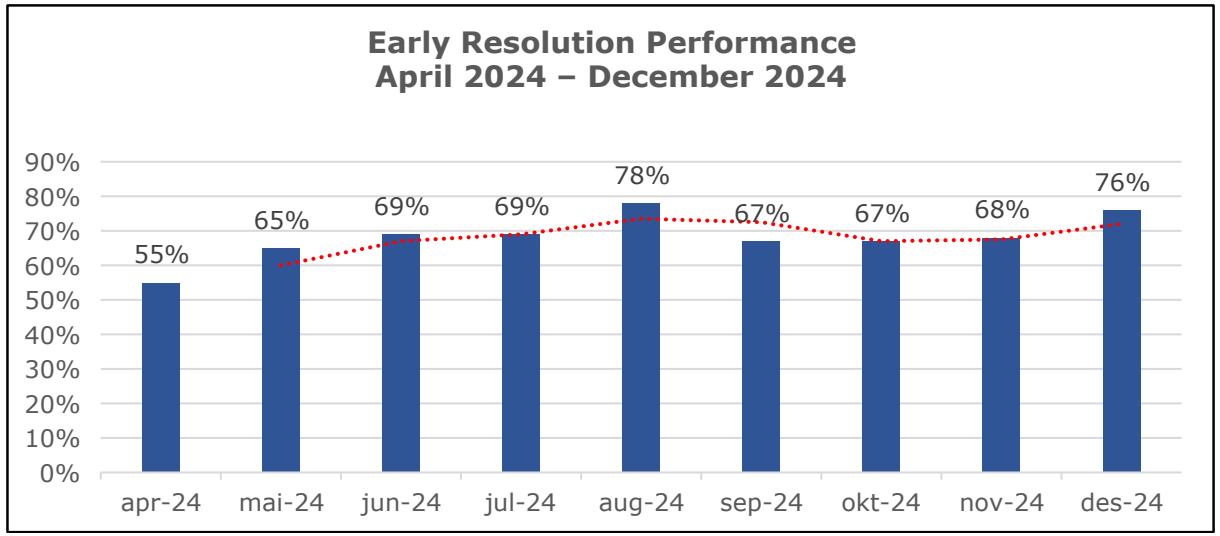
- Medical gases training program on ESR
- Sharing of medicine incident data with divisional education leads and engaging assistance to improve medicines safety
- Current review of the revalidation, error management and education provisions



Metrics: -

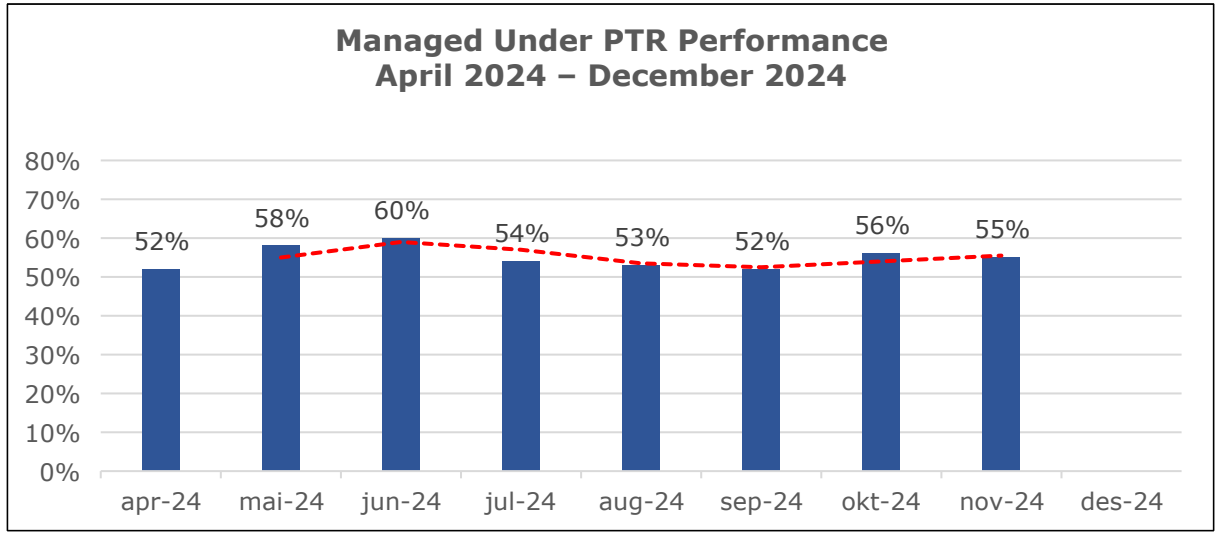
- 30 day performance
- Concerns
  - Review layers to look at compliance and closure
- Compliments
- PALs (especially early resolution)

QOF Measure – Pillar 3
Concerns 30 day Performance Q1, Q2 & Q3 2024/25



Quarter	Early Resolution Performance	% Difference	
Q1	66%	-	
Q2	71%	7.3%	↑
Q3	68%	4.3%	↓

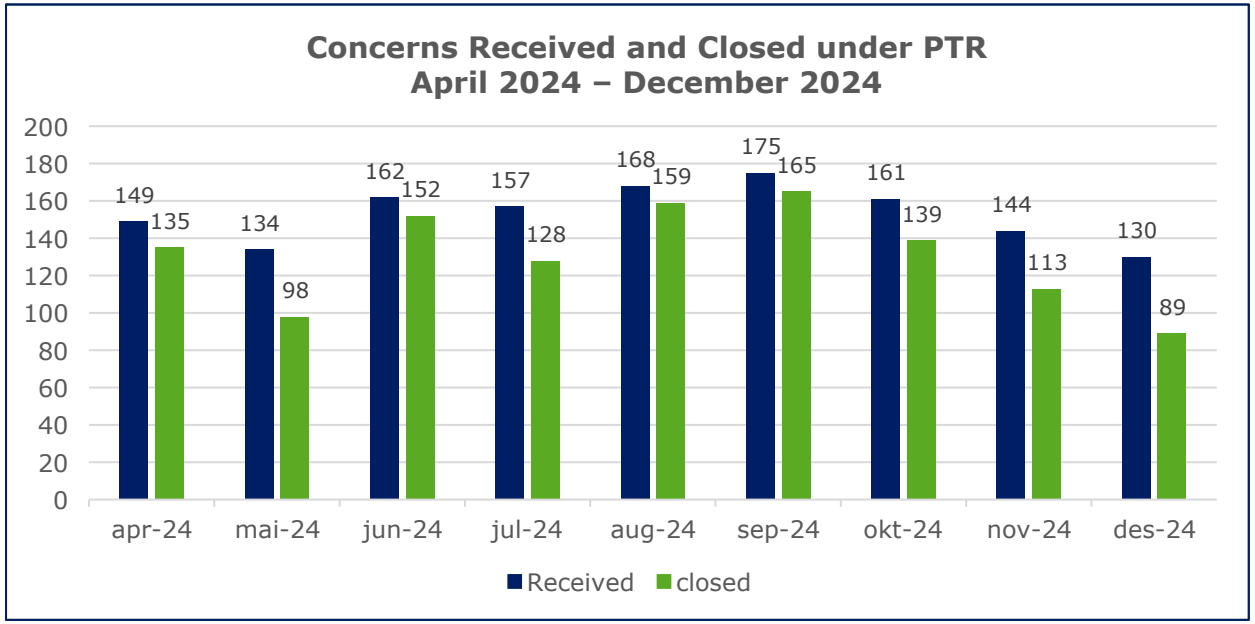
These measures aim to maintain high standards of patient care and service quality despite the pressures faced. Early Resolution average rate YTD – 67%.

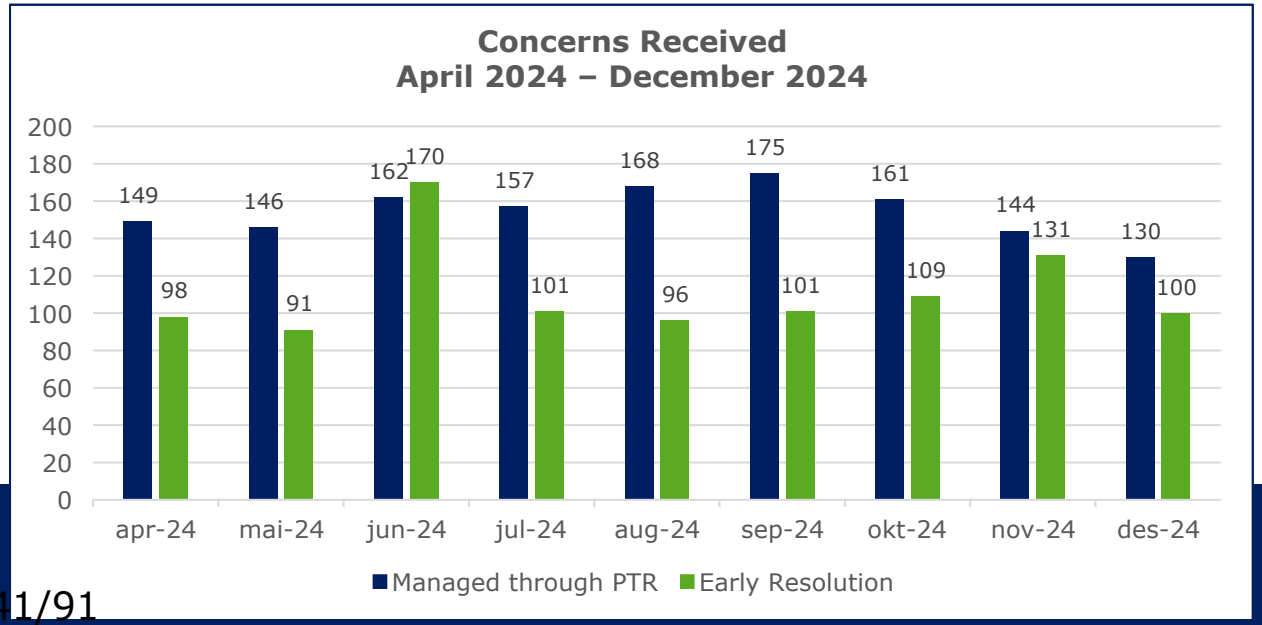


Quarter	Managed Under PTR	% Difference	
Q1	57%	-	
Q2	53%	7.3%	↑
Q3	Under validation		

PTR Concerns compliance rate, averaged 55% for concerns received and completed within compliance.

QOF Measure – Pillar 3
Concerns Q1, Q2 & Q3 2024/25





Divisional Position

Clinical Support Services: Despite an increase in the number of concerns received. CSS saw a slight downturn in formal compliance in October 2024, however this was improved and exceeding the WG compliance target by the end of November 2024. Furthermore, they have maintained 100% compliance with Early Resolution matters across October and November.

Mental Health & Learning Disabilities: Although the Division's compliance with formal concerns is lower than expected, they are consistently reducing the number of open concerns each month. Early resolution compliance has remained steady across the reporting period.

Surgery: Has now become the Division holding the most formal concerns. Their compliance has been maintained at an average of 70.5%. Early Resolution performance has been 100% throughout the reporting period.

Medicine: Has seen steady progress in reducing the number of overdue complaints with only 2 in 6-9-month category at the end of November, representing an 80% reduction in this bracket since the end of Q2.

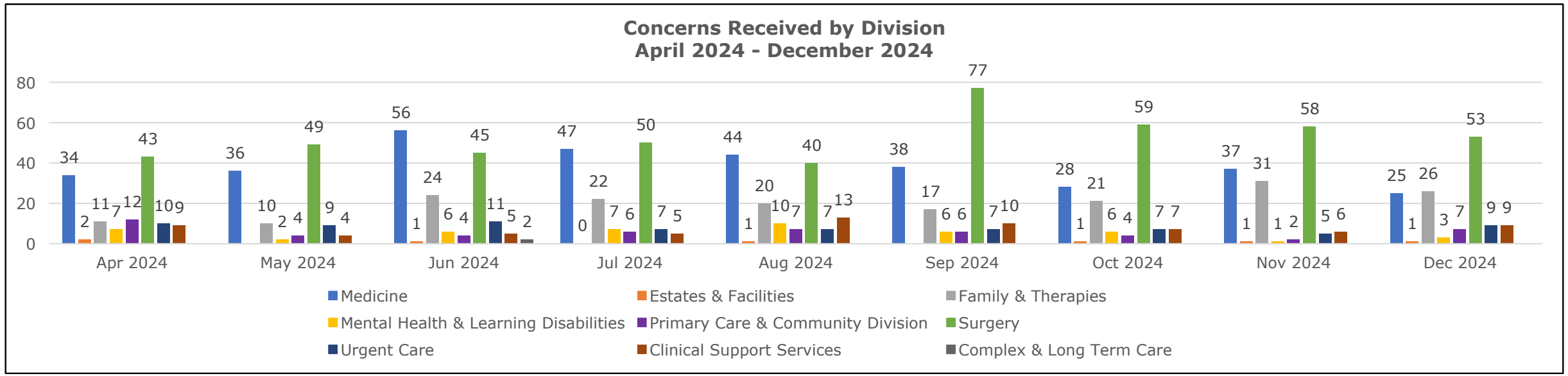
Urgent Care: Have continued to achieve compliance with managed under PTR matters across the first 2 months of Q3. Again achieving 100% Early Resolution compliance in October. At the end of November, they had 7 complaints open in total.

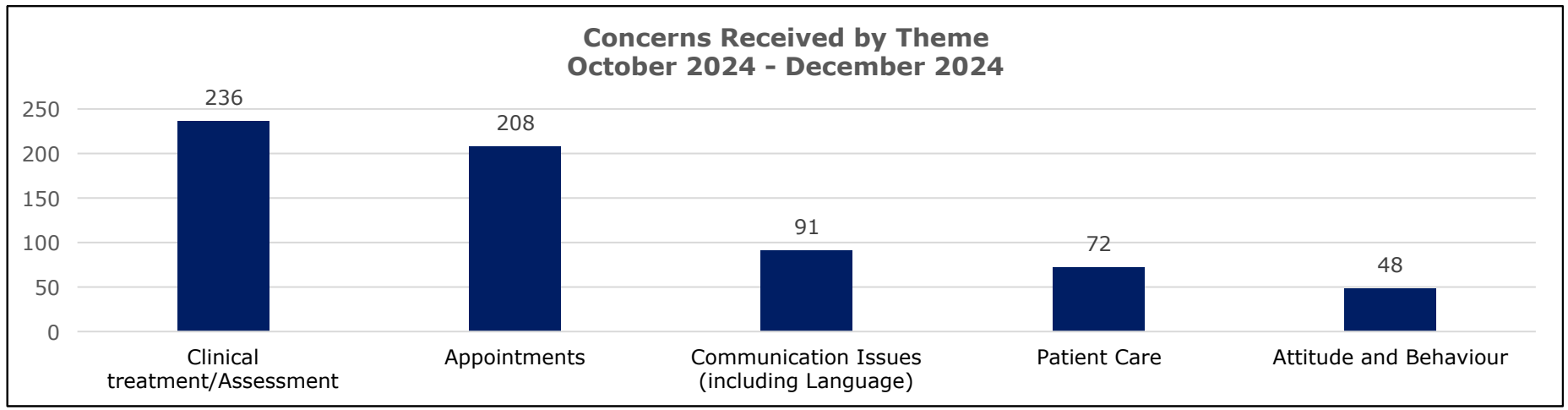
Primary Care & Community: continued to achieve compliance for October, however this did tail off in November following closures of some older concerns. Positively they achieved 100% Early Resolution compliance the same month.

Family & Therapies: Compliance remained largely the same at the end of Q2 and beginning of Q3, however this did decrease in November. Although Early Resolution has continued to improve across Oct and Nov.

Estates & Facilities: The Division have been 100% compliant with closing their concerns.

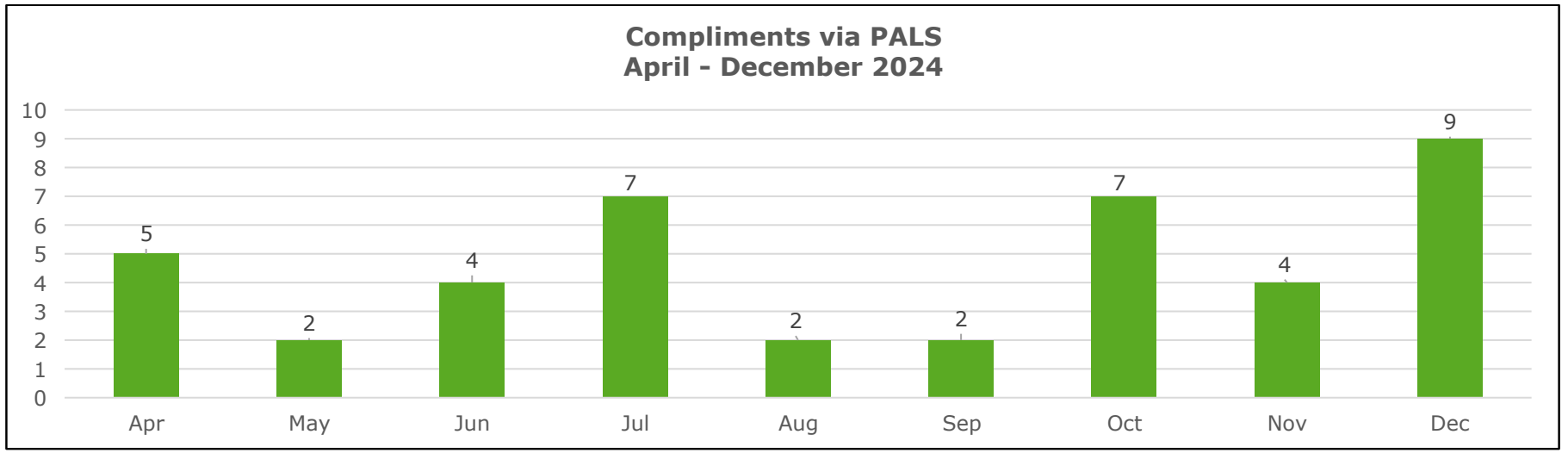
QOF Measure – Pillar 3
Concerns & Compliments Q1, Q2 & Q3 2024/25

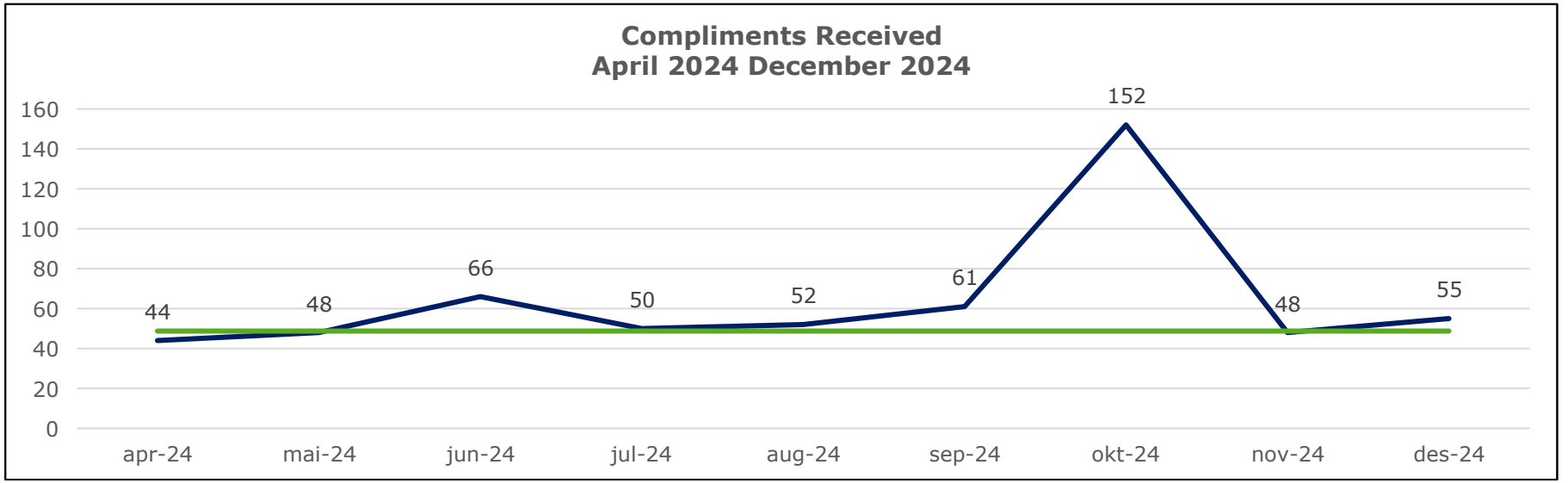




Across Quarter 3 appointments and clinical treatment and assessment continue to be the overriding themes in terms of the highest numbers of concerns received.

QOF Measure – Pillar 3
Compliments Q1, Q2 & Q3 2024/25





The recording of Compliments has remained positive month on month, with all concerns teams being vigilant in identifying and recording positive comments identified within concerns received. In October, there was a significant rise in the number of recorded compliments, thanks to ward C4 actively logging all of the compliments received by card.

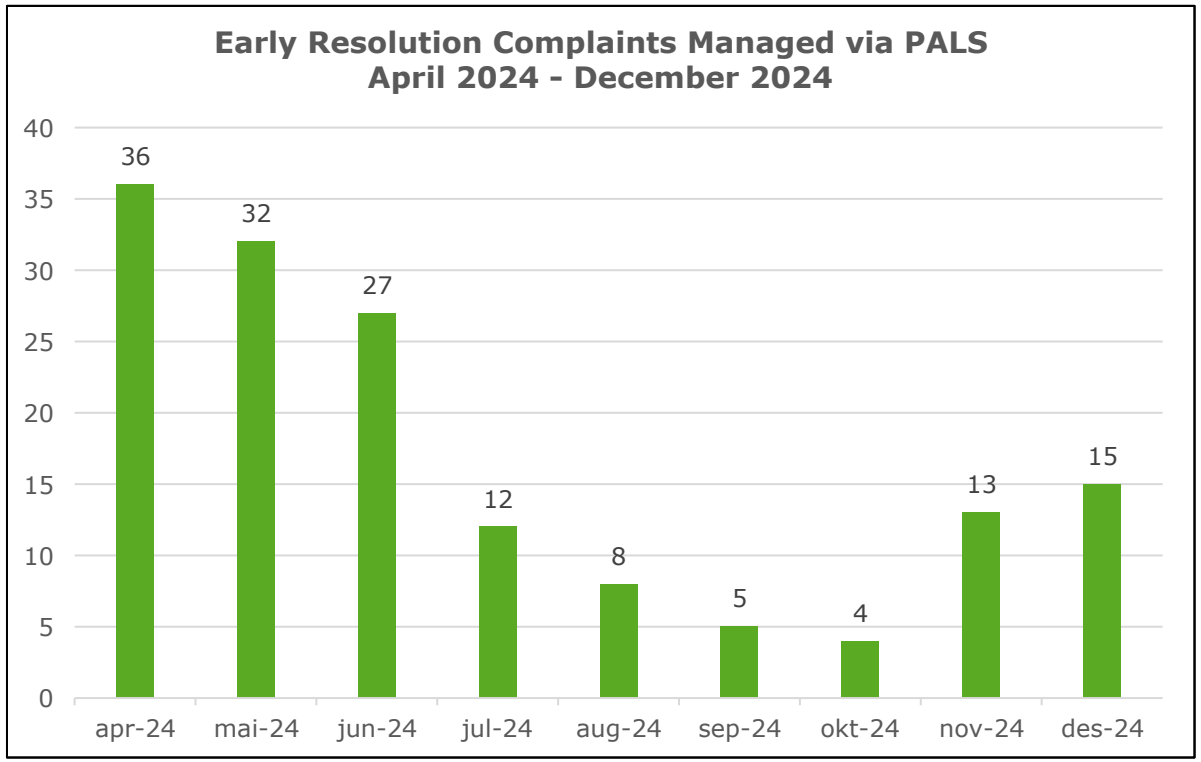
PTR – Achievements Q1, Q2 & Q3 2024/25

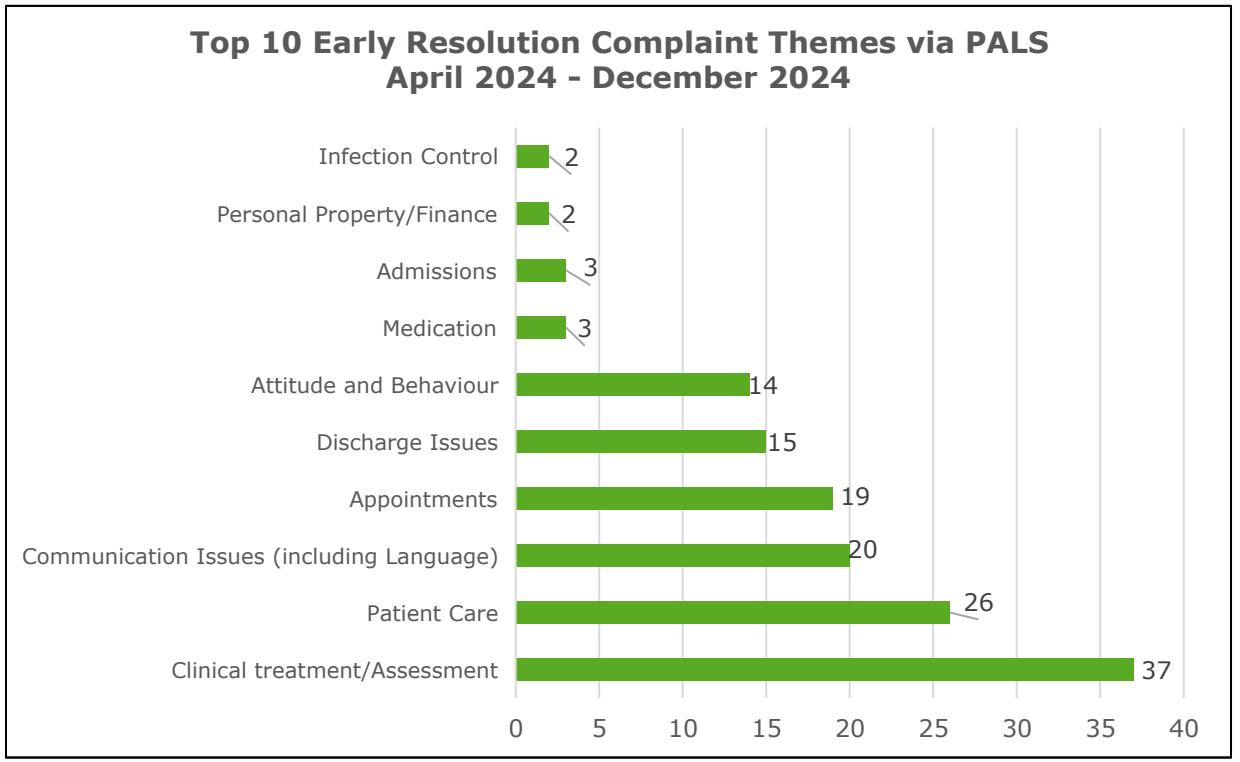
Achievements	Update
Ongoing clinical practitioner engagement sessions	Engagement sessions have been attended by the Head of Patient Safety, Quality & Learning and Senior QPS Manager to promote the changes in PTR, ensuring visibility and the support that can be offered by the team around the management of concerns and PSOW matters.
Appointment of B7 Concerns & PSOW Manager	Following a competitive recruitment process. A new Concerns Manager has been appointed, following an extended period without a Concerns Manager.
Division of Surgery/CSS and Urgent Care & Medicine aligned Divisional hub centralisation	Centralisation will reduce duplication, provide greater complaint and PTR capability, whilst also providing a more robust structure and oversight for both hub teams.

PTR - Actions, Learning & Improvement

Issue	Action Taken	Position/ Learning & Improvement	Timescale
Staffing deficits across the PTR teams	Consolidation of resources across the concerns teams	This will offer greater resilience, support, and resources across all of the teams.	January 2025
	Concerns & PSOW Manager has been recruited	We have recruited to this post. The successful candidate brings a wealth of PTR knowledge and management from her current post at C&VUHB.	January 2025
Datix training requirement	Targeted training sessions and intervention with PTR team members	Greater support and experience is being consolidated across the complaint's hubs. This will ensure uniformity of data entry, complaints management, removal of duplication and extending cross-divisional knowledge bases. This will also support ongoing WRP action plan recommendations regarding Datix Cymru validation.	January 2025
Greater than 9-month concerns	Weekly meetings with DDON, Head of QPS and Sr QPS Manager	Targeted meetings to set actions and escalation, ensuring that the oldest concerns are being moved through the system via the appropriate channels in order to bring resolution to complainants. EDoN to hold bi-monthly meeting with DDON, Head of QPS and Sr QPS Manager.	January 2025

QOF Measure – Pillar 3: Patient Advice & Liaison Service – Q1-3 2024/25



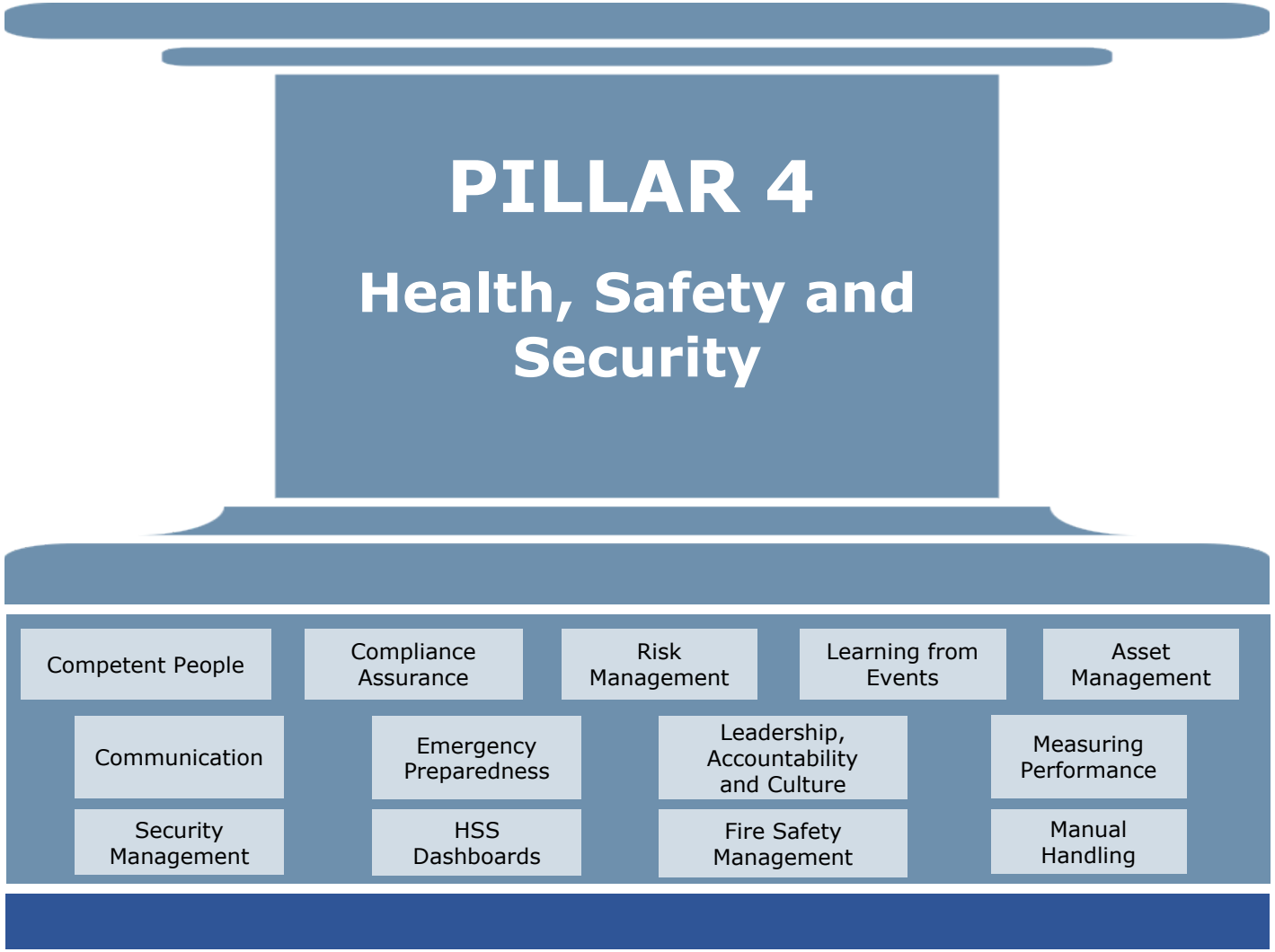


Early Resolution Complaints Managed via PALS
Complaints that come directly to the PALS team are often managed via Enquires unless specifically requested "Logged as Complaint" by the complainant.

All calls that are transferred from the Putting Things Right Team since November 2024 are logged as an Early Resolution Complaint following guidance provided by Quality and Patient Safety Leads. Therefore, we are likely to see a increase in Early Resolution Complaints.

Average number of ER complaints - 17 a month over April – December 2024.

Top Theme – Clinical Treatment / Assessment 26.2% of Early Resolution Complaints.



Metrics: -

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

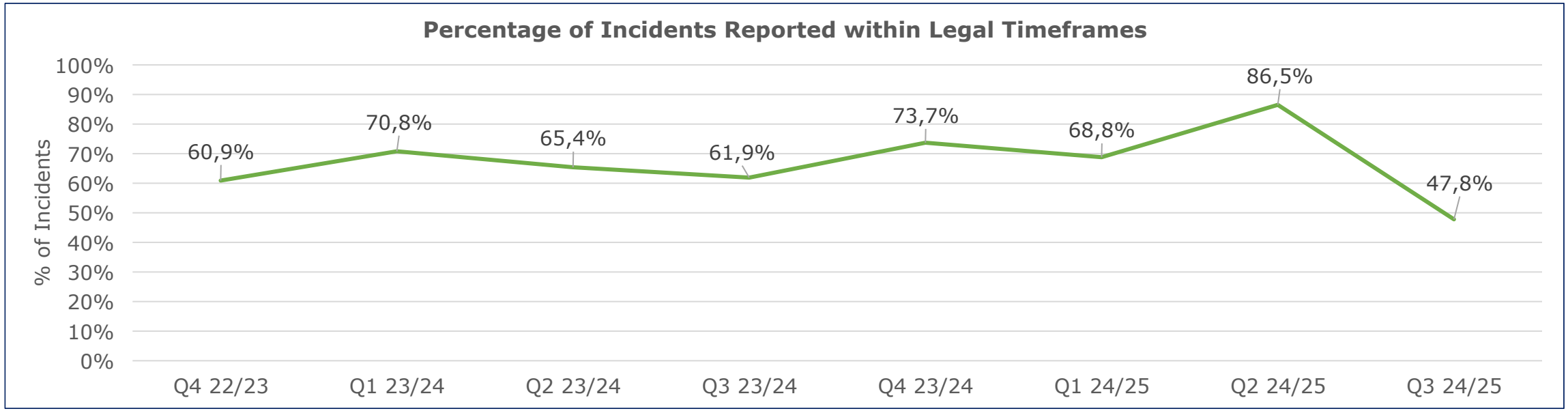
QOF Measure – Pillar 4
Health, Safety and Security RIDDOR reporting

Reporting of Injuries, Diseases and Dangerous - Occurrences Regulations

During Q3 (October 2024 to December 2024), the Health Board have reported **23 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

47.8% of these cases were reported within the legal timeframes within the legislation.

This is a significant reduction from the previous quarter and the main reasons for this reduction was due to either late reporting or further investigation.



QOF Measure – Pillar 4
Health, Safety and Security Mandatory training

Health and Safety Statutory and Mandatory Training:

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

There has been a 1% increase in manual handling training compliance. There has been no movement in the other disciplines.

Health & Safety	**86%**
Fire Safety	**83%**
Violence & Aggression	**86%**
Manual Handling	**69%**

Health and Safety Training for Senior Leaders:

Part 1 of the IOSH Safety for Executives and Directors was delivered to members of the Executive Team in Q3 2024/25. Part 2 is planned for Q4 2024/25.

Health and Safety Policies:

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

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

Violence Prevention & Reduction Strategy:

The Health Board are currently developing a Violence Prevention & Reduction Strategy. The strategy will identify key goals for the Health Board.

The strategy will be published in Q1 2025/26.

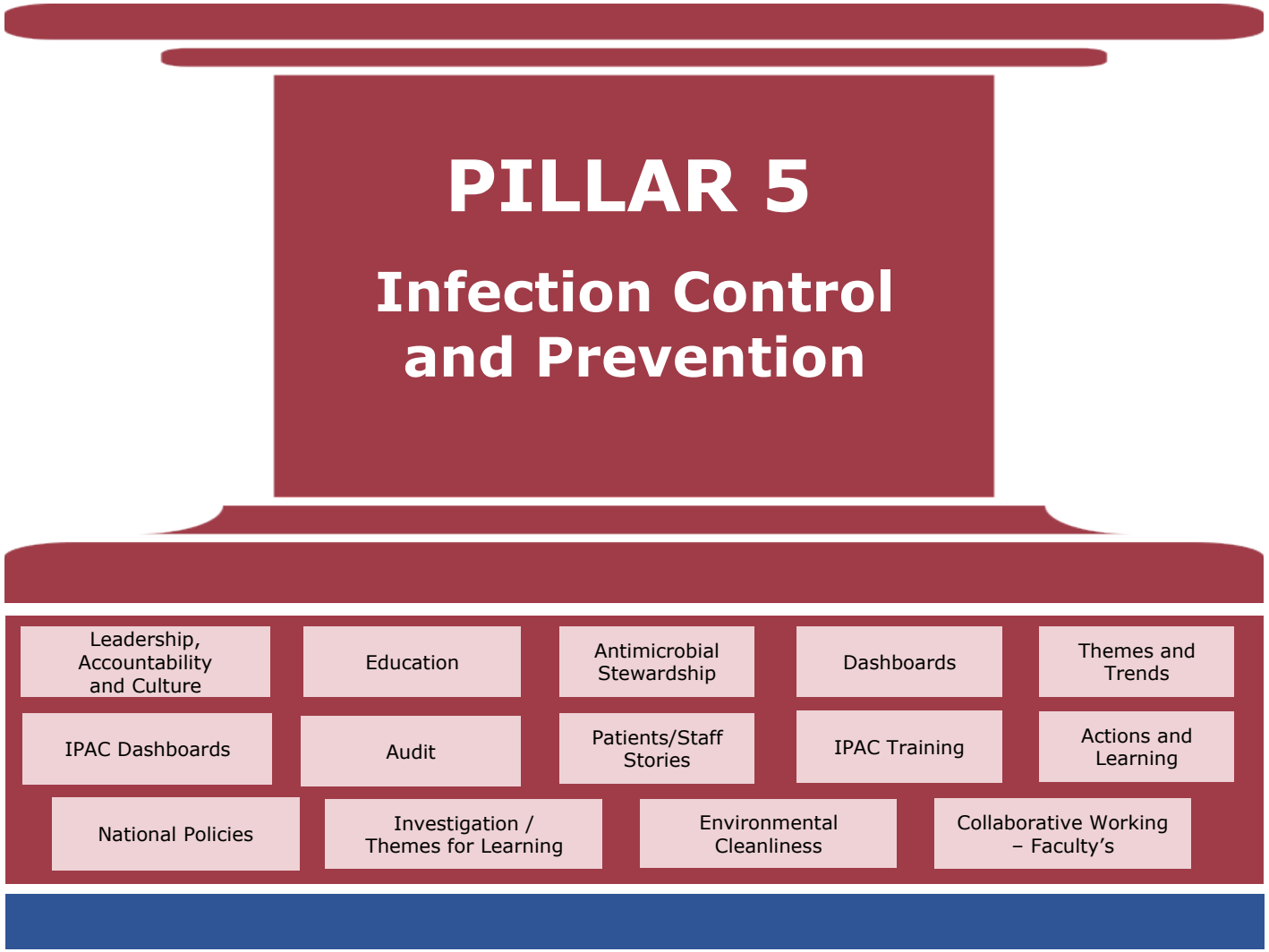
Health and Safety Executive Engagement:

There has been no further engagement with the HSE during Q3 2024/25.

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

South Wales Fire & Rescue Service Activity:

The Health Board have complied with the requirements of the two enforcement notices relating to fire safety at Residences at Nevill Hall Hospital (Gerylyn and Bron Haul).



Metrics: -

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

Developing Metrics: -

- DECI and Hand Hygiene

Pillar 5: Infection Prevention – Welsh Government Goals

Current Count of Cases for FY 24/25

Table 1. Current FY count of specimens by HB, Apr - Dec 24

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

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

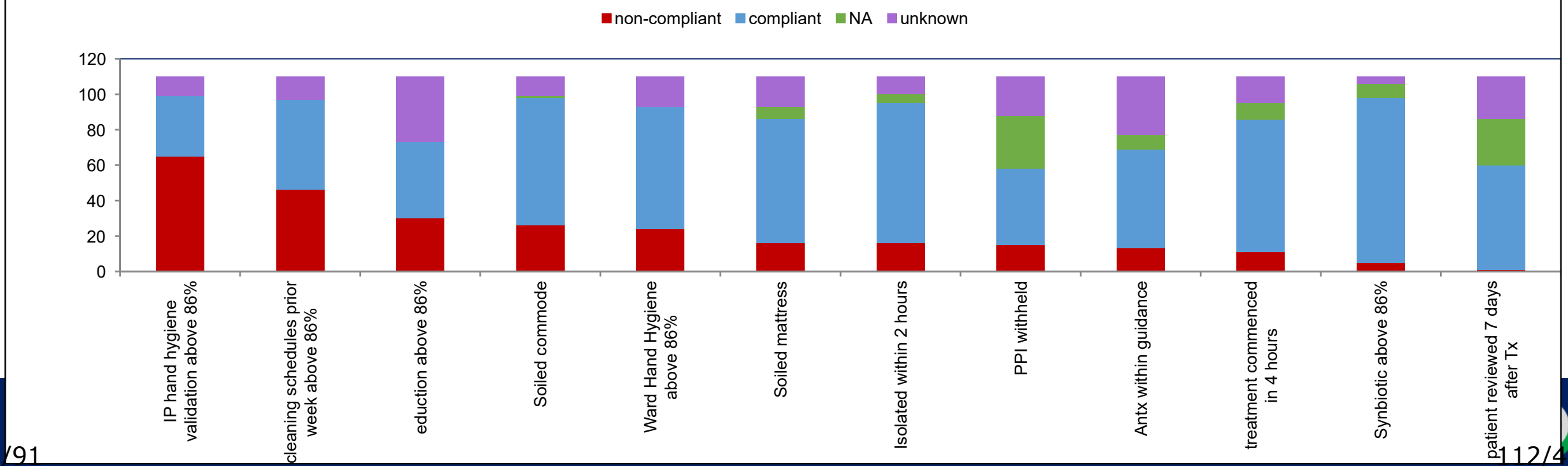
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	223	13	129	285	94	32
Betsi Cadwaladr UHB	274	11	123	401	104	19
Cardiff and Vale UHB	164	5	133	214	95	31
Cwm Taf Morgannwg UHB	131	6	94	266	86	11
Hywel Dda UHB	150	5	93	272	80	20
Powys THB	20	0	1	1	0	0
Swansea Bay UHB	205	4	93	170	90	13
Velindre NHST	4	1	1	10	8	0
Wales	1171	45	667	1619	557	126

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	50.5	2.92	28.95	63.96	21.1	7.18
Betsi Cadwaladr UHB	52.84	2.12	23.72	77.34	20.06	3.66
Cardiff and Vale UHB	43.05	1.31	34.92	56.18	24.94	8.14
Cwm Taf Morgannwg UHB	39.16	1.79	28.1	79.51	25.71	3.29
Hywel Dda UHB	51.7	1.72	32.05	93.75	27.57	6.89
Powys THB	19.83	0	0.99	0.99	0	0
Swansea Bay UHB	70.96	1.38	32.19	58.85	31.15	4.5
Velindre NHST						
Wales	49.71	1.91	28.27	68.62	23.61	5.34

Pillar 5 - C difficile

Issue	Action	Learning & Improvement
223 cases. The rate of C difficile in ABUHB is 50.05 per 100,000 population for Apr - Dec 24. This is 36% higher (60 more cases) than the equivalent period 23/24 Healthcare associated = 108 Community acquired = 93 Relapse/indeterminate = 22	▪ Ongoing proactive enhanced cleaning ▪ Bespoke education ▪ Ongoing dashboard monitoring via AMAT ▪ C difficile faculty developed ▪ Refreshed intranet resources	▪ Overview of HB guidance for the management of lines ▪ Compliance increasing several areas now able to achieve bronze accreditation

Compliance with Fundamental Measures



Pillar 5 – Healthcare Associated Infections

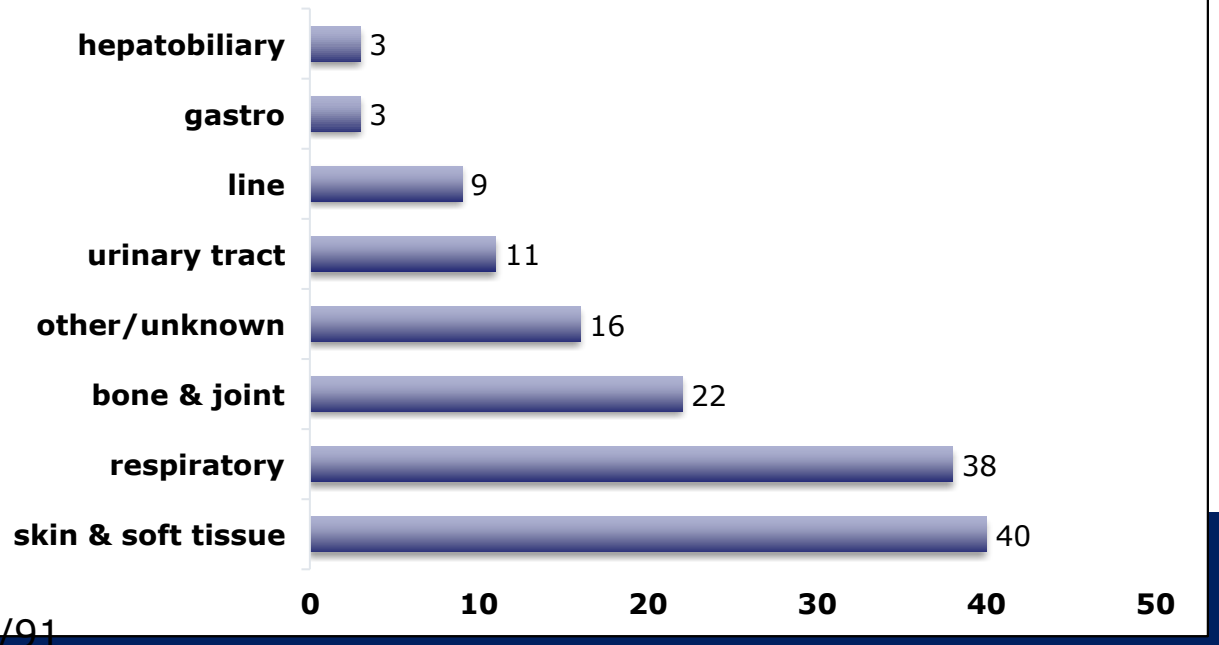
Staph Aureus Blood Stream Infections

Issue	Action	Learning & Improvement
142 cases. The rate of Staph Aureus in ABUHB is 31.87 per 100,000 population for Apr - Dec 24. This is 63% higher (55 more cases) than the equivalent period 23/24. Healthcare Associated = 47 Community Acquired = 92 Relapse/Indeterminate = 3	▪ Main source of infection is UTI Webinar implemented August promoting 9 key standards ▪ Promotion of external devices for ladies ▪ Oral hygiene promotion	▪ Webinar for line care implemented ▪ ANNT incorporated into ward accreditation ▪ Monitor MRSA screening and bundle compliance via AMA

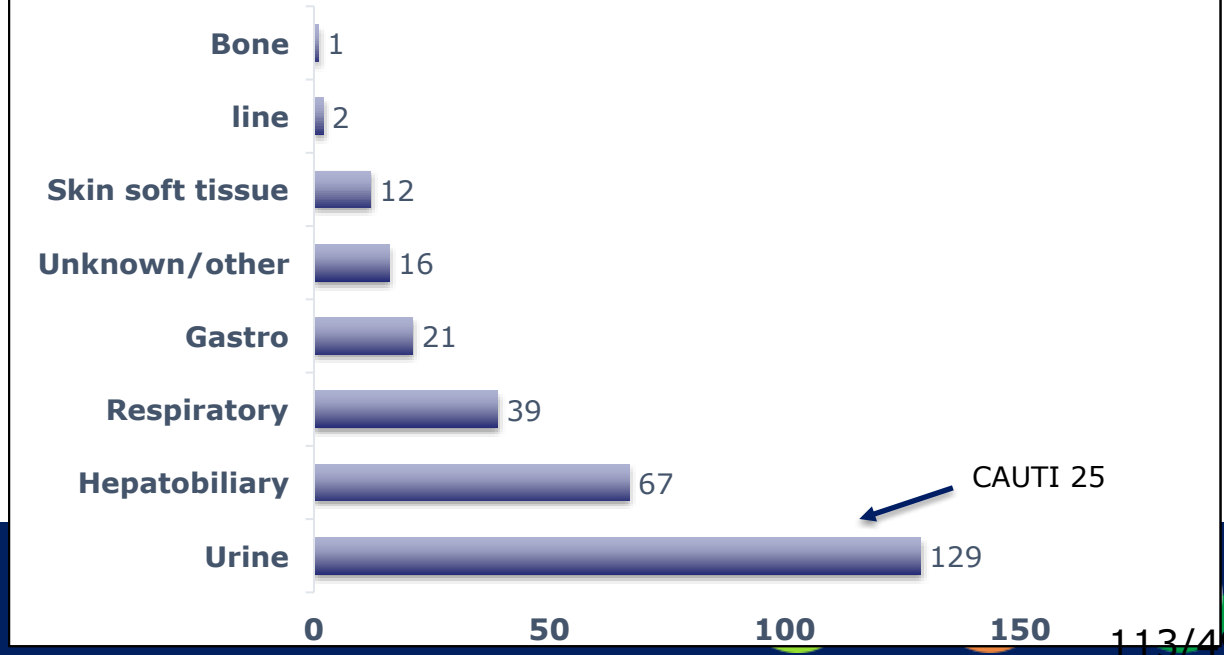
E coli Gram Negative Blood Stream Infections

Issue	Action	Learning & Improvement
285 cases. The rate of E coli BSI in ABUHB is 63.96 per 100,000 population for Apr - Dec 24. This is 5% higher (14 more cases) than the equivalent period 23/24. Healthcare Associated = 68 Community Acquired = 210 Re-isolate/Indeterminate = 7	▪ Main source of infection is UTI Webinar implemented August promoting 9 key standards ▪ Promotion of external devices for ladies ▪ Oral hygiene promotion	▪ No catheter November arranged for primary care

Source of Infection



Source of Infection

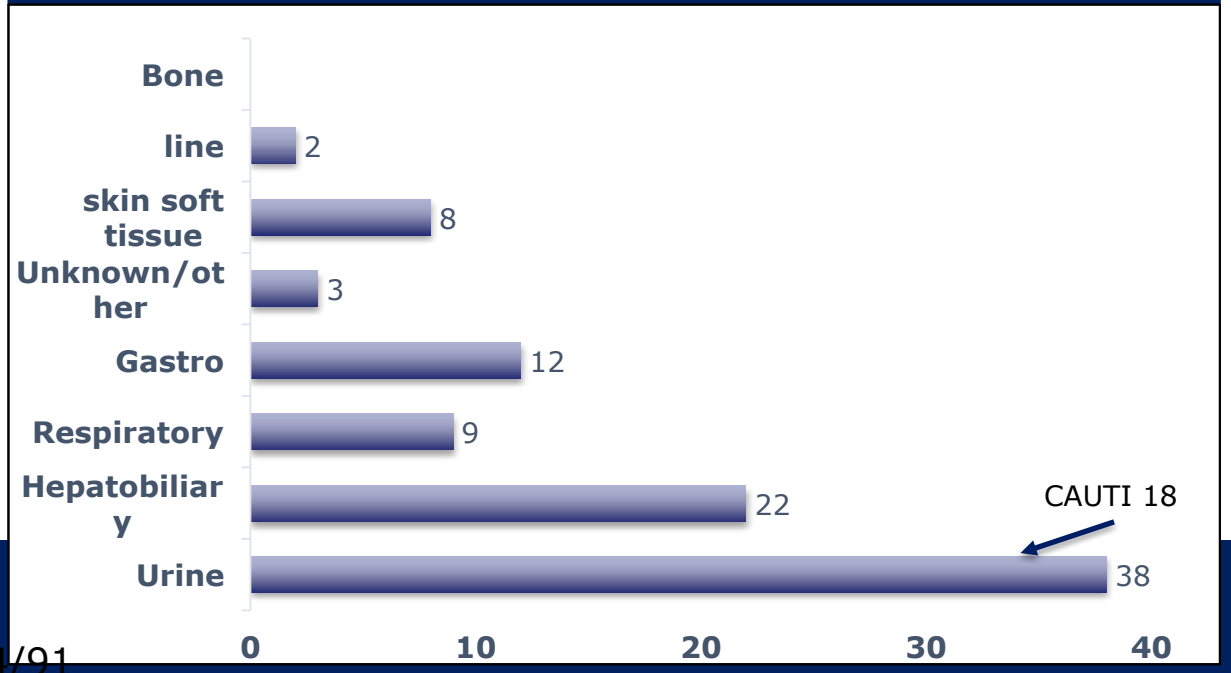


Pillar 5 - Healthcare Associated Infections

Klebsiella Gram Negative Blood Stream Infections

Issue	Action	Learning & Improvement
94 cases. The rate of Klebsiella BSI in ABUHB is 21.10 per 100,000 population for Apr - Dec 24. This is 12% less (12 less cases) than the equivalent period 23/24. Healthcare Associated = 33 Community Acquired = 59 re-isolate/Indeterminate = 2	▪ Sepsis, Antimicrobial Stewardship and Infection prevention training to new Doctors	▪ Prescribing within policy

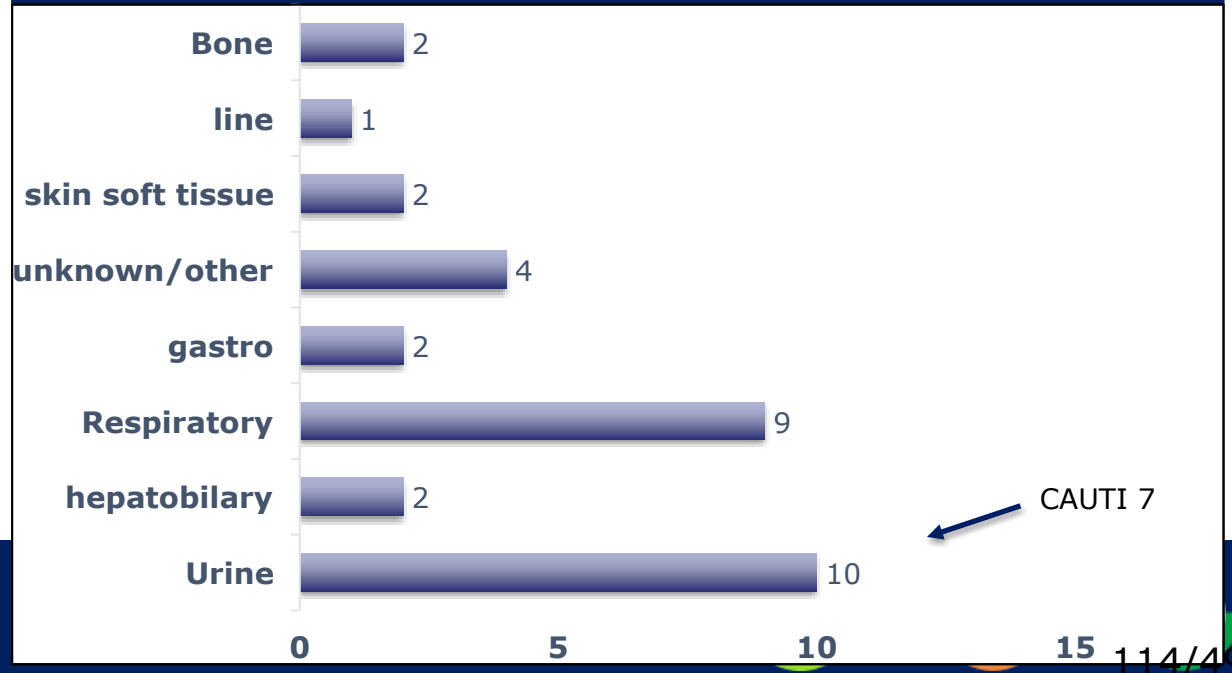
Source of Infection



Pseudomonas Gram Negative Blood Stream Infections

Issue	Action	Learning & Improvement
32 cases. The rate of Pseudomonas BSI in ABUHB is 7.18 per 100,000 population for Apr - Dec 24. This is 77% higher (14 more cases) than the equivalent period 23/24. healthcare associated = 15 community acquired = 17	▪ Reviewed training resources for water flushing ▪ Incorporated flushing onto the ward accreditation environmental audit	▪ Increase staff awareness

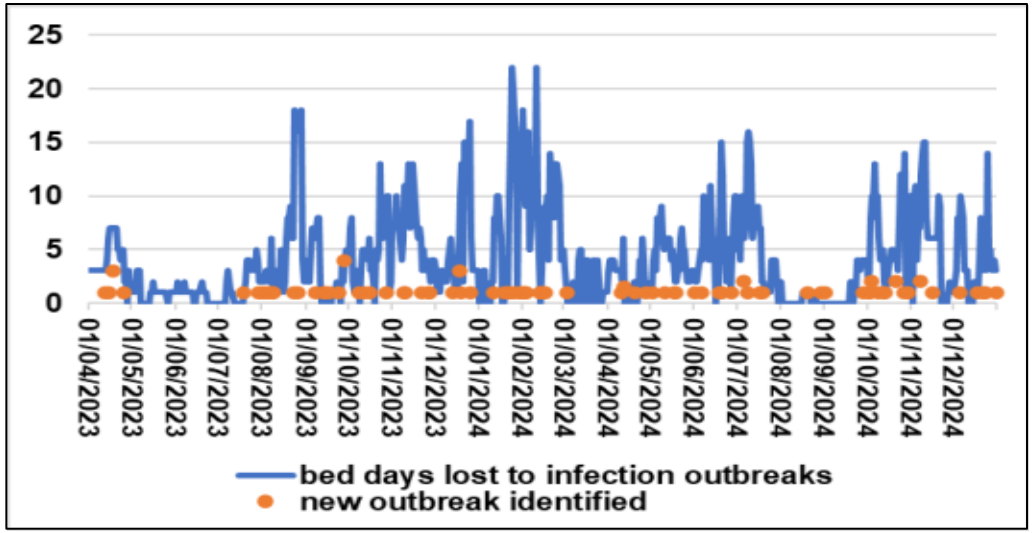
Source of Infection

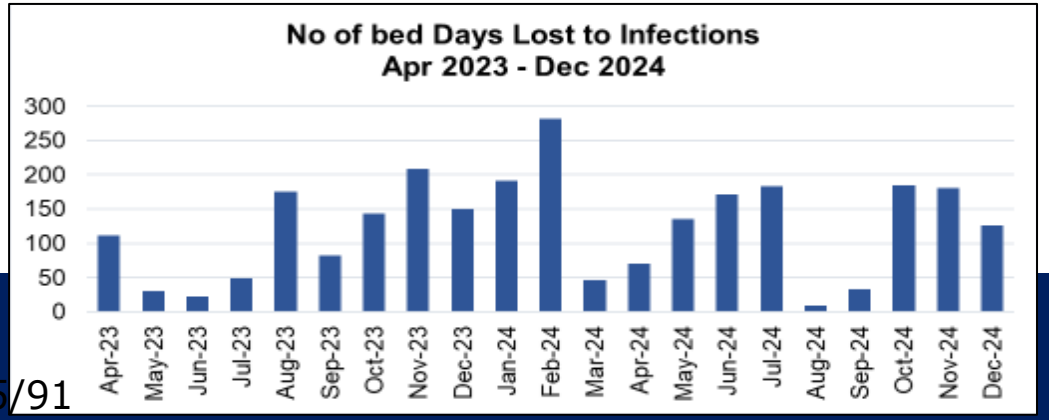


Pillar 5 Infection Prevention – Bed Days Lost

Issue

Ward closures due to infections:
17 = C difficile
21 = Covid 19
2 = Norovirus





Actions

C difficile

- Outbreak control meetings convened
- Samples sent for genomic sequencing to identify same strains
- One sporadic genomic sequencing & 2 cases linked from D2E indicating cross infection likely occurred
- 5 wards - no links identified
- Decant HPV clean

Covid-19

- Promoted covid safety measures
- Enhanced cleaning of touch point areas
- Patients cohorted on a like for like infection

Norovirus

- Enhanced cleaning
- Isolation of infection patients

Learning & Improvement

C difficile

- Inappropriate sample collection
- High dust
- Antibiotics not within guidelines
- Not withholding PPI while on antibiotics
- Compliance with fundamental IP

Covid-19

- Ventilation
- Symptomatic staff/visitors to wear face covering
- Visitors

Norovirus

- Shared facilities

Infection Prevention – Critical Incidents

Issue	Cause	Remedial Action	Who	When
Measles outbreak at The Grange University Hospital	Children not isolated in the Emergency Department	• Contact tracing to identify exposed patients and staff • Screening triage questionnaire reviewed • Triage booth installed outside • Exposed children and staff reviewed and offered advice/treatment • Staff education • Public Health warn and inform letters	Ward Managers Senior Nurses PHW Infection Prevention Team Occupational Health	Completed April/May 2024
Several incidences of patients with Group A strep blood stream infection at Nevill Hall Hospital, Royal Gwent, Ysbyty YF & YAB	Patient's not isolated for 24 hours while on antimicrobial treatment	• Contact tracing to identify exposed patients and staff • Prophylactic antimicrobials • Warn and inform letters	Ward and medical staff Infection Prevention Team Occupational Health	Completed April, June, July & August 2024
Patient exposure to Tuberculosis (TB) identified from bronchial washings taken in Endoscopy at The Royal Gwent Hospital	Unknown cause. TB not suspected while the patient was on MAU	• Contact tracing to identify exposed patients and staff	TB Nurse Specialists Infection Prevention Team	Completed June 2024
Patient exposure to Carbapenemase-producing enterobacterales (CPE)	Patient not screened on transfer from another Health Board	• Contact tracing to identify exposed patients and staff • 10 contacts screened for CPE in line with national guidance • No further patients identified positive	Infection Prevention Team Clinical Team	Completed July 2024
Staff member identified as Tuberculosis positive	Staff member known to have a respiratory infection	• Contact tracing to identify exposed patients, staff & household contacts • TB screening offered to people over 8 hours exposed	Public Health Wales Occupational Health TB Nurse Specialists Infection Prevention Team	Completed December 2024

Infection Prevention – Decontamination

Issue	Cause	Remedial Action	Who	When
Community Dental Service (CDS) washers have been tested but not serviced, indicating non compliance with required standard.	Lack of works and estates trained staff to undertake the role and their focus on other decontamination testing, eg HSDU.	All Wales Authorised Engineer (Decon) AE(D) aware. Waiting CDS agreement on release of monies for band 5 Works personnel.	Authorised Person (D). Works & Estates lead. CDS Directorate	October 2024 October 2024
Delay in centralised endoscopy unit project build at the Royal Gwent Hospital (RGH). Still increased demand on the interim unit with breakdowns occurring.	Non agreement of revenue costs initially created delay however this has since been approved by ABUHB Board and still awaits decision for funding by Welsh Government.	The interim decon unit continues to decontaminate scopes however has failings on recent Bowel Screening Wales (BSW) audit. Action plan produced to address issues.	Still awaiting Welsh Government funding review HSDU lead	End October 2024
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D) for JAG accreditation.	Identified significant progress with works & estates input. Electronic track & trace (T&T) indicated requirement for green rating.	Ward staff have been trained in weekly testing for decontamination and has been accepted by AE(D) Wales. Awaiting report to decide JAG accreditation.	Directorate manager & Senior Nurse	November 2024
AP(D) role not fully functioning from a governance aspect.	Lack of AP(D)s and decontamination works trained staff. Remains under review.	Decontamination manager continues to support AP(D)with joint report review.	General Manager Facilities / Works & Estates	December 2024
Risk of losing automated decon process for US probes in Radiology Units. Compatibility issue with Trophon preclean.	Trophon 1s HPV probe disinfectors are obsolete. Disinfection assurance only on Incidin Oxywipe at this moment	Replacement programme within Ultrasound directorate & agreed on 8 new machines. All Wales meeting with possible independent testing proposed.	Ultrasound Lead Decontamination manager & Ultrasound Lead	November 2024 November 2024

Water Safety

Issue	Cause	Remedial Action	Who	When
Raised water counts within Augmented Care at The Grange, Royal Gwent, Nevill Hall Hospitals and Ysbyty Aneurin Bevan	Taps not frequently run within the clinical area	▪ Increased staff awareness ▪ Filters placed on taps ▪ Retesting with the aim for clearance ▪ Flushing poster developed ▪ Training video for cleaning of clinical hand washing sink ▪ Water safety plan	Infection Prevention Works and Estates Clinical local teams	Ongoing

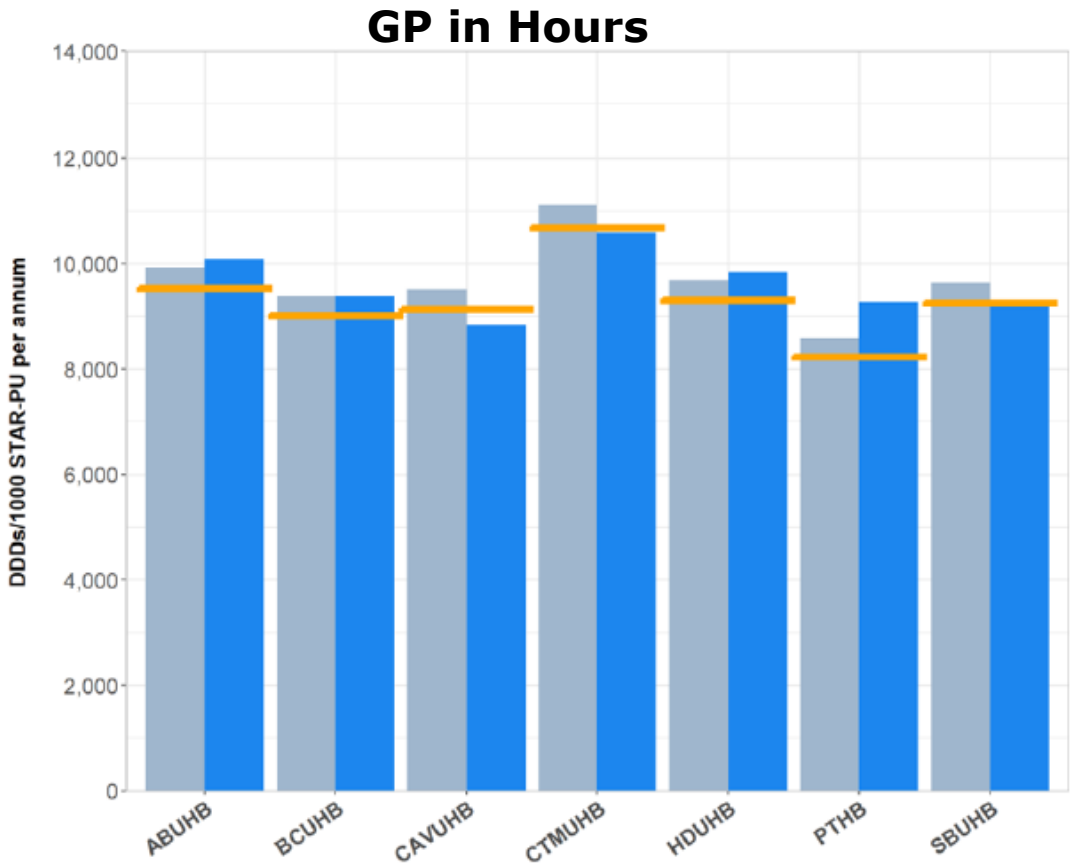
WG Antimicrobial Targets: Primary Care

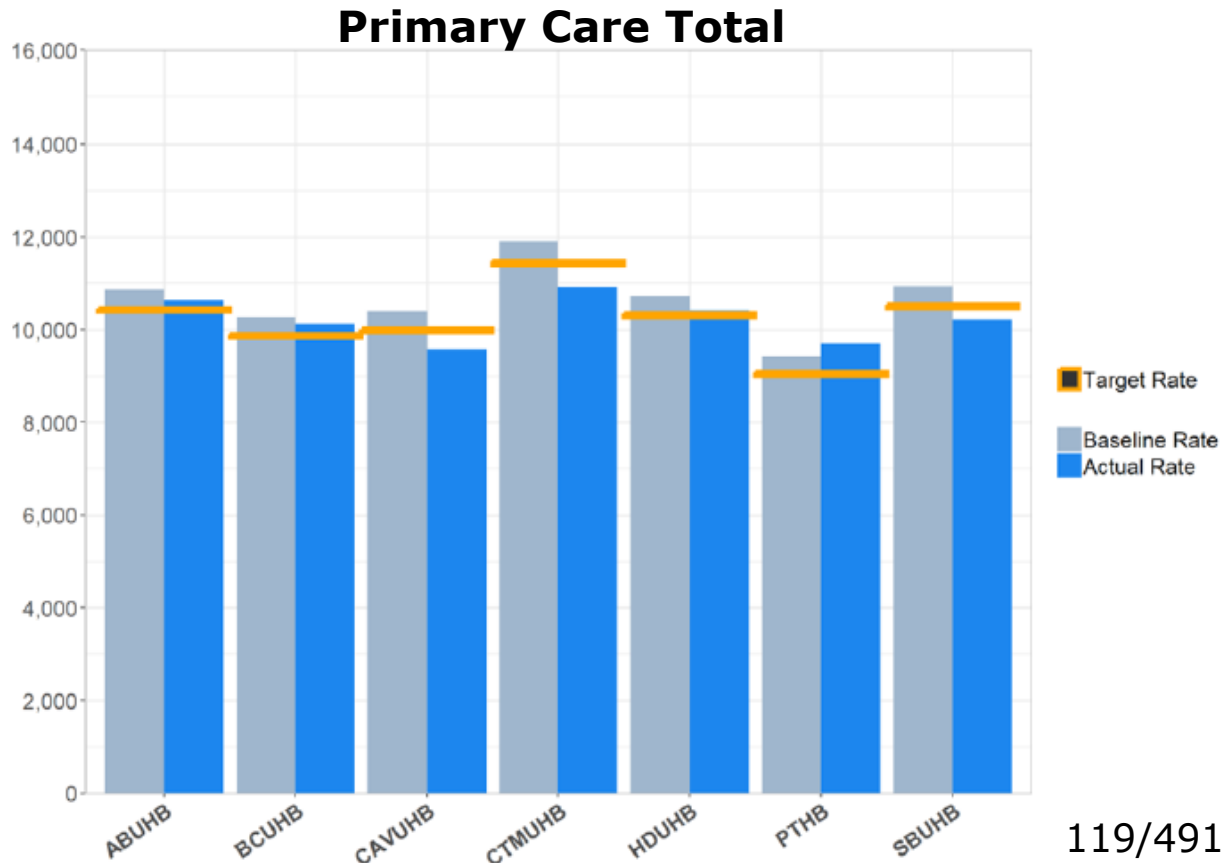
Target 11a: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline
(measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PUs)

ABUHB 2023/24 FYE position received from Public Health Wales:

- GP in hours: **1.6% increase** on 2019/20 baseline
- Primary care total (GP in hours, plus, GP out of hours, independent prescribers, and the Community Pharmacy Common ailments Service UTI and sore throat test and treat services): **2.1% reduction** compared to 2019/20 baseline

Progress for all WG antimicrobial targets is reported annually





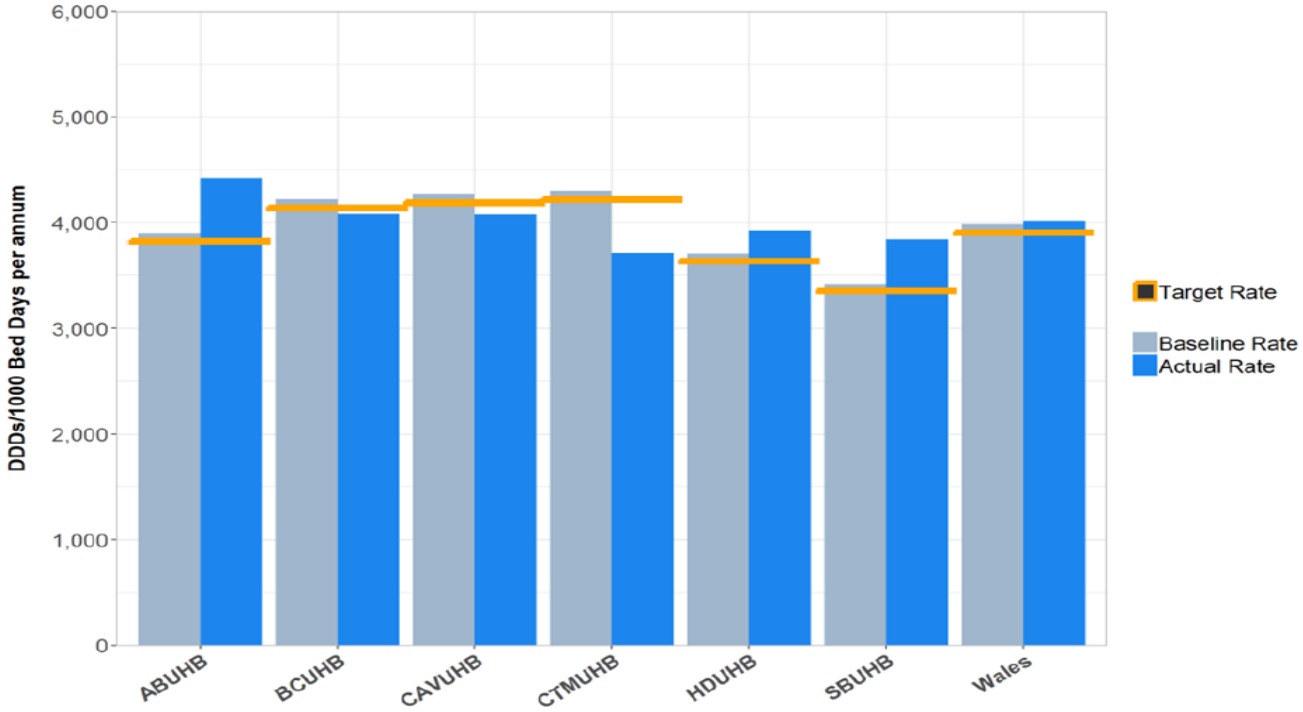
WG Antimicrobial Targets: Secondary Care

Target 11b: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline
(measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PUs)

ABUHB 2023/24 FYE position received from Public Health Wales: overall **13.3% increase** in consumption

- Positions for individual hospitals are available, *however* given movement of clinical services since the 2019/20 baseline year these should be interpreted with extreme caution:
  - Grange University Hospital **11.3% increase** (N.B. surrogate baseline used)
  - Nevill Hall Hospital **13.8% reduction**
  - Royal Gwent Hospital **5.4% reduction**
  - Ysbyty Ystrad Fawr **141.3% increase**

- E-prescribing roll out will aid progress against this target, e.g.
  - Imposing 'hard stops' of antibiotics, where antibiotics will automatically be discontinued
  - Using order sets (standard prescriptions) for specific infections that will guide users to shorter courses, e.g. 5 days of antibiotics for a pneumonia
  - Allowing searching & visualisation of patients on prolonged antibiotic courses



WG Antimicrobial Targets: Secondary Care

Target 12: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30
(measured in defined daily doses (DDDs), equivalent to number of days of antibiotics dispensed)

ABUHB 2023/24 FYE position received from Public Health Wales: **62.9% usage in access category**

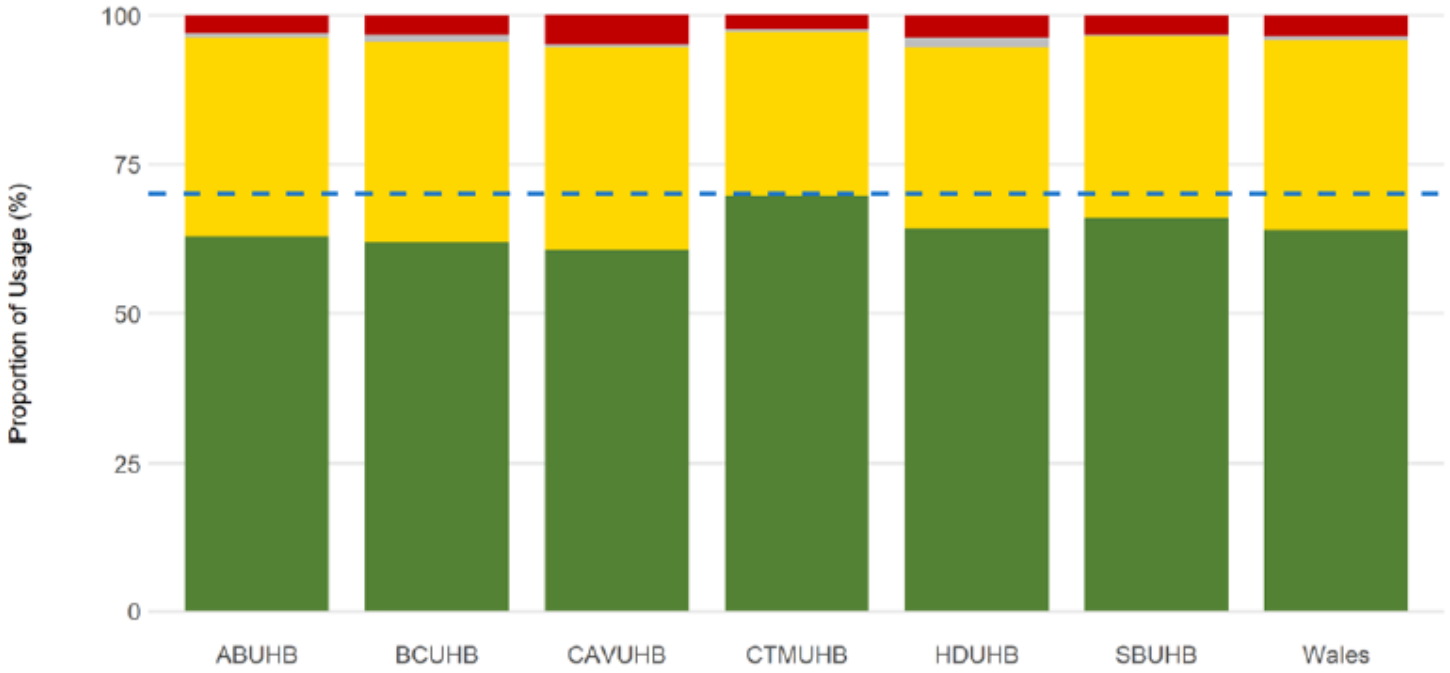
Positions for individual sites are:

- Grange University Hospital **62.7%**
- Nevill Hall Hospital **64.3%**
- Royal Gwent Hospital **63.4%**
- Ysbyty Ystrad Fawr **60.1%**

Roll out of penicillin allergy de-labelling activities in secondary care has commenced which should allow more patients to receive penicillins, most of which are in the access category

e-prescribing roll out will also aid this target e.g.

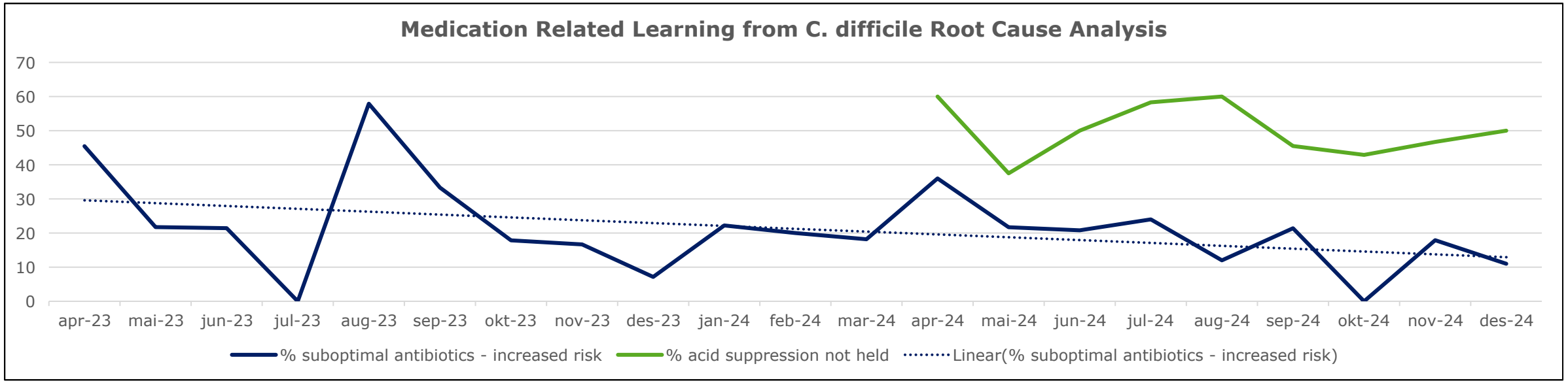
- Using order sets (standard prescriptions) for specific infections that will align prescriptions with ABUHB antimicrobial guidelines
- Allowing searching & visualisation of patients on prolonged watch/reserve courses



	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	SBUHB	Wales
Reserve	3.1	3.3	5.0	2.4	3.8	3.3	3.5
Other	0.7	1.1	0.4	0.5	1.5	0.2	0.7
Watch	33.3	33.7	34.2	27.6	30.6	30.6	31.9
Access	62.9	61.9	60.5	69.6	64.1	65.9	63.9

Issue	Action	Learning and Improvement	Who	When
Primary care in-hours GP antimicrobial usage increasing, in spite of audit & feedback cycles with high-prescribing practices	Attended Primary Care Clinical Directors meeting to discuss	Hybrid strategy agreed: thematic work at scale (e.g. syndrome-based education) plus continue 1:1 work for high prescribing practices with a lighter touch approach. To meet Assistant Primary Care Divisional Director for Partnerships & explore opportunities via professional collaboratives Jan 2025.	Consultant Antimicrobial Pharmacist	November 2024
Antimicrobial staffing: capacity will be limited due to 0.7 WTE long-term sickness since Nov 24, 0.4 WTE project support vacancy from Jan & 0.7 WTE maternity leave from Jan 25 (of total team capacity of 4.33 WTE AMS time)	Exploring options for maternity leave cover with secondary care pharmacy team. Plan for replacing project support role to be discussed.	Secondary care pharmacy unable to release pharmacist for secondment. Suggestion of utilising technician time instead being explored, as are temporary appointments/additional hours.	Consultant Antimicrobial Pharmacist	April 2025
Proportion of PPIs being continued 'inappropriately' while on antibiotics is higher than proportion of suboptimal antibiotics	Secured agreement for 4 site audit of practice in secondary care	Audits currently in progress	Lead Antimicrobial Pharmacist for Secondary Care	February 2025
Use of order sets (standard prescriptions) in electronic prescribing (ePMA) key to improving antimicrobial use in secondary care. Need to be embedded from go-live to ensure behaviour change	Discuss with ePMA lead pharmacist once in post Collaborate with other health boards using the Better system to share workload AMS team to prioritise developing order sets in 25/26		Lead Antimicrobial Pharmacist for Secondary Care	2025/26 FY

C. difficile Antibiotic Themes

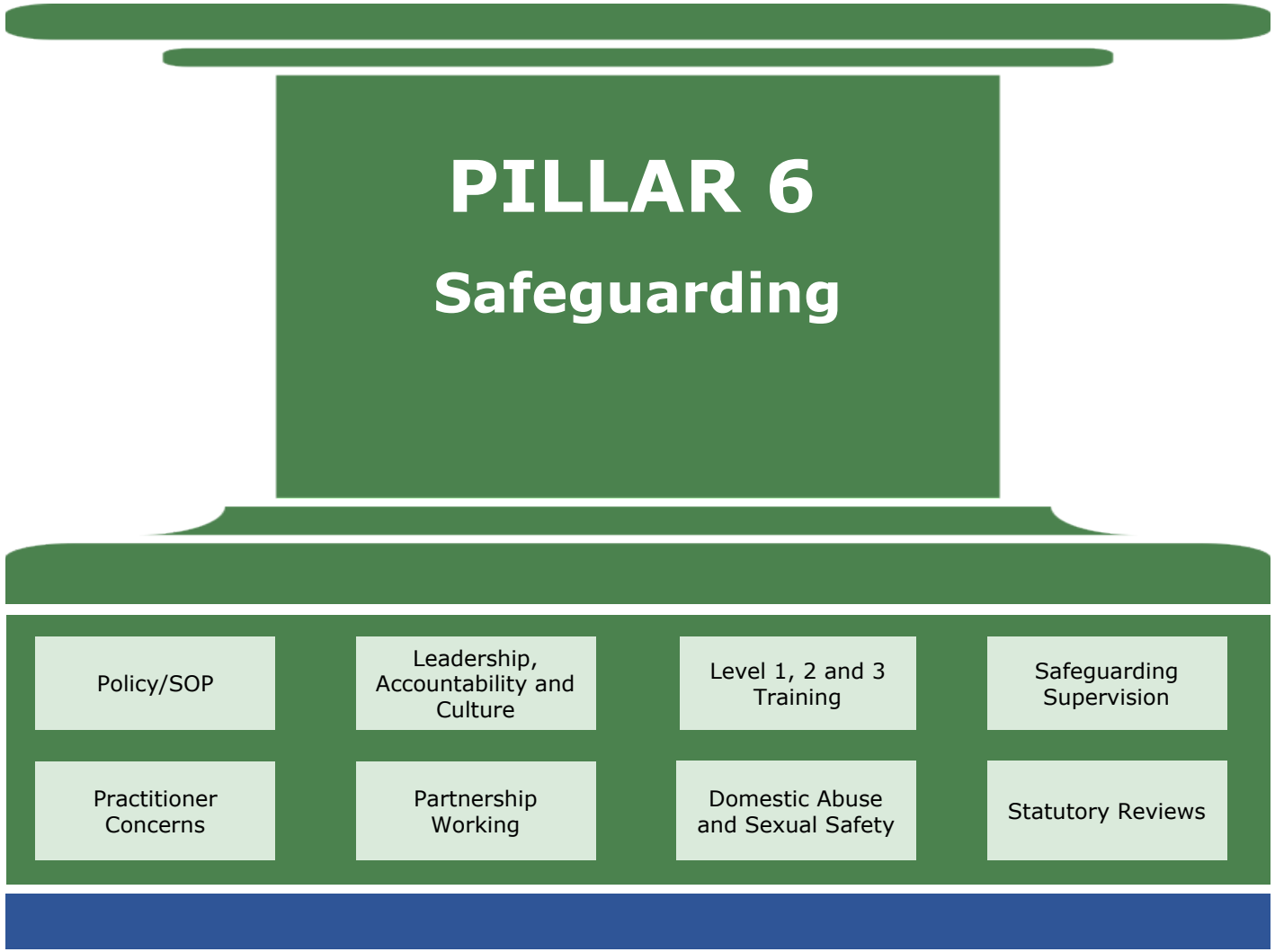


October 2024 – December 2024

Antibiotic Finding	HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	1	1	3	0	**5**
No suboptimal antibiotics	16	3	3	2	**24**
Possible suboptimal use – no increased risk	7	3	1	2	**13**
Possible suboptimal use – increased risk of C. diff	4	2	0	1	**7**
Awaiting GP Response	0	8	1	0	**9**
RCA pending	3	1	0	0	**4**
Total	**31**	**18**	**8**	**5**	**62**

Q3 learning

- For patients receiving suboptimal antibiotics there were no themes in drug, disease or site/location to enable targeted action
- Acid suppression medicines not held in 46% of the 37 patients prescribed them



Metrics: -

- Adult Duty to Report / Child Duty to Report
- Training compliance

Developing Metrics:

- Themes from domestic homicide reviews and serious case reviews

Pillar 6: Safeguarding – Duty to Report

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

Refresh Of Safeguarding Strategic Meetings

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

In light of the above, it has been agreed that the following Sub Groups will be formally introduced in January 2025:

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

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

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

Pillar 6: Safeguarding – Training Compliance

Training Module	Compliance %
Adult Safeguarding Level 1	87%
Children's Safeguarding Level 1	85%
Adult Safeguarding Level 2	90%
Children's Safeguarding Level 2	89%

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

All training for Safeguarding Level 1 and 2 is now above the required 85% compliance.

Level 3 Children's and Adults training continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR and that compliance data can then be analysed. A final list of staff has now been identified and the ESR team are in the process of uploading this to the system.

Safeguarding Actions

Issue	Action	Learning and Improvement	Who	When
Safeguarding Level 3 Training Non-Compliance ▪ Delays in being mandated via ESR	Extensive work has been completed by Corporate Safeguarding and the ESR Team which should result in mandate showing on staff records from the beginning of 2025.	Upon completion of this action it will be simple for managers at all levels of organisation to monitor compliance and identify areas for improvement.	ESR Team	Q4
Decommissioning of Specialist Domestic Abuse Service in General Practice ▪ Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme	A number of presentations are being delivered to the NCNs to outline what services are available to support survivors of Domestic Abuse and an interim pathway for management of a disclosure has been provided to practices. This was delivered in one of the six NCN Areas in November 2024, with the further five areas scheduled in Q4	System leaders in primary care will have received bespoke training and support to enable them to embed pathways within their practices.	Corporate Safeguarding	Q4
Significant increase in safeguarding referrals and strategy meetings for vulnerable children and adults ▪ It is unclear if there is any singular cause for this increase in activity, though improved staff awareness will be a contributory factor.	At this current time there is no singular system that monitors the Health Boards Activity in relation to Safeguarding, so analysis of themes and trends is problematic. There are plans to implement the Once For Wales Datix Safeguarding Module in April 2025, which will then provide an overview of activity and inform strategy moving forward.	With an absence of robust and validated data, safeguarding activity is difficult to predict, so developing more robust methods of monitoring increased activity will facilitate early escalation and inform planning.	Corporate Safeguarding	Q4

Additional Indicators

Section 5

Ward / Team Accreditation

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

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

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

Phase 3: HV, DN, Maternity services, Specialised Teams,

Phase 2 Progress:

- Theatre audits will be live by end of January.
- Meeting ED/MIU in January to review their audit plan
- Critical care are live, met in Dec to provide support.
- MAUs/SAU are live
- OPD / clinics to be reviewed.

Independent Reviews:

- Total **14** reviews performed
- 8 achieved Bronze (6 require reassessment)
- 3 booked in Jan 2025 with a further 12 areas ready for Bronze assessment

NEXT STEPS:

- Progress with phase 2
- Coordinate timely cross divisional Independent Reviews when applicable
- Add senior nurse audits to provide further assurance prior to independent reviews.
- Develop Ward Accreditation Padlet for the Intranet
- Liaise with ABCi department to determine how they can support Wards / Teams with improvement projects: meeting in Jan 2025
- With the assistance of data analyst identify organisational themes for learning

Ward / Team Accreditation

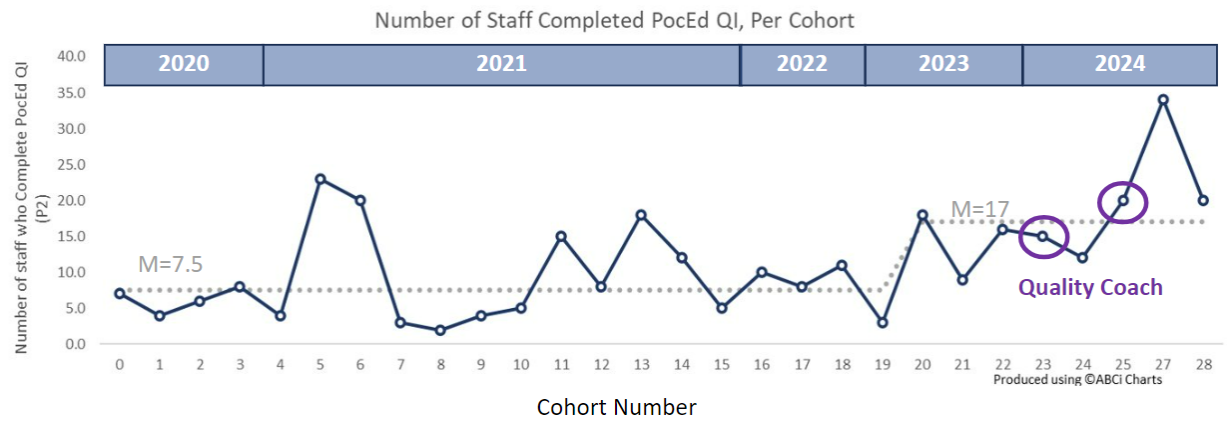
Issue	Action	Learning and Improvement	Who	When
The independent Reviews have raised questions regarding timescales for completion of risk assessments-current target has been set at 6 hours for all risk assessments. Environment audits are identifying safety risks in some areas (ie, emergency equipment availability)	Benchmarking has identified other areas ask for risk assessments to be in place but not audited to a timeframe. **Requested senior nurses undertake a 1 patient 1 day audit monthly and environment audits to monitor documentation quality / provide assurance the audits are reflective of the areas practice.**	The 6-hour target for all risk assessments may have prevented some wards from qualifying for Bronze award following independent review **Continue to audit to the 6 hour target for all risk assessments.** Professional practice senior nurse to present independent review themes at senior nurse meetings to share learning. Areas that have not achieved Bronze are offered support from the professional practice team.	Senior Nurses professional Practice	January 2025
Delay in progressing some areas in phase 2 of the programme.	Ongoing meetings with ED and Theatre staff to determine what and how to audit. -develop and adjust exiting audits. Theatre audits to be uploaded / live by February. Meeting ED in January to devise audit plans.	Delayed progress – it takes time to determine what to audit and how the to adapt the audits to specialised areas. Meetings with specialist areas have been productive.	Senior Nurses Professional Practice ED Senior Nurse and Band 7s Theatre Senior Nurses / Practice Educators	February 2025
Analysing the data and pulling themes	Data analyst to assist the programme has been agreed- currently developing JD to advertise band 7 post	AMaT is an excellent platform to undertake the audits and see the results at a glance. It is excellent for wards/Teams to analyse their individual data. However, it is not easy to create organisational reports from the data or to pull organisational themes	Senior Nurses Professional Practice Data Analyst	Ongoing

Quality Improvement: Q3

Workforce QI Skills Development Framework

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

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



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

- 47 staff trained in total over 6 cohorts

Staff undertaking Quality Improvement Coach Programme undertake Poced QI and PocEd Measurement initially.

Quality Improvement Coaches embedded

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

- Cohort 1 completed in November 2024
- Dates set up for 2025
- 31 coaches in total have completed the programme (inc. 3 external candidates). Further 6 in process

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

- 12890/1000000 minutes of QI Coaching delivered in 2024

Access to data systems supporting QI

Visualising data in time series

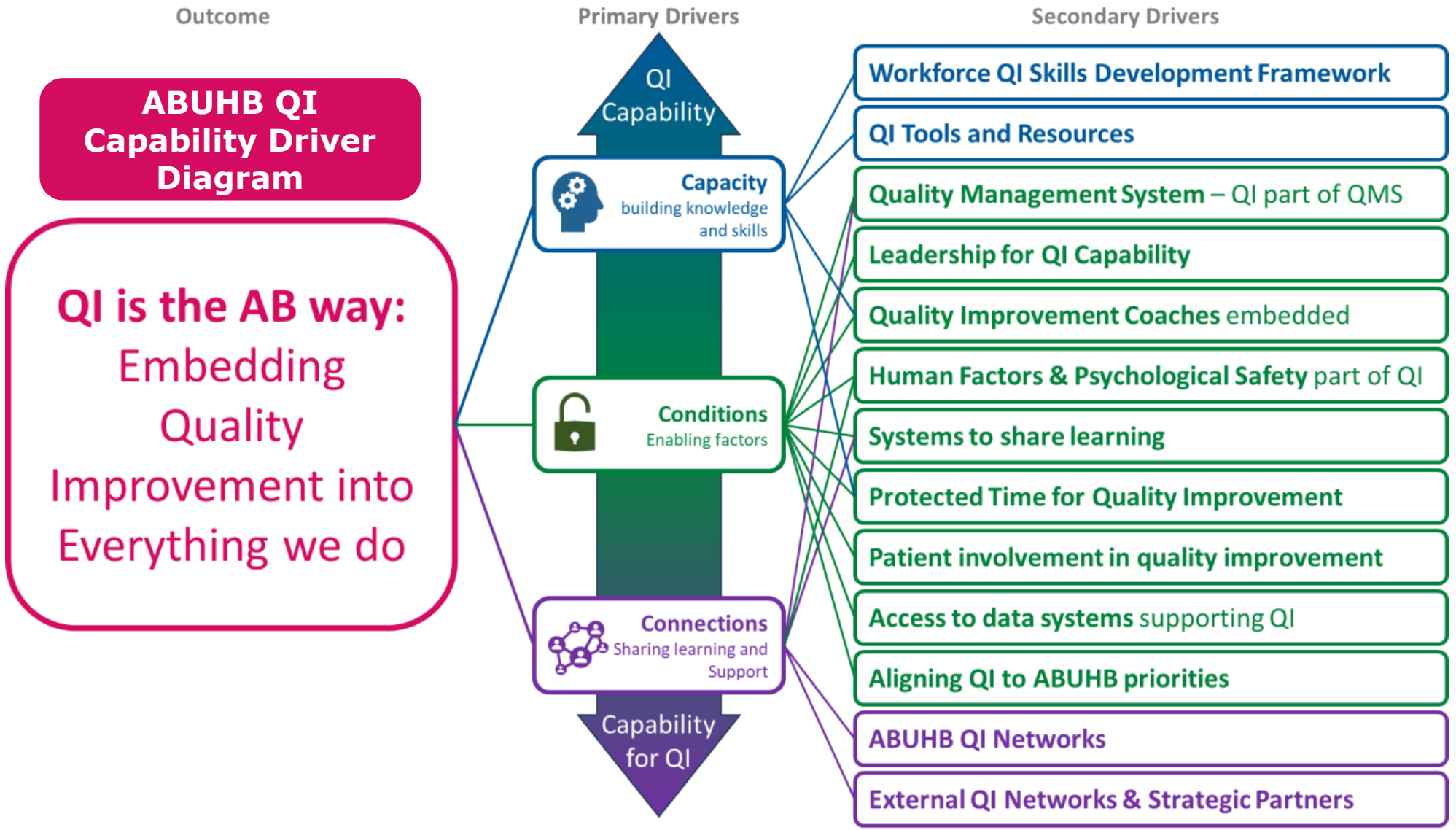
- Working with Digital, Data and Technology team to standardise time series data visualisation in Qlik

Quality Improvement: Q3

Quality Improvement Capability Strategic Approach: Embedding Quality Improvement into Everything we do – 2025 – 2028

- Approved by AB Executive Team and Public Board in November 2024
- Board Development Session – October 2024
- Discussion as part of workshop facilitated with Maxine Power – October 2024. Draft QI Capability Approach commended as -

'one of the best she had seen'



For Information

Clinical Effectiveness

Section 6

Ninth Patient Report of the National Emergency Laparotomy Audit
December 2021 to March 2023

Clinical Leads:
Babu Muthuswamy - Consultant Intensivist & Anaesthetist
Helen Williams - Consultant Anaesthetist
Gethin Williams - Surgical Consultant

Rationale:	The NELA dataset is a comprehensive record of the processes and outcomes of care in England and Wales over 10 years. This dataset provides rich insights into improving the care of patients. Efforts should be made to learn the lessons contained within this data to support and drive local quality and service improvements. NELA is working with THIS Institute on a national programme to improve the timeliness of care in the early pathway. Work began in Spring 2024. Trusts and Health Boards are encouraged to join this work as participants in the discovery and testing phases.
Objectives:	This is the ninth annual report of the National Emergency Laparotomy Audit (NELA) and examines care received by NHS patients in England and Wales undergoing emergency laparotomy (emergency bowel surgery) between 1 December 2021 and 31 March 2023. Year 9 of the audit was extended to align with the NHS financial year

Presented at Clinical Standards and Effectiveness Group 28th November 2024

Median time to antibiotics in patients with suspected sepsis was 3.1 hours from arrival in hospital.

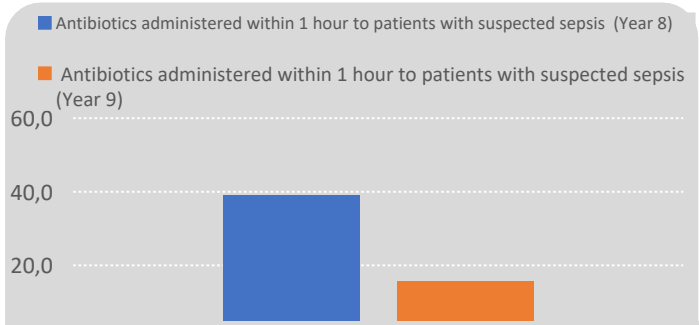
Patients with sepsis suspected at time of arrival in hospital waited a median of **15.5 hours from time of admission** until surgery.

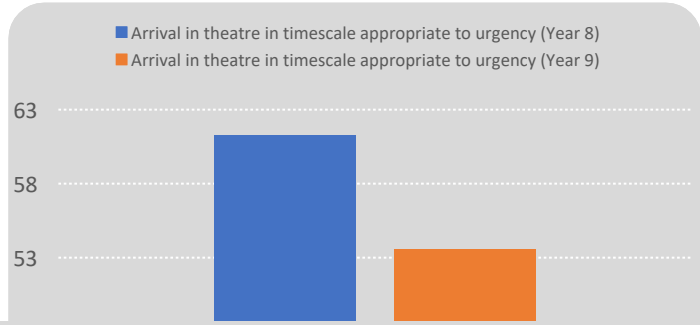
Message 1

Patients with significant and time-sensitive intra-abdominal pathologies, including those with suspected sepsis, frequently did not receive timely care consistent with published guidance.

For example, amongst those with suspected sepsis:

- only 20% received antibiotics within 1 hour
- 25% waited at least 6.5 hours after arrival in hospital before receiving antibiotics
- 50% waited for more than 15 hours before arrival in theatre
- performance varied significantly between hospitals.



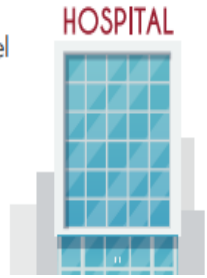


ABUHB has decreased performance for 1 hour Antibiotic and time to theatre timescale appropriate to urgency

ABUHB No. of cases for year 8 was 331 and for year 9, with the additional 4 months of data to align with the NHS financial year was 410 cases

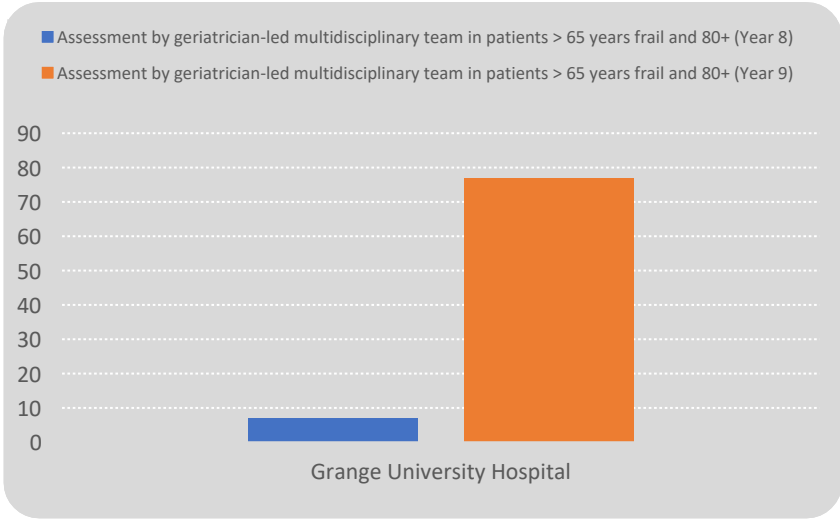
100% Case Ascertainment and data completeness

27,863 patients who had emergency bowel surgery in England and Wales were included in the Year 9 audit from 173 hospitals.



ABUHB frailty assessment in patient >=65 years improved from 94.1% in year 8 to 97.4% in year 9.

33.2% of patients aged 80 or over, or 65+ and frail, had geriatrician input (31.8% in Year 8).



Message 2

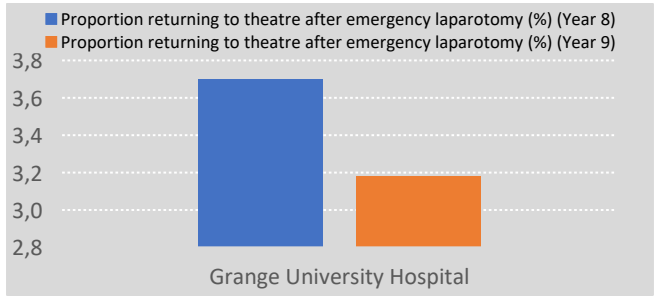
The majority of older patients and those living with frailty do not receive expert multidisciplinary care after emergency laparotomy (33% receive input). There is compelling evidence of an association between geriatrician input and reduced mortality, supporting the case for improving this intervention.

Message 3

There is hospital-level variation in risk-adjusted mortality. Additionally, there is higher mortality amongst those from more deprived quintiles in each nation. Differences in outcomes between patients in different hospitals and from varying levels of deprivation need to be recognised and acknowledged. Reasons are likely multifactorial but must be explored further.

There was no change in Adjusted Mortality for GUH from Year 8 to Year 9, both 9.6%.

Improvements in mortality have plateaued – **in-hospital mortality was 9.3%** compared to 9.2% in Year 8 and 9.1% in Year 7.



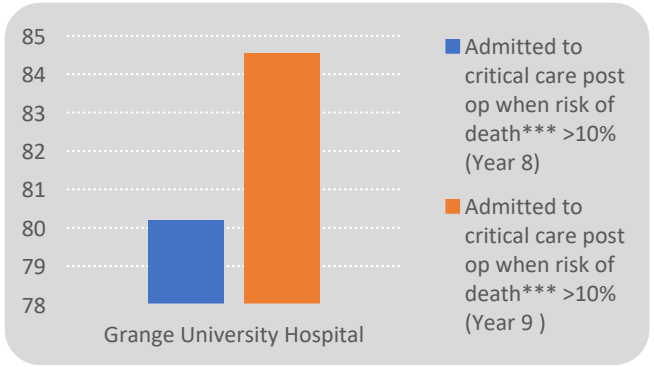
ABUHB returning to theatre after emergency laparotomy has decreased from 3.7% in year 8 to 3.2% in year 9.

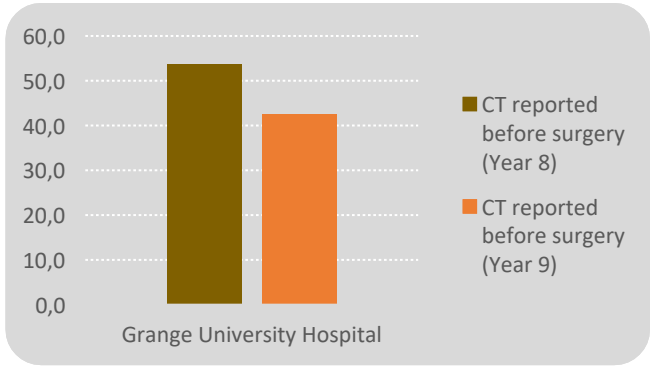
80.3% of high-risk patients were admitted to critical care postoperatively (79.1% in Year 8). **13.9% of high-risk patients** were admitted to a normal ward.

Message 4

14% of high-risk patients did not receive immediate postoperative critical care contrary to published guidance. Instead, they were transferred to a normal ward following surgery; 7% of these patients subsequently died.

91.1% of patients received a preoperative CT scan **30.8% of patients** had their scan outsourced (26.3% in Year 8, 19.1% in Year 7).





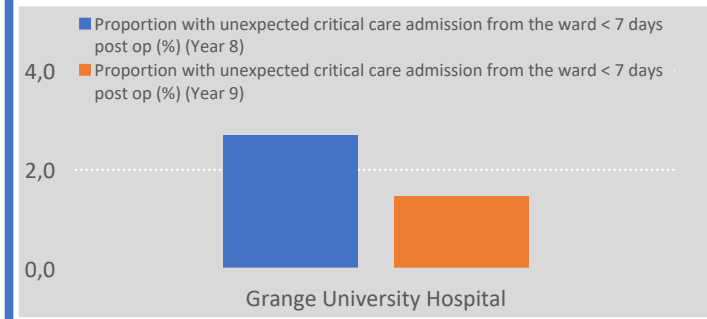
86.1% of patients with a high documented risk had **consultant surgeon** input before surgery.

71.4% of patients with a high documented risk had **consultant anaesthetist** input before surgery.

Presence of both **anaesthetic and surgical consultants** during surgery in high-risk patients was **90.4% (91.3% in Year 8)**.

ABUHB pre-operative input with consultant Surgeon is 89.9% and Consultant Anaesthetists is 89.9% (both 88%)

Consultant Surgeon and Anaesthetist present in theatre when risk of death* >=5% was 77.6% in year 8 and increased to 90.4% for year 9**



Aneurin Bevan University Health Board saw a reduction in patients with unexpected return to Critical Care from the ward within 7 days post operatively.

Preoperative assessment of risk **has dropped below target**, to 84.6% after peaking at 86.8% in Year 8.

ABUHB Risk documented preoperatively in year 8 was 88.5% and has improved in year 9 to 96.1%

Postoperative length of hospital stay (LOS) has not significantly changed over the last five years, **with a median in Year 9 of 11 days**.

ABUHB patients LoS for year 8 was 8 days and in year 9 it has increased to 10 days LoS - this is the average LoS across Wales.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	**Description**
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Not on Risk register as continuous pathway improvement

Key Successes:	
1	Reduction in the risk-adjusted mortality for NELA patients (significant drop from previous years)
2	Consultant presence for high-risk patients, both in anaesthetics and surgery
3	Return to theatre rates – low
4	Improved rates of COTE review post operatively (vs. national mean)
5	Successful running of the NELA M&M meetings throughout the year

Key Concerns:	
1	Contemporaneous input of patient-level data at the time of surgery (potential impacting on the quality assurance of the timelines for antibiotic administration, for example, and other metrics)
2	Failed business case for improved access to geriatricians for the elderly and frail patients
3	Critical care access could be better (vs elective surgical patients getting care in SHC and Critical care)
4	Timeliness of antibiotic administration to patients with sepsis or, deemed at high risk of sepsis

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:
1	Royal Colleges should work together to publish consensus pathways for patients presenting to hospital who might require emergency laparotomy. These pathways should include: ❑ diagnostic, radiological, and initial management phases of a patient's presentation prior to a decision to operate ❑ targets for timeliness of each pathway step. ***Royal Colleges of Emergency Medicine, Radiologists, Surgeons, and Anaesthetists.***	NELA CRG to pick up with Royal College representatives on CRG	Royal Colleges	
2a)	Commissioners should ensure that Trusts/hospitals provide adequate specialist care for older patients and those with frailty following emergency laparotomy, per guidance published by the Royal College of Surgeons of England, British Geriatrics Society, and the Centre for Perioperative Care. ***Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales.***	Further expansion of sessional time from Geriatric consultant needed (Currently delivering 2 sessions per week)	Clinical director of surgery and divisional director SCD- aware of the business case. Concerns highlighted	2025/26
2b)	Commissioners should ensure that Trusts/hospitals provide adequate specialist To expand the pool of clinical staff with the requisite specialist skills, Royal Colleges of Physicians, Surgeons and Anaesthetists should consider working together to develop common competency-based training curriculae around optimising perioperative care for older patients and those living with frailty who undergo emergency surgery. ***Royal Colleges of Physicians, Anaesthetists and Surgeons.***		Royal Colleges	
3	Healthcare services provided to those from more deprived backgrounds need to be matched to their greater need. This requires strategic planning. ***NHS England; Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales***	ABUHB to highlight to WG via relevant key stakeholders		

Clinical Leads Local Recommendations (if applicable)		S.M.A.R.T Actions	Responsible	Due Date	Progress
1	COTE consultant expansion needed	Business case taken to SCD	CD Surgery/ Divisional director	2025/ 26	In progress
2	Contemporaneous inputting of patient level data, at the time of operation	CEPOD lead to be made aware	NELA leads	25/26	In progress

National Ovarian Cancer Audit
State of the Nation Report 2024

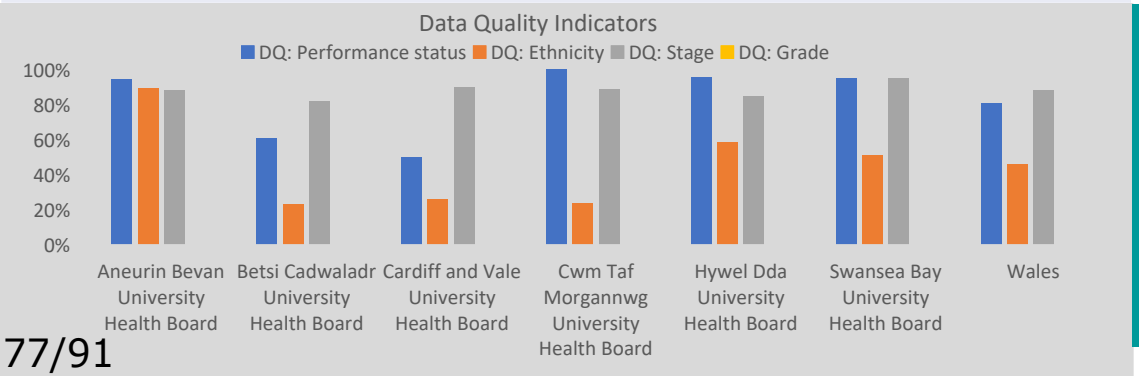
An audit of care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022

Published September 2024

Clinical Lead:	**Leena Gokhale - Consultant Obstetrics & Gynaecology**
NICE Guidelines	**NG12 & CG122**

Rationale:	The care for women with ovarian cancer is informed by various national guidelines. NOCA evaluates care for women with ovarian cancer against standards derived from guidelines for ovarian cancer (NG12 & CG122) that were published by the National Institute for Health and Clinical Excellence (NICE), which include recommendations for the recognition and referral pathways and the treatment of early (stage 1) and advanced (stage 2 to 4) ovarian cancer.
Objectives:	The National Ovarian Cancer Audit (NOCA) aims to evaluate the patterns of care and outcomes for women with ovarian cancer in England and Wales, and to support services to improve the quality of care for these women. Ovarian cancer affects the ovaries. It mostly affects women, but it can affect anyone who has ovaries. This State of the Nation (SotN) report publishes information on the care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022. It is the audit's first annual assessment of NHS services. It aims to share good practice and highlight where care can be improved.

Presented at Clinical Standards and Effectiveness Group – 28th November 2024



Quality Performance Indicators

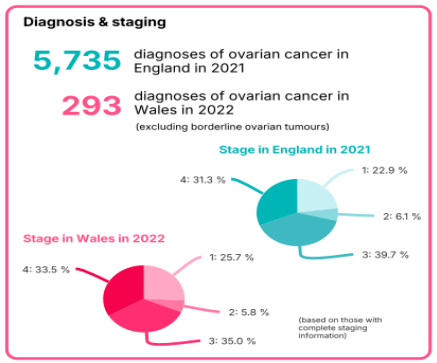
QPI 1	Patients to be discussed at diagnosis at a specialist MDT prior to a decision for treatment	**Target 95 %** **99%**
QPI 2	Patients diagnosed with Stage 2-4 or unstaged Ovarian cancer to receive anticancer treatment of any type	**Target 80%** **65%**
QPI 3	Patients with Stage 2-4/ unstaged ovarian cancer to receive cytoreductive surgery.	**Minimum target 55%** **46.5%** **Optimal target 70%**
QPI 4 a	Patients with ovarian cancer should have recording of FIGO stage, WHO performance status, at diagnosis	**Target 95%** **86%**
b	Patients with ovarian cancer undergoing primary or interval debulking surgery should have recording of residual disease	**Target 95%** **100%** (1pt)
QPI 5 a	Patients with non-mucinous epithelial ovarian cancer on histology to be tested for germline BRCA1/2 testing	**Target 90%**
b	Patients with advanced high grade serous and clear cell cancer on histology to be tested for tumour BRCA1/2 testing	**Target 90%**
QPI 6	Patients to be enrolled into an NCRI portfolio study at diagnosis.	**Minimum Target 5%**

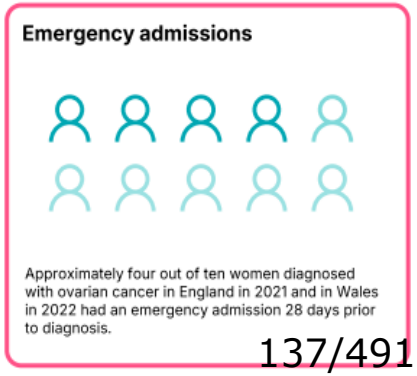
Good Practice

Working with acute oncology services to identify women with possible ovarian cancer admitted in general medical and surgical wards and ensuring that decision making for these patients is done in conjunction with gynaecological oncology MDTs.

Data completeness:

12.0% of women with ovarian cancer in England in 2021 and 11.0% in Wales in 2022 did not have histology or cytology recorded in the national cancer registration data and 28.5% women in England and 12.3% in Wales did not have staging information recorded.





Performance indicator 1: 41.4% of women diagnosed in England in 2021 and 40.6% diagnosed in Wales in 2022 had an emergency admission within 28 days prior to diagnosis.

Data Completeness Indicator 1: Emergency admission prior to diagnosis	Denominator (N)	Rate (%)	Rank among 130 care providers
Aneurin Bevan University Health Board	57	57.9%	18
Wales	293	40.6%	NA
ENGLAND & WALES	6,028	41.4%	NA

Performance Indicator 1: Emergency admission prior to diagnosis	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	45.9%	10
WALES	293	40.6%	NA
ENGLAND & WALES	6,028	41.4%	NA

Performance indicator 2: 72.7% of women diagnosed in England in 2021 and 76.7% in Wales in 2022 had any treatment (i.e., surgery and/ or chemotherapy) recorded between one month prior and nine months following diagnosis.

Performance Indicator 2: Receipt of any treatment (surgery and/or chemotherapy)	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	104	79.0%	6
WALES	227	76.7%	NA
ENGLAND & WALES	4,978	72.9%	NA

Performance indicator 4: 69.4% of women diagnosed in England in 2021 and 74.4% in Wales in 2022 were alive one year after diagnosis (IQR across integrated gynaecological cancer systems 64.2% to 72.5% in England; min 63.0% and max 85.6% across three integrated gynaecological cancer systems in Wales).

Performance indicator 4: One-year survival	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	75.9%	6
WALES	293	74.4%	NA
ENGLAND & WALES	6,028	69.6%	NA

Performance indicator 4: One-year survival (case-mix adjusted)	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	70.8%	19
WALES	293	74.4%	NA
ENGLAND & WALES	6,028	69.6%	NA

Assurance level	**Description**
Limited	The project did not achieve the standards or criteria being audited against
Risk level	**Description**
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Has this audit been placed on a Risk Register – Yes, Local risk register

Key Successes:	
1	Data capture for Good Practice. AB highest in Wales
2	QPI 2, Receipt of any treatment: SE Wales better than England and the rest of Wales
3	QPI 4, 1 year survival: SE Wales better than England and the rest of Wales

Key Concerns:	
1	57% present as Emergency Admissions
2	No information available for the platinum based chemotherapy numbers
3	Access to data from Tertiary providers including UHW & Velindre

Clinical Leads Local Recommendations: (if applicable)		**S.M.A.R.T Actions:**	**Responsible:**	**Due Date:**	**Progress:**
1	Working with acute oncology services to identify women with possible ovarian cancer admitted in general medical and surgical wards and ensuring that decision making for these patients is done in conjunction with gynaecological oncology MDTs.	Work with AOS to develop pathways			Meet with newly appointed Lead AOS Nurse

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	Reduce the current rate of emergency admissions by: (i) Improving efforts to increase symptom awareness amongst women and primary care professionals. (ii) Reviewing diagnostic pathways to improve timely testing. **Goal 1**: Increase the proportion of patients receiving timely diagnosis and treatment decisions.	Liaise with PC for early referral	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	RDC Referral pathway reviewed and complete. Radiology reporting standardisation agreed
2	Review the percentage of women with stage 2 to 4, or unstaged ovarian cancer who receive treatment (any type), explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. **Goal 3**: Increase the proportion of patients receiving surgery. **Goal 4:** Increase the proportion of patients receiving chemotherapy.	Outside of the remit of Cancer Unit. This is within the UHW/VCC SLA	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Not applicable to local Health Board
3	Review the use of platinum-based chemotherapy in women with epithelial ovarian cancer (stage 2 to 4, or unstaged), explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. **Goal 4:** Increase the proportion of patients receiving chemotherapy.	VCC SLA	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Not applicable to local Health Board
4	Review one-year survival in women diagnosed with ovarian cancer, explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. **Goal 5:** Improve rates of survival and reduce variation in survival.	CSG and Tertiary unit	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Increasing symptom awareness amongst patients and PCC colleagues. Social Media awareness session posted on HB's Facebook page
5	Improve the completeness and quality of data items recorded in the national cancer datasets (e.g. percentage of women with recorded diagnosis based on histology or cytology in the national cancer registration data and percentage of women with recorded staging information) **Goal 1-5**	Within our remit	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	This will be audited in 12 months

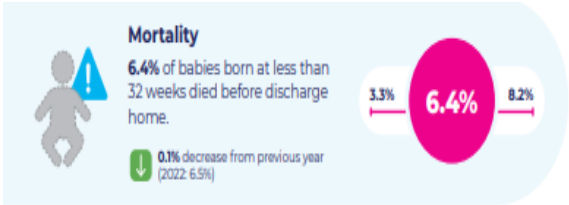
Audit Title: National Neonatal Audit Programme (NNAP) Summary report on 2023 data	Clinical Lead:	Dr Sunil Reddy –Neonatal Consultant
	Nice Guidelines	NICE QS 193 Quality Statements 1-5
Rationale:	The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels. NNAP supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes.	
Objectives:	The NNAP aims to help neonatal units improve care for babies and their families by identifying area of quality improvement in relation to the delivery and outcomes of care. The NNAP dashboard presents results for each of the 10-performance metrics as annual rolling averages and is updated monthly. 1. Mortality until discharge 2. Optimal perinatal care composite metric (component measures: antenatal steroids, antenatal magnesium sulphate, birth in a centre with a NICU, deferred cord clamping, normal temperature on admission, breastmilk feeding in the first 2 days of life) 3. Clinical outcomes composite metric (component measures: bloodstream infection, BPD, NEC, preterm brain injury) 4. Parental consultation within 24 hours of every admission 5. Parental inclusion in consultant ward rounds 6. Breastmilk feeding composite metric (component measures: breastmilk feeding at day 14, breastmilk feeding at discharge home) 7. Follow-up at two years 8. On-time screening for retinopathy of prematurity 9. Neonatal nurse staffing 10. Non-invasive breathing support	

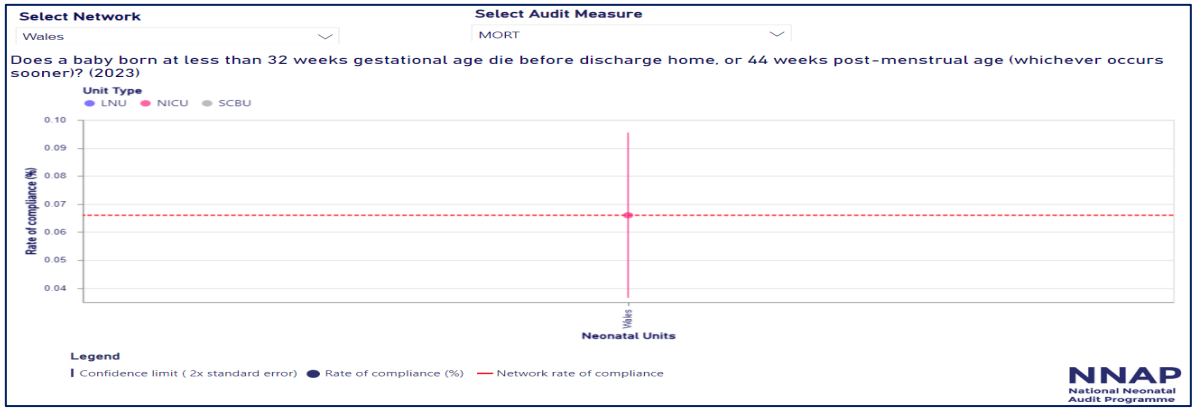
Presented at Clinical Standards and Effectiveness Group – 28th November 2024

Aneurin Bevan University Health Board 10-performance metrics

Outcomes of Neonatal Care:

1. Mortality until discharge (Wales rate)
2. Optimal perinatal care composite metric:
   a) antenatal steroids
   b) antenatal magnesium sulphate
   c) birth in a centre with a NICU
   d) deferred cord clamping
   e) normal temperature on admission
   f) breastmilk feeding in the first 2 days of life





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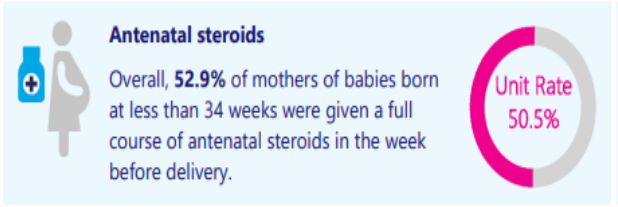
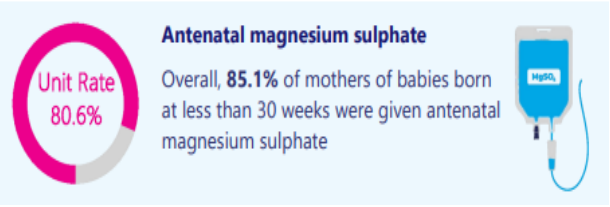
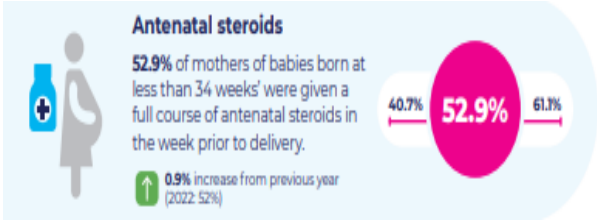




National rate:



National rate:

Deferred cord clamping

68.3% of babies born at less than 34 weeks' had their cord clamped at or after one minute.

62.1% **68.3%** 77.1%

7.9% increase from previous year (2022: 60.4%)

Temperature on admission

80.4% of babies born at less than 34 weeks' were admitted with a temperature within the recommended range of 36.5°C-37.5°C.

75.5% **80.4%** 85.1%

4.1% increase from previous year (2022: 76.3%)

Parent consultation within 24 hours

95.2% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

92.6% **95.2%** 97.4%

0.7% decrease from previous year (2022: 95.2%)

Parent inclusion in consultant ward rounds

38.7% of baby care days had a consultant-led ward round with at least one parent included.

25.7% **38.7%** 62.3%

8.5% decrease from previous year (2022: 47.2%)

Neonatal nurse staffing

79.3% of nursing shifts were staffed according to recommended levels.

69.3% **79.3%** 91.2%

8.2% increase from previous year (2022: 71.1%)

Bronchopulmonary dysplasia (BPD)

31.5% of babies born at less than 32 weeks developed BPD or died.

25.6% **31.5%** 39.1%

0.2% increase from previous year (2022: 31.3%)

Breastmilk feeding in first 2 days of life

62% of babies born at less than 34 weeks' received their mother's milk in the first 2 days of life.

41.4% **62%** 78.3%

13% increase from previous year (2022: 49%)

Breastmilk feeding at 14 days of life

79.6% of babies born at less than 34 weeks' received their mother's milk at 14 days of life.

70.4% **79.6%** 90.3%

0.6% increase from previous year (2022: 79%)

Breastmilk feeding at discharge

63% of babies born at less than 34 weeks' received their mother's milk at discharge.

47.4% **63%** 82%

0.1% increase from previous year (2022: 62.9%)

On-time screening for retinopathy of prematurity (ROP)

78.4% of eligible babies were screened on time for ROP.

65.4% **78.4%** 86.4%

9.4% increase from previous year (2022: 69%)

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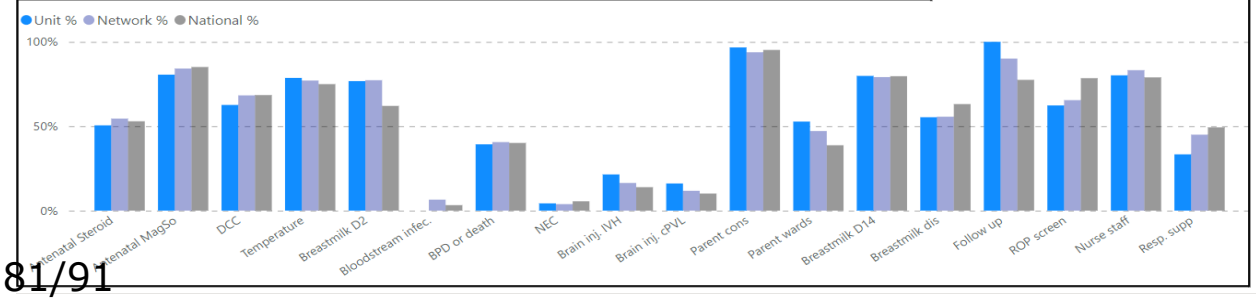

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Deferred cord clamping

Overall, **68.3%** of babies born at less than 34 weeks had their cord clamped at or after one minute.

Unit Rate 62.6%

Temperature on admission

Overall, **80.4%** of babies born at less than 32 weeks were admitted within the recommended range of 36.5°C-37.5°C.

Unit Rate 83.6%

Parental consultation within 24 hours

Overall, **95.2%** of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission

Unit Rate 96.7%

Parent inclusion on consultant ward rounds

Overall, **38.7%** of baby care days had a consultant-led ward round with at least one parent included.

Unit Rate 52.8%

Neonatal nurse staffing

Overall, **79.3%** of nursing shifts were staffed according to recommended levels.

Unit Rate 83.1%

Bronchopulmonary dysplasia (BPD)

Overall, **31.5%** of babies born at less than 32 weeks developed BPD or died.

Unit Rate 39.3%

Breastmilk feeding in the first two days

Overall, **62%** of babies born at less than 34 weeks received their mother's milk in the first 2 days of life.

Unit Rate 76.7%

Breastmilk feeding at 14 days

Overall, **79.6%** of babies born at less than 34 weeks received their mother's milk at 14 days of life.

Unit Rate 79.8%

Breastmilk feeding at discharge

Overall, **63%** of babies born at less than 34 weeks received their mother's milk at discharge home.

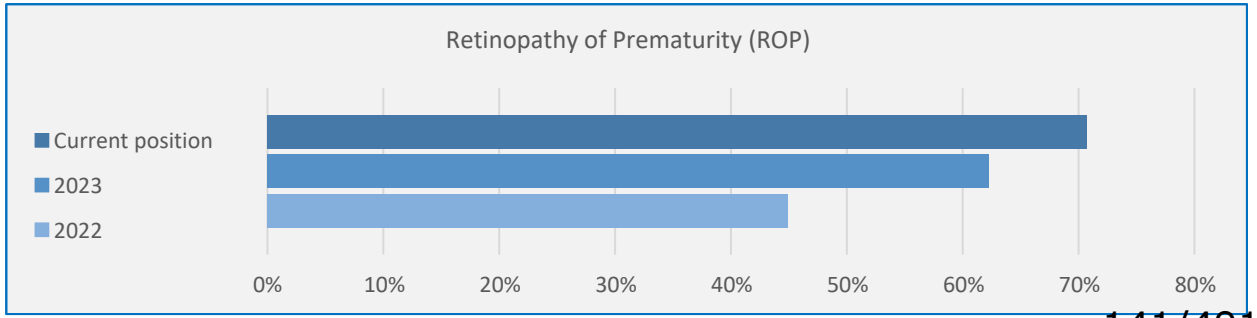
Unit Rate 55.3%

Screening for retinopathy of prematurity

(ROP) Overall, **78.4%** of eligible babies were screened on time for ROP.

Unit Rate 62.3%

ALERT outlier status for ROP



NICE Quality statement 1:
Preterm babies having respiratory support soon after birth and before admission to the neonatal unit are given continuous positive airways pressure (CPAP), if clinically appropriate, rather than invasive ventilation.

NICE Quality statement 2:
Preterm babies who need surfactant are given it using a minimally invasive technique if they do not need invasive ventilation.

NICE Quality statement 3:
Preterm babies having invasive ventilation are given volume-targeted ventilation (VTV) in combination with synchronised ventilation.

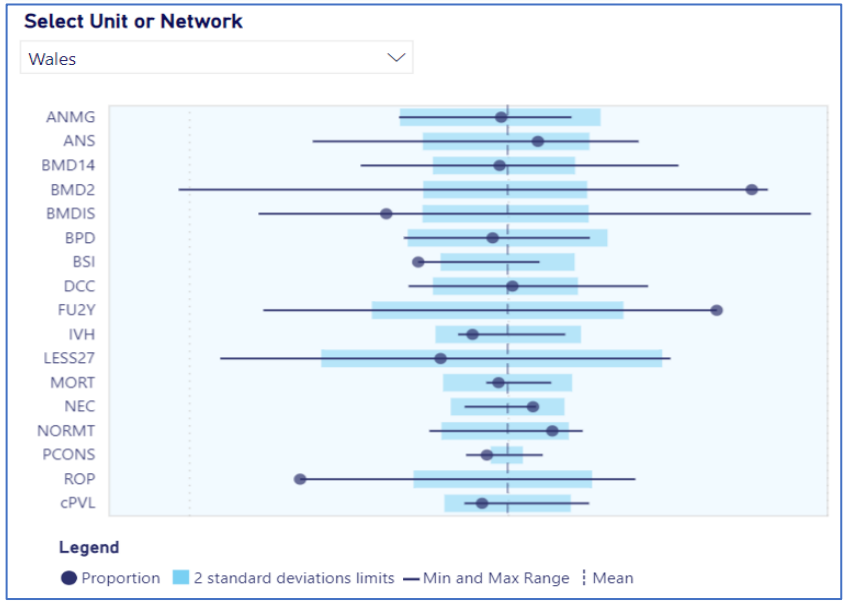
NICE Quality statement 4:
Preterm babies have a target oxygen saturation of 91% to 95% after stabilisation.

NICE Quality statement 5:
Parents and carers of preterm babies who are having respiratory support are helped to care for their baby.

What proportion of babies born between 22-31 weeks gestation age only receive non-invasive breathing support during the first week of life?

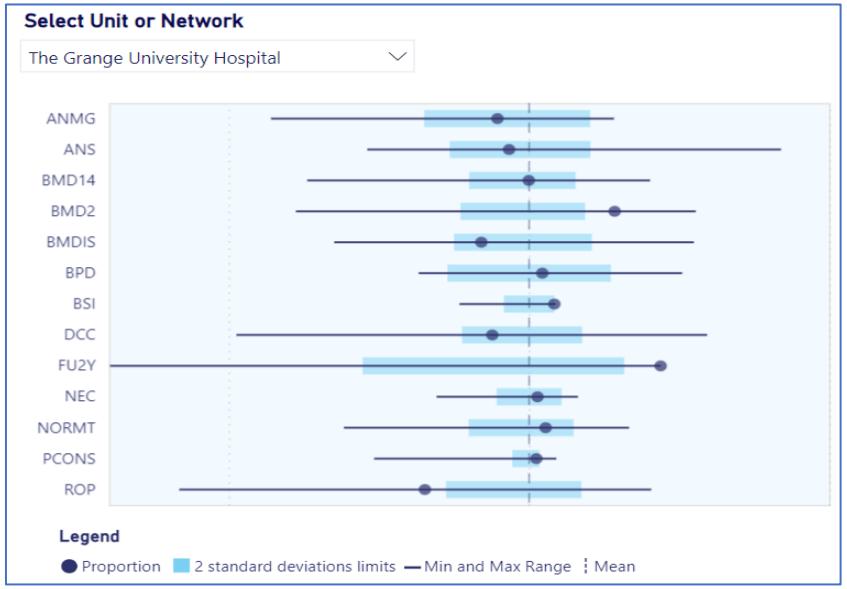
The Grange University Hospital

33.3%



Measures

MORT: Treatment effect of mortality
BPD: Treatment effect of bronchopulmonary dysplasia or death
NEC: Treatment effect of necrotising enterocolitis
BSI: Treatment effect of bloodstream infection
ANS: Antenatal steroids
ANMG: Antenatal magnesium sulphate
DCC: Deferred cord clamping
NormT: Normal temperature
BMD14: Breastmilk day 14
BMDIS: Breastmilk at discharge
BMD2: Breastmilk at day 2
PCons: Parental consultation in 24h
ROP: Retinopathy of prematurity
FU2Y: Two year follow up
TRESP: Treatment effect of non-invasive respiratory support



The above demonstrates Aneurin Bevan University Health Board are mostly within the 2 standard deviation limits, apart from:

- **BD2 Breast milk at day 2 – better than std deviation and within max range**
- **Two year follow up – at 100%**

- **Retinopathy of prematurity remains outside the std deviation limit and is an ALERT outlier**

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

Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Not placed on a Risk Register due to: Achieving most measures with continuous work ongoing to improve outcomes.

Key Successes:	
1	The HB is above the mean on 8 of the 13 measures and within the mean on 4 measures
2	Breast feeding at d/c – golden drops

Key Concerns:	
1	Retinopathy of Prematurity – has increased since 2022 (44.9% to 62.3%) with the current data being 70.7%
2	Work on ensuring data entry for late onset sepsis
3	Breast feeding rates at discharge- remains a challenge

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	National Health Service England and health departments in the Devolved Governments should: • Ensure that Neonatal Networks with low rates of survival review their mortality data and develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices. • Review survival rates in very preterm infants and work with The National Institute for Health and Care Research (NIHR)to support future research investigating the reasons for the observed geographical variation in mortality.	The Health Board participates in the MATNEO & PERIPREM Cymru Networks	Dr Sunil Reddy	Ongoing
2	National Health Service England and health departments in the Devolved Governments should ensure that Neonatal Networks work with their constituent units and are: • Regularly reviewing and addressing their rates of missing data for preterm brain injury (intraventricular haemorrhage, cystic periventricular leukomalacia, and post haemorrhagic ventricular dilatation) and necrotising enterocolitis. • Utilising the NNAP restricted access dashboard to validate these data in order that units and networks can develop quality improvement plans based on babies' outcomes.	• These are ongoing processes within the Health Board • Dashboards are used for benchmarking continuously	Dr Sunil Reddy	Ongoing
3	In order for perinatal teams to identify and implement the necessary perinatal interventions at the earliest opportunity, the Departments of Health in England, Wales, Scotland, and the Isle of Man should: • Commission public health campaigns aimed at raising public and professional awareness of the nature and importance of the signs and symptoms of preterm labour and the effectiveness of clinical interventions. • Work with relevant manufacturers and distributors to address supply chain challenges in the delivery of quantitative fetal fibronectin testing kits		• Badgernet is not being used within the maternity units. • Steroids & Magnesium Sulphate – already captured Maternity – looking at the data	
4	Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.		The Health Board is already reviewing dashboard data	
5	Neonatal Networks should work with their constituent units and encourage them to use the monthly data available in the NNAP restricted access dashboard to identify cases where optimal parental partnership in care did not occur. These data will support neonatal units to enhance their delivery of family centred care.		The Health Board is already reviewing dashboard data – good results for parental involvement	

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date :Progress:
1	ROP – local awareness, Ophthalmologist, using the RCPCH calculator, dedicated neonatal nurse entering the eligible babies, avoid postponing the exam	Monitor the improvement with online live dashboard	Sunil Reddy	

Audit Title:
National Audit of Primary Breast Cancer
State of the Nation Report 2024
An audit of care received by people diagnosed with primary breast cancer in England and Wales during 2019-2021

Published September 2024

Clinical Lead:
Rhiannon Foulkes – Consultant Surgeon

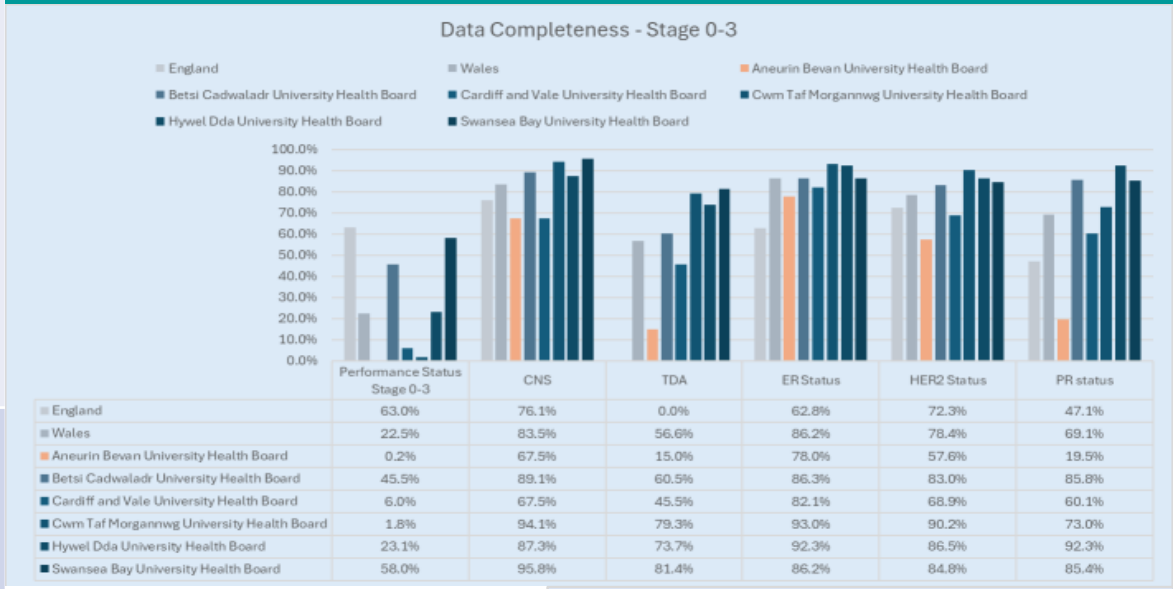
Nice Guidelines	**NG101** **QS12**

Rationale:	The purpose of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people diagnosed with primary breast cancer in England and Wales, and to support services to improve the quality of care for these people. For people treated in Wales, NATCAN receives the data from the Wales Cancer Network (WCN) in Public Health Wales. WCN provides patient-level data from the Cancer Network Information System Cymru (CaNISC) electronic patient record system. This State of the Nation report publishes information on the care received by people diagnosed with breast cancer during 2019-21 in England and Wales. Wales also provided 2022 data which has been included. It is the audit's first annual assessment of NHS breast services and shares examples of good practice as well as highlighting where care needs to improve.
Objectives:	The aim of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people with primary breast cancer in England and Wales, and to support services to improve the quality of care for these patients. This work builds on that of the National Audit of Breast Cancer in Older Patients (NABCOP) but has been expanded to include younger people and men with breast cancer. This report has focused on the patterns of care at a national level, in England and Wales, for different groups of women and men. We report on indicators that were defined to monitor progress against the 5 NAoPri healthcare QI goals: 1. Improve the movement of patients through the care pathway. 2. Reduce unwarranted variation for patients undergoing surgery. 3. Reduce unwarranted variation for patients having non-surgical oncological treatments. 4. Improve access to breast reconstruction after mastectomy. 5. Improve and reduce unwarranted variation in primary breast cancer outcomes.

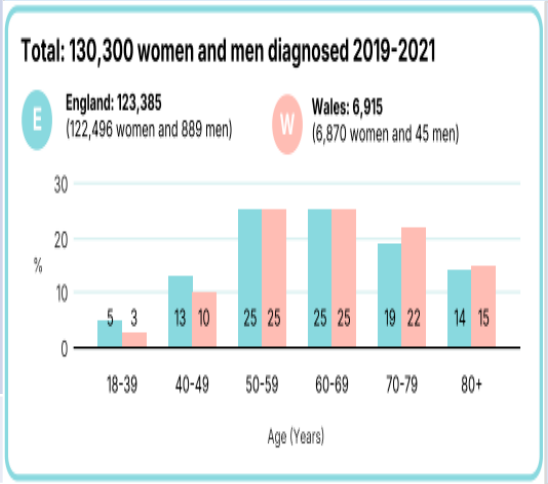
Presented at Clinical Standards and Effectiveness Group – 28th November 2024

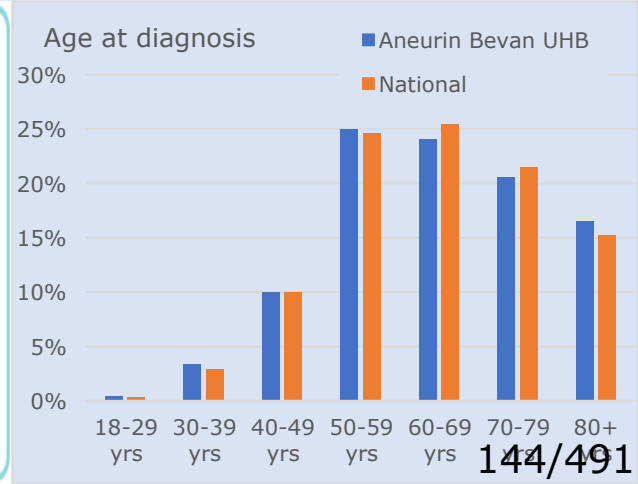
Key Messages:

NHS organisations should ensure the data on key data items submitted to NDRS and CaNISC are complete. Particular attention should be given to data on "patient seen by a clinical nurse specialist (CNS) at diagnosis," and date and type of cancer recurrence. Completeness of data on molecular markers (including hormone receptor and human epidermal growth factor receptor 2 (HER2) status), and performance status items should be improved. The reasons for poor data completeness are likely to vary across organisations and data items – recording of information at MDT, data entry/audit resource.

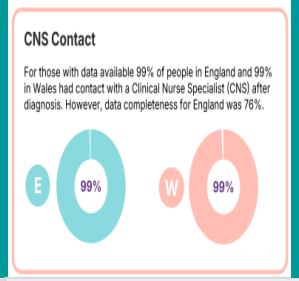


	Performance Status Stage 0-3	CNS	TDA	ER Status	HER2 Status	PR status
England	63.0%	76.1%	0.0%	62.8%	72.3%	47.1%
Wales	22.5%	83.5%	56.6%	86.2%	78.4%	69.1%
Aneurin Bevan University Health Board	0.2%	67.5%	15.0%	78.0%	57.6%	19.5%
Betsi Cadwaladr University Health Board	45.5%	89.1%	60.5%	86.3%	83.0%	85.8%
Cardiff and Vale University Health Board	6.0%	67.5%	45.5%	82.1%	68.9%	60.1%
Cwm Taf Morgannwg University Health Board	1.8%	94.1%	79.3%	93.0%	90.2%	73.0%
Hywel Dda University Health Board	23.1%	87.3%	73.7%	92.3%	86.5%	92.3%
Swansea Bay University Health Board	58.0%	95.8%	81.4%	86.2%	84.8%	85.4%



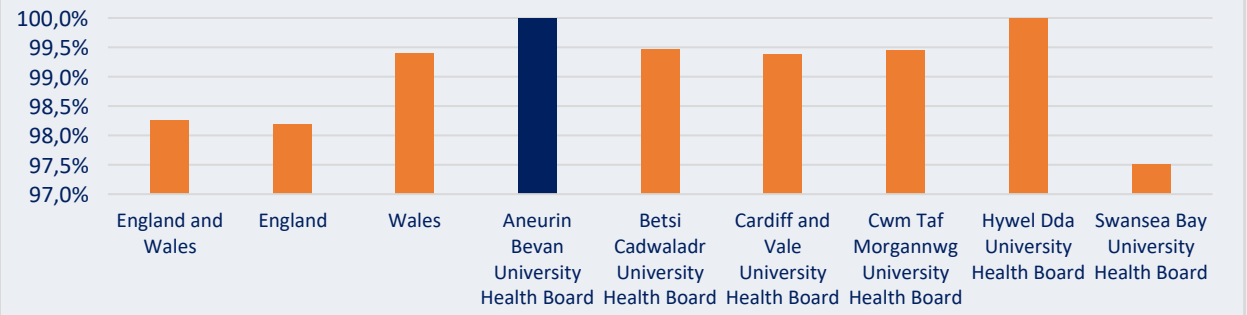


Key messages:
The proportion of people who had Triple Diagnostic Assessment (TDA) in a single hospital visit was 56.6% in Wales. For England only, TDA status was estimated from the date of diagnosis & the date of biopsy, & it was assumed that imaging was performed prior to biopsy. We estimate the proportion of people who had TDA in England was 55.0% between 2019 & 2021. NHS organisations with low values should increase the proportion of people who have TDA.

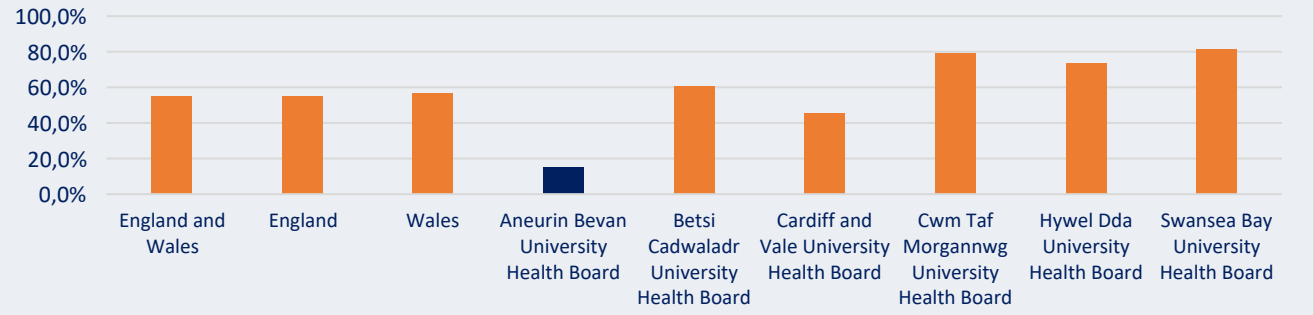


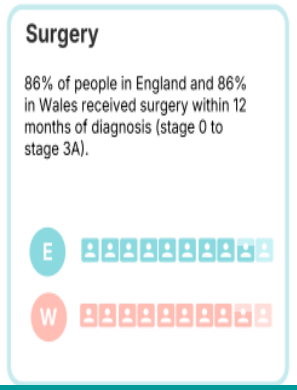
Key messages:
The proportion of people in 2019-21 who saw a CNS at diagnosis was 99.4% in Wales. For England, the actual levels of performance are uncertain because information on CNS contact was only available for 76.1% of patients diagnosed between 2019 and 2021. Among people with this data, 98.8% were reported as having seen a CNS. The patterns of care were similar for women and men on these two indicators.

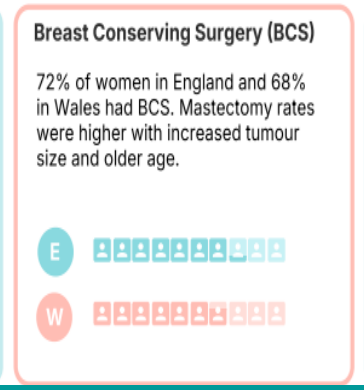
Contact with Clinical Nurse Specialist (CNS) after diagnosis

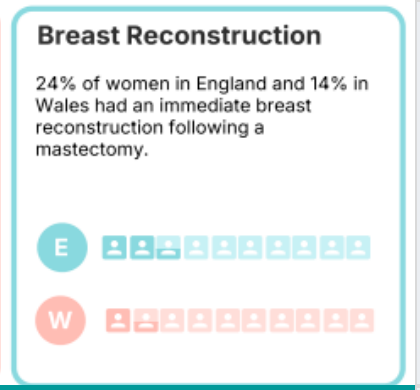


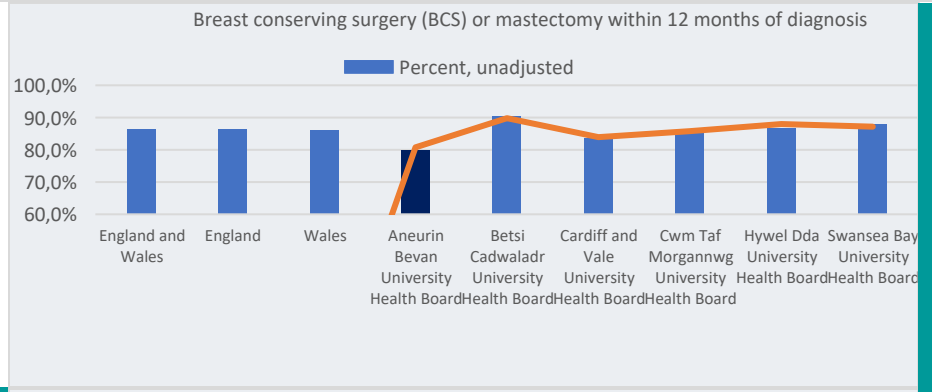
Triple Diagnostic Assessment (TDA) in single hospital visit





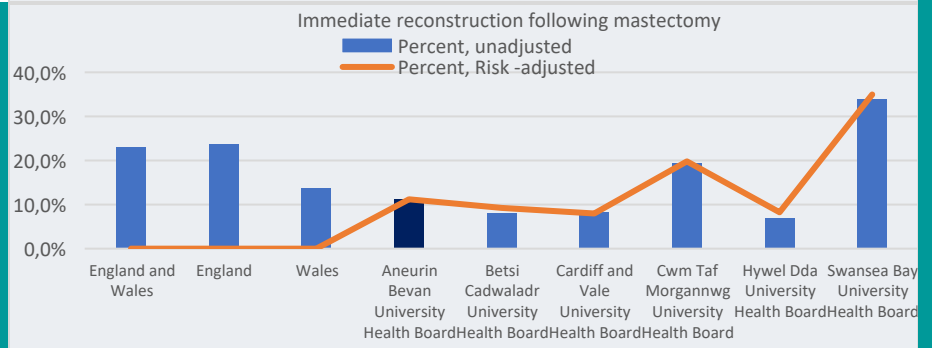




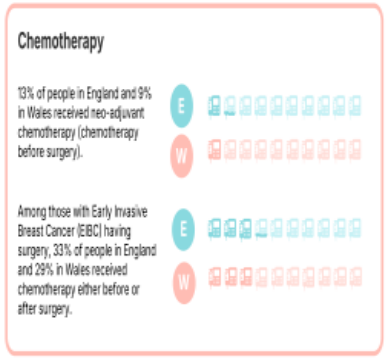


Key Messages:
Overall, 86.4% of people diagnosed in 2019-21 received surgery in England and Wales within 12 months of diagnosis (England=86.4%; Wales=86.0%). The proportions of women and men who had surgery were similar (respectively, 86.4% and 83.2%) but the type of surgery differed, with 71.8% of women having breast conserving surgery and 93.6% of men having mastectomy (of those who had surgery).

In England and Wales, the percentage of women with non-invasive breast cancer and EIBC who had breast conserving surgery were 75.6% and 71.3%, respectively (of those who had surgery). The percentage of women with EIBC having mastectomy increased with tumour stage (T1: 15.9%; T2: 36.6%; T3: 81.1%) and increased among women aged over 70 years.

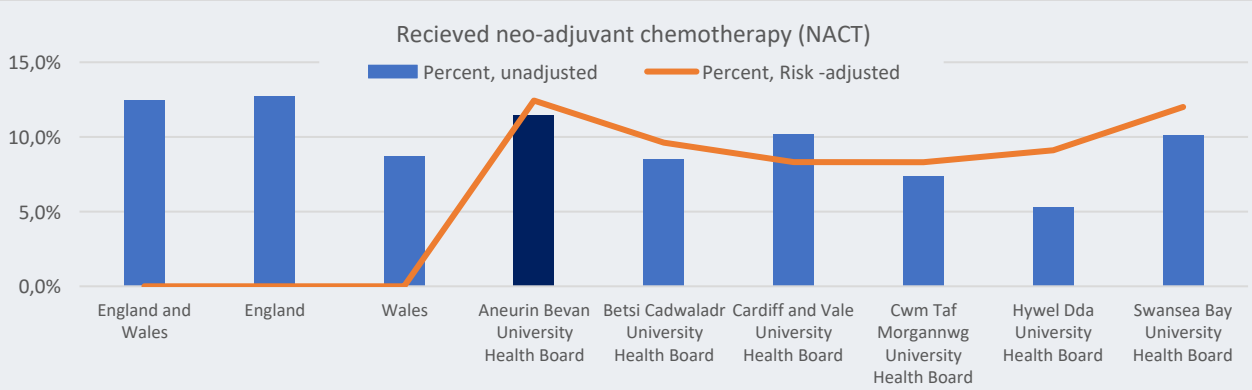


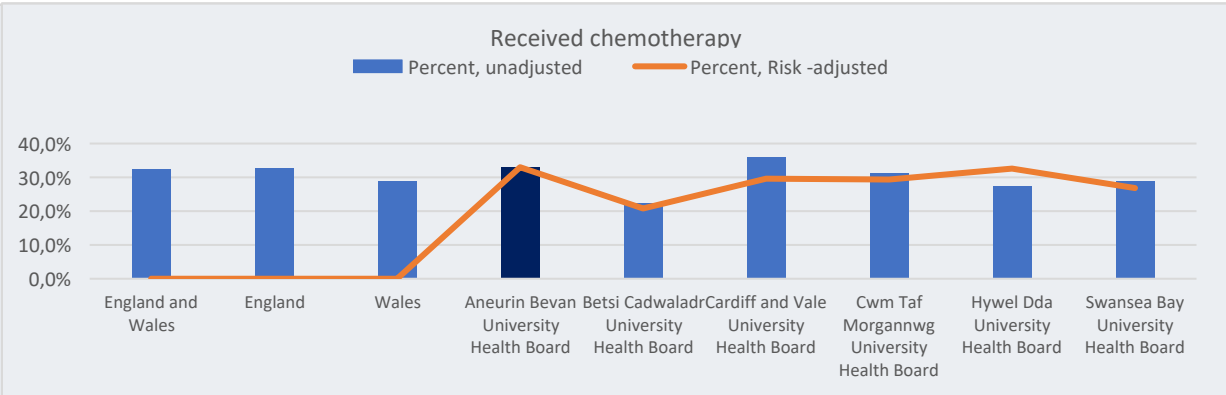
Key messages: Among women (diagnosed 2019-21) who had mastectomy, the rates of immediate reconstruction for non-invasive and EIBC were 40.8% and 21.0%, respectively. Among women with invasive disease, the use of immediate reconstruction was less frequent among women with larger tumours. Use of immediate reconstruction was much more frequent in younger women (70 years, 3.1%). The use of immediate reconstruction was lower in Wales compared to England. There was considerable variation by English NHS organisation, with rates of immediate reconstruction less than 10% for 16 English NHS breast units and above 40% for 10 English NHS breast units (with people allocated to the organisation of diagnosis). The coverage for England & Wales was 23.0%.



Key messages:
Among people with EIBC who had surgery within 12 months of diagnosis, 12.5% had neo-adjuvant chemotherapy (NACT) (England = 12.7%, Wales = 8.7%). Few men received NACT. The use of NACT was higher among women with HER2 positive or triple negative disease (stage 2-3A). The use of NACT decreased with age and was rarely used among women aged 80+ years. Rates of NACT were under 10% for 35 NHS breast units and above 20% for 12 NHS breast units (patients allocated to organisation of diagnosis).

Key messages:
Among women and men diagnosed with EIBC (2019-2021) who received primary surgery, the overall percentage of people who had adjuvant chemotherapy was 18.8%. The rates were similar for women and men. When combined with patterns of neo-adjuvant chemotherapy, the overall percentage of people who had chemotherapy was 32.4% (England: 32.6%, Wales: 28.8%). The percentage of women who had primary surgery within 12 months and who received chemotherapy was higher among women with ER negative, ER negative/ HER2 negative and HER2 positive disease (stage 2-3A). Rates of treatment varied by age, with lower use of chemotherapy as age at diagnosis increased.





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

Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Not on Risk Register due to: **Since the publication of this audit ABUHB breast service has now moved to fully one stop TDA**

Report Successes:	
1	High compliance for CNS patient contact at diagnosis
2	High levels of eligible patients receiving NACT
3	Acceptable levels of BCS and IBR rates

Report Concerns:	
1	Data Recording for ER, PR and HER2 status
2	Recording of Performance Status
3	Limited number of patients with access to same day TDA

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service. **Goal 1** - Improve the movement of patients through the care pathway.	Aim for >95% of all patients to receive single visit TDA Breast Unit Opened Feb 2024 – now offering TDA in a single visit to all patients	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Nov 24	Achieved
2	Review the use of neo-adjuvant chemotherapy for all patients with early invasive breast cancer in order to reduce the levels of unexplained regional variation. **Goal 3** - Reduce unwarranted variation for patients having non-surgical oncological treatments.	Aim to continue current standard All cases discussed at MDT with oncology presence	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Nov 24	Achieved
3	Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness within breast MDTs should include full tumour characterisation, ER13 and HER213 status (for invasive breast cancer), performance status, the NABCOP fitness assessment14 data items (for people aged 70+ years) as well as data on Triple Diagnostic Assessment (TDA) and contact with Clinical Nurse Specialists (CNS). (Recommendation aligned with the report for the National Audit of Metastatic Breast Cancer15.) **Goal 1-5**	• Aim for >95% documentation rate for ER, PR and HER2 status • Change to MDT proforma to collect performance status routinely • In house testing of HER2 • Path to test for PR on all tumours	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
4	Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: a) Education on the recording of recurrence, sharing the NAoMe Guide to collecting COSD data for breast cancer recurrence20 with NHS organisations. b) Reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. (Recommendation aligned with the report for the National Audit of Metastatic Breast Cancer15.) **Goal 5** - Improve and reduce unwarranted variation in primary breast cancer outcomes.	• Aim for >95% rate for recording breast cancer recurrence • All patients to be discussed at MDT • Standard MDT Proforma implemented for data capture of key parameters	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
5	Review rates of immediate reconstruction and, where rates are identified as below the mean, act to improve access to immediate reconstruction by ensuring it is offered to all women, unless precluded by comorbidity or adjuvant therapies.	• Aim for >80% BCS rate • Aim for >20% rate for IBR post mastectomy • Cases discussed at MDT	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	Revision of MDT proforma to include PS for all new breast cancer diagnoses	Change Proforma with Cancer Services	Michael Rees	Feb 25 - In progress
2	In house testing for HER2	Business case development with pathology	Michael Rees/James Harrison	Apr 25 - In progress

Audit Title:
National Audit of Metastatic Breast Cancer (MBC)
State of the Nation Report 2024

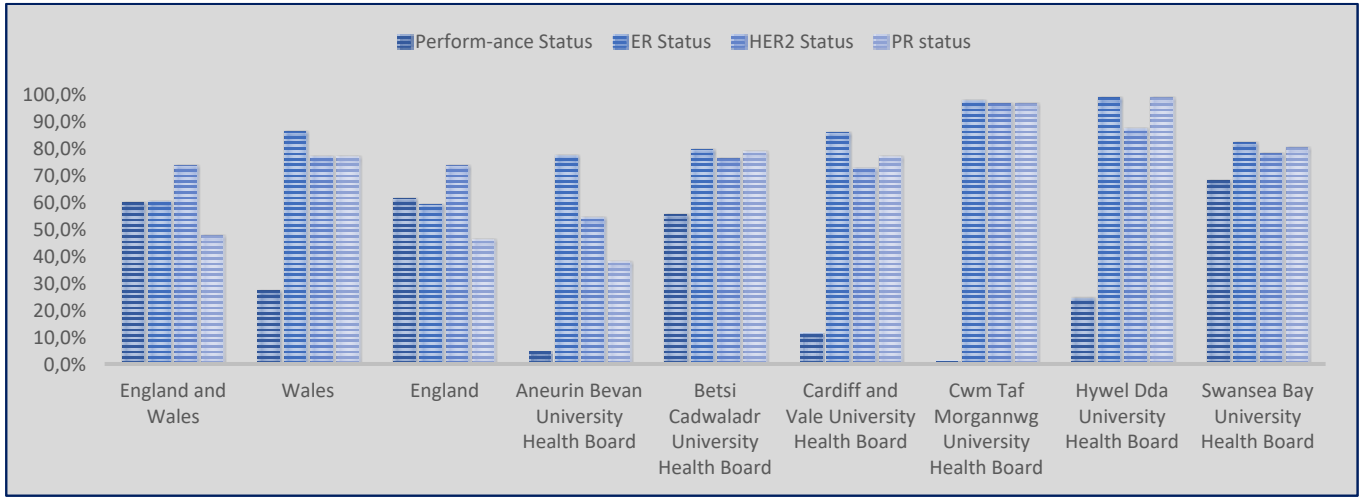
An audit of care received by people diagnosed with metastatic breast cancer
in England and Wales during 2019-2021

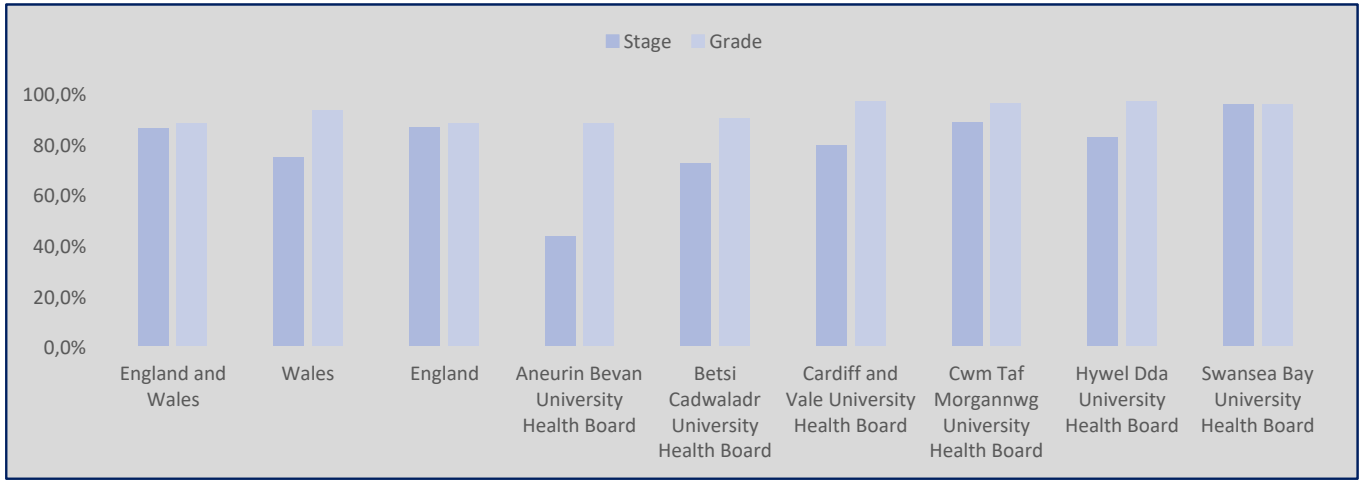
Clinical Lead:
Mr Michael Rees – Consultant Breast Surgeon • General Surgery

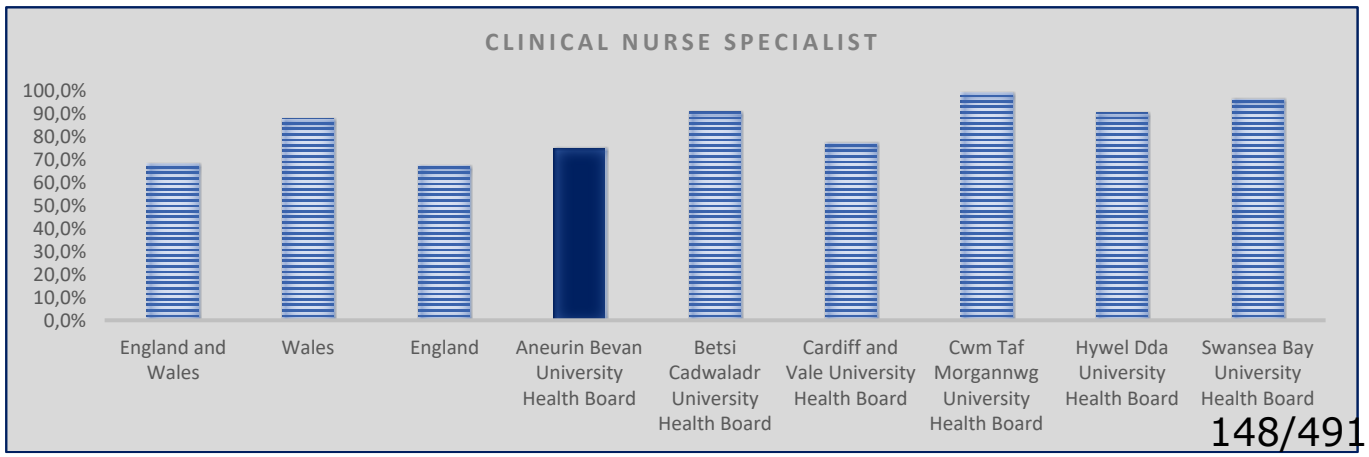
Rationale:	This State of the Nation report publishes information on the care received by women and men diagnosed with MBC during 2019-21 in England and Wales. The care of people diagnosed with primary breast cancer (stages 0 to 3C) is reviewed in the NAoPri.
Objectives:	The aim of the National Audit of Metastatic Breast Cancer (NAoMe) is to evaluate the patterns of care and outcomes for people with metastatic breast cancer (MBC) in England and Wales, and to support services to improve the quality of care for these patients. This work builds on that of the National Audit of Breast Cancer in Older Patients (NABCOP1) but has been expanded to include younger people and men with breast cancer.

Presented at Clinical Standards and Effectiveness Group – 28th November 2024

DATA COMPLETENESS

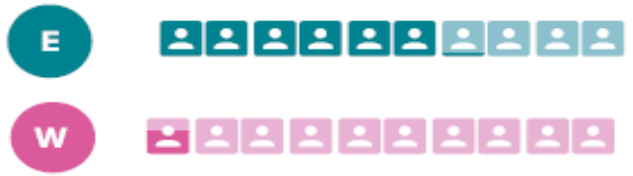


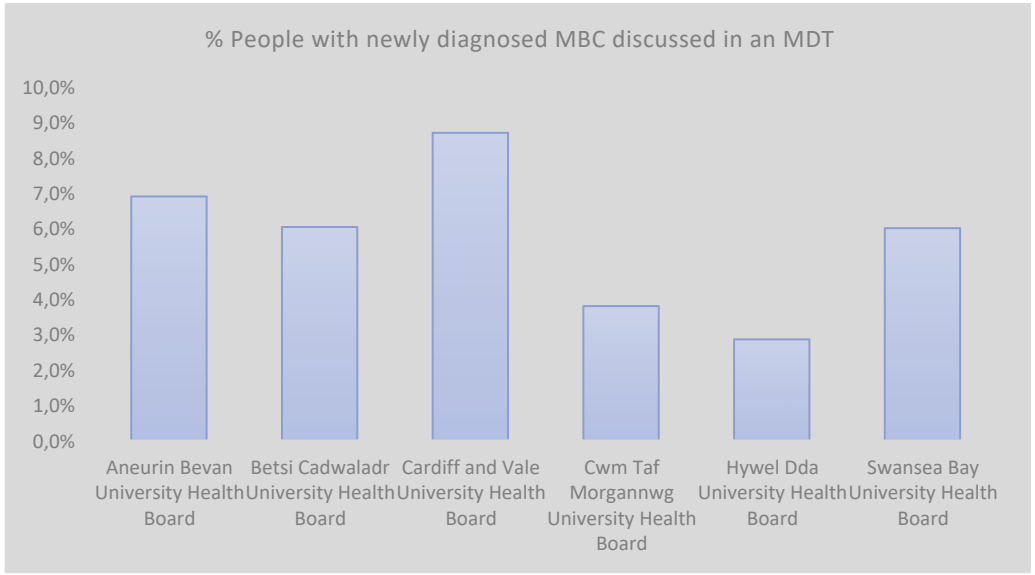




Multidisciplinary Discussion

In England 61% of women with de-novo MBC had a record of multidisciplinary team discussion of their care. In Wales this was only 6% (low data completeness).





Percentage of people with recurrent metastatic breast cancer who had a metastatic lesion biopsied to inform care.

No data for Welsh Health Boards , numerator for Wales 269

Percentage of people with ER positive metastatic breast cancer who received CDK 4/6 inhibitors as first line treatment.

No data for Welsh Health Boards , numerator for Wales 216

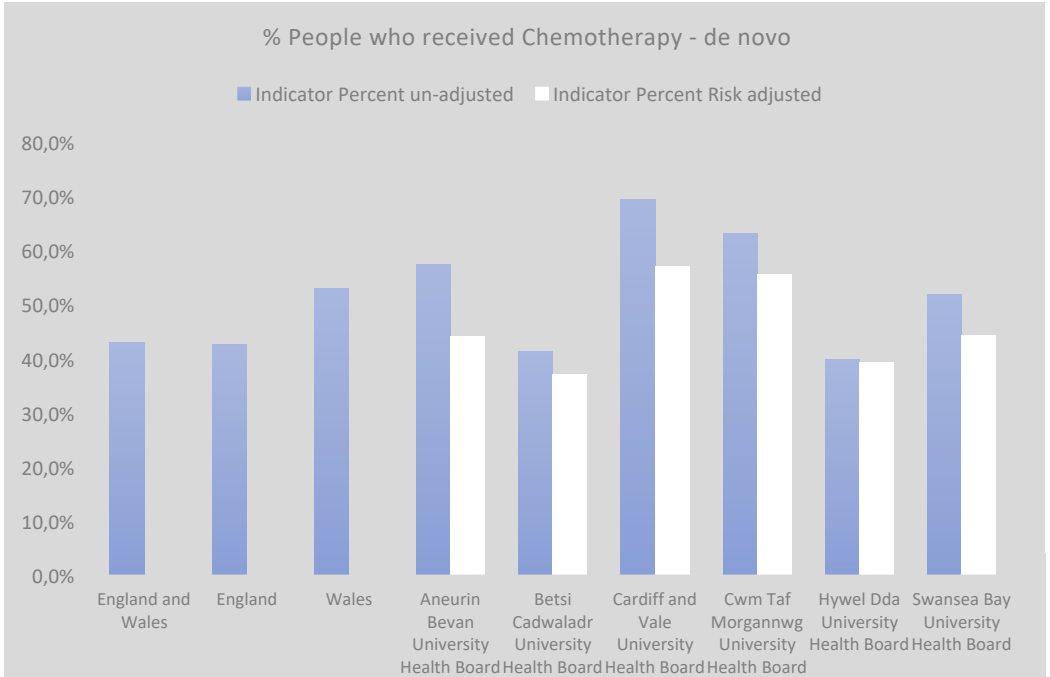
- **Percentage of people with HER2 positive MBC who received anti-HER2 therapy as first line treatment -** No data for Welsh Health Boards , numerator for Wales 86

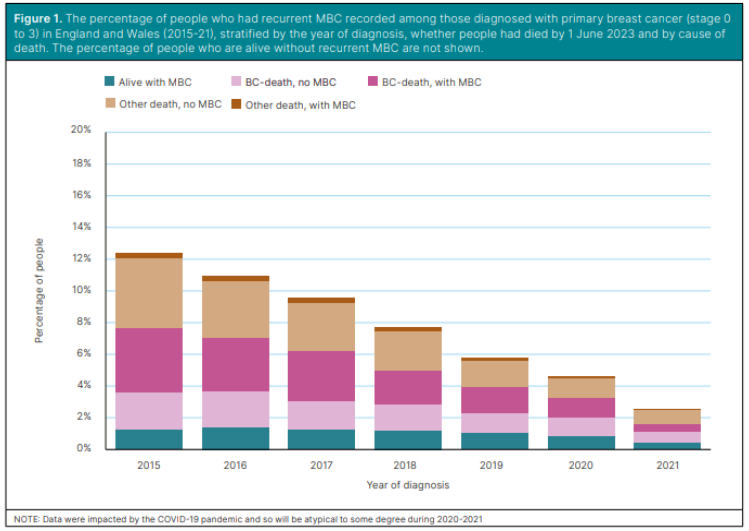
Chemotherapy for recurrent disease

In England 40.4% of people with recurrent MBC received chemotherapy. Use of chemotherapy was greater among younger women with triple negative breast cancer.

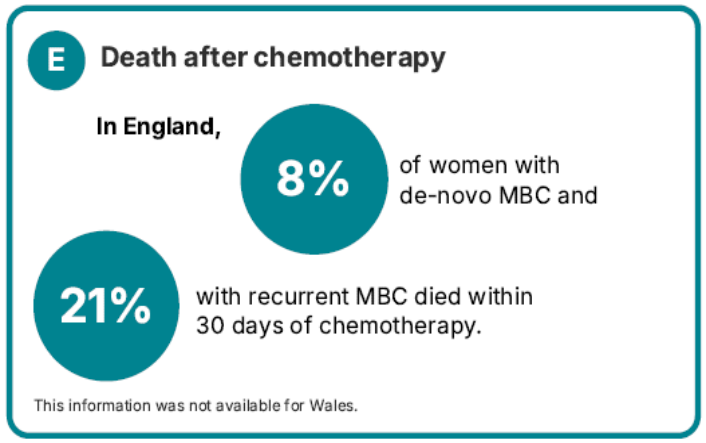
Percentage of people who received chemotherapy - NAoMe recurrent

No data for Welsh Health Boards , numerator for Wales 269





This chart reflects the decrease in deaths related to MBC across the UK from 2015 - 2021



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

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings

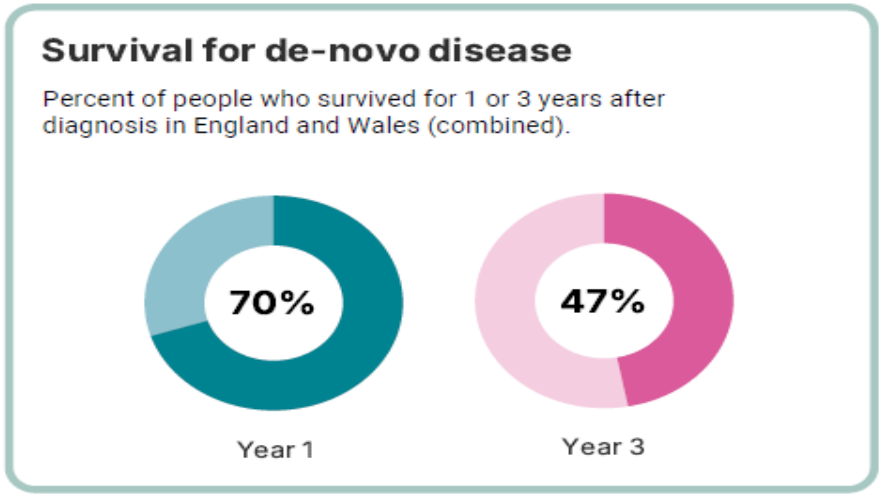
Not on Risk register due to: Poor performance largely the result of incomplete data/poor integration with CANISC records.

Key Successes:	
1	Recording of grade of cancer
2	Review by CNS at diagnosis
3	Chemotherapy rates in line with national average

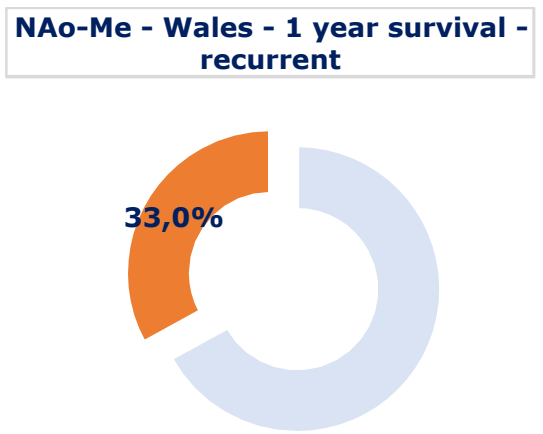
Report Concerns:	
1	Limited data completeness for a number of areas
2	Documented low rates of discussion at MDT (?CANISC integration)
3	Documented low rates or patients receiving a biopsy (?CANISC integration)

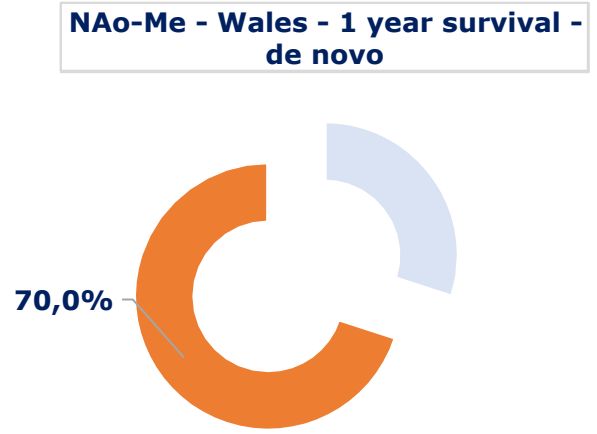
Percentage of women with death recorded within 30 days of a chemotherapy cycle.

No data for Welsh Health Boards , numerator for Wales 250



Wales de-nono – 3-year Survival – 43%





Wales: Breast Care Teams and Clinical Management in Welsh NHS Health Boards

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
Goal #1 – Improve the movement of patients through the care pathway.				
1	Ensure the care for people newly diagnosed with MBC (either de-novo or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting.	• Aim for >70% of all patients to be discussed at MDT • Better integration with CANISC • Appointment of metastatic BCN	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress
2	Examine biopsy rates for MBC and aim to increase this where feasible if the results may have therapeutic implications.	• All patients biopsy records to be recorded on MDT proforma • Better integration with CANISC	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress
3	Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness within breast MDTs should include full tumour characterisation, ER8 and HER212 status, performance status, the NABCOP fitness assessment data items (for people aged 70+ years) and contact with clinical nurse specialists (CNS). *(Recommendation aligned with the report for the National Audit of Primary Breast Cancer8)*	• Clinical lead currently responsible • Consider separate MDT lead role to ensure better data completion	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Dec 25 In progress
4	Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: (a) Education on the recording of recurrence, sharing the NAoMe Guide to collecting COSD data for breast cancer recurrence13 with NHS organisation. (b) reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. *(Recommendation aligned with the report for the National Audit of Primary Breast Cancer14 .)*	• Aim for >70% of all patients to be discussed at MDT • Better integration with CANISC • Appointment of metastatic BCN • Consider separate MDT lead role to ensure better data completion • Appointment of metastatic breast care nurse	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
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 progress of 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 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 for each quarter and form part of maternity services IMTP. These are highlighted in green. Amber denotes areas for ongoing work to achieve compliance rates.

The 3 areas highlighted as red denote work that has not progressed as yet.

Quarter 1	Completed
Care delivered through trauma informed model	√ introduced to mandated training
Women supported re birth plan	√
Healthy lifestyle	√
Inform all parents (bereaved) review take place	√
Daily emergency checks	Ongoing monitoring
Cleaning hand hygiene audits	Ongoing monitoring
90% MBRRACE reported <7days	√ linked in with NICU
Caesarean section SOP	Work ongoing Monitoring of SSI rates continues overall rate 3.85% (2022 SSI report)
4 hours mandated CSfM	√
Wellbeing peer supporters across all areas	√ Audited through CSfM
Support flexible working arrangements	√
Leadership academy band 7 & 8	√
Birth rate plus compliance	√ additionality not included
Education for midwives Bsc and Msc	√
Recruitment drive & improvement	√
Positive public promotion	√
Implementation of safe care	This was not rolled out to maternity services when introduced to Health Board Working with Assistant Divisional nurse to review application to maternity staffing

	as this differs to birth rate plus maternity staffing – maternity service undergoes a 3 yearly staffing assessment which was completed in 2022, a full birth rate plus staffing review is due for completion 2025. Currently compliant to Birth rate plus with vacancies :- 1 wte x band 7 4.4 wte Band 6
Digitised process for training records	√
Dedication to research	√

Quarter 2	Completed
Caring for you campaign	√
100% women signposted healthier together	√
Early access to specialist care for women with underlying conditions	√
100% women informed re hygiene and wound care	√ ongoing audit via badgernet signposted healthier together
100% women low risk able to chose birth in any setting pathway	√ push notification via badgernet
100% Women who wish to breast feed offered support to breast feed/ express within an hour of birth.	Action plan in place re infant feeding
Ensure all women whose baby died unexpectedly are offered a PM	√ ongoing monitoring via PMRT and MBRRACE
Audit entenox in environment	√ first pilot results for review

Quarter 3	Completed
100% of eligible women offered signposted vaccination	√ monitored via badgernet
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	√
95% Midwives will have completed MECC training	√ ongoing training part year 54%
Dedicated governance team with allocated sessional time lead midwife, governance lead midwife, consultant and admin support.	√

All adverse outcomes investigated sensitively within time frames and in collaboration with families.	Work ongoing to improve timely responses
95% MDT Prompt training.	92% ongoing monitoring Additional faculty and leads in place for anaesthetics and obstetrics
Adoption of IFS standards with monthly MDT IFS training target 95% compliance.	Training sessions implemented across the year 24/25 Additional faculty supported to increase compliance and fully adopt standards.
All midwifery staff working in intrapartum care trained in neonatal life support.	√
85% all staff completed level 2 safeguarding	√
All midwives working in HDU undertaken critical care prompt.	HDU PROMPT recommenced – support in place for new staff
All maternity staff receive perinatal mental health training.	√
Implementation of Swartz huddles.	√ safety huddles implemented
95% maternity staff undertake civility saves lives training	54%part year training introduced in September 2024
Human factors incorporated into mandated training.	√
100% preceptor midwives to undergo Once for Wales preceptorship programme.	√
85% up to date PADR	70% compliance

Quarter 4	Completed
A review of the management structure to include Director of midwife consultant midwife and specialist midwifery team, to include succession planning.	Succession planning sessions in place Labour ward coordinator development commenced Review of management structure ongoing Director of Midwife & additional consultant midwife post not progressed additional funding required.
Maternity records will be digitalised and embedded into practice.	√
Bespoke reports will be available via Badgernet and real time accessible data collection.	√
Review environmental footprint at GUH to support patient flow and discharge.	√ part of ongoing mat.neo work
Ensure safer working environments through nitrous oxide destruction.	√ Audit complete and ongoing work to review
Quality improvement programmes embedded through service to address patient flow and pathway	√

Monthly QI and research forums embedded in practise and QI training incorporated into mandatory training study days	√
100% staff have an exit interview.	√
There will be an additional option for pool birth in the alongside midwife led unit.	Waiting on W&E
Induction of labour pathway to improve information, communication and reduce delays in transfer to labour ward.	Pathway developed Circulated to maternity CEF
85% staff completed ICP training & ANTT.	66%part year training
Direct access to maternity service with 80% of women who will have been booked for their pregnancy by 10/40.	SPA referral implementation working with primary care to support
Adoption of the All-Wales Family Engagement Framework.	This is ongoing work that is being developed with services across Wales and in partnership with the consultant midwife group. Currently still in draft and therefore unable to adopt at this time frame.
Increase options for outpatient induction at all LGH sites.	√ Available at 3 LGH sites
100% recording of CO2 monitoring.	Check of equipment / new monitors sourced ongoing monitoring – for audit 2025
All mothers and babies who are able will be kept together and ensuring skin to skin contact following birth.	√
100% of women with GDM are offered support to harvest breast milk.	√ ongoing work requires audit 2025
Adoption of CIVICA across the service, measurement of patient experience through patient reported outcome measures.	√
The 30-day response times for formal concerns to increase to 80%, with majority of concerns responded to informally within 48 hours.	Increase in informal response to address concerns – not meeting 80% 30 day time frame, fortnightly meeting with PTR
Implementation of combined maternity and neonatal dashboard with accurate	Maternity/neo dashboard complete on grape to expand to incorporate further measures from NICU

data reporting of real time clinical outcome measures.	
Thematic analysis of ATTAIN data and monthly shared learning through MDT perinatal meeting, reduction in term admissions.	√ ongoing work re reduction

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Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee 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.

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 January 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Learning from Deaths Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

To ensure the Health Board benefits from the scrutiny of deaths by the Medical Examiner and to enable triangulation of other sources of information available with respect to patients deaths a "Learning from Death Framework" has been developed.

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

The framework aims to provide a model of mortality data reported in three tiers which will allow review of:

- **Tier One mortality indicators (Health Board Level measures)** eg the Risk Adjusted Mortality Index (RAMI) which adjusts risk for individual patient risk

factors/co-morbidities, crude all cause and inpatient mortality. These system level indicators will include comparisons with peers.

- **Tier Two mortality indicators (Divisional mortality indicators)** that will support a proposed approach to mortality oversight. Learning from deaths will be supported by identifying trends in mortality data that require additional scrutiny. These measures will include:
  - Systematic reporting of mortality at Divisional Quality and Safety meetings or a similar forum.
  - Triangulation of information from the Medical Examiner where increases in mortality rates are noted, e.g. if stroke deaths are observed to increase, thematic reviews of Medical Examiner referrals relating to this specific patient group will be undertaken to identify any contributory factors.
  - Case note reviews will be undertaken where a Tier one mortality indicator raises concern about outcomes in a particular clinical area.
  - Presentation of mortality themes and trends at the Health Board Mortality Review Group to support organisational learning.
- **Tier Three Mortality Indicators (Directorate level indicators)** eg: Mortality indicators agreed in each Directorate based on results of national audit or benchmarking exercises. There are multiple clinical databases in use across the organisation and mortality data is included in many of these resources.
  - Where an existing mortality measure does not exist, the Directorate and Quality and Patient Safety Team will work together to develop bespoke measures from CHKS (a health care intelligence system procured by the UHB).
  - Reviewing National Clinical audit data available to specialities and consideration of benchmarking.

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

Cefndir / Background

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

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

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

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

Asesiad / Assessment

A learning from death report has been produced for the period January to June 2024.

Data collated for this report is attached and demonstrates that:

Tier One

- For the period January to June 2024, the Health Board's RAMI is 106.9, an improvement from 111.9 during the same period in 2023.
- Over this time period, the Health Board is the 2nd best-performing Health Board in Wales compared to others in the peer group.
- RAMI helps measure hospital performance by adjusting mortality rates based on patient risks. Its accuracy depends on how well patient data (known as clinical coding) is recorded. Between January and June 2024, 18.3% of consultant episodes at the Health Board remained uncoded.
- The Health Board's RAMI fluctuates, but crude mortality rates have remained stable. To understand areas with higher mortality rates, detailed individual mortality reports are needed. The Health Board is working with the software provider CHKS to improve the mortality alert module. This will help identify and investigate any concerns promptly.
- Since the start of the COVID-19 pandemic, the Health Board has tracked crude mortality (the total number of deaths) to monitor excess deaths caused by COVID-19. These deaths have now reduced.

Tier Two

- Reporting of stillbirth, neonatal and maternal deaths follows a robust internal process and is reported to Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and is case specific. For this reporting period - the rates of death for stillborn babies was 3.2/1000 and neonatal deaths was 2.3/1000. The perinatal death rate was 5.9/1000. There were zero maternal deaths during this reporting period.

- The Medical Examiner Service (MES) has expanded to cover the scrutiny of deaths for pediatrics, neonates, maternity and gynecology. A meeting has taken place with the Division and MES to map out the end-to-end

governance process for the reporting of deaths in line with the MES process (e.g. PRUDiC deaths of children in the community).

- The number of sudden and unexpected deaths (SUDs) in Mental Health and Learning Disability (MHLD) is the same as in 2023. There are many unknowns regarding the cause and circumstances of death for patients in contact with mental health services. In February 2024, 35% of SUDs were unclassified; this time, 33% remain unclassified, often due to limited reporting, limited Coroner feedback, and no post-mortem feedback.
- There were significantly fewer suicides or suspected suicides this period compared to 2023, with 7 confirmed deaths versus 27 last year. Suicides occur more often in men, especially those aged 36-45.
- For physical health, it is positive that reports are now received when people with a Learning Disability die, aiding in learning from unexpected or premature deaths. The increase in reported deaths is likely due to improved reporting and infrastructure. Most physical health-related deaths occur in men aged 46-65, primarily in community services, and are considered untimely.

Tier Three

- Health Board Emergency Department admitted Mortality is better than peer comparators.
- 30-day MI inpatient mortality has decreased compared to last year and is now 2.8% compared to 3.5%.
- 30-day inpatient stroke mortality is 11.4%, compared to 14.3% last year. This is still lower than the All-Wales peer value of 12.9% and is the 3rd lowest in Wales.
- The rate of mortality in hospital within 30 days of elective surgery is 0%, compared to 0.04% last year. Between Jan – June 24 there are zero recorded mortalities within 30 days of elective surgery.
- The rate of mortality in hospital within 30 days of non-elective surgery is 1.4%, compared to 1.7% last year, which is still lower than the All-Wales peer value of 1.8%.
- Engagement with Clinical Leads ensures an enhanced understanding of mortality themes and trends. For this report many of the Divisions have shared examples learning and improvement to support the report.

Medical Examiner (ME)

- For this reporting period, a total of 467 referrals from the Medical Examiner's service (Jan-Jun 24). This is 36% of all in-patient deaths. 99 of these cases have been taken to the Mortality Review Screening Panel. Common themes for the ME referrals include:
- **DNACPR**: Highlighted in 15% of recent referrals, compared to 14% previously. This often refers to forms not co-signed in part 6.
- **Communication**: Increased from 13% to 19%, covering communication with families, clinicians, and the Care After Death Team. This rise reflects the increase in referrals as ME coverage expands.
- **Covid**: Remains steady at 9%.

- **Pressure Damage**: Decreased from 11% to 5%.
- **Delayed**: More frequently mentioned, referring to perceived delays in treatment, investigation, or ambulance services.
- To adapt to the expansion of the ME Service. During 2024 the ME Service has developed to cover community cases and continue to adapt to this growth.
- This report has ensured that there is a link with the development of Bereavement services and the Care After Death Team.

The attached report provides details for areas for improvement and document learning from clinical areas. The report includes the reported mortality indicators as agreed un the Health Board's mortality framework and is embedded with narrative provided by multiple clinical areas.

Next steps

- The Health Board now has access to the CHKS alerts module for mortality and will design tailored graphs and charts to suit our specific needs. This will support the development of a Standard Operating Procedure (SOP) to provide guidance for all staff involved in mortality peer reviews.
- Initial steps are underway to develop an internal Health Board QLIK App that will leverage the measures currently provided externally through CHKS. This will support the use of dashboards for individual directorates, ensuring that specific measures can be monitored efficiently and remain relevant to their unique requirements.

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

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Learning from Deaths Report

MORTALITY DATA AND NARRATIVE REPORT

JANUARY 2024 TO JUNE 2024

Introduction

This Learning from Deaths report covers the period January 2024 to June 2024. Since the previous report (covering the period Oct 2022-Dec2023) the following actions have been taken:

- **Framework Engagement**: The Learning from Deaths Framework has been distributed to Divisions to ensure there is engagement in responding to and learning from patient deaths under their care. The framework supports systematic ward-to-board reporting and monitoring of mortality, providing accurate data to identify trends. It triangulates condition-specific mortality data with information from the Medical Examiner.
- **Mortality Reviews**: The framework and report reinforces the commitment to conducting mortality reviews using a structured methodology to identify care problems and draw conclusions for improvement.

The “Learning from Deaths Report” seeks to bring together all learning from deaths and to provide assurance that we are systematically learning from deaths and implementing necessary improvements. The report will be brought to PQSOC 6 monthly.

Areas to highlight

- The **Learning from Death report** presents mortality data at three levels **(Health Board, Divison, Directorate)**:

- **Tier 1**: **Health Board level data**:.
  - For the period January to June 2024, the Health Board's RAMI is 106.9, an improvement from 111.9 during the same period in 2023.
  - Over this time period, the Health Board is the 2nd best-performing Health Board in Wales compared to others in the peer group.
  - The Health Board's RAMI fluctuates, but crude overall mortality rates have remained stable. To understand areas with higher mortality rates, detailed individual mortality reports are being designed. The Health Board is working with the software provider CHKS to develop a mortality alert module. This will help identify any specialties which are mortality outliers for investigation.

  (*RAMI helps measure hospital performance by adjusting mortality rates based on patient risks. Its accuracy depends on how well patient data (known as clinical coding) is recorded. Between January and June 2024, 18.3% of consultant episodes at the Health Board remained uncoded (100% of deaths were coded). A coding improvement program in underway).*

Areas to highlight

Tier 2: **Divisional level data**:

- Reporting of stillbirth, neonatal and maternal deaths follows a clear internal process and is reported to the national "*Mothers and Babies Reducing Risk through Audits and Confidential Enquiries*" Audit (MBRRACE) and is case specific. For this reporting period - the rates of death were for stillborn babies was 3.2/1000 and neonatal deaths was 2.3/1000. The perinatal death rate was 5.9/1000. zero maternal deaths,
- The Medical Examiner Service (MES) has expanded to cover the scrutiny of deaths for Paediatrics, neonates, maternity and Gynaecology. A meeting has taken place with the Division and MES to map out the end-to-end governance process for the reporting of deaths in line with the MES process (e.g. PRUDiC deaths of children in the community).
- The number of sudden and unexpected deaths (SUDs) in Mental Health and Learning Disability (MHLD) is the same as in 2023. The MH&LD Division produce a detailed report on SUDs annually with benchmarking against other areas. ABUHB is not an outlier in this domain. The cause and circumstances of death for patients in contact with mental health services is not always clear when the death occurs in the community. In February 2024, 35% of SUDs were unclassified; this time, 33% remain unclassified, often due to lack of a national approach to structured reporting, limited Coroner feedback, and no post-mortem feedback. Encouragingly there were significantly fewer suicides or suspected suicides this period compared to 2023, with 7 confirmed deaths versus 27 last year. Suicides occur more often in men, especially those aged 36-45.
- Since the previous report, deaths are now received when people with a Learning Disability die, aiding in learning from unexpected or premature deaths and to ensure parity of esteem for patients with learning disabilities and their ability to access physical care in a timely manner. The increase in reported deaths is likely due to improved reporting and infrastructure.

Areas to highlight

- **Tier 3**: **Directorate level Data**:
  - Health Board Emergency Department admitted Mortality is better than peer comparators.
  - 30-day MI inpatient mortality has decreased compared to last year and is now 2.8% compared to 3.5%.
  - 30-day inpatient stroke mortality is 11.4%, compared to 14.3% last year. This is still lower than the All-Wales peer value of 12.9% and is the 3rd lowest in Wales.
  - The rate of mortality in hospital within 30 days of elective surgery is 0%, compared to 0.04% last year. Between Jan – June 24 there are zero recorded mortalities within 30 days of elective surgery.
  - The rate of mortality in hospital within 30 days of non-elective surgery is 1.4%, compared to 1.7% last year, which is still lower than the All-Wales peer value of 1.8%.
  - Engagement with Clinical Leads ensures an enhanced understanding of mortality themes and trends. For this report many of the Divisions have shared examples of learning and improvement to support the report. (Examples are provided in the appendices)

(We are working with divisions to consider meaningful metrics for regular review)

Areas to highlight

Medical Examiner (ME)

- During the current reporting period, a total of 467 referrals from the Medical Examiner's service were received (Jan-Jun 24). This is 36% of all in-patient deaths. 99 of these cases have been taken to the Mortality Review Screening Panel. Common themes for the ME referrals include:
    - **DNACPR**: Highlighted in 15% of recent referrals, compared to 14% previously. This often refers to forms not co-signed in part 6.
    - **Communication**: Increased from 13% to 19%, covering communication with families, clinicians, and the Care After Death Team. This rise reflects the increase in referrals as ME coverage expands.
    - **Covid**: Remains steady at 9%.
    - **Pressure Damage**: Decreased from 11% to 5%.
    - **Delayed**: More frequently mentioned, referring to perceived delays in treatment, investigation, or ambulance services.
    - To adapt to the expansion of the ME Service. During 2024 the ME Service has developed to cover community cases and continue to adapting to this growth.
    - This report has ensured that there is a link with the development of Bereavement services and the Care After Death Team.

Areas for development

A governance framework

- Process in development for review of condition/procedure-specific mortality.
- Ensuring mortality data is reported through Directorate Quality and Patient Safety meetings.
- Reviewing how formal assurance and escalation reports will come from M&M reviews.
- **Challenges**: Slow developments in software (CHKS). Lack of interface in systems makes it difficult to triangulate mortality data with ME reviews, Mortality and Morbidity (M&M) reviews, and Inquests.

Coding

- Welsh Government Targets:
    - 95% coding completeness by the end of the month following discharge
    - 90% of coding errors corrected within 35 days.
- Health Board's coding completeness is at 82% (100% of deaths coded), coding accuracy is 96%
- **Improvement Plans**: New clinical coding structure introduced. Raise the profile of clinical coding through initiatives like Lunch & Learn sessions. Develop coding automation to allow coders to focus on complex cases.
- **Challenges**: National issue in Wales with retaining trained coders, many work from home and NHS England pays one band higher at each grade. Incomplete or unclear patient records.

Care After Death Team - Notification of Death via QR Code

- The Health Board supports a QR code based system driven by the Medical Examiner Service (MES).
- **Concerns**: Following QR code notification there is a lack of notification to the Care After Death (CAD) Team, leading to documentation and audit trail issues. Duplication of documentation causing potential discrepancies. Restricted access to directly contact the MES, which could delay death certification and impact families.
- **Actions**: The CAD Team is working with the MES to create a form that streamlines the process and ensures a complete audit trail.

Learning and Improvement

- Divisions have contributed to this report by providing examples of learning and improvement from mortality and morbidity reviews.
- The Health Board now has access to the CHKS alerts module for mortality and will design tailored graphs and charts to suit our specific needs. This will support the development of a Standard Operating Procedure (SOP) to provide guidance for all staff involved in mortality peer reviews.
- Initial steps are underway to develop an internal Health Board QLIK App that will leverage the measures currently provided externally through CHKS. This will support the use of dashboards for individual directorates, ensuring that specific measures can be monitored efficiently and remain relevant to their unique requirements.

- National reports of the themes and trends associated with the deaths of people with learning disabilities is being reviewed by the MHLD team.
- Perinatal and maternal deaths are reviewed to determine local lessons learned from the nation-wide system. This can be seen in this report, with examples of specific action plans reported to the PQSOC, as is the case for other national reports.

For Information

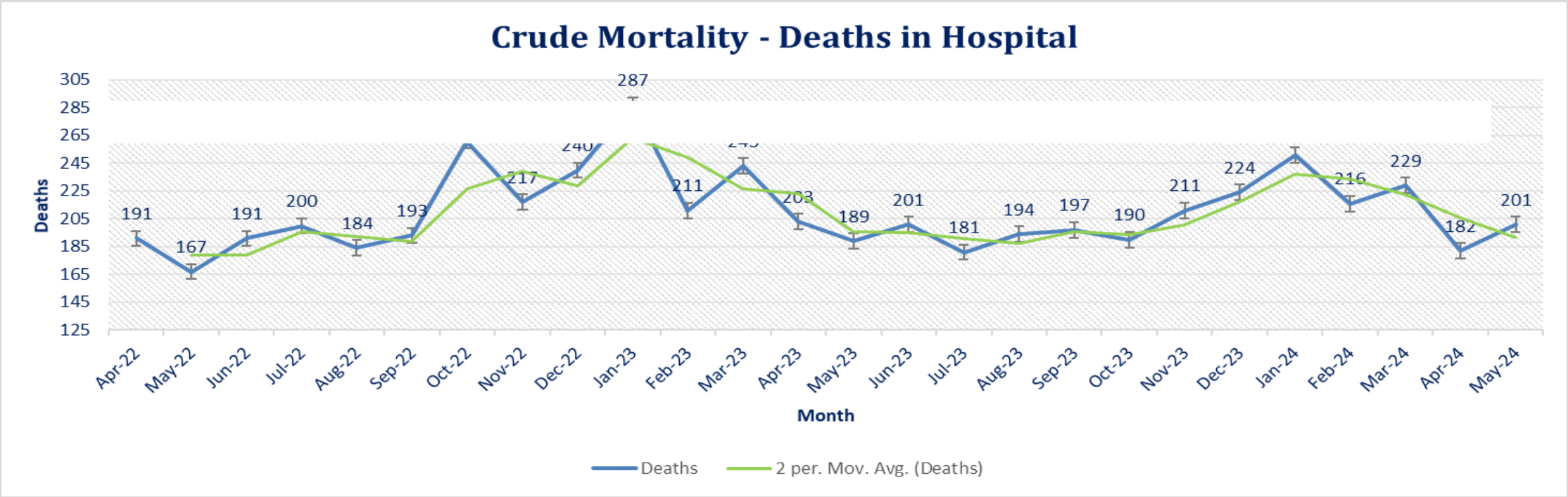
MORTALITY INDICATORS

LEARNING AND IMPROVEMENT PROVIDED AS PART OF THE HEALTH BOARD MORTALITY FRAMEWORK

Aneurin Bean University Health Board Mortality Framework

Tier 1	Risk Adjusted Mortality Index (RAMI)		ABUHB Crude Mortality Data		All Cause Mortality Data		
External Controls	Medical Examiner Service Scrutiny						
	His Majesty's Coroners Processes						
Tier 2	Surgery Division	Clinical Support Services	Medicine Division	Urgent Care Division	Primary Care & Community (including Complex Care)	Family & Therapies Division	Mental Health & Learning Difficulties Division
Internal Mortality Control	M&Ms	M&Ms	M&Ms	M&Ms		PRUDiC	Concise & Comprehensive Reviews
Tier 3	Surgery Division	Clinical Support Services	Medicine Division	Urgent Care Division	Primary Care & Community (including Complex Care)	Family & Therapies Division	Mental Health & Learning Difficulties Division
	30-day post elective surgery inpatient mortality	Local mortality measures	Stroke mortality	ED Attendance	Local specific mortality	Maternal mortality	Suicide (in patient and population measure)
	30 post non-elective surgery inpatient mortality		Cardiology/MI			Perinatal Mortality/ 1,000 births	Learning disability deaths
						Still Birth/1,000 births	Drug related death panel
National Audit	NHFD National Cancer Audits	NELA ITU - ICNARC	Cardiology - MNAP Stroke - SSNAP		NACEL	Maternity & Neonatal Board MBRRACE NMPA	NCISH

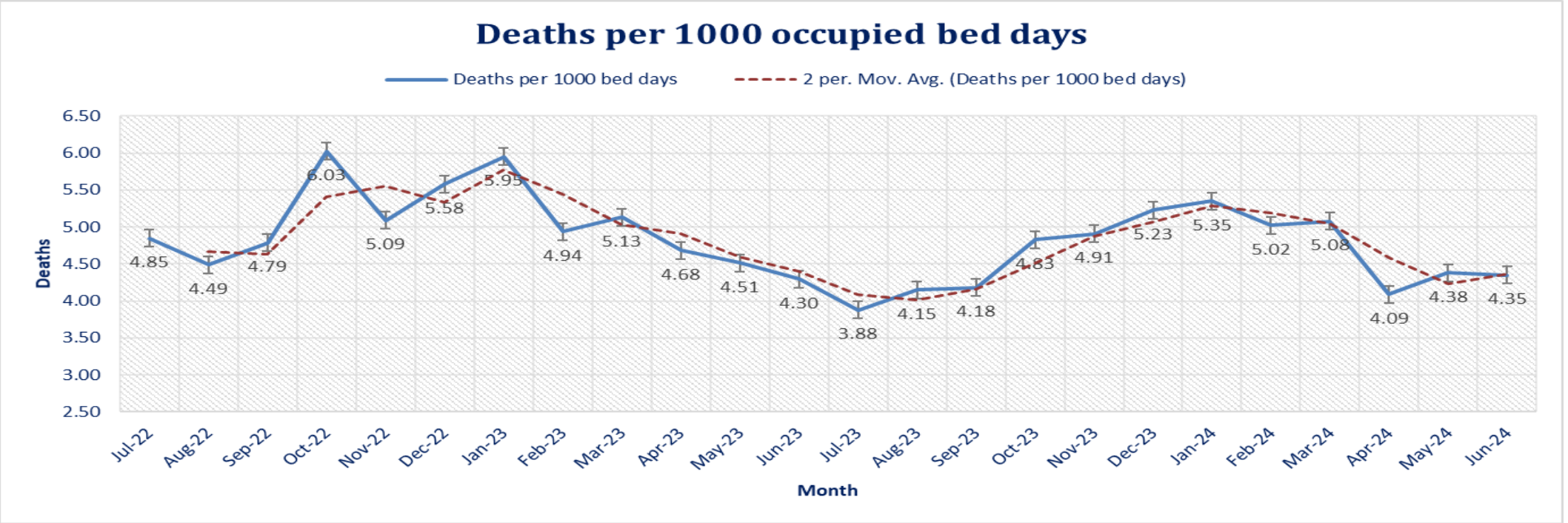
Tier one Mortality Indicators - Crude mortality



Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous four years, identifying trends above or below this average. This measure was particularly useful during the Covid-19 pandemic to track excess deaths. The data includes all-cause mortality and deaths where Covid was mentioned on the death certificate, as seen in the Aneurin Bevan University Health Board.

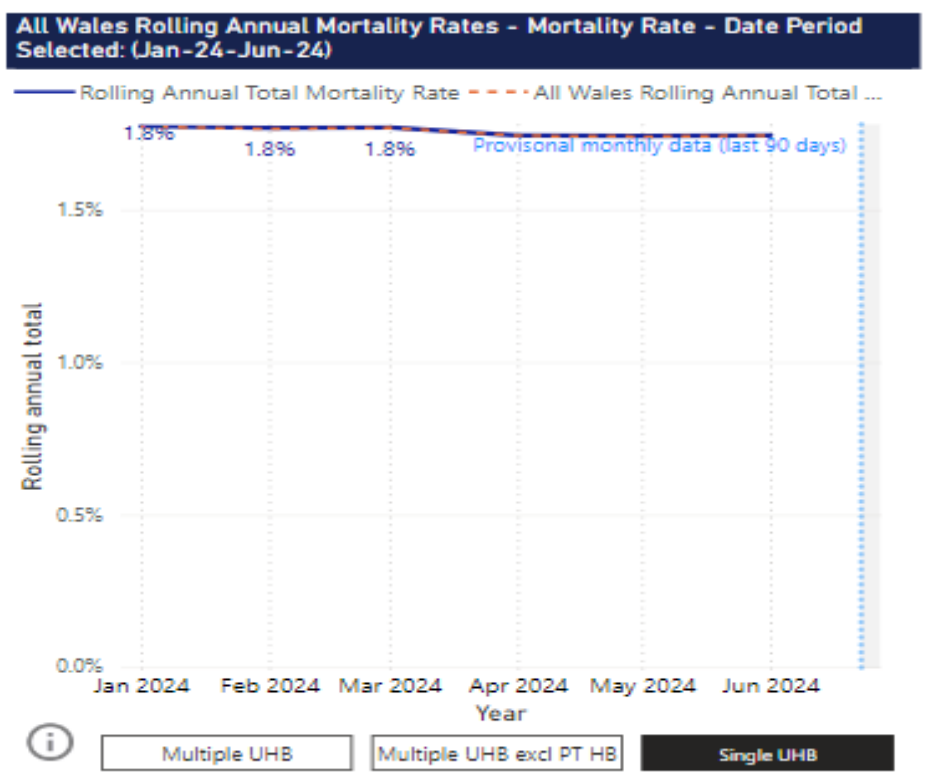
Tier one All-Cause Mortality

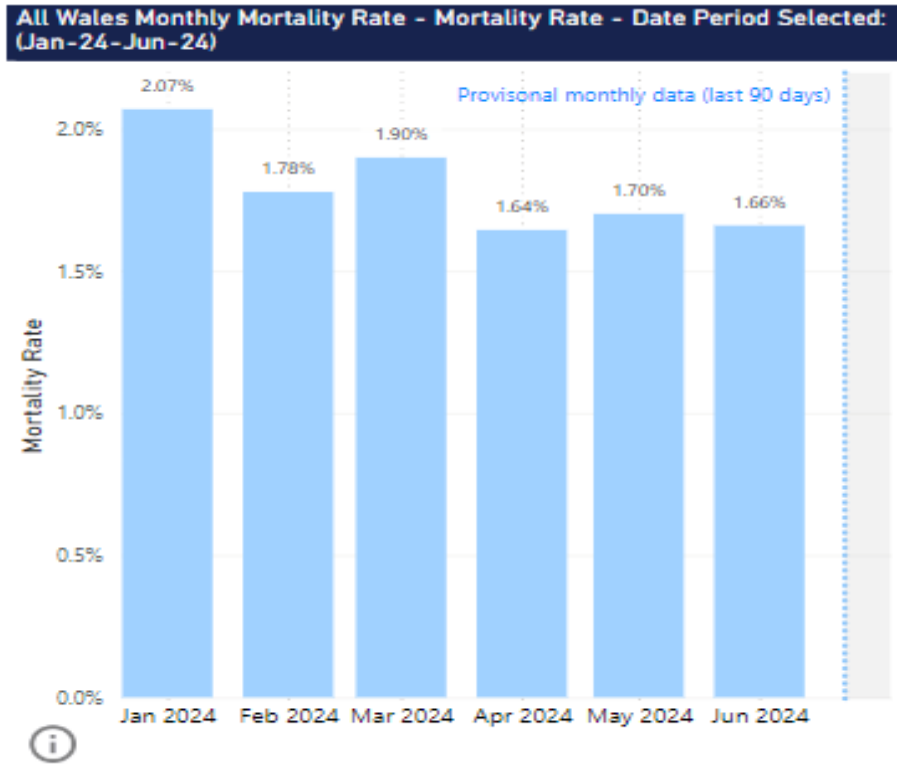
All-cause mortality measures the total number of deaths from any cause in a population over a specific period. Unlike measures focusing on specific diseases, it counts every death, regardless of the cause. It's usually expressed as the number of deaths per 1,000 people per year.



- Deaths per 1000 occupied bed days – a steady decline is observed from January 23 to July 23 (18-month lowest point of 3.88). However, has increased though Autumn/Winter 23/34
- Currently within 0.5 in June 24 compared to June 23.

Tier one - Rolling Mortality Rate

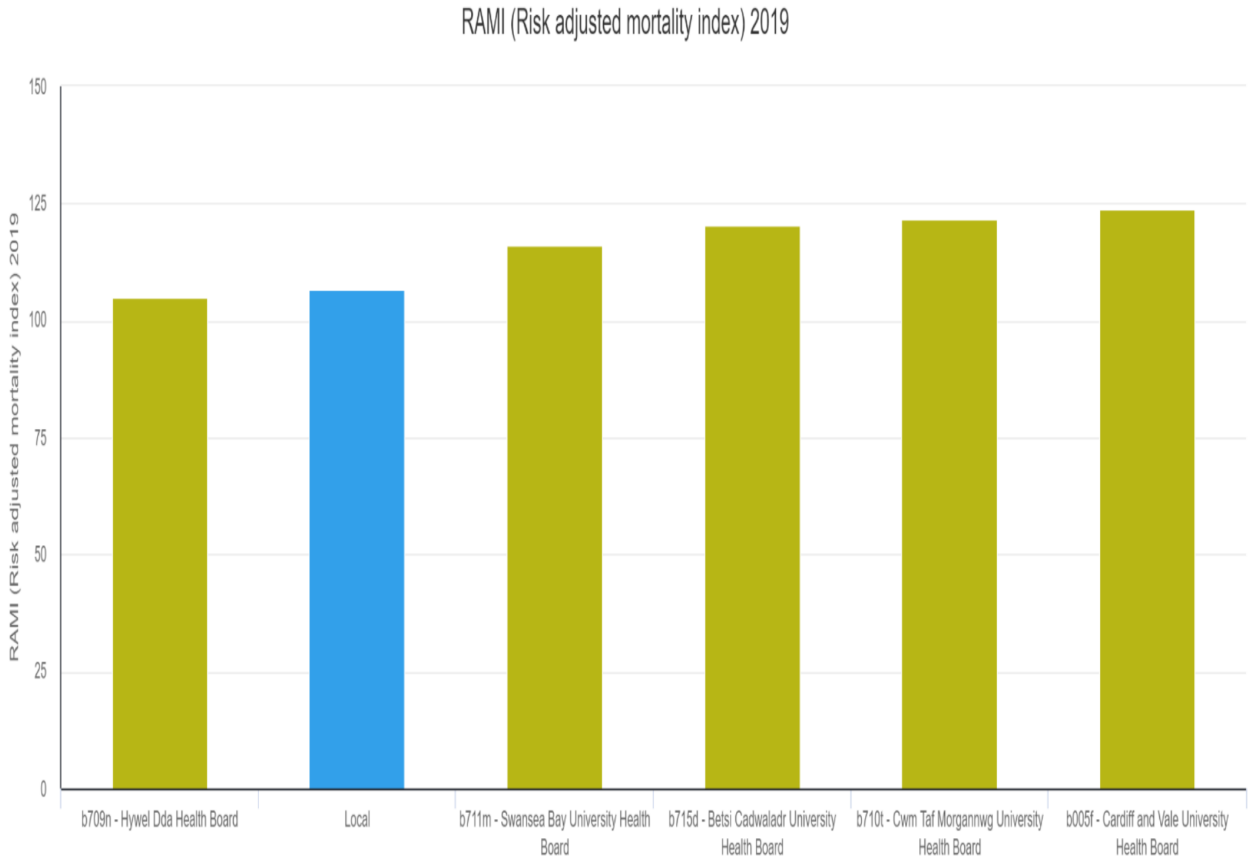




- Whilst the Health Board RAMI has continued to vary, the crude mortality and mortality rate are flat and consistent.
- This emphasises the need for an individual mortality report to undertake deep dives in high mortality specialties.
- The Health Board has been working with CHKS to develop a mortality indicators module. This has now been switched on which will enable an alert notification for mortality indicators and the deep dive process can be developed.

Tier one Mortality Indicators - Risk-Adjusted Mortality Index (RAMI)

- **RAMI** is a metric used to measure hospital or treatment-related deaths, considering the initial health status of patients.
- **Patient Differences**: Patients vary in age, health conditions, and illness severity. Some are at higher risk of dying due to their initial health status.
- **Adjustment Process**: This metric adjusts the raw death numbers to account for these differences, providing a fairer comparison between hospitals or doctors.
- **Fair Comparison**: It helps determine if a hospital's death rate is better or worse than expected, given how sick its patients were.
- This way, hospitals treat very sick patients aren't unfairly judged by their higher death rates.



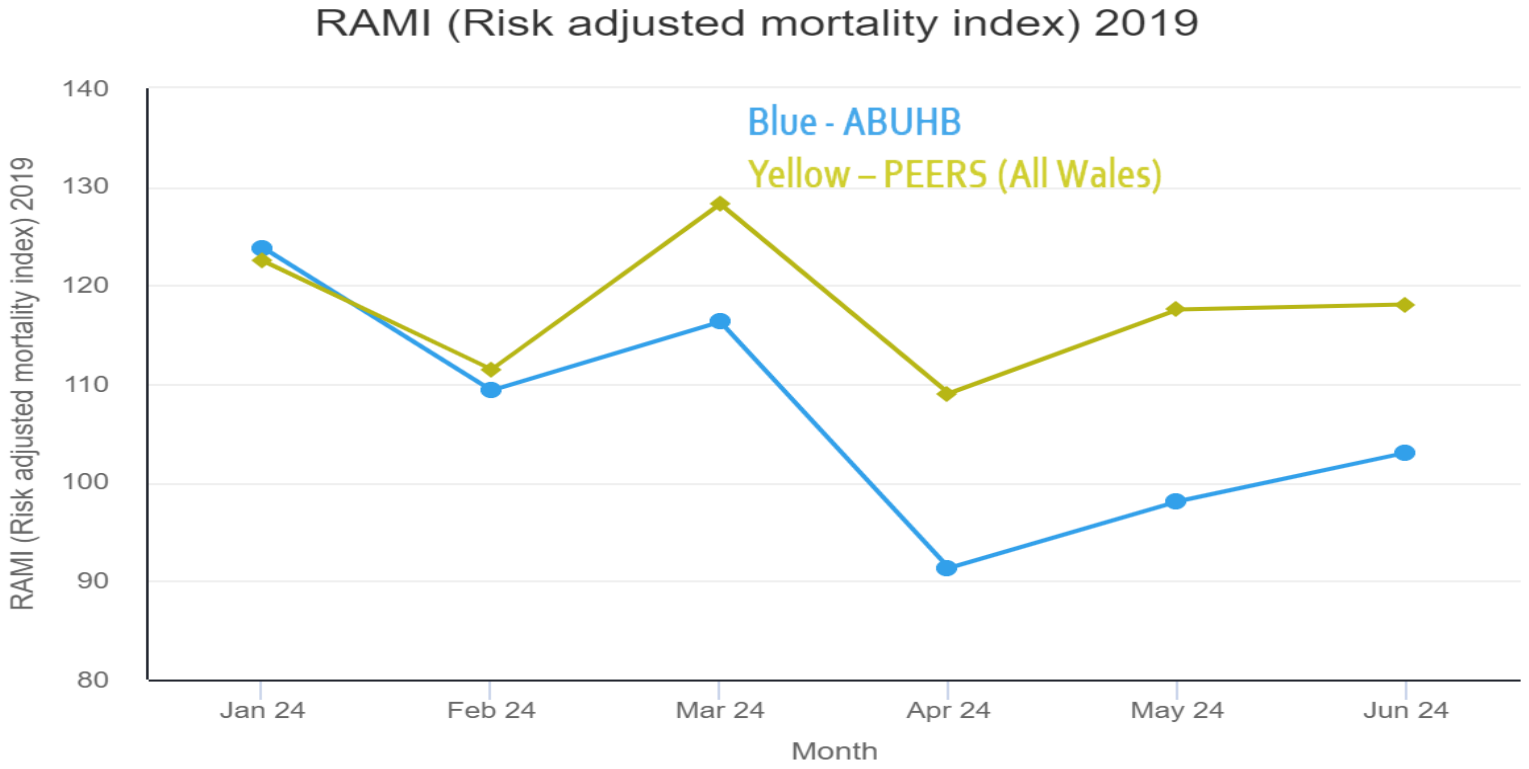
The Health Board is the 2nd best performing Health Board within the Welsh Peer Group.

Tier one Mortality Indicators RAMI

The accuracy of RAMI (Risk-Adjusted Mortality Index) relies on the completeness and accuracy of clinical coding.

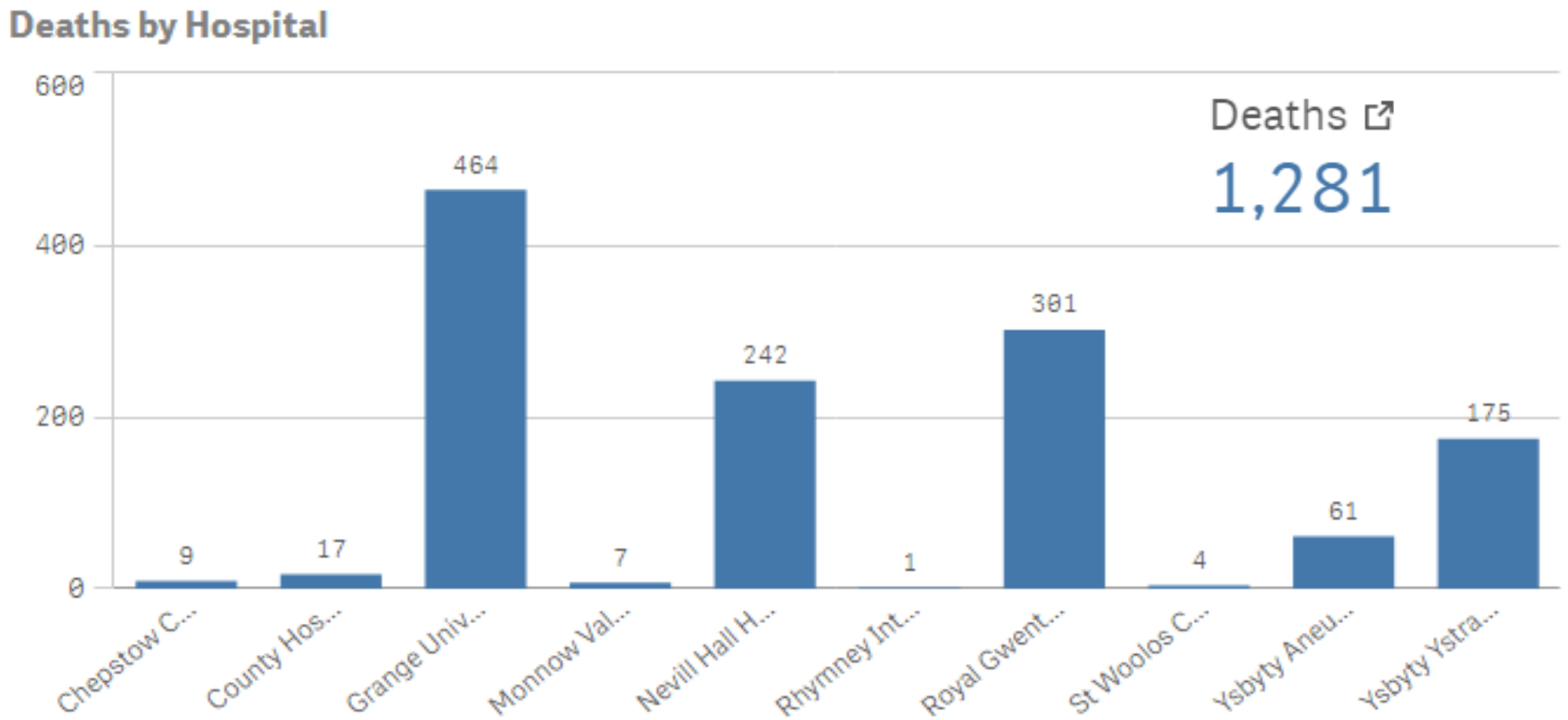
Between January 2024 and June 2024, 18.25% finished consultant episodes at ABUHB were uncoded.

In 2014, Professor Palmer reviewed RAMI and questioned its validity as a sole measure. He recommended a blended approach using multiple data sources, including mortality reviews, national benchmarking, and national audits, to ensure quality improvement and assurance around mortality.



- The Health Board is currently performing better than the Welsh Peer Value average as an overall value of RAMI.
- Consistent and linear performance against Welsh Peers from February 2024.

Tier one All-Cause Mortality per site



Coding

The Welsh Government targets for clinical coding are: 95% coding completeness by the end of the following month (e.g. March discharges coded by end of April). 90% of clinical coding errors corrected within 35 days of identification.

Currently, the Health Board's coding completeness is at 82% due to increased activity and the need to train many Trainee Coders. To achieve national targets, the Health Board plans to:

- Introduce a new clinical coding structure for a more robust process.
- Continue raising the profile of clinical coding through initiatives like Lunch & Learn sessions.
- Develop coding automation to allow coders to focus on complex cases.

Challenges include higher volumes of finished consultant episodes, incomplete or unclear patient records, and excessive use of abbreviations, which delay coding and hinder automation efforts.

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

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

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

Tier 2 Mortality Indicators

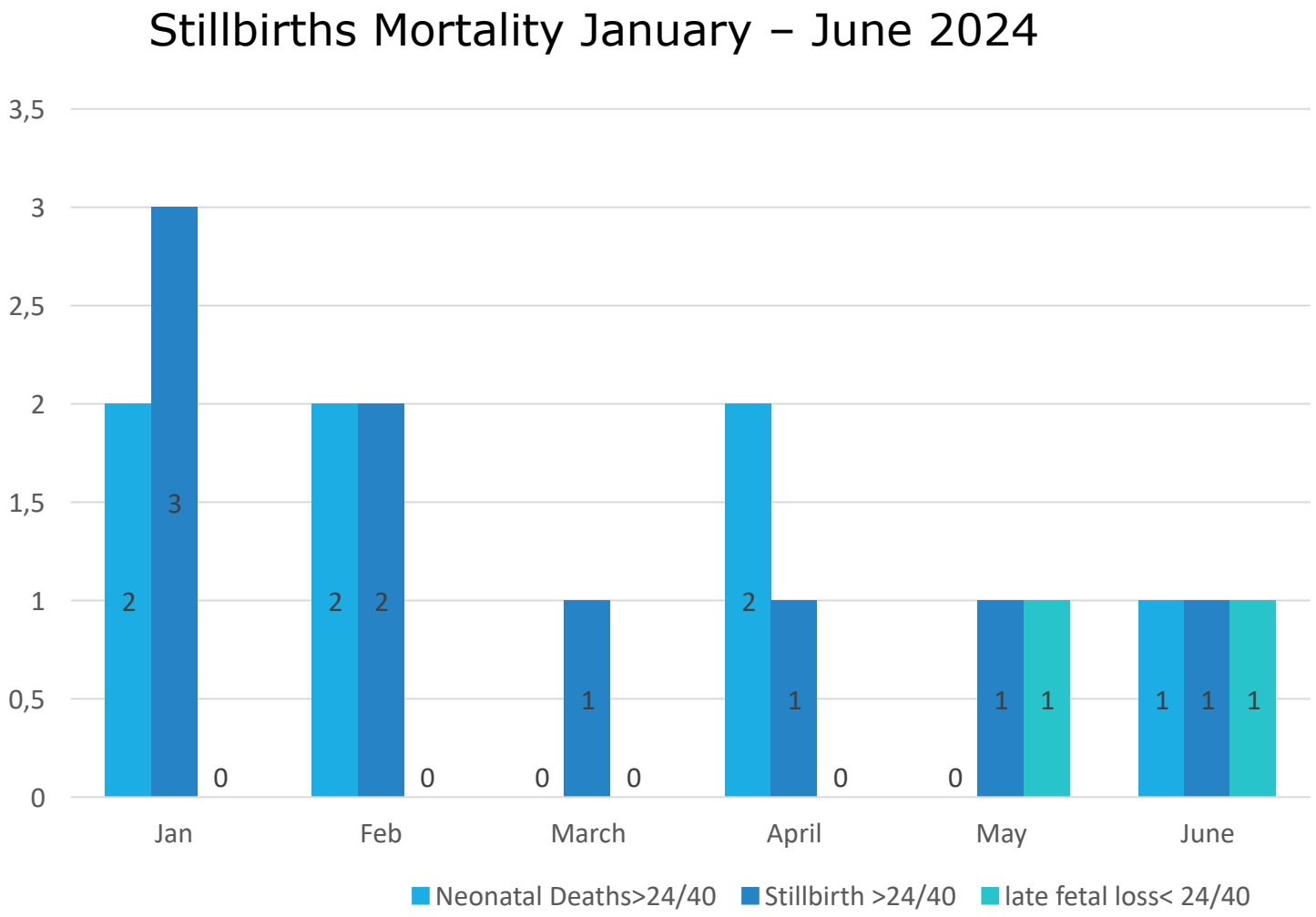
Identifying Divisional mortality indicators will enhance mortality oversight by:

- Systematically reporting mortality at Divisional Quality and Safety meetings.
- Triangulating information from the Medical Examiner when mortality rates increase, such as thematic reviews for specific patient groups like stroke patients.
- Conducting case note reviews to provide assurance when other clinical reviews are absent.
- Presenting mortality themes and trends at the Health Board Mortality Review Group to support organisational learning.

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

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

Tier Two –Mortality

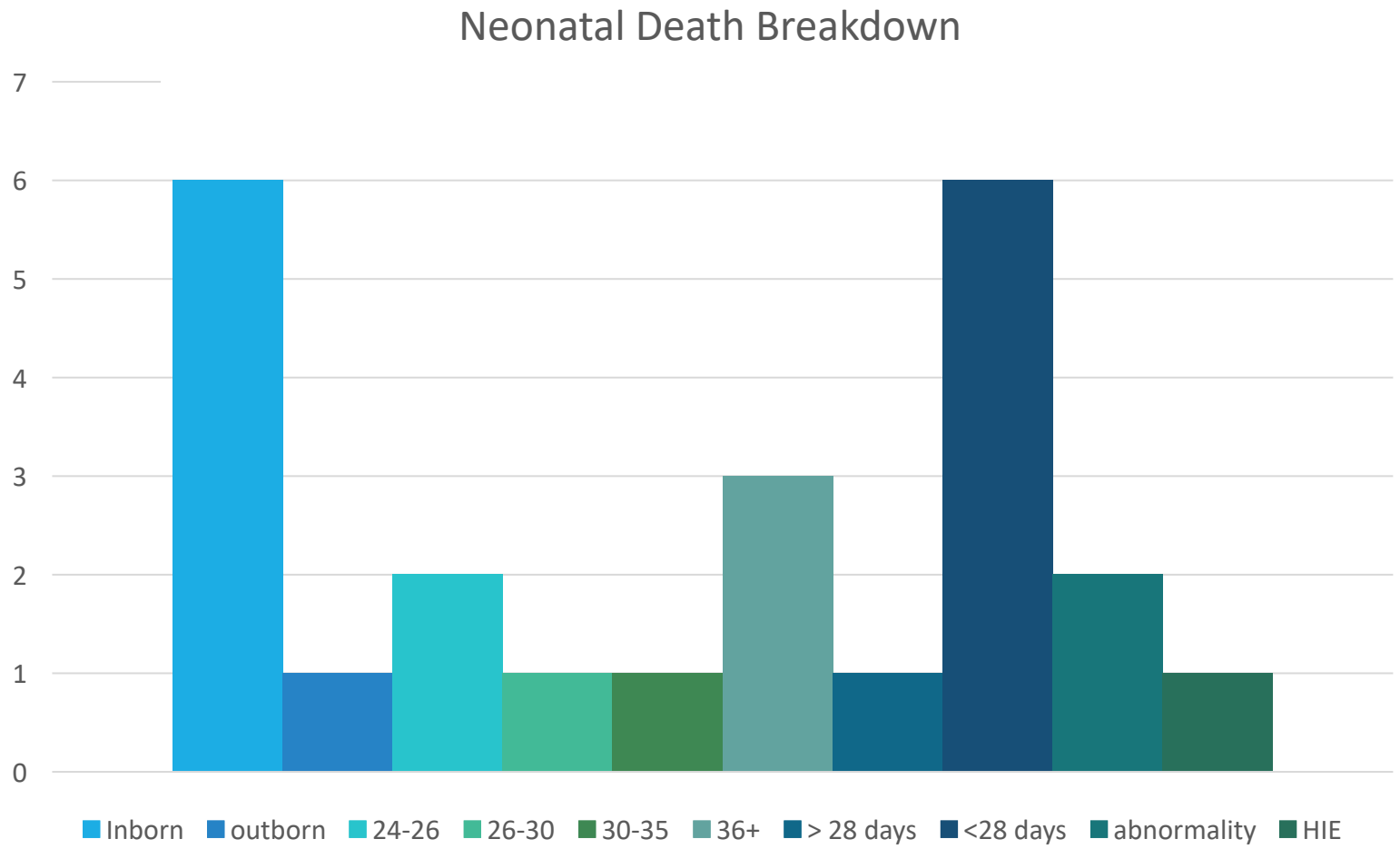


- Zero maternal deaths from Jan – June 2024
- There were 9 stillborn babies for 2559 births (Jan – June inclusive). Rate of 3.15/1000
- 6 Neonatal deaths (NDD). Rate of 2.34/1000
- Total 15 perinatal deaths. Rate of 5.86/1000
- This doesn't include abnormalities

Stillbirth Case Mix and Findings

- 9 stillbirths > 24/40
- 6 <37/40
- 2 late fetal loss 22/23+6/40
- 7 white : 2 black
- Placental changes malperfusion
- Abnormality
- Infection
- Abruption
- Parvovirus hydrops

Tier Two Neonatal Mortality January – June 2024



Neonatal Death - Case Mix and Findings

- 6 inborn : 1 out-born
- 4 babies < 36/40
- 5 white : 1 mixed : 1 Asian
- 1 term baby Hypoxic Ischaemic encephalopathy
- 1 term baby abnormality died in hospice
- Infection
- Growth restriction
- Extreme prematurity

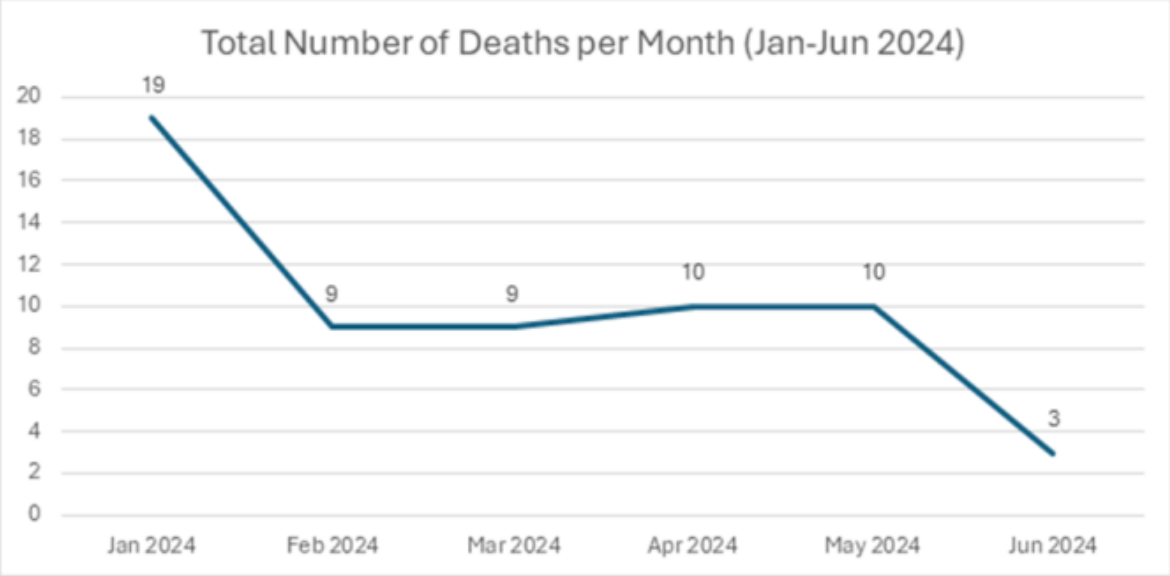
Learning and actions

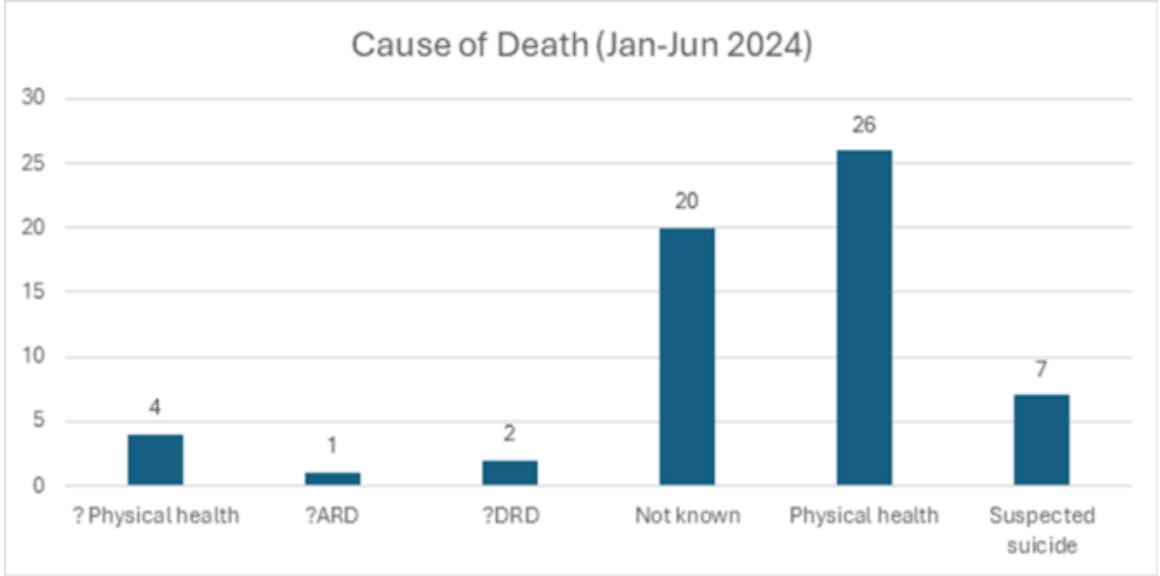
- **Supporting Women with Language Barriers-** The Health Board is ensuring that translation services are available for women who need language support during pregnancy and birth.
- **Monitoring Carbon Dioxide (CO_2) in Pregnancy -** CO_2 levels will be monitored during pregnancy to ensure safety. There is a review of equipment and a plan to purchase additional monitors to improve care.
- **New Labour Guidelines –** A guidelines is being developed for the latent phase of labour to ensure better support and care during early labour.
- **Managing Reduced Foetal Movement –** Ongoing audit to review the how the Health Board responds to reports of reduced foetal movement to ensure timely and effective management.
- **All-Wales Standards for Foetal Surveillance -** Implementing the All-Wales standards for foetal surveillance, including: Updated training for healthcare staff. New guidelines for interpreting CTG (cardiotocography) readings and monitoring foetal health.
- **Growth Monitoring -** Conducting audits to monitor baby growth using the "Gap and Grow" package to identify any concerns early.
- **Improving Outcomes for Premature Babies -** Adopted the PERIPrem optimisation tool and carrying out ongoing audits to improve the care and outcomes for premature babies.

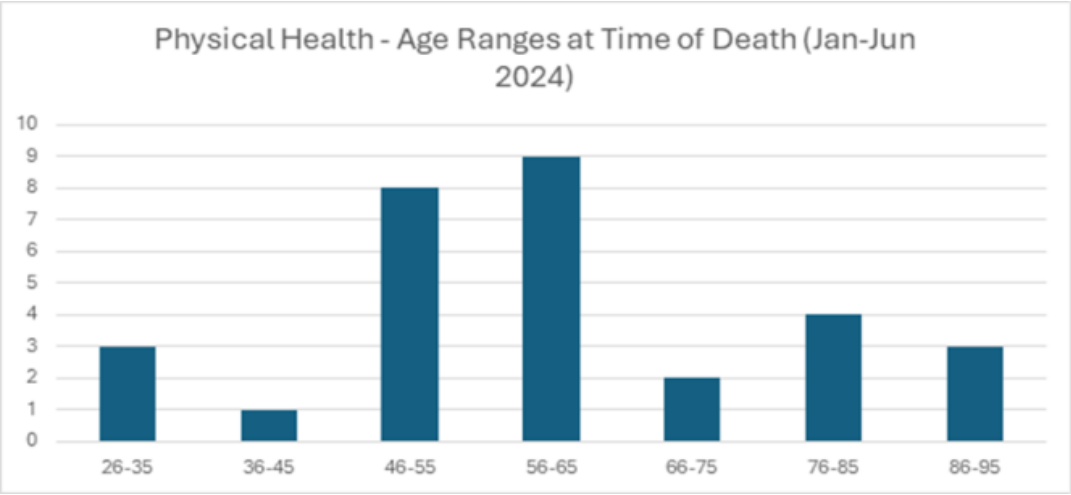
Provided by Jayne Beasley - Head of Midwifery & Gynaecology

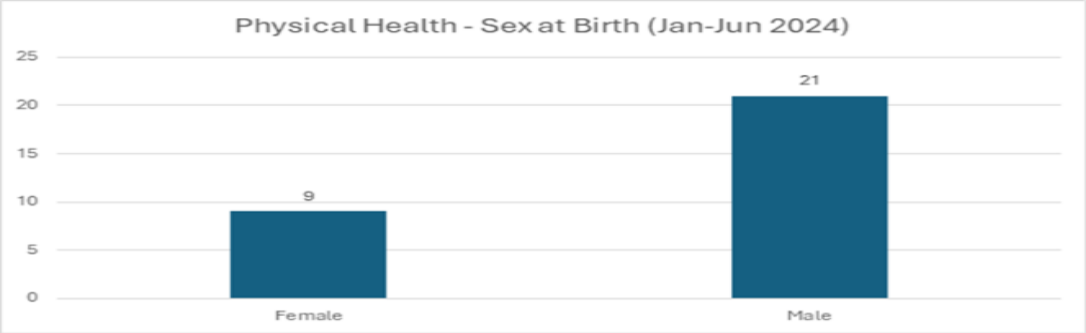
Tier Two – MHLD sudden and unexpected deaths (SUDS)

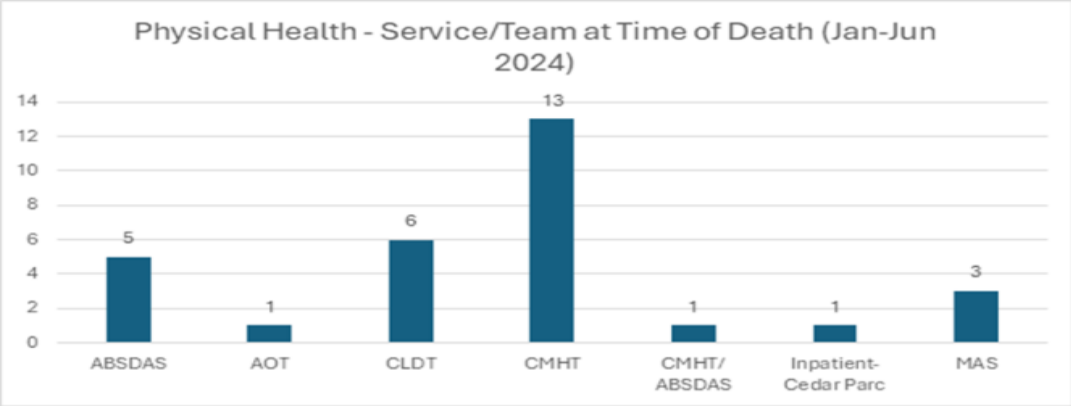
- In the period January – June 2024, there were 60 sudden and unexpected deaths (SUDS) registered by the Mental Health and Learning Disabilities Division. The first chart shows the frequency of SUDS by month in this period. This is a similar number to that reported in the same period in 2023.
- The cause of death is detailed below in the second chart. According to the Learning Report into Sudden and Unexpected Deaths (Feb 2024), the Quality and Patient Safety Team often lacks information on the cause of death. Classifying a death as suicide is complex and time-consuming. For this and previous reports, a death is coded as suicide or suspected suicide if the Coroner has ruled it as such, or if clinical records show identifiable risk factors or means indicating an intention to end life (e.g., suicide note). At the time of this report, 33% of deaths remain of unknown cause.







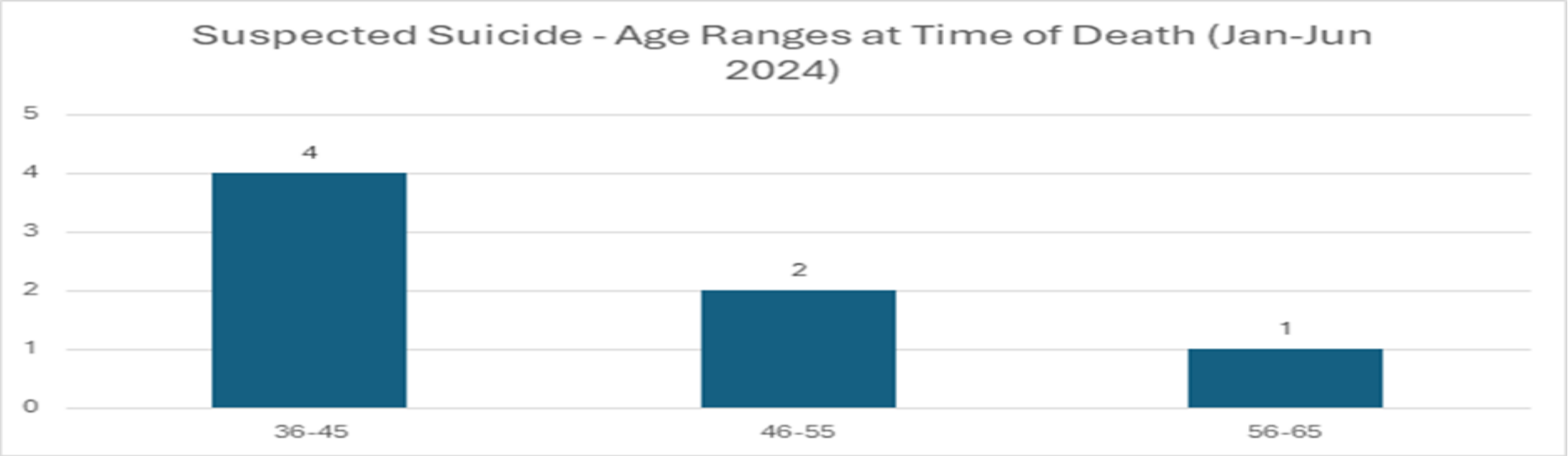




Tier Two – MHLD Sudden Unexpected Deaths

- These charts illustrates the number of unexpected deaths across different age ranges. Previous reports have clarified that deaths over 75 years old are not considered premature but may still be unexpected. Deaths by sex at birth, showing that 97% of sudden unexpected deaths (SUDs) due to physical health issues occurred in community services, with only one death in an acute hospital setting.
- The final chart shows the service provision at the time of death by physical health causes.
- Compared to the February 2024 report, there is a higher number of deaths in the Memory Assessment Service. Examination of these three deaths (two males, one female; mean age 83 years) showed no concerning patterns, with causes being a fall, pulmonary embolism, and perforated ulcer. All were investigated as part of the normal process.
- Previously, 66% of those dying unexpectedly had sought help for alcohol or substance use, though few were engaged with specialist services. This time, a detailed analysis of patient characteristics is pending. Among those who died from physical health causes and were open to drug and alcohol services, 57% were male with a mean age of 51 years. Additionally, there were three deaths related to alcohol and drugs.

Tier Two - Death by Suicide



- In the period of study, seven deaths were classified as suicide or suspected suicide. The age is represented at the time of death and mirrors the findings found in last period of study. More men than women take their own lives and it appears more likely in younger age groups.
- Of the confirmed or likely suicides (n = 7), 86% were in community services at the time of their death. Points of contact are displayed in figure 10. All occurred in the Adult Directorate; 2 deaths occurred in Newport, 1 in Caerphilly and 1 in Blaenau Gwent. The remaining deaths occurred in Pan-Gwent service. Due to the low number, we have not corrected these per 100,00 of the population as it can distort the interpretation of the data.

Learning MHLD

The February learning report highlighted several key points:

- There is regular variation in the number of deaths, with no time-related or seasonal trends in deaths by physical health causes or suicide.
- More men die unexpectedly than women, especially men under 60, aligning with national trends.
- Unexpected deaths are more common among those not in a relationship or economically inactive, consistent with national data.
- Higher numbers of unexpected deaths occur among people with psychotic or affective disorders, and suicides are more common among those with drug disorders or substance use issues.
- When controlling for population size, there is little variation in death rates by area, except for a higher number of suicides in Monmouthshire.
- Certain diagnostic categories, such as substance use, affective disorders, and psychotic disorders, are overrepresented in sudden unexpected deaths (SUDs).

Areas of good practice:

- Access to evidence-based care for those with Personality Disorders, resulting in a favorable rate of unexpected deaths compared to national trends.
- Consistent use of NEWS for monitoring physical health in acute services.

Recommendations for Clinical Governance and Reporting (From MH&LD Division):

1. Action Plan Development: Assign action owners and track progress through divisional QPS meetings.
2. Steering Group Review: Review attendance of the MH+LD Divisional representative on the Gwent Suicide and Self Harm Prevention Steering Group.
3. Learning Dissemination: Continue sharing learning through Top Tip Tuesday memoranda and NCISH awareness sessions.
4. Physical Health Monitoring: Regular audits to monitor progress in physical health clinics in Community Services; LD services support GPs with annual health checks.
5. Recovery Through Sport: Increase access to initiatives supporting physical activity in the community.
6. Hot Spot Analysis: Examine hot spot areas for targeted service provision and staff well-being support.
7. Audit Cycle: Implement an audit cycle to ensure access to evidence-based care and identify barriers.
8. Mortality Data Collection: Continue manual collection of mortality data until a digital solution is developed.
9. Annual Review: Consider mortality data in Divisional Quality & Patient Safety meetings annually and at Health Board level.
10. Benchmarking: Seek forums for benchmarking findings and engaging in peer-based learning for improvement.

Provided by Division Mental Health and Learning

Tier 3 Mortality Indicators

- Once Tier 2 indicators are established, work will focus on identifying appropriate indicators within each Directorate. Multiple clinical databases, including mortality data, are used across the organisation. Directorates that may benefit include Emergency Laparotomy Surgery, Cardiology, Neonatal Unit, Intensive Care, Surgery, and Stroke.
- National Clinical Audit data will be used to triangulate and benchmark mortality data for Directorates. Where no existing mortality measure is in place, bespoke measures will be developed with the Directorate and Quality and Patient Safety Team using CHKS.
- A governance framework will be developed as part of the Learning from Death Framework to support a systematic approach to condition/procedure-specific mortality, including:
  - Systematic reporting of mortality data through Directorate Quality and Patient Safety meetings.
  - Triangulation of mortality data with Medical Examiner reviews, Mortality and Morbidity (M&M) reviews, and Inquests.
  - Formal assurance and escalation reporting from M&M reviews.
  - Assurance and exception reporting to Quality and Patient Safety meetings.

Tier 3 Mortality Indicators - Crude Mortality

Description	Local Numerator	Local Denominator	Jan 24 - Jun 24	Peer Value	Performance	Alert
Mortality Rate	1395	84122	1.6583%	1.8056%		
430 - Geriatric Medicine	588	5211	11.284%	10.953%		⚠
190 - Anaesthetics	45	201	22.388%	1.2972%		⚠

- Specialties Included: Selected specialties that match those used in the RAMI (Risk-Adjusted Mortality Index) system, focusing only on specialties with at least 25 patients to ensure the sample size is meaningful for analysis.

- More Deaths: In some specialties within Aneurin Bevan University Health Board (ABUHB), there were more deaths compared to peer health boards (similar healthcare providers).

- Anaesthetics
  - CHKS suggests there are more deaths recorded in the Anaesthetics specialty compared to peer health boards.
  - This needs detailed investigation to determine the cause. We will check whether this is due to:
    - Actual differences in patient outcomes
    - Or differences in how deaths are coded or recorded compared to other health boards.

Next Steps:

- A "deep dive" analysis will help us understand whether this finding reflects reality or if there are inconsistencies in how data is recorded.

Tier 3 Mortality Indicators RAMI

Description	Local Numerator	Local Denominator	Jan 24 - Jun 24	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	1316	1231	106.92	117.79		
430 - Geriatric Medicine	533	453	117.72	90.06		⚠
340 - Respiratory Medicine	144	81	177.89	135.74		⚠
190 - Anaesthetics	45	10.9	413	30.980		⚠

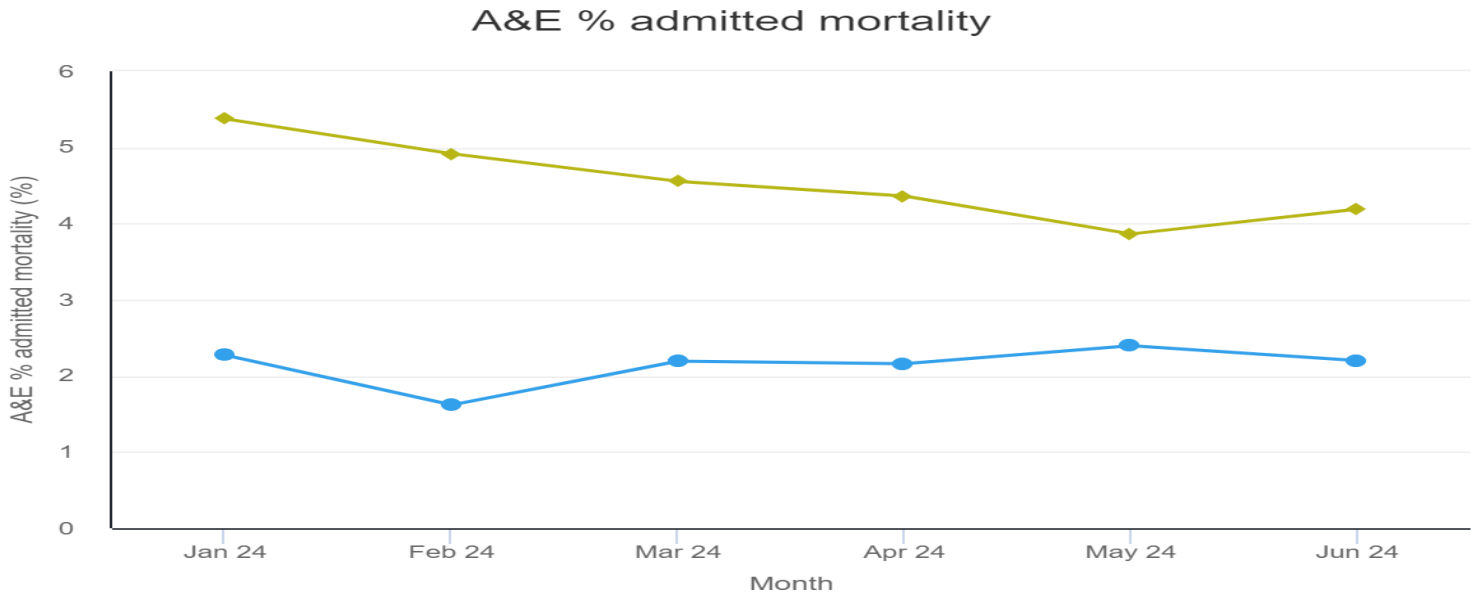
The RAMI values have been reviewed for specialties with a sample size of 25 patients or more to ensure meaningful comparisons.

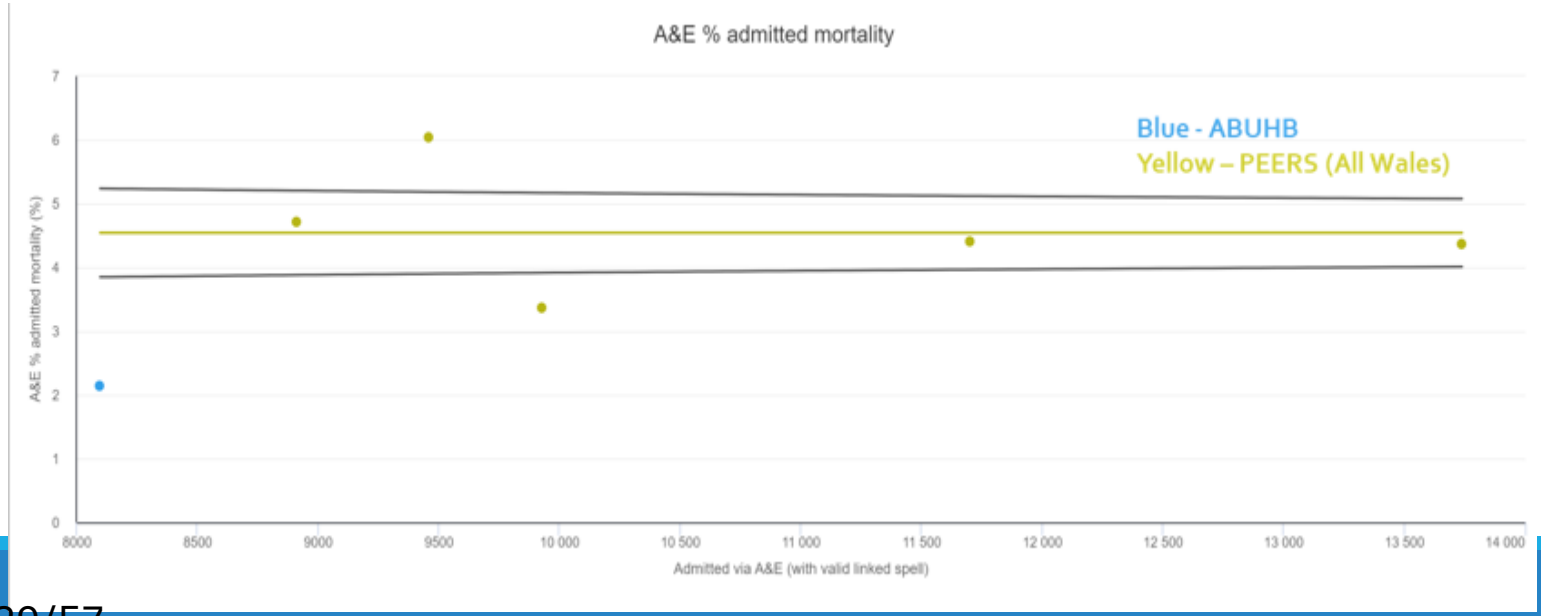
Lowest RAMI: The specialty with the lowest RAMI is Geriatric Medicine. However, this value is higher than the Welsh Peer average, indicating potential areas for improvement.

Highest RAMI: The specialty with the highest RAMI is Anaesthetics, which suggests a higher rate of mortality in this area compared to peers.

Respiratory Medicine – Coding Issue: In Respiratory Medicine, ABUHB tends to use a generic Respiratory Medicine code more frequently than other health boards. This coding practice may impact the RAMI calculation and make comparisons with peers less accurate.

Emergency Department admitted Mortality





Blue - ABUHB

Yellow – PEERS (All Wales)

- ABUHB has consistently performed below the Welsh Peer Value for ED admitted Mortality

ED Admitted Mortality Indicator

- **What It Measures**: The percentage of patients who die after being admitted from ED.
- **Purpose**: Assesses the quality of emergency and overall hospital care, highlighting potential issues like delays in treatment or inadequate assessments.
- **Influencing Factors**:
  - **Severity of Cases**: Higher mortality rates in hospitals with more severe cases.
  - **Timeliness of Care**: Delays in diagnosis or treatment can increase mortality rates.
  - **Quality of Care**: Availability of specialist services and adherence to clinical guidelines impact mortality rates.
- **Benchmarking and Improvement**: Used to compare performance with other hospitals and national standards, helping to implement targeted interventions to reduce mortality rates.

Emergency Department (Learning)

The monthly ED mortality and morbidity meetings aim to review specific cases identifying areas for improvement in patient care and outcomes. Multiple cases are discussed involving different medical conditions and patient outcomes. Cases include patients who have died or where there is learning or a diagnosis is rare or interesting in some way. **Examples include**:

- Patient A with knee pain and a missed tibial plateau fracture. Delay in medical and T&O review led to a conservative management approach after the fracture was identified later.
- Patient B with right loin pain and urosepsis. Delays in triage & treatment, insufficient documentation, lack of senior review were noted.
- Patient C with chest pain diagnosed with ruptured aortic dissection. Patient successfully transferred for surgical repair & recovering.
- Patient D with a large pulmonary embolism (PE). Issues included a missed prescription for apixaban and the need for thrombectomy.
- Patient E with wrist dislocation & ulnar nerve dysfunction following a rear-end shunt. Discussed delays in manipulation & T&O referral.
- Patient F with severe sepsis and a sore throat. The patient experienced a significant infection and required ITU admission.
- Patient G with increasing shortness of breath, history of TB exposure. Six weeks to confirm TB diagnosis, patient treated- antibiotics.

- **Immediate Actions**: Detailed discussions of each case are conducted, and immediate feedback was provided to the teams involved.
- **Long-term Strategies**: Plans to improve documentation practices, review processes, triage protocols, transfer protocols, and imaging techniques were discussed. Regular training sessions and audits were recommended.

Recommendations

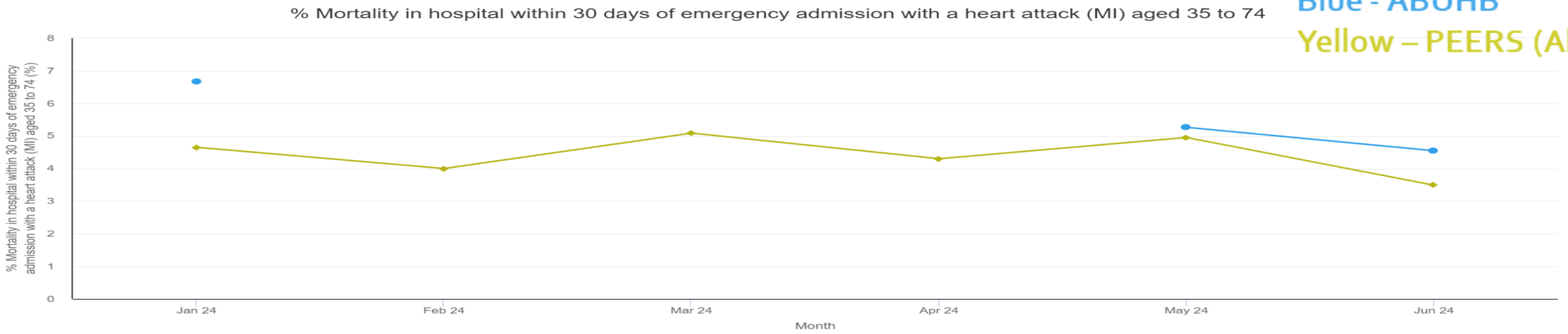
- **Documentation**: Improve documentation of patient advice, esp regarding syncope & DVLA notifications.
- **Timely Reviews**: Ensure timely medical and T&O reviews to avoid delays in diagnosis and treatment.
- **Triage and Treatment**: Enhance triage processes, ensure timely administration of antibiotics for sepsis.
- **Senior Reviews**: Increase the frequency and documentation of senior reviews to ensure proper escalation and management of critical cases.
- **Patient Information**: Clearly document patient information leaflets & advice given to patients.
- **Transfer Processes**: Improve protocols for transferring critically ill patients to ensure timely and appropriate care.
- **Imaging Techniques**: Evaluate use of different imaging techniques to ensure accurate & timely diagnosis.
- **Aggressive Treatment**: Consider aggressive treatment approaches for rare and high-risk conditions, such as gastrointestinal tumours.
- **Follow-up Care**: Ensure proper follow-up care and communication with patients, especially those with complex or chronic conditions.

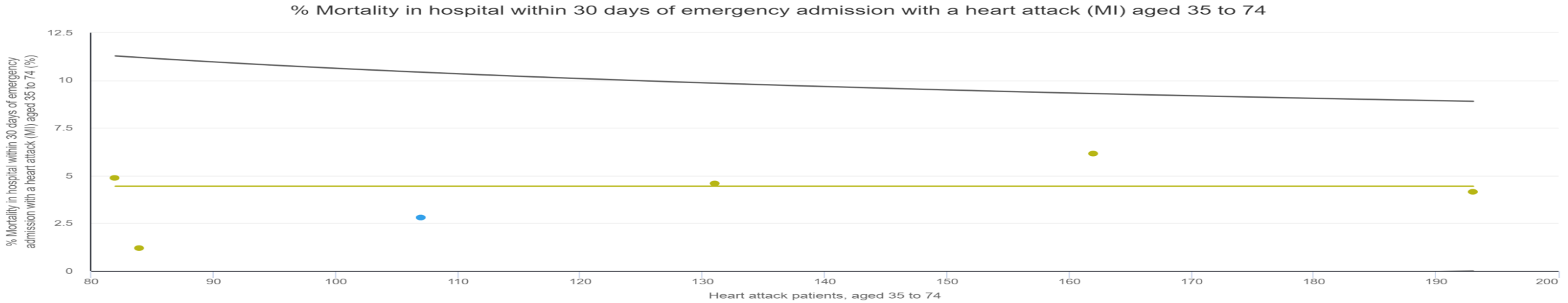
Provided by Dr Ryan Hobbs

Specific Condition Mortality MI

Blue - ABUHB

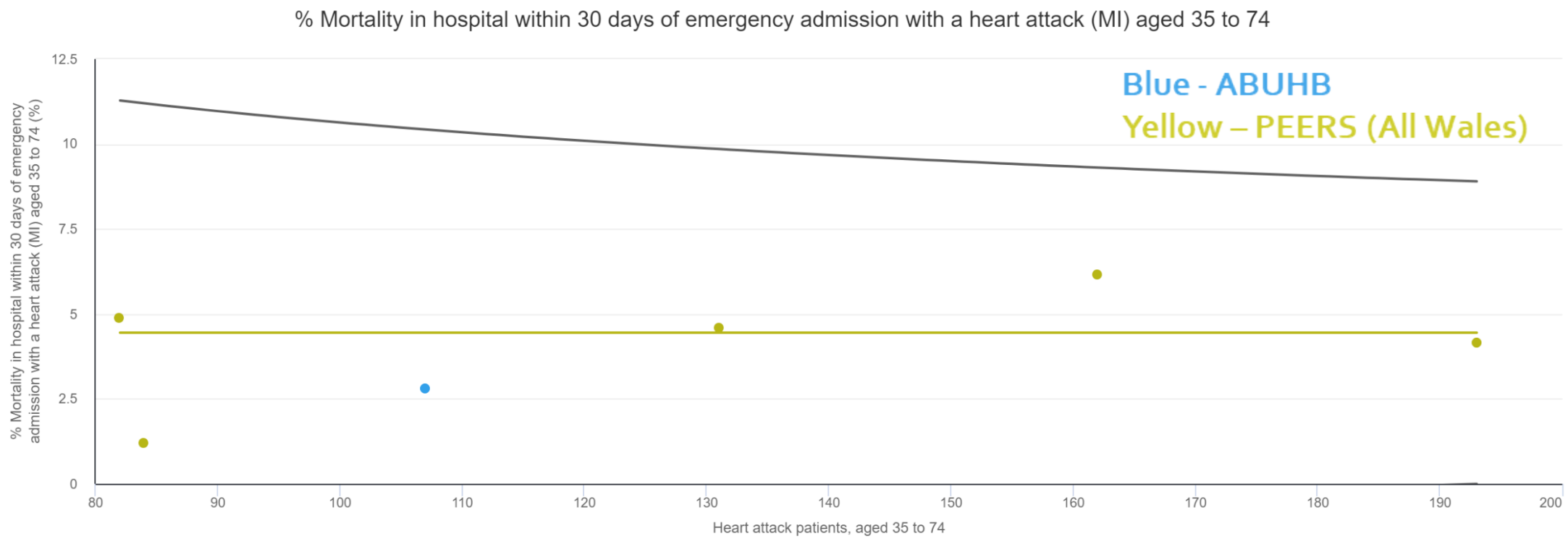
Yellow – PEERS (All Wales)





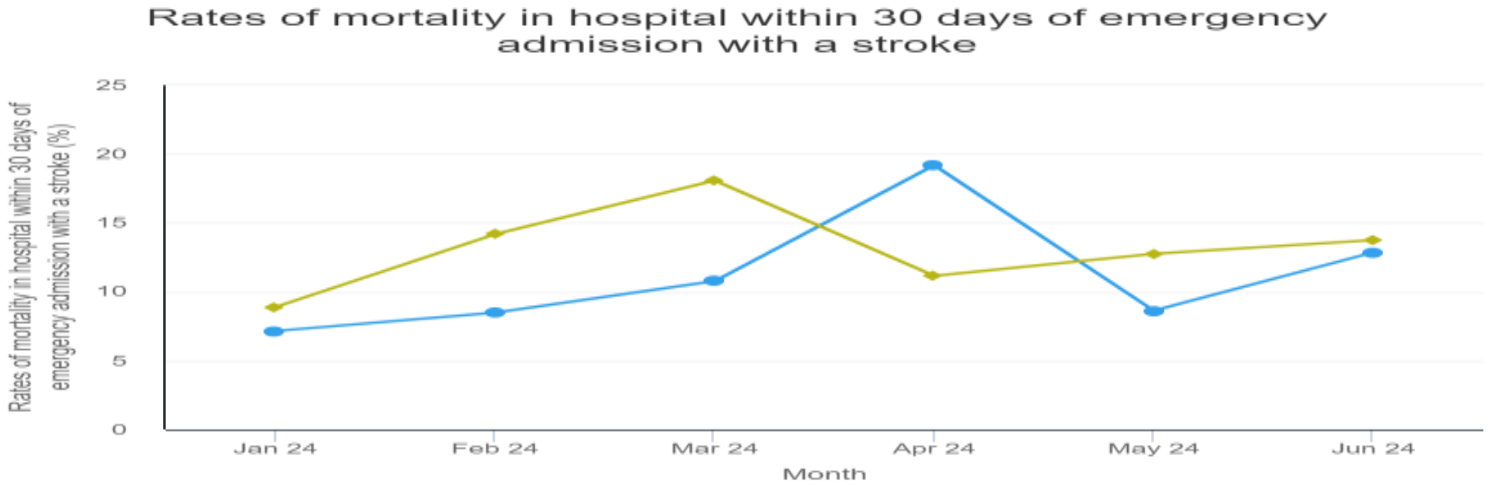
- 3 deaths between January 2024 – June 2024
- June 2024 – 4.54%
- Patients with remediable issues are transferred to Cardiff for intervention

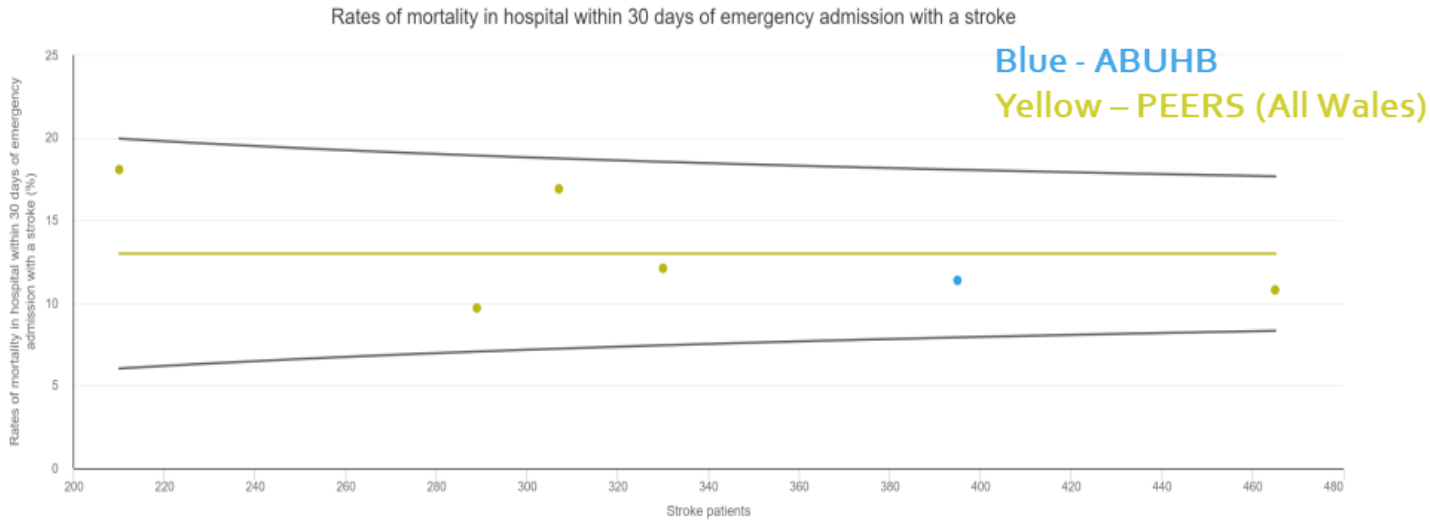
Specific Condition Mortality MI



- 3 deaths between January 2024 – June 2024
- June 2024 – 4.54%

Specific Condition Mortality (Stroke)





30-day inpatient stroke mortality is currently slightly lower than the peer average. This year is 11.4%.

Biggest risks and challenges across the Stroke pathway

Key points include:

- **Protecting the urgent intervention pathway**: Ensuring effective front door to HASU (Hyper Acute Stroke Unit).
- **Sustaining rehabilitation**: Addressing medical and therapy cover in a fragile rehabilitation pathway.
- **National Programme uncertainty**: Focus on HASU rather than the entire pathway.
- **Bristol Thrombectomy service**: Operating hours.
- **Public awareness**: FAST campaign and reaching seldom heard groups.

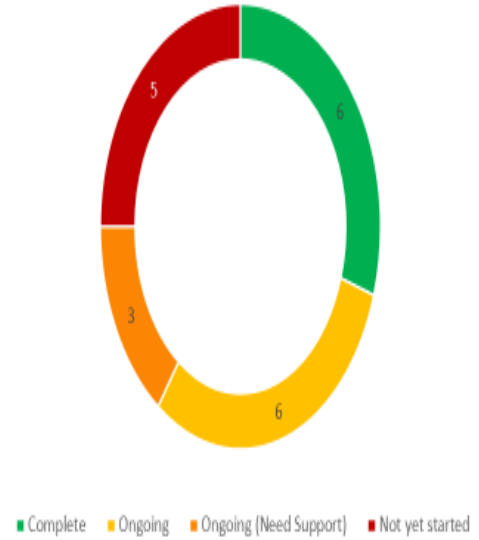
Strengths:

- Good performance in thrombolysis, timely stroke consultant access, and mortality outcomes.
- Community Neuro Rehab Service: Exemplar model for Wales, despite national funding cuts.
- Niwrostiwt Neurological Conditions Recovery College: NHS Wales Awards runner-up.
- In-house 'Living Well After Stroke' service.
- Peer support and volunteer roles in YYF.

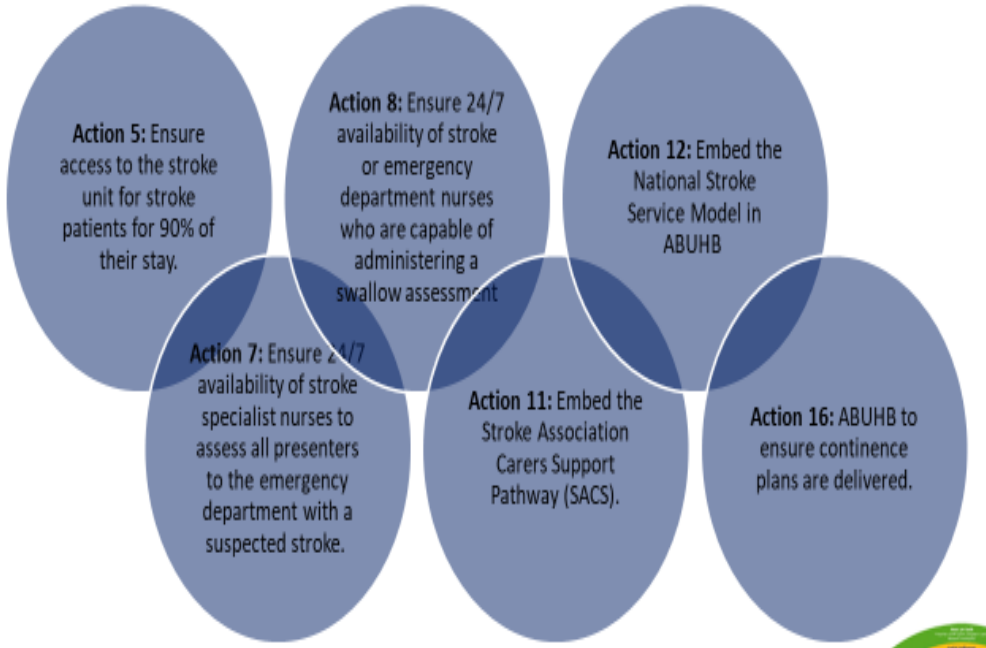
Specific Condition Mortality (Stroke)

Stroke Improvement Plan (incorporating Therapy Review, GIRFT Report, and HIW recommendations)

- 20 Recommendations across the entire stroke pathway from Pre-alert to Post-Discharge after six months
- Recommendations around process, leadership, staffing and MDT working
- Designed to improve the performance of the service and to improve patient outcomes



Ongoing work



GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board
Dyfodol Clinigol Clinical Futures

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board
Dyfodol Clinigol Clinical Futures

Learning – Acute Medicine

1. **Deteriorating Patient**

Issues Identified:

- Themes across multiple Datix incidents and Serious Incidents.
- Problems with calculating and acting on NEWS scores according to Health Board **Deteriorating Patient Policy.**
- Issues with signing off and acting on blood gas information.

Actions Taken:

- Added deteriorating patient policy to Mortality and Morbidity (M&M) reviews.
- Weekly teaching sessions.
- Reminding staff about the role of ICU outreach.

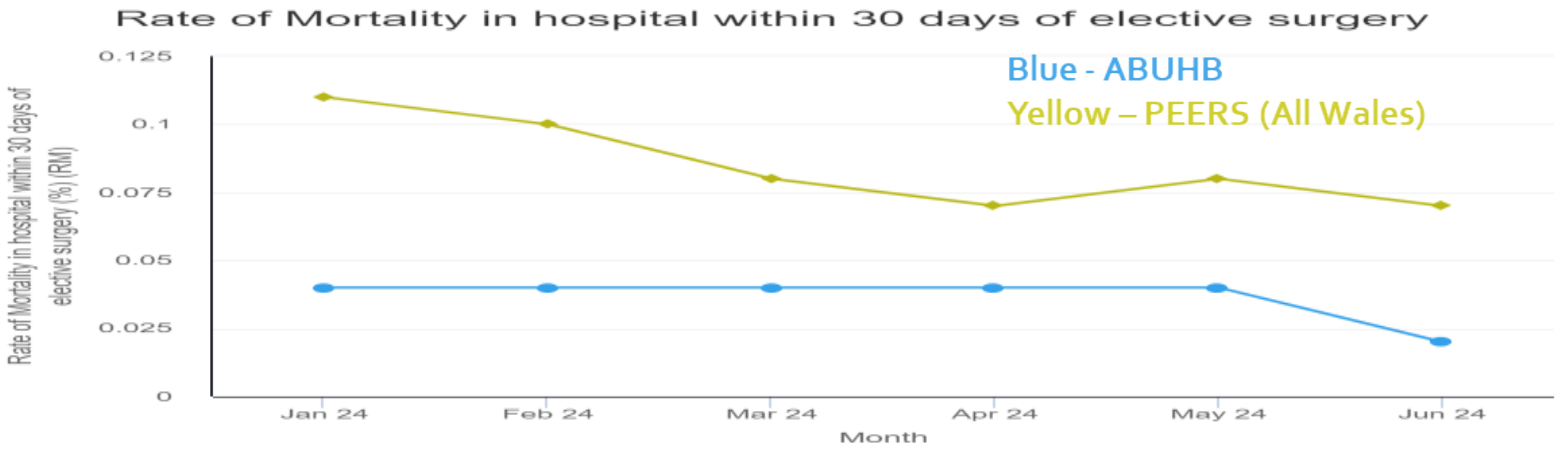
2. Discharge Documentation

Issues Identified:

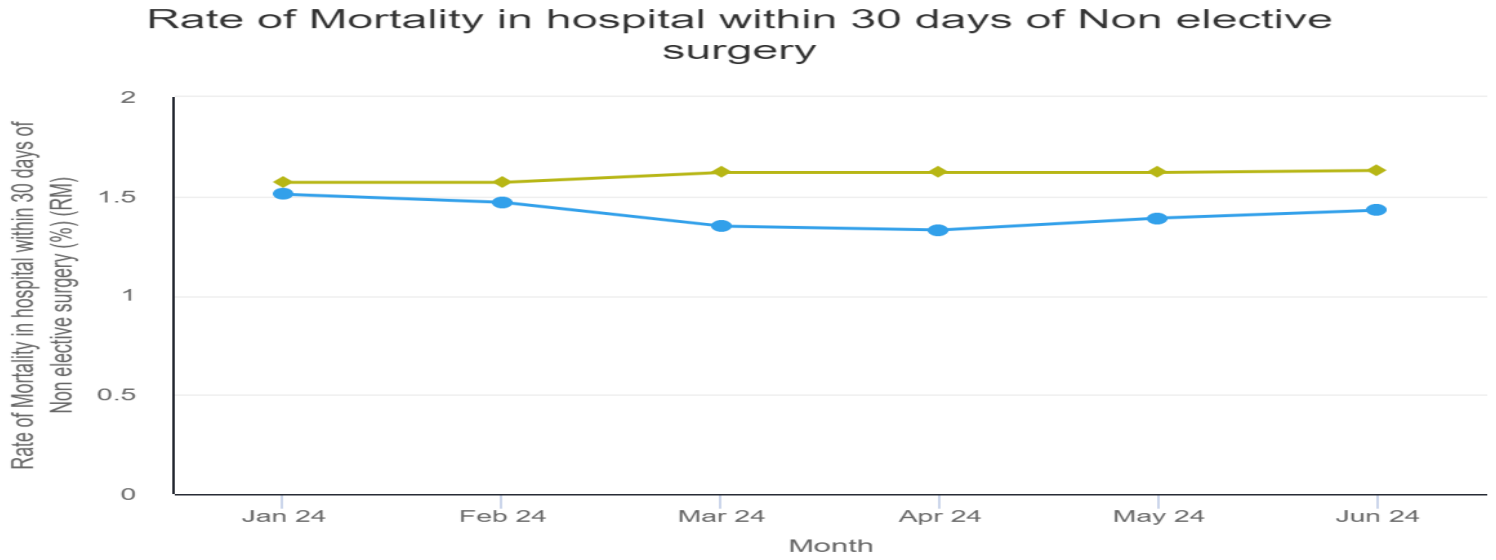
- Patients often discharged without a discharge letter.
- Prescriptions given on a WP10, leading to missed information between GPs and patients sometimes leaving without important medication.

Provided by Dr Ifor Capel

Surgery mortality

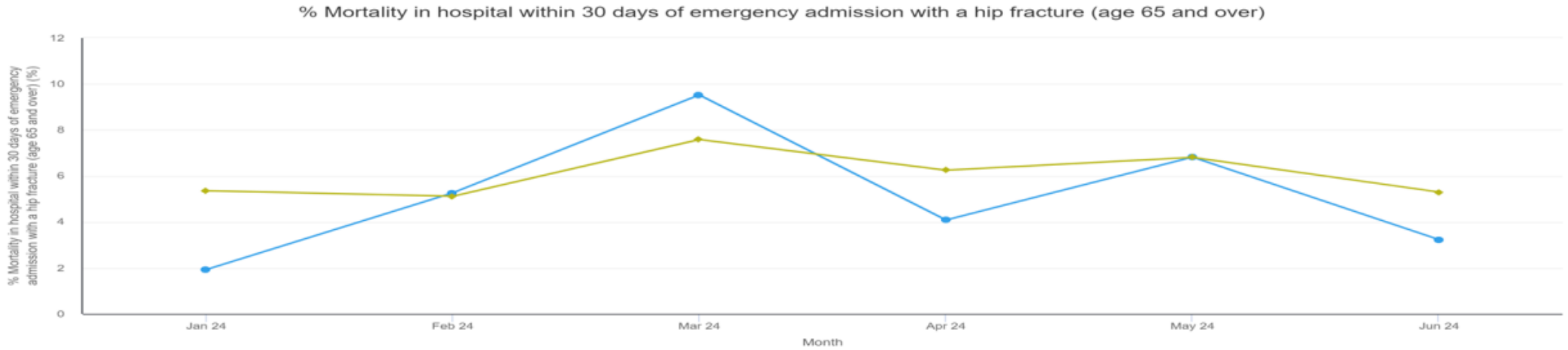


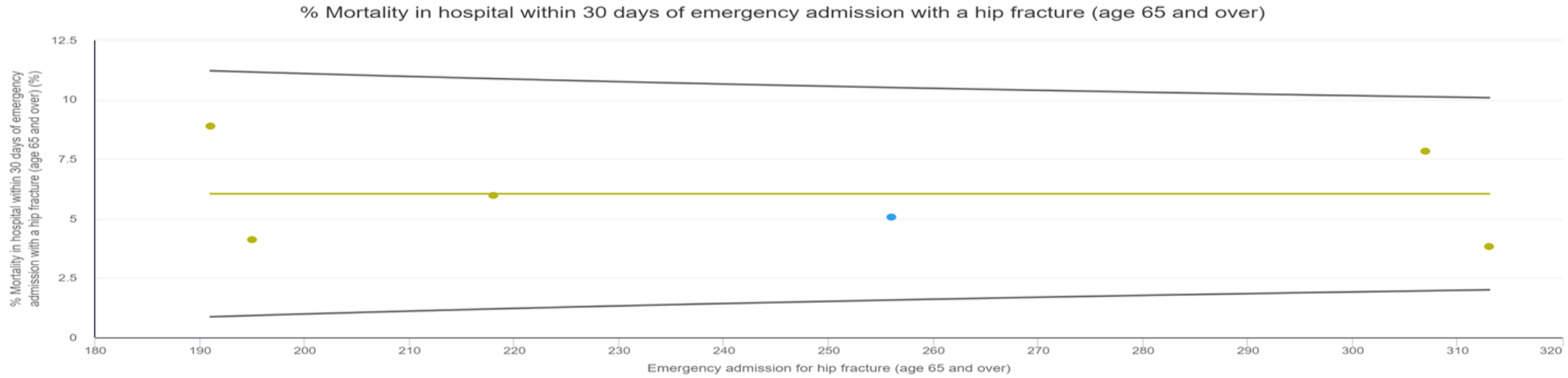
The rate of mortality in hospital within 30 days of elective surgery has decreased by 53.4%. This year was 0.03%, compared to 0.07% last year. This is lower that the All-Wales peer value of 0.15%.



The rate of mortality in hospital within 30 days of non-elective surgery has increased 5.3%. From 1.6%, as compared to 1.5%, still lowers than all the All-Wales peer value of 1.8%.

Tier Three - Condition specific mortality





- % Mortality in hospital within 30 days of emergency admission with a hip fracture (Age 65+)
- Decrease from a high in March 23 of 11.9%.

Learning – General Surgery

The weekly review meetings help the Directorate identify areas where patient care can be improved. Some key issues have been noted over the past few years that are also relevant to general surgery. We want to share these findings and what we're doing to address them:

1. **Managing Patient Transfers Between Care Levels**: Our processes for stepping patients down or up (transferring between different levels of care) can sometimes cause frail, elderly patients to be moved between sites unnecessarily. While we aim to use Treatment Escalation Plans (TEP) to guide these decisions, implementing them can be challenging, especially for patients who are terminally ill or too frail for invasive treatment. We continue to review this to improve patient experience.

2. **Improving Communication with Families**: We've identified that communication with families about a patient's care or deterioration needs improvement. With many teams involved in care, especially in high-pressure settings like The Grange model, it can be difficult to keep families fully informed. We are working on ways to make communication clearer and more consistent.

3. **Reducing Delays in Care**: reported by our Clinical Administrative (CAD) team, have shown some signs of improvement. However, we are continuing to focus on streamlining processes to reduce waiting times and provide timely care.

Provided by General Surgery Directorate Dawn Baker Lari

Learning - Critical Care Unit

The Critical Care Unit are committed to learning and improving the care delivered to patients. There is a proactive Morbidity and Mortality (M&M) process. The department also include Merit system in these discussions and call it M&M&M. These meetings help the department reflect on patient outcomes and improve the quality of care. Here are some of the changes and improvements the units have made based on these reviews:

1. **Targeting Groups for Better Care:**
Using data from ICNARC (Intensive Care National Audit and Research Centre), we've identified patient groups with slightly higher-than-expected mortality rates. For example, patients with multi-organ failure and severe liver disease. To improve outcomes, we've focused on taking a multi-specialty and multi-disciplinary approach when deciding on treatment plans, including organ support therapies and when to consider withdrawing life-sustaining treatment.

2. **Reducing Emergency Re-admissions:**
ICNARC emergency re-admissions within 48 hours of discharge from our unit. In response, we've improved our discharge processes by:

Requiring a medical-to-medical handover. Performing observations every four hours (more often than standard guidelines suggest). Completing a bedside check to confirm it's appropriate for a patient to leave the unit.

3. **Safe Transfers to Critical Care**:
After an incident involving a failure in oxygen delivery during patient transfer, we worked closely with our outreach teams and transfer practitioners to improve safety. We developed a triage risk protocol and updated our intra-hospital transfer checklist to ensure patients are safely monitored during transfers, with the right equipment and staff in place.

Learning - Critical Care Unit

4. Improving Post-Cardiac Arrest Care:
Patients who experience cardiac arrest (both in and out of hospital) often have a high risk of mortality. To improve care, we introduced a guideline based on national evidence to standardise treatment. This includes a clear bedside guide and monitoring chart to ensure consistent care, such as maintaining temperature control to support neurological recovery.

5. Enhancing Tracheostomy Care:
Recognising the need for safer tracheostomy care, our Speech and Language Therapy (SLT) team, along with ENT specialists and clinical staff, have developed:

- Standardised equipment and care plans.
- A clear local algorithm for identifying concerns and acting quickly.

6. Safe Discharge from Critical Care to Home:
More patients are now being discharged directly from Critical Care to home. To support this, our brilliant therapy teams, including occupational therapists, ensure patients are ready for this transition. We:

- Document safety advice for patients.
- Involve families to help with the discharge process and ongoing care.

Provided by Dr Hayden Stephenson and Dr Phillipa Jones

Learning from Inquests

The Health Board approaches each Inquest with learning at its heart. In the Interests of the Deceased's family, and to assist the Coroner, the Health Board will endeavour to share openly any learning, actions and improvements that have arisen from its investigations. This has included submission of;

- Patient Safety Incident Reports
- Concise Review Reports
- Divisional Action Plans
- Lesson Learning Statements

Over the last 12 months 'Lesson Learning Statements' have been submitted to provide narrative to support the formal Action Plans, providing a wider context, assurance and up to date status of actions and learning, since inception of the original action plan. These have proved effective and have been welcomed.

This has had a positive effect on the low numbers of Prevention of Future Death Reports being issued by the Coroner to the Health Board. Between 1 January 2024 – 31 June 2024 the Health Board received two Prevention of Future Death Reports.

Feedback has been provided post Inquest by the Legal Services Team on cases where learning has been identified to help promote learning within each Division and within the Health Board. Clinicians and senior members of the Divisions also regularly attend Inquest's with the Health Board's Inquest Team and assisting in feeding back the learning from deaths.

Provided by Haf Jones – Legal Services

Learning from Complaints

The Division of Medine has been reviewing themes from complaints.

- **Communication Issues**: One of the main complaints is about communication around end-of-life care.
- **Training Review**: The Division are working with the Gastroenterology team in reviewing training on bereavement and end-of-life care, including having earlier conversations with families.
- **Standardised Checklist**: A checklist is being developed to ensure a consistent process after a patient dies, supporting the bereaved.
- **Mortuary Process**: The team will work with the mortuary to create a process for staff and plan to make an educational video. This will respect spiritual beliefs and traditions.
- **Palliative Care Collaboration**: Working with palliative care to focus on communication and a family-centred approach when someone passes away and their family is called to the hospital.

- *Provided by Natalie Skyrme*

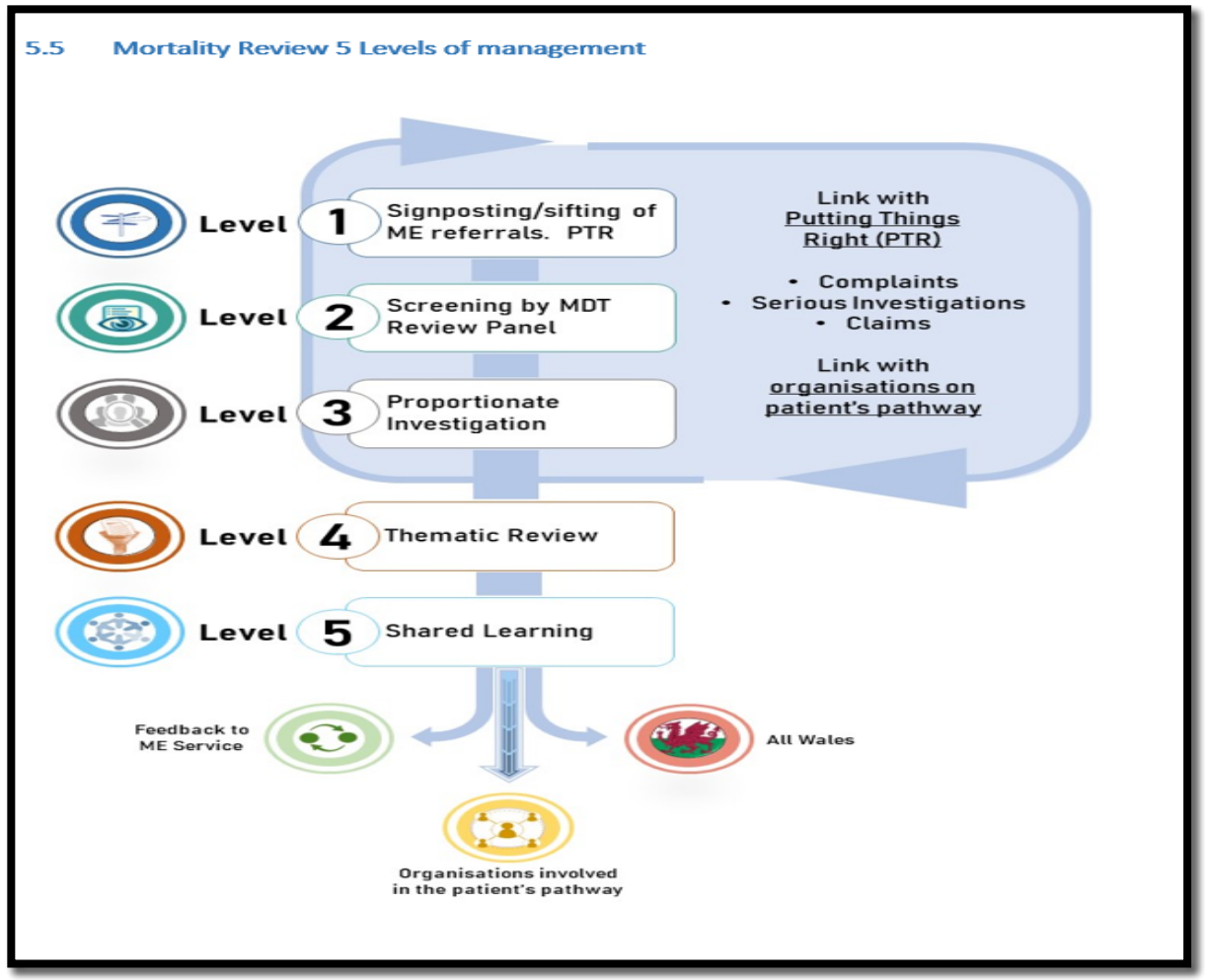
The Medical Examiner Service

The Medical Examiner (ME) Service in Wales is hosted by. NHS Wales Shared Services Partnership (NWSSP). The ME service provides independent scrutiny of all deaths that are not investigated by the coroner (HMC). Scrutiny is undertaken by an ME, who is an experienced doctor with additional training in death certification and the review of documented circumstances of the death. Their job is to ensure that an accurate cause of death of recorded, to identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

In order to provide the highest level of independent scrutiny of the cause of, and circumstances surrounding, a death, all MEs and Medical Examiner Officers (MEO) in Wales are directly employed by NWSSP, and Medical Examiners will generally not be involved in the scrutiny of deaths in the area in which they work. Updates can be found at: Medical Examiner Service - NHS Wales Shared Services Partnership.

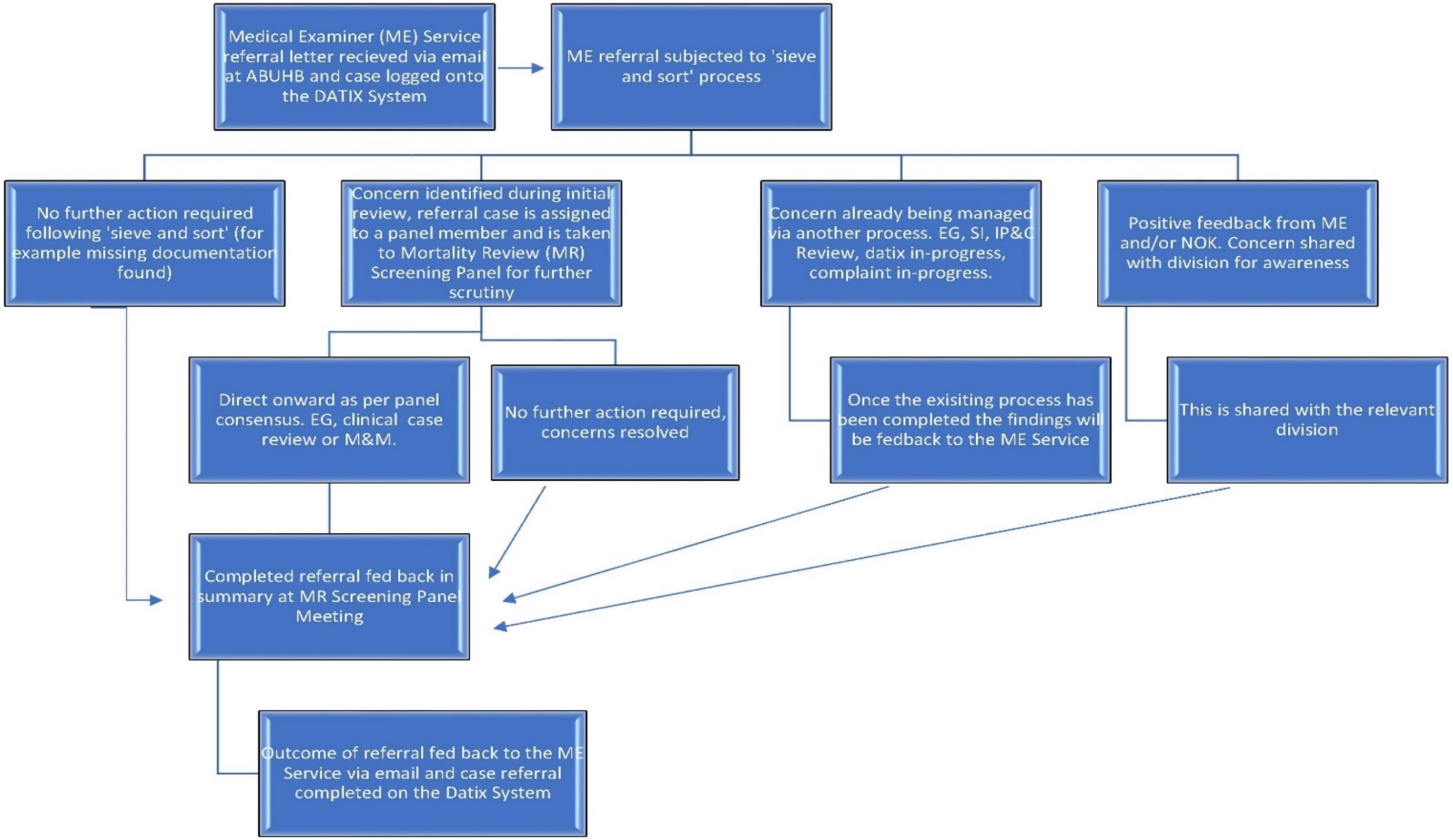
The ME Service system provides external, independent scrutiny of the treatment and care delivery and reports back cases for concern to the Health Board for further review.

ABUHB Mortality Review Process



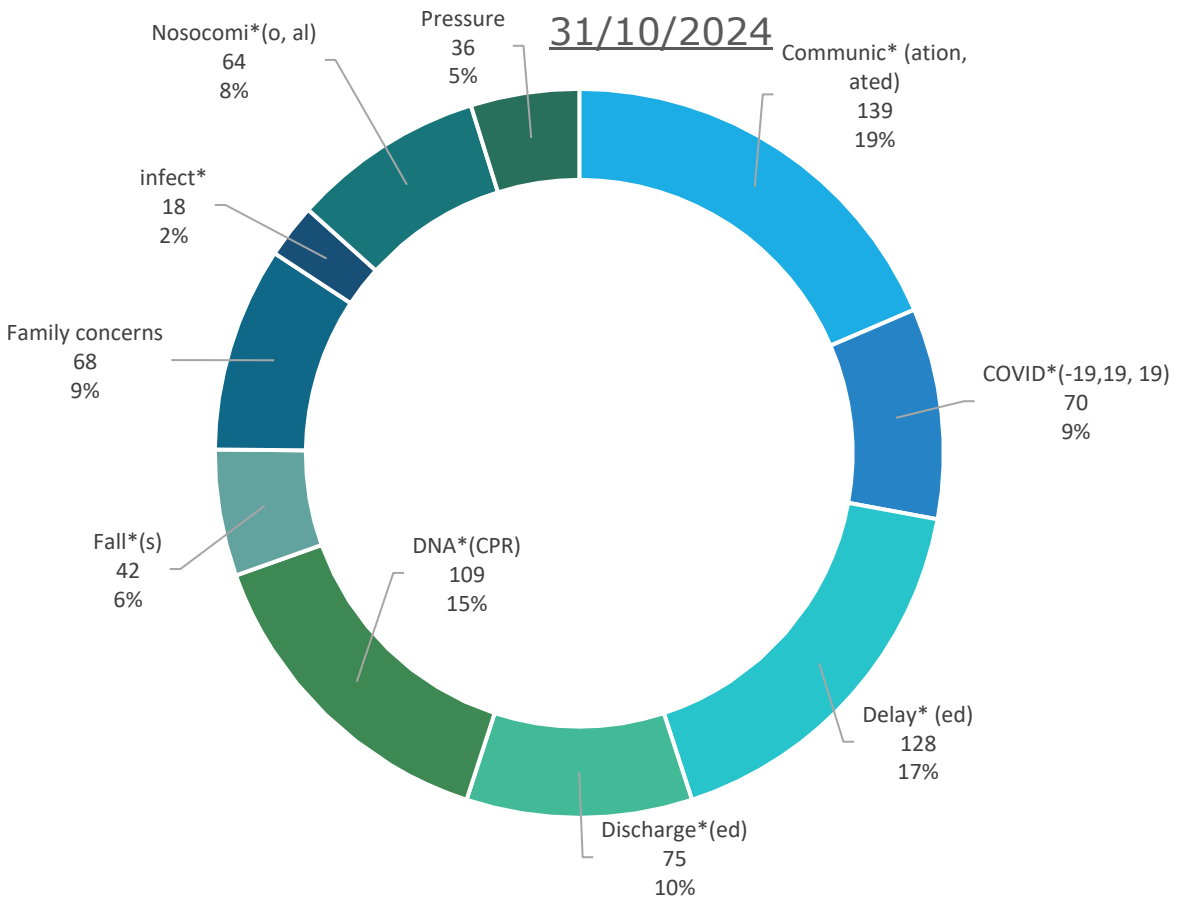
- All mortality cases referred to the Health Board by the Medical Examiner (ME) undergo an initial review (level 1) to determine if further action is needed and avoid duplication.
- If further investigation is required, the case moves to a level 2 review, where it is discussed by the Mortality Review Screening Panel. This multidisciplinary panel meets weekly to review cases and decide on necessary actions, which are then assigned to relevant teams or clinicians.
- Actions may include clinical reviews at mortality and morbidity (M&M) meetings, investigations under PTR processes, or reviews by specific panels such as the Falls Review Panel. This constitutes a level 3 review.
- The ME service was fully implemented by the end of 2024, covering all deaths, including those in Primary Care and Community. No paediatric or maternity death referrals have been received from the ME Service yet.
- As the ME service has been continually increasing – this data set looks at a longer period of time.

ABUHB Mortality Review Screening Panel Process



of Times Words Appear in **'Reason for Referral'** in M.E Document

For Inpatient Deaths between 01/12/2023 AND 31/10/2024



This analysis helps us understand the key areas for improvement in patient care, especially around **documentation, communication, and timeliness**. NHS Wales is committed to addressing these themes to improve the quality of care and patient experience

Thematic Analysis of Referrals to the Medical Examiner Service identifies common themes in the reasons for referrals to the Medical Examiner (ME) service. Here's what the data shows:

DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)

- 109 referrals (15%) mention DNACPR forms.
- This is similar to the 114 referrals (14%) recorded in the previous data set.
- The timeframe for the latest data is shorter (335 days compared to 426 days previously), so while the percentage remains similar, the number has slightly decreased.
- Issues often involve DNACPR forms not being co-signed correctly in part 6.

Communication Issues

- Communication remains a common theme, covering interactions with families, clinicians, and the Care After Death Team.
- Referrals related to communication have increased from 13% previously to 139 referrals (19%) in the latest data set.
- This increase is expected as the ME service has expanded and is handling a higher volume of referrals.

COVID-19 Related Referrals

- Referrals related to COVID-19 (either caught in hospital or in the community) remain consistent at 9% in both the previous and current data sets.

Pressure Damage

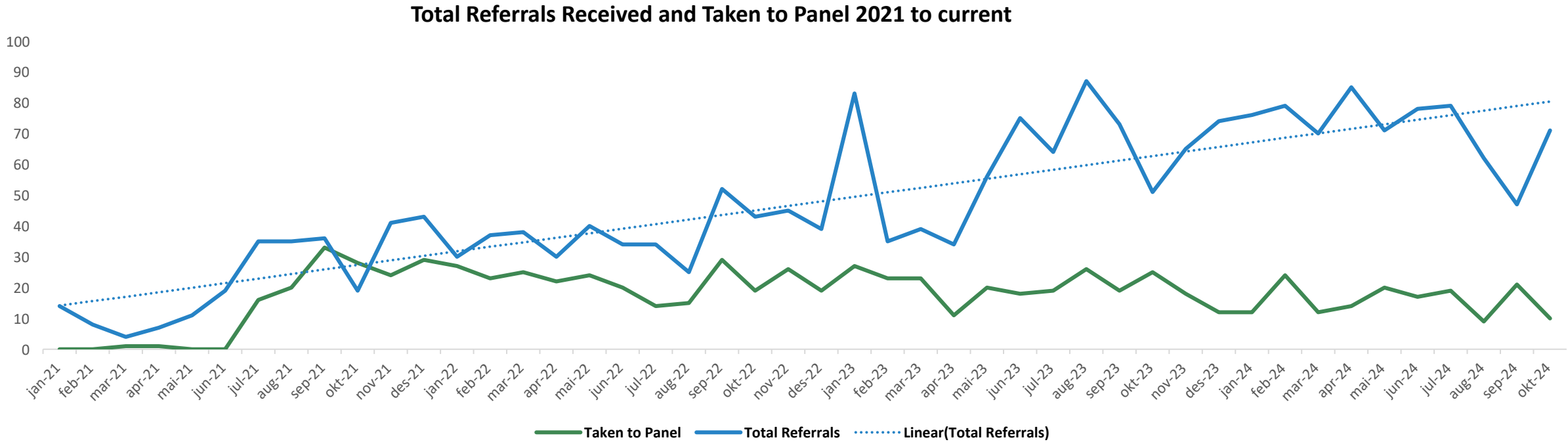
- Referrals due to pressure ulcers or injuries have significantly decreased: From 86 referrals (11%) in the previous set to 36 referrals (5%) in the latest set.

Delays

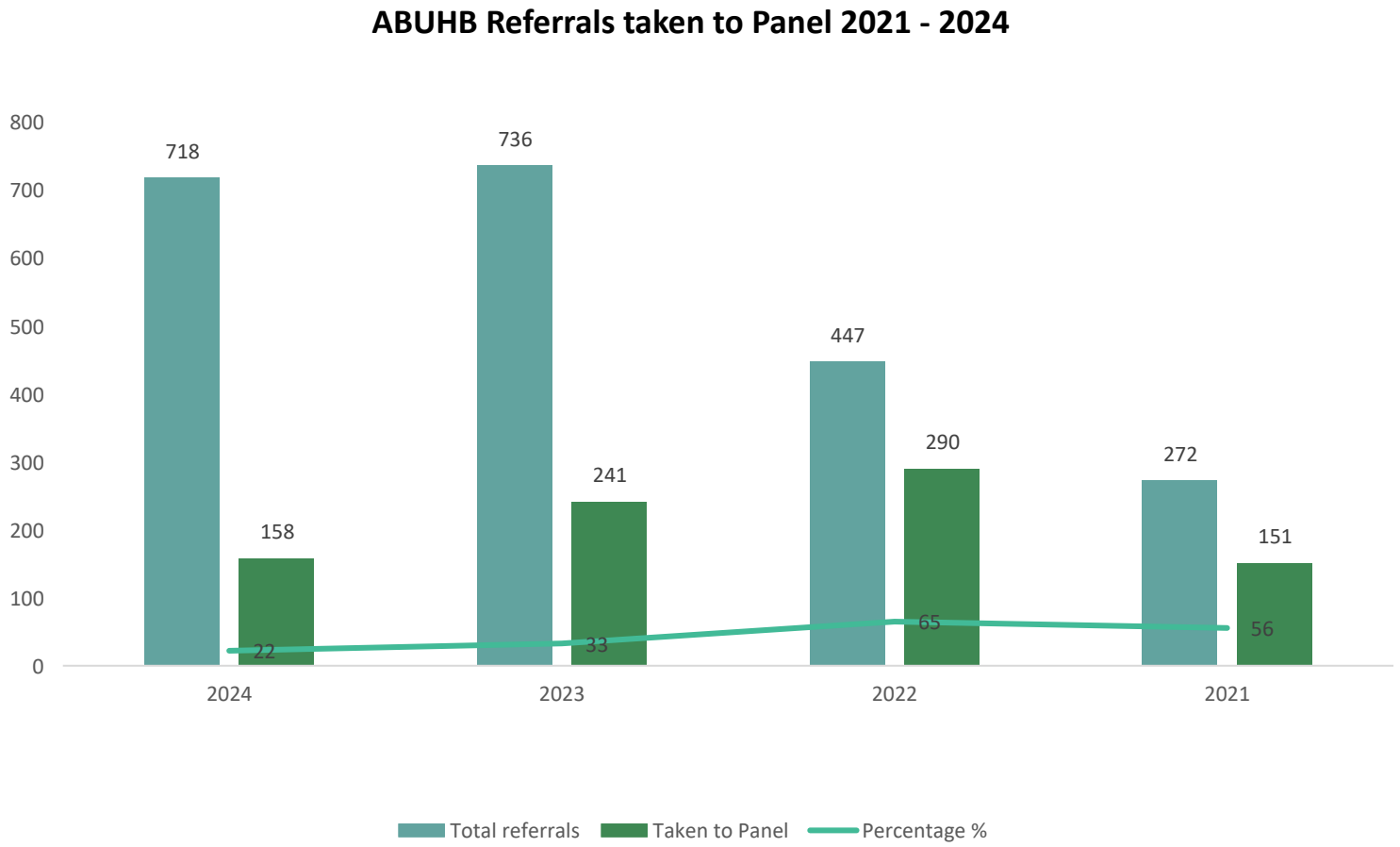
- The term 'delayed' has appeared more frequently in the recent data. This can refer to:
- Perceived delays in treatment or investigations.
- Delays related to ambulance response times.
- Concerns raised by Next of Kin (NOK) or the ME service.

ABUHB Mortality Review Service Growth

- **Growth of Mortality Review**: Since the Medical Examiner (ME) service started in 2021, the ABUHB Mortality Review Screening Process has grown, especially in 2024 when it expanded to cover community settings.
- **Case Gap**: There's still a gap between the number of cases received and those that proceed to panel.
- **Resource Strain**: The ME service was started without extra resources or investment, putting a strain on the Medical Directors' team and reducing resources for clinical audits. This strain has increased since the service expanded to the community.



ABUHB Mortality Review Service Growth



The graph illustrates the substantial gap between the number of cases which proceed to panel and those which are closed at level one or managed via an existing route (for example; on-going incident investigation, falls panel scrutiny or SI).

This graph further reinforces the increase in referrals received.

	01/10/2022 to 01/12/2023	01/12/2023 ot 31/10/2024
Number of Days	426	335
Total ME Referrals	797	783
No Further Action	405 (51%)	164 (21%)
Referred to...		
IP&C	70 (9%)	33 (4%)
Cardiac Audit	11 (1%)	8 (1%)
Awareness	88 (11%)	39 (5%)
Positive Feedback	27 (3%)	15 (2%)
M&M	51 (6%)	13 (2%)
SI*	47 (6%)	20 (3%)
Clinical or Concise Review	73 (9%)	22 (3%)
Discharge Review	0	4 (1%)
ME referred to Coroner	153 (19%)	150 (19%)
Closed on Datix	6 (1%)	140 (19%)

ME Referral Destination

- **Data Comparison**: It's hard to compare this data set with the previous one due to changes in terminology and processes. The previous data set also covered 91 more days.
- **No Further Action**: Referrals needing no further action at level 1 have decreased. This includes concerns already being investigated through other processes, like Datix. The decrease might be due to better quality referrals and fewer duplicate concerns.
- **IP&C Referrals**: These have decreased, matching the drop in nosocomial COVID-19 cases.
- **SI Referrals**: Serious Incident (SI) referrals have also decreased.
- **HMC Referrals**: The number of cases referred to the Health and Mortality Committee (HMC) remains steady at 19% in both data sets.

Positive Feedback

She said the care (*her mother*) received was excellent and she could not have wished for better care.

"At every point (the staff) were all amazing. Communication was excellent - we knew everything they were doing and why. They really looked after me and my mum too. I really can't thank them enough"

The care (*he*) received was marvellous and (*they*) couldn't fault it.

The team were absolutely brilliant.

She said the actual nurses and HCAs were amazing, they looked after the family as well as (*her husband*). She said "they were absolutely lovely".

She said "I honestly can't fault them at all, they gave 100%". She said (*the staff*) were very attentive, very respectful and mindful.

The care (*Dad*) received was fantastic

The care (*her husband*) received was excellent on both wards that he was on during his last admission. She said the nursing team were brilliant and she couldn't thank them enough.

I was very impressed by all the nurses and clinicians who cared for mum. I'm very grateful to them"

She said the care was excellent.

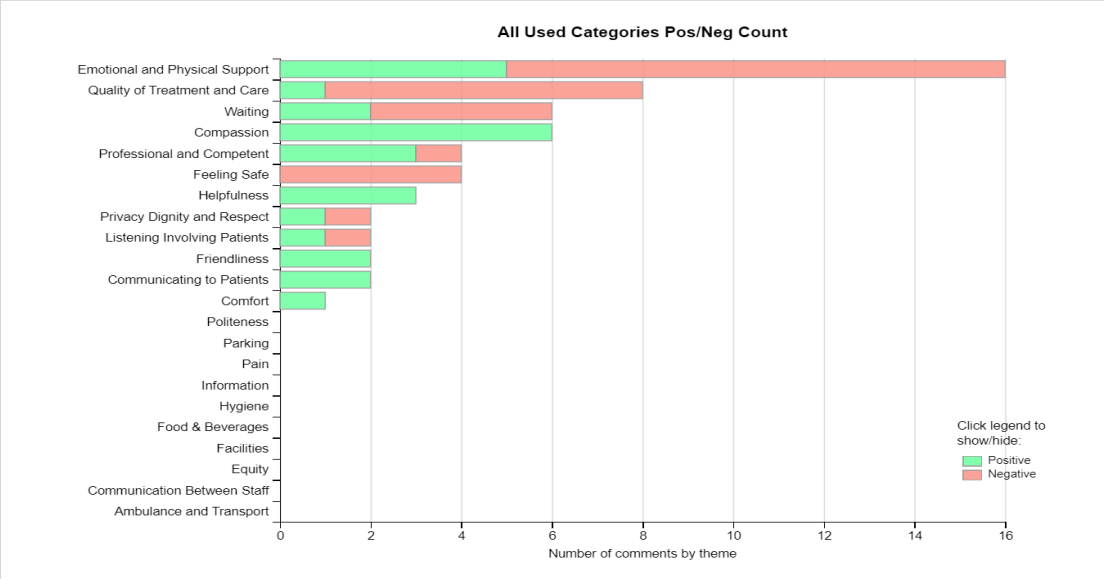
In the hospital (*the staff*) were second to none, absolutely brilliant, the ward staff were brilliant and the ward manager superb.

Bereavement Survey

Bereavement Survey (CIVICA)
1st Sept 2024 – 30th Nov 2024

74	44%
Responses	Satisfaction

A new bereavement survey has been created and built into the CIVICA patient feedback system, this has been shared with ABUHB Bereavement Collaborative, the results reflect the feedback from the collaborative members, this survey will be publicised in January 2025.



Bereavement Survey

Heat Map - 1st Sept 2024 – 30th Nov 2024

Location/Department	Responses	8 - Were you contacted by anyone following your loss?	10 - Were you offered any bereavement support?	12 - How soon did someone contact you for bereavement support?	14 - Did you find it helped you?	17 - Were you able to communicate in your preferred language?	18 - How would you rate your overall experience?	Overall
		Bereavement Survey/Arolwg Profedigaeth	Bereavement Survey/Arolwg Profedigaeth	Bereavement Survey/Arolwg Profedigaeth	Bereavement Survey/Arolwg Profedigaeth	Bereavement Survey/Arolwg Profedigaeth	Bereavement Survey/Arolwg Profedigaeth	
End of Life & Bereavement Service	66	20	16	72	58	93	38	44
	Overall	20	16	72	58	93	38	44
	Benchmarks	85	85	85	85	85	85	85

Next steps

- Work with Directorates to establish mortality indicators
- Develop a Mortality Review Committee
- Ensure there are robust and timely governance processes regarding mortality outcomes within the Health Board
- Increase engagement with clinicians regarding mortality processes
- Improve identification of learning from mortality reviews
- Establish Mortality and Morbidity meetings throughout all Directorates
- Establish the mortality outlier model in CHKS to create alerts
- Develop and implement the mortality review process for deep dives into directorates with condition specific mortality lying outside control limits

Glossary

DEFINITIONS FOR THE REPORT

Graph and chart glossary

Risk-Adjusted Mortality Index (RAMI)

- **What It Shows**: A comparison of hospital mortality rates after adjusting for patient risks like age, health conditions, and severity of illness.
- **How to Read It**: Compare the Health Boards RAMI score to 100. A score **below 100** means fewer deaths than expected; a score **above 100** indicates more deaths than expected

Crude Mortality Rates

- **What It Shows**: The number of patients who died in the hospital without adjusting for risk factors.
- **How to Read It**: A rolling monthly total of mortality within Hospital.

Deaths Per 1,000 Occupied Bed Days

- **What It Shows**: The number of deaths in relation to the total day's hospital beds were used.
- **How to Read It**: Look for trends—if the rate is decreasing, it indicates improvement in patient outcomes. Spikes might suggest seasonal factors or specific issues requiring attention.

Graph and chart glossary

MI-Related Mortality

- **What It Shows**: Death rates within 30 days of admission with an MI
- **How to Read It**: Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

Stoke-Related Mortality

- **What It Shows**: Death rates within 30 days of admission with a Stroke
- **How to Read It**: Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

A&E Admitted Mortality

- **What It Shows**: Death rates where patients have been admitted via A&E
- **How to Read It**: Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

MMBRACE-UK

All deaths are reported to MMBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) ensures the quality of neonatal care through:

Systematic Review and Surveillance:

- **National Surveillance**: Collects data on late fetal losses, stillbirths, and neonatal deaths to identify trends.
- **Perinatal Mortality Review Tool (PMRT)**: Facilitates thorough, multidisciplinary reviews of neonatal deaths.

Detailed Investigations:

- **Confidential Enquiries**: Conducts in-depth reviews of selected cases.
- **Root Cause Analysis (RCA)**: Identifies systemic issues and care delivery problems.

Governance and Accountability:

- **Annual Reports**: Provides insights and recommendations.
- **Board-Level Oversight**: Ensures accountability and compliance through regular reporting.

Quality Improvement Initiatives:

- **Targeted Actions**: Develops interventions like staff training and protocol revisions.
- **Monitor Impact**: Tracks effectiveness of changes.

Learning and Communication:

- **Multidisciplinary Learning**: Organises sessions to address gaps.
- **Transparency**: Engages families and publishes findings.

This approach ensures robust scrutiny, promotes patient safety, and drives quality improvements in maternal and neonatal care.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Pharmacy and Medicines Management Annual Report 2023-24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jonathan Simms, Clinical Director of Pharmacy

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

ADRODDIAD SCAA / SBAR REPORT

Sefyllfa / Situation

Wales Audit Office (WAO) recommended that health bodies should have an annual agenda item at the Board (or relevant committee) covering pharmacy services, medicines management, primary care prescribing and homecare medicines services.

There is also an expectation from Welsh Government that an annual prescribing report showing progress in priority areas of safe prescribing, antimicrobial stewardship and value is scrutinised by the Board or the Patient Quality, Safety and Outcomes committee.

The annual report provides an update on these areas together with other key developments which have been mapped to the six domains of quality - safe, timely, effective, efficient, equitable and person centred.

The Report was accepted by the Executive Committee 19th December 2024.

Cefndir / Background

In 2016 the Wales Audit Office (WAO) published a report on 'managing medicines in primary and secondary care' following individual health board reviews in acute hospitals and primary care. The report was subsequently considered by the Public

Accounts Committee and recommendations published, which have been considered by Welsh Government.

One of the original recommendations identified in the WAO report was the need for prescribing and medicines management to have a higher profile within health boards and to have an annual agenda item at the Board to discuss an annual report.

Asesiad / Assessment

The Committee is asked to specifically note the following areas identified within the annual report.

1. In January 2024, the Pharmacy Service published its Vision and Mission Statement.

   "To deliver a gold standard of excellence in everything we do, for the benefit of all"

   Within this are 5 strategic goals in line with the ABUHB Clinical Futures plan. This has also been supported by career pathways and roles and responsibility guidance to support workforce development.

   This work has been in response to the current workforce challenges within the acute pharmacy service. Benchmarking data shows that the level of pharmacy staffing per 100 beds is below the national and Welsh averages. Total WTE in post per 100 beds is 17.4, whilst the total WTE establishment per 100 beds is 19.5, reflecting current vacancy rates of 11% (Wales mean 5.8%). This, together with high staff turnover rates and sickness, results in an increasingly stretched workforce. Our approach to this is discussed in section 8.2 of the report.
2. The Value and Sustainability work programme to deliver on the 13 national recommendations set by Welsh Government overseen by the Medicines Management Programme board.
3. Service developments included
   - approval of the business case for the new pharmacy robot in the Royal Gwent Hospital.
   - the Pharmacy Emergency Department service, which became fully operational in July 2023.
   - securing funding for the Value based Healthcare Diabetes (Cardio Renal) Project.
   - the extension of the Pharmacy Community Resource Team to all boroughs following a successful Regional Integration Fund bid.
4. The contribution of pharmacy services to improved patient safety and medicines governance through direct patient care and the work of the Medicines and Therapeutics Committee, Medicines Safety Group, and the Controlled Drugs Local Intelligence Network (CDLIN).
   - The report describes progress with the goals identified in the Medication Safety Strategy which was launched in March 2022.

- Progress made in implementing the regulatory requirements for Valproate prescribing.
- Appointment of the Clinical Director of Pharmacy as the new ABUHB Controlled Drug Accountable Officer and development of an action plan to ensure suitable governance arrangements are in place for the management, administration, and storage of controlled drugs.
- The compliance required to ensure Home Office licencing for controlled drugs within Pharmacy departments and other services.

5. The performance of the Health Board against the National prescribing indicators.

Argymhelliad / Recommendation

The PQSOC is asked to note the contents of the Pharmacy and Medicines Management Annual Report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	NA
Safon(au) Gofal ac Iechyd: Health and Care Quality Standard(s):	2.6 Medicines Management 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
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:	
Workforce	Not Applicable
Service Activity & Performance	
Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment	**No does not meet requirements**
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. Choose an item.

Aneurin Bevan University Health Board

Pharmacy and Medicines Management Annual Report 2023-24

"Our service aims to provide safe, home to home, timely, patient focused care, to empower patients to stay healthy, to improve health, to reduce harm and maximize efficiencies from medicines."

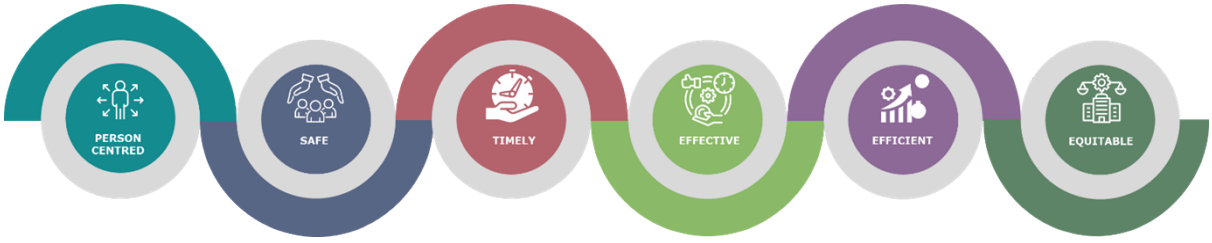


Table of Contents

1 Executive Summary

The Wales Audit Office (WAO) report **Managing medicines in primary and secondary care | Audit Wales,** recommends that prescribing and medicines management maintains a high profile across each Health Board (HB). This annual report provides an overview of ABUHB pharmacy services, medicines management (MM), primary care prescribing, homecare medicines services and controlled drugs (CD) management. Additional key developments have been identified which are mapped to the Health and Care Quality Standards 2023. These also support the ambitions of 'Pharmacy: Delivering a Healthier Wales to transform pharmacy services in Wales.'

> **Next three year plan launched to transform pharmacy in Wales | GOV.WALES**
>
> **Pharmacy: Delivering a healthier Wales (rpharms.com)**

The delivery of pharmacy services necessitates a workforce that is highly skilled, focused, and motivated to ensure the provision of high-quality patient care across various sites and settings. Current ABUHB acute/secondary care pharmacy staffing levels, benchmarked as number of staff per 100 beds, are below both national and Welsh averages. Total WTE in post per 100 beds is 17.4, whilst total WTE in establishment per 100 beds is 19.5, reflecting current vacancy rates. The Wales Median overall is 18 WTE per 100 beds against a median of 20.1 WTE in England.

Acute pharmacy team vacancy rates are 11% (Wales mean 5.8%, England & Wales combined 17%), placing ABUHB in the upper quartile of Welsh peers. The pharmacist vacancy rate is 13% (Wales mean 7.4%), also in the upper quartile. There is a clear vacancy issue with band 7 Pharmacists, where ABUHB currently has a 50% vacancy rate compared to the national average of 31%, resulting in a substantial impact on delivery of ward-based services across all sites. Due to the high pharmacist vacancy rate, the pharmacy team relies more heavily on pharmacy technicians compared to peers nationally.

The pharmacy workforce at ABUHB faces significant challenges. Establishment baseline per 100 beds is low compared to the rest of Wales. This, combined with a high vacancy rate of 11%, a 10.4% staff turnover rate, and a high sickness/ absence rate of 7%, particularly for pharmacists — results in an increasingly stretched workforce.

Staffing is therefore one of the greatest risks to pharmacy services in the future. Our approach to this issue is set out in Section 8.2

Key Drivers/Documents

The duty of quality came into effect on 1 April 2023. It introduced the Health and Care Quality Standards and applies to NHS bodies in Wales with two overarching aims:

- To improve the quality of healthcare services
- To improve outcomes for people in Wales

Duty of Quality - Home (sharepoint.com)

Health and Care Quality Standards - NHS Wales Executive

The 12 Health and Care Quality Standards 2023 are Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEP) care delivered through: Leadership, Workforce, Culture and Valuing People, Information, Learning, Improvement and Research, Whole Systems Approach.

2023-24 saw several key strategic publications which influence pharmacy services in Wales:

- **CEPP National Audit - focus on antibiotic prescribing** (April 2023) developed to promote antibiotic prescribing in accordance with existing guidelines and to support clinicians in promoting quality improvement by reviewing antimicrobial prescribing within their practice.

- May 2023, Welsh Government (WG) **Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES**

- June 2023, Health Education and Improvement Wales (HEIW) launched the **Strategic Pharmacy Workforce Plan - HEIW (nhs.wales)** The 10-year plan set out long term goals, principles, and short-term actions needed to transform the pharmacy profession in Wales. It has 31 key actions that will drive change and improvement in how to develop, value, and support the whole pharmacy workforce throughout Wales.

- September 2023, the RPS Wales review, `**Prescribing progress: Transforming clinical hospital pharmacy in Wales for enhanced**

patient care,' made 36 recommendations covering areas including patient-centred care, prescribing, use of technology and workforce development

- The WG response to the Welsh Hospital review, also published September 2023, committed to 61 "strategic actions" providing a blueprint for transforming hospital clinical pharmacy services to meet the ambitions set out in the RPS's long-term vision for pharmacy in Wales. To address these actions, the Directors of Pharmacy peer group has undertaken a prioritisation exercise and assigned actions to each director to take forward collaboratively across Wales.

- **Decarbonisation: inhaler prescribing, use and disposal 2023–2030. A national strategy for Wales** (November 2023) sets out a national strategy to reduce carbon footprint of inhalers and outlines key actions for the NHS and its partners in Wales.

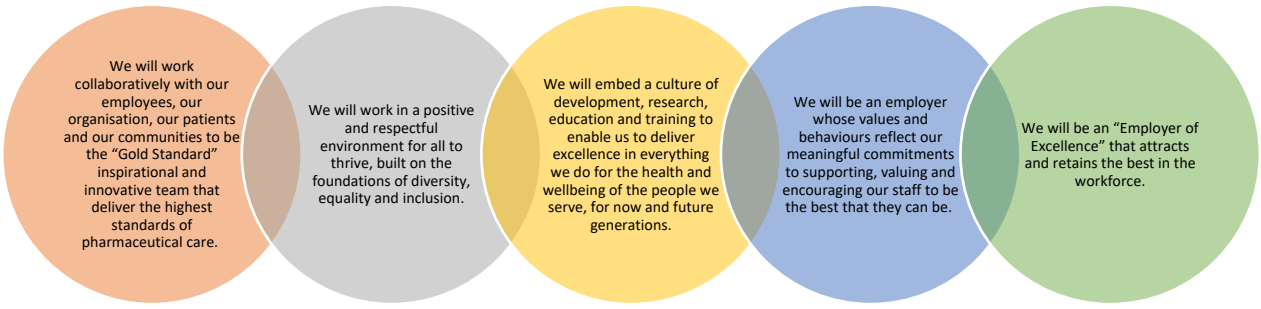
- February 2024, AWMSG endorsed their new 5-year Medicines strategy **AWMSG Strategy for Wales: 2024-2029 - All Wales Therapeutics and Toxicology Centre (nhs.wales),** improving the health and wellbeing of people in Wales by enabling patients to get the best outcomes from their medicines.

Pharmacy Vision

In January 2024, ABUHB Pharmacy Service published its newly designed Pharmacy Vision and Mission statement.

"To deliver a gold standard of excellence in everything we do, for the benefit of all"

As part of this document, the 5 strategic goals are in-line with the ABUHB Clinical Futures plan.



"The strategic goals are in line with the ABUHB Clinical Futures strategy, "Pharmacy: Delivering a Healthier Wales" the WG Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales and "The Wellbeing of Future Generations Act".

We seek to embed Pharmacy staff as an integral component of multi-professional teams – providing a golden thread of leadership, support and expertise in all areas of a patient's journey linked to medicines. This will include medicines procurement, medicines preparation, medicines optimisation and clinical management, addressing health inequalities and continuously improving patient safety."

2 Introduction

2.1 Pharmacy and Medicines Management (MM)

2.1.1 Pharmacy Services

The pharmacy directorate has responsibility for services across the whole care pathway, with pharmacy professionals working in the managed sector in primary and secondary care, together with responsibility for the pharmacy contract and development of services across 125 community pharmacies.

There are 280 staff comprising of pharmacists, pharmacy technicians, pharmacy assistants and clerical staff working across primary care, four acute hospital sites, community hospitals, intermediate care, GP practices and NCNs to support safe and cost-effective prescribing, dispensing and administration of medicines.

Pharmacy Staffing	FTE	Headcount
040 Pharmacy (Acute and CRT)	218.57	241
040 Primary Care Management Costs	20.86	24
040 NCNs	9.52	15
	249	**280**

2.1.2 Medicines Management

'Medicines management' covers all processes and behaviours that influence the clinical and cost-effective use of medicines as well as positive health outcomes for patients.

Medicines are the most common therapeutic intervention used in healthcare.

It is estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended. This represents not only an economic cost due to wasted medicines, but also a cost arising from increased demands for healthcare and a detrimental impact to patient's quality of life due to non-adherence and worsening condition. A common reason for poor compliance is where patients do not have an opportunity to access appropriate support to understand how to best utilise their medication.

Medicines safety is an important consideration. Unsafe medication practices and medication errors are a leading cause of injury and harm to individuals. It is estimated that 6.5% of all hospital admissions are medication-related, with evidence

suggesting that 72% of these are deemed avoidable. Up to 50% of hospital admissions may involve a prescribing error. In 2017, the World Health Organization (WHO) issued a medication safety challenge to reduce the level of severe, avoidable harm related to medications by 50% over the next 5 years.

This was followed by a series of WHO initiatives, such as the Global Patient Safety Challenge: Medication Without Harm and the Global Patient Safety Action Plan 2021-2030, to address patient harm associated with use of medications.

In March 2024, WHO published Global burden of preventable medication-related harm in health care: a systematic review (who.int) and Medication without harm: Policy brief (who.int) to support the implementation of the global action plan with a focus on four domains: the patient and the public; health and care workers; medicines as products; and systems and practices of medication within the three action areas: high-risk situations, polypharmacy and transitions of care.

The financial pressure on prescribing will continue to grow across all sectors due to an ageing population and introduction of new and innovative medicines. It is therefore important that the focus continues to ensure a prudent approach to effective MM, through delivery of cost-savings opportunities and value-based initiatives across all Divisions, supported by Pharmacy.

3 Safe

Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising incidents that go right and learning when things go wrong to prevent re-occurrence. People's health, safety and welfare are actively promoted and protected; risks identified and monitored and where possible, risks to safety are reduced or prevented.

In September 2023, the Grange University Hospital (GUH) pharmacy team won the "Patient Safety Development in Secondary Care" category at the Welsh Pharmacy Awards.

"GUH pharmacy staff have strived to put patients and their safety first as per NHS Wales values. Through the education and training of staff we have ensured that patients are prescribed the correct medications, and they are available for administration in a timely manner. Development of staff has ensured job satisfaction which has been proven to improve patient safety and reduce medication related harm. We have shown a commitment to working in partnership within multi-disciplinary teams and this have been a proven success through the delivery of the access to medication action plan.

Overall GUH pharmacy staff have collaborated, pioneered and adapted practice to ensure high quality, efficient and safe patient care in a challenging and fast paced environment."

3.1 Medicines safety

3.1.1 Medication Safety group

The Medicines Strategy Group (MSG) is a multidisciplinary group chaired by the Clinical Director of Pharmacy, which meets quarterly with representation from all divisions, pharmacy and corporate teams.

At meetings each Division presents an exception report to provide assurance that medication safety incidents have been reviewed and actioned appropriately. This includes looking at actions taken, identifying trends and themes, and sharing lessons learnt.

These reports and discussions allow MSG to agree whether further action is required to assure organisational learning e.g. changes to policy, sharing ERASE poster or issuing further communication or education. This has fostered a culture of collaboration and celebration of work done well.

3.1.2 Medication Safety Strategy update

The health board Medication Safety Strategy 2022-25 launched in 2022 sets out its ambitions over a three-year period and focuses on five priority goals, each of which has their own set of objectives and measures to support delivery.

Goal 1: Improve reporting/learning from medication incidents and good practice

Good progress on all five actions to achieve goal; one outstanding action to ensure Family and Therapies Division have pharmacy representation on their QPS group.

Goal 2: Support safe and secure storage of medicines

Good progress on all actions. Outstanding actions include monitoring compliance with MM e-learning and safe medicines administration training and roll out of Medicines Administration, Recording Review, Storage and Disposal (MARRS) policy which has been recently signed off by AWTTC.

Goal 3: Reduce harm from high-risk medication and transition of care

Progress made on all four actions to achieve goal; further actions required in all domains. Progress made in ensuring a bi-annual MDT review of medication incidents considered high-risk and findings triangulated with contributory factors and pharmacist intervention data. Further work required to ensure feedback from incidents are communicated through a recognised and agreed cascade to ensure organisational learning is achieved.

Goal 4: Learn from and contribute to the national safety agenda

Good progress made in ensuring prompt and targeted response to medicines related patient safety notices and alerts and ensuring representation on All-Wales group to ensure ABUHB work aligns with national priorities. Focus to improve collaborative working and providing assurance of compliance with ongoing audit, national prescribing indicators and sharing data intelligence where necessary.

Goal 5: Develop and implement strategies to improve medication safety culture across ABUHB

Some progress made but many actions to achieve goal outstanding, including developing the medication safety communication strategy to ensure good practice is shared and organisational learning is accessible to all employees and contractors. The focus for the next year will be to engage with the divisions, Aneurin Bevan Continuous Improvement (ABCi) and Research and Development to ensure the good work undertaken in the medication safety field is captured and shared and successes are celebrated within all sectors of care. This will include a commitment to support global and national medication safety campaigns and active encouragement for staff to get involved in safety work.

3.1.3 High Risk Medicines

3.1.3.1 Anticoagulants

A thematic review of anticoagulant incidents was undertaken using DATIX, serious incidents, pharmacist interventions and specific information from a workshop with practice pharmacists. The work highlighted the complexity of the issues, and a decision was made to focus on improving safety of patients discharged on newly initiated direct oral anticoagulants (DOACs). This workstream focused on:

- Updating the policy for "Initiation and Discharge of Patients on anticoagulation from hospital."
- Training sessions in areas of high impact e.g. MAU and ED to junior doctors, nurses, and physician associates to increase understanding and how to make the experience as safe as possible for patients.
- Increasing capacity to counsel patients by upskilling pharmacy technicians with a robust and ongoing competence-based training.
- Ensuring adequate counselling booklets available in necessary areas.

3.1.4 Internal Safety Alerts and Communication

Several internal alerts, memos and communication posters and shortage letters were cascaded with Medication Safety sign off to ensure safe use and storage of medication. The table lists the internal alerts, memos and ERASE posters produced and cascaded during 2023-24.

Date	Internal Alert	Rationale
17/04/2023	Paracetamol dosing	Risk of unintentional overdose of oral paracetamol in adult patients.
03/06/2023	Accurate drug history	Failure to undertake an accurate drug history can result in the wrong medication being prescribed for a patient with potential catastrophic harm.
01/09/2023	Potent synthetic opioids implicated in heroin overdoses and deaths	NPSA issued an alert in response to an elevated number of overdoses in people who use drugs, primarily heroin, in various parts of the UK. This may be related to nitazenes and requires a rapid and complete course of naloxone.
26/10/2023	Ethylpharm incompatible connectors	Reduce risk of failure of pre-filled syringes (PFS) not deploying by ensuring use of compatible connectors.
05/01/2024	Treatment for hyperkalaemia	Provide further guidance in response to the Patient Safety Notice for potential risk of underdosing with calcium gluconate in severe hyperkalaemia.
18/01/2024	Acute patients not to self-administer medication as an inpatient	Short term change in practice in response to a safety incident whilst self-administration policy is updated.
01/02/2024	Warfarin interaction with tramadol	Potentially fatal interaction from co-prescribing highlighted from a coronial

		investigation and a subsequent Prevention of Future Deaths Report.
Date	**Shortage Memo**	**Rationale**
30/04/2023	Ketamine shortage	Shortage of IV 10mg in 1ml (20ml vial) prep and necessary switch to 50mg in 1ml (10ml vial) and mitigation of risk.
23/06/2023	Amiodarone PFS	Shortage of 300mg in 10ml PFS and necessary switch to ampoules for injection 150mg in 3ml and mitigation of risk.
28/06/2023	GlucaGen® shortage	Shortage of GlucaGen® 1mg powder for injection kit and necessary switch to Ogluo® 1mg pre-filled auto-injector pens.
15/03/2024	Salbutamol shortage	Shortage of salbutamol 5mg nebules and rationalisation of stock supply and prescribing.

3.1.5 Medication Safety Campaigns

Great engagement was seen across all sectors during #MedSafetyWeek (November 2023) with key safety messages being shared and new Medication Safety Boards displayed across wards and clinical areas to highlight best practice. Themes focused on opioid use, yellow card reporting, emergency medication administration, safe storage of medication and oxygen supplies.

3.1.6 Yellow Cards

There has been a significant increase (+50%) in yellow card reporting in secondary care following an initiation of a rolling training programme which includes junior doctors, pharmacists, non-medical prescribers. This was expanded to include pharmacy technicians, physician associates, vaccination nurses, practice nurses and the Emergency Department.

Use of QR codes and specifically developed speciality posters and cards were used to improve accessibility of yellow card reporting for commonly used and black triangle drugs which require automatic reporting of ADRs.

ABUHB Yellow Card Champions attended the Medication Safety Day at Cardiff City Stadium to celebrate 40 years of YCC Wales. To support national campaigns ABUHB workstreams have been aligned with the Yellow Card Centre (YCC) Wales which has enabled sharing of good practice and a collaborative approach.

3.2 National Safety Alerts

3.2.1 Valproate prescribing

In November 2023, the MHRA produced a National Safety Alert requiring organisations to implement new regulatory measures for oversight of prescribing of valproate to new patients and existing female patients. In addition to the existing requirements of the pregnancy prevention programme, the HB was required to implement 2 new measures where all new patients under 55 starting on valproate must be signed off by two specialists with documentation that no other treatment is effective or tolerated, and reproductive risks have been considered. All existing

women of childbearing age also required a second signatory specialist at their next annual review.

The Senior Pharmacist Primary Care led on the implementation of the alert and chaired a working group with ABUHB clinicians and consultants from neurology and mental health. Regular meetings were held to review current compliance with the original pregnancy prevention programme and develop action plans to ensure implementation of MHRA recommendations.

In order to support implementation, a specific Valproate-Pregnancy-Prevention-Programme-Resources page was developed.

The Divisional Mental Health pharmacist and Neurology Directorate pharmacist continued to support directorates to deliver the valproate action plan, developing standard operating procedures and providing information for a business case to fund additional administrative and clinical staff to deliver the regulatory changes. Work has also commenced in developing a specific policy within Mental Health and Learning Disabilities.

During 2023-24, a valproate audit using AMaT was included as part of the HB GP practice incentive scheme to support compliance with national patient safety indicator. The data of the valproate audit were collated and analysed. Results provided evidence that the number of female patients of childbearing age continues to reduce year on year. The percentage compliance of patients receiving a review and completion of the annual risk assessment form (ARAF) as part of the pregnancy prevention programme has increased 2022-23 to 2023-24: Mental Health increase from 28% to 42% and Neurology increase from 13% to 72%.

This demonstrated that the initial pilot audits have significantly improved number the of patients with an ARAF in place. MH have produced an SOP to improve compliance. Valproate prescribing remains a priority area for the Medicines Safety Group.

3.3 Quality

3.3.1 Research & Development (R&D)

An ABUHB pharmacy R&D strategy is in development to support a transition towards undertaking research being seen as business as usual. An ongoing programme of quality improvement projects has been in place throughout 2023-24 and an individual has undertaken the Cardiff University research methods module, preparing a protocol to undertake research in cardiology.

The monthly R&D peer support group has continued to support individuals from all sectors to develop service improvement research questions, and write-up findings for dissemination, with two members of the group presenting posters at conferences this year.

2023-24 saw a significant milestone, with the antimicrobial team running the first independently run clinical trial in pharmacy, with the Consultant Antimicrobial pharmacist as principal investigator for the UK Antimicrobial Registry study and the antimicrobial team undertaking the consent and data collection processes.

3.3.2 Quality Improvement projects

The following Quality Improvement projects were undertaken by HEIW Post Registration Foundation Pharmacist trainees during 2023-24:

- Improving weekday ordering of inpatient controlled drugs at the Royal Gwent Hospital (RGH).
- Reducing inappropriate medication administration omissions on a care of the elderly ward.
- Optimising Pabrinex® prescribing practices: addressing overprescribing in alcohol withdrawal to prevent Wernicke's encephalopathy.
- Reducing number of controlled drug orders on a weekend and bank holiday at NHH.

3.4 Governance

3.4.1 Controlled Drugs (CDs)

3.4.1.1 CD Local Intelligence Network (CDLIN)

The CD LIN met quarterly during 2023-24. Meetings were held via MS Teams and chaired by Health Board CD Accountable Officer (CDAO). Dr James Calvert stepped down from the role of CDAO in December 2023, with Jonathan Simms taking over in January 2024.

Membership of the group includes representation from across ABUHB, other health boards and Trusts, as well as private organisations who use CDs. i.e. Welsh Ambulance Service Trust (WAST), St David's Hospice, St Joseph's hospital and local private mental health facilities. Local intelligence, concerns and incidents are shared via quarterly occurrence reports.

CD incidents of concern and themes are discussed, with opportunities for shared learning. Community Pharmacy report the largest number of Datix submissions, with medication supply errors accounting for these. Medicine Division reports the second highest, with administration, documentation and stock control/security issues being the most reported. Missing CDs and stock control continue to be monitored.

3.4.1.2 Police CD Liaison Officer (CDLO)

In September 2023, ABUHB were informed that the Gwent Police CDLO would be retiring at the end of December 2023. Gwent Police confirmed they would no longer support witnessing of destruction of CDs in community pharmacies. In the interim, one Gwent Police inspector would act as point of contact for the CDLIN until a new CDLO was in post.

3.4.1.3 CD Destruction

Police Officers and Authorised witnesses approved by the CDAO are authorised to witness CD destruction. With the loss of support from Gwent police, the HB has developed standard operating procedures and trained health board pharmacy staff in primary and secondary care to become authorised witnesses to ensure destruction

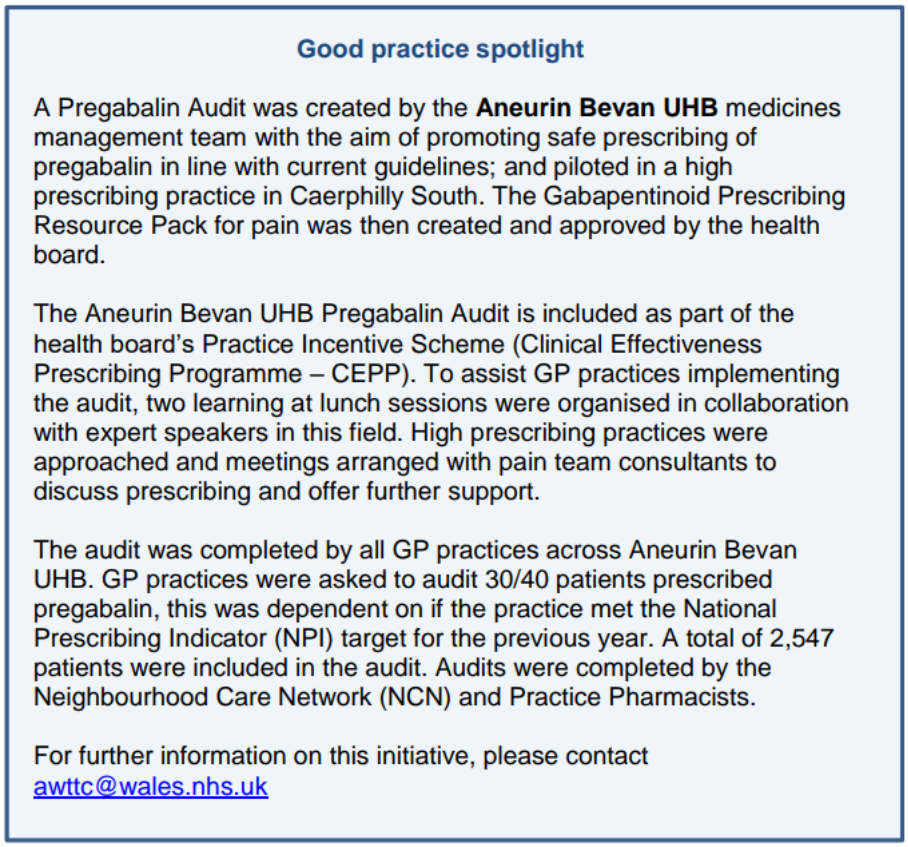
across hospital sites, independent community pharmacies and GP practices. Multiple pharmacies have their own authorised witnesses who are suitably trained and accredited to witness and submit reports of CD destruction. These are signed off by the CDAO to allow CD destruction in pharmacies across ABUHB.

3.4.1.4 Gabapentinoid Prescribing

Concerns were raised at the CDLIN over the safety of gabapentinoid (pregabalin and gabapentin) prescribing, following a fatal drug poisoning within the HB. ABUHB currently has the second highest gabapentinoid prescribing level in Wales, approximately 10% above the Welsh national average, as measured by the National Prescribing Indicators (NPIs), and prescribing continues to increase.

A pregabalin audit was included as part of the GP Practice Prescribing Incentive Scheme (CEPP). Data was collected using AMaT and used to identify prescribed indication and if initiations were from GPs or secondary care.

The pharmacy team collaborated with the ABUHB Chronic Pain Group to develop an evidence-based Gabapentinoid Prescribing Resource Pack providing practical resources to support GPs. Two education sessions were organised to increase awareness of safety concerns and provide practical skills to encourage best practice. High prescribing practices received a face-to-face visit from the HB pain consultants and prescribing advisers. This work was shared at the AWTTC Best Practice event in June 2023 and featured as a "Good practice spotlight" in the National Prescribing Indicators 2023-24: Quarterly reports March 2024:



Good practice spotlight

A Pregabalin Audit was created by the **Aneurin Bevan UHB** medicines management team with the aim of promoting safe prescribing of pregabalin in line with current guidelines; and piloted in a high prescribing practice in Caerphilly South. The Gabapentinoid Prescribing Resource Pack for pain was then created and approved by the health board.

The Aneurin Bevan UHB Pregabalin Audit is included as part of the health board's Practice Incentive Scheme (Clinical Effectiveness Prescribing Programme – CEPP). To assist GP practices implementing the audit, two learning at lunch sessions were organised in collaboration with expert speakers in this field. High prescribing practices were approached and meetings arranged with pain team consultants to discuss prescribing and offer further support.

The audit was completed by all GP practices across Aneurin Bevan UHB. GP practices were asked to audit 30/40 patients prescribed pregabalin, this was dependent on if the practice met the National Prescribing Indicator (NPI) target for the previous year. A total of 2,547 patients were included in the audit. Audits were completed by the Neighbourhood Care Network (NCN) and Practice Pharmacists.

For further information on this initiative, please contact awttc@wales.nhs.uk

awttcn/national-prescribing-indicators-2023-2024-analysis-of-prescribing-data-to-march-2024-pdf/

3.4.1.5 Care Home CD audit

The pharmacy care home team have undertaken CD audits in nursing homes (NHs). The audit identified poor practice which included concerns with storage and handover of CD cabinet keys, poor documentation in CD and drug liable to misuse registers, poor processes for destruction and disposal of patient own CDs.

The care home team worked on QI projects with the complex care and care at home team to improve knowledge, safety and reporting of medication including CD incidences in NHs. Following the CD audit, the team have started to develop an education pack and plan to deliver training session to the homes via teams.

3.5 Inspections

3.5.1 Home Office CD licences

In February 2023, the Home Office (HO) and Chief Pharmaceutical Officer for Wales wrote to all HBs requesting a priority review of all services using CDs. Suitable arrangements should be in place where CDs are supplied to different services within ABUHB or to other organisations. Assurance was needed of compliance with the requirements for CD licensing.

Nevill Hall Hospital (NHH) Pharmacy already maintained a HO CD Licence. Applications were submitted to the HO for all other hospital pharmacy sites in 2023. Inspection visits took place between September 2023 and January 2024 and licences subsequently approved for RGH and Ysbyty Ystrad Fawr (YYF), with GUH licence expected in due course.

Following a review of CD use in Dental services, IV sedation services using midazolam in Clytha Park and Cwmbran were stopped and moved solely to YYF until HO inspections in February 2024 and licences had been received.

Aneurin Bevan Specialist Drug and Alcohol Service (ABSDAS) moved stock of Buvidal® from Tysiriol, Maindiff and Lower Dock St sites back to acute hospital sites, and prescriptions were dispensed through hospital Pharmacies.

3.5.2 Wholesale Distribution Authorisation (WDA) MHRA Licence

NHH Pharmacy Department has held a WDA licence since 2018. This is a MHRA licence to allow legal distribution and supply of medication to other legal entities. For NHH, WDA customers include Welsh Ambulance Trust, Powys Teaching Health Board, St David's Hospice and the Longtown Mountain rescue charity, supplying critical medicines for their patients.

The MHRA inspection of NHH occurred in May 2024. The inspection went well and will be reported fully in the next Annual Report

3.6 Electronic Prescribing and Medicines Administration (ePMA)

The Secondary Care ePMA programme aims to digitalise the process for prescribing, processing, and recording administration of medicines. This will replace the existing paper-based system, including prescription and administration record charts, as well as discharge and outpatient prescription forms, and will connect with existing NHS Wales systems and the new National Medicines Repository.

As part of the Digital Medicines Transformation Portfolio, a local procurement exercise was undertaken to identify specific requirements for ePMA capability for ABUHB. A preferred supplier was identified, and work is underway to submit a business care to WG to secure ongoing funding for roll-out and maintenance programme. The significant contribution of ePMA to medicines safety and management is well recognised.

Once WG funding is approved, the program will proceed to recruitment of key posts, including a lead digital pharmacist and a lead digital pharmacy technician. These posts will then undertake the core medicines database and configuration of the system. YYF is proposed as the initial pilot site.

As part of the implementation work, the ePMA team will scope benefits and collect baseline data, as well as process mapping both current and intended processes.

3.7 Risks & Concerns

3.7.1 Divisional/Directorate Risk

The exception report below was submitted to the Primary Care and Community Division's Quality and Patient Safety meeting for the last quarter of 23/24. This includes specific risks from the directorate's risk register

Exception Report for Divisional QPS Meeting					
Borough/ directorate	**Pharmacy**				
Completed by:		**Reporting period:**	January	**To:**	March 2024
Date Completed:	**4/4/24**		**Date of Borough/ directorate QPS Meeting:**		*April 2024*

Highlights

- From January 2024 Jonathan Simms became new ABUHB CD Accountable Officer. A CD intranet page is in development to highlight the updated CD policy which will include new mechanisms to highlight CD concerns.
- Gwent Police CD Liaison Officer retired December 2023. Gwent Police have appointed a new CD Liaison officer (CDLO). Primary care pharmacy staff have been trained to undertake Witness of CD Destruction in primary care.
- 4 permanent pharmacy closures, 3 recent pharmacy contract reduction in hours and permanent closures on Saturdays in Newport and Caerphilly areas in weekend opening hours, putting further pressure on remaining pharmacies.
- HO CD Licences. RGH and YYF have been granted licences. GUH awaited.
- Community Dental service CD Home Office visit took place 7th February and approved and await HO licence. Substance misuse yet to submit application
- MHRA valproate patient safety alert: 2 signatories required for annual review of existing women of childbearing age. HB yet to declare compliance. SBAR and business cases submitted to Execs from Neurology and Mental Health.
- RGH robot replacement update: risk moved to Corporate Risk Register. Final PPD and SBAR to be reviewed by Executive Team on 11th April for approval of additional costs. Anticipated robot installation July-October 24.
- Patient complaints being received following recent generic switches from work directed WG. Putting things right team working with team. Processes put in place to manage concerns and assess appropriateness of switch.

Pillars of HB Quality Strategy

1. Patient and staff experience and stories

Highlight areas of good practice / improvement / deterioration / concern

Prison have recently recruited 1WTE pharmacy technician and 0.4WTE prison pharmacist for HMP Usk and Prescoed. Both now in post

2. Incident reporting –falls, pressure ulcers, MM, mortality

Thematic review of data identifying trends & themes –triangulate incidents / concerns / risks – what is this telling us?

MM incidents discussed at quarterly medicines safety group meeting and CD LIN. Community pharmacy account for large proportion of incidents reported e.g. CD stock discrepancies, dispensing errors. Processes put in place to ensure closure of incidents in a timely manner.

CD incidents on Datix are also directed to CDAO email address. New processes are being put in place to allow employees and contractors to raise concerns/whistle blow direct to CDAO.

3. Complaints, concerns and compliments

PTR Compliance – include run chart and trajectories (incidents, concerns, risks, PSOW referrals, LFERs for redress).

MHRA sodium valproate alert. Deadline of 31st January. New patients (male and female) under 55 yrs require 2 specialist signatories before initiation. All existing female patients of childbearing age to have a review and dual sign off. HB still not able to declare compliance. Neurology have submitted a business case for additional consultant and clinical support. SBARs submitted to execs with action plans from Neurology and Mental Health.

GP practices have completed an audit of the female patients of childbearing age on valproate. Data being analysed. Patient Lists and findings shared with Neurology and Mental Health.

Patient Complaints being received following recent generic switches from work directed WG. Putting things right team working with team. Processes put in place to manage concerns and assess appropriateness of switch.

4. Health, safety and security

Mandatory and statutory training compliance, highlight environmental risks, incidents related to adverse staffing levels

Mandatory training compliance for ABUHB pharmacy team across all sectors – 91.57%

5. Infection control and prevention

Primary care now has 1WTE antimicrobial pharmacist after recently appointing an additional 0.4WTE pharmacist.

6. Safeguarding

Summary of safeguarding concerns managed by the borough/directorate and learning identified

No Concerns

Top 3 Risks identified on borough/directorate risk register
Report to be included which presents all risks >12 RAG rated, by borough / directorate, handler, review date, mitigated risk level, 1 line synopsis

Description of Risk	Date identified	Action being taken or planned to mitigate	RAG Rating
Community Pharmacy closures and further reduction of operating hours are likely, along with withdrawals from rota service.	2023	4 pharmacy closures this year • Knights Newbridge • 3 Boots: Caerleon Rd, Chepstow Rd, Pontypool 3 pharmacies requested to close on Saturdays. HB has been out for public consultation. Bellevue pharmacy, Jhoots pharmacy Risca and Mayberry's pharmacy Blackwood. Requests are being monitored – continued further pressure on community pharmacy services.	9 - Amber
Gwent Police withdrew CDLO post at end of Dec 2023. The CDLO witnesses CD destruction across the HB and contractors	Sept 2023	Primary care pharmacy staff have been trained to undertake authorised witness for CD destruction role to support independent pharmacies and GP practices. Gwent Police have appointed a new CDLO who is due to start but with restricted capacity.	9 - Amber
Staffing: 31 WTE vacancies across acute sites.	2019	Non-patient facing and non-essential services reduced or removed.	20 - red

Top Borough/ Directorate Concerns being managed within the borough/directorate (may include clusters/amber incidents/complaints/key safety concerns)

Issue	Action being taken or planned to mitigate	RAG Rating
Patient complaints following work by MM Team to switch to generic or more cost-effective alternatives as per WG directive to eliminate no or low value prescribing	Lead Pharmacist and Putting Things Right team have compiled process to deal with patient complaints. Complaints referred to panel for consideration. Contact details of PTR shared with GP practice.	6

Potential Consequence x Likelihood of Adverse Outcome - RISK SCORE

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

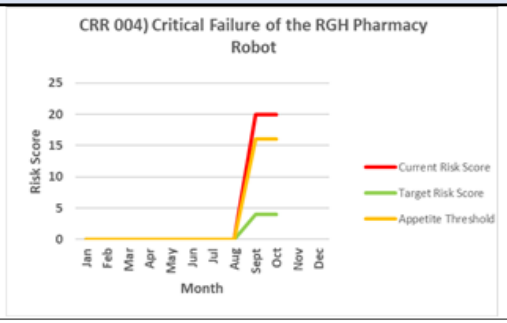
3.7.2 Corporate Risk - RGH Robot Operational Risk

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 potential impact on patient safety and flow. There have been a number of critical failures over the last few months that have lasted a few days and meant that the system has had to enact Business Continuity. This indicates the high fragility of the system and the very real likelihood of a total system crash that is unrepairable.			
Impact	➢ Unintended patient harm from missed doses of medicines due to the disruption in supply. ➢ 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.			
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)*

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

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

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• GUH and YYF staff are trained to complete 'critical low' supplies for bulk items that fall below set PAR levels for onsite Omnicell's prior to top-up trigger from RGH. • Automated daily reports to sites are in place to trigger supply to maintain critical levels of stock across hospital sites in between centralised top-up from RGH. • A contingency plan is in place and 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**

4 Timely

Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, treat people based on identified and agreed clinical priority.

4.1 Pharmacy Emergency Department (ED) Service

A dedicated ED pharmacy service became operational in July 2023. The service provides daily 12-hour cover, 7 days per week on a rota basis.

The team consists of:
- 1 WTE x band 8b Divisional Pharmacist Urgent Care
- 4 WTE x band 8a Independent Pharmacist Prescribers
- 3 WTE x band 5 MM Pharmacy Technicians
- 0.3 WTE x band 3 Pharmacy Assistant

The pharmacy team clinically review patients and undertake medicines reconciliation within 24 hours, currently achieving a compliance level of 80% of patients reviewed within the working day, a target stipulated by WG, NICE and Royal College of Emergency Medicine (RCEM).

The benefits of service include:

- Increased patient safety and experience.
- Pharmacist prescribing increasing rates of correct medicines reconciliation.
- Optimising medicines to prevent/reduce patient harm.
- Improved ED/GUH patient flow by expediting discharges/patient transfers.
- Education of nursing/doctor staff.
- Advice of safe storage and administration of medicines.
- Governance issues addressed including PGDs, guidelines/policies.
- Reduction in re-admissions due to medication related issues.
- Medicine savings due to reduced wastage and use of patient-own medicines.
- Medication counselling to ensure best use of medicines.

Some examples of patient and staff feedback are shown below.

"I came into resus on Monday 18th September 2023 being breathless which was quickly getting worse. I had a CT scan on my chest. Owain, who is in the Pharmacy Dept was checking my medication needs and whilst checking the CT results picked up that I had 2 large clots in my lungs and then reported this to my consultant. I cannot thank him enough. He is and always will be my hero."
"Great way of running the Pharmacy side of things as this team are crucial to patients like myself"

"Much better service, can access advice and obtain medicines much quicker"
- ED nurse

"Excellent service as there's someone around to communicate with to provide the best patient care for the majority of the day"
- ED nurse

"Valuable resource for advice guidance and info regarding patient medication, drug charts, dosing and prescribing"
- ACP

"It's great, the other day I had a drug query at 7:30pm and could talk to a Pharmacist about it, brilliant availability, really helpful staff and overall great service. Junior doctors find this service particularly helpful, thank you!"
- ED Consultant

4.2 Emergency Duty Commitment (EDC) Pharmacist service

The EDC Pharmacy service provides out-of-hours pharmacist support to ABUHB, Powys Teaching Health Board and St David's Hospice Care. It is an invaluable resource that provides timely support and access to medicines which significantly enhances patient care during the out-of-hours period.

The service operates a dedicated rota comprising of 18 pharmacists working as a pair over the course of a week during the period of 5pm to 8.30am, Monday to Friday, plus 12.30pm to 9.30am on weekends and Bank Holidays.

The EDC pharmacists offer a range of essential services including:

- Providing advice to all healthcare professionals
- Ensuring emergency access to medicines and CDs out of hours
- Offering a backup service to palliative care in the community
- Supporting and facilitating rapid access to emergency medicines during major incidents

During 2023-2024, the EDC service handled 517 calls, distributed as follows:

- 43% GUH
- 14% RGH
- 13% NHH
- 7% YYF
- 23% other areas

Most calls were related to requests for supply of medication (57%) followed by requests for advice (20%). The EDC Pharmacists have access to technology such as remote dispensing, Omnicell Explorer and Checkit automated fridge monitoring which enables the majority of calls to be handled remotely. Only 6% of calls required attendance to a site.

4.3 Critical care

During 2023-24, ABUHB critical care pharmacy representatives worked with UK-wide critical care leads, and representatives from the Faculty of Intensive Care Medicine (FICM), RPS and UK Clinical Pharmacy Association (UKCPA) as contributors to the RPS & UKCPA Advanced Pharmacist Critical Care Curriculum. This document sets the standard for critical care pharmacists working in the UK and provides clear career, credentialing and assurance pathways for the specialty. This will be taken forward for implementation with Education and Training leads.

Following discussions with the Welsh Intensive Care Society (WICS), a critical care pharmacist representative has been elected to the WICS Council. This is the first time a pharmacist member has been present. Such national representation of the profession in a pivotal critical care organisation within Wales will ensure that the pharmacy agenda is heard at the highest level. This appointment will have positive influence on patient care.

Critical care pharmacy at ABUHB has also been instrumental in ensuring the profession is represented in the HEIW Critical Care Workforce Model. Pharmacy will benefit through the resourcing and development of its services and staff and will ultimately improve the quality of care provided to the critically ill in Wales.

4.4 Transfer Lounge GUH

Upon GUH opening, ABUHB made the decision not to commission pharmacy services for the GUH transfer lounge. The last year has seen a significant number of medicine challenges which have been escalated to the Division as a patient safety concern. Despite not being resourced to service the area, pharmacy recognised the considerable risk within the area and so have provided support where possible to try to reduce the risk to patients.

Pharmacy undertook a risk assessment which identified the following issues:

- Patients own medications not stored in lockers
- Fridge temperatures not being recorded daily
- No basic ward stock list to prevent patients missing critical medication doses whilst awaiting transfer to another site. Staff currently borrowing medication from other wards.
- Expired medication stock being left on unit with risk of being used for other patients.
- Medicines reconciliation not occurring within 24 hours

The risk assessment identified that the operational model of the transfer lounge was unclear and not fit for purpose. The transfer lounge was intended to house patients awaiting transport home or to another hospital site, but some patients were having to stay on the unit for several days, receiving substandard care to that on a ward.

Actions/Mitigations undertaken include:

- Nursing staff informed to use lockers for storage of patient's own medication
- Education of nursing staff regarding fridge temperature monitoring and supply of correct HB paperwork for recording.
- Development of a basic stock list and supply of medications made.
- WOREQ2 account created to ensure ability to re-order medications.
- Education of nursing staff on how to manage medicines no longer required on the unit.
- Nursing staff to highlight patients who have not received medicines reconciliation and are remaining on the unit for more than 1 day.
- Staff to be aware of critical medicines policy and when to escalate to pharmacy for support.

The transfer lounge is only staffed by one registered nurse (RN) which causes a concern when managing CDs. Issues have arisen when a CD is needed, as agency staff are unable to order, leading to delays in patient care. Following several incidents, the following was agreed:

- Transfer lounge will only store patient's own medication in the CD cupboard.
- Patients' own medication to be checked and recorded by 2 RNs daily.
- In the absence of the patients' own medication staff, RNs advised to secure the medication from A0 in exceptional circumstances only.
- Support provided from the operations manager or senior nurses for any activity requiring a witness.

A new proposed model for the Transfer Lounge is being developed which will include a pharmacy technician (B5) to facilitate provision of discharge medication to prevent delayed discharges. This will improve medicines governance at transfer and step down to other sites, as well as providing an opportunity to counsel patients to reduce incidence of re-admission through safe discharge.

4.5 Omnicell

During early 2024, a new Omnicell was installed on D5 West at RGH, to allow re-location of wards at St. Woolos Hospital. Pharmacy undertook extensive re-configuration of the Omnicells located on C5 East, C6 East and C6 West. The team provided robust training for all St Woolos hospital nursing staff that moved site, to ensure the Omnicells could be used to issue medication safely.

Additionally, the use of OmniExplorer was extended to allow staff a HB-wide view of where medications are located when stock outage occurs.

4.6 Patient Group Directions (PGDS)/Homely Remedies

ABUHB has 165 PGDs in use across primary and secondary care.

The PGD Approval Group met 7 times during this period and 33 PGDs were approved. Group members include a Senor Primary Care Pharmacist, Clinical Informatics Pharmacist, Consultant Musculoskeletal Physiotherapist, Senior Nurse for Professional Practice and a Consultant Acute Care Physician. The group meets to review existing PGDs, as well as auditing the use of existing PGDs. Five requests were received for new PGDs to support services in Radiology, Speech and Language Therapy, Ophthalmology, and Dental.

The PGDs have helped improve access to medicines in out-of-hours, dental, mental health, sexual health, dental, endoscopy, radiology, ophthalmology, occupational health and admission units. UKHSA and All-Wales PGD templates are used for all ABUHB immunisation PGDs, as determined by national guidance and immunisation programmes. This has also included PGDs for the influenza and COVID vaccination programme. The scope of the Mass Vaccination Centres has been widened to allow wider delivery of immunisation programme for children.

The new antivirals for treatment of positive COVID cases are included in the list of PGDs for patients at high risk.

The PGD approval group has extended its terms of reference to also review homely remedies protocols. Homely remedies are medicines used to treat minor ailments, which can be purchased over the counter and do not need to be prescribed e.g. antihistamines used in Prison and Mass Vaccination Centre.

In November 2023, ABUHB Senior Primary Care Pharmacist was nominated as Chair of the All-Wales PGD Advisory Board. The board reviews All-Wales national templates produced by the Welsh Medicines Advice Service.

5 Effective

Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

5.1 Medicines and Therapeutics Committee (MTC)

In 2023-2024, the MTC met six times.

Table 1:

Summary of items considered at MTC meetings during May 23 – March 24

Item	Outcome	Examples
New medicine/ formulary application	11/12 approved 1/12 rejected	Sufentanil 30 microgram sublingual tablets for management of acute moderate to severe pain in adult patients; indications peri-operative and post-operative surgical or procedural pain – **TLS Red** SimAlvia (alverine/simeticone) capsules for IBS (on basis mixed evidence and unconvincing cost effectiveness)
License extensions for existing formulary medicines	4/4 approved 1/1 rejected	Line extension for Trimbow high strength inhaler MDI 172/5/9 to be added to formulary Line extension for Wynzora cream (Calcipotriol 0.005% / Betamethasone dipropionate 0.05%) for topical treatment of psoriasis – rejected on cost basis with 3 alternative preparations of medicine available
New or revised Shared Care Protocols (SCPs)	Nil	

Traffic Light Status (TLS) Change	6/7 approved 1/7 rejected	TLS Change from Red to Amber for Ferric maltol (Ferracru) for treatment of iron deficiency anaemia in Inflammatory Bowel Disease (IBD) TLS change for Lokelma from Red to Amber with Share Care Protocol for management of heart failure
ABUHB Prescribing guidelines (new or revisions)	12/12 approved	Gabapentinoid Pain Prescribing Support Pack for CEPP Prescribing Guideline - Treatment and management of heart failure in primary care
Subgroup formularies	1/1 approved	Continence formulary updated and reviewed by Continence group and revision approved by MTC
Policies	1/1 approved	ABUHB Policy Covering Supply of Free Samples of Prescription Items – updated, reviewed and endorse. Submitted to Clinical Standards and Policy Group

- There has been a 50% increase in new medicine requests to MTC compared to 2022/2023 Annual Report, but 100% decrease in new/updated SCPs. Frequency of Traffic Light System (TLS) change requests remained unchanged.

- Group updated and reviewed Terms of Reference (ToR), approval granted in Sept 2023 and endorsed by the MM Programme Board (MMPB).

- As part of work reviewing the ToR, considerable work was carried out to improve membership and recruit to existing and new vacancies of the MTC. Recruitment has been partially successful, increasing from 17 to 21 members.

- Newsletter circulated after each MTC meeting to ABUHB prescribers, containing headlines and useful information regarding formulary decisions and prescriber issues at ABUHB. MTC Newsletters can be found here.

- 27 non-formulary requests were received to prescribe non-formulary medications. These were considered by the MTC Chair/Deputy and all approved (none rejected). Majority of requests were for lidocaine plasters, an item of low priority for funding/low value. Reducing lidocaine plasters prescribing continues to remain in the MTC work program with frequent reviews and interventions to reduce prescribing. In February 2024, revised guidelines were issued to all prescribers across primary and secondary care.

- In 2023-24, 75 medicine were approved by NICE. ABUHB implementation process for these was via the High-Cost Drugs Implementation Planning Group (HCDIPG) - a sub-group of MTC. Following this process and review of directorate

implementation plans by HCDIPG, all 75 were added to formulary. MTC agreed and recorded the appropriate formulary status for each.

5.2 Antimicrobial Stewardship

The Antimicrobial Stewardship team maintains oversight of antimicrobial usage and implements strategies to optimise use of antibiotics across ABUHB. Pharmacy both chair and provide professional secretariat for the ABUHB Antimicrobial Working Group and Antimicrobial Guideline Group, including development & review of 592 local treatment guidelines.

Achievements for 2023/24 include:

- Completion of audit/feedback cycles in 5 highest-prescribing GP practices.
- Ongoing weekly antimicrobial ward rounds at 3 of the 4 main hospitals. Exception being medical rounds at GUH, due to microbiology staffing levels. 1263 patients with complex antimicrobial regimens were reviewed and 1782 interventions made to optimise antimicrobial prescribing, including stopping treatment in 15% patients.
- Work with Quality Patient Safety team to add antimicrobial usage and stewardship audits to assurance dashboards.
- Delivering 65 hours of education to 1123 multi-professional individuals across primary and secondary care, including new groups such as Physician Associates. Fifth year medical student teaching rolled out to all postgraduate centres.
- Quinolone safety checklist launched for World Antimicrobial Awareness Week, which supported ABUHB response to MHRA quinolone safety alert in January 2024.
- Opening of UK Antimicrobial Registry study in March 24, to collect real world data on outcomes with newer antimicrobials in secondary care. Run an independent research study with Consultant Antimicrobial Pharmacist as Principal Investigator.
- Recruitment of 0.4 WTE band 8a primary care antimicrobial pharmacist and 0.39 WTE senior project support officer.

5.3 National Prescribing Indicators

The All-Wales Medicines Strategy Group (AWMSG) has developed and endorsed National Prescribing Indicators (NPIs) since 2003 as a means of promoting safe and cost-effective prescribing. The indicators identify the therapeutic priorities for NHS Wales and have a focus on safety, stewardship or efficiency. The methodology for establishing the NPI targets is based on the principle of encouraging all HBs, local cluster groups and practices to achieve prescribing rates in the best quartile. The threshold for achievement is based on prescribing rate of the best performing 25% of practices in Wales, for quarter 3 of the preceding financial year. The target is therefore not an absolute value and can be achieved if there is movement towards the threshold set.

For 2022-2025, the National Prescribing Indicators: Supporting Safe and Optimised Prescribing focus on the following priority areas:

- Analgesics (including opioids, tramadol, and gabapentin and pregabalin)
- Anticoagulants in atrial fibrillation

- Antimicrobial stewardship (including total antibacterial items and the '4C antimicrobials': co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin)
- Decarbonisation of inhalers

These four priority areas were supported by additional indicators:

- Safety
  - Prescribing safety indicators
  - Hypnotics and anxiolytics
  - Yellow Cards

- Efficiency
  - Best value biological medicines
  - Low value for prescribing

5.3.1 Clinical Effectiveness Prescribing Programme (CEPP)

The primary care MM team promote safe and cost-effective prescribing through the GP Prescribing incentive scheme (CEPP). For 2023-24 the scheme involved:

- Pre-qualifiers:
  - Prescribing Visit – GP practice meeting with MM team
  - Complete Annual Valproate Prevent Pre-Assessment patient safety audit

- Show progress in 4 prescribing indicators:
  - 3 are national indicators (total antimicrobial items per 1000 STAR-PUs, 4C antimicrobial items per 1000 patients and gabapentin/pregabalin DDDs per 1000 patients)
  - 1 local indicator – achieve Scriptswitch acceptance rate of 40% or more

- Complete Pregabalin Prescribing Support Package:
  - Complete pregabalin audit
  - Attend Chronic Pain Group training session
  - Review 10 patients prescribed pregabalin

5.3.2 ABUHB position against NPIs (March 2024)

The table below shows the extent to which GPs in HBs met the target or indicator thresholds in March 2024:

- The figure in the cell is the number of practices in each HB meeting the target or indicator threshold.
- The percentage figure and cell colour represent the proportion of practices in each HB meeting the target or indicator threshold.
- The target for antibacterial items per 1,000 STAR-PUs is by HB. The crosses indicate that no HB has achieved this target.

It should be noted that the table provides the percentage of practices achieving the threshold target. This is established in the December quarter of the preceding year

and based on the best performing quartile of all GP practices in Wales. Therefore, at baseline only 25% of practices in Wales will achieve the threshold target.

Health boards/practices achieving the indicator targets/thresholds – Quarter ending March 2024

Indicator Description	Aneurin Bevan	Betsi Cadwaladr	Cardiff And Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
Tramadol DDDs per 1,000 patients	20 29%	23 24%	30 54%	8 18%	15 31%	6 38%	14 31%
Gabapentin and pregabalin DDDs per 1,000 patients	14 21%	20 21%	35 63%	2 4%	14 29%	1 6%	10 22%
Antibacterial items per 1,000 STAR-PUs	✗	✗	✗	✗	✗	✗	✗
4C antibacterial items per 1,000 patients	15 22%	53 55%	24 43%	15 33%	11 23%	1 6%	24 53%
DPIs and SMIs as a percentage of all inhalers	35 51%	31 32%	40 71%	27 60%	46 96%	5 31%	15 33%
Hypnotics and anxiolytics ADQs per 1,000 STAR-PUs	19 28%	25 26%	36 64%	7 16%	8 17%	8 50%	14 31%
Low Value for Prescribing (UDG) spend (£) per 1,000 patients	4 6%	34 35%	16 29%	4 9%	9 19%	5 31%	11 24%

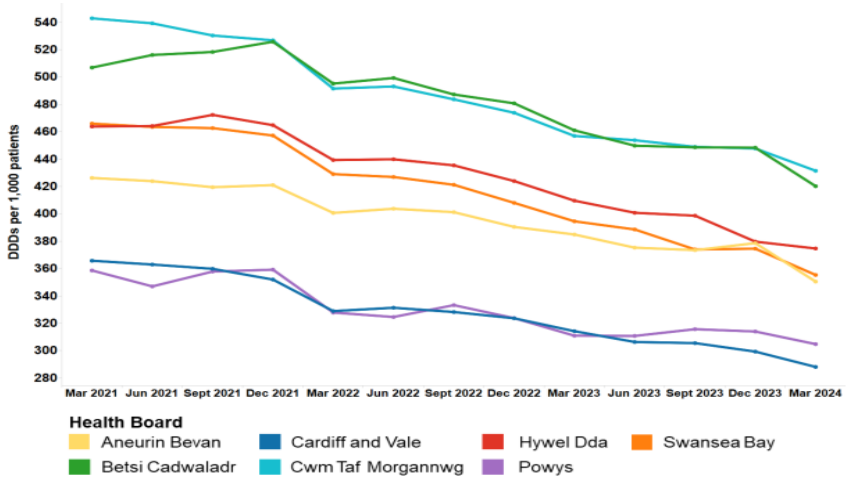
Percentage of practices meeting threshold: 0% 100%

This information should be seen in the context of trends in prescribing performance. Further information is provided in the National Prescribing Indicators 2023-2024: Quarterly reports - All Wales Therapeutics and Toxicology Centre, together with a brief summary below, which outlines the specific actions taken to improve performance.

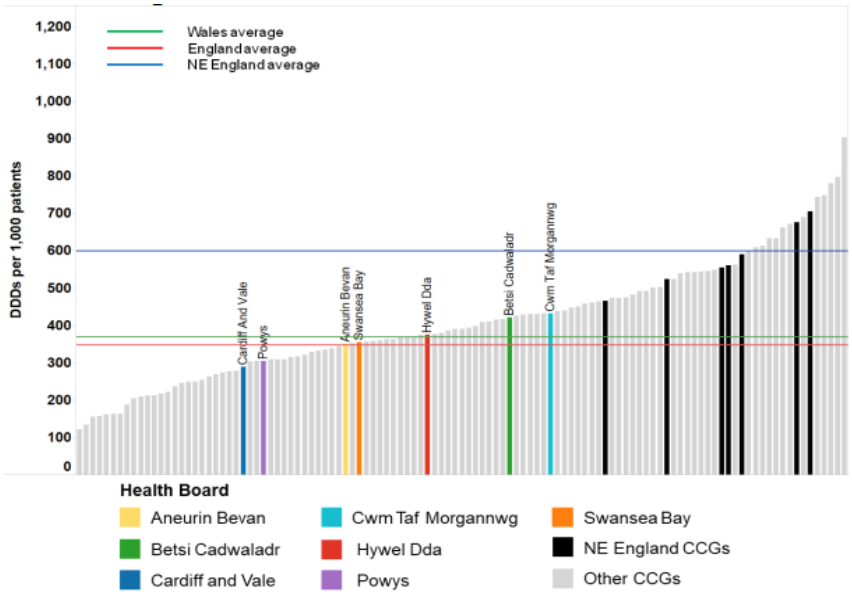
5.3.2.1 Tramadol DDDs per 1000 patients

ABUHB is the third lowest prescriber in Wales and continues to show a reduction in prescribing in line with the aim of the indicator:

Trend in tramadol prescribing DDDs per 1000 patients



Tramadol Items in Welsh HBs and English CCGs (March 2024 quarter)

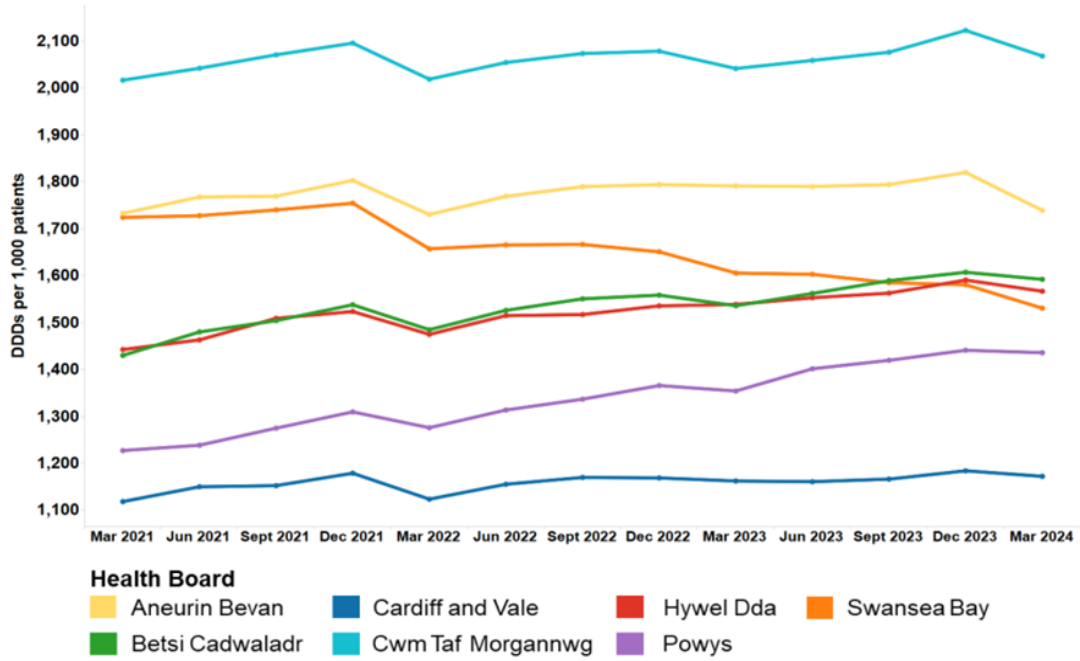


Feedback from practices highlights the difficulty with tramadol deprescribing in established patients. The focus is to limit initiation to new patients. Work is ongoing to deprescribe, albeit slowly, and decreasing trends are evident. Tramadol prescribing levels are monitored through the ABUHB Pain Group, and the highest prescribing practice Abersychan, North Torfaen, received a visit from the pain team to support deprescribing with the outcome of a steep and sustained reduction (12.4% decrease in 2023/24).

5.3.2.2 Gabapentin and Pregabalin (DDDs per 1000 patients)

ABUHB has a historically high use of these agents for neuropathic pain. Across Wales, pregabalin and gabapentin prescribing showed a sharp reduction in the March quarter 2024:

Trend in gabapentin and pregabalin prescribing DDDs per 1,000 patients (March 2024 Qtr)

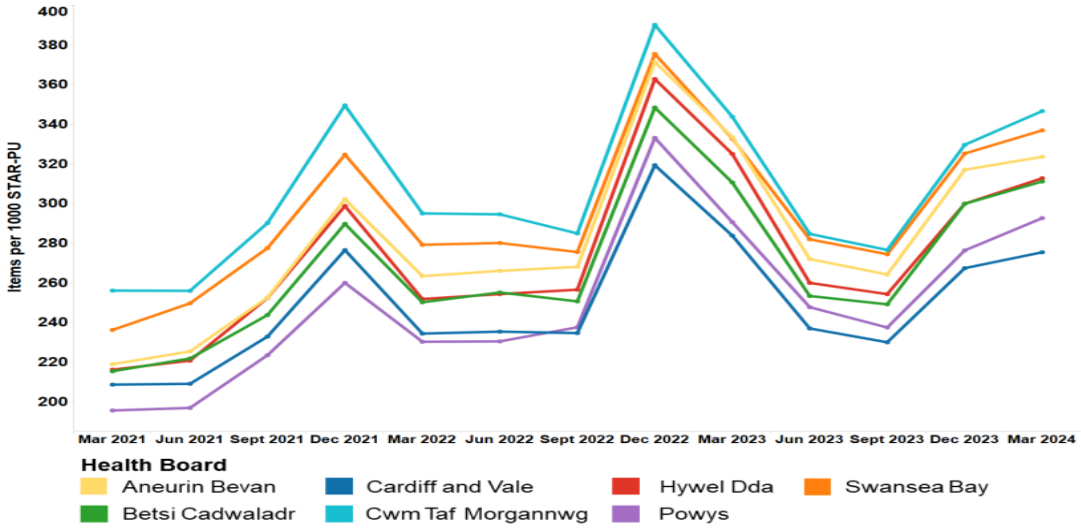


Gabapentinoid prescribing formed a key focus of CEPP 2023-24. This included mandatory attendance at one of two online training sessions for GP practices, presented by Dr Sue Jeffs (Pain Consultant) and Dr Julia Lewis (Consultant in Addiction). This highlighted the risks and concerns with the overuse of opioids and gabapentinoids; and promoted the Gabapentinoid Pain Prescribing Support Pack (developed by the Chronic Pain Group) which provides supportive resources to aid patient reviews and dose reduction plans in primary care.

All practices were asked to undertake a pregabalin audit on the Audit Management and Tracking (AMaT) digital platform to identify the indication, initiator (primary or secondary care), high dose use and high-risk patients. Practices were asked to develop an action plan following their audit. The top high use practices had a face-to-face meeting with a pharmacist and Pain Consultant to discuss specific prescribing issues. The highest outlier practice Trosnant Lodge, North Torfaen, reduced gabapentinoid prescribing by 6.1% between Q1 and Q4 2023-24.

These actions have resulted in an overall ABUHB decrease in gabapentinoid prescribing of 4.4% in Q4 2023-24 and ABUHB featured as a "Good practice spotlight" for this focussed initiative in the AWTTC National Prescribing Indicators 2023-24: Quarterly reports March 2024 (see section 3.4.1.4 Gabapentinoid Prescribing).

5.3.2.3 Total Antibiotic Prescribing (Items per 1000 STAR-PUs)

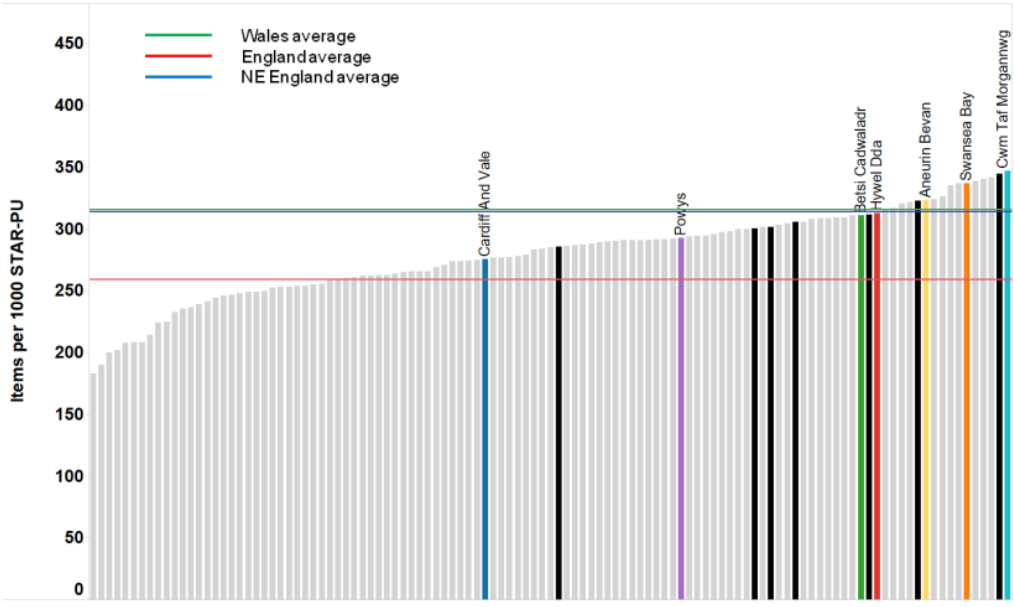


The ABUHB target for this measure is a quarterly reduction of 10% against a baseline of data from April 2019-March 2020. The GP practice target is to maintain performance levels within lower quartile, or show a reduction towards the quartile below, based on quarterly data from April 2022–March 2023. ABUHB is ranked fifth in terms of overall performance:

Trend in antibacterial prescribing items per 1,000 STAR-Pus

Antibacterial prescribing in Welsh health boards and English CCGs

(March 2024 qtr)



This remains a priority indicator in the CEPP. The prescribing trend is in line with other HBs. It should be noted that antibiotic use peaked in winter 2022-23 due to the invasive Group A Strep outbreak, during which the UKHSA, via national media outlets, encouraged patients to present for antibiotics. This has undone many years

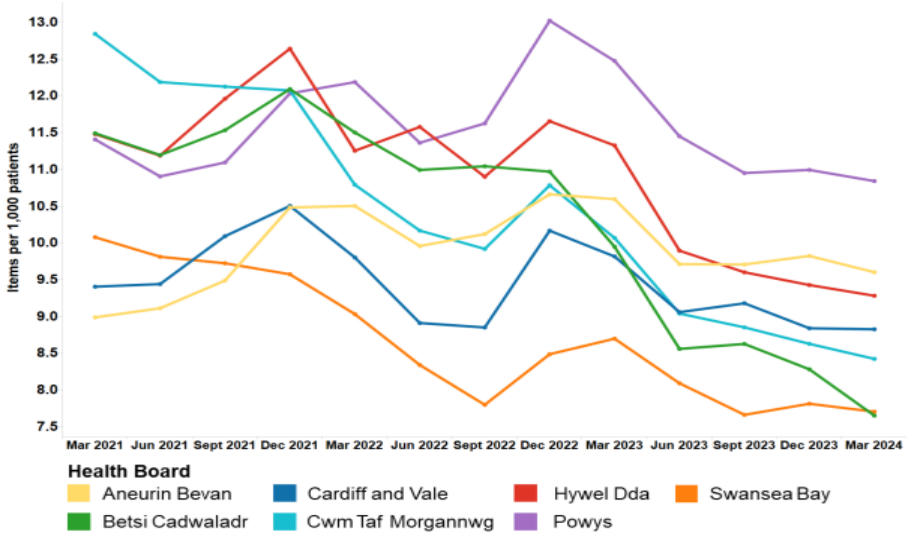
of public health messaging around antibiotic-seeking behaviours and prescribing levels remain elevated following this event. Significant efforts are required to reverse this.

ABUHB Antimicrobial Stewardship team includes two primary care pharmacists. A 0.4WTE primary care antimicrobial pharmacist post that was vacant for over 18 months was filled in 2023-24. The team engage outlier practices with audit and feedback cycles to identify prescribing themes, promote prescribing resources and agree an action plan with each practice. This approach has seen a reduction of antibacterial items per 1000 STAR PUs at two targeted outlier practices between Q4 2022/23 and Q4 2023/34: 6.7% decrease at Blaenavon Medical Practice and 5.9% decrease at Abersychan Group Practice, North Torfaen.

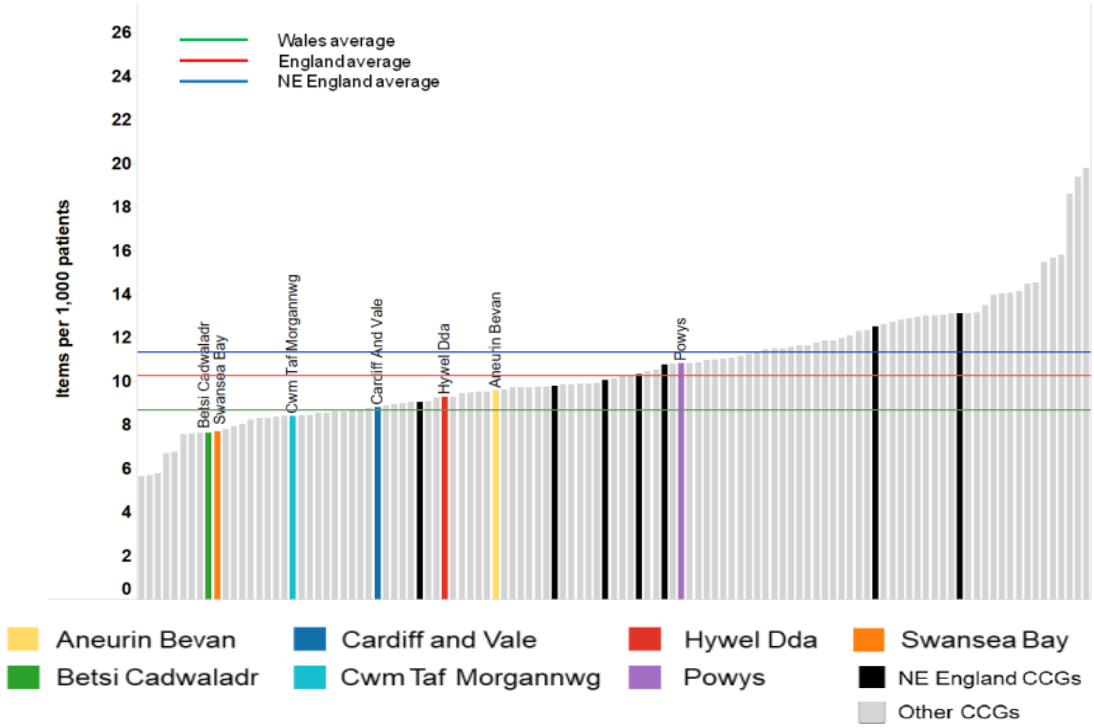
5.3.2.4 4C Antimicrobial Prescribing (items per 1000 Patients)

Although it is apparent that performance deteriorated from the lowest prescribing Health Board in Q2 2021/22 to the second highest in Q4 2023/24, ABUHB decreased prescribing by 9% between Q4 2022/23 and Q4 2023/24 in line with the aim of the indicator:

Trend in 4C antimicrobial items per 1,000 patients



4C Antimicrobial items per 1,000 in Welsh health boards and English CCGs (March 2024 quarter)



Broad spectrum antibiotics are associated with an increased risk of healthcare associated infections and this remains a priority indicator in the CEPP.

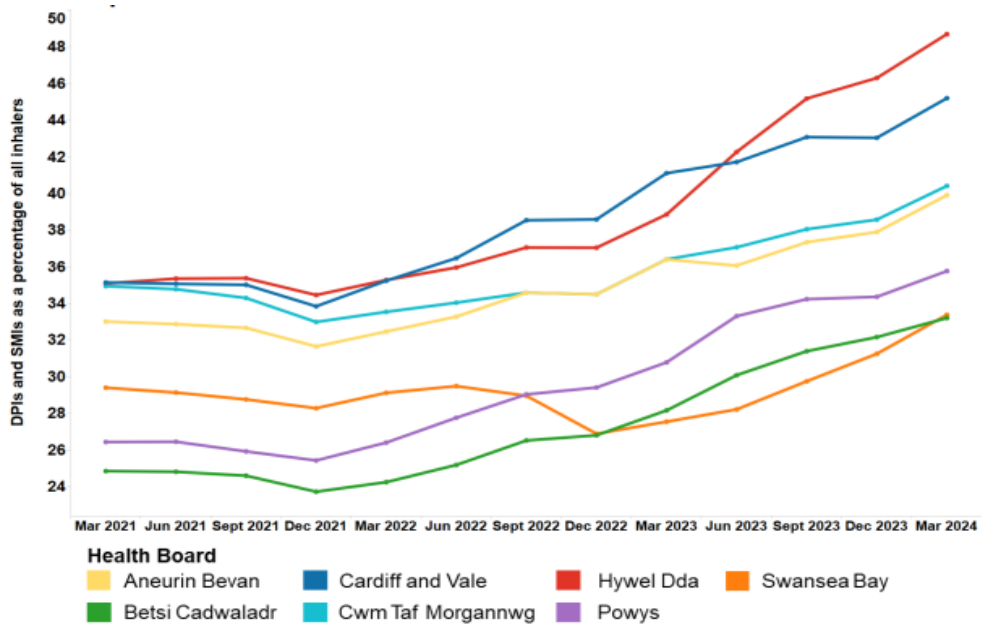
Evidence of benefit has been demonstrated in both Blaenavon Medical Centre and Abersychan Group Practice following support from the primary care antimicrobial pharmacists and both have seen a subsequent significant decrease in 4C prescribing between Q4 2022/23 and Q4 2023/24: 55.6% decrease at Blaenavon and 44.1% decrease at Abersychan.

5.3.2.5 Dry Powder Inhalers (DPIs) and Soft Mist Inhalers (SMIs) as a percentage of all inhalers

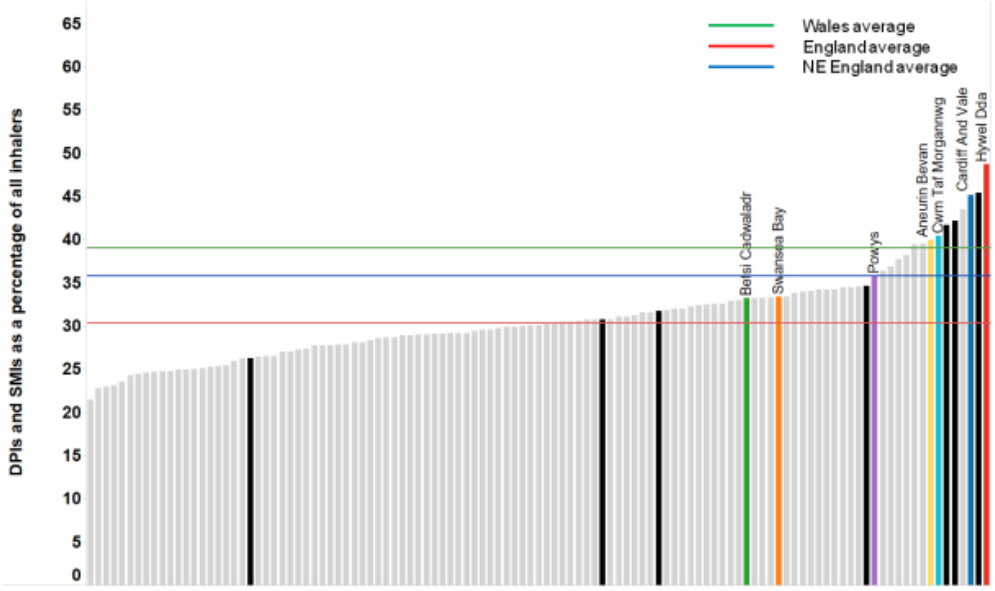
Metered dose inhalers (MDIs) are estimated to be responsible for 4% of the NHS entire carbon footprint. The target is a shift to 80% of inhalers being low global warming potential alternatives (for example, DPIs or SMIs) by 2025.

ABUHB achieved the indicator target threshold of 37.5% in Q3 2023/24 and has continued to exceed the target reaching 39.9% in Q4 2023/24:

Trend of DPIs and SMIs as a percentage of all inhalers



DPIs and SMIs as % of inhalers in Welsh HBs and English CCGs (March 2024 qtr)



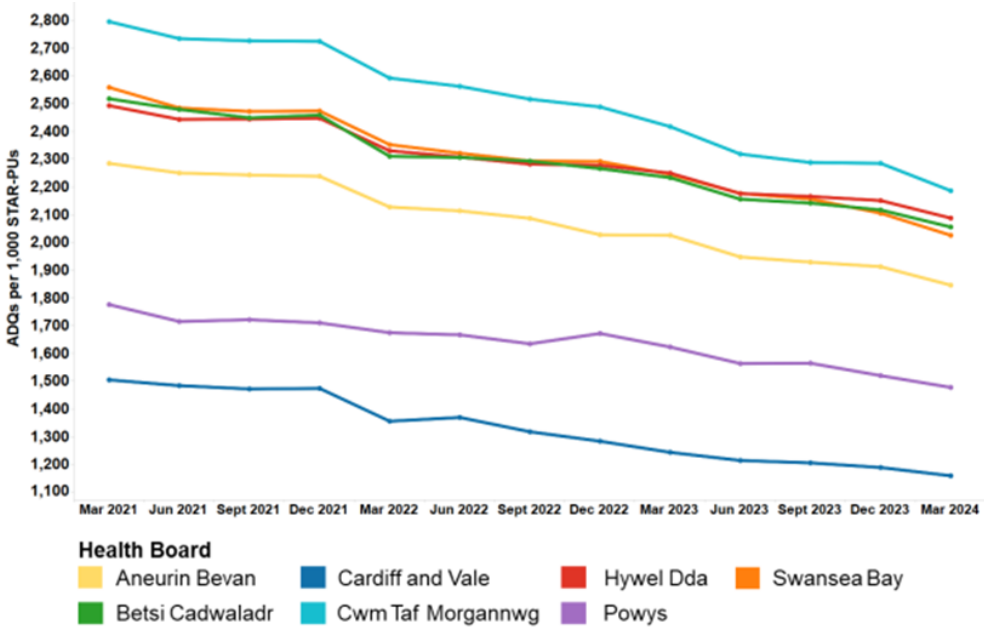
ABUHB continues to make progress towards this indicator target. In response to the NHS Wales decarbonisation strategic delivery plan GOV.WALES, ABUHB started work on the decarbonisation of inhalers with a focussed approach including the indicator in CEPP and supporting General Practice with Green Inhaler QI projects, part of the GMS contract. (See further detail in section 6.3.1 Green Inhaler Project).

5.3.2.6 Hypnotics and Anxiolytics ADQs per 1000 STAR-PUs

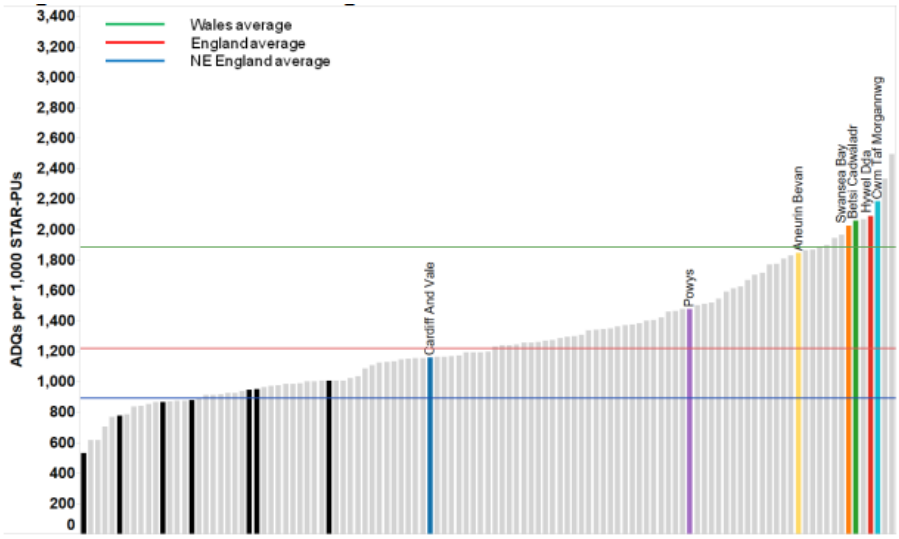
There has been concern with regards to the high level of hypnotic and anxiolytic prescribing in NHS Wales. ABUHB hypnotic and anxiolytic use is the 3rd lowest in

Wales and is positioned below the Welsh average. The HB continues to show a downward trend, reducing by 9% between Q4 2022/23 and Q4 2023/24:

Trend Hypnotics and Anxiolytics ADQs per 1000 STAR-PUs



Hypnotic and Anxiolytic prescribing in Welsh HBs and English CCGs (March 2024 qtr)



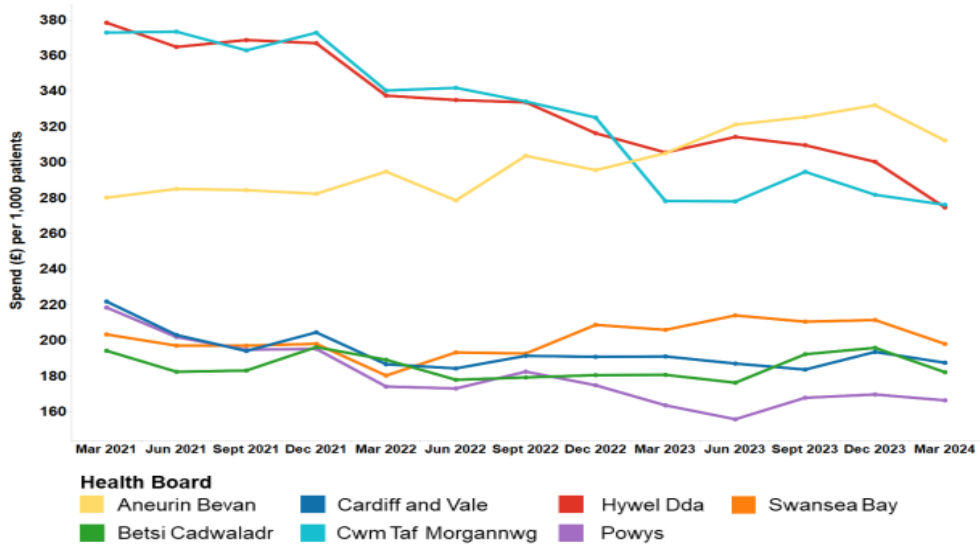
Practices are encouraged to use the AWTTC toolkit to audit patients and deprescribe.

5.3.2.7 Low value prescribing

The aim of the Low Value for Prescribing in NHS Wales initiative is to minimise prescribing items that offer a limited clinical benefit to patients and where more cost-effective treatments may be available.

The spend for low value prescribing has shown an increase during 2023/24:

Trend in Low value for Prescribing (UDG) spend per 1000 patients



As an NHS Value and Sustainability national priority, this indicator is being monitored by MMPB. The drivers for this increase are being investigated and an action plan for each item is being developed:

Low Value for Prescribing Paper 1

Item/Item Group	Action
Co-proxamol	No further action due to minimal prescribing
Lidocaine plasters	Review of local guidelines Reinforce ABUHB position to all clinicians Identify and engage with outlier practices to deprescribe
Tadalafil once daily	Low priority due to minimal savings and impact
Liothyronine	Refer patients to Endocrinology for review MTC consider review of formulary status from amber to red Promote lower acquisition cost preparations through ScriptSwitch
Doxazosin MR	Non-formulary message and promote switch to immediate release doxazosin and through ScriptSwitch Consider SOP to target switches

Low Value for Prescribing Paper 2

Item/Item Group	Action
Omega-3 fatty acid compounds	Await AWTTC statement to support deprescribing of non-formulary indications (CVD) in view of MHRA alert January 2024.

	Identify outlier practices in preparation for review MTC formulary review discussion planned
Oxycodone and naloxone combination product	Non formulary message on ScriptSwitch
Paracetamol and tramadol combination product	
Perindopril arginine	Non formulary message and promote switch to perindopril erbumine through ScriptSwitch

Low Value for Prescribing Paper 3

Item/Item Group	Action
Chloral hydrate	MTC review of formulary status to red in 2024
Minocycline	AMS team to explore static prescribing rates and advise on actions to reduce prescribing
Ascorbic Acid	MTC to review formulary status to red/non formulary
Ketovite	No further action due to minimal prescribing
Alimemazine	MTC to review formulary status to red
Blood glucose testing strips	Await All-Wales procurement review Renew SOP to enable pharmacy technician-led clinics in preparation for switch to All Wales BGTS Analyse ABUHB data through SPIRA dashboard Engage with Diabetic Specialist nurse team to refresh ABUHB BGTS Guidance
Aliskiren Probiotics Selenium Probiotics Rubefacients Silk garments	Non formulary message on ScriptSwitch

5.4 Transforming Access to Medicines (TrAMs)

The Transforming Access to Medicines programme is an NHS Wales initiative aimed at establishing a shared Pharmacy Technical Service (PTS) for Wales. The original business case was submitted to WG for approval following work from a dedicated project team drawn from every acute local HB and Velindre NHS Trust, supported by the NHS Wales Shared Services Partnership (NWSSP). The case detailed the transformation required to deliver PTS on a national level, moving away from the traditional local approach, to a regional/national one, allowing the NHS to capitalise on the emerging benefits of automation to build capacity and resilience, and unifying patient and clinician experience.

During 2023-24, ABUHB Pharmacy developed proposed operational models and corresponding staffing provisions for ABUHB that will be implemented once the TrAMs programme is launched. These models cover the ordering, receipting, dispensing, checking, dispatching and stock rotation of critical ready-to-administer injectable medicines, such as chemotherapy and parenteral nutrition. For ABUHB patients to continue to receive these treatments in a safe and timely manner, it is essential these staffing models are followed. The staffing provision for these models has been submitted to the TrAMs programme team. An SBAR report has also been presented to the ABUHB Executive Team, highlighting this submission and the assumptions used in calculating staffing requirements.

5.5 Radiopharmacy

Nuclear Medicine (NM) is a specialised area of radiology, where very small amounts of radioactivity are administered to a patient in the form of a radiopharmaceutical injection. This allows the structure and function of internal organs to be visualised using a gamma camera. ABUHB has two NM departments, one at RGH and another at NHH, both of which use injectable radiopharmaceuticals to perform vital diagnostic tests.

The Pharmacy team were asked to provide support to NM in mid 2023, following an abrupt halt in the supply of ready-to-administer doses of radiopharmaceuticals when the usual supplier unexpectedly closed down. Alternative suppliers were only able to provide multi-dose vials of radiopharmaceuticals, meaning that individual patient doses had to be drawn up in the NM departments.

Quality Assurance pharmacists worked closely with the NM service leads from October 2023 to support safe procurement, draw-up and governance of radiopharmaceutical use at both sites. This included implementing formal Quality and Technical agreements; improving NM record-keeping for radiopharmaceutical use; writing a set of SOPs to cover aseptic technique, transfer decontamination and cleaning processes; and establishing a pharmacy "Train the Trainer" aseptic technique programme for radiographers. As a result of the support from pharmacy, the NM service is now providing safe and effective interventions for patients which are underpinned by appropriate organisational governance arrangements.

5.6 Policy development

During 2023-24, four Pharmacy policies were updated and ratified by the Clinical Standards and Policy group. In addition the self-administration policy was removed so that this could be reviewed and updated, due to inappropriate use at ward level without adequate governance.

ABUHB 1108	**Protocol for the Use and Administration of Ferric Derisomaltose in Adults.pdf**	**20/04/2023**	**20/04/2026**
ABUHB 0099	**Use of Injectable Drugs Policy.pdf**	**18/05/2023**	**18/05/2026**
ABUHB 0804	**Antimicrobial Stewardship Policy.pdf**	**30/05/2023**	**30/05/2026**
ABUHB 0093	**Dispensing TTH Medicines Out of Hours or in areas without Pharmacy Support.pdf**	**16/02/2024**	**16/02/2027**

5.7 Clinical Informatics

During 2023-24, Pharmacy have been involved in 2 main projects:

5.7.1 e-handovers

E-handovers have been rolled out to all ABUHB sites with a plan to allow better sharing of information between sites with a standardised formatting. The next iteration is planned for release in 24/25.

5.7.2 Homecare SharePoint

The second major project has been the development of the Homecare SharePoint pages. The SharePoint pages aim to be a one-stop resource for clinical teams to access homecare resources.

6 Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.

6.1 Medicines Management Programme Board (MMPB)

The MMPB meets monthly and oversees implementation and delivery of the MM work streams, with the aim to ensure that medicines prescribed do the greatest good with the minimum effective intervention and the least harm, within available resources. This supports the implementation of the Health and Care Quality Standards with respect to the domains for effective and efficiency care.

MMPB roles include:

- Leadership on safe and effective use of medicines
- Development of the MM Optimisation plan
- Monitoring financial performance of the work stream
- Maximising benefits of the primary – secondary care interface
- Scrutinising performance using KPIs and benchmarking
- Ensuring appropriate actions resulting from internal and external audit
- Approving annual MM Savings plans including any associated components
- Providing oversight on horizon scanning of NICE / AWMSG

6.1.1 Value and sustainability

In October 2023 and March 2024, WG wrote to HBs following meetings of the NHS Value and Sustainability Board. The letter described a series of recommended actions to reduce expenditure and address the significant financial challenge faced by NHS Wales. All HBs were asked to focus on 13 national priorities and ensure that:

1. Best value product is chosen every time
2. Losses from local procurement are minimised
3. No-or-low value prescribing is eliminated

VALUE AND SUSTAINABILITY NATIONAL PRIORITIES

Key Activity		Opportunity
1	Biological Medicines	Biological medicines are only initiated with the lowest acquisition cost biosimilar.
2	Low Cost Biosimilars	All patients currently treated with a reference product or higher cost biosimilar medicines are prescribed the lowest acquisition cost biosimilar medicine.
3	Secondary care switch to generics	Complete switch to generic use for abiraterone, apixaban, lanreotide, lenalidomide, teriflunomide, sugammadex and dovobet in secondary care.
4	GP Prescribing	GPs stop prescribing medicines by brand where significantly lower cost generics are available.

5	Stop outsourcing	Stop outsourcing of preparation of nivolumab, atezolizumab and rituximab to commercial sector and purchase all future supplies from the NWSSP.
6	Off-contract costs	Review all off-contract procurement, stop all unjustified purchasing and put systems in place to recover any excess costs.
7	Off-contract recovery costs	Identify an individual from procurement and finance teams to work with NHS Wales Procurement to ensure all recoverable costs associated with off-contract purchasing are recovered.
8	Low priority prescribing	Revisit areas previously identified as low priority for prescribing in Wales.
9	DOAC analysis	Undertake analysis of direct oral anticoagulant (DOAC) prescribing in primary care and ensure patients prescribed DOACs for non-valvular atrial fibrillation are reviewed and, where clinically appropriate, switched to apixaban
10	Preferred list of dry eye	Ensure all patients prescribed a treatment for dry eye are only prescribed a dry eye preparation included on the ABUHB preferred list, or where the HB does not have its own preferred list, the preferred list of another HB.
11	Best value switch	Review patients prescribed liothyronine with the intention of switching to thyroxine or where considered clinically appropriate, ensuring best value liothyronine preparation is prescribed
12	Emollients	Limit prescribing of bath and shower emollients
13	GP restricted medications	HBs should ensure GPs stop prescribing medicines from a list of restricted medicines including those available to purchase over the counter which are of limited clinical value

The HB was asked to consider these priorities, progress where appropriate and give assurance these opportunities are realised as quickly as possible.

Dashboards have been developed to support monitoring:

- Optimising Medicines Value Toolkit - Power BI
- Server for Prescribing Information Reporting and Analysis (SPIRA) - All Wales Therapeutics and Toxicology Centre (nhs.wales)

ABUHB progress and savings realised against the 13 priorities are monitored monthly through the MMPB meetings.

6.1.2 Prescribing Efficiencies

The table below shows month 12 savings forecast for each division and comparative performance in previous years.

During 23/24, a newly funded 1 WTE 8B Divisional Programme pharmacist post for Medicine became available and saw successful recruitment. Alongside the Divisional Programme pharmacist for Scheduled care, these roles focus on delivering value and sustainability priorities within secondary care, along with directorate and procurement colleagues.

Division	2021-22 Savings Delivered £'000	2022-23 Savings Delivered £'000	2023-24 Savings Forecast £'000
Primary Care	935	1,180	4,227
Family & Therapies	93	49	43
Mental Health	0	0	269
Scheduled Care	273	1,515	1,294
Clinical Support Services	0	0	0
Medicine	460	0	190
Urgent Care	11	0	9
All other Divisions	0	0	0
sub-total	836	1,564	1,804
Velindre	0	0	0
Other Welsh Health Boards	0	0	0
Total ABUHB	**1,771**	**2,744**	**6,031**

6.1.2.1 Scriptswitch®

In the 2023-24 CEPP scheme, ABUHB promoted Scriptswitch, an innovative prescribing decision support tool, delivering savings and improving patient care. GP practices were incentivised to meet an acceptance rate of 40%. Scriptswitch provides prescribing information and alternative recommendations at the point of prescribing via a clear and pop-up message. Details for the recommendation and cost-benefit in the case of a switch are summarised in the display. Prescribers choose to accept or decline any recommendation.

Summary for 2023-24

175,682 switches were offered with an overall acceptance rate of 43.23% (76,824).
Return on investment is £10.20 for every £1 spend

ABUHB calculated annual saving

- £229,819 of Acute prescription savings
- £925,737 of Repeat prescriptions savings
- **Total saving £1,155,556**

6.1.2.2 Prescribing Intervals

All-Wales Guidance on Prescribing Intervals (October 2022) concluded that, there would be a benefit to pharmacies, GPs and patients if dispensing intervals were extended, allowing more patients to have prescribed medicines dispensed less frequently. GP practices and pharmacies have been encouraged to review intervals and extend where suitable. The graphs below show progress made during 2023-24:

Summary of progress made for increasing prescribing intervals

The Welsh Analytical Prescribing Support Unit (WAPSU), the analytical unit of the All Wales Therapeutics and Toxicology Centre (AWTTC), has developed a dashboard to report on progress in increasing the interval of prescribing durations within primary care in Wales. These data related to a selected basket of medicines which has been agreed by key stakeholders across Wales. This report provides some of the main metrics provided within the dashboard.

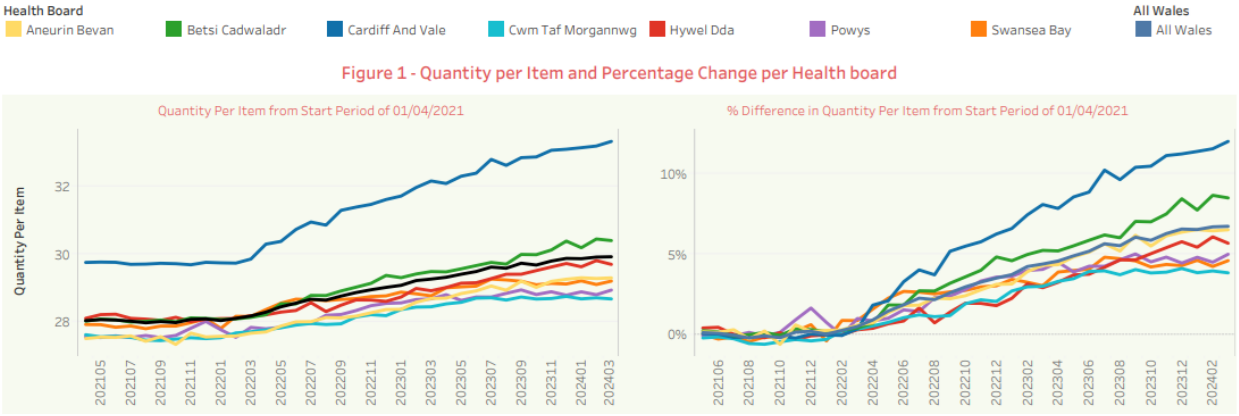


Figure 1 - Quantity per Item and Percentage Change per Health board

6.2 Value Based Healthcare

6.2.1 Diabetes project

In 2023, the value-based healthcare team, funded a project to provide a diabetes optimisation service to GP practices focusing on the prescribing sodium-glucose co-transporter-2 inhibitors (SGLT2is) to improve health outcomes. The project team consisted of independent prescribing pharmacists (IPs) and a pharmacy technician and is supported by secondary care consultant nephrologists and diabetologists.

The project objectives were to identify patients with Type 2 Diabetes who have CKD/risk of chronic kidney disease and who would benefit from initiation of an SGLT2i. Lifestyle and dietary advice were provided, medication optimised and where necessary treatments deprescribed.

Over 500 patients were reviewed with ABUHB. In March 2024, the project secured funding for a second year.

6.3 Decarbonisation

6.3.1 Green Inhaler Project

In response to the NHS Wales decarbonisation strategic delivery plan GOV.WALES, ABUHB started work on the decarbonisation of inhalers including developing resources for health care professionals and raising awareness education sessions. These have supported General Practice with their Green Inhaler QI projects and working towards the preferential prescribing of low global warming inhalers with the National Prescribing Indicator included in the GP prescribing incentive scheme (CEPP).

During 2023-24, further education sessions on sustainable inhaler prescribing were provided for Foundation Pharmacists, Managed Practices, Primary Care Respiratory Specialist Nurses and NCNs. This included a respiratory 'Back to Basics' presentation at pan Gwent Winter Pressures events to highlight value-based respiratory care is good for patients, the planet, and the organisation. This was also reinforced at a therapeutic respiratory review presented to MMPB.

The Respiratory MM Pharmacist collaborated with other health care professionals on a local and national level to promote sustainable respiratory prescribing. This included working with the National Asthma Clinical Lead to update the All-Wales Asthma guideline which supports reducing salbutamol over-reliance and providing data and educational support to ABUHB primary care respiratory nurses to reduce salbutamol over-reliance in high prescribing practices.

6.3.2 Paracetamol practice initiative

Paracetamol is one of the most widely prescribed drugs for hospital inpatients. Many patients in GUH received IV paracetamol doses, when oral paracetamol tablets would be safer, more effective and provide cost savings of £13,000 and environmental savings (400kg plastic waste reduction/700kg CO2 saving/year).

In conjunction with the pharmacy team, an anaesthetic clinical fellow introduced an intervention on the automated pharmacy dispensing units (Omnicells) in theatres, prompting nursing staff to consider oral paracetamol instead of IV.

This resulted in a 21% reduction in IV paracetamol use, with only 24% of IV paracetamol given without clear indication. This has since been expanded to GUH wards and across ABUHB.

The initiative received the 2023 Barema & Association of Anaesthetists Environmental award.

7 Equitable

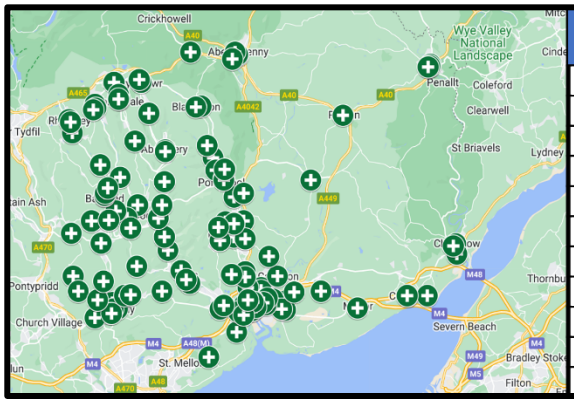
Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.

7.1 Community Pharmacy Services

One hundred and twenty-five community pharmacies provide NHS pharmaceutical services to the citizens of ABUHB in accordance with the terms of service laid out in the NHS (Wales Pharmaceutical Services) Regulations 2020. Alongside dispensing services, pharmacies provide a range of additional commissioned clinical services. As independent contractors, community pharmacies also provide private services outside the remit of the NHS terms of service. These private services include delivery, provision of compliance aids and travel vaccinations.

7.1.1 Pharmacy distribution and opening hours

Community pharmacies are distributed across the HB according to previous historical arrangements for control of entry. They must open for 40 "core" hours and may also



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

open for additional "supplementary" hours. The HB must be notified of all changes to opening hours but only core hours need HB consent for change.

Opening hours range from 8am to 8pm Monday to Saturday, with some pharmacies opening between 10am and 4pm on Sundays. Most pharmacies are open between 9am and 6pm Monday to Friday and just over half open for at least part of the day on Saturday. Eight pharmacies open on Sundays.

7.1.1.1 Pharmacy reduction in hours

In 2023-24, ten pharmacies reduced opening hours including stopping Saturday hours. Six of these involved a change to supplementary hours. This is an ongoing trend to reduce total opening hours to maintain viability.

7.1.1.2 Pharmacy reduction in hours

Five pharmacies ceased to trade during 2023-24. Two Boots pharmacies in Newport, one Boots in Pontypool, Knights Pharmacy in Newbridge and Allied in Ystrad Mynach. The closures did not create a gap in services and no new pharmacies opened in their place.

7.1.2 Contract Monitoring

In 2023-24, 41 pharmacies received contract monitoring visits with 39 fully compliant with the terms of service during the monitoring period. Remedial notices were needed to effect change in 11 cases and 1 breach notice was issued. The community pharmacy team continue to work with the remaining two contractors to attain compliance.

7.1.3 Performance Related Sanctions

During 2023-24, 88 potential breaches of NHS Terms of Service were investigated, and 3 breach notices issued.

7.1.4 Information Governance

Community pharmacy professionals' access to NHS data sources (Choose Pharmacy) is monitored using the National Intelligent Integrated Audit Solution (NIIAS) system. During 2023-24, 44 potential breaches were identified, documented and communicated to superintendent pharmacists for investigation and appropriate action.

7.1.5 Patient Safety Incident Reporting

Community pharmacies are obliged by the NHS term of service to report patient safety incidents to the "Once for Wales Primary Care Wales National Incident Reporting tool", DATIX Cymru. All reports are received by the HB community pharmacy lead and a MM pharmacy technician, for receipt and closure. Responsibility for investigation and management lies with the pharmacy contractor. During 2023-23, 384 incidents were receipted and closed. For context, over 16 million prescription items and 100,000 patient consultations were completed during the same period.

7.1.6 Service commissioning

Alongside dispensing services, the clinical services listed below are also commissioned by ABUHB. The services are commissioned via 764 individual SLAs, stipulating provision in line with agreed national or local service specifications. NWSSP manage an additional 162 agreements for the Clinical Community Pharmacy Service and the Pharmacist IP Service.

Service name	Number of pharmacy providers
Care Home Support	4
Clinical Community Pharmacy Service • Common Ailments • Emergency Contraception • Emergency Supply • Seasonal Influenza	125
Covid vaccination service	5
Directly Observed Therapy	commissioned on demand
Discharge medication Review	125
Inhaler use review	43
Medicines Administration Record Supply	106
Needle Exchange	27
Out of hours rota	64
Palliative Care Out of Hours	7
Pharmacist Independent Prescriber	37
Prison supply service	1
Smoking cessation level 2	123
Smoking Cessation level 3	93
Sunday rota	25
Supervised Consumption	115
Tuberculosis Compliance Support	2
Urgent Medicines Supply	24
Waste Reduction Intervention	107

7.1.6.1 Community Pharmacy Activity

During 2023-24, ABUHB community pharmacies:

- Dispensed 16,384,273 prescription items (+0.5%)
- Provided:
  - 63,089 Supervised medication doses (11%)
  - 53,619 Common Ailments consultations (+44%)
  - 18,668 Emergency Supply consultation (supplying 31,661 med) (+29%)
  - 14,095 Seasonal Influenza vaccinations (-43%)
  - 11,677 Pharmacist IP consultations (+130%
  - 4,228 Emergency Contraception consultations (+5%)
  - 4,510 Smoking Cessation (level 3) consultations (+36%)
  - 3,500 Medicines Administration Record Charts (-30%)
  - 2,403 Discharge Medication Reviews (+8%)

7.2 Prison services

ABUHB are responsible for overseeing healthcare and pharmacy services at HMP Usk and Prescoed.

In April 2023, the Lead Prison Pharmacist submitted an action plan in response to Welsh Government's 'Pharmacy Service Review' in HMP Usk and Prescoed. This plan laid out the vision for improvements to pharmacy provision in both prisons to ensure equitable healthcare for prisoners residing in the sites.

2023 saw the recruitment of new staff to the Prison Pharmacy team. The team now has a part time pharmacist and 2 part time pharmacy technicians who ensure pharmacy cover across the prison sites. The team undertakes:

- Audit and report into MM, medicines strategy, Prison Delivery Group and Prison Partnership Board meetings; including attending prisoner MDT meetings to support with medication queries and complex patients.
- Collaborative work with other prison pharmacy teams through All-Wales Prison Pharmacy Group, allowing sharing of best practice and knowledge.

7.2.1 Prison Pharmacy service

The pharmacy service to prisoners provides:

- Face-to-face clinical reviews with the prisoners.
- Targeted codeine medication reviews, supporting reduction where appropriate.
- Pharmacy technician led medicines reconciliation.
- Support with Cell Medication Checks, enabling pharmacy technicians to highlight compliance and safety issues.
- Increased monitoring of high-risk medication including SCPs in line with ABUHB guidelines.

- Support with Public Health response to Flu and COVID outbreaks.
- Health promotional information provided to prisoners to support taking medication during Ramadan, 'Staying safe in the sun' and managing medications in the prison environment.
- Yellow card reporting of suspected side effects to medicines, response to MHRA safety alerts and medication shortages, to minimise disruption to treatment.

7.2.2 Community Pharmacy Provision to Prison

The community pharmacy provision of medication to the prison was reviewed, a new enhanced service created, and additional funding secured to help ensure sustainability of ongoing provision. After a successful tendering process, Raglan Pharmacy secured ongoing pharmacy provision to HMP Usk and HMP Prescoed.

7.3 Mass Vaccination Programme

The pharmacy vaccination team consists of 6 WTE Band 4 senior assistant technical officers (SATO) staff, managed by a Band 6 senior pharmacy technician and led by a Band 8b lead pharmacist. The team provide a core immunisation resource to support improving uptake rates, address vaccine inequities and mobilise a response to outbreaks and emerging risks.

2023-24 saw the Mass Vaccination Programme change to a vaccination service supporting implementation and delivery of the National Immunisation Framework (NIF). In addition to delivering Spring and Autumn COVID-19 vaccine programmes, the team supported increased uptake of child/adult flu and MMR vaccine.

The vaccine storage and distribution hub moved from the vaccination centres to the central Llanfrechfa Grange Hospital site. Vaccination clinics were held in a variety of community centres and hospital outpatient departments across ABUHB. The role of the pharmacy team has developed to focus more on multiple vaccine ordering, storage and distribution from vaccine hub to vaccination sites; as well as providing clinic support, diluting vaccine and managing vaccine supply.

GP practices and multiple community pharmacies are commissioned to deliver COVID-19 vaccines. The pharmacy team have a role in providing training and support to these primary care sites, as well as managing vaccine ordering and stock management for all sites.

8 Person Centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

8.1 Patients

8.1.1 Secondary Care

Several developments were enacted over the 2023/24 period within the secondary care sector to improve person-centred care. These changes were essential, both to maintain pharmacy services during times of severe staff shortages/vacancies, as well as providing opportunities for staff to upskill, learn new skills and improve job satisfaction.

The role of a pharmacy technician enhanced significantly – with improvements in compiling patient medicines reconciliation and becoming smoking cessation champions at ward level. This provides a benefit to patients in ensuring timely medicines reconciliation, as discrepancies can be resolved quickly and efficiently ensuring patients receive the right medications at the right time.

Smoking cessation remains a high priority within the HB and we have a number of staff who provide this service. Patients can access support as inpatients but also make lifestyle changes that can continue once they have been discharged from hospital, as they have increased knowledge and access to available services in the community.

GUH site saw implementation of a pharmacy technician and pharmacy assistant rotational programme, where staff were assigned to rotate through several specialist areas. This ensured staff were competent and confident to provide a service in these areas which resulted in improved staff wellbeing and a better patient experience.

RGH initiated a pharmacy-technician led ward service to areas where patient turnover/acuity was lower, allowing the pharmacy technician to be the first point of contact of review and queries. The pharmacy technicians in collaboration with the ward pharmacist developed a RAG rating system to standardise the process for escalating patients to the pharmacist where clinically required. This allowed the scarce pharmacist resource to be utilised in areas of higher demand where their clinical skills provided greater input to patient care.

8.1.2 Homecare

Homecare services continue to expand and deliver greater savings to ABUHB, with additional medicines regularly being made available to clinical teams. The total number of patients managed via homecare increased from 1,925 to 2,324 over the period April 2023 to April 2024, an increase of 21%.

Patients under the care of Medicine account for 52% of the total. The total spend over the financial year has increased by £340k, an increase of 2.6% on the previous year; and represents 23% of secondary care medicines expenditure. Continued work to deliver savings using best-value biosimilars has resulted in this increase being less than the 3.6% increase seen within non-homecare expenditure.

Distribution of patients across homecare providers has changed over the past year. Some services closed as a result of poor provider performance and significant negative press coverage, and other providers also saw challenges in managing services. Where this occurred, patients were transferred to more appropriate providers or repatriated to ABUHB care where appropriate.

The homecare digital infrastructure migrated to SharePoint, resulting in an entirely paperless archive process. Due to the requirements of the Medicines Act 1968, prescriptions remain "paper-bound", although pharmacy tested the potential possibilities with digital prescribing. Data-collection and reporting processes for medicines expenditure improved. Out-of-Area recharging and detailed reports were generated with finance each month.

The All-Wales homecare landscape progressed, with significant operational and strategic changes, leading to centralised delivery of contracting and service level agreements under NWSSP. NWSSP stepped forward to chair the Welsh Homecare Medicines Committee to redefine the committee's strategic objectives and delivery standardisation across Wales regarding the quality of provision of homecare services. There continues to be significant challenges relating to the implementation of the All-Wales automated invoice processing initiative and the automated update of the Primary Care record.

Within ABUHB, the Homecare Policy was reworked in response to the report published in November 2023 by the Public Services Committee, and the revised RPS Professional Standards for Homecare Services 2024.pdf (rpharms.com) published in January 2024.

8.1.3 Community Resource Team (CRT)

In October 2023, the CRT Pharmacy team were awarded Regional Integration Fund (RIF) Extension funding for 7 posts as system resilience: 3 WTE pharmacists (band 8a); 2 WTE pharmacy technicians (band 5); 2 WTE pharmacy assistants (band 3).

The aim of the successful bid was to:

- Roll out CRT Pharmacy service across all 5 boroughs.
- Provide cover across boroughs and improve consistency of service.
- Provide a more proactive approach by visiting patients identified as more vulnerable/at risk for medicines review at home.
- Utilise vacant 0.7 WTE 8a post funding from the acute service for community hospital ward cover in Chepstow and County hospital sites to fund an 8th new post, a band 6 clinical pharmacy technician to lead the ward pharmacy service.

All 8 posts were successfully filled in 2023-24.

Employing pharmacy assistants to process WP10 prescriptions to community pharmacies and chasing/checking stocks has allowed better staffing skill mix. One of the pharmacy assistants works in Caerphilly borough which has the highest patient throughput; the other based between Chepstow and County hospital sites providing support to the ward pharmacy service.

All band 8a clinical pharmacists are IP qualified.

The pharmacy technicians started the BTEC level 4 Pharmacy Clinical Services qualification. All pharmacy technicians undertook clinical interventions that contributed to improved safety of frail elderly patients with remote pharmacist support.

8.1.4 Care homes

The care home pharmacy team was re-established in the summer of 2023 and consists of a pharmacist and two pharmacy technicians with the aim to improve MM in ABUHB care homes by providing specialist pharmacy knowledge, escalating any causes of concern, providing the right support, streamlining processes and improving knowledge of medication. The team provide support to GP surgeries and pharmacies to improve working relationships and streamline processes to ultimately improve resident care.

During 2023-24 the team visited all ABUHB NHs with the complex care governance nurses to offer pharmacy support.

Work undertaken by the pharmacy technicians included:

- Completion of 25/47 NH annual medication audits and 1 residential home (upon request by Care Inspectorate Wales). Provision of verbal feedback and extensive written report of recommendations. Report shared with supplying GP surgery and pharmacy.
- Links with GP surgeries to support care home processes and created posters for reference.
- Additional advice and support to specific NHs when requested.

- Researching/answering queries and give advice to governance nurse/CIW.
- Work with secondary care to improve discharge process for NH residents.
- Compiling new SOPs for medication audit in a NH, writing a detailed report and collating in SharePoint folder.
- Supporting homes with implementing a new medication ordering process when My Health On-Line (MHOL) discontinued.
- Developing a fridge storage poster following audit concerns.
- Working with antimicrobial pharmacist and public health nurses to address national shortage of scabies treatment during an outbreak in a home and creating a policy of how to obtain treatment under these circumstances.
- Attending and contribute to 8-weekly All-Wales Care Home Forum.

The care home pharmacist provided a clinical pharmacy service to care homes, completing medication reviews and feeding back the information to GP surgeries. These reviews included a visit to the home to discuss medication with staff (and residents if able), review of medication administration record charts and a remote review of the medication using CWS and Welsh Clinical Portal. Reports were sent to the home and GP surgery, with recommended actions such as; querying indications for medication, suggested monitoring and polypharmacy reviews. The baseline data from these initial reviews was collated to improve the service going forward.

The care home pharmacist provided training sessions to health care support workers and nurses in complex care on medication, administration, commonly prescribed medicines and side effects etc. and responded to any medication queries or issues.

8.2 Staff and resources

8.2.1 Staff Profile

The pharmacy directorate has evolved its workforce in all sectors in line with the ABUHB Pharmacy Clinical Futures workforce plan (and Delivering a Healthier Wales), ensuring that skills, expertise and practice are aligned to provide the highest value for local demographic needs. This has included advancing practice and roles for pharmacist, pharmacy technicians and pharmacy assistants, including developing the role of the clinical pharmacy technician and further embedding of pharmacist Non-Medical Prescribers (NMPs) into intermediate, primary and secondary care services.

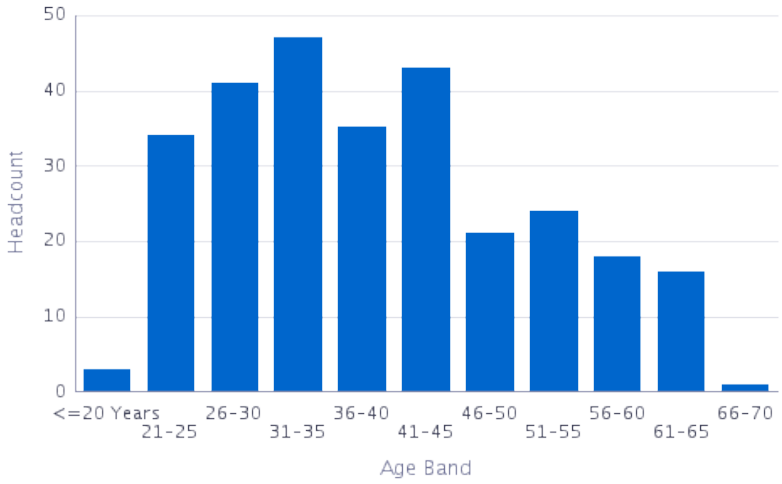
Recognition must be given that this wholescale system wide upskilling and advancement is not necessarily a sustainable model moving forward, without significant investment or allocation of resource across the sectors. There is a now a real risk of workforce training 'burnout', given the ever-increasing demands from areas including service delivery redesign/expansion and training programme requirements.

Benchmarking of Pharmacy Services (from HEIW) demonstrates that, compared with all other HBs in Wales, ABUHB continues to have a substantially lower number of pharmacy staff (hospital and primary care) per 10,000 population across all pay bands.

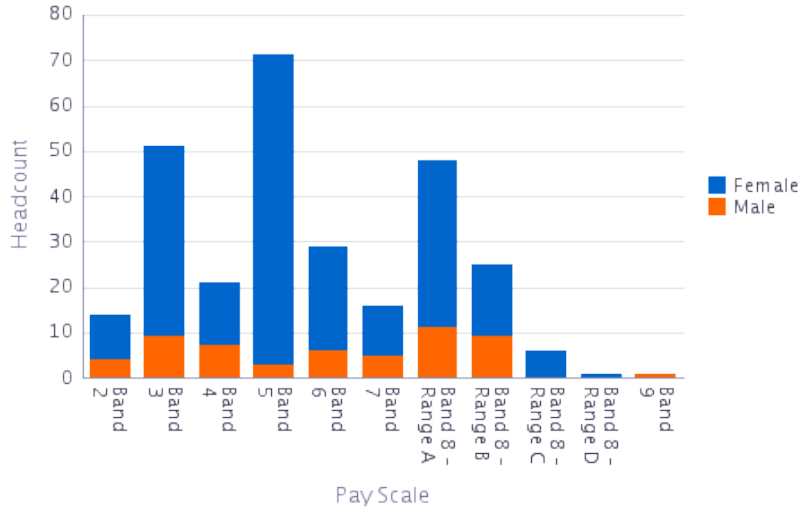
Health board	Population Est 2023	FTE April 2024	FTE per 10K population
ANEURIN BEVAN UNIVERSITY LHB	595412	97.76	1.64
BETSI CADWALADR UNIVERSITY LHB	691991	187.26	2.71
CWM TAF MORGANNWG UNIVERSITY LHB	446514	130.14	2.91
CARDIFF AND VALE UNIVERSITY LHB	518269	168.39	3.25
HYWEL DDA UNIVERSITY LHB	388139	110.40	2.84
POWYS TEACHING LHB	134439	12.59	0.94
SWANSEA BAY UNIVERSITY LHB	389640	147.98	3.80
Wales	**3164404**	**918.73**	**2.90**

This issue was also identified in the Wales Audit Office review of MM for ABUHB. The low staffing levels impact on the ability to deliver services and limit opportunities for staff training and development.

The age profile of the pharmacy team across all sectors shows 21% of the team are over the age of 50.



81% of Pharmacy staff are female.



8.2.2 Primary care

Retirement and staff moving across into direct employment at GP practices has resulted in opportunities to recruit younger staff into the team and innovatively move towards the new primary care structure. Alongside the core MM team of lead pharmacists, prescribing advisers and prescribing support pharmacy technicians are the re-established care home team, new prison pharmacy team and primary care antimicrobial pharmacists.

Neighbourhood Care Networks (NCNs) continue to see a reduction in the number of band 8a practice-based pharmacists as more practices choose to directly employ both pharmacists and pharmacy technicians.

Continuous recruitment and retainment challenges have had expected consequences on service delivery and ability to fully engage with opportunities to develop and train staff. Additionally, primary care has limited recourse to entry level roles and established layers of workforce infrastructure for resilience, with more weighting towards specialist roles in both the pharmacist and pharmacy technician groups. As a high priority for the next 12 months, and potentially in

collaboration with secondary care and CRT, work will be undertaken in looking at sustainable workforce pipelines into primary care to build resilience and identifying potential for more utilisation of the pharmacy assistant role.

8.2.3 Secondary care

The secondary care pharmacy workforce remains on the national staff shortage list and faces major ongoing challenges in the recruitment and retention of highly skilled and trained staff.

The delivery of pharmacy services necessitates a workforce that is highly skilled, focused, and motivated to ensure the provision of high-quality patient care across various sites and settings. Current ABUHB acute/secondary care pharmacy staffing levels, benchmarked as number of staff per 100 beds, are below both national and Welsh averages. Total WTE in post per 100 beds is 17.4, whilst total WTE in establishment per 100 beds is 19.5, reflecting current vacancy rates.

Acute pharmacy team vacancy rates are 11% (Wales mean 5.8%), placing ABUHB in the upper quartile of peers. The pharmacist vacancy rate is 13% (Wales mean 7.4%), also in the upper quartile. There is a clear vacancy issue with band 7 Pharmacists, where ABUHB currently has a 50% vacancy rate compared to the national average of 31%, resulting in a substantial impact on delivery of ward-based services across all sites. Due to the high pharmacist vacancy rate, the pharmacy team relies more heavily on pharmacy technicians compared to peers nationally.

Pharmacy technician roles have been identified as a pivotal driver for future developments and opportunities across pharmacy services. However, ABUHB are entering a period of challenge with the age profile of a significant portion of the secondary care legacy pharmacy technician workforce. Work has been started to mitigate this risk through succession planning and workforce mapping. However, this remains a key concern in the coming year – not just with the loss of the person, but the skills, knowledge and experience that are lost after long-term careers in ABUHB.

The requirement for and from pharmacy technician roles is anticipated to exponentially increase across all sectors. The Pharmacy directorate have instigated a number of pieces of work to meet this demand including developing new pharmacy assistant roles (band 2+3) to reduce the identified staffing gaps, and to enable release of pharmacy technician resource to take on more advanced roles

In 2023, due to difficulties in procuring a HEIW commissioned course, a fallow period for training pharmacy technicians in Wales between Spring 2023 and February 2024 was encountered leading to significant workforce impact of no new registrants during this period.

Retention of band 6 and 7 pharmacists continues to be a significant issue in secondary care as pharmacists move for promotion to 8a posts in other sectors or neighbouring HBs. ABUHB also has the additional challenge of losing staff across the border to England, as well as the workforce recognising the inherent staffing shortages experienced at ABUHB and the impact this has on morale and wellbeing.

Staff are also leaving for portfolio/split role working opportunities which other sectors are more primed to offer. This is of particular concern when looking at increasing trainee pharmacist and band 6 training pipelines in the current challenging climate, where there is real risk of very little return on investment in retention of staff. Work is currently being undertaken to see where innovation with newly designed roles would mitigate this risk i.e. split HEIW/HB Band 7 roles.

The secondary care pharmacy workforce at ABUHB faces significant challenges. Establishment baseline per 100 beds is low compared to the rest of Wales. This, combined with a high vacancy rate of 11%, a 10.4% staff turnover rate, and a high sickness/ absence rate of 7%, particularly for pharmacists — results in an increasingly stretched workforce.

8.2.3.1 Pharmacy Assistant Business Case

The pharmacy assistant role has huge potential to positively impact overall pharmacy staffing and the roles of the team. With the upskilling of both pharmacists and pharmacy technicians to step into expanding clinical and technical roles, backfilling with pharmacy assistants is an essential component to ensure medicine supply, ward stocks, patient counselling and similar tasks are maintained within ABUHB acute sites. These tasks are the backbone of the pharmacy service, without which the basic tasks of providing patients with the medicines they need would fail, negatively affecting patient experience, patient discharge and patient flow. The pharmacy directorate recognise that this staffing group is a pre-requisite for continued role redesign and over the next year will prioritise writing a business case to be submitted to the organisation for consideration.

8.2.3.2 Value based recruitment/stakeholder panels

Whilst the challenges outlined in recruitment and retention are significant, the directorate has viewed this as an opportunity to innovate and improve. Over the last year, work has been undertaken to review recruitment and retention approaches. This has involved a review of processes with an overarching foundation of instilling values-based recruitment (VBR) principles. This has included implementing post interview panel debriefs, work on a pharmacy specific managers guide to recruitment processes, running VBR workshops, and inclusion of stakeholder panels for key posts. This work has been undertaken working closely with peers and colleagues in Recruitment/Workforce OD, and other HBs. The introduction of the stakeholder panel has proven to be an effective tool to aide recruitment processes. Post recruitment work has also been implemented around on-boarding processes, induction and engagement with new staff coming into the organisation. This has allowed meaningfully engagement as early as possible therefore demonstrating the value placed on staff.

8.2.3.3 Workforce Development Documents

Over the last few months, the directorate has launched a suite of documents to serve as key tools in workforce development across all sectors. The intention behind the documents is to promote clear setting of expectations and outline opportunities for personal and professional development for all staff.

The first versions of a "Pharmacy Career Pathway" for each staffing group and accompanying "Roles and Responsibilities" guidance, detailing examples and standards of performance in each AFC band for each staffing group has been shared widely. These are linked directly to the Pharmacy Vision and Mission Statement launched earlier in the year and it is intended that this work will be built upon collaboratively with staff.

8.2.3.4 Bank staff

Whilst other healthcare professional groups have access to additional streams of staffing during shortages, including locum and bank staff, these routes have continued to prove difficult for the pharmacy service. Whilst availability of locum staff is largely outside the control of the service, the ability to set up recruitment through the bank at ABHUHB, remains an area of frustration. It is felt that this is a potential area where the organisation could help to improve the pharmacy staffing deficit, through providing access and support to set up bank access to recruit staff.

8.3 Training

Widescale whole system changes have been enacted through the recent changes in the GPhC initial education and training standards (IETP) for pharmacists and pharmacy technicians, which has been felt across all sectors and services in the health board. New training programmes to support these changes have led to significant changes in how both staffing groups are trained, and what their level and abilities are on completion of that training. Implementation of the programmes has provided several challenges, with wide ranging impact on new and legacy workforce. Nevertheless, the directorate is strongly committed to delivering the highest quality training and development opportunities to all staff including trainees and has made a significant investment to ensure the service is in the best position to deliver this.

A key example of commitment to positively engage with the changes is where the primary care MM team offered an innovative programme of training to multi-sector Foundation Pharmacists. Over 2023-24, three cohorts of training to Foundation Pharmacists were supported during their Primary Care placement. This training not only provided the staff with core teaching and understanding of primary care MM topics such as data analysis, prescribing dilemmas and NPI but also a wider understanding of the varied roles the pharmacy team has in the primary care setting. Feedback from both Foundation Pharmacists and HEIW commended the value of this training and the engagement.

Facilitation of training and development across ABUHB is undertaken by dedicated resource in the form of the pharmacy Education and Training team. However, there have been several high impact challenges within the team which has had subsequent consequences on training and development. Primarily, a key issue has been identified in the lack of sufficient dedicated resource based in Primary Care. At present, there is only an overarching 8C Principal Pharmacist Education and Training/Workforce Modernisation (0.6WTE) role to cover primary care, CRT and secondary care. Additionally, there have been substantial periods of vacancies in this role and within the wider secondary care team. With the number of changes to education and

training and requirements for advancing practice, increased investment in embedding key education and training specialist posts across sectors will be transformative. The roles will act as conduits to support the delivery of high quality, effective training and development for all staff and allow ABUHB to successfully meet and overcome the training and development challenges, both now and in the future.

8.3.1 Pharmacists

The first steps in implementation of the new IETP standards for pharmacists began in 2022 and have increased over each subsequent year. ABUHB trainee pharmacists now routinely complete a multi-sector training year (formerly pre-registration year) and then go onto a post foundation programme that incorporates NMP in second year of qualification. By 2026, the IETP implementation will reach the point where the trainee pharmacist year will incorporate NMP so pharmacists will then qualify with a NMP accreditation. This will be underpinned by undergraduate clinical placements throughout years 1-4 of the degree course, similar to those seen with medical undergraduate students. Whilst these are impressive strides forward in the professions development, there is a heavy resource requirement needed from sectors to provide the training from undergraduate upwards and to ensure it is of the necessary quality and level. Alongside this, changes to the HEIW funding of the post qualification training programme (formerly Post Graduate Clinical Diploma - now Post Registration Post Foundation training) has led to a number of high impact challenges.

The effect of the band 6 post-foundation pharmacist training funding and delivery model has destabilised the secondary care pharmacy workforce infrastructure with far reaching consequence. Funding models have changed in long standing HEIW commissioned Band 6 pharmacist training posts, from 50% HEIW funded down to 20%. The directorate has worked hard to mitigate the negative impact at present, though more work is required for long term sustainable solutions. The funding changes will mean long- and short-term impact on training places available and there is a need to ensure that the requirements for specialist knowledge and skills development will now be met through HB pathways. Lack of specialist therapeutics training opportunities through the new training programme is particularly concerning, where this route has traditionally been pivotal to the upskilling of trainees working in the specialist services i.e., aseptics, quality assurance, medicines information but to name a few.

Further challenges are added through lack of clarity from the national commissioning funding model from 2026 onwards for the band 6 programme, as well as ever increasing requirements needed from the HB to fulfil the delivery of all training programmes. With the funding deficit, the ABUHB may be at risk of further recruitment and retention issues if unable to find sustainable resourse to match the band 6 opportunities available in other HBs - with the possibility trainees may not choose ABUHB to even start their Foundation Pharmacist (formerly pre-registration) year, knowing there would be limited opportunity for progression.

In September 2025 the first cohort of the new Post Registration Foundation Pharmacist (PRFP) trainees will complete their course, with all 6 trainees expected to complete the programme with a NMP qualification. In August 2026 the trainee

Foundation Pharmacist year (formerly pre-registration year) will commence the programme to incorporate NMP. The impact of this change will be wide-ranging but will bring many opportunities which ABUHB is determined to harness. Work is already underway within the HB and nationally to look at changing entry level roles and responsibilities centred to the NMP, to ensure maximum value and fulfilment in early career pathways for pharmacists and their patients.

In the last 12 months, work has taken place to review and reset band 6 and band 7 rotational plans aligned to further development opportunities. With the changes to the Post Registration Post Foundation programme and removal of specialist modules, there was an identified need to deliver what was required from the workforce in terms of skills, knowledge and experience. Work is ongoing, involving training plans, development pathway mapping etc. and the possibility of extension into CRT and primary care sectors for future positive impact.

There has been a determined positive shift in ensuring access to development opportunities in relation to advancing practice, whether formal or informal for all pharmacists. Over the last year development of the pharmacist workforce has covered a plethora of different avenues including specialist clinical e.g. Post Graduate Diplomas/MScs, research opportunities e.g. R&D modules and leadership e.g. leadership development programmes. Whilst there is a need for highly supported and resourced initial training of pharmacists in all sectors, there is a strong recognition that equal weighting needs to be given to ensure the whole workforce continues to evolve and develop over their whole career to enable the service to meet the needs of now and the future. Special consideration has been given in all sectors to ensure that legacy workforce have completed or are completing their NMP qualification, with a very low number still requiring training.

8.3.2 Pharmacy Technicians

In line with the changes to the initial education and training of pharmacy technicians, the new HEIW commissioned Pre-Registration Pharmacy Technician (PRPT) Level 4 programme delivered by the University of East Anglia has been utilised across secondary care, with retention of all qualified trainees from the first cohort across the HB in February 24. Alongside the change in training from a Level 3 to a Level 4 qualification, the programme involves a substantial resource commitment from staff and services to ensure the success of the programme. As part of the commitment to the success of implementing and continuing to deliver the programme with further cohorts of trainees, there is a requirement to look at opportunities for upskilling legacy workforce and utilising innovation to aid the delivery of the requirements. Based on the successes in secondary care, a further assessment is being undertaken as to how the programme could be utilised in Primary Care and CRT.

Legacy workforce upskilling and development of the pharmacy technician workforce has continued to be a priority. Secondary care, CRT and primary care have supported staff in both the Buttercups and Bradford Level 4 development programmes specifically aligned to utilisation in service development opportunities e.g. specialist clinics. In secondary care, the PWDS Clinical Prioritisation training has also been utilised linked to the innovative launch of pharmacy technician-led wards, which has

had positive implications for other areas of use. Pharmacy has very strong links to HB training and development opportunities and have put several pharmacy technicians through the HB Masterclasses and Leadership programmes.

8.3.3 Pharmacy Assistants

Pharmacy Assistants remain the only unregistered staffing group in pharmacy that provide clinical services. There is a need to maintain and develop standards of practice to an exemplary level as this staffing group is key to the future success of pharmacy services in all areas. ABUHB pharmacy has already led the development of this workforce by upskilling pharmacy assistants to deliver MM services which have now been adopted across Wales.

Though there is limited access to funded development opportunities, given that HEIW Advanced Practice funding is not generally available for the level of development needed, the HB continues to invest in this key staffing group e.g. secondary care Band 4 pharmacy assistant completing ILM Level 4. New roles and opportunities for utilising this workforce have been identified in our care home, Prison and CRT services which will be supported by bespoke development pathways to enable the most value and return on investment from the role. This is turn will have large scale positive effect on releasing pharmacy technicians and pharmacists to then take on additional and advanced roles.

8.3.4 Academy

The business case to re-establish the Primary Care Academy was approved with funding and recent recruitment of 0.4 WTE band 8b lead pharmacist. The proposal will be to recruit 2-3 foundation or newly qualified pharmacists to undertake NMP qualification and post registration qualifications with support from GP practices. In addition, there will be opportunities for multi-sector pre-registration pharmacy technician posts.

8.3.5 Continued Professional Development

The pharmacy directorate continues to focus on opportunities for workforce development wherever possible and fully engages with the utilisation of available resources such as the HEIW Advanced Practice funding to support this agenda.

Over the last 12 months, there has been a positive shift in culture around development and fostering education and training into every staff member role. A range of development including formal, in-house and opportunistic professional development arising from innovation has been successfully utilised by staff. Recent examples include pharmacy technicians completing the Level 4 Clinical Diploma and Clinical Prioritisation training and pharmacists completing MSc module in Genomics. Whilst new training programmes provide excellent development opportunities, legacy workforce development and ongoing training and development opportunities following qualification is a leading goal for the HB.

The pharmacy team provide an in house learning @ lunch program open to all staff across primary care, secondary care and CRT. Sessions are run monthly over Teams, with each session recorded and then uploaded to the central "learning @ lunch" pharmacy page within SharePoint, along with supplementary resources.

The sessions are organised through HB pharmacy links, covering a range of topics relevant to all sectors with both in-house and guest speakers. The library of recorded sessions also provides a resource for new staff joining the HB.

In primary care, a quarterly practice pharmacist meeting is held at GUH Education Centre. This provides education and training session for NCN and directly employed pharmacists. Lead pharmacists and consultants provide updates on national ABUHB guidance and provide pharmacists opportunities to share best practice.

8.4 Non-Medical Prescribers (NMP)

Pharmacist NMPs can prescribe any medicine for any medical condition within their area of competence and scope of practice. The Clinical Director for Pharmacy is responsible for the safe implementation and practice of NMP for pharmacists employed by ABUHB.

At the end of March 2024 there were 67 pharmacist NMPs on the ABUHB register:

- 15 NCN
- 7 Primary care pharmacy
- 9 Urgent care
- 2 Surgery
- 2 Medicine
- 32 Secondary care pharmacy

Whilst these numbers represent a large number of the pharmacist workforce in patient facing roles, ABUHB is committed to ensuring that all legacy workforce pharmacists in appropriate roles will either be in NMP training or will soon be commencing training over the next 12 months.

In October 2023, HEIW published the national standards for competency assurance of independent and supplementary prescribers in Wales. In response the HB updated its NMP Prescribing Policy.

At present there is a large piece of work being undertaken collaboratively across the HB, and within Pharmacy, to address the requirements from the standards. This will involve an incremental stepwise plan over the coming 12 months with a particular focus on standardising approaches to the requirements and supporting staff to meet what is needed. The HB is fully committed to meeting all standards and requirements, and it is envisioned this will be a workforce development opportunity with significant positive impact. Of note is the work being progressed on the Designated Prescribing Practitioner (DPP) role and how ABUHB pharmacists will be able to support the next generation of NMP pharmacists from 2026 in the delivery of that large scale training requirement.


PHARMACY
ANEURIN BEVAN
UNIVERSITY HEALTH BOARD

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Radiation Protection Committee (RPC) – Annual Report 23/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr Executive Director of Allied Health Professions & Health Science (AHP & HS)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Hatch Assistant Director of AHP & HS

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The intention of the report is to provide assurance to the Patient, Safety, Quality Outcomes Committee (PSQOC) that all activities related to the use of Ionising Radiation and the storage and disposal of radioactive substances in Aneurin Bevan University Health Board (ABUHB) are carried out in accordance with National legislation, published guidance and local policies and procedures; with patient and staff safety at the forefront.

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Radiation Protection Committee (RPC) ensures that activities involving the use of ionising radiation within the Health Board (HB) adhere to the Health and Safety, Risk Management and Clinical Governance arrangements of ABUHB, aligned to legislative requirements.

The primary objective of the RPC (the committee) is to provide assurance that the key systems, pathways and processes are efficient, safe, effective, responsive and robust. The committee considers external and internal assurance reports and monitors action plans, in relation to all aspects of radiation protection, resulting from improvement reviews/notices from Health Inspectorate Wales (HIW), Health and Safety Executive (HSE), Radiation Protection Advisor (RPA)/ Medical Physics Expert (MPE) and other external assessors. The committee review and act upon any actions arising from reports provided by the Radiation Protection Group (RPG), the Community Dental Service, Orthopaedics and the RPA.

The committee is ultimately accountable to the Health Board Chief Executive via the Executive Director AHP & HS, Medical Director and the Divisional Patient Safety & Quality (DPSQ). The Committees membership is detailed in the RPC Annual Report for 23/24.

Cefndir / Background

The use of ionising radiation within the UK is governed by the following statutory instruments and the Health Board (HB) is committed to ensuring that the provision of these regulations, together with the highest standards of best practice in ionising radiation safety, are fully implemented at all times.

- The Ionising Radiations Regulations 2017 (IRR17)
- The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17)
- Environmental Permitting Regulations 2016 and 2018 amendment (EPR16, 18)
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (as amended 2011 and 2019) (CDG2009)

These regulations are supported by various Approved Codes of Practice (ACoP) and guidance notes published by the enforcing agencies and other organisations (Health and Safety Executive, Department of Health and Social Services, Welsh Government, Natural Resources Wales, Public Health England, Health Protection Agency (Formerly Health Protection Agency or NRPB)) and professional bodies (Royal College of Radiology, Institute of Physics and Engineering in Medicine, College of Radiographers, Society for Radiation Protection).

The Health Board has followed the general guidance on good practice with respect to the radiation protection issues and legislation as detailed in the document "Medical and Dental Guidance Notes" 2002 (MDGN) and subsequent versions published by the Institute of Physics and Engineering in Medicine (IPEM).

The specific details regarding the implementation of all radiation protection requirements and associated issues are contained within the individual department's Local Rules, patient protection documentation (IR(ME)R17 documents) and other associated documents.

The Committee has been established in the HB to formulate appropriate policies, monitor the level of compliance with all legislative requirements in relation to radiation protection, identify areas of non-compliance and initiate remedial action to mitigate risk. The RPC will report to the DPSQ who will submit an exceptions report to HB Executive Director AHP & HS to ensure the Chief Executive remains informed of specific issues that may require their attention.

Asesiad / Assessment

Please refer to the Annual RPC report 23/24.

Argymhelliad / Recommendation

The Committee is requested to note the contents of this Annual report which aims to provide assurance on activities related to the use of Ionising Radiation in ABUHB.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	RPC – Radiation Protection Committee RPG – Radiation Protection Group RPA – Radiation Protection Advisor DPSQ – Divisional Patient Safety & Quality

	IRR17 – Ionising Radiation Regulations 2017 IR(ME)R17 – Ionising Radiation (Medical Exposure) Regulations 2017 MDGN – Medical & Dental Guidance Notes
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	Not Applicable Choose an item.

Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	

Agenda Item:

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Radiation Protection Committee (RPC)

Annual Report 2023/2024

Table of Contents	Page No.

2023/2024 Radiation Protection Committee (RPC) Annual Report

Introduction

This report covers the financial year from April 2023 to March 2024.The Radiation Protection Committee (RPC) has been established by the Health Board (HB) to formulate appropriate policies monitor the level of compliance with all legislative requirements in relation to radiation protection, identify areas of non-compliance and initiate remedial action to mitigate risk. Any Standard Operating Procedures (SOP) or protocols pertaining to the use of ionising radiation will be ratified by the RPC before being adopted into practice.

The RPC is chaired by a Consultant Radiologist and convened by the Radiology Directorate Manager. Membership consists of senior stakeholder with representation from across the HB including Radiology, Theatres, Trauma & Orthopaedics and Community Dentistry. The Radiation Protection Advisor (RPA) and Medical Physics Expert (MPE) contribution is provided by RPS Velindre and Cardiff and Vale University Health Board

The RPC meets every four months and was compliant with this for the period covered by this report.

The use of ionising radiation within the UK is governed by the following statutory instruments and the Health Board is committed to ensuring that the provisions of these regulations, together with the highest standards of best practice in ionising radiation safety, are fully implemented at all times

- The Ionising Radiations Regulations 2017 (IRR17)
- The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17)
- Environmental Permitting Regulations 2016 and 2018 amendment (EPR16, 18)
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (as amended 2011 and 2019) (CDG2009)

These regulations are supported by various Approved Codes of Practice (ACoP) and guidance notes published by the enforcing agencies and other organisations (Health and Safety Executive, Department of Health and Social Services, Welsh Government, Natural Resources Wales, Public Health England, Health Protection Agency (Formerly Health Protection Agency or NRPB)) and professional bodies (Royal College of Radiology, Institute of Physics and Engineering in Medicine, College of Radiographers, Society for Radiation Protection).

The HB has followed the general guidance on good practice with respect to the radiation protection issues and legislation as detailed in the document "Medical and Dental Guidance Notes" 2002 (MDGN) and subsequent versions published by the Institute of Physics and Engineering in Medicine (IPEM).

The specific details regarding the implementation of all radiation protection requirements and associated issues are contained within the individual department's Local Rules, Procedure Documents (IR(ME)R17 documents) and other associated documents.

Local Rules relate to IRR17 and provide the instructions to be followed to ensure a safe working environment when dealing with ionising radiation. They include the requirement for warning lights, designation of controlled radiation areas and systems of work for the area.

Procedure Documents relate to IR(ME)R17 and provides instructions to follow to ensure the practices involving exposures to ionising radiation by patients is kept as low as reasonably practicable.

RPA / MPE Activity

Equipment Testing: -

Any equipment involved in the exposure of patients to ionising radiation are subject to annual checks by the Radiation Protection Advisor (RPA). This involves a series of Quality Assurance (QA) tests which indicates any variation from established baselines e.g. consistency of radiation output. Any variations from baselines can result in the requirement for remedial action with intervention by engineers. If a piece of equipment fails the QA tests, then its activity would be suspended until remedial work was carried out to address the issue.

As part of their annual programme the RPA undertook 155 testing events.

There were 32 checks that resulted in remedial recommendations which have been addressed.

There were 3 tests that resulted in failures. These 3 units were not returned to service until corrective work was completed and subsequently checked by the RPA. An example of the failed tests is given below:

- Royal Gwent CT – A fault was found with inconsistent radiation outputs. The fault was traced to a bad connection in one of the cables and the engineers fixed the fault. RPS Velindre staff attended and confirmed that the fault had been rectified and the radiation output was now consistent and within the established limits.

The RPA continues to provide commissioning support for any new equipment installed including the planning phase when shielding factors need to be considered. In the planning stage the RPA is required to approve the building plans including the location of the equipment within it ensuring any risk of exposure to staff or the public to ionising radiation is mitigated.

The RPA review the physical structure of the room and calculate the shielding effectiveness based on wall, floor, ceiling and door construction. Prior to any new room being commissioned RPA approval is required to confirm compliance with IRR17 legislation.

Personal Dosimetry: -

Under IRR17 it is a requirement that when working in a controlled area, the member of staff must wear a personal dosimetry device. These come in various forms but are intended to measure any radiation that the member of staff is exposed to during their work.

No individual results for Classified Workers were noted to exceed the periodic proportion of any classification limit for the 2023 calendar year. Two individual results for non-Classified Workers did exceed this level, although their total for the calendar year did not warrant further attention.

For the period, dosemeters not returned within the required 85 days after the end of wear period, and for which a charge was consequently levied, this was 103 out of 6017, which is 1.7% compared to an average customer base rate of 1.9%. Cost of these non-returned dose meters was £3275.40. Dosemeters outstanding but still within the 85 days currently stands at 179.

Environmental Monitoring: -

It is a Health and Safety Executive (HSE) expectation that the 'Employer' undertakes routine environmental radiation monitoring in all areas where ionising radiation is used in order to demonstrate the protection of staff or public occupying adjacent areas. In practice, we have tended to rely upon personal radiation dosimetry results to demonstrate satisfactory environmental radiation doses. However, it is noted that HSE do not regard this as a robust approach and request to see results of specific environmental radiation surveys.

Site	Department	Date badges placed	Date retrieved	Report sent date	Notable findings / comments
YYF	X-ray	Jul 2023	Oct 2023	31/01/2024	none
NHH	Sentinel node theatre	Aug 2023	Nov 2023	26/02/2024	none
Chepstow	X-ray	Nov 2023	Feb 2024	02/04/2024	1 extra monitoring badge for the processing area for 1 year then assess
YYF	Sentinel node theatre	20/03/2024	Due 20/06/2024	*	*
NHH	Radiology	Due 13/06/2024	*	*	*
RGH	Sentinel node theatres	Due 16/05/2024	*	*	*

*The summary of monitoring covers the period of this report (April 23-March 24) and will extend into the subsequent reporting period April 24-March 25.

Permit Variation:-

Radiopharmaceutical production within the Radiopharmacy facility at University Hospital Wales (UHW), who supplied radiopharmaceuticals to ABUHB permanently ceased in October 2023. The radiopharmaceutical supply from the UHW Radiopharmacy was in the form of single use, patient specific, syringes.

ABUHB are now procuring radiopharmaceuticals from other suppliers. The new radiopharmaceutical supply is in the form of vials as opposed to single use syringes previously supplied by UHW. The net result of the change in supply arrangements is that the total activity required to be received and stored on site is higher. We are currently operating within existing limits but this does impact the capacity the Nuclear Medicine service has to address the demand. A permit variation application has therefore been submitted to Natural Resources Wales (NRW) but to date has not been approved.

The permit variation application is being progressed by Radiation Protection Service Cardiff (RPSC) in collaboration with the HB.

RPA Audit - Documentation (Employer's Procedures) and document QA

An aspect of the RPA Service Level Agreement (SLA) with ABUHB is to review the documentation in place to ensure compliance with IRMER17. This not only ensures regular review but also ensures the departments are prepared for any compliance inspections from Health Inspectorate Wales (HIW).

This was the second theme of the IRMER audit programme by RPA (Appendix 4). The aim of this audit is to ensure that ABUHB is compliant with the requirements for employer's procedures for certain matters (regulation 6(1) and schedule 2) and that a quality assurance programme for these has been established (regulation 6(5)(b)).

Regulation 6(1) states that the employer must ensure that written procedures are in place for the matters detailed in Schedule 2 and any other matter in relation to which the IRMER17 regulations mandate the establishment of procedures.

Schedule 2 lists the matters that require written procedures relating to exposures to ionising radiation. There are sixteen in total and include matters such as patient identification, identity of duty holders and the making of enquiries of individuals of child bearing potential to establish whether the individual is or may be pregnant or breast feeding. More detail and the full list of Employers Procedures can be found in the Statutory Instrument (Appendix 6).

This was the second in a three-year programme of IR(ME)R compliance audits undertaken by the Radiation Protection Service, Cardiff.

Feedback from the RPA was that the Employer's Procedures are well developed with a review process in place for Radiology and theatres, who have recently combined documents. Some amendments have been recommended to improve the document Quality Assurance (QA) for the Community Dental Service (CDS), who have separate Employer's Procedures in place. These recommendations to the documentation have subsequently been implemented.

HSE Consent Process

HSE have outlined a new consent application process for consented practices, which will be a three-step process consisting of an application form, safety assessment and site inspection (managed through an online portal). ABUHB is already in possession of the appropriate consents, however, any new or existing consent must be renewed.

Further guidance is awaited from HSE; however, it is known that the new consent process will focus upon risk assessments and their content. In 23/24 and into 24/25 the ABUHB Radiation Risk Assessments have been reviewed and updated with the support of the RPA in preparation for any requested submission.

HIW Inspection

On 25th and 26th April 2023 Nevill Hall Radiology department underwent an announced two-day IR(ME)R inspection from HIW. Prior to the inspection, staff, patients and carers were asked to complete questionnaires and senior staff within the department were asked to complete and submit a self-assessment questionnaire.

During the inspection, the inspectors toured the department including main X-ray, Mammography and CT, gathered further information from the Site lead, CT Superintendent and Senior Management team and met with clinical staff members, they also requested to view the online training compliance of the entire team. After the inspection the Radiology team were required to complete an improvement plan to identify how the findings from the inspection would be addressed. Overall, the inspection was a success with "no immediate concerns" identified during the inspection and "no immediate assurance issues" regarding patient safety were identified during the inspection. The full report and action plan can be found in Appendix 3.

Diagnostic Reference Level (DRL) Group

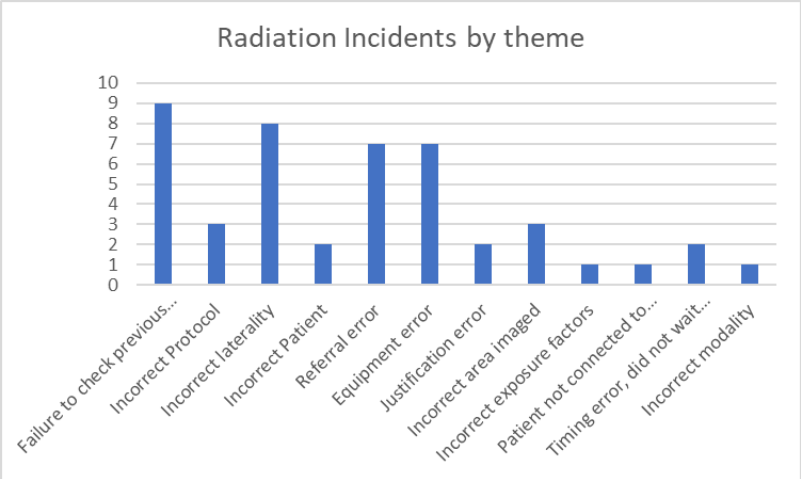
The purpose of the DRL group is to review patient dose levels and set local DRL's, compare DRL's across the Directorate and investigate any variations identified and to recommend any changes required to technique protocols to allow compliance with the DRL.

The group meets monthly, comprises of clinical and managerial staff members from ABUHB and Medical Physics and reports to the Radiation Protection Group.

Reportable radiation incidents

In 2023/2024 46 radiation incidents occurred within ABUHB radiology, 11 of these were reported to HIW.

The incidents had the following themes:



For each reportable incident and investigation is undertaken and a report submitted to HIW. HIW were satisfied with all investigations submitted and no additional information was required.

It is important to note that the 11 HIW reportable incidents across the 23/24 financial year were part of the 352,000 examinations undertaken involving ionising radiation for this same period and are within the anticipated number of incidents expected for a Health Board serving the population of ABUHB.

RPC is assured that these incidents are as a result of human error and not failures in the procedures in place governing the exposure of patients to ionising radiation.

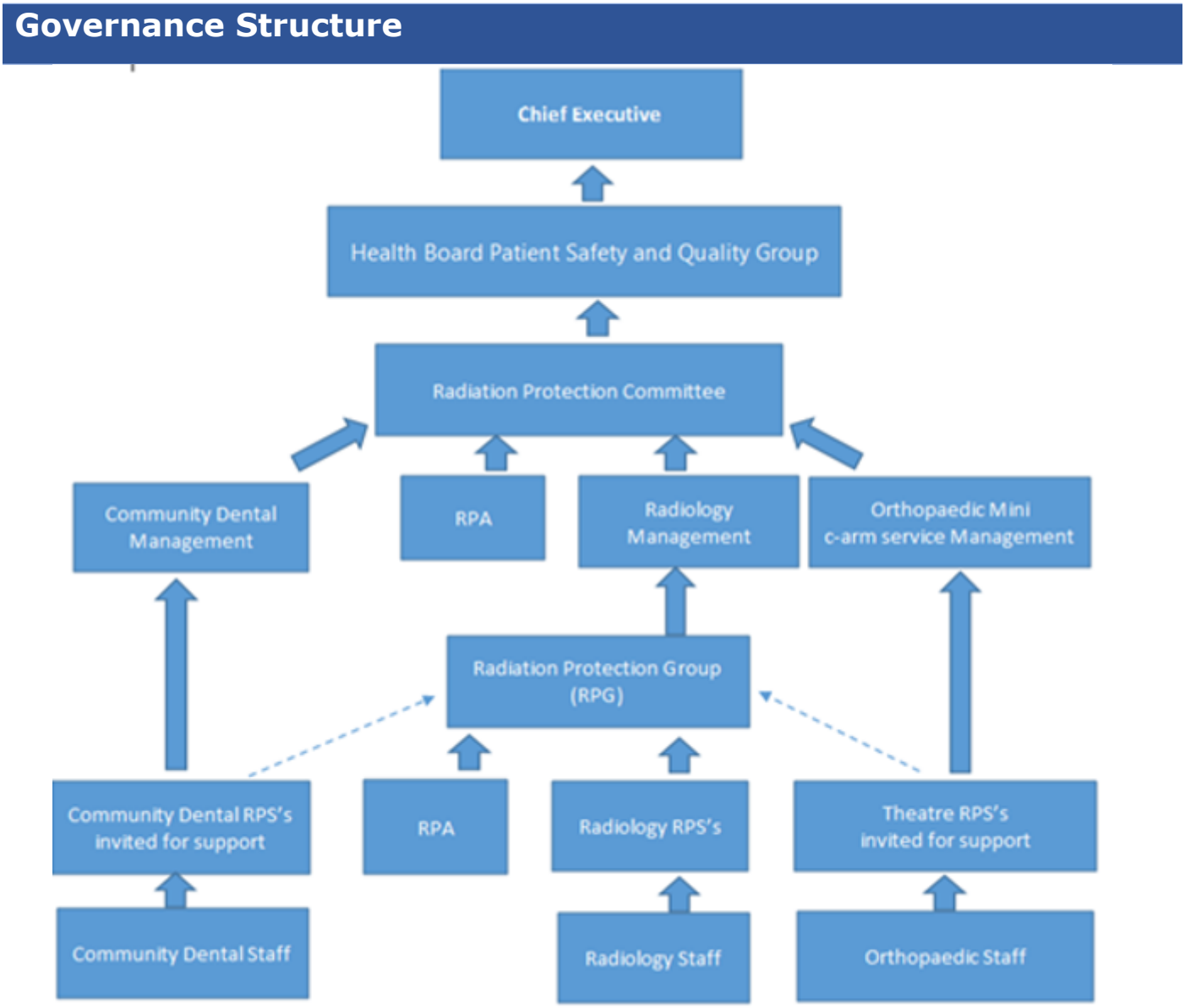
An essential part of the incident investigation is the learning outcome. For each incident a root cause analysis is undertaken and once identified, appropriate learning is shared. This learning can range from a simple learning outcome notice to reinforce processes to PowerPoint presentations on the wider impact of incidents across the Directorate (PPT presentation Appendix 7).

Financial Year 24/25

The RPC membership is expanding in 24/25 to accommodate those Directorates / Specialities who are undertaking examinations requiring ionising radiation under their own management, namely Urology and Breast Surgery. Additional representation from W&E colleagues will provide updates on the management of Radon across the Health Board.

RPC will continue to ensure HB compliance with the relevant legislation and that any amendments to said legislation are reflected in the appropriate supporting documentation. RPC will receive updates on any pending inspections and the progression of processes associated with HSE consent.

2025 will see an updated review of governance structures.



Appendices

1. ABUHB Ionising Radiation Policy

ABUHB%20Ionising%20Radiation%20Pc

2. RPC Terms of Reference

RPC%20Terms%20of%20Reference.doc

3. Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced), 25th and 26th April 2023

03377 - Nevill Hall IR(ME)R - Full Repor

4. Documentation (Employer's Procedures) and document QA

IRMER audit report theme 2 AB UHB v2 c

5. HSE Registration Certificate for use of ionising radiation

registrationcertificate.pdf

6. IRMER 2017 statutory instrument

IRMER17 statutory instrument.pdf

7. Learning outcome presentation

Incident Workshop 2024 ...

Aneurin Bevan University Health Board

IONISING RADIATION SAFETY POLICY

Policy Lead: Radiation Protection Committee

EXECUTIVE SUMMARY

Overview:	This Policy establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Health Board. The Health Board will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low as Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.
Who is the policy intended for:	All Health Board Staff working with ionising radiation
Key Messages included within the policy:	Identification of the legislation governing the use of Ionising Radiation Role and responsibilities of key personnel in the management of radiation protection issues. Introduction and Implementation of control measures to restrict exposure to ionising radiation. Responsibility of all staff to work in accordance with the control measures and to report any non-compliances.

PLEASE NOTE THIS IS ONLY A SUMMARY OF THE POLICY AND SHOULD BE READ IN CONJUNCTION WITH THE FULL POLICY DOCUMENT.

Contents

1. Introduction

This document establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all services provided by the Aneurin Bevan University Health Board.

The Health Board will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low as Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.

Within the Health Board, Ionising radiation is employed in diagnosis, treatment, research, quality assurance and other related applications.

The use of ionising radiation within the UK is governed by the following statutory instruments and the Health Board is committed to ensuring that the provisions of these regulations, together with the highest standards of best practice in ionising radiation safety, are fully implemented at all times

- The Ionising Radiations Regulations 2017 (IRR17)
- The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17)
- Environmental Permitting Regulations 2016 and 2018 amendment (EPR16, 18)
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (as amended 2011 and 2019) (CDG2009)

These regulations are supported by various approved codes of practices (ACoP) and guidance notes published by the enforcing agencies and other organisations (Health and Safety Executive, Department of Health and Social Services, Welsh Government, Natural Resources Wales, Public Health England, Health Protection Agency (Formerly Health Protection Agency or NRPB)) and professional bodies (Royal College of Radiology, Institute of Physics and Engineering in Medicine, College of Radiographers, Society for Radiation Protection).

The Health Board has followed the general guidance on good practice with respect to the radiation protection issues and legislation as detailed in the document “Medical and Dental Guidance Notes” 2002 (MDGN) and subsequent versions published by the Institute of Physics and Engineering in Medicine (IPEM).

The specific details regarding the implementation of all radiation protection requirements and associated issues are contained within the individual department’s Local Rules, patient protection documentation (IR(ME)R17 documents) and other associated documents.

This Policy must be read in conjunction with other relevant Health Board & Division Policies, including those on Waste Management, Clinical Evaluation, Pregnancy Tests, etc.

2 Responsibilities

The Health Board’s Chief Executive carries the overall responsibility for implementing the requirements of the regulations governing work involving ionising radiation throughout all premises managed by the Health Board.

To assist in discharging this responsibility the Chief Executive entitles the Medical director and executive Director of therapies who will entitle all Clinical Directors, Medical Practitioner and Radiology Service leads, who in turn will entitle all Directorate Managers, whose services are involved with working with ionising radiation, to assume the general responsibility for ensuring

that radiation safety arrangements throughout their Directorates are representative of best practice and satisfy the requirements of the regulations.

To assist the Clinical Directors in discharging these responsibilities the Chief executive requires Directorate and department managers, whose departments are associated with work involving ionising radiation, to implement all necessary radiation protection arrangements outlined in this policy and as advised by the Radiation Protection Adviser(s) (RPA), Radioactive Waste Adviser(s) (RWA) and Medical Physics Expert(s) (MPE).

It is the responsibility of each Clinical Director, Directorate managers and Department Managers to keep themselves aware of radiation protection issues within their Service and consult with the Radiation Protection Supervisors (RPS), the RPA, RWA and the MPE over any issues that have radiation protection implications.

It is the responsibility of each Clinical Director, Directorate Manager and Departmental Manager to ensure that all managers responsible for operational and estates facilities, maintain an awareness of potential problem areas associated with all work with ionising radiation such as drainage systems for departments using unsealed radioactive sources, roof spaces with restricted access above areas where work with ionising radiation is conducted, any known weaknesses in Radiation Protection shielding, prevailing security measures etc.

It is the responsibility of Clinical Directors, Directorate Managers and Departmental Managers to keep themselves aware of any radiation protection issues within their service and to consult with the Radiation Protection Supervisors (RPS), the RPA, the RWA, and the MPE over any issues that have radiation protection implications.

It is the responsibility of the Clinical Director, Directorate Manager and Departmental Managers, where appropriate, to ensure that all radiation risk assessments are prepared in respect of all work undertaken with Ionising Radiation. Radiation risk assessments must be reviewed no less frequently than two yearly to ensure that they remain relevant to the work undertaken.

A radiation risk assessment must be undertaken:

a) In advance of a new service being introduced

b) Whenever a significant change in work activity takes place.

All managers responsible for operational and estates facilities must, in consultation with the RPAs, RWAs, RPSs, Directorate managers and Department Managers, formulate systems to facilitate access by contractors, service engineers and other persons, into these problem areas. Such arrangements will involve facilities managers producing and issuing “Permits to Work” that detail the conditions under which work may be carried out as specified by the RPAs and the RPSs supervising the work with ionising radiation in the affected area and the department manager.

It is the responsibility of Clinical Directors, Directorate Managers and Departmental Managers, where appropriate, to ensure that local rules for radiation protection are drawn up to govern all work with ionising radiation undertaken within the department or area within the department. Local rules for radiation protection must be periodically updated to ensure that they remain relevant to the work undertaken and take into account the findings of relevant radiation risk assessments.

It is the responsibility of the Clinical Directors, Directorate Managers and Departmental Managers responsible for departments where medical exposure of individuals takes place to establish procedures in accordance with IR(ME)R17 (Schedule 2).

Each Directorate is required to ensure that sufficient funds are made available to the department managers to implement all relevant radiation protection requirements and risk reduction methods associated with this policy or as advised by the RPA, RWA and the MPE.

Each Clinical Director, Directorate Managers, Department Managers and managers responsible for operational and estates facilities, are required to involve the RPA, RWA and MPE at the earliest opportunity in the planning for refurbishment or site development work, changes to existing services or the development of new services. They are further required, based on risk assessments, to make arrangements for the funding and implementation of all necessary radiation protection requirements as advised by the RPA, RWA and the MPE

Based on risk assessment each Directorate will make arrangements to prioritise additional funding, to cover the cost of implementing unforeseen expenditure with respect to radiation safety, patient dosimetry and security issues from changes in the regulations, technological advances in radiation protection, working practices and associated training issues, as advised by the RPA, RWA and MPE.

It is a requirement that all staff, working with ionising radiation,

a. Exercise reasonable care and follow the provisions of the Local Rules, IR(ME)R17 Policies and Procedures, Natural Resources Wales permits and other related working instructions.

b. Use, as instructed, any personal protective equipment and personal dosimeters provided and to report to the Radiation Protection Supervisor or line manager, any defects in such equipment and dosimeters.

c. Undertake appropriate Radiation Protection training relative to their role.

d. Report immediately to the RPS or line manager, if an incident occurs in which a person is exposed to radiation, and adhere to their local incident reporting process as detailed in IR(ME)R 2017 Employer's Procedure Schedule 2(I).

e. Report immediately to their RPS or line manager, if they suspect that a radioactive source has been damaged, lost or stolen. Further advice on managing the incident should be sought from the RPA and RWA.

f. Do not recklessly endanger the safety of others.

g. Report to the departmental manager when it is suspected that an overexposure or unintended exposure due either to equipment malfunction, or failure to comply with IR(ME)R17 procedures, has taken place. They must adhere to their local incident reporting process as detailed in IR(ME)R 2017 Employer's Procedure Schedule 2(I).

It is a requirement that Aneurin Bevan University Health Board holds the appropriate authorisations to work with ionising radiations. This includes the provisions for prior notification, registration and consent under IRR 17, the issue of permits for the use and disposal of radioactive materials under EPR16(18) and having an Employer licence to authorise the administration of radioactive medicinal products to patients under IR(ME)R17.

It is the responsibility of departmental managers to ensure that periodic reviews are undertaken of individual's compliance with the provisions of local rules for radiation protection made under the IRR 17. Reviews of procedures should also be undertaken no less frequently than two yearly, to identify any necessary amendments.

Failure to follow the provisions of this policy and the local arrangements in place for radiation safety within a department or service will result in disciplinary action.

3 Organisation (Radiation Protection Committee)

The Radiation Protection Committee (RPC) has been established by the Health Board to formulate appropriate policies, monitor the level of compliance with various legislation in relation to Radiation Protection, identify areas of non-compliance and initiate remedial action to mitigate risk. The RPC will report to the DPSQ who will submit an exceptional report to Health Board Patient Safety and Quality Group via the Executive Director of Therapies & Health Science to keep the Chief Executive informed of specific issues that require their attention.

The terms of reference and membership of the committee are detailed in Appendix 1.

4 Advice and Assistance

4. 1. **Radiation Protection Adviser**

In accordance with the requirements of the Ionising Radiation Regulations 17 the Radiology Manager under entitlement from the employer will appoint in writing one or more individuals as the Health Board's Radiation Protection Adviser (RPA). The appointment requirements and the scope of advice required under IRR17 are given in Appendix 3.

Radiation protection advisory and support services are provided via a Service Level Agreement with the Velindre University NHS Trust Radiation Protection Service (RPS Cardiff). Suitably experienced clinical scientists, working within RPS Cardiff, who hold certificates, recognised by the Health and Safety Executive that enable them to act as RPAs are appointed as the Health Board's RPA. These clinical scientists may also act as Medical Physics Experts for the purposes of radiological procedures involving x-rays.

Apart from fulfilling the function of a RPA as detailed in IRR17 and accompanying approved code of practice (ACoP) these individuals are require to be proactive in advising the Chief Executive, and those persons to which s/he has assigned specific tasks, on the general requirements for ionising radiation safety and the specific means of achieving compliance with the requirements of all regulations governing the use of ionising radiation in the UK.

The RPA is required to keep the Chief Executive, Chairperson of the RPC, Clinical Director, Directorate Mangers, Department Managers, RPSs and MPEs up to date with advances in radiation practice, pertinent guidance from professional bodies, Government Organisations and Enforcement Agencies, etc. and proposals to amend existing legislation or introduce new legislation associated with work involving Ionising Radiation as applicable to the health care environment.

In instances where such changes affect the working practices within a single department or across a service the RPA will advise each Clinical Director, department managers, RPSs and MPEs as to the appropriate means of implementing such changes.

In instances where such changes must be implemented on a Health Board wide basis the Chairperson of the RPC with the RPA will convene a sub group (to include representatives from the services) to scrutinise the changes, formulate an action plan for the production any new policy or the amendment of existing policies as required, the implementation of the changes into working practices and the production of all necessary documentation associate with the changes. The Chairperson of the RPC will be responsible for ensuring that changes in Health Board wide Policy documents (new, replacement or amended) will be developed and approved in accordance with the Health Board's Policy for Policies.

The RPAs are ex officio members of the RPC and normally report to the Chief Executive through the committee structure. In instances where the RPAs believe that immediate action is required to remedy instances of non-compliance or potential non-compliance the RPAs are required to report directly to the Clinical Director, Directorate Manager and if necessary to the Chief Executive.

The RPAs are required to;

a. Advise and assist the Chief executive and all Clinical Directors, Directorate managers and staff in performing all duties and tasks associated with radiation protection issues.

b. Maintain and make available to all Health Board employees a comprehensive library of all relevant radiation protection documents. These will include Statutory Instruments, ACoP, Guidance Notes, advice and guidance provided by the government, its agencies and professional bodies, text books, advice and guidance provided by the European Community, advice and guidance provided by international organisations (International Commission of Radiological Protection), etc.

c. Advise and assist each Clinical Director, Directorate Manager, Department Managers and Radiation Protection Supervisors in all safety, security and transport issues (in consultation with a Dangerous goods safety advisor (DGSA) and a RWA, where necessary) associated with the delivery, keeping, use and disposal of radioactive materials.

d. Advise and assist each Clinical Director, Directorate Managers Department Managers, Clinical Staff and Radiation Protection Supervisors in all relevant patient safety issues.

e. Select an approved dosimetry service to provide radiation monitoring facilities in accordance with the requirements of IRR17.

f. In conjunction with department managers, formulate an effective monitoring programme for staff working with ionising radiation.

g. Assess the results of the monitoring programme and interfacing, on behalf of the Chief Executive, with the approved dosimetry service, on matters relating to dose results and record keeping issues, as required by IRR17.

h. Ensuring that, in instances where individuals may be required to be designated as “Classified Persons” under the requirements of IRR17, the matter is referred to the RPA through the head of the department concerned and/or the Chairperson of the RPC.

   Within the health care environment radiation protection arrangements generally ensure that there is no requirement to designate workers as classified workers in accordance with the requirement of the Ionising Radiations Regulations 2017 (IRR17). If it ever becomes necessary to designate classified workers then the Chief Executive will assign the task of ensuring compliance for the medical surveillance of such employees as required under IRR17, for classified persons, cases of overexposure, etc., to the Radiology Directorate Clinical Director.

i. Interface on behalf of the Chief executive with individuals responsible for enforcing or monitoring compliance with legislation governing work with ionising radiation.

4.2 Radiation Protection Supervisor

Department Managers in consultation with the RPA will select one or more individuals to act as Radiation Protection Supervisors (RPS) in accordance with the requirements of the Ionising Radiations Regulations 2017 (IRR17). The suitability of the individual for this role will be assessed by the departmental managers with input from the RPA and they will arrange or select suitable training schemes for the RPS. Managers will state the role specification for the RPS detailing all tasks delegated to the role. A role description can be found in Appendix 6.

Under IRR17 the role of the RPS is to supervise that work undertaken with Ionising Radiation within the department is carried out in accordance with the Local Rules. Other tasks, associated with the day-to-day practical aspects and or management of radiation protection issues, may be assigned to the RPS by the department managers.

Department Managers must formally appoint the RPS in writing and local circumstances within each service will dictate the appointment process.

Department managers will consult with the RPA over documents (copies of legislation, ACoP, Guidance Notes, etc.) that will be required to be held by the RPS to assist him/her in discharging his/her duties, and as reference documents for all staff working within the department, and the manager ensure that all such document are purchased and available to the RPS.

4.3 Medical Physics Experts

It is a requirement of IR(ME)R17 that Medical Physics Experts (MPE) are involved in providing or available to provide expert advice for every medical exposure.

The Health Board does not provide radiotherapy services but if such services are to be provided at a future date, arrangements must be made at the planning stage, in consultation with the Radiation Protection Service Cardiff, to appoint Medical Physics Experts in advance of the start of clinical work.

Diagnostic radiology, quality assurance, imaging support and patient dosimetry services are provided via a Service Level Agreement with the Velindre University NHS Trusts Radiation Protection Service (RPS Cardiff). Suitably experienced Clinical scientists working within RPS Cardiff are appointed as MPEs for the purposes of radiological procedures involving x-rays.

Radiopharmaceuticals and physics support services for nuclear medicine are provided via a service level agreement with the Cardiff and Vale UHB Medical Physics Department. Suitably experienced Clinical scientists working within the Medical Physics Department are appointed as MPEs for the purposes of nuclear medicine imaging and assay procedures.

All MPE's are appointed on behalf of the Employer must hold certification as MPE's in their specialty by a body recognised by the Department of Health and Social care that enables them to act in that capacity.

All MPEs are appointed in writing by the Radiology Manager under entitlement from the Employer.

4.4 Qualified Person

Radiation Protection Instrument testing services provide via a Service Level Agreement with the Velindre University NHS Trusts Radiation Protection Service (RPS Cardiff). Suitably experienced clinical scientists working within RPS Cardiff act as Qualified Persons for the purposes of testing radiation protection instruments in accordance with the Ionising Radiations Regulations 2017. These Qualified persons are appointed by the Head of the Radiation Protection Service.

4.5 Radioactive Waste Adviser

In accordance with the requirements of the Environmental Permitting Regulations 2016 (as amended 2018) (EPR16(18)) the Radiology Manager under entitlement from the employer will appoint in writing one or more individuals as the Health Board's Radioactive Waste Adviser (RWA). The appointment requirements and the scope of advice required under EPR16(18)are given in Appendix 3.

Suitably experienced clinical scientists working within the Radiation Protection Service at Velindre Hospital who hold certificates issued by a body recognised by the Environmental Agencies (RPA2000) that enable them to act as radioactive waste advisers are appointed as the Health Board's RWAs.

The RWAs are required to;

a. Make all necessary arrangements for the licencing of radioactive substances and the authorised limit for the disposal of sources for each of the Health Board's sites under the requirements of EPR16(18)).

b. Set individual department limits for the holding of radioactive substances on each of the Trusts sites and monitor compliance with each of the sites' EPR16(18) licence.

c. Set individual department limits for the accumulation and disposal of radioactive waste from Health Board sites, co-ordinate the disposal records

from all departments on each of the Health Board's sites and monitor overall compliance with each of the sites' EPR16(18) licenced limits.

d. Provide advice on and undertake compliance audits with respect to the requirements of the EPR16(18) regulations including the management of sealed sources (and High-activity Sealed Radioactive Sources if applicable)

e. Liaise with Natural Resources Wales regarding regulatory matters including pollution inventory and other submissions.

f. Undertake environmental impact assessments regarding the discharges of radioactive wastes within the Health Board.

g. Produce a Health Board statement of the application of Best Available Techniques (BAT) within the Health Board to minimise the radiological impact of radioactive discharges on the environment.

5. Duty holders under IR(ME)R 17

Please refer to the respective IR(ME)R 2017 Employer Procedure 2(b) for further details for each of the below duty holders within ABUHB. IR(ME)R 2017 Employer Procedure 2(b) also details the specific training requirements for each duty holder role:

5.1 Employer:

In the context of IR(ME)R 17, the employer is considered to be Aneurin Bevan University Health Board. If the Health Board contracts a third party to provide services, then the Health Board will be the employer as regards the operators for the purpose of the Regulations, but the third party is the employer of the operators for employment law purposes.

Equipment ownership has no impact on the employer responsibilities under IR(ME)R 17.

5.2 Operator:

The operator is any person who is entitled, in accordance with departmental written procedures, to undertake the practical aspects of a medical exposure and is adequately trained. Operators may include radiographers, Assistant Practitioners, medical practitioners, clinical scientists/medical physicists, clinical technologist/medical physics technicians and nurses. To ensure they are adequately trained all new employers will undertake an induction programme which covers all the equipment they will make medical exposures on and the associated regulatory policies and procedures. They will be signed off as competent by a senior radiographer on each aspect prior to them receiving entitlement as an operator. The entitled operator will receive additional training before the introduction of any new procedures and examinations. The Operator will not be entitled to undertake the examination until they have been signed off as competent to do so by an entitled member of staff.

5.3 Practitioner:

The Practitioner is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the Health Board's written procedures

to take responsibility for an individual medical exposure. The primary responsibility of the Practitioner is to justify medical exposures.

In some cases, the practitioner may also undertake practical aspects of an exposure and so become an Operator with regard to these specific functions.

The Practitioner in Nuclear Medicine must hold an ARSAC licence specifying the range of radionuclides and pharmaceuticals that they may prescribe. This license has to be renewed every 2 years by the Practitioner. In line with the six-monthly meetings to monitor the departmental ARSAC license, this renewal will be monitored.

Arrangements may be put in place for an individual to authorise a medical exposure on behalf of the Practitioner under a Delegated Authorisation Guideline (DAG) drawn up by the Practitioner. Under such an arrangement, the individual acts as IR(ME)R 17 Operator for this function. This arrangement may also apply to justification of exposures involving radionuclides and pharmaceuticals. The responsibility for justification remains with the Practitioner.

Arrangements must also be put in place for the justification of exposures to carers and comforters and this is detailed in the respective IR(ME)R 2017 Employers Procedure Schedule 2(n).

5.4 Referrer:

The referrer is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with departmental written procedures to refer individuals for a medical exposure.

6. Arrangements for Compliance with IR(ME)R 17

6.1 Written procedures

Employer's standard operating procedures, covering the areas specified in Schedule 2 of IR(ME)R 2017, specific to the respective Directorates where medical exposures are undertaken, are maintained within the work instructions and local policies and procedures of those departments. A listing is maintained by each department summarising, as a minimum, the local versions of the fourteen standard operating procedures specified. Further standard operating procedures may be added as required, but it should be borne in mind that such procedures will then be legally binding upon the organisation and its employees.

The IR(ME)R 2017 Schedule 2 Employer's Procedure (EP) Documents within ABUHB cover the use of ionising radiation in the following Directorates/services:

1. Radiology, Breast Services *and* Orthopaedic use of mini-c arms (covered by one set of EP documents)

2. Community Dentists (have their own set of EP documents)

   Protocols for all standard imaging procedures involving medical exposures are maintained within each department.

Where patient referrals under IR(ME)R 17 are made, referral procedures are part of each department's IR(ME)R 17 standard operating procedures and permit the referral of patients for diagnostic radiological/nuclear medicine investigations. Appropriate instruction regarding the referral process must be given to all relevant staff.

All new IR(ME)R 17 policies and standard operating procedures must be submitted to the RPC for ratification and formal adoption on behalf of the Health Board. Only those documents that have been confirmed as "suitable for purpose" will be ratified.

Quality Assurance programmes must be introduced, in consultation with the RPAs and MPEs, to assess the effectiveness of policies and procedures. Details must be included in the Employers' Procedure Document 2(d). In addition, each Directorate that undertakes work with ionising radiation in ABUHB (i.e. Radiology, Orthopaedic mini c-arm service, and Community Dentists) must have their own Quality Assurance Policy which includes:

1. Equipment inventory.
2. Maintenance of equipment.
3. Purchase of new or modified equipment.
4. Equipment checks and tests.
5. The review of the Health Boards Standard Operating Procedures for imaging procedures.
6. Training.

All documentation and written arrangements concerning IR(ME)R 17 must be reviewed within agreed timeframes as detailed in Employer Procedure Document Schedule 2(d).

Whenever departments' activities overlap, the managers must liaise to ensure compatibility between both departments IR(ME)R 17 Policies and Procedures. Formal written procedures must be established between these departments to detail all agreed arrangements.

6.2 Entitlement of Duty Holders

Under IR(ME)R the Employer is the legal person who carries out or engages others to carry out medical exposures at any given registered establishment. They are responsible for ensuring that all written procedures for medical exposures are in place, including employer's procedures, standard operating procedures and protocols for all procedures and equipment.

The Employer is able to delegate entitlement to others; being entitled by the Employer, means that permission has been given to act, in compliance with the Regulations, according to the specific responsibilities of a Duty Holder role.

Entitlement is granted by the Employer to Referrers to be able to request imaging, and to the Practitioner and Operator who are able to undertake medical exposures following appropriate training and working within a strict scope of entitlement. These entitlements are confirmed in writing detailing their entitlements. See IR(ME)R 2017 Employer Procedure Schedule 2(b) for details.

If an individual is entitled to undertake an IR(ME)R17 role by another organisation, this does not lead to automatic entitlement by Aneurin Bevan University Health Board to undertake a similar role. Any relevant certification held by an individual (e.g. the holding

of a licence issued by ARSAC) may be taken into consideration in establishing their competence to be entitled to undertake an IR(ME)R17 role.

Entitlement should only be undertaken by authorised individuals as per the entitlement pathway from the Chief Executive. The entitlement must follow an auditable pathway and documentation kept to show:

i) The date on which entitlement took place

ii) The task and scope of practice for which entitlement has taken place

iii) The identity of the person undertaking the entitlement and their delegated authority

Details of this process are recorded in the Employers' Procedure Document 2(b). The individual being entitled shall receive formal notification and details of the scope of the entitlement.

A list will be held by each Directorate of its duty holders, detailing the specific functions for which they are entitled to act. This list forms part of the IR(ME)R17 documentation and it must be made readily available to all staff. This list must be updated whenever there are changes in personnel.

The Employer must establish referral criteria for medical exposures, reflecting prevailing national professional guidance and these are referenced in departmental documentation.

Department managers must ensure that appropriate instruction regarding the referral process must be given to all relevant staff.

Policies/procedures are required to enable referrals for diagnostic radiological/nuclear medicine investigations from non-medically qualified health care professionals where required. In all such instances referral guidelines and the scope of referral must be agreed in consultation with the Radiology Clinical Director and Radiology Directorate Manager.

The IR(ME)R 17 Practitioner and Operator have a legal duty to comply with the procedures established by the Employer.

All staff acting as practitioners and operators must be aware of and conversant with the IR(ME)R17 policies, procedures, protocols and the relevant Standard Operating Procedures. This may also include delegated authorisation guidelines issued by the practitioner.

Systems must be introduced to monitor and audit compliance with the IR(ME)R17 Policies and Procedures and Standard Operating Procedures and the Results of the Audits will be submitted to the RPC for comment and where necessary advice on remedial action.

6.3 Optimisation of Exposure

Arrangements must be made, in consultation with the MPE, to implement a dose optimisation strategy for all radiological practices and introduce and monitor Diagnostic

Reference Levels (DRL), as required by IR(ME)R17, for all standard radiological investigations and standard nuclear medicine procedures.

Quality Assurance programmes must be introduced, in consultation with the MPEs, to assess the effectiveness of equipment, policies and procedures.

6.6 Administration of radioactive substances to patients

In departments employing sealed and unsealed radioactive sources for diagnostic purposes, cross reference with the Employer licence and practitioner ARSAC licence must be undertaken before new radioactive medical products are introduced into clinical practice. Where the licence(s) does not cover such products the medical practitioner and/or Employer must obtain an endorsement to their licence to cover this new work in accordance with the requirements of IR(ME)R 17.

Research ARSAC licence applications are required for clinical trial procedures if they are not covered by existing licences.

Arrangements must be in place that medical practitioners are reminded, well in advance of the date of expiry of their licence, of the need to renew their licence issued under the IR(ME)R17 or certificates under previous legislation. At present, an automatic reminder is generated by the ARSAC secretariat in advance of expiry of current certificates or licences.

7. General arrangements for Radiation Protection

Before any individual is permitted to work with ionising radiation, arrangements must be made to assess the individual's training requirements and implement means of delivering any required training (as identified by the department manager with support from the RPA if required), monitoring the training programme and assessing the individual's performance.

Radiation risk assessments must include all reasonably foreseeable fault or accident situations and a consideration of the radiation dose received by relevant individuals under such circumstances. They will consider the need for and type of personal radiation dosimetry to be undertaken and whether classified radiation worker status is required. An RPA must be consulted in the preparation of any radiation risk assessment.

The Local Rules are intended to protect staff, the general public and the environment and they will specify general radiation protection requirements and specific requirements identified in IRR 17.

Department managers must discuss any new proposed or planned uses of ionising radiation with the RPA and MPE at the planning stage.

Systems must be in place to ensure that all new or modified installations that are used in connection with ionising radiation(s) are subject to a critical examination under IRR 17 prior to first use.

The Local Rules identify potential hazards and provide measures that enable staff to work safely and arrangements must be in place to ensure that all staff working within the department are made aware of all issues detailed in the Local Rules and given training in their implementation and observance.

The service manager is responsible for ensuring that all staff are adequately supervised where required. The RPS is responsible for ensuring that the provisions of the local rules for radiation protection are followed. The RPS must report any non-compliance with the Local Rules to the department manager who, in consultation with the RPA, will investigate the reasons for the non-compliance and put in place measures to ensure that such breaches are not repeated. In instances where breaches are identified by the RPA as serious or in instances where breaches cannot be resolved within the department the department manager will seek a solution by referring the issue to the Clinical Directors and Service Manager and the chairman of the RPC.

Arrangements must be in place to ensure that Local Rules are reviewed at a frequency advised by the RPA and that radiation risk assessments are reviewed annually or whenever there are changes to equipment or working practices.

A set of clinical protocols detailing each diagnostic radiological/nuclear medicine investigation performed in the department must be produced for use by all staff.

Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as practitioners, referrers and/or operators.

Quality Assurance programmes must be put in place following consultation with the RPAs and MPEs, to assess equipment performance and consistency.

Department Managers must ensure that any member of the department staff who has been allocated duties associated with ionising radiation is given written instructions regarding the role involvement: e.g. formulating and documenting Local Rules, quality assurance activities, IR(ME)R 17 policies and procedures; performing specific duties under the provisions of these documents; or performing other tasks directly related to or loosely associated with the Health Board's radiation protection policy or general radiation protection matters. The manager must ensure that all such individuals are given adequate resources and protected time in which to carry out the assigned tasks.

Systems must be in place to facilitate an exchange of written information, including any hand over forms or permissions to work, on radiation safety matters with contractors' Outside Workers who install, maintain or service equipment either associated with any work activity involving ionising radiation or located in a radiation area or restricted area.

Systems must be in place to keep all staff aware of their general responsibilities with regard to radiation protection (2.10) and keep all staff aware of the need to report any incident or near misses involving ionising radiation that may have resulted in the uncontrolled release of radioactive materials or the unintended exposure of patients, staff or other persons.

All incidents, involving unintended exposures of patients or staff, significant spillages of unsealed radioactive materials, theft/loss/damage of radioactive materials, breaches of disposal limits etc., must be investigated by the department manager in consultation with the RPS and the RPA/RWA/MPE. The department manager must ensure that a written report is produced following the investigation to detail the circumstances, findings and remedial measures required to reduce the possibility of such incidents occurring in the future. The MPE will be involved for the purposes of estimating doses to patients and the RPA will be involved in all instances to assess the risks associated with the incident and advise the department manager with regard to the necessity for reporting such incidents to government agencies. The following examples are not exhaustive;

a) Incidents involving the unintended exposure of patients are reportable under IR(ME)R17 to the Healthcare Inspectorate Wales (HIW). Guidance for the reporting of incidents are from the CQC Significant Accidental or unintended

Exposure guidance adopted by HIW. If the unintended exposure is due to an equipment fault, further reporting may be required to the MHRA.

b) Incidents involving radioactive materials are reportable to Natural Resources Wales under the Environmental Permitting Regulations 2016(18) and the Health and Safety Executive under IRR 17 depending on the severity. Guidance can be received from the RWA.

c) Loss or theft of radioactive materials must also be reported to the police. Further guidance can be received from the RWA.

All such incidents must be reported following the Health Board's normal incident reporting procedure.

In departments where unsealed radioactive materials are employed) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, and disposal of the radioactive materials. Additional instructions will be required with respect to hygiene, the care of patients, monitoring for the presence of radioactive materials and the selection and testing of radiation protection instruments.

In departments where sealed radioactive sources are employed (Nuclear Medicine,) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, leak testing and ultimate disposal or transfer of the radioactive materials.

For security reasons suitable procedures must be in place to ensure that all necessary signage and notices do not advertise the details of radioactive materials to the general public.

The department manager will ensure that detailed records are kept of the purchase, storage, use and disposal of all radioactive materials together with quantitative records of the disposal of sealed and unsealed radioactive materials. They will make arrangements to return copies of the disposal records to the RWA on a regular basis as determined by the RWA.

Control measures must be introduced to check at appropriate intervals the presence of all sources on a regular basis or whenever used and to monitor that activities detailed in the EPR 2016(18) permits and associated department limits are not breached. An annual audit should be undertaken to ensure that this process is taking place. With respect to the disposal of sealed or unsealed radioactive materials, monitoring to prevent breaches will be based on the department limits assigned by the RWA.

Systems must be implemented to ensure that any radiation protection instruments used to demonstrate compliance with IRR17 are fit for use and are sent for testing before first use, for annual testing, or for testing after repair, to the Qualified Person. Before purchasing any new or replacement instruments the department manager will seek the advice of the RPA and Qualified Person with respect to the selection of the most appropriate instrument.

The Divisional Directors shall ensure that adequate arrangements are in place for reporting radiation incidents, obtaining advice from Radiation Protection Advisers and making external reports to enforcing agencies.

Disposal of radiological equipment shall be undertaken with advice from the Specialist Estates Services branch of NHS Wales Shared Services Partnership (NWSSP).

7.1 Radiation Protection Group

The RPS must report to the Radiation Protection Group (RPG). The RPG is convened by Radiology and invites representatives from other directorates and divisions who undertake work involving ionising radiation. The RPG monitor, review and audit radiation protection and quality assurance arrangements within the respective Directorates. The terms of reference of this group are detailed in Appendix 2. Each Directorate using ionising radiation must submit an RPS report to RPC. This ensures the RPC are kept aware of when local rules have been reviewed and the broad extent of revisions made, if any.

Appendix 1

Aneurin Bevan University Health Board

Radiation Protection and Medical Exposures Committee (RPC)

Terms of Reference

1.1 Purpose

Identify and monitor all current activities and co-ordinate all future developments related to the use of Ionising Radiation and the storage and disposal of radioactive substances in Aneurin Bevan University Health Board.

To ensure that these activities are carried out in accordance with National legislation, published guidance and local policies and procedures; with patient and staff safety at the heart.

To ensure that the group's activities adhere to the Health and Safety, Risk Management and Clinical Governance arrangements of Aneurin Bevan University Health Board.

1.2 Objectives

The primary objective of the Committee is to provide assurance to the Board that the key systems, pathways and processes are efficient, safe, effective, responsive and robust.

In addition the committee will:

- Consider external and internal assurance reports and monitor action plans, in relation to all aspects of radiation protection, resulting from improvement reviews/notices from the HIW, Health and Safety Executive, RPA/MPE and other external assessors.
- To review and act upon any actions arising from reports provided by the Radiation Protection Group, the Community Dental Service, Orthopaedics and the Radiation Protection Advisor.

1.3 Accountability

The RPC will be accountable to the Health Board Chief Executive via the Executive Director of Therapies & Health Science and the DPSQ.

1.4 Membership

Radiation Protection Lead (Chair) – Consultant Radiologist
Radiology Services Professional Lead (Convener)
Radiology Services Manager
Research Lead for Radiology
Radiology Services Administrator (Secretary)
Radiation Protection Advisor (Velindre)
Medical Physics Expert (Velindre)
Nuclear Medicine Technologist
Consultant Radiologist
Consultant Orthopaedic Surgeon
Directorate Manager for Orthopaedics (or deputy)
Community Dentist Representative

1.5 Quorum

Business will only be conducted if the meeting is quorate. The Committee will be quorate with 5 members, including at least Chair, Convener, Radiation Protection Advisor (or Medical Physics Expert) and a representative from Radiology, Orthopaedics and Community Dentistry.

1.6 Attendance by Members

The Chair and a representative of the Radiation Protection Service (Radiation Protection Advisor or Medical Physics Expert), or their nominated deputy will be expected to attend 100% of the meetings. Other committee members and mandatory participants will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

1.7 Frequency

The Radiation Protection Committee will meet every 4 months.

Additional meetings may be arranged when required to support the effective and safe functioning of the Radiology Directorate.

1.8 Reporting

The minutes of the meeting will be circulated to all members in draft form following the meeting; with the finalised minutes sent to the Executive Director of Therapies & Health Science.

Feedback from the Radiation Protection Committee will be presented at the Radiology Clinical Governance Meeting

1.9 Monitoring Effectiveness

The Committee will undertake an annual review of its performance against it Terms of Reference and work plan in order to evaluate the achievement of its duties. This review will be presented to ABUHB Patient Safety and Quality Group in the form of the Committee's annual report.

2.0 Review

These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Appendix 2

Radiation Protection Group (RPG)

Terms of Reference and Membership

To monitor, review and audit radiation protection and quality control arrangements within the radiology department he Radiology Directorate has established a Radiation Protection Group.

The RPG reports to the Radiation Protection Committee. (See Appendix 8)

Remit of RPG :

To review issues with managers relating to the supervision of work as required by the Radiation Protection Supervisors.

Plan and assist with the annual audit cycle for RPSs and Quality Control Radiographers.

Review audit results with managers and implement any action required from the audit results.

Review Quality Control results and implement any actions required

Agree and arrange purchase of quality control equipment

Review any incidents with managers.

Plan and implement with managers annual reviews of Local Rules and implement any agreed changes

Plan and review annually the Quality Control Programme with managers.

Assist with the annual review of IR(ME)R17 Policies and Procedures

Compile regular reports to RPC

Plan training programmes with RPA

Plan implementation of advice received from RPC, MEC or RPA

Membership

Radiology Department Managers, Radiation Protection Supervisors, Nominated Quality Control Radiographers, Radiation Protection Advisor and Medical Physics Experts.

Appendix 3

RPA appointment requirements and Scope of Advice

RPA Appointment

Under the requirements of the Ionising Radiations Regulations 2017 (IRR 17) radiation employers are required to appoint and consult with a Radiation Protection Adviser (RPA). The Health and Safety Executive requires that the individuals wishing to act as an RPA must demonstrate that they meet the HSE's criteria of competence and that employers select from such RPAs one or more who have suitable knowledge and experience for the employers type of work [Regulation 14 and Paragraphs 257 to 270 of the Approved Code of Practice (ACOP)].

If more than one RPA is appointed, duties will be shared between them The scope of the advice that will be provided by these individuals will include the items for statutory consultation listed in IRR 17, Schedule 4 and the issues listed in the draft Approved Code of Practice, paragraph 263 as detailed below.

Scope of Advice

In general the RPA will be required to advise on the measures to be taken to comply with IRR 17, together with other relevant legislation on use of ionising radiation. The scope of the advice required will include:

IRR 17, Schedule 4 RPA must be consulted on the following:-

1. Implementation of requirements as to controlled and supervised areas.

2. The prior examination of plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to ionising radiation.
3. The regular calibration of equipment provided for monitoring levels of ionising radiation and the regular checking that such equipment is serviceable and correctly used.

4. The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation.

Approved Code of Practice (ACOP), Paragraph 263

The advice of the RPA should cover, where relevant, but not limited to, the following:

- Optimisation and establishment of appropriate dose constraints;

- Plans for new installations and the acceptance into service of new or modified radiation sources in relation to any engineering controls, design features, safety features and warning devices relevant to radiation protection;

- Categorisation of controlled and supervised areas;

- Classification of workers;

- Outside workers;
- PPE;
- Workplace and individual; monitoring programmes for exposed workers;
- Investigation and analysis of accidents and incidents and appropriate remedial actions;
- Employment conditions for pregnant and breastfeeding workers;
- Preparation of appropriate documentation such as prior risk assessments and written procedures.

In addition to the specific matters set out in Schedule 4, radiation employers are required to consult a Radiation Protection Adviser where advice is necessary for the observance of the Regulations.

Additional guidance on these matters is given in ACOP paragraphs 257 to 270.

Appendix 4

Radioactive Waste Adviser

The Basic Safety Standards Directive (BSSD)[1] requires employers to appoint 'radiation protection experts to advise them about work with radioactivity that may affect people and the environment. Parts of the BSSD place specific requirements on permit holders and require qualified experts to be involved in the discharge of specific duties. The BSSD also requires that arrangements are in place to recognise the capacity of such qualified experts.

Within the EPR 2018 amendment, Section 3 Regulation 7, there is a requirement on permit holders to consult a radioactive waste adviser on the following;

(a) Achieve and maintain an optimal level of protection of members of the public;

(b) Accept into service adequate equipment and procedures for measuring and assessing exposure of members of the public and radioactive contamination of the environment;

(c) Check the effectiveness and maintenance of equipment as referred to in paragraph (b) and ensure the regular calibration of measuring instruments

Recognition of Radioactive Waste Adviser

RWAs are recognised by holding a RPA2000 RWA certificate that is valid for 5 years

Appointment of Radioactive Waste Adviser

A permit holder (Employer) must appoint suitable Radioactive Waste Advisers if the permit is for the accumulation or disposal of radioactive waste. The permit holder is responsible for ensuring that any Radioactive Waste Adviser appointed is "suitable" to give relevant advice on the permit holder's business. This appointment must be in writing and should include the scope of advice which the Radioactive Waste Adviser is required to give.

Staff of the Radiation Protection Service holding accreditation act as Radioactive Waste Adviser and are formally appointed by the permit holder (Employer).

1. *Council Directive 2013/59/EURATOM 2013 (laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionising radiation).*

Appendix 5

Medical Physics Expert

Medical Physics Experts must be appointed by the Chief Executive.
A medical physics expert must contribute to the following matters:

- Optimisation of the radiation protection of patients and other individuals subject to exposures, including the application and use of diagnostic reference levels.
- The definition and performance of quality assurance of the equipment
- Acceptance testing of equipment
- The preparation of technical specifications for equipment and installation design
- The surveillance of the medical radiological installations
- The analysis of events involving or potentially involving accidental or unintended exposures
- The selection of equipment required to perform radiation protection measurements
- The training of practitioner and other staff in relevant aspects of radiation protection
- The provision of advice to an employer relating to compliance with these regulations.

Appendix 6

Radiation Protection Supervisor Role Specification

Base Location

Department

Accountable to

Reports to

Liaises with Radiation Protection Adviser

Job Summary:

The Radiation Protection Supervisor (RPS) will play a supervisory role in assisting the Health Board to comply with the requirements of the Ionising Radiations Regulations 2017. The RPS will be directly involved in the work with ionising radiation and will exercise adequate supervision to ensure that the work is done in accordance with Local Rules.

The only responsibility of the Radiation Protection Supervisor specified under IRR17 is to supervise the work with ionising radiations. Overall responsibility for radiation protection matters lies with the departmental manager. However, additional duties may be delegated to the RPS as detailed below.

MAIN DUTIES AND RESPONSIBILITIES

Restriction of Exposure

To observe, from time to time, all procedures involving ionising radiation and to and to keep a record of this process for audit purposes. To issue instructions necessary to maintain radiation doses as low as reasonably practicable.

Notification of work and certain occurrences

To notify, in writing, the responsible manager:

(i) Of any proposed changes in, or additions to, work activity

(ii) Immediately of any damage to a radioactive source, spillage, loss or suspected loss of radioactive substances.

(iii) If any change of equipment, usage or conditions, which might affect radiological safety; of any monitoring instrument used to demonstrate compliance with the Regulations which has not been calibrated to acceptable national standards.

(iv) Immediately of any incident involving equipment malfunction resulting in patient exposure much greater than intended.

(v) Immediately of any incident or suspected incident involving staff exposure much greater than intended.

3. Local Rules, Systems of Work and Radiation Risk Assessments

To assist in the writing of Local Rules, Systems of Work and Radiation Risk Assessments and ensure that these are adhered to.

4. Information, Instruction and Training

To attend courses and receive training as recommended by the RPA.

To promulgate local Rules and Systems of Work to ensure that necessary safety information and guidance is given to all staff, outside contractors and any other persons who enter controlled or supervised radiation areas.

5. Additional Duties

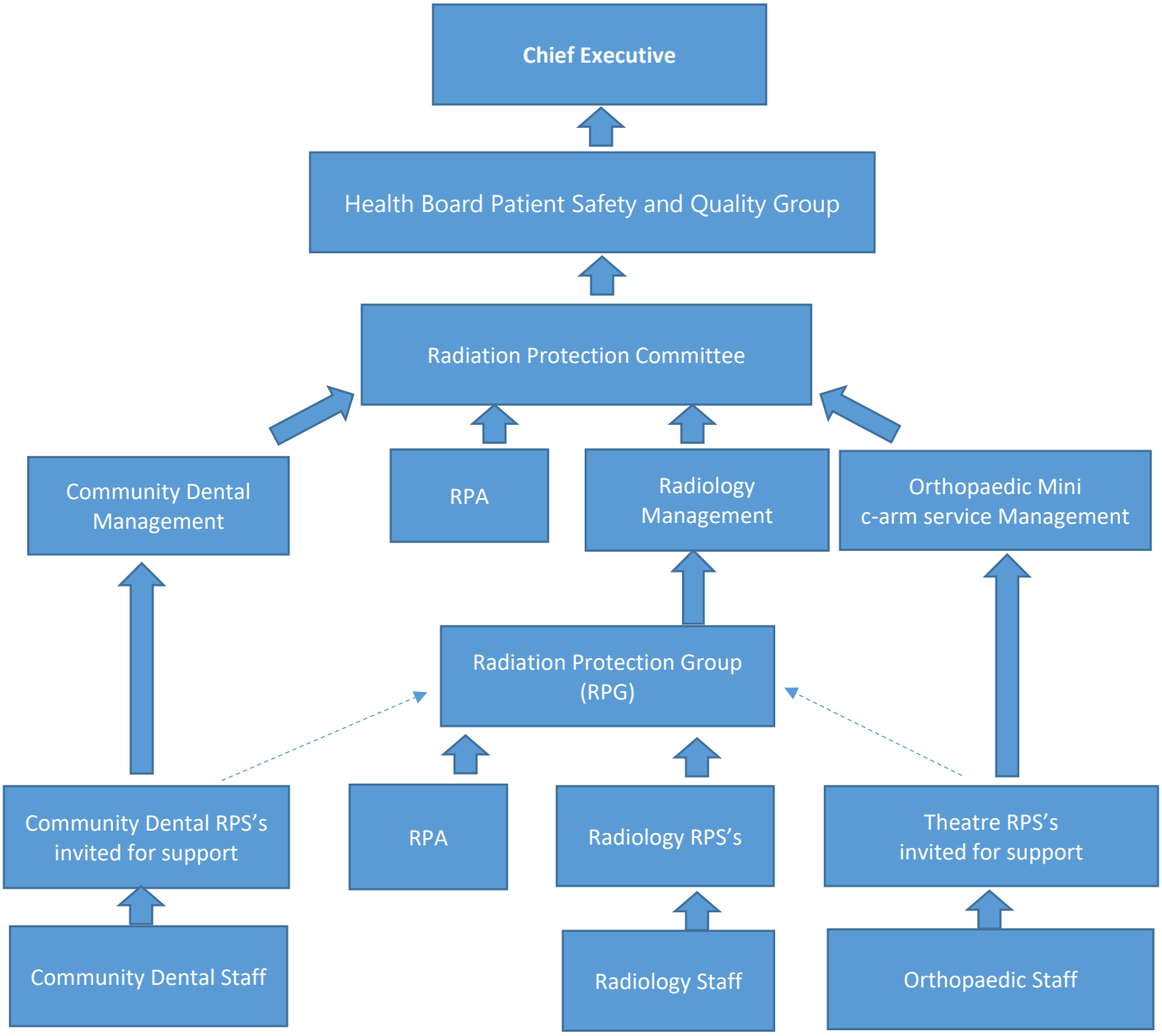
Dependent on the work carried out in the Department the responsible manager may delegate to the RPS specific tasks to comply with Regulations

These requirements must be listed and attached to both this Role Specification and to the Local Rules.

The RPS must provide a report to the Radiation Protection Group (RPG) prior to each meeting. Their report will form part of the six-monthly report submitted by the RPG to the Radiation Protection Committee.

APPENDIX 7

Radiation Protection Governance Structure



Aneurin Bevan University Health Board
Radiation Protection and Medical Exposures Committee (RPC)
Terms of Reference

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To ensure that the group's activities adhere to the Health and Safety, Risk Management and Clinical Governance arrangements of Aneurin Bevan University Health Board.

1.2 Objectives

The primary objective of the Committee is to provide assurance to the Board that the key systems, pathways and processes are efficient, safe, effective, responsive and robust.

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1.7 Frequency
The Radiation Protection Committee will meet every 4 months.
Additional meetings may be arranged when required to support the effective and safe functioning of the Radiology Directorate.

1.8 Reporting
The minutes of the meeting will be circulated to all members in draft form following the meeting; with the finalised minutes sent to the Executive Director of Therapies & Health Science.
Feedback from the Radiation Protection Committee will be presented at the Radiology Clinical Governance Meeting

1.9 Monitoring Effectiveness
The Committee will undertake an annual review of its performance against it Terms of Reference and work plan in order to evaluate the achievement of its duties. This review will be presented to ABUHB Patient Safety and Quality Group in the form of the Committee's annual report.

2.0 Review
These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced)

Diagnostic Imaging Department, Nevill Hall Hospital, Aneurin Bevan University Health Board

Inspection date: 25 and 26 April 2023

Publication date: XX XXX 20XX

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

Our purpose

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

Our values

We place people at the heart of what we do. We are:

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

Our goal

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

Our priorities

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

Contents

1. What we did

Full details on how we conduct Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspections can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Diagnostic Imaging Department at Nevill Hall Hospital, 25 and 26 April 2023.

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors, a HIW Intelligence Manager and a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. The inspection was led by a HIW Senior Healthcare Inspector.

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

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about their experiences of attending the Diagnostic Imaging Department at the hospital.

Suitable arrangements were in place to promote the privacy and dignity of patients and we saw staff treating patients with respect and kindness.

Information was available to patients on how to provide feedback and how to raise a concern about their care. The results of a recent survey of patients were displayed on a “you said, we did” board.

This is what the service did well:

- Patients provided positive feedback about the service they had received and the approach of the staff
- The results of a recent patient survey were posted on a “you said, we did” board
- Efforts were made to promote the Welsh language.

Delivery of Safe and Effective Care

Overall summary:
We found arrangements were in place to promote effective infection prevention and control and decontamination within the department.

Staff we spoke to were aware of the health board’s policies and procedures in relation to safeguarding. Staff could describe the actions they would take should they have a safeguarding concern.

There were also positives identified relating to the training and development opportunities available to staff and the work of the oversight groups.

We identified improvement was needed to comply with the Ionising Radiation (Medical Exposure) Regulations 2017 in some areas. This included referral forms for exposures performed during surgical theatre cases were not being completed by the referrer but were completed by the radiographer contrary to regulations. When this was identified by the inspection, the employer issued a letter to instruct all staff to stop this process with immediate effect.

Additionally, some other areas required improvement, relating to pregnancy testing and employer's procedures.

This is what we recommend the service can improve:

- Ensure staff have the appropriate procedure and training to perform pregnancy tests
- Carry out the required changes identified during the inspection process to the employer's procedure.

This is what the service did well:

- Staff we spoke with had a clear understanding of their IR(ME)R roles and responsibilities
- Training and development opportunities for staff to become advanced practitioners
- The Diagnostic Reference Level (DRL) groups work on the establishment of local DRLs.

Quality of Management and Leadership

Overall summary:
The Chief Executive of the health board was the designated employer under IR(ME)R and clear lines of reporting and responsibility were described and demonstrated.

Staff demonstrated they had the correct knowledge and skills to undertake their respective roles within the department.

The department's compliance with the health board's face to face mandatory training and appraisals was generally good.

Whilst feedback from staff was generally positive, there were some negative responses and comments from staff that needed to be addressed. These were mainly in relation to staffing numbers, staff support and senior management.

This is what we recommend the service can improve:

- Whilst staff understood the meaning of duty of candour, they had not received the appropriate training
- The health board needs to take action to address the less favourable comments highlighted within the 'Quality of Management and Leadership' section of this report.

This is what the service did well:

- The management team demonstrated a commitment to learn from the inspection findings and make improvements where identified
- Staff were confident about raising concerns and staff spoke well when interviewed both in a one-to-one setting and in the department
- The majority of staff had completed over 90% of their mandatory training and appraisals were over 98% completed.

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

3. What we found

Quality of Patient Experience

During the inspection HIW issued paper and online questionnaires to obtain views and feedback from patients and carers. As only nine responses were completed, this low number needs to be borne in mind when considering these responses. Responses were positive across all areas, with all patients who answered rating the service as 'very good' or 'good'. Patient comments included the following:

> *"Very helpful and friendly staff at reception and in X-ray department. Well done."*

> *"The service was very good. I was amazed that I had an appointment at 7.30 on a Sunday evening. Well done for going all out for providing such a great service."*

Health promotion, protection and improvement

Posters were clearly displayed, advising patients to inform staff if they were pregnant or breastfeeding. There was also a variety of posters on display advising patients on the benefits and risks of the exposure.

Written information was also available on the benefits of stopping smoking, as well as providing details of support organisations for patients with cancer and their carers.

Dignity and respect

Staff were seen being kind and caring to patients and treating them with respect. Discreet and appropriate conversations were heard at the reception desk when patients booked in, and in the waiting room. We also noted staff assisting patients with mobility difficulties.

Individual changing rooms were available providing privacy when patients were required to change out of their clothes for their procedure. We noted one changing room that had been installed within an X-ray room, where there were no nearby changing facilities. We also saw doors to rooms where X-rays were performed were closed when being used. The X-ray rooms with spacious and clean.

When asked whether staff treated them with dignity and respect and whether measures were taken to protect their privacy, all patients in the questionnaire agreed. All patients also stated they were able to speak to staff about their

procedure without being overheard by other patients and that staff listened to them.

During the inspection we used online questionnaires to obtain views and feedback from staff. A total of 32 were completed.

When asked whether patients' privacy and dignity were maintained, 81% who answered agreed. A total of 78% of staff who answered agreed they were satisfied with the quality of care they gave to patients.

Patient information and consent

Bilingual signage in both Welsh and English was displayed and bilingual posters providing information for patients were clearly displayed within the department. Staff informed us there were a handful of Welsh speaking staff working in the department and we were told that those staff wore lanyards to show they were happy to communicate in Welsh. It was also noted that there was over 90% staff compliance with the mandatory training on Welsh Language awareness, an NHS Wales course.

There was a hearing loop available at reception and staff confirmed they could access a translation service should this be required to assist communication with patients whose first language was not English.

All patients said that they were given enough information to understand the benefits and risks of the examination.

When asked whether staff had explained what they were doing, all patients who answered this question agreed.

Communicating effectively

We saw evidence of an alert on the system to identify patients with specific needs. We were also told that there was flexibility with appointments and that patients could "walk in" with a GP referral without an appointment.

All patients stated that they were able to find the department easily at the hospital.

Care planning and provision

There was evidence that patients received timely care in receiving their examination. We saw that patients were seen in a timely manner whilst in the department. Posters were also displayed informing patients to tell reception staff if they had waited longer in reception than expected.

We were told that if there was a delay, patients would be informed accordingly.

We were also provided with an example where a dementia patient that was unable to confirm their identity. Staff contacted the patient's consultant to seek positive identification before the scan was carried out.

Staff and senior staff we spoke with were able to give examples of where arrangements and systems were in place to promote an efficient service.

All patients who answered this question agreed that they were told at reception how long they would likely have to wait. Most patients agreed that the waiting time between referral and appointment was reasonable.

Only 41% of staff who answered the questionnaire agreed patients were informed and involved in decisions about their care.

Equality, diversity and human rights

The arrangements in place to make the service accessible to patients were described by staff. These included a hearing loop and bilingual information. Corridors were wide and equipment allowed for mobility and access needs.

Staff we spoke with demonstrated a good awareness of their responsibilities in protecting and promoting patients' rights when attending the department. Equality, Diversity and Human Rights awareness formed part of the health board's mandatory staff training programme. Staff we spoke with also provided examples of reasonable adjustments having been made so that patients could access the department to have their examination.

Over 75% of staff who completed the questionnaire felt they had fair and equal access to workplace opportunities.

Citizen engagement and feedback

Information was displayed around the department on how patients and families were able to provide feedback about their care. There was also information displayed on how the organisation had learned and improved based on feedback received, called a 'you said, we did' board. This information was based on the last feedback survey dated January 2023.

Senior staff described suitable arrangements for managing concerns and complaints made by patients about their care. Posters advising patients of how to make a complaint or provide feedback were prominently displayed in the department.

Staff we spoke with confirmed patient feedback had been shared with them together with any learning identified. Additionally, staff confirmed that details and information relating to complaints was shared with staff to ensure there was learning across the department.

All patients said they were involved as much as they wanted to be in decisions about their examination.

A total of 78% of staff said that patients were informed and involved in decisions about their care.

When asked whether they could access the right healthcare at the right time (regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) 89% of patients said they had.

More than half of the patients said they would not know how to complain about poor service.

Whilst 94% of staff who answered the question in the questionnaire agreed patient experience feedback was collected within their department, only 59% agreed that they received updates on patient experience feedback in their department. Furthermore, whilst 15% of staff agreed that feedback from patients was used to make informed decisions within their department, 66% did not know. Whilst 85% of staff agreed their organisation acted on concerns raised by patients, only 34% agreed the organisation took swift action to improve when necessary.

Delivery of Safe and Effective Care

HIW required senior staff within the department to complete and submit a self-assessment questionnaire prior to our inspection. This provided HIW with detailed information about the department and the employer's key policies and procedures in respect of the Ionising Radiation (Medical Exposure) Regulations 2017. This document and the supporting evidence submitted were used to inform the inspection approach.

The self-assessment questionnaire was returned to HIW within the agreed timescale and was comprehensively completed. Where we required additional information or clarification in respect of the responses within the self-assessment, senior staff provided this promptly.

Compliance with Ionising Radiation (Medical Exposure) Regulations

Duties of employer

Patient identification

The employer had a suitable employer's written procedure in place to correctly identify the individual to be exposed to ionising radiation. This also set out the procedure to follow when patients were unable to confirm their identity verbally or in writing such as patients who are unconscious.

Staff we spoke with also had a clear understanding of the correct patient identification process.

Individuals of childbearing potential (pregnancy enquiries)

There was an employer's written procedure on pregnancy enquiries, that referred to signs being visible in radiology waiting areas relating to female patients. The use of the term female is not considered gender inclusive and needs to be updated in the procedure.

There was no information included in the procedure on ensuring gender inclusivity for these enquiries. The Society of Radiographers had published guidance to assist practitioners in understanding the needs of individuals with gender diversity and those with diversity in their sexual characteristics. However, we were told in discussion with senior staff, that work had started on this. Staff stated that they were waiting on guidance from the All-Wales Image Quality Forum, who had discussed this issue and were currently trialling this in another health board.

Senior staff also informed us that radiographers may from time to time be involved in carrying out a pregnancy test prior to the exposure. A procedure needs to be

established to outline this process for radiographers to follow when carrying out pregnancy tests. In addition, the procedure must define what is classed as a high dose examination and when the 10 day and 28 day rule apply.

The employer needs to establish a procedure to ensure radiographers are fully trained and competent before carrying out pregnancy tests of patients.

Staff we spoke with described the action they would take to make enquires of individuals, which was consistent with the employer's written procedure.

We audited a random sample of ten referral forms. These showed operators had completed pregnancy enquires, in accordance with the employer's written procedure, where appropriate.

Non-medical imaging exposures

Senior staff confirmed that non-medical imaging exposures were performed in the department. There was also an employer's written procedure in place for these types of exposures.

The Delegated Authorisation Guidelines (DAGs) in place did not clearly reference whether it covered both paediatric and adult patients.

The employer is to ensure that the DAGs clearly reference that they cover both paediatric and adult patients.

Referral guidelines

The employer had established referral guidelines for the range of exposures to be performed within the department. The documentation supplied confirmed that individuals used i-Refer, making the best use of clinical radiology 8th edition as the standard for radiology referrals.

We were told during the discussion with senior staff that referral forms for exposures performed during surgical theatre cases were not being completed by the referrer but were completed by the radiographer. We identified this as poor practice and not in keeping with the requirements of the duty holder role and responsibility of the referrer. During the inspection we required senior staff to take more timely action to stop this custom. Before the end of our inspection, we received written assurance from the employer that action had been taken in this regard.

The employer is required to provide an update on the action taken to ensure the employer's written procedure, is corrected and is adhered to by entitled

referrers making a referral prior to exposures performed during surgical theatre cases.

Duties of practitioner, operator and referrer

Departmental staff we spoke with had a good understanding of their roles and responsibilities under IR(ME)R.

The SAF completed stated that medical referrers were sent letters entitling them to refer patients to the radiology department. All medical referrers can refer for all examinations. Non-medical referrers receive individual entitlement letters to act as referrers within their agreed referral protocol detailing their scope of referral from the radiology clinical director.

The sample of ten referral forms examined showed that referrals had been made in accordance with referral guidelines, included sufficient clinical details and had been appropriately completed.

Justification of individual exposures

There was a procedure in place that covered the justification and authorisation of medical exposures involving exposure to ionising radiation. The purpose of this procedure was to ensure that all examinations involving ionising radiation are justified before the exposure was made. Radiologists and Radiographers were entitled as IR(ME)R practitioners for the purposes of justifying imaging examinations involving ionising radiation. Radiographers were entitled as IR(ME)R operators for the purposes of authorising imaging examinations.

The referral forms we examined showed the above procedure had been followed.

Optimisation

An image optimisation team (IOT) had been established in the department, the team ensured standardisation of imaging protocols across the Directorate. However, we were told the group had not met recently. It was recommended that this important group needs to be re-established.

Senior staff confirmed current BIR guidance around the use of patient contact shielding had been implemented in the department.

Staff we spoke with were able to describe how to ensure the doses were as low as reasonably practicable (ALARP). This included making sure the equipment was quality checked, selecting the correct protocols and the proper positioning of the patient.

Diagnostic reference levels (DRLs)

The employer had a written procedure describing the process for the setting, auditing and reviewing of DRLs established for imaging examinations performed in the department.

We evidenced local DRLs had been established and these were below national DRLs. Both local and national DRLs were clearly displayed in work areas within the department for staff reference. Radiation Protection Service Cardiff (RPSC) carry out dose audits and provided recommended local DRLs that are evaluated by the DRL group. The recommendations of this group are presented to the Radiation Protection Committee (RPC) for ratification.

Staff we spoke with confirmed they were aware of the employer's written procedure. They described the action they would take should they identify a DRL has been consistently exceeded and this was in accordance with the employer's procedure.

Paediatrics

Senior staff confirmed that medical exposures were not performed on a regular basis on children at the department. The vast majority of paediatric work is carried out in The Grange Hospital.

We were told that the CT scanning of paediatric patients is limited. The department follow specific protocols, that had been set up with support from the manufacturer's applications specialist and the scanner would dose modulate to ensure exposures were ALARP and optimised.

Clinical evaluation

There was an employer's written procedure in place for carrying out and recording an evaluation for medical exposures performed at the department.

The sample of referral forms we examined included five retrospective referral forms. These all showed evidence of a timely clinical evaluation being completed.

From the information supplied we noted an extensive list of operators outside radiology who performed clinical evaluation. These areas were listed in employer's procedure EP (j), which is the procedure for the evaluation of each medical exposure. These staff were not listed in the EP (b), which related to the identification of entitlements.

The entitlement table at EP (b)(i) needs to be updated to include all lines of entitlement accountability for operators.

It was also positive to note that three reporting radiographers had been trained, signed off as competent and entitled to clinically evaluate general X-ray examinations within specific guidelines. Another reporting radiographer had been trained, appropriately signed off as competent and entitled to clinically evaluate chest and abdominal X-ray examinations within specific guidelines. An advanced practice vascular access service is in place which is jointly led by an advanced practice radiographer. A further reporting radiographer is currently completing this training.

Furthermore, a mammographer had been trained, appropriately signed off as competent and entitled as a Consultant Radiographer (breast imaging). They undertook mammographic image interpretation and reporting along with other duties under local agreement with the Breast Speciality Consultant Radiologists.

Each of the duties held by these individuals were demonstrated on the entitlement matrix.

Equipment: general duties of the employer

There was an employer's written procedure in place to ensure a quality assurance programme in respect of equipment was followed.

We noted that the equipment inventory was overdue for review in March 2023. We were told that nothing had changed in the equipment inventory. Senior staff provided an equipment inventory that was found to be incomplete and did not include all the information required under IR(ME)R. This included the year of manufacture and other areas were missing, with N/A filled in areas for some equipment.

The employer needs to ensure that the review of the equipment inventory is completed in a timely manner and that the equipment inventory is completed in full.

The quality assurance programme in place for all relevant equipment was also described in the self-assessment provided.

Senior staff we spoke with described the equipment replacement programme, which scheduled the replacement of equipment in line with service needs and available funding. Radiology was represented on the divisional capital projects board where replacement priorities could be highlighted. The department aimed to replace at least one room per site per year. This was prioritised on the replacement programme.

There was a recently re-established level A quality assurance (QA) programme for each piece of equipment. There was also a document that detailed the quality control (QC) tests for each piece of equipment and the results were logged locally. It was apparent that a lot of work had been completed to ensure this work was now being completed in a timely manner.

However, the in-house QC testing for the mini C-arm used in theatres was not available on request during the inspection. The level B testing was completed by the medical physics experts (MPEs) in November 2021. We were subsequently informed that the in house QC testing could not be supplied. This testing needs to be completed as a matter of urgency and in a timely manner in the future.

The employer needs to ensure that a robust system is put in place to avoid past issues with level A testing.

The employer is to ensure that in-house QC testing of the mini C-arm used in theatres is completed as a matter of urgency and is completed in a timely manner in the future.

The employer is to provide HIW with assurance that the MPE has provided the support required to theatres to set up the QC testing and training.

Duties of the employer

Entitlement

There was a written employer's procedure in place to identify individuals entitled to act as referrer, practitioner or operator within a specified scope of practice.

All medically qualified staff were made aware of their responsibilities as a referrer at their hospital induction. General Practitioners received a letter of entitlement from the Radiology Clinical Director detailing their responsibilities.

However, it was not recorded that operators were entitled to perform quality control testing on equipment in the entitlement records provided.

The employer needs to ensure that the entitlement records of operators are updated to include quality control testing of equipment.

During the review of the self-assessment, we were told that the advanced practice nurse was not an IR(ME)R operator and always has a radiographer present in the room when exposures were required. However, we noted that the nurse was performing the duties of a non-medical referrer, when they were not entitled to do so.

We recommend that after completing the relevant training and assessment of competency, the advance practice nurse is entitled as a non-medical referrer before they refer for chest X-rays.

Procedures and protocols

The SAF stated that The Radiation Protection Group (RPG), or representatives of this group, reviewed the written procedures and protocols. Authorisation for the updates was given by the Radiation Protection Committee. The authorised documents were stored on the shared area called SharePoint and hard copies were stored in the department which are then available for staff to view.

Senior staff we spoke with also described the process for reviewing and revising the employer's written procedures and protocols. There was an employer's procedure for this area. The purpose of this procedure was to ensure that a regular review of all policies, procedures and protocols were followed.

Whilst we were provided with evidence of written examination protocols, these need to specify whether they are for adults, children or both.

Significant accidental or unintended exposures

Senior staff described suitable arrangements for the analysis, recording and reporting of accidental or unintended exposures. We saw that guidance was readily available in the department for staff should they suspect an accidental or unintended exposure had taken place. This process included involvement of MPEs so that an assessment of the dose could be performed to identify whether the incident was notifiable to HIW.

We saw arrangements were in place for the sharing of learning from incidents with departmental staff and with wider teams within the organisation.

There was an employer's written procedure in place for reporting and investigating accidental and unintended exposures. However, the clinically significant, accidental and unintended exposures part of the employer's procedure required clarity on who makes the decision on what was clinically significant and in defining when the patient was informed or not and where this was recorded.

We recommend that the relevant procedure relating to clinically significant, accidental and unintended exposures part of the employer's procedure is updated. This is to include who makes the decision on what is clinically significant and in defining when the patient is informed or not and where this is recorded.

The process of sharing information was also described, this included issuing learning outcome notices throughout the health board to ensuring the wider dissemination of information. This was in addition to the passage of information from lessons learned.

Staff responses in the questionnaire were as follows:

- Their organisation encouraged them to report errors, near misses or incidents – 97%
- Their organisation treated staff who were involved in errors, near misses or incidents fairly – 63%
- When errors, near misses or incidents were reported, their organisation took action to ensure that they do not happen again – 81%
- The last time they saw an unintended exposure, error, near miss or incident, they or a colleague reported it – 91%
- They were given feedback about changes made in response to reported errors, near misses and incidents – 91%
- If they were concerned about unsafe practice, they would know how to report it – 94%
- Many said they would feel secure raising concerns about unsafe clinical practice (66%) although less than half of the respondents said they are confident their concerns would be addressed (34%).

Staff comments included:

> *"Following incidents, learning outcomes are provided and displayed. However, seem to be target blame on to the radiographer, even if multiple errors took place prior to the resulting incident. These errors fail to be followed up with no visible action been taken to prevent them from happening again."*

> *"Although we have had a number of radiation incidents, this appears to have had no effect on higher management, who are only concerned with numbers. Patients are not considered as people, only figures, which is against my belief as a radiographer. There is also no concern for staff - staff are burnt out due to minimal numbers working in the department*

covering gaps on rotas, sickness and annual leave - this has a detrimental effect on concentration and mental well-being."

"Staff are hardworking and dedicated. Only frustration is in senior management beyond our immediate line manager not being accessible and the feeling of not being listened to. "

"I feel that very senior management within Radiology do not speak to staff before they implement changes. They make it seem that staff are replaceable & that they don't care that staff are leaving."

Safe Care

Managing risk and health and safety

The department was easy to find and accessible with good disabled access including wide corridors. The treatment rooms were spacious with mobility aids seen in the rooms.

The department was on both the ground and first floor within the hospital. The ground floor would benefit from a refresh and some remedial maintenance work, this included missing and broken ceiling tiles. We also noted fold down chairs marked as condemned and some seating pads in the waiting areas were split and worn and need to be replaced as they posed an infection prevention and decontamination risk.

The health board need to ensure that the remedial work in the department including the split chairs and missing ceiling tiles is completed.

Whilst the environment was generally safe and secure with limited clutter and tripping hazards, we noted a large yellow unlocked and unsecured clinical waste bin near the lifts on the ground floor that was for clinical waste.

The health board need to ensure that that the large yellow bin is secured and put in a more appropriate place.

There were a range of risk assessments in place that staff were able to describe and knew where to find the assessments.

Infection prevention and control (IPC) and Decontamination

There were suitable arrangements in place to promote effective IPC. All treatment areas of the department we saw were visibly clean and tidy and the equipment we saw was also clean. We saw staff cleaning equipment between patients to help reduce cross infection.

Personal protective equipment was readily available for staff to use. Suitable handwashing and drying facilities and hand sanitiser were also readily available within the department.

Staff we spoke with were aware of their responsibilities in relation to IPC and decontamination. Additionally, senior staff were able to describe how medical devices, equipment and relevant areas of the unit were decontaminated.

The specific arrangements in place to treat symptomatic patients or patients with confirmed infections when attending the unit were also described. This included the room identified for patients with an infection, such as COVID-19, which would be cleaned thoroughly after use. There would be a minimum number of staff attending infected patients and the department made efforts to ensure no cross over with other patients.

All the patients who completed the questionnaire said that the setting was clean. However, when asked whether in their opinion that IPC measures were being followed only 56% said yes. Almost all staff agreed that their organisation implemented an effective infection control policy. Their questionnaire replies included:

- There is an effective cleaning schedule in place (94%)
- Appropriate PPE is supplied and used (100%)
- The environment allows for effective infection control (88%).

Some comments we received about infection prevention and control procedures are below:

> *"Plentiful and organised PPE and cleaning products available for all staff members, which are kept in a safe and practical space. Stock is monitored and replenished efficiently. Maintaining both staff and patient safety in regards to infection control has been second to none."*
>
> *"Cleaning schedules are completed for each room daily and the surfaces used are cleaned between each patient."*

Safeguarding children and safeguarding vulnerable adults

All staff we spoke with were aware of the health board's safeguarding policies and procedures and where to access these. They were also able to describe the actions they would take should they have a safeguarding concern.

There was evidence from the sample of five training records we examined that showed that all staff were up to date with training, which had been completed at an appropriate level according to their role within the department.

Effective care

Participating in quality improvement activities

Clinical audit

Senior staff provided examples of clinical audits that had been completed. We were told that clinical audits completed by medical staff were completed on a department audit template and audits were registered centrally. There was also a standard report template, with medical colleagues presenting their findings in various formats and were presented at the clinical audit meeting.

Other clinical audit and departmental audits would be discussed at the radiology operational group and may also feed into the clinical audit meeting and clinical governance meeting where appropriate.

We noted that some audit findings found non-compliance with IR(ME)R, for example documenting pregnancy checks, dose recording and justification. In such cases, there was no evidence of robust action to implement change. The re-auditing of identified issues needed to be completed sooner rather than wait 6 months before the next audit. Staff need to comply with the procedures that they were working too.

Any issues identified during an audit need robust action and must to be rechecked in a timely manner and not wait until the next audit is due.

Expert advice

Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in and provide advice on medical exposures performed at the department. The employer had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R.

Medical physics support was considered to be good, this was evidence by their involvement in various groups and committees as well as advising staff when required. Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in, and provide advice on, medical exposures performed at the department.

We were told that MPEs actively participate in image optimisation via both the image optimisation group and the DRL group. Advice was also given on

establishment of local DRLs and compliance with these was audited on a routine and ad hoc basis. Advice would also be given on specific optimisation projects.

During discussion with the MPEs we were told that level B testing of equipment was up to date.

Medical Research
Medical research was not currently performed at the hospital, although it was performed at other sites within the health board. However, an employer's procedure was available and clearly written.

Records management
Generally, we found suitable arrangements were in place for the management of records used within the department.

A sample of five current patient referral documentation and five retrospective patient referral documentation were examined. The sample showed that the referral records had been completed fully to demonstrate appropriate patient checks had been performed. This included patient identification, sufficient clinical details, enquiries made of pregnancy status where applicable, justification had been carried out and the referral appropriately signed by an entitled referrer.

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on services carried out by Nevill Hall Hospital and their experience of working there. In total, we received 32 responses from staff. Not all respondents answered every question.

Responses from staff were mixed, with most being satisfied with the quality of care and support they gave to patients (78%) and many agreeing that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (59%). However, over half of respondents felt that they would not recommend their organisation as a good place to work (59%).

Staff comments included the following:

> *"Staffing levels have declined over the last few years, adding increased pressures on staff with little support. Progression is minimal, leading to high staff turnover. Resulting in increased training pressures, and no allocated time for this due to reduced numbers of staff. The outcome of this is inadequate training and increased chances of incidents through lack of knowledge."*

> *"Under pressure to scan too many patients during a 12 hour shift. Not enough breaks. Patients are not cared for and treated like patients. Patients are now seen as no's/targets. Feels like a production line. Don't feel valued in work"*

> *"Staff are hardworking and dedicated. Only frustration is in senior management beyond our immediate line manager not being accessible and the feeling of not being listened to."*

We asked staff how the setting could improve the service it provided. Staff suggested:

> *"More interaction with senior management and staff to address issues. Looking at the ooh rota and lone working and get staff opinion."*

> *"Building repairs needed, particularly leaking roof. Little career progression opportunities in some modalities."*

Governance and accountability framework

The Chief Executive of the health board was the designated employer under IR(ME)R and had overall responsibility for ensuring the regulations were complied with. Where appropriate the employer had delegated tasks to other professionals working in the health board to implement IR(ME)R.

We were provided with details of the organisational structure. Clear lines of reporting and responsibilities under IR(ME)R were described and demonstrated.

The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements where needed.

Management described the process to engage with staff on a regular basis, this included an open-door policy at the department, as well as visiting the department on a regular basis.

Staff in the questionnaire commented on the new portering system. This system required requests to be made for both the job to deliver the patient and to collect the patient, from radiology. The second job could not be entered onto the system until the patient was ready to be collected, which staff believed lead to increased pressure on staff to care for the patient in the meantime. Management stated that there had been regular meetings with the portering supervisor in relation to this.

A member of staff commented that:

> *"The current portering system is not fit for purpose and is unsafe for patients. This needs urgent improvement as detrimental to patients and lone working staff. Lone working staff (all out of hours, 5pm-9am and all weekend) results in inability to look after multiple patients, safely issues for example cardiac arrest and fitting. Other issues are violence and aggression, manual handling, lack of support in decision making for junior staff no emotional support on top of single handedly managing a busy workload. Chronic short staffing erodes staff morale and is unsafe for patients. Blame culture towards patient facing staff no responsibility being taken by management even if indirectly as a result of poor decision making from senior management."*

Staff agreement, in the questionnaire, was as follows

- They were content with the efforts of their organisation to keep them and patients safe – 41%
- Care of patients was their organisation's top priority – 50%

- Senior managers were visible – 34%
- Communication between senior management and staff is effective (38%)
- Senior managers were committed to patient care – 45%
- Their immediate manager can be counted on to help them with a difficult task at work (66%) and that their immediate manager gives them clear feedback on their work (66%)
- Their immediate manager asked for their opinion before making decisions that affected their work – 56%
- Their organisation was supportive – 53%.

One comment we received about management was:

> *"Staff are hardworking and dedicated. Only frustration is in senior management beyond our immediate line manager not being accessible and the feeling of not being listened to."*

Workforce planning, training and organisational development

We viewed a sample of competency records for five staff and the training and entitlement matrix maintained by the department. The training records, entitlement, scope of practice and competency were well documented and linked to the appropriate equipment training records provided. However, a process of refresher training needs to be established, some of the training records dated back to 2012. Additionally, the non-medical referral training needed the dates of entitlement included.

The training records of staff need to be updated, following refresher training.

The training records of non-medical referrers needs to be completed in full.

Most respondents (81%) felt they had received appropriate training to undertake their role. Staff commented:

> *"More training on the Modalities we are required to use as fail safe (Nuclear Medicine CT)."*

> *"We are expected to use a machine where we are unable to get regular practice on if the CT scanner goes down."*

Senior staff provided details of the number and skill mix of staff working in the department and confirmed this was sufficient to deliver the services that were provided.

However, only 36% of staff agreed that there were enough staff to enable them to do their job properly. Staff told us:

> *"Management have failed to address the portering issues that have been raised multiple times. This has resulted reduction in the standards of patient care while in our department, for example patient's having lengthily waits in cold corridors waiting for porters.*
>
> *Following incidents, learning outcomes are provided and displayed. However, seem to be target blame on to the radiographer, even if multiple errors took place prior to the resulting incident. These errors fail to be followed up with no visible action been taken to prevent them from happening again."*

We reviewed staff training records in relation to the health board's mandatory training programme. These showed staff were expected to complete training on a range of topics relevant to their role. The mandatory training records of five staff were checked and there was good training compliance noted, with over 90% of staff having completed all the mandatory training. Management were aware of those staff who had not completed all of their training and were able to described the reasons why. The process to ensure compliance was also explained, which included supporting those members of staff who struggled with online training.

There were clear arrangements in place for staff supervision and appraisals. Senior staff described the process in place for newly qualified staff with an induction process and a mentor assigned to the member of staff. Compliance with the appraisal process was also noted as being 98%, which was considered to be good practice. In the staff questionnaire, 94% of staff said they had an appraisal, annual review or development review in the last 12 months.

Staff we spoke with were confident when raising concerns and spoke well when interviewed. Whilst staff understood the meaning of the duty of candour, they had not received any training on this new duty.

The health board are to ensure that staff receive appropriate training on the duty of candour.

When asked about whether they agreed staff had fair and equal access to workplace opportunities (regardless of age, disability, gender reassignment,

marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation), 75% agreed. Staff told us:

> *"At Nevill Hall we were made to work 12.5 hour shifts , 7 days a week Another hospital within ABUHB do not work 7 days. They do not work weekends. Would have liked the opportunity to work at this hospital. In order to maintain my family/work life balance "*

> *"New opportunities, experiences, progression and learning sessions are vastly advertised to us as staff."*

A total of 81% of staff agreed that their job was not detrimental to their health and 75% of staff agreed that their current working pattern/off duty allows for a good work-life balance. However, only 41% of staff agreed they would recommend their organisation as a place to work.

That being said, 84% agreed that their workplace was supportive of equality and diversity.

It was positive to note that the majority of staff (78%) said they were aware of the occupational health support available to them. However, only 59% agreed the organisation took positive action on health and wellbeing.

It was disappointing to note that 10% of staff who answered the question indicated they had faced discrimination at work within the last 12 months.

The health board is required to inform HIW of the action taken to address the issues relating to staff discrimination and other less positive staff comments and percentage agreements in the report.

Other replies to the questionnaire included:

- That staff could meet the conflicting demands on their time at work – 72%
- That they were involved in deciding on changes introduced that affected their work area - 41%
- Almost all of respondents felt they are able to access the ICT systems needed to provide good care and support for patients - 97%.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Nevill Hall Hospital

Date of inspection: 25/26 April 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Nevill Hall Hospital

Date of inspection: 25/26 April 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The employer needs to establish a procedure to ensure radiographers are fully trained and competent to carry out pregnancy tests on patients.	IR(ME)R 2017 Regulation 11 (3)(d)(i) and 12 (8) (d)	Radiology will review their involvement and role in pregnancy testing. ABUHB have engaged with Professional Leads across Wales to discuss current practice. If it is agreed that we require direct involvement in the pregnancy testing process, a draft SOP has been developed to address training needs for radiography staff.	Radiology Services Manager	30th September 2023
The employer is to ensure that the DAGs clearly reference that they cover both paediatric and adult patients.	IR(ME)R 2017 Regulation 11 (5)	The current DAG's in place will be updated to reflect they relate to patients 16 years of age or older and that paediatric requests will be justified by Radiologists.	Cross Sectional Modality Lead, NHH	31st July 2023

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A SOP has been developed, communications have started with staff from early pregnancy unit regarding training for Radiology staff on completing pregnancy tests and delivering unexpected news.

The employer is required to provide an update on the action taken to ensure the employer's written procedure is corrected and is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	IR(ME)R 2017 Regulation 6 (2), 6 (5) and 10 (5)	An immediate change in process was implemented to ensure referral forms are received prior to any exposure to ionising radiation in theatre. Communication was made with all Directorates to ensure the change was implemented. The procedure document has been updated to reflect the change in practice and audit is ongoing to ensure compliance.	Radiology Site Lead, NHH	Change implemented immediately Compliance audit ongoing
The employer is to ensure the entitlement table in EP (b)(i) is updated to include all lines of operator entitlement accountability.	IR(ME)R 2017 Regulation 10 (3) and Schedule 2 (b)	Employer procedure document 2(b)(i) will be updated to include the entitlement of operators for clinical evaluation under the non-reporting agreements. Following the update the document will be ratified by RPC.	Radiology Servi	31st August 2023
The employer is to ensure that the review of the equipment inventory is completed in a timely manner and that the equipment inventory is completed in full.	IR(ME)R 2017 Regulation 15 (1) (b) and 15 (2)	The equipment inventory has been reviewed and updated with all relevant information.	Radiology Site Lead, NHH	Completed
The employer is to ensure that a robust system is put in place to avoid past issues relating to keeping level A testing up to date.	IR(ME)R 2017 Regulation 15 (3)	A team of trained staff has been established in NHH Radiology to ensure Level A testing is completed regularly and in a timely manner. The role of this team is to coordinate the	Radiology Site Lead, NHH	Completed

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Work has begun, Mark Wilkes and Samantha Howells to meet to finalise

		Level A testing. Further communication has been issued to all Radiography staff to reinforce their responsibilities for QA of equipment.		
The employer is to ensure that: • Evidence of the in-house quality control testing for the mini C-arm used in theatres is completed as a matter of urgency	IR(ME)R 2017 Regulation 15 (3)	Staff have been identified to be trained on the Level A QA testing and this will begin on 17th July 2023 with the help of the MPE. A baseline of results will be established to allow the monthly testing to be implemented.	Directorate Manager, Orthopaedics	31st July 2023
• The quality control testing of the mini C-arm is completed in a timely manner in the future		A QA programme has been established within the theatre department for regular QA testing of the mini c-arm and there is a training plan to ensure this programme can be maintained. Assurance of compliance will be given to RPC.		31st July 2023
• They provide HIW with assurance that the MPE has provided the support required to theatres to set up the QC testing and training.		The MPE has attended the T&O Directorate meeting on 16.6.23 and detailed the legal requirements to carry out QA and discussed that T&O have signed up to the Health Board's Employer's Procedures which state that they will carry out QA. A spreadsheet and set of instructions for the QA has been provided and training for the operators is being arranged.	Medical Physics Expert	Completed (ongoing)

The employer is to ensure that the entitlement records of operators are updated to include quality control testing of equipment.	IR(ME)R 2017 Regulation 10 (3) and Schedule 2 (b)	The individual entitlement document template will be updated to ensure the operator role includes Level A QA tests.	Radiology Site Lead, NHH	Completed
The employer is to ensure that following the completion of the relevant training and competency assessment, the advance practice nurse is entitled as a non-medical referrer before they refer for future chest X-rays.	IR(ME)R 2017 Regulation 6 (2) and 6(5) and Schedule 2 (b)	A non-medical referrer protocol will be written to identify the scope of practice for the advanced practice nurse to refer for chest x-rays. Following acceptance of the protocol and relevant training the individual will be entitled as a referrer with a defined scope of referral.	Radiology Servi	31st July 2023
The employer is to ensure that the relevant procedure relating to the clinically significant, accidental and unintended exposures is updated. This is to include who makes the decision on what is clinically significant and in defining when the patient is informed or not and where this is recorded.	IR(ME)R 2017 Regulation 8 (1) and Schedule 2 (l)	Procedure document 2(l) will be updated to reflect that the Clinical Director of Radiology, or a named Deputy, will make the decision on whether an incident is clinically significant based on the information presented to them. This decision will be included in the investigation report associated with any SAUE or CSAUE investigation. In ABUHB, all patients involved in SAUE or CSAUE incidents are informed.	Radiology Site Lead, NHH	31st August 2023

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2023-09-22 13:49:57

A draft non-medical referrer protocol has been written. Draft needs to be updated for all non-medical referrers and then approved

The health board needs to ensure that the remedial work in the department including the split chairs and missing ceiling tiles is completed.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The split chairs will be removed from use and replacement, non-upholstered chairs procured. The Estates lead in NHH has been contacted to ensure the ceiling tiles are replaced.	Radiology Site Lead, NHH Facilities Manager, NHH	30th September 2023 30th September 2023
The health board need to ensure that that the large yellow bin is secured and put in a more appropriate place.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The Estates lead has been contacted and the existing bin will be replaced with a secured clinical waste bin. This will be located in an appropriate location.	Facili... Mana...	...July 2023
Any issues identified during an audit need robust action and must be rechecked in a timely manner and not wait until the next audit is due.	IR(ME)R 2017 Regulation 7	We will ensure any issues identified from an audit will have an associated robust action plan and re-audit within 1 month to ensure compliance.	Radiology Quality & Governance Manager	Completed
The training records of staff need to be updated, following refresher training.	IR(ME)R 2017 Regulation 6 (3) (b), 17 and Schedule 3	The equipment training records for staff will be amended to include a section to identify any update training.	Radiology Site Lead, NHH	Completed

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2023-09-22 13:50:45

Chairs have been chosen, moving through the procurement process

The training records of non-medical referrers needs to be completed in full.	IR(ME)R 2017 Regulation 6 (3) (b), 17 and Schedule 3	The date of entitlement for non-medical referrers will be included on the non-medical referrer matrix.	Radiology Site Lead, NHH	31st December 2023
The health board are to ensure that staff receive appropriate training on the duty of candour.	Standard 7.1 Workforce	The Health Board have provided online training via the ESR system for all staff and we will ensure all staff have completed the training within 3 months.	Radiology Site Lead, NHH	30th September 2023
The health board is required to inform HIW of the action taken to address the issues relating to staff discrimination and other less positive staff comments and percentage agreements in the report.	Standard 6.2 Peoples Rights	Staff meetings have already taken place to discuss issues raised in the HIW report. Minutes of the meeting have been distributed to every member of staff. Pathways for escalation of issues have been clarified within the department which includes a range of Band 7 staff and Society of Radiographer representative. Staff have been reminded that feedback can be made in person or anonymously. Arrangements for senior management to have a more visible presence on site have been actioned alongside the site lead. The on-site Senior Management rota will be published and be available for all staff groups to view.	Radiology Site Lead, NHH Radiology Management Team	Ongoing

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2023-09-22 13:51:23

A non-medical referrer team has been established and work is on going

		Senior Management maintain their 'open door' policy towards staff and will continue with the ongoing staff engagement sessions and are actively engaged with 'People First Initiative for Wellbeing'. This engagement is encouraged and supported from a Divisional perspective. To address the requirements of the ABUHB Clinical Futures model the Radiology Management team undertook a full staff consultation in 2020 and implemented a 12.5 hour day, 7 days a week roster in November 2020 across all the major sites. One CT scanner was restricted to a five day working week while the required staffing compliment was established. The recruitment is progressing and we aim to have all sites on the same service provision by the end of 2023. The staffing establishment within each department continues to be reviewed and are reflective of the current service demand. The Radiology Directorate have Divisional support in ensuring vacancies are recruited		

		without delay to minimise any vacancy shortfall. Radiology Directorate have a clear plan for staff training and progression and this is included in the IMTP. The Radiology Directorate continue to successfully train advanced practice within its workforce and provide opportunities to all staff across the Directorate for progression. This has been acknowledged and appreciated during the inspection / report. The management team have worked closely with the modality and site leads to develop robust induction and training programmes to ensure staff are competent to work independently. The Radiology Directorate have weekly performance meetings and monthly operational group meetings where demand and capacity issues are addressed. In these forums we are able to review the current workload with the site and modality leads to ensure service utilisation is optimised. Radiology have invested in new equipment e.g. new equipment, alarm call systems,		

		controlled access doors etc to ensure a safe environment for our staff and patients at all times. The Radiology Directorate management team will continue to ensure that all staff across all sites get equal access to the progression and training opportunities.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Mark Wilkes

Job role: Radiology Services Manager

Date: 23.06.2023

Radiation Protection Service

02920 316 268
RPS.Cardiff@Wales.NHS.UK

File Ref:

Radiation Protection Audit
Aneurin Bevan UHB

Ionising Radiations (Medical Exposures) Regulations 2017

Documentation (Employer's Procedures) and document QA

April 2023

Introduction

This is the second theme of the IRMER audit programme. The aim of this audit is to ensure that your organisation is compliant with the requirements for employer's procedures for certain matters (regulation 6(1) and schedule 2) and that a quality assurance programme for these has been established (regulation 6(5)(b)). It is the second in a three-year programme of IR(ME)R compliance audits undertaken by the Radiation Protection Service, Cardiff. Information gathered in the first audit will also be used to interpret the answers to this audit.

Summary of findings

The Employer's Procedures are well developed with a review process in place for radiology and theatres, who have recently combined procedures. Some amendments have been recommended to improve the document QA for the Community Dental Service (CDS), who have separate Employer's Procedures in place.

Recommended actions

1. Employers Procedures Overview

1.1. For radiology and theatres, it is recommended that it is made clear in the Employer's Procedures the individual scope of the procedures. Currently the radiology and theatres combined version states: "all examinations where the patient is receiving an exposure to ionising radiation" but it is recommended that this is amended to reflect how the CDS have their own Employers Procedures.

1.2. It is the employer's duty to ensure that Employer's Procedures are in place for all exposures to which IR(ME)R applies. Services leads in collaboration with the RPC must ensure that the procedures are compatible between services where applicable.

1.3. The RPC should determine whether it is appropriate for there to be two sets of Employer's Procedures in use and if so, what level of consistency between them is required.

2. Preparation of and changes to Schedule 2 Procedures

2.1. For the CDS, it is understood that the procedures are currently being updated. The procedures are collated within the "Use of ionising radiation in community dental clinics local rules, policies and procedures". In the audit form, this has been referred to as the "local rules document". It is recommended that the document "Use of ionising radiation in community dental clinics local rules, policies and procedures" is split to extract the Employer's Procedures into a separate document. Having the separate documentation would also be beneficial to updating the documents and to help distinguish between IRR17 and IR(ME)R17 requirements and responsibilities.

2.2. For the CDS, there appears to be some misunderstanding in the responses in regard to document QA, as the RPS and the RPA are listed. This is likely due to how the Employer's Procedures are incorporated into a larger document with local rules and risk assessments. It is recommended that the "QA of IRMER procedures" document is expanded for the CDS, similar to what is implemented for radiology and theatres to list the documentation. This can then document the consultation process for the Employer's Procedures.

3. Changes to Schedule 2 procedures

3.1. For the CDS, following on from section 2 above, there is reference again to the RPA. We understand that the RPA in this scenario is also the MPE, but as stated above we recommend to consider the Employer's Procedures as a separate document.

3.2. For the CDS it was noted that "most written procedures have the date of issue/review and author on them." It is recommended that the procedures are audited to ensure that adequate version control is throughout all the documents (as already self-actioned). Consideration should be given to using a document management system such as Qpulse for the CDS, if not being used already.

4. Audit and responsibility for compliance

4.1 It is recommended that periodic audits are undertaken to regard to document quality assurance. For radiology and theatres this will be in compliance with "PD 2(d) QA of IRMER procedures" and for the CDS this will be in regard to the "IR00SC5a" procedure that must be expanded. For example in the radiology and theatres procedure it outlines that the Employer's Procedures are renewed every two years and authorised and issued by the chairperson of the RPC, Dr Branimir Klasic. Checking that this has happened could form part of the routine audit.

Actions from previous theme 1 audit.

- An update on the progress of theme 1 actions was not provided in the theme 2 response.
- With relevance to this audit a summary of theme 1 actions are included in the action plan below (abridged actions from the summary section).

Action Log

Action		Responsible Person	Date for Completion	Date Completed
Theme 1: Governance and Framework				
A) Radiation Protection Policy and Procedure				
1	The HB should ensure that all directorates are using the latest version of the radiation protection policy. It should also be made clear how the review is prompted			
2	Run staff training session in regard to the radiation protection policy			
3	Determine and document how it is ensured that relevant staff are aware of the radiation protection policy.			
4	Determine and document how staff are made aware of a new policy version.			
B) Medical Exposures Committee				
1	Ensure that it is clear which is the correct version of the terms of reference (ToR) for this committee			
2	The HB should ensure that all directorates undertaking medical exposures are represented at and engaged with this committee.			
3	The HB should clarify where the RPC sits in the HB's governance structures.			
4	The HB should clarify whether the Radiology Directorate Manager has a HB-wide responsibility for radiation protection, or whether parallel structures are required and if so, at what point these converge.			
5	It should be made clear in the TOR that the Radiology Services Manager is responsible for the dissemination of the minutes and maintaining action lists.			
6	It should be made clear in the TOR that the Radiology Services Administrator is responsible for attendance monitoring.			
7	In the ToR, under section 1.5 Quorum, it's listed that two RPAs are required. We understand that this a typo, perhaps for RPSs. Please review this section to clarify.			
8	The governance framework documented in Appendix 8 of the Ionising Radiation Policy should be expanded or replicated to include directorates outside radiology. It is also not clear where lines are			

	drawn whether these mean “reports to”, “is responsible for”, “shares minutes with” etc – arrows showing direction of responsibility would clarify this.			
C) Image Optimisation Teams and other radiation protection champions				
1	The Health Board needs to be assured that all exposures are optimised, including from theatres and the community dental service. The RPC should determine the best mechanism for achieving effective optimisation in directorates outside radiology and for reporting on this. It is unlikely that a RIOT on the same scale of that in radiology will be appropriate, but an approach such as nominating “optimisation champions” from within these directorates to coordinate, drive forward and report on optimisation work could be a workable approach.			
2	The radiology RIOT has not met in recent months, and the ToR do not reflect the most recent incarnation of this group. The functioning and ToR of this group should be reviewed.			
D) Clinical audit				
1	The HB must be assured that appropriate provision has been made for clinical auditing, in accordance with available guidance from professional bodies.			
2	We have not been able to determine what the arrangements are for clinical audit within the theatre directorate. The HB should seek assurance that an appropriate Programme of clinical audit is in place.			
Theme 2: Documentation (employer’s procedures) and document QA				
A) Employers Procedures Overview				
1.1	For radiology and theatres, it is recommended that it is made clear in the Employers Procedures the individual scope of them (so the radiology department and theatres).			
1.2	Services leads in collaboration with the RPC must ensure that the procedures are compatible between services where applicable and that each service has suitable Employers Procedures.			
1.3	The RPC should determine whether it is appropriate for there to be two sets of EPs in use and if so, what level of consistency between them is required.			
B) Preparation of and changes to Schedule 2 Procedures				
2.1	For the CDS, it is recommended that the document “Use of ionising radiation in community dental clinics local rules, policies and procedures” is split to extract the Employer’s Procedures into a separate document.			

2.2	For the CDS, a "QA of IRMER procedures" document must be expanded as soon as possible as per IR(ME)R schedule 2 to outline more detail on document QA, similar to what is implemented for radiology and theatres. This can then document the consultation process for the Employer's Procedures.			
C) Changes to Schedule 2 procedures				
3.2	For the CDS it is recommended that the procedures are audited to ensure that adequate version control is throughout all the documents (as already self-actioned). Consideration should be given to using a document management system such as Qpulse for the CDS, if not being used already.			
D) Audit and responsibility for compliance				
4.1	It is recommended that periodic audits are undertaken to regard to document quality assurance, across radiology and theatres and the CDS (example given in the recommendations).			
Other				
Return partially completed copy of this table to RPS Cardiff.			2 months after report issued	
Return completed copy of this table to RPS Cardiff when all actions are complete.				

We would be pleased to assist with advice and to hear of any changes implemented as a consequence of this audit.

If you require clarification of any of the points raised in this report or if you require any additional help or information please do not hesitate to contact us.

Report circulation: Andrew Carter (Radiology Manager)
Andrea Boycott (Radiology Acute Services Manager)
Jonathan Thomas (Directorate Manager, Theatre Services)
Michelle Jones (Theatre Manager, YYF)
Rebecca Fitzpatrick (Community Dentist)

Audit carried out by: Andrew Carter (Radiology Manager)
Andrea Boycott (Radiology Acute Services Manager)
Michelle Jones (Theatre Manager, YYF)
Rebecca Fitzpatrick (Community Dentist)
Belinda Gorell (Clinical Scientist, Radiation Protection Service, Cardiff)

Report written by: B.M. Gorell
Belinda Gorell (Clinical Scientist, Radiation Protection Service, Cardiff)

Report approved by: Signature

Susan Doshi (MPE, Radiation Protection Service, Cardiff)

Audit checklist

The following colour coding system has been adopted in regard to the responses:

- For the whole Health Board: Black
- Radiology and theatres (joint response submitted for theme 2): Purple
- Community Dental Service (CDS): Green

A. Employers Procedures Overview

Information Required	Auditee Response
Which modalities / department(s) using X-rays in diagnostic or interventional radiology does this set of Employer's Procedures apply to?	All general x-ray departments, computed tomography, nuclear medicine and interventional radiology. Recently it was agreed that the T&O-led mini-c-arm service would soon be incorporated into our Employer's Procedures. Work is underway towards this. There is one set of employer's procedures for all diagnostic radiography services in ABUHB. Community Dental Clinics.
Is this scope clearly documented in the procedures? *(Please complete a separate form for each set of Employer's Procedures within the organisation, which are relevant to the use of X-rays.)*	In each procedure there is a 'scope' subheading which states that the procedure applies to all examinations where the patient is receiving an exposure to ionising radiation. It is not specified in each individual procedure which 'departments' as such that the procedures refer to. Yes. Local Rules and Policies and Procedures are found in document
Is there a procedure / oversight to ensure consistency between all the different sets of Employers Procedures within the organisation? Where is this documented?	N/A. One set of employer's procedures exists. There is only one document of Policies and Procedures for all staff to follow

B. Preparation of Schedule 2 Procedures

For the following Employer's Procedures (as per Schedule 2 of IR(ME)R17) please state the date each is due for review, the review period and provide a copy of the procedure. (Detailed review of the content of these procedures is not within the scope of this audit).

Radiology and theatres:

Required Procedures	Date of next review	Review period	Copy of procedure provided
A. Identification procedure	November 2023	Every 2 years	PD 2(a) Identification.docx
B. Identification of those entitled to act as duty holders with a scope of practice	July 2023	Every 2 years	PD 2(b) Identify entitlements .docx

	November 2023	Every 2 years	PD 2(b)(i) Entitlement Flowchart.docx
C. Pregnancy /breastfeeding enquiry procedure	April 2023 May 2022 (Guidance on contraception) March 2023 (Flowchart)	Every 2 years Every 2 years Every 2 years	PD 2(c) Pregnancy check.docx PD 2(c)(i)Guidance on Contraception.docx PD 2(c)(ii)Pregnancy flowchart.docx PD 2(c)(ii)Pregnancy flowchart.docx
D. QA of written procedures and equipment	May 2024	Every 2 years	PD 2(d) QA of IRMER procedures equipment.docx
E. Assessment of patient dose and administered activity	October 2022 (Assessment of dose) November 2023 (Assessment of activity)	Every 2 years Every 2 years	PD 2(e) Assessment of patient dose.docx PD 2(e) Assessment of patient dose.docx
F. Diagnostic Reference Levels (DRLs)	October 2023 October 2023 (Log of patient doses greater than expected)	Every 2 years Every 2 years	PD 2(f) DRLs.docx PD 2(f)(i) Exceeded dose log.docx
G. Exposures for research programs	May 2024	Every 2 years	PD 2(g) Research.docx
H. Giving information and written instructions in relation to consent for treatment or diagnosis with radioactive substances	November 2023	Every 2 years	PD 2(h) Patient information NM.docx
I. Information and communication on benefits and risks to patients prior to treatment or diagnosis	September 2023	Every 2 years	PD 2(i) - Information for patients benefits v risks.docx
J. Recording and evaluation of each exposure	November 2023	Every 2 years	PD 2(j) Clinical Evaluation.docx
K. Minimisation of accidental and unintended exposures	December 2022	Every 2 years	PD 2(k) - Minimise unintended doses.docx

L. Reporting, analysis and management of clinically significant unintended or accidental exposures	October 2023 September 2023 (Flowchart for reporting)	Every 2 years Every 2 years	PD 2(l) Unintended exposures.docx PD 2(l)(ii) Flowchart for reporting accidental or unintended exposures.docx
M. Non-medical imaging exposures	April 2022	Every 2 years	PD 2(m) Non-medical exposures.docx
N. Dose constraints and guidance for Carers and Comforters	October 2023	Every 2 years	PD 2(n) - Carers & Comforters.docx

CDS:

Required Procedures	Date of next review	Review period	Copy of procedure provided
A. Identification procedure	July 2020	Yearly. We are currently updating	Yes, documented in: "Use of ionising radiation in community dental clinics local rules, policies and procedures".
B. Identification of those entitled to act as duty holders with a scope of practice	July 2020	Yearly. We are currently updating within our local rules	
C. Pregnancy enquiry procedure	July 2020	Yearly. We are currently updating within our local rules	
D. QA of written procedures and equipment	July 2020	Currently updating	
E. Assessment of patient dose and administered activity	July 2020	Currently updating	
F. Diagnostic Reference Levels (DRLs)	July 2020	Yearly. We are currently updating	
G. Exposures for research programmes	N/A (procedure outlining N/A)		
H. Giving information and written instructions in relation to consent for treatment or diagnosis with radioactive substances	N/A (procedure outlining N/A)		

I. Information and communication on benefits and risks to patients prior to treatment or diagnosis	July 2020	Yearly. We are currently updating within our local rules	
J. Recording and evaluation of each exposure	July 2022		
K. Minimisation of accidental and unintended exposures	July 2020	Yearly. We are currently updating within our local rules	
L. Reporting, analysis and management of clinically significant unintended or accidental exposures	July 2020	Yearly. We are currently updating within our local rules	
M. Non-medical imaging exposures	N/A (procedure outlining N/A)		
N. Dose constraints and guidance for Carers and Comforters	Carer and Comforter Leaflet March 2022 Dose restraints July 2022	Yearly. We are currently updating within our local rules	

With reference to the above procedures; please give details on the following: For this set of Employer's Procedures who: - Has responsibility for ensuring procedures are written?	 Radiology Management Team The RPS has responsibility for making sure the procedures are written with authorisation from the Clinical director and advise from our RPA.
- Can write the procedures? - Can authorise the procedures? Where is this documented?	Radiology Management Team Radiation Protection Committee PD 2(D) QA of IRMER procedures and equipment Detailed in local rules

Is there a formal requirement for consultation? If so, which staff roles should be consulted?	Changes/amendments to the procedures are discussed at the Radiology Operational Group meeting before being ratified by the RPC. Once procedures are reviewed by RPA they are reviewed and approved by the RPC
Who (role) provides additional input?	Consultant radiologists, and MPE where required. RPA Arnold Rust
When is expert advice (e.g. Medical Physics Expert, MPE) sought?	When there are any queries with regards to dose, new legislation or for advice on how other health boards have implemented IR(ME)R guidelines into their procedures. Adequate testing, Patient dose and local DRLs, Routine surveillance, QA procedures, Maintenance and fault logs.
On what references are procedures based (e.g. sources of best practice)?	IR(ME)R, CQC, HIW, SoR, SCoR recommendations and legislation. Guidance on best practice is sourced from Guidance notes for Dental Practitioners for on the safe Use of X-ray Equipment 2nd Edition from FGDP
How is it ensured that all relevant staff are aware of the content and location of the procedures? Where is this documented?	Staff must read through the procedures at induction. This is documented in their induction competency paperwork. All staff are informed of changes via email and via staff briefings/visual aids. This is documented in PD 2(d) QA of IRMER procedures and equipment. Procedures are printed and kept in the department in a designated folder and are available on SharePoint and QPulse to view. Local Rules and Procedures are regularly reviewed and a paper copy is disturbed to all clinics. Signage from staff is collected to ensure they have received and read this documentation and this is information is stored with the RPS. Radiation induction for all new staff.

C. Changes to Schedule 2 procedures

Information Required	Auditee Response
What is the process for stakeholders to request changes in the Employer's Procedures?	All staff can report any instances where they become aware of procedures or protocols that are not being followed, or are not having the expected effect. In doing so they can request changes to the employer's procedures. This should be brought to the attention of the departmental manager who will escalate this to the senior management team who oversee and instigate changes to the procedures. Requests for employment changes in procedures are directed to clinical director of CDS and considered with input from the RPA.
What is the procedure for the review of Employer's Procedures and which staff roles should be consulted?	PD 2(d) QA of IRMER procedures and equipment. Internal Health and Safety Group and Quality Improvement Groups monitors the review of Policy and Procedures
Is the MEC / RPC / RSC involved in this process?	The procedures would be reviewed at the Radiation Protection Group meetings and sent to the Radiation protection committee for sign off. In turn this group would then report to the Health Board Quality and patient safety group, chaired by the DOTH. No - RPC review Local Rules, Policies and Procedures document after RPA
How are changes (new or revisions) to the Employer's Procedures disseminated?	Once approved, changes and updates must be communicated to departmental staff via email or staff briefing or notice(s). Through distribution of paper copy to each clinic, where it is stored in the local rules and procedures folder. It is also found on our share drive and revised copies are emailed to all staff. A signature is required and collected to make sure all employees have read and understand any new procedures.
Does this include dissemination to other stakeholders within the organisation that use this set of Employer's Procedures?	Soon T&O will be operating within our IR(ME)R procedures, and yes we will ensure that any changes to procedures are cascaded to the RPSs and senior management within their team for dissemination. Local procedures are not disseminated to other stakeholders within the organisation
How is version control achieved? Is the status of the written procedure clear? Does each document include details on but not limited to: version number, date of	All included Most written procedures have the date of issue/review and author on them. The most up to date local rules policies and

issue/review, authorisation and author. If copies of the procedures are available in paper format or in multiple electronic locations, how is document control achieved?	procedures can be found in each locality within the local rules folder. The procedures are kept in one place on SharePoint and one place on QPulse. The printed versions are checked regularly to ensure they are correct. The version number/review date are used to ensure the correct version is in use. There are some electronic written procedures on use of some x-ray films and computer software found on the one drive that need reviewing, with regards to making sure a date of issue/review and author is visible.

D. Audit and responsibility for compliance

Who has responsibility for ensuring that staff comply with these Employer's Procedures?	The Chief Executive acts as the employer under IR(ME)R and this is implicit in the Ionising Radiation Safety Policy. To assist in discharging this responsibility the Chief Executive entitles the Medical director and executive Director of therapies who will entitle all Clinical Directors, Medical Practitioner and Radiology Service leads, who in turn will entitle all Directorate Managers, whose services are involved with working with ionising radiation, to assume the general responsibility for ensuring that radiation safety arrangements throughout their Directorates are representative of best practice and satisfy the requirements of the regulations. The RPS Rebecca Fitzpatrick.
How is compliance assured and reported within the organisation?	The employer takes the following steps to ensure written procedures are complied with for the following duty holders: Referrers – Non-Medical referrers undertake online training provided by radiology on ESR, prior to them being given entitlement to request examinations. All medically qualified staff are made aware of their responsibilities as a Referrer at their hospital induction. General Practitioners receive a letter of entitlement from the Radiology Clinical Director detailing their responsibilities. The Radiology Directorate engage with GP Lead of Primary Care as required. Where any revision of patient pathways are required, Radiology Directorate will attend the Local Medical Committee. Practitioners – Regulation 11 Justification of Medical exposures involving Ionising Radiation', sets out the responsibilities of the Practitioner. During their training in the department staff are entitled upon their understanding of the role of the practitioner. Staff are monitored on their work as Practitioners and recorded on the entitlement matrix as being Practitioners.

	Operators – The Operators can only be appointed once they have completed their training in individual examination rooms. During their training in the department staff are entitled dependent upon their understanding of the role of the Operator, including an understanding of procedures, roles and responsibilities. Upon completion of induction, they are appointed as Operators and recorded as such on the entitlement matrix. Staff working with ionising radiation must report immediately to the Health Boards Chief Executive, via their line manager or radiation protection supervisor, if they suspect that a radioactive source has been damaged, lost or stolen. Further advice on managing the incident should be sought from the RPA and RWA. Staff working with ionising radiation must report to the departmental manager when it is suspected that an overexposure or unintended exposure due either to equipment malfunction or failure to comply with IR(ME)R17 procedures has taken place. The Datix system is used locally to ensure that senior radiology and ABUHB execs are made aware. All staff are informed to advise the clinical director of failures in procedure or room for improvement and all procedures and policies are subject to regular audit.
Detail any audits that are undertaken to assess whether correct document quality assurance and document control procedures have been followed.	The current RPG Audit schedule outlines 10 compliance audits over a 12-month period which looks to evaluate compliance with written procedures and data quality. The IR(ME)R audit programme is discussed and agreed upon by the Radiation Protection Group. The current programme includes a Request Card audit to include checks of patient ID, pregnancy checking and assessment of patient dose. Data is currently being collected to support an audit looking at the correct use of room codes in RadIS, and a further audit to support local DRLs is being conducted as a collaborative effort with radiation protection clinical scientists. There is no formal audit procedure for the local policy and procedures document. A review date is applied to the final document and the document itself is reviewed by the RPA prior to completion. Our internal QI group and RPA regularly check review dates to ensure they are kept up to date.

Health and Safety at Work etc. Act 1974

Ionising Radiations Regulations 2017

Certificate of Registration No. REG-010009

1. An application for a registration under Regulation 6 of the Ionising Radiations Regulations 2017 was made by:
   Aneurin Bevan University Health Board

   Application date: 10/04/2024

   For work with: Working with a radiation generator (for example, X-ray devices)

   This application has been accepted.

2. This certificate of registration is issued on the basis of the information provided at the time of the application by:
   Aneurin Bevan University Health Board

3. The registration is subject to the following conditions:

- Any material change to the information supplied upon application is immediately notified to HSE.
- The cessation of the work referred to in this certificate is immediately notified to HSE.
- The work referred to in this certificate is carried out in accordance with the Ionising Radiations Regulations 2017.

4. HSE may, at any time:

- review the registration
- revoke the registration

HM Radiation Team Date of Issue: 10/04/2024

STATUTORY INSTRUMENTS

2017 No. 1322

HEALTH AND SAFETY

The Ionising Radiation (Medical Exposure) Regulations 2017

Made - - - -	*20th December 2017*
Laid before Parliament	*22nd December 2017*
Coming into force - -	*6th February 2018*

The Secretary of State, being the Minister designated(**1**) for the purposes of section 2(2) of the European Communities Act 1972(**2**) in relation to safety measures in regard to radioactive substances and the emission of ionising radiation, in exercise of the powers conferred by that section and by section 56 of the Finance Act 1973(**3**), makes the following Regulations. Regulation 4 and Schedule 1 (the Licensing Authority) are made with the consent of the Treasury.

Citation and commencement

1. These Regulations may be cited as the Ionising Radiation (Medical Exposure) Regulations 2017 and come into force on 6th February 2018.

Commencement Information

I1 Reg. 1 in force at 6.2.2018, see **reg. 1**

Interpretation

2.—(1) In these Regulations—

"accidental exposure" means an exposure of an individual **[**[F1]in error when no exposure was intended**]**;

"adequate training" means training which satisfies the requirements of Schedule 3 and the expression "adequately trained" is to be construed accordingly;

(1) S.I. 1977/1718; there are no relevant amendments.
(2) 1972 c. 68; section 2(2) was amended by section 27(1)(a) of the Legislative and Regulatory Reform Act 2006 (c. 51), and by Part 1 of the Schedule to the European Union (Amendment) Act 2008 (c. 7). In so far as these Regulations deal with matters that are within the devolved competence of Scottish Ministers, the power of the Secretary of State to make regulations in relation to those matters in or as regards Scotland is preserved by section 57(1) of the Scotland Act 1998 (c. 46).
(3) 1973 c. 51; amendments have been made to section 56 by S.I. 2011/1043; there are other amendments to that section which are not relevant for the purposes of these Regulations.

"assessment" means prior determination of amount, parameter or method;

"carers and comforters" means individuals knowingly and willingly incurring an exposure to ionising radiation by helping, other than as part of their occupation, in the support and comfort of individuals undergoing or having undergone an exposure;

"clinical audit" means a systematic examination or review of medical radiological procedures which seeks to improve the quality and outcome of patient care through structured review, whereby medical radiological practices, procedures and results are examined against agreed standards for good medical radiological procedures, with modification of practices, where indicated, and the application of new standards if necessary;

[F2"clinical evaluation" means interpretation of the information resulting from an exposure, including the outcome and implications;**]**

"diagnostic reference levels" means dose levels in medical radiodiagnostic or interventional radiology practices, or, in the case of radio-pharmaceuticals, levels of activity, for typical examinations for groups of standard-sized individuals or standard phantoms for broadly defined types of equipment;

[F3"dose reference levels" means dose levels in radiotherapeutic practices for typical localisation or verification exposures for groups of standard-sized individuals or standard phantoms for broadly defined types of equipment;**]**

"dose constraint" means a restriction set on the prospective doses of individuals which may result from a given radiation source;

"employer" means any person who, in the course of a trade, business or other undertaking, carries out (other than as an employee), or engages others to carry out, those exposures described in **[**F4regulation 3(1)**]** or practical aspects, at a given radiological installation;

"employer's procedures" means the procedures established by an employer pursuant to regulation 6(1);

"equipment" means equipment **[**F5(including any software)**]** which—

(a) delivers ionising radiation to a person undergoing exposure; F6...

(b) F7... directly controls or influences the extent of such exposure **[**F8; or

(c) directly assists an operator in carrying out a clinical evaluation;**]**

[F9"ethics committee" means—

(a) an ethics committee established or recognised in accordance with Part 2 of the Medicines for Human Use (Clinical Trials) Regulations 2004;

(b) the Ethics Committee constituted by regulations made by the Scottish Ministers under section 51(6) of the Adults with Incapacity (Scotland) Act 2000; or

(c) any other committee established to advise on the ethics of research investigations in human beings, and recognised for that purpose by or on behalf of the Secretary of State, the Scottish Ministers or the Welsh Ministers;**]**

F10...

"health screening" means a procedure for early diagnosis in population groups at risk;

[F11"individual detriment" means clinically observable deleterious effects in individuals or their descendants, the appearance of which is either immediate or delayed and, in the latter case, implies a probability rather than a certainty of appearance;**]**

"interventional radiology" means the use of X-ray imaging techniques to facilitate the introduction and guidance of devices in the body for diagnostic or treatment purposes;

"ionising radiation" means the transfer of energy in the form of particles or electromagnetic waves of a wavelength of 100 nanometres or less or a frequency of 3×10^{15} hertz or more capable of producing ions directly or indirectly;

"Licensing Authority"—

(a) for the purpose of licensing any practitioner in respect of the administration of radioactive substances means the Secretary of State;

(b) for the purpose of licensing any employer in respect of the administration of radioactive substances means—

(i) in England, the Secretary of State;

(ii) in Scotland, the Scottish Ministers; and

(iii) in Wales, the Welsh Ministers;

"medical exposure" means an exposure coming within any of paragraphs (a) to (e) of **[**F12regulation 3(1)**]**;

"medical physics expert" means an individual or a group of individuals, having the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure, whose competence in this respect is recognised by the Secretary of State;

"medical radiological" means pertaining to radiodiagnostic and radiotherapeutic procedures, and interventional radiology or other medical uses of ionising radiation for planning, guiding and verification purposes;

"medical radiological procedure" means any procedure giving rise to a medical exposure;

"non-medical imaging exposure" means any deliberate exposure of humans for imaging purposes **[**F13using medical radiological equipment,**]** where the primary intention of the exposure is not to bring a health benefit to the individual being exposed;

"operator" means any person who is entitled, in accordance with the employer's procedures, to carry out practical aspects including those to whom practical aspects have been allocated, medical physics experts and, except where they do so under the direct supervision of a person who is adequately trained, persons participating in practical aspects as part of practical training;

"patient dose" means the dose concerning patients or other individuals undergoing exposures to which these Regulations apply;

"practical aspect" means the physical conduct of **[**F14an exposure to which these Regulations apply**]** and any supporting aspects, including handling and use of **[**F15equipment**]**, the assessment of technical and physical parameters (including radiation doses), calibration F16... of equipment, preparation and administration of radio-pharmaceuticals, clinical evaluation and image processing;

"practitioner" means a registered health care professional who is entitled in accordance with the employer's procedures to take responsibility for **[**F17the justification of**]** an individual exposure;

"quality assurance" means all those planned and systematic actions necessary to provide adequate assurance that a structure, system, component or procedure will perform satisfactorily in compliance with generally applicable standards and quality control is a part of quality assurance;

"quality control" means the set of operations (programming, coordinating, implementing) intended to maintain or to improve quality and includes monitoring, evaluation and maintenance at required levels of all characteristics of performance of equipment that can be defined, measured, and controlled;

[F18"radiation protection adviser" means an individual who, or a body which is competent to advise on radiation protection in relation to occupational and public exposures;**]**

"radioactive substance" means any substance that contains one or more radionuclides the activity or activity concentration of which cannot be disregarded from a radiation protection point of view;

[F19"radioactive waste adviser" means an individual who, or a body which is competent to provide expert advice on radioactive waste management and environmental radiation protection;**]**

"radiodiagnostic" means pertaining to in-vivo diagnostic nuclear medicine, medical diagnostic radiology using ionising radiation, and dental radiology;

"radiological installation" means a facility where exposures to which these Regulations apply are performed;

"radiotherapeutic" means pertaining to radiotherapy, including nuclear medicine for therapeutic purposes;

"referrer" means a registered health care professional who is entitled in accordance with the employer's procedures to refer individuals for exposure to a practitioner;

"registered health care professional" means a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002(**4**);

"relevant enforcing authority" means—

(a) in England, the Care Quality Commission(**5**);

(b) in Scotland, the Scottish Ministers; and

(c) in Wales, the Welsh Ministers;

"unintended exposure" means any exposure to ionising radiation which is significantly different from the exposure intended for a given purpose.

(2) In these Regulations, where an individual is—

(a) an employer;

(b) a referrer;

(c) an operator; or

(d) a practitioner,

and is also an individual coming within at least one other of sub-paragraphs (a) to (d), that individual is subject to each of the duties applying to every person described in a sub-paragraph which also describes that individual.

Textual Amendments

F1 Words in reg. 2(1) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(2)**

F2 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(3)**

F3 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(4)**

F4 Words in reg. 2(1) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(5)**

(4) 2002 c. 17. Section 25 has been amended by paragraph 17 of Schedule 10 and Part 2 of Schedule 15 the Health and Social Care Act 2008 (c. 14), sections 220, 222 and 224 of and paragraphs 56 and 62 of Schedule 15 to the Health and Social Care act 2012 (c. 7), section 5(1) of the Health and Social Care (Safety and Quality) Act 2015 (c. 28), paragraph 1 and 2 of Schedule 4 to the Children and Social Work Act 2017 (c. 16).

(5) Established by section 1 of the Health and Social Care Act 2008 (c. 14).

F5 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(6)(a)**
F6 Word in reg. 2(1) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(6)(b)**
F7 Word in reg. 2(1) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(6)(c)**
F8 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(6)(d)**
F9 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(7)**
F10 Words in reg. 2(1) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(8)**
F11 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(9)**
F12 Words in reg. 2(1) substituted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(10)**
F13 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(11)**
F14 Words in reg. 2(1) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(12)(a)**
F15 Word in reg. 2(1) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(12)(b)**
F16 Words in reg. 2(1) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(12)(c)**
F17 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(13)**
F18 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(14)**
F19 Words in reg. 2(1) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **2(15)**

Commencement Information
I2 Reg. 2 in force at 6.2.2018, see **reg. 1**

Application

3.—**[**F20(1)**]** These Regulations apply to the exposure of ionising radiation in England and Wales and Scotland—

(a) to patients as part of their own medical diagnosis or treatment;

(b) to individuals as part of health screening programmes;

(c) to patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes;

(d) to carers and comforters;

(e) to asymptomatic individuals;

(f) to individuals undergoing **[**F21a**]** non-medical imaging **[**F22a non-medical imaging exposure**]**.

[F23(2) Regulation 21 and paragraphs 1 and 2 of Schedule 4 apply to the exposure of ionising radiation in Northern Ireland.**]**

Textual Amendments

F20 Reg. 3 renumbered as reg. 3(1) (6.2.2018) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (S.I. 2018/121), regs. 1(2), **2(2)(a)**

F21 Word in reg. 3(1)(f) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **3(a)**

F22 Words in reg. 3(1)(f) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **3(b)**

F23 Reg. 3(2) inserted (6.2.2018) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (S.I. 2018/121), regs. 1(2), **2(2)(b)**

Commencement Information

I3 Reg. 3 in force at 6.2.2018, see **reg. 1**

The Licensing Authority

4.—(1) The Licensing Authority may upon payment of a fee (where required) issue a licence to a person required by these Regulations to hold a licence.

(2) A licence described in paragraph (1) may be—

(a) issued for such period as the Licensing Authority considers appropriate;

(b) subject to such conditions as the Licensing Authority may consider appropriate; and

(c) varied or revoked at any time.

(3) Schedule 1 makes further provision relating to the application for, and the issue of, a licence described in paragraph (1).

Commencement Information

I4 Reg. 4 in force at 6.2.2018, see **reg. 1**

Requirement to hold a licence

5.—(1) A person must hold a valid licence issued by the Licensing Authority if that person—

(a) is an employer, in which case that person must hold a licence in respect of each radiological installation at which radioactive substances are to be administered for such purposes as may be specified in that licence; or

(b) is a practitioner, in which case that person must hold a licence in order to justify, within the meaning of regulation 11 an exposure involving the administration of radioactive substances for such purposes as may be specified in that licence.

(2) In this regulation, "purpose" when describing the purpose for which a licence is issued, means diagnosis, treatment or research.

Commencement Information

I5 Reg. 5 in force at 6.2.2018, see **reg. 1**

Employer's duties: establishment of general procedures, protocols and quality assurance programmes

6.—(1) The employer must ensure that written procedures are in place in respect of—

(a) those matters described in Schedule 2; and

(b) any other matter in relation to which these Regulations mandate the establishment of procedures.

(2) The employer must take steps to ensure that any written procedures are complied with by the referrer, practitioner and operator.

(3) The employer must take steps to ensure that every practitioner or operator engaged by the employer to carry out exposures or any practical aspect—

(a) complies with the provisions of regulation 17(1); and

(b) undertakes continuing education and training after qualification including, in the case of clinical use of new techniques, training related to those techniques and the relevant radiation protection requirements.

(4) The employer must ensure, where appropriate, that written protocols are in place for every type of standard radiological practice coming within these Regulations, including practices involving non-medical imaging.

(5) The employer must—

(a) establish recommendations concerning referral guidelines for **[**F24exposures to which these Regulations apply**]**, including radiation doses, and ensure that these are available to the referrer;

(b) establish quality assurance programmes for written procedures and written protocols;

(c) regularly review and make available to an operator, diagnostic reference levels in respect of an exposure falling within—

(i) **[**F25regulation 3(1)(a)**]**—

(aa) where the exposure involves interventional radiology procedures, in which case, diagnostic references levels are to be provided where appropriate; and

(bb) where the exposure does not involve interventional radiology procedures, in which cases regard must be had to **[**F26international and national diagnostic reference levels and local dose surveys**]** where available;

(ii) **[**F27regulation 3(1)(b)**]** or (e) in which cases regard must be had to **[**F28international**]** and national diagnostic reference levels **[**F29and local dose surveys**]** where available;

(iii) **[**F30regulation 3(1)(f)**]** where practicable **[**F31, in which case regard must be had to local dose surveys where available;**]**

[F32(ca) regularly review and make available to an operator, dose reference levels in respect of radiotherapeutic procedures for typical localisation or verification exposures falling within regulation 3(1)(a), in which case, regard must be had to international and national dose reference levels and local dose surveys where available;**]**

(d) establish dose constraints **[**F33for individual effective or equivalent doses over a defined appropriate time period —**]**

(i) for biomedical and medical research programmes falling within **[**F34regulation 3(1)(c)**]** where no direct medical benefit for the individual is expected from the exposure; F35...

(ii) with regard to the protection of carers and comforters falling within **[**[F36]regulation 3(1)(d)**]**; **[**[F37]and

(e) conduct local dose surveys where practicable.**]**

[F38](6) . . . . . .

(7) The employer must ensure appropriate reviews are undertaken whenever diagnostic reference levels **[**[F39]or dose reference levels**]** are consistently exceeded and ensure that corrective action is taken where appropriate.

(8) The employer must take measures to raise awareness of the effects of ionising radiation amongst individuals capable of childbearing or breastfeeding.

Textual Amendments

F24 Words in reg. 6(5)(a) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(a)**

F25 Words in reg. 6(5)(c)(i) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(i)(aa)**

F26 Words in reg. 6(5)(c)(i)(bb) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(i)(bb)**

F27 Words in reg. 6(5)(c)(ii) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(ii)(aa)**

F28 Word in reg. 6(5)(c)(ii) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(ii)(bb)**

F29 Words in reg. 6(5)(c)(ii) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(ii)(cc)**

F30 Words in reg. 6(5)(c)(iii) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(iii)(aa)**

F31 Words in reg. 6(5)(c)(iii) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(b)(iii)(bb)**

F32 Reg. 6(5)(ca) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(c)**

F33 Words in reg. 6(5)(d) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(d)(i)**

F34 Words in reg. 6(5)(d)(i) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(d)(ii)**

F35 Word in reg. 6(5)(d)(i) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(d)(ii)**

F36 Words in reg. 6(5)(d)(ii) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(d)(iii)**

F37 Reg. 6(5)(e) and word inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(2)(e)**

F38 Reg. 6(6) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(3)**

F39 Words in reg. 6(7) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **4(4)**

Commencement Information

I6 Reg. 6 in force at 6.2.2018, see **reg. 1**

[F40Employer's duties: co-operation between employers

6A.—(1) This regulation applies where, in respect of the same individual, two or more employers carry out or engage others to carry out in their behalf—

(a) those exposures described in regulation 3(1) or any practical aspects;

(b) a referral for any such exposures; or

(c) a justification of any such exposures.

(2) The employers concerned must co-operate with each other to the extent necessary (by the exchange of information or otherwise) to ensure that each such employer—

(a) has access to information on the exposure, or the potential exposure, of the individual to ionising radiation; and

(b) is enabled to comply with the requirements of these Regulations in so far as their ability to comply depends upon such co-operation.**]**

Textual Amendments

F40 Reg. 6A inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **5**

Employer's duties: clinical audit

7. The employer's procedures must include provision for the carrying out of clinical audit **[**F41, and for the taking of any appropriate action in relation to the results of such audit,**]** as appropriate.

Textual Amendments

F41 Words in reg. 7 inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **6**

Commencement Information

I7 Reg. 7 in force at 6.2.2018, see **reg. 1**

Employer's duties: accidental or unintended exposure

8.—(1) The employer's procedures must provide that the referrer, the practitioner, and the individual exposed or their representative (if there is one) are informed of the occurrence of a clinically significant unintended or accidental exposure and of the outcome of the analysis of this exposure.

(2) The employer's quality assurance programme must, in respect of radiotherapeutic practices, include a study of the risk of accidental or unintended exposures.

[F42(3) The employer must establish a system for—

(a) recording analyses of events involving or potentially involving accidental or unintended exposures proportionate to the radiological risk posed by the practice; and

(b) the taking of any appropriate action in relation to such analyses.**]**

(4) Where the employer knows or has reason to believe that an accidental or unintended exposure has or may have occurred in which a person, while undergoing—

(a) any exposure, was or could have been exposed to levels of ionising radiation significantly greater than those generally considered to be proportionate in the circumstances;

(b) a radiotherapeutic exposure was or could have been exposed to levels of ionising radiation significantly lower than those generally considered to be proportionate in the circumstances,

the employer must—

(i) undertake an immediate preliminary investigation of the incident;

(ii) unless that investigation shows beyond a reasonable doubt that no such exposure has occurred, immediately notify the relevant enforcing authority;

(iii) conduct or arrange for a detailed investigation of the circumstances of the exposure and an assessment of the dose received; and

(iv) notify the relevant enforcing authority, within the time period specified by the relevant enforcing authority, of the outcome of the investigation and any corrective measures adopted.

Textual Amendments

F42 Reg. 8(3) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **7**

Commencement Information

I8 Reg. 8 in force at 6.2.2018, see **reg. 1**

Relevant enforcing authority's duties: accidental or unintended exposure

9. The relevant enforcing authority must put in place mechanisms enabling the timely dissemination of information, relevant to radiation protection in respect of **[**[F43]exposures to which these Regulations apply**]**, regarding lessons learned from significant events.

Textual Amendments

F43 Words in reg. 9 substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **8**

Commencement Information

I9 Reg. 9 in force at 6.2.2018, see **reg. 1**

Duties of the practitioner, operator and referrer

10.—(1) The practitioner **[**[F44], the operator and the referrer**]** must comply with the employer's procedures.

(2) The practitioner is responsible for the justification of an exposure and such other aspects of an exposure as is provided for in these Regulations.

(3) Practical aspects of an exposure or part of it may be allocated in accordance with the employer's procedures by the employer or the practitioner, as appropriate, to one or more individuals entitled to act in this respect in a recognised field of specialisation.

(4) The operator is responsible for each practical aspect which the operator carries out as well as for any authorisation given pursuant to regulation 11(5).

(5) The referrer must supply the practitioner with sufficient medical data (such as previous diagnostic information or medical records) relevant to the exposure requested by the referrer to enable the practitioner to decide whether there is a sufficient net benefit as required by regulation 11(1)(b).

(6) The practitioner and the operator must cooperate, regarding practical aspects, with other specialists and staff involved in an exposure, as appropriate.

Textual Amendments

F44 Words in reg. 10(1) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **9**

Commencement Information

I10 Reg. 10 in force at 6.2.2018, see **reg. 1**

Justification of individual exposures

11.—(1) A person must not carry out an exposure unless—

(a) in the case of the administration of radioactive substances, the practitioner and employer are licensed to undertake the intended exposure;

(b) it has been justified by the practitioner as showing a sufficient net benefit giving appropriate weight to the matters set out in paragraph (2);

(c) it has been authorised by the practitioner or, where paragraph (5) applies, the operator;

(d) in the case of an exposure taking place in the course of a research programme under **[**[F45]regulation 3(1)(c)**]**, that programme has been approved by an ethics committee and, in the case of the administration of radioactive substances, approved by an expert committee who can advise on the administration of radioactive substances to humans;

(e) in the case of an exposure falling within **[**[F46]regulation 3(1)(f)**]** (non-medical imaging), it complies with the employer's procedures for such exposures; and

(f) in the case of an individual of childbearing potential, the person has enquired whether that individual is pregnant or breastfeeding, if relevant.

(2) The matters referred to in paragraph (1)(b) are—

(a) the specific objectives of the exposure and the characteristics of the individual involved;

(b) the total potential diagnostic or therapeutic benefits, including the direct health benefits to the individual and the benefits to society, of the exposure;

(c) the individual detriment that the exposure may cause; and

(d) the efficacy, benefits and risk of available alternative techniques having the same objective but involving no or less exposure to ionising radiation.

(3) In considering the weight to be given to the matters referred to in paragraph (2), the practitioner justifying an exposure in accordance with paragraph (1)(b) must have regard, in particular to—

(a) recommendations from appropriate medical scientific societies or relevant bodies where a procedure is to be performed as part of any health screening programme;

(b) whether in circumstances where there is to be an exposure to a carer or comforter such an exposure would show a sufficient net benefit taking into account—

(i) the likely direct health benefits to a patient;

(ii) the possible benefits to the carer or comforter; and

(iii) the detriment that the exposure might cause;

(c) in the case of asymptomatic individuals where a medical radiological procedure—

(i) is to be performed for the early detection of disease;

(ii) is to be performed as part of a health screening programme; or

(iii) requires specific documented justification for that individual by the practitioner, in consultation with the referrer,

any guidelines issued by appropriate medical scientific societies, relevant bodies or published by the Secretary of State;

(d) the urgency of the exposure, where appropriate, in cases involving—

(i) an individual where pregnancy cannot be excluded, in particular if abdominal and pelvic regions are involved, taking into account the exposure of both the person concerned and any unborn child; and

(ii) an individual who is breastfeeding and who undergoes an exposure involving the administration of radioactive substances, taking into account the exposure of both the individual and the child.

(4) In deciding whether to justify an exposure under paragraph (1)(b) the practitioner must take account of any data supplied by the referrer pursuant to regulation 10(5) and must consider such data in order to avoid unnecessary exposure.

(5) Where it is not practicable for the practitioner to authorise an exposure as required by paragraph (1)(c), the operator must do so in accordance with guidelines issued by the practitioner.

F47(6) . . . . . .

Textual Amendments

F45 Words in reg. 11(1)(d) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **10(2)(a)**

F46 Words in reg. 11(1)(e) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **10(2)(b)**

F47 Reg. 11(6) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **10(3)**

Commencement Information

I11 Reg. 11 in force at 6.2.2018, see **reg. 1**

Optimisation

12.—(1) In relation to all exposures to which these Regulations apply except radiotherapeutic exposures, the practitioner and the operator, to the extent of their respective involvement in an exposure, must ensure that doses arising from the exposure are kept as low as reasonably practicable consistent with the intended purpose.

(2) In relation to all radiotherapeutic exposures the practitioner must ensure that exposures of target volumes are individually planned and their delivery appropriately verified taking into account that doses to non-target volumes and tissues must be as low as reasonably practicable and consistent with the intended radiotherapeutic purpose of the exposure.

(3) Without prejudice to paragraphs (1) and (2), the operator must select equipment and methods to ensure that for each exposure the dose of ionising radiation to the individual undergoing

the exposure is as low as reasonably practicable and consistent with the intended diagnostic or therapeutic purpose and in doing so must have regard, in particular to—

(a) quality **[**F48control**]**;

(b) assessment and evaluation of patient dose or administered activity; F49...

(c) adherence to such diagnostic reference levels for radiodiagnostic examinations **[**F50and interventional radiology practices**]** falling within **[**F51regulation 3(1)(a)**]**, (b), (e) and (f) as the employer may have established, **[**F52and

(d) adherence to such dose reference levels for radiotherapeutic practices for typical localisation or verification exposures falling within regulation 3(1)(a) as the employer may have established,**]**

as set out in the employer's procedures.

(4) For each medical or biomedical research programme falling within **[**F53regulation 3(1)(c)**]**, the employer's procedures must provide that—

[F54(a) consent to take part in the research programme is given by or, where appropriate, on behalf of, the individuals concerned;**]**

(b) the individuals concerned **[**F55, or their representative (if there is one) where appropriate,**]** are informed in advance about the risks of the exposure;

(c) the dose constraint set down in the employer's procedures for individuals for whom no direct medical benefit is expected from the exposure is adhered to; and

(d) individual target levels of doses are planned by the practitioner, either alone or with the input of the referrer, for patients who voluntarily undergo an experimental diagnostic or therapeutic practice from which the patients are expected to receive a diagnostic or therapeutic benefit.

(5) In the case of **[**F56regulation 3(1)(d)**]**, the employer's procedures must provide that appropriate guidance is established for the exposure of carers and comforters.

(6) In the case of patients undergoing treatment or diagnosis with radioactive substances, the employer's procedures must provide that, where appropriate, written instructions and information are provided to—

(a) the patient, where the patient has capacity **[**F57or, as the case may be, competence**]** to consent to the treatment or diagnostic procedure;

[F58(aa) where the patient is in England or Wales and is a child under the age of 16 who lacks competence to consent, a person with parental responsibility for the child;

(ab) where the patient is in Scotland and is a child under the age of 16 who lacks capacity to consent, a person with parental responsibility for the child; or**]**

[F59(b) where the patient is a person aged 16 or older who lacks capacity or, as the case may be competence, to consent, the person who appears to the operator to be the most appropriate person.**]**F60...

F61(c) . . . . . .

(7) The instructions and information referred to in paragraph (6) must—

(a) specify how doses resulting from the patient's exposure can be restricted as far as reasonably possible so as to protect persons in contact with the patient;

(b) set out the risks associated with ionising radiation; and

(c) be provided to the patient or other person specified in paragraph (6) as appropriate prior to the patient leaving the radiological installation where the exposure was carried out.

(8) In complying with the obligations under this regulation, the practitioner and the operator must pay particular attention in relation to—

(a) F62... exposures of children;

(b) F62... exposures as part of a health screening programme;

(c) F62... exposures involving high doses to the individual being exposed;

(d) where appropriate, individuals in whom pregnancy cannot be excluded and who are undergoing **[**F63an**]** exposure, in particular if abdominal and pelvic regions are involved, taking into account the exposure of both the individual and any unborn child; and

(e) where appropriate, individuals who are breastfeeding and who are undergoing **[**F64an**]** exposure involving the administration of radioactive substances, taking into account the exposure of both the individual and the child.

(9) The employer must take steps to ensure that a clinical evaluation of the outcome of each exposure, other than where the person subject to the exposure is a carer or a comforter, is recorded in accordance with the employer's procedures including, where appropriate, factors relevant to patient dose.

[F65(10) In this regulation, the references to—

(a) a person's capacity are to be read—

(i) in relation to England and Wales, in accordance with the Mental Capacity Act 2005 (in the case of a person aged 16 years or older); and

(ii) in relation to Scotland, in accordance with the Age of Legal Capacity (Scotland) Act 1991 (in the case of a person under the age of 16) and the Adults with Incapacity (Scotland) Act 2000 (in the case of a person aged 16 years or older); and

(b) "parental responsibility" are to be read—

(i) in relation to England and Wales, in accordance with the Children Act 1989; and

(ii) in relation to Scotland, in accordance with the Children (Scotland) Act 1995.**]**

Textual Amendments

F48 Word in reg. 12(3)(a) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(2)(a)**

F49 Word in reg. 12(3) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(2)(b)**

F50 Words in reg. 12(3)(c) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(2)(c)(i)**

F51 Words in reg. 12(3)(c) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(2)(c)(ii)**

F52 Reg. 12(3)(d) and word inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(2)(d)**

F53 Words in reg. 12(4) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(3)(a)**

F54 Reg. 12(4)(a) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(3)(b)**

F55 Words in reg. 12(4)(b) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(3)(c)**

F56 Words in reg. 12(5) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(4)**

F57 Words in reg. 12(6)(a) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(5)(a)**
F58 Reg. 12(6)(aa)(ab) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(5)(b)**
F59 Reg. 12(6)(b) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(5)(c)**
F60 Word in reg. 12(6) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(5)(d)**
F61 Reg. 12(6)(c) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(5)(e)**
F62 Word in reg. 12(8)(a)-(c) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(6)(a)**
F63 Word in reg. 12(8)(d) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(6)(b)**
F64 Word in reg. 12(8)(e) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(6)(b)**
F65 Reg. 12(10) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **11(7)**

Commencement Information
I12 Reg. 12 in force at 6.2.2018, see **reg. 1**

Estimates of population doses

13. The employer must collect dose estimates from **[**[F66]exposures to which these Regulations apply**]**, taking into consideration the distribution by age and gender of the exposed population and, when so requested, must provide the dose estimates to the Secretary of State.

Textual Amendments
F66 Words in reg. 13 substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **12**

Commencement Information
I13 Reg. 13 in force at 6.2.2018, see **reg. 1**

Expert advice

14.—(1) The employer must ensure that a suitable medical physics expert is appointed and involved, in accordance with paragraph (2), in relation to every type of exposure to which these Regulations apply.

(2) A medical physics expert must—

(a) be closely involved in every radiotherapeutic practice other than standardised therapeutic nuclear medicine practices;

(b) be involved in practices including standardised therapeutic nuclear medicine practices, diagnostic nuclear medicine practices and high dose interventional radiology and high dose computed tomography;

(c) be involved as appropriate for consultation on optimisation, in all other radiological practices not mentioned in **[**[F67]sub-paragraphs (a) and (b)**]**; and

(d) give advice on—

(i) dosimetry and quality **[**F68control**]** matters relating to radiation protection concerning exposures;

(ii) physical measurements for the evaluation of dose delivered;

(iii) medical radiological equipment.

(3) A medical physics expert must also contribute to the following matters—

(a) optimisation of the radiation protection of patients and other individuals subject to exposures, including the application and use of diagnostic reference levels **[**F69and dose reference levels**]**;

(b) the definition and performance of quality assurance of the equipment;

(c) acceptance testing of equipment;

(d) the preparation of technical specifications for equipment and installation design;

(e) the surveillance of the medical radiological installations;

(f) the analysis of events involving, or potentially involving, accidental or unintended exposures;

(g) the selection of equipment required to perform radiation protection measurements;

(h) the training of practitioners **[**F70, operators**]** and other staff in relevant aspects of radiation protection;

(i) the provision of advice to an employer relating to compliance with these Regulations.

(4) The medical physics expert must, where appropriate, liaise with a radiation protection adviser and a radioactive waste adviser.

F71(5) . . . . . .

Textual Amendments

F67 Words in reg. 14(2)(c) substituted (6.2.2018) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (S.I. 2018/121), regs. 1(2), **2(3)**

F68 Word in reg. 14(2)(d)(i) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **13(2)**

F69 Words in reg. 14(3)(a) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **13(3)(a)**

F70 Word in reg. 14(3)(h) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **13(3)(b)**

F71 Reg. 14(5) omitted (1.10.2024) by virtue of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **13(4)**

Commencement Information

I14 Reg. 14 in force at 6.2.2018, see **reg. 1**

Equipment: general duties of the employer

15.—(1) An employer who has control over any equipment must—

(a) implement and maintain a quality assurance programme in respect of that equipment which must as a minimum permit—

(i) the assessment of the dose of ionising radiation that a person may be exposed to from an exposure to which these Regulations apply, by way of the ordinary operation of that equipment; and

(ii) the administered activity to be verified;

(b) draw up, keep up-to-date and preserve at each radiological installation an inventory of equipment at that installation and, when so requested, must provide it to the relevant enforcing authority.

(2) The inventory referred to in paragraph (1)(b) must contain the following information **[**F72for equipment other than software**]**—

(a) name of manufacturer;

(b) model number;

(c) serial number or other unique identifier;

(d) year of manufacture; and

(e) year of installation.

[F73(2A) The inventory referred to in paragraph (1)(b) must contain the following information for equipment that is software—

(a) name of software company;

(b) brand name;

(c) current software version;

(d) year of original installation; and

(e) year of current software version installation in clinical use.**]**

(3) An employer must undertake adequate—

(a) testing of any equipment before it is first used for **[**F74an exposure to which these Regulations apply**]**;

(b) performance testing at regular intervals;

(c) performance testing following a maintenance procedure which is capable of affecting the equipment's performance.

(4) A person must not use fluoroscopy equipment unless that equipment features—

(a) a device to control automatically the dose rate; or

(b) an image intensifier or equivalent device.

(5) Equipment used for interventional radiology and computed tomography must have a device or other feature capable of informing the **[**F75operator**]**, at the end of an exposure of relevant parameters for assessing the patient dose.

(6) An employer must—

(a) put in place any measures necessary to improve inadequate or defective performance of equipment;

(b) specify acceptable performance criteria for equipment; and

(c) specify what corrective action is necessary when, following the application of any criteria specified under paragraph (b), equipment is ascertained to be defective; such corrective action may include taking the equipment out of service.

Textual Amendments

F72 Words in reg. 15(2) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **14(2)**

F73 Reg. 15(2A) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **14(3)**

F74 Words in reg. 15(3)(a) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **14(4)**

F75 Word in reg. 15(5) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **14(5)**

Commencement Information

I15 Reg. 15 in force at 6.2.2018, see **reg. 1**

Equipment installed on or after 6th February 2018

16.—(1) This regulation only applies in respect of—

(a) equipment installed on or after 6th February 2018; and

(b) an employer who has control of any such equipment.

(2) Equipment used for external beam radiotherapy with a nominal beam energy exceeding 1 MeV must have a device or other feature, the purpose of which is, to verify key treatment parameters.

(3) Equipment used for interventional radiology must have a device or other feature capable of informing any person involved in the conduct of an exposure of the amount of radiation produced by the equipment during such an exposure.

(4) Equipment used for planning, guiding and verification purposes must have a device or other feature capable of informing the practitioner, at the end of an exposure, of relevant parameters for assessing the dose.

(5) Equipment used for interventional radiology and computed tomography must have the capacity to transfer, to the record of a person's exposure, information relating to relevant parameters for assessing the dose.

(6) Insofar as not already provided in this regulation, any equipment producing ionising radiation must—

(a) have a device, or other feature, capable of informing the practitioner of relevant parameters for assessing the patient dose; and

(b) where appropriate, have the capacity to transfer this information to the record of a person's exposure.

Commencement Information

I16 Reg. 16 in force at 6.2.2018, see **reg. 1**

Training

17.—(1) Subject to the following provisions of this regulation a practitioner or operator must not carry out any exposure or any practical aspect without having been adequately trained.

(2) A certificate issued by an institute or person competent to award degrees or diplomas or to provide other evidence of adequate training is, if such certificate so attests, sufficient proof that the person to whom it has been issued has been adequately trained.

(3) Nothing in paragraph (1) above prevents a person from participating in practical aspects of the procedure as part of practical training if this is done under the supervision of a person who is adequately trained.

(4) The employer must keep and have available for inspection by the relevant enforcing authority an up-to-date record of all relevant training undertaken by all practitioners and operators engaged by the employer to carry out any exposures or any practical aspect of such exposures showing the date or dates on which training qualifying as adequate training was completed and the nature of the training.

(5) Where the employer ("employer A") enters into a contract with another employer ("employer B") to engage a practitioner or operator otherwise employed by that employer B, employer B is responsible for keeping the records required by paragraph (4) and must supply such records to employer A immediately upon request.

(6) Schedule 3 makes further provision about the training of practitioners and operators.

Commencement Information
I17 Reg. 17 in force at 6.2.2018, see **reg. 1**

Enforcement

18. These Regulations are to be enforced by the relevant enforcing authority as if they were health and safety regulations made under section 15 of the Health and Safety at Work etc. Act 1974(**6**) and the provisions of that Act, as regards enforcement and offences, are to apply for the purposes of these Regulations.

Commencement Information
I18 Reg. 18 in force at 6.2.2018, see **reg. 1**

Defence of due diligence

19. In any proceedings against any person for an offence consisting of the contravention of these Regulations it is a defence for that person to show that the person took all reasonable steps and exercised all due diligence to avoid committing the offence.

Commencement Information
I19 Reg. 19 in force at 6.2.2018, see **reg. 1**

Revocation and transitional provision

20.—(1) The Ionising Radiation (Medical Exposure) Regulations 2000(**7**) are revoked.

(2) Subject to the transitional provisions in paragraph (3), the Medicines (Administration of Radioactive Substances) Regulations 1978(**8**) and the Medicines (Radioactive Substances) Order 1978(**9**) are also revoked to the extent that they apply in England and Wales and Scotland.

(3) Any certificate issued to a person under the Medicines (Administration of Radioactive Substances) Regulations 1978 which is valid on 6th February 2018 is deemed—

(6) 1974 c. 37; section 15(1) was substituted by paragraph 6 of Schedule 15 to the Employment Protection Act 1975 (c. 71) and amended by S.I. 2002/794. There are other amendments to section 15 not relevant for the purposes of these Regulations.
(7) S.I. 2000/1059; amended by paragraph (1) of Schedule 8 to the Care Act 2014 (c. 23), S.I. 2004/1031, S.I. 2006/2523, S.I. 2006/2806, S.I. 2007/1898, S.I. 2009/462, S.I. 2011/1567 and S.I. 2012/1916.
(8) S.I. 1978/1006, amended by S.I. 1995/2147, 2005/2754 and 2006/2407.
(9) S.I. 1978/1004, amended by S.I. 2006/2407.

(a) to be a licence issued under these Regulations for as long as that certificate remains valid; and

(b) to license the employer responsible for the medical radiological installation for the matters specified in that certificate.

(4) Nothing in paragraph (3) prevents a person from applying for a licence under these Regulations on or after the date that they come into force.

Commencement Information
I20 Reg. 20 in force at 6.2.2018, see **reg. 1**

Consequential amendments

21. Schedule 4 sets out amendments consequential on the making of these Regulations.

Commencement Information
I21 Reg. 21 in force at 6.2.2018, see **reg. 1**

Review

22.—(1) The Secretary of State must from time to time—

(a) carry out a review of the regulatory provision contained in these Regulations; and

(b) publish a report setting out the conclusions of the review.

(2) The first report must be published before the end of the period of five years beginning with the coming into force of these Regulations.

(3) Subsequent reports must be published at intervals not exceeding 5 years.

(4) Section 30(3) of the Small Business, Enterprise and Employment Act 2015(**10**) requires that a review carried out under this regulation must, so far as is reasonable, have regard to how **[**[F76]the international obligations implemented by these Regulations are implemented in other countries which are subject to those obligations.**]**

(5) Section 30(4) of the Small Business, Enterprise and Employment Act 2015 requires that a report published under this regulation must, in particular—

(a) set out the objectives intended to be achieved by the regulatory provision referred to in paragraph (1)(a);

(b) assess the extent to which those objectives are achieved;

(c) assess whether those objectives remain appropriate; and

(d) if those objectives remain appropriate, assess the extent to which they could be achieved in another way which involves less onerous regulatory provision.

(6) In this regulation, "regulatory provision" has the same meaning as in sections 28 to 32 of the Small Business, Enterprise and Employment Act 2015 (see section 32 of that Act).

(10) 2015 c. 26. Section 30(3) was amended by the Enterprise Act 2016 (c. 12), section 19.

Textual Amendments

F76 Words in reg. 22(4) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **15**

Commencement Information

I22 Reg. 22 in force at 6.2.2018, see **reg. 1**

Signed by authority of the Secretary of State for Health.

Stephen Brine
Parliamentary Under-Secretary of State,
Department of Health

20th December 2017

We consent

Mark Spencer
Heather Wheeler
Two of the Lords Commissioners of Her Majesty's Treasury

20th December 2017

SCHEDULE 1

Regulation 4

Licensing

Licence applications: general

1.—(1) A person required by regulation 5 to hold a licence must make an application to the Licensing Authority in the form specified from time to time by the Licensing Authority.

(2) A person applying for a licence under sub-paragraph (1) must provide to the Licensing Authority—

(a) such of the information described in paragraph 2 as the Licensing Authority may from time to time specify necessary to determine the licence application;

(b) upon request in writing, any other information which the Licensing Authority requires for the purpose of considering the licence application; and

(c) the fee specified in paragraph 4.

(3) A person issued a licence under these Regulations ("the licensee") must apply to the Licensing Authority if the licensee seeks a material change to the licence in respect of any matter dealt with by that licence.

Commencement Information

I23 Sch. 1 para. 1 in force at 6.2.2018, see **reg. 1**

Licence applications: indicative list of information

2. The information referred to in paragraph 1(2) is information relating to—

(a) responsibilities and organisational arrangements for protection and safety;

(b) staff competences, including information and training;

(c) design features of the radiological installation and of radiation sources;

(d) anticipated occupational and public exposures in normal operation;

(e) safety assessment of the activities and the facility in order to—

(i) identify ways in which potential exposures or accidental and unintended medical exposures could occur;

(ii) estimate, to the extent practicable, the probabilities and magnitude of potential exposures;

(iii) assess the quality and extent of protection and safety provisions, including engineering features, as well as administrative procedures;

(iv) define the operational limits and conditions of operation;

(f) emergency procedures;

(g) maintenance, **[**F77quality control**]**, inspection and servicing so as to ensure that the radiation source and the facility continue to meet the design requirements, operational limits and conditions of operation throughout their lifetime;

(h) management of radioactive waste and arrangements for the disposal of such waste, in accordance with applicable regulatory requirements;

(i) management of disused sources;

(j) quality assurance.

Textual Amendments

F77 Words in Sch. 1 para. 2(g) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **16(2)**

Commencement Information

I24 Sch. 1 para. 2 in force at 6.2.2018, see **reg. 1**

Licence applications: urgent cases

3. The licensing authority may, on a case by case basis, relax any of the requirements relating to the making of an application for a licence in respect of a proposed urgent medical radiological exposure.

Commencement Information

I25 Sch. 1 para. 3 in force at 6.2.2018, see **reg. 1**

Licence applications: employer fees

4.—(1) The fee payable by a person described in column 1 of Table 1 in respect of an application type specified in column 2 of that table is the corresponding amount in column 3.

(2) No fee is payable where the amount specified in column 2 is "0".

[F78Table 1

Licence type (1)	*Application type (2)*	*Fee (£) (3)*
Employer	New	298
	Amendment of an existing licence	244
	Renewal of an existing licence	244
	Notification	0
Practitioner	New	0
	Amendment of an existing licence	0
	Renewal of an existing licence	0
	Particular patient request	0**]**

Textual Amendments

F78 Sch. 1 Table 1 substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **16(3)**

Commencement Information

I26 Sch. 1 para. 4 in force at 6.2.2018, see **reg. 1**

Review

5.—(1) A person who is aggrieved ("an aggrieved person") by—

(a) a decision of the Licensing Authority—

(i) refusing to issue a licence;

(ii) imposing a limit of time upon a licence; or

(iii) revoking a licence; or

(b) the terms of any conditions attached to a licence by the Licensing Authority,

may ask the Licensing Authority for a review.

(2) Any aggrieved person seeking a review must—

(a) within 28 days of the date that the person was notified of the decision, or the terms, which caused them to become an aggrieved person request the Licensing Authority to undertake a review described in paragraph (1) ; and

(b) must particularise in writing the reasons for seeking the review.

(3) The Licensing Authority must undertake a review, and provide the results of that review in writing to the aggrieved person.

Commencement Information

I27 Sch. 1 para. 5 in force at 6.2.2018, see **reg. 1**

Destination of fees

6. A fee payable under these Regulations is payable to the Secretary of State.

Commencement Information

I28 Sch. 1 para. 6 in force at 6.2.2018, see **reg. 1**

SCHEDULE 2 Regulation 6

Employer's Procedures

1. The employer's written procedures for exposures must include procedures—

(a) to identify correctly the individual to be exposed to ionising radiation;

(b) to identify individuals entitled to act as referrer or practitioner or operator within a specified scope of practice;

(c) for making enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding;

(d) to ensure that quality assurance programmes in respect of written procedures, written protocols, and equipment are followed;

(e) for the assessment of patient dose and administered activity;

(f) for the use and review of such diagnostic reference levels **[**F79and dose reference levels**]** as the employer may have established **[**F80under regulation 6(5)(c) and 6(5)(ca)**]**;

(g) for determining whether the practitioner or operator is required to effect one or more of the matters set out in regulation 12(4) including criteria on how to effect those matters and in particular procedures for the use of dose constraints established by the employer for biomedical and medical research programmes falling within **[**F81regulation 3(1)(c)**]** where no direct medical benefit for the individual is expected from the exposure;

(h) for the giving of information and written instructions as referred to in regulation 12(6);

(i) providing that wherever practicable, and prior to an exposure taking place, the individual to be exposed or their representative is provided with adequate information relating to the benefits and risks associated with the radiation dose from the exposure;

(j) for the carrying out and recording of **[**F82a clinical evaluation**]** for each exposure including, where appropriate, factors relevant to patient dose;

(k) to ensure that the probability and magnitude of accidental or unintended exposure to individuals from radiological practices are reduced so far as reasonably practicable;

(l) to ensure that the referrer, the practitioner, and the individual exposed or their representative are informed of the occurrence of any relevant clinically significant **[**F83accidental or unintended**]** exposure, and of the outcome of the analysis of this exposure;

(m) to be observed in the case of non-medical imaging exposures;

(n) to establish appropriate dose constraints and guidance for the exposure of carers and comforters;

[F84(o) for the carrying out of clinical audit, and for any appropriate action to be taken in accordance with regulation 7; and

(p) for making, amending and cancelling any referrals for exposure.**]**

Textual Amendments

F79 Words in Sch. 2 para. 1(f) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **17(a)(i)**

F80 Words in Sch. 2 para. 1(f) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **17(a)(ii)**

F81 Words in Sch. 2 para. 1(g) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **17(b)**

F82 Words in Sch. 2 para. 1(j) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **17(c)**

F83 Words in Sch. 2 para. 1(l) substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **17(d)**

F84 Sch. 2 para. 1(o)(p) inserted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **17(e)**

Commencement Information

I29 Sch. 2 para. 1 in force at 6.2.2018, see **reg. 1**

SCHEDULE 3

Regulation 17

Adequate Training

1. Practitioners and operators must have successfully completed training, including theoretical knowledge and practical experience, in—

(a) such of the subjects detailed in Table 1 as are relevant to their functions as practitioner or operator; and

(b) such of the subjects detailed in Table 2 as are relevant to their specific area of practice.

[F85Table 1

Radiation production, radiation protection and statutory obligations relating to ionising radiations

Fundamental Physics of Radiation	
Properties of Radiation	Excitation and ionisation
	Attenuation of ionising radiation
	Scattering and absorption
Radiation Hazards and Dosimetry	Biological effects of radiation - stochastic and deterministic
	Risks and benefits of radiation
	Absorbed dose, equivalent dose, effective dose, other dose indicators and their units
Management and Radiation Protection of the individual being exposed	
Special Attention Areas	Pregnancy and potential pregnancy
	Asymptomatic individuals
	Breastfeeding
	Infants and children
	Medical and biomedical research
	Health screening
	Non-medical imaging
	Carers and comforters
	High dose techniques
Justification and authorisation	Justification of the individual exposure
	Use of existing appropriate radiological information
	Alternative techniques
Radiation Protection	Diagnostic reference levels
	Dose reference levels
	Dose Constraints
	Dose Optimisation
	Dose reduction devices and techniques
	Dose recording and dose audit

Fundamental Physics of Radiation	
	General radiation protection
	Quality Assurance for written procedures and written protocols
	Quality Control for the routine inspection and testing of equipment
	Risk communication
	Use of radiation protection devices
Statutory Requirements, Non-Statutory Guidance and other documents	
	Regulations
	Non-statutory guidance
	Local procedures and protocols
	Individual responsibilities relating to exposures
	Responsibility for radiation safety
	Proactive use of clinical audit
	Analysis of events involving accidental or unintended exposures
	Study of risk of accidental or unintended exposures**]**

[F86Table 2

Diagnostic radiology, radiotherapy and nuclear medicine

All Modalities	
General	Fundamentals of radiological anatomy
	Factors affecting radiation dose
	Dosimetry
	Fundamentals of clinical evaluation
	Identification of the individual being exposed
	Equipment specification
Contrast Media	Use and preparation
	Contraindications
	Use of contrast injection systems
Diagnostic radiology	
General	Principles of radiological techniques

Diagnostic radiology	
Specialised Techniques	Production of X-rays
	Computed Tomography
	Interventional procedures
	Hybrid imaging
Practical aspects for diagnostic radiology	Patient positioning
	Equipment selection and use
	Protocol selection
	Optimisation of image quality and radiation dose
	Dose assessment and recording
	Image acquisition, artefacts, processing, display and storage

Radiotherapy	
General	Production of ionising radiation
	Treatment of malignant disease
	Treatment of benign disease
	Principles of external beam radiotherapy
Specialised techniques	Brachytherapy
	Intra-operative radiotherapy
	Proton therapy
	Magnetic Resonance Linac therapy
	Computed Tomography: applications limited to radiotherapy
	Advanced techniques
Radiobiological Aspects for Radiotherapy	Fractionation
	Dose rate
	Radiosensitisation
	Target volumes
	Organs at risk
	The Radiobiological effect of gaps in treatment
	The Radiobiology of re-treatment
Practical Aspects for Radiotherapy	Patient positioning
	Equipment selection and use

Radiotherapy	
	Principles of localisation techniques
	Principles of planning techniques
	Principles of dose calculation and verification techniques
	Principles of treatment techniques
	Principles of on-treatment imaging
	Optimisation of image quality and radiation dose
Radiation Protection Specific to Radiotherapy	Side effects—early and late
	Toxicity
	Assessment of efficacy

Nuclear Medicine	
General	Atomic structure and radioactivity
	Radioactive decay
	Principles of molecular imaging and non-imaging exposures
	Principles of molecular radiotherapy
Molecular Radiotherapy	Dose rate
	Fractionation
	Radiobiology aspects
	Radiosensitisation
Specialised techniques	Quantitative imaging—advanced applications
	Hybrid imaging—advanced applications
	Selective Internal Radiation Therapy
Radiopharmaceuticals	Calibration
	Working practices in the radiopharmacy
	Preparation of individual doses
Practical aspects for nuclear medicine	Patient positioning
	Equipment selection and use
	Protocol selection
	Optimisation of image quality and radiation dose
	Dose assessment and recording

Nuclear Medicine	
	Image acquisition, artefacts, processing, display and storage
Radiation Protection Specific to Nuclear Medicine	Conception, pregnancy and breastfeeding
	Radiation protection arrangements for radioactive individuals**]**

Textual Amendments

F85 Sch. 3 Table 1 substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **18(a)**

F86 Sch. 3 Table 2 substituted (1.10.2024) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024 (S.I. 2024/896), regs. 1(2), **18(b)**

Commencement Information

I30 Sch. 3 para. 1 in force at 6.2.2018, see **reg. 1**

SCHEDULE 4

Regulation 21

Consequential amendments

Amendment of the Justification of Practices Involving Ionising Radiation Regulations 2004

1.—(1) The Justification of Practices Involving Ionising Radiation Regulations 2004(**11**) are amended as follows.

[F87(2) For regulation 21 (saving for medical practices) substitute—

"**21.** Nothing in regulation 4(5) or 5(3) shall prevent anything permitted under regulation 11 of the Ionising Radiation (Medical Exposure) Regulations 2017 or regulation 11 of the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018.".**]**

Textual Amendments

F87 Sch. 4 para. 1(2) substituted (6.2.2018) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (S.I. 2018/121), regs. 1(2), **2(4)(a)**

Commencement Information

I31 Sch. 4 para. 1 in force at 6.2.2018, see **reg. 1**

Amendment of the Human Medicines Regulations 2012

2.—(1) The Human Medicines Regulations 2012(**12**) are amended as follows.

(11) S.I. 2004/1769; there are amending instruments but none is relevant.
(12) S.I. 2012/1916 as amended by S.I. 2014/490; there are other amending instruments but none is relevant.

[F88(2) In regulation 173 (exemption for certain radiopharmaceuticals), for paragraph (d) substitute—

"(d) for administration—

(i) in England and Wales and Scotland in accordance with a licence issued under the Ionising Radiation (Medical Exposure) Regulations 2017;

(ii) in Northern Ireland in accordance with a licence issued under the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018.".";**]**

[F89(3) For regulation 240 (radioactive medicinal products), substitute—

"**Radioactive medicinal products**

240.—(1) Regulation 214(2) does not apply to—

(a) a radioactive substance, administration of which results in a medical exposure; or

(b) any other prescription only medicine if it is being administered in connection with a medical exposure,

if Conditions A to E are met.

(2) Condition A is that the prescription only medicine is administered by an operator acting in accordance with the procedures and protocols referred to—

(a) in England and Wales and Scotland, in regulation 6(1) and (4) of the Ionising Radiation (Medical Exposure) Regulations 2017 which apply to the exposure;

(b) in Northern Ireland, in regulation 6(1) and (4) of the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018 which apply to the exposure.

(3) Condition B is that the medical exposure has been authorised by—

(a) an IRME practitioner; or

(b) where it is not practical for an IRME practitioner to authorise the exposure, an operator acting in accordance with written guidelines issued by an IRME practitioner.

(4) Condition C is that—

(a) in England and Wales and Scotland, the IRME practitioner mentioned in sub-paragraph (a) or (b) of paragraph (3) is the holder of a licence issued under the Ionising Radiation (Medical Exposure) Regulations 2017;

(b) in Northern Ireland, the IRME practitioner mentioned in sub-paragraph (a) or (b) of paragraph (3) is the holder of a licence issued under the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018.

(5) Condition D is that the prescription only medicine is not a product subject to special medical prescription.

(6) Condition E is that, in the case of a prescription only medicine that is not a radioactive substance, it is specified in the protocols referred to in paragraph (2).

(7) In this regulation—

"IRME practitioner" means—

(a) in relation to a medical exposure in England and Wales and Scotland, a practitioner for the purposes of the Ionising Radiation (Medical Exposure) Regulations 2017;

(b) in relation to a medical exposure in Northern Ireland, a practitioner for the purposes of the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018;

"medical exposure" has the same meaning—

(a) in England and Wales and Scotland as in the Ionising Radiation (Medical Exposure) Regulations 2017;

(b) in Northern Ireland as in the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018;

"radioactive substance" has the same meaning—

(a) in England and Wales and Scotland as in the Ionising Radiation (Medical Exposure) Regulations 2017;

(b) in Northern Ireland as in the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018.".**]**

Textual Amendments

F88 Sch. 4 para. 2(2) substituted (6.2.2018) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (S.I. 2018/121), regs. 1(2), **2(4)(b)(i)**

F89 Sch. 4 para. 2(3) substituted (6.2.2018) by The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 (S.I. 2018/121), regs. 1(2), **2(4)(b)(ii)**

Commencement Information

I32 Sch. 4 para. 2 in force at 6.2.2018, see **reg. 1**

Amendment of the Ionising Radiations Regulations 2017

3.—(1) The Ionising Radiations Regulations 2017(**13**) are amended as follows.

(2) In regulation 2(1) (interpretation)—

(a) omit the definition of "carers and comforters";

(b) insert after the definition of "calendar year"—

> ""carers and comforters" means individuals knowingly and willingly incurring an exposure to ionising radiation by helping, other than as part of their occupation, in the support and comfort of individuals undergoing or having undergone a medical exposure (other than as a carer and comforter);";

(c) in the definition of "medical exposure", after paragraph (d), insert—

> "(e) carers and comforters;".

(3) In regulation 3 (application)—

(a) in paragraph (2), omit "33";

(b) omit paragraph (4).

(4) Omit regulation 33 (equipment used for medical exposure).

(5) In regulation 35(6) (duties of employees)—

(a) in sub-paragraph (a), after "overexposure;" insert "or";

(b) in sub-paragraph (b), omit "or" the second time it appears;

(c) omit sub-paragraph (c).

(6) In regulation 38(2)(d) (exemption certificates)—

(a) before "25(2)" insert "and";

(b) omit "and 33(1)".

(13) S.I. 2017/1075.

Commencement Information

I33 Sch. 4 para. 3 in force at 6.2.2018, see **reg. 1**

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations implement, as respects Great Britain, some of the provisions of Council Directive 2013/59/Euratom (OJ No L13,17.1.2014, p1) laying down basic safety standards for protection against the dangers from exposure to ionising radiation. The Directive repeals Directives 89/618/Euratom, 90/641/Euratom, 96/26/Euratom, 97/43/Euratom and 20013/122/Euratom.

In particular, these Regulations transpose Directive requirements relating to dangers arising from ionising radiation in relation to medical exposure. They impose duties on employers and those with responsibilities for administering ionising radiation to protect persons undergoing medical exposures whether as part of their own medical diagnosis or treatment, as part of research, as asymptomatic individuals, as those undergoing non-medical imaging using medical radiological equipment or as carers and comforters of persons undergoing medical exposures.

These Regulations revoke other Regulations relating to medical exposures and prior-authorisation for the administration of radioactive substances for the purposes of diagnosis, treatment and research.

Regulation 2 is an interpretation provision. Regulation 3 sets out the medical exposures to which the Regulations apply.

Regulation 4 sets out conditions under which the Licensing Authority may issue a licence for the administration of radioactive substances. Further provisions relating to the application for and the issuing of such licences are contained in Schedule 1.

Regulation 5 requires the employer and the practitioner who wish to administer radioactive substances to hold a valid licence issued by the Licensing Authority. Such licences will specify the radiological installation and purposes as appropriate.

Regulation 6 requires the employer to establish a framework of general procedures, protocols and quality assurance programmes. The procedures must cover the matters set out in Schedule 2 as a minimum. Written protocols, where appropriate, must be in place for standard radiological practices. The employer must establish recommendations regarding referral guidelines, establish quality assurance programmes for standard operating procedures, review and make available diagnostic reference levels, establish dose constraints where appropriate and raise awareness of the effects of ionising radiation amongst individuals capable of childbearing or breastfeeding.

Regulation 7 requires the employer's procedures to include provision for clinical audit to be carried out.

Regulation 8 sets out the duties of the employer in relation to accidental or unintended medical exposures including provisions for providing information about clinically significant exposures, quality assurance programmes for radiotherapy, analysis and recording of events involving or potentially involving accidental or unintended exposures and processes for investigating and notifying the relevant enforcing authority when significant events have occurred.

Regulation 9 sets out the duties of the enforcing authority with regard to timely dissemination of information relating to significant accidental or unintended exposures.

Regulation 10 sets out the respective responsibilities of practitioners, operators and referrers. Practitioners and operators are required to follow the framework of procedures provided by the employer. The practitioner is responsible for the justification of a medical exposure. Authorisation of exposures is addressed here and in regulation 11. The operator is responsible for each practical aspect he or she carries out. The referrer must provide medical data as required by the practitioner in order that appropriate justification can take place.

Regulation 11 prohibits any medical exposure which has not been justified and authorised and sets out matters to be taken into account for justification. These include requirements relating to licensing and approval by an expert advisory committee, in the case of research, for exposures involving administration of radioactive substances. Justification of the exposure of carers and comforters is also required and recommendations or guidelines should be considered as part of justification of the exposure of asymptomatic individuals.

Regulation 12 provides for the optimisation process, and specifies the elements that are the responsibilities of the operator and the practitioner, depending on their involvement. Specific requirements are included for exposures in research, for carers and comforters and for exposures involving radioactive substances. Particular regard should be given to the exposures of children, exposures involving high doses, exposures of individuals involved in health screening programmes and pregnant or potentially pregnant or breastfeeding individuals. Regulation 12 also requires the employer to take steps to ensure that a clinical evaluation is recorded of each medical exposure.

Regulation 13 requires employers to provide when requested, to the Secretary of State data relating to dose estimates from diagnostic and interventional medical exposures.

Regulation 14 provides for suitable medical physics experts to be appointed and involved in relation to medical exposures.

Regulation 15 sets out general duties of the employer with respect to medical radiological equipment. These include requirements for quality assurance programmes, appropriate testing of equipment, performance criteria and actions to be taken when equipment does not perform appropriately.

Regulation 16 sets out additional requirements for equipment installed when the Regulations come into force including the transfer of information relating to patient dose where appropriate.

Regulation 17 prohibits a practitioner or operator from carrying out a medical exposure without having been adequately trained, except if supervised appropriately for practical aspects when undergoing training. The employer must keep and make available training records during inspections undertaken by the relevant enforcing authority. Further information regarding adequate training is set out in Schedule 3.

Regulation 18 provides that the Regulations are made enforceable as health and safety regulations under the Health and Safety at Work etc. Act 1974 (c. 37).

Regulation 19 provides there is a defence of due diligence to proceedings for an offence under the Regulations that all reasonable steps were taken and due diligence exercised.

Regulation 20 revokes the Ionising Radiation (Medical Exposure) Regulations 2000 (SI 2000/1059) and, subject to transitional provisions relating to existing certificates, the Medicines (Administration of Radioactive Substances) Regulations 1978 (S.I. 1978/1006) and the Medicines (Radioactive Substances) Order 1978 (S.I. 1978/1004).

Regulation 21 and Schedule 4 make provision consequential on the coming into force of these Regulations.

Regulation 22 makes provision for the review of these Regulations at the end of the period of 5 years beginning with the date on which they coming into force.

A full impact assessment has not been prepared to accompany this instrument as it has a low cost to business. However, a regulatory triage assessment accompanies this instrument.

Changes to legislation:
There are currently no known outstanding effects for the The Ionising Radiation (Medical Exposure) Regulations 2017.

INCIDENT WORKSHOP

This presentation is intended to raise awareness of the increasing number of radiation incidents taking place in ABUHB and ensure learning, reflection and the generation of ideas to prevent further incidents.

It is not intended to cast blame on individuals and all incident examples have been anonymised.

This presentation is intended to be interactive.

X-ray leads and modality leads must ensure this presentation is delivered to all Radiographers and Assistant Practitioners either in a group setting or individually.

This presentation should be delivered face-to-face and not sent out via email.

WHAT SHOULD YOU DO IMMEDIATELY AFTER AN INCIDENT? (ASK GROUP)

BE OPEN

- TELL YOUR PATIENT. BE HONEST, APOLOGISE. REASSURE. EXPLAIN IT IS GOING TO BE REPORTED AND INVESTIGATED. TELL THEM THEY MAY LATER HAVE A PHONE CALL ABOUT IT FROM YOUR MODALITY LEAD.
- TELL ANY REFERRERS INVOLVED AND RADIOLOGISTS INVOLVED.

CHECK IF OTHER PATIENTS ARE AFFECTED?

- CHECK ANY OTHER PATIENTS AFFECTED – WAS THIS INTENDED FOR SOMEONE ELSE? IS SOMEONE ELSE STILL WAITING FOR THEIR SCAN? IS THIS PATIENT'S SCAN IN THE WRONG FOLDER – COULD SOMEONE LOOK AT IT AND ACT ON IT? INFORM EVERYONE AND RESOLVE ASAP.

PACS AND RADIS

- ASK PACS TO MOVE IMAGES TO THE CORRECT FOLDERS WHERE REQUIRED. YOU SHOULD NOT DELETE ANY IMAGES OR PUT THEM ON THE NON-REPORTING LIST EVEN IF THE PATIENT WAS NOT INTENDED TO HAVE THAT IMAGING.
- ENSURE RADIS EPISODES ARE UPDATED AND REFLECT WHAT HAS HAPPENED.

REPORT IT

- TELL YOUR RPS.
- TELL SUPT/MODALITY LEAD/SITE LEAD

INFORMATION TO INCLUDE ON DATIX WHEN YOU REPORT A RADIATION INCIDENT (ASK GROUP)

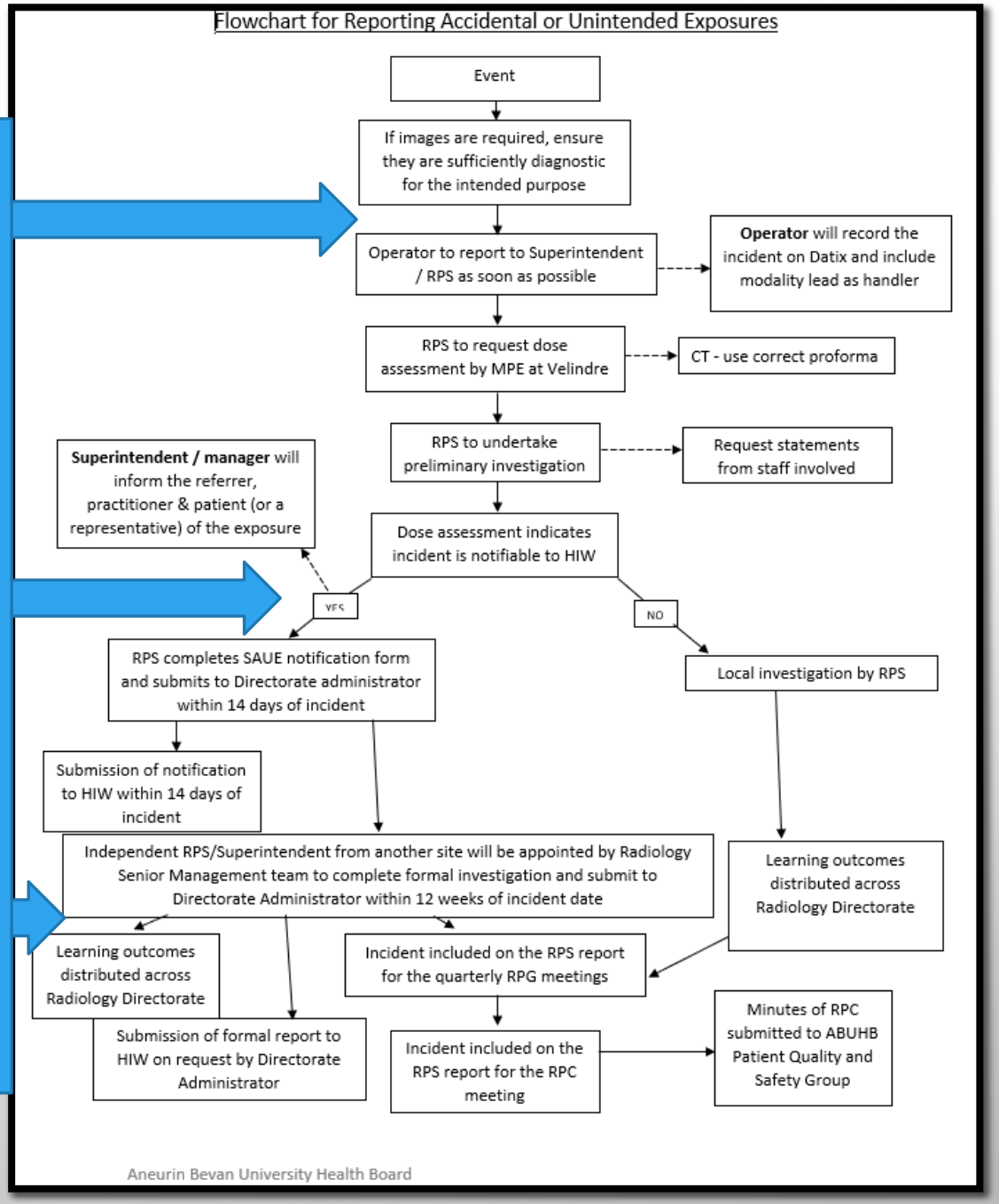
- ANONYMOUS FULL DESCRIPTION OF THE INCIDENT
- FACTUAL, NO OPINIONS
- BE SURE TO MAKE IT VERY CLEAR IF IT IS A NEAR MISS OR AN ACTUAL INCIDENT
- NO BLAME/EXCUSES. DON'T SAY SHORT-STAFFING OR BUSY SHIFT* CAUSED ME NOT TO CHECK THE PATIENT'S ID OR READ WHAT THE FORM SAID
- NON-EMOTIONAL

*(THE ROOT CAUSE AND CONTRIBUTING FACTORS ARE

This is a flowchart which is an appendix to Employer Procedure 2(l)

When and how do we communicate with the patient about the incident?

(Ask group if they know what happens at each arrow point before clicking forward)



WHAT IS A HIW NOTIFIABLE INCIDENT?

CRITERIA FOR NOTIFYING HIW

- ALL “ACCIDENTAL” EXPOSURES MUST BE NOTIFIED TO HIW *REGARDLESS* OF DOSE I.E. AN INDIVIDUAL WHO WAS NOT MEANT TO RECEIVE ANY RADIATION
- ALL “UNINTENDED” EXPOSURES WHERE THE DOSE IS *SIGNIFICANTLY GREATER THAN INTENDED*
- MORE THAN ONE INDIVIDUAL EXPOSED WITH THE SAME INCIDENT / THEME

RPS CARDIFF TELLS US WHAT IS NOTIFIABLE AND WHY, WHEN THEY SEND US THEIR DOSE ASSESSMENT REPORT BACK.

TYPE OF NOTIFIABLE INCIDENTS

AUE - ACCIDENTAL OR UNINTENDED EXPOSURE

THESE ARE STILL INCIDENTS AND NEED TO BE FULLY INVESTIGATED, WITH REFLECTIVE STATEMENTS AND LEARNING CASCADED, *BUT THEY ARE NOT NOTIFIABLE TO HIW.*

SAUE – SIGNIFICANT ACCIDENTAL OR UNINTENDED EXPOSURE

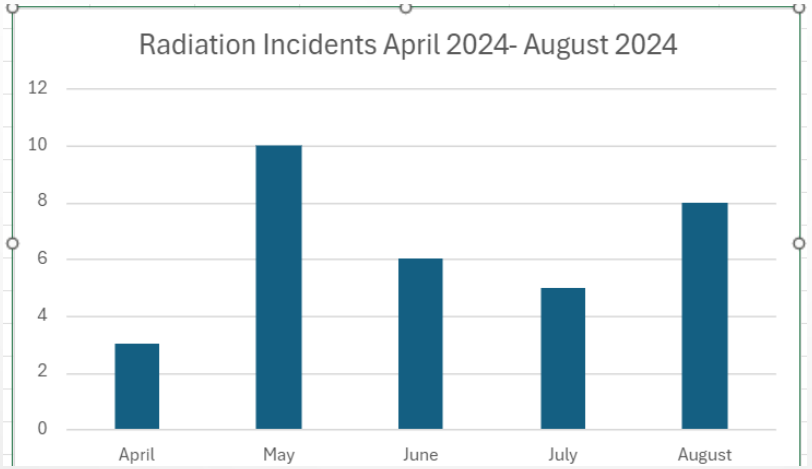
THESE ARE NOTIFIABLE TO HIW UNDER THE CRITERIA ON THE PREVIOUS SLIDE.

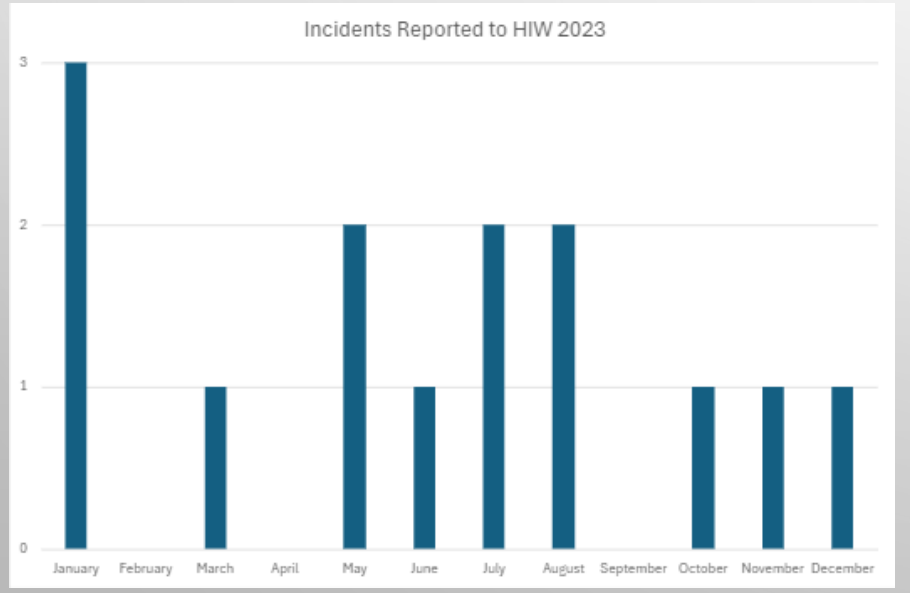
CSAUE – CLINICALLY SIGNIFICANT ACCIDENTAL OR UNINTENDED EXPOSURE

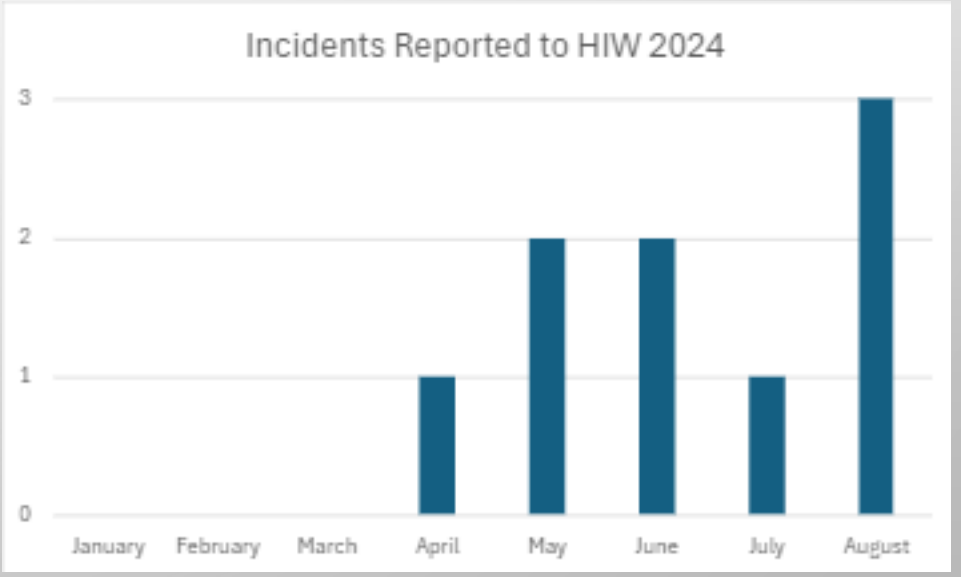
THESE ARE NOTIFIABLE TO HIW UNDER THE CRITERIA ON THE PREVIOUS SLIDE AND THE PATIENT HAS SUFFERED AN ADVERSE OUTCOME DUE TO THIS INCIDENT.

These are more unusual but we have sadly had one of these in recent years– will discuss this later in presentation.

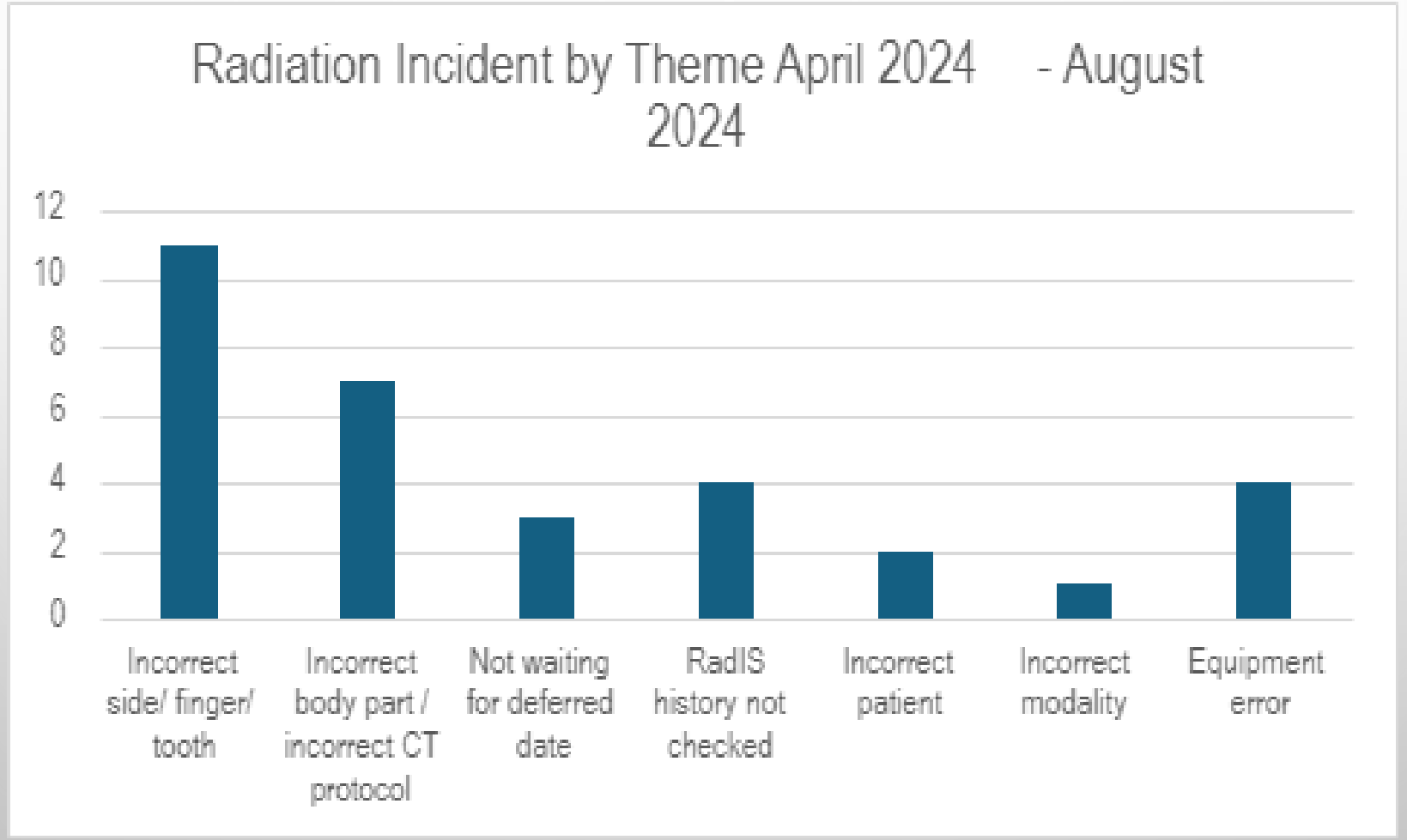
SO WHAT HAS CHANGED? WHY ARE WE WORRIED?







COMMON THEMES



WHY DOES IT MATTER? (ASK THE GROUP)

- **PATIENTS**

INCREASED CANCER RISK. DECREASED PATIENT CONFIDENCE IN SERVICE. INCREASED COMPLAINTS. CAN BE VERY DISTRESSING FOR PATIENTS TO LEARN THAT THEY HAVE RECEIVED MORE RADIATION THAN WAS INTENDED:

EXAMPLE 1: *PREGNANT PATIENT WHO HAD CT SCAN, PATIENT WASN'T CONNECTED TO THE CONTRAST PUMP. RADIOGRAPHER REALISED AFTER THE SCAN WAS COMPLETED AND THEN CONNECTED THE PUMP. PATIENT THEREFORE HAD REPEAT SCAN WITH CONTRAST.*

THIS INCIDENT WAS A CSAUE AS FOETUS LIKELIHOOD OF CHILDHOOD CANCER WAS DOUBLED (NORMALLY 1 IN 500, WAS 1 IN 250 AFTER THE INCIDENT). PREGNANT PATIENT HAD HISTORY OF PREVIOUS CHILD PASSING AWAY FROM CHILDHOOD CANCER AND WAS VERY DISTRESSED.

WHY DOES IT MATTER?...CONTINUED

- **PATIENTS: EXAMPLE 2:**

- PATIENT WAS NOT INFORMED AT THE TIME OF THE INCIDENT THAT THEY HAD HAD AN UNNECESSARY SCAN DUE TO MISTAKEN IDENTITY (NOT ID'D CORRECTLY). PATIENT WAS DISCHARGED.
- SUPERINTENDENT MADE ATTEMPTS TO CALL TO SPEAK TO PATIENT BUT COULD NOT GET AN ANSWER.
- SUPERINTENDENT SENT LETTER TO PATIENT EXPLAINING WHAT HAD HAPPENED AND APOLOGISING. PATIENT PHONED TO SAY THEY WERE VERY UPSET THAT THEY HAD NOT BEEN TOLD AT THE TIME AND FELT THAT IT HAD BEEN COVERED UP.
- PATIENT STATES THEY MAY GO 'PUBLIC' WITH THIS.

WHY DOES IT MATTER? CONTINUED…

- **ABUHB EXECUTIVE CONFIDENCE IN RADIOLOGY.** EVERY INCIDENT AND HIW REPORT IS SENT TO THE CEO AND EXECUTIVE TEAM. RAISES THE PROFILE OF RADIOLOGY……. IN THE WRONG WAY!
- **RAISES THE PROFILE OF ABUHB RADIOLOGY TO HIW** – CAN MAKE DIRECT COMPARISON WITH OTHER HEALTH BOARDS. THEY MAY QUESTION, ARE WE SAFE? DO WE NEED ANOTHER INSPECTION?
- **OTHER HEALTH BOARD'S CONFIDENCE IN ABUHB.** THESE NUMBERS ARE PUBLIC. CAN IMPACT RECRUITMENT AND GENERATE BAD PUBLICITY.

ROOT CAUSE AND CONTRIBUTING FACTORS

FOR EACH INCIDENT, THE INVESTIGATOR HAS TO DECIDE WHAT THE ‘ROOT CAUSE’ WAS, AND WHAT THE ‘CONTRIBUTING FACTORS’ WERE:

- DEFINITION OF ROOT CAUSE:

THE TRIGGERING EVENT THAT RESULTS IN AN INCIDENT OR NEAR MISS.

- DEFINITION OF CONTRIBUTING FACTORS:

A CIRCUMSTANCE OR CONDITION THAT INFLUENCES THE LIKELIHOOD OF AN INCIDENT.

EXAMPLE OF INCIDENT 1 – TEAM OR INDIVIDUAL TO PROVIDE ANSWERS BELOW

Incorrectly scanned a patient in CT and the patient was actually for an MRI scan.
Patient referred for an MRI scan. Request incorrectly entered onto RadIS as CT scan, appointment booked with patient. Patient attended and CT scan performed.
Request form clearly stated MRI in examination requested. Clinical details included clinical questions that would require an MRI scan to answer.
Request had not been justified.
Operator 'did not realise patient was intended to have an MRI scan'.

- ROOT CAUSE?
- CONTRIBUTING FACTOR?
- WHAT WOULD YOUR ACTIONS BE AFTERWARDS
- CONSEQUENCES TO PATIENT
- HOW WOULD YOU STOP THIS HAPPENING AGAIN?

EXAMPLE OF INCIDENT 2 – TEAM OR INDIVIDUAL TO PROVIDE ANSWERS BELOW

A patient arrived in the department for a follow up chest x-ray. The x-ray was completed. It was then noticed that the clinical details included 'follow up chest X-ray, to be performed 6 weeks from (date of previous X-ray). This has occurred twice in the last 3 months.

- ROOT CAUSE?
- CONTRIBUTING FACTOR?
- WHAT WOULD YOUR ACTIONS BE AFTERWARDS
- CONSEQUENCES TO PATIENT
- HOW WOULD YOU STOP THIS HAPPENING AGAIN?

EXAMPLE OF INCIDENT 3 – TEAM OR INDIVIDUAL TO PROVIDE ANSWERS BELOW

A request was received for a chest X-ray. When patient attended department two request forms had been stuck together, the chest x-ray request and a request for an abdominal X-ray. After both X-rays had been performed it was noticed that the request for an abdominal X-ray was for a different patient.
The abdominal X-ray had been performed on the incorrect patient, the patient was only intended to have a chest X-ray.

- ROOT CAUSE?
- CONTRIBUTING FACTOR?
- WHAT WOULD YOUR ACTIONS BE
- CONSEQUENCES TO PATIENT
- WHAT SHOULD THE ACTIONS BE FOR THIS INCIDENT?

EXAMPLE OF INCIDENT 4 – TEAM OR INDIVIDUAL TO PROVIDE ANSWERS BELOW

Examination performed on opposite side to side stated on radiology request form. Eleven times in the last five months imaging has been performed on either the incorrect side or the incorrect finger or the incorrect tooth.

- ROOT CAUSE?
- CONTRIBUTING FACTOR?
- WHAT WOULD YOUR ACTIONS BE AFTERWARDS
- CONSEQUENCES TO PATIENT
- HOW WOULD YOU STOP THIS HAPPENING AGAIN?

WHAT'S THE COMMON THEME IN THESE EXAMPLES? (ASK THE GROUP)

- **OPERATORS DO NOT APPEAR TO BE ROUTINELY COMPLETING THE PRE-PROCEDURAL CHECKS.**

….SADLY IT IS NOT CO-INCIDENCE THAT THE ONLY TIME THAT A PATIENT HAS NOT BEEN ID'D CORRECTLY, THAT IT HAPPENED TO BE THE WRONG PERSON. IT UNFORTUNATELY MUST BE THE CASE THAT THIS IS OFTEN NOT COMPLETED CORRECTLY.

…AND IT IS NOT CO-INCIDENCE THAT WHEN A PATIENT HAS HAD A REPEAT UNNECESSARY SCAN, THAT THE RADIOGRAPHER ONLY FORGOT TO ASK THAT ONE AND ONLY TIME WHETHER THEY HAD ANY PREVIOUS SCANS COMPLETED. IT UNFORTUNATELY MUST BE THE CASE THAT THEY DON'T ROUTINELY ASK THIS QUESTION.

STOP AND THINK ABOUT YOUR PRE-PROCEDURE 'AUTOPILOT'.

DO YOU:

- ALWAYS CHECK ID WITH OPEN QUESTIONS (WHAT IS YOUR NAME ? CAN YOU TELL ME YOUR DOB?)
- ALWAYS CHECK CLINICAL DETAILS/HISTORY/PREVIOUS IMAGING WITH OPEN QUESTIONS?
- ALWAYS CHECK THE MODALITY FOR THE SCAN?
- ALWAYS CHECK IF THE PATIENT IS PREGNANT AND FOLLOW THE PROCEDURE?

WHAT COULD YOU DO DIFFERENTLY?

RE-SET YOUR AUTOPILOT.

→ SLOW DOWN → PAUSE → CHECK.

CHANGES TO PROCESSES FOLLOWING CONCERNING INCREASE IN INCIDENTS

- *REFLECTIVE* STATEMENTS MUST BE COMPLETED – **USE THE CORRECT TEMPLATE -** STAFF REFLECTIVE STATEMENT TEMPLATE.DOCX (FOUND IN RADIOLOGY VARIOUS>IRMER 2017)
- **STAFF INVOLVED IN INCIDENTS WILL BE INVOLVED IN THE INVESTIGATION AND WILL MEET WITH THE INVESTIGATOR**
- REMINDING ALL STAFF ABOUT HCPC PROFESSIONAL STANDARDS, WE HAVE A DUTY TO REPORT UNSAFE PRACTICE.
- FROM NOW IN ABUHB, EVERY INCIDENT WILL BE REVIEWED AND IF CONCERNS ARISE ACTION WILL BE TAKEN IN LINE WITH EITHER THE CAPABILITY POLICY OR THE DISCIPLINARY POLICY.
- ESCALATION TO SENIOR MANAGEMENT TEAM AFTER SECOND INCIDENT WITHIN 12 MONTHS
- ESCALATION TO SENIOR MANAGEMENT CAN ALSO OCCUR AT ANY TIME

WHAT ELSE CAN BE DONE TO DECREASE INCIDENTS?

ALL SUGGESTIONS WELCOME

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Presentation of Nurse staffing Levels following the reconfiguration of Respiratory /GIM service
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kelly Downes, Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance that the Health Board is meeting its statutory requirements to calculate the Nurse staffing levels on all wards included in the recent reconfiguration of the Respiratory and General Internal Medicine Model effective from 11 November 2024.

Cefndir / Background

There is a statutory requirement under the Nurse Staffing Levels (Wales) Act 2016 for all health boards / trusts to undertake bi-annual recalculations of nursing establishments and planned rosters on all 25B wards (adult medical & surgical wards and paediatric wards). Each health board / trust in Wales must calculate the number of nurses and those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse. The nursing establishments must be sufficient to ensure nurses can care for patients sensitively.

The statutory guidance also requires the recalculation of ward establishments for any ward where there is a change of purpose.

An SBAR was presented to the Executive Committee in September 2024 seeking approval to reconfigure the Respiratory Medicine Service and to deliver a General Internal Medicine (GIM) model at Grange University Hospital (GUH) to include:

- Closure of the Medicine inpatient beds on ward 4/4 at Nevil Hall Hospital (NHH) - inclusive of 22 Respiratory and 6 Endocrine & Diabetes beds

- Delivery of a phased Respiratory in-reach model at NHH and Ysbyty Ystrad Fawr (YYF)
- Clear clinical accountability for 16 General Internal Medicine (GIM) beds at GUH

The Respiratory GIM reconfiguration proposal involved centralising respiratory services to GUH and creating dedicated GIM beds in GUH. In addition, there is a strategic aim to reduce the original Clinical Futures bed base by decommissioning a ward.

As per the well-established Nurse Staffing Act processes, all 25B wards underwent Autumn recalculations during the months of September and October 2024.

All wards affected by the Respiratory and GIM reconfiguration underwent a further recalculation in November as a result of the change of purpose.

Asesiad / Assessment

The wards requiring recalculation included:

- C4 GUH Respiratory
- B4 GUH Stroke
- 4.4 NHH Non – Invasive (NIV) respiratory stepdown

All staff affected by the reconfiguration were supported by the Divisional and Workforce & Organisational Development (WFOD) teams through the Organisation Change Policy (OCP) process. NHH had sufficient nursing vacancies to accommodate staff who did not wish to change base. Staff were given the opportunity to relocate to alternative sites if they wished to do so.

Acute Respiratory will be centralised at GUH (from ward 4/4 at NHH). The capacity within GUH will be reconfigured to provide 16 GIM inpatient beds across Wards B4 and C4 under the care of respiratory consultants.

This will require a reconfiguration and relocation of Respiratory High Care Unit (RHCU) to an alternative area within the GUH-Machen Wing on C2.

Ward C.4 GUH (Respiratory & Gen med) 45 beds

A deep dive was undertaken of Ward C4 regarding the proposed respiratory reconfiguration which will comprise of 45 beds. The breakdown being 6 Respiratory High Care beds, 15 General Medical beds and 24 Respiratory beds.

The patients under the care of the respiratory team will be split across 3 wards over 2 floors:

C4: 32 beds, 26 Respiratory beds and 8 Gen Med beds
B4: 8 Gen Med beds
C2: 6 beds Respiratory High Care (Machen wing)

The new roster will provide leadership consistency in the form of a Band 6 on every shift plus a coordinator Monday to Friday. The additional HCSW will support with the flow through the unit as the geography of the unit will cover 2 floors.

Ward C4 footprint will increase and take over the management of 8 beds on Ward B4. Some of the funding to accommodate this increase in footprint will be transferred from Ward B4 budget to Ward C4 budget.

The extra funding for the additional staffing required to support the increase in Ward C4 footprint (additional to the WTEs being transferred from Ward B4 budget) was approved following the submission of the reconfiguration paper to the Executive Committee in September 2024.

Roster Pre Reconfiguration

		Mon	Tues	Wed	Thurs	Frid	Sat	Sun
Shift	**Beds**	**31**	**31**	**31**	**31**	**31**	**31**	**31**
E	**RN**	7	7	7	7	7	7	7
E	**HCSW**	5	5	5	5	5	5	5
L	**RN**	7	7	7	7	7	7	7
L	**HCSW**	5	5	5	5	5	5	5
N	**RN**	7	7	7	7	7	7	7
N	**HCSW**	5	5	5	5	5	5	5

Total WTE 68.83 plus 1WTE Supernumerary Ward Manager

Roster post reconfiguration

		Mon	Tues	Wed	Thurs	Frid	Sat	Sun
Shift	**Beds**	**45**	**45**	**45**	**45**	**45**	**45**	**45**
E	**RN**	**9**	**9**	**9**	**9**	**9**	8	8
E	**HCSW**	7	7	7	7	7	7	7
L	**RN**	8	8	8	8	8	8	8
L	**HCSW**	7	7	7	7	7	7	7
N	**RN**	8	8	8	8	8	8	8
N	**HCSW**	7	7	7	7	7	7	7

Total WTE 86.95 plus 1WTE Supernumerary Ward Manager

The changes to the planned roster and funded establishment will be supported by:

5.69 WTE Band 5 RN to transfer from Ward B4.
5.69 WTE Band 2 HCSW to transfer from Ward B4.

Paper submitted to Executive Committee in September agreed extra funding of:
0.60 WTE Band 6 RN - £32,644
5.84 WTE Band 2 HCSW - £215,844

Total additional staff for C4 Template: **18.12 WTE**

Additional Costings: £248,488

Ward B.4 GUH (Hyperacute Stroke) 15 beds

Ward B4 has historically been difficult to calculate, the ward has 31 beds and comprises of 15 hyperacute stroke and 8 general medical beds. Additionally, there are 8 haematology beds managed by scheduled care.

Following the reconfiguration, the B4 footprint and funded establishment will reduce and comprise of 15 stroke beds, 8 of which will be hyperacute (HASU) beds.

The haematology beds will remain the same, however, haematology will be required to move to a different wing on B4 to accommodate the extension of C4 on to B4 to accommodate 8 Gen Med beds overseen by the Respiratory team.

Roster Pre Reconfiguration

		Mon	Tues	Wed	Thurs	Frid	Sat	Sun
Shift	**Beds**	**23**	**23**	**23**	**23**	**23**	**23**	**23**
E	**RN**	4	4	4	4	4	4	4
E	**HCSW**	4	4	4	4	4	4	4
L	**RN**	4	4	4	4	4	4	4
L	**HCSW**	4	4	4	4	4	4	4
N	**RN**	4	4	4	4	4	4	4
N	**HCSW**	4	4	4	4	4	4	4

Total WTE 46.37

Roster Post Reconfiguration

		Mon	Tues	Wed	Thurs	Frid	Sat	Sun
Shift	**Beds**	**15**	**15**	**15**	**15**	**15**	**15**	**15**
E	**RN**	3	3	3	3	3	3	3
E	**HCSW**	3	3	3	3	3	3	3
L	**RN**	3	3	3	3	3	3	3
L	**HCSW**	3	3	3	3	3	3	3
N	**RN**	3	3	3	3	3	3	3
N	**HCSW**	3	3	3	3	3	3	3

Total WTE 34.70

To support the changes with the increase to the respiratory footprint on C4, 8 beds on B4 will become part of the C4 footprint. The budget for 5.69 WTE Band 5 and 5.69 WTE Band 2 HCSW will transfer directly from B4 to C4 roster.

Costings: RN 5.69 WTE & HCSW 5.69 WTE **(£215,844)** to be transferred from B4 budget to C4 Budget**.**

Ward 4.4 NHH 26 beds with capacity to surge to 30 beds

On completion of the respiratory reconfiguration ward 4.4 will no longer be a respiratory step down ward. The staff will no longer be providing NIV therapy to stepdown patients from the GUH and therefore, will not require 3 RNs by night. The ward has been repurposed as care of the elderly ward and the planned roster has been recalculated.

The financial impact of this change is £90,665. However, this will support reduction in variable pay. The variable pay costings from May to October 2024 (5 months) for HCSW enhanced care was £122,480. Throughout the month of November 2024 every night shift apart from 3 nights, the HCSW requirement was for 4 5 HCSW per night.

The triangulation of professional judgement, acuity data and quality indicators support the need for 4 HCSWs by night for the delivery of safe care.

The new roster template will require a reduction of 2.85WTE RN's and an increase of 5.69 WTE HCSW's with an expectation that variable pay will reduce significantly.

This establishment change is supported by the Divisional Leadership Team and robust monitoring arrangements are in place to monitor roster efficiencies.

Roster Pre Reconfiguration

		Mon	Tues	Wed	Thurs	Frid	Sat	Sun
Shift	**Beds**	**26**	**26**	**26**	**26**	**26**	**26**	**26**
E	**RN**	4	4	4	4	4	4	4
E	**HCSW**	3	3	3	3	3	3	3
L	**RN**	4	4	4	4	4	4	4
L	**HCSW**	3	3	3	3	3	3	3
N	**RN**	3	3	3	3	3	3	3
N	**HCSW**	2	2	2	2	2	2	2

Total WTE: 35.15 15 (Annual Costs 1,534,989)

Roster Post Reconfiguration

		Mon	Tues	Wed	Thurs	Frid	Sat	Sun
Shift	**Beds**	**26**	**26**	**26**	**26**	**26**	**26**	**26**
E	**RN**	4	4	4	4	4	4	4
E	**HCSW**	3	3	3	3	3	3	3
L	**RN**	4	4	4	4	4	4	4
L	**HCSW**	3	3	3	3	3	3	3
N	**RN**	2	2	2	2	2	2	2
N	**HCSW**	4	4	4	4	4	4	4

Total WTE: 37.9 (Annual Costs: 1,625,654)

New Template Additional Costings: £90,665

Total Additional- costings for the Respiratory/Gen Med reconfiguration

Ward	WTE	Annual Costings
Ward C4	RN band 5 +5.69	+£283,871 from B4 (cost neutral)
	HCSW band 2 +5.69	+£215,844 from B4 (cost neutral)
	RN band 6 +0.60	+£32,644 (Approved)
	HCSW band 2 +5.69	+£215,844 (Approved)
Ward B4	RN band 5 -5.69	-£283,871 transfer to C4 (Approved)
	HCSW band 2 -5.69	-£215,844 transfer to C4 (Approved)
Ward 4/4	RN band 5 -2.85	-£156,225
	HCSW band 2 +5.69	+£246,890 **(Seeking Approval**)
Total cost	**All wards**	**£339,153**
Approved		**£248, 488**
Unfunded	**Ward 4.4**	**£90,665**

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Committee is asked to:

- Receive ASSURANCE that the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA where there has been a change of purpose.

- NOTE that the funding for the wards in GUH that have changed purpose has already been approved (respiratory / Gen med reconfiguration paper).

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):	3.1 Safe and Clinically Effective Care 5. Timely Care 7.1 Workforce 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.

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

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

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

Health board / trust	ABUHB	Site	GUH	Ward Name	C4/RU	Period Reviewe	from	31 August 2024	to	04 November 2024

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

Current Roster

68.83 WTE

Headcount per shift

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Beds		31	31	31	31	31	31	31
Early (LD) Shift	RN	7.00	7.00	7.00	7.00	7.00	7.00	7.00
Early (LD) Duration	HCSW	5.00	5.00	5.00	5.00	5.00	5.00	5.00
Late Shift	RN	7.00	7.00	7.00	7.00	7.00	7.00	7.00
Late Duration	HCSW	5.00	5.00	5.00	5.00	5.00	5.00	5.00
Night (LN) Shift	RN	7.00	7.00	7.00	7.00	7.00	7.00	7.00
Night (LN) Duration	HCSW	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Band 7	1.00	Band 6	8.28	Band 5	31.58	Band 4	0.00	Band 3	0.00	Band 2	27.97

Total No. Staff WTE: **68.83**

Inclusive of uplift

Proposed Roster (after review)

86.95 WTE

Headcount per shift

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Beds		45	45	45	45	45	45	45
Early (LD) Shift	RN	9.00	9.00	9.00	9.00	9.00	8.00	8.00
Early (LD) Duration	HCSW	7.00	7.00	7.00	7.00	7.00	7.00	7.00
Late Shift	RN	8.00	8.00	8.00	8.00	8.00	8.00	8.00
Late Duration	HCSW	7.00	7.00	7.00	7.00	7.00	7.00	7.00
Night (LN) Shift	RN	8.00	8.00	8.00	8.00	8.00	8.00	8.00
Night (LN) Duration	HCSW	7.00	7.00	7.00	7.00	7.00	7.00	7.00

Band 7	1.00	Band 6	8.88	Band 5	37.42	Band 4	0.00	Band 3	0.00	Band 2	39.65

Total No. Staff WTE: **86.95**

Inclusive of uplift

Ward Shift Types

12 hour shifts

Acuity & Dependancy (e.g. Welsh Levels of Care)

Professional Judgement

A deep dive was undertaken of C4 in regards to the proposed respiratory reconfiguration which will comprise of 45 beds. The breakdown being 6 High Care beds, 15 Gen med beds and 24 respiratory beds. Present during the meeting was the ward manager, senior nurse, Head of Nursing, Directorate Manager, Senior Nurses for Professional Standards and a member of the finance and workforce team.
Professional discussions were undertaken using the triangulated approach. The ward acuity was discussed alongside staffing levels and QI's.
HAPU - all deemed unavoidable, nil related to staffing within the reporting period.
1 Fall with fracture - wrist not staffing related all interventions in place.
x15 medication errors were reported during the reporting period. Appropriate training has been completed on the ward as well as reflections and BESS scores.
Currently no open complaints
Mandatory and statutory training compliance: fire safety 88%, fire safety 91%, violence and aggression 91% and manual handling 56% with plans in place to improve.
PADR compliance is at 95%.
Safecare compliance is at 96.77%.
Vacancies: Band 6 = 1.28 WTE Band 5 = 0.73 WTE, Band 2 7.73 WTE

Quality Indicators

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatient wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Number of closed incidents/ complaints during current year (1st March - 31st August 2024)	Total number of incidents/ complaints not closed and to be reported on/during the next year	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)	0	0	0	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	0	0	0	0
Medication errors never events	0	0	0	0
Any complaints about nursing care	2	0	0	0

Outcome Summary

Current roster to change to compliment the new bed base. The new propsed roster will give leadership consistenty in the form of a band 6 on every shift plus a coordinator Monday to Friday. The additional HCSW will support with the flow through the unit as the geography of the unit as it now over 2 floors. The additional staffing as per the proposed roster will be funded from the respiratory paper which has been agreed and the movement of some establishment from B4. This has been approved - .

Changes in roster supported through - Staff to transfer from B4:

RN's B5	5.69
HCSW's B2	5.69
Agreed paper new posts RN B6	0.6
HCSW's B2	5.84
Total additional staff	18.12

Person(s) informing the calculation	Ward Sister / Charge Nurse	Lynsey Rees	Senior Nurse / Matron	Lynsey Hook	Divisional Nurse / Head of Nursing	Natalie Skyrme / Karen Collins
Authorising person	Designated Person (e.g. Exceutive Director of Nursing)		Date Calculation made by person(s) informing the calculation	5th November 2024	Date Presented to Board	
					Date to be reviewed (latest date)	

Nurse Staffing Levels (Wales) Operational Guideance. Refer to Appendix 5: Factors which must be considered during the calculation process

This template states the minimum dataset / information that is required and has been agreed nationally

Health board / trust	ABUHB	Site	GUH	Ward Name	B4	Period Reviewe	from	September 1st 2023	to	04 November 2024

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

Current Roster

46.37 WTE

Headcount per shift

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Beds		23	23	23	23	23	23	23
Early (LD) Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Early (LD) Duration	HCSW	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Late Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Late Duration	HCSW	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Night (LN) Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Night (LN) Duration	HCSW	4.00	4.00	4.00	4.00	4.00	4.00	4.00

Band 7 1.00 | Band 6 2.00 | Band 5 21.01 | Band 4 0.00 | Band 3 5.59 | Band 2 16.78

Total No. Staff WTE

Ward Shift Types

12 hour shifts

46.37

Inclusive of uplift

Proposed Roster (after review)

34.70 WTE

Headcount per shift

		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Beds		15	15	15	15	15	15	15
Early (LD) Shift	RN	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Early (LD) Duration	HCSW	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Late Shift	RN	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Late Duration	HCSW	3.00	3.00	3.00	3.00	33.00	3.00	3.00
Night (LN) Shift	RN	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Night (LN) Duration	HCSW	3.00	3.00	3.00	3.00	3.00	3.00	3.00

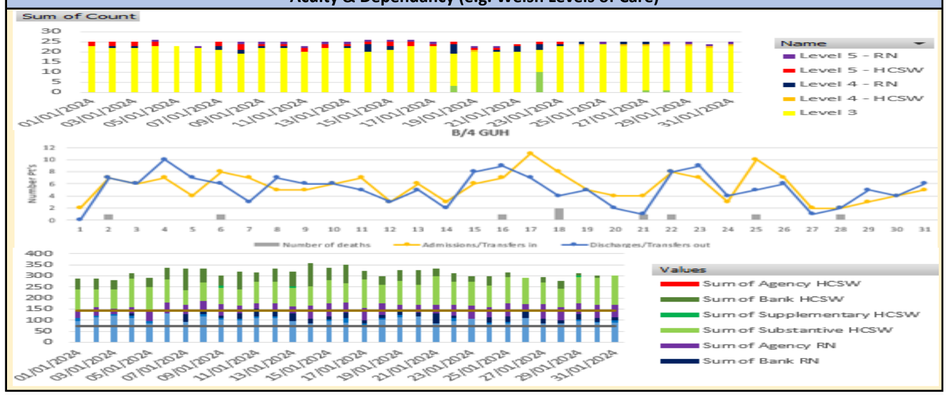
Band 7 1.00 | Band 6 2.00 | Band 5 15.17 | Band 4 0.00 | Band 3 5.59 | Band 2 10.94

Total No. Staff WTE

34.70

Inclusive of uplift

Acuity & Dependancy (e.g. Welsh Levels of Care)



Professional Judgement

B4 was origionally a 15 bedded hyperacute stroke ward. The ward as a whole has 31 beds with x 8 Haematology (SC beds) and a further x8 medical beds. Stroke and the x8 medical beds are managed by the Stroke Band 7. Haematology have their own leadership structure. Due to the changes the respiratory footprint B4 will reduce to 15 bed (8 HASU and 7 stroke beds). Haematolgy beds will remain.

All QI's reviewed between September 2023 - April 2024:

HAPU - x6 grade 2's between September - April, 1 SDT in September (unavoidable), review evidenced not staffing related, not reportable. Ongoing case for review for x1 ungradeable PU, Not staffing related, therefore not reportable.

Falls x26 since september, x1 fracture to finger not related to staffing, therefore not reportable.

Medication errors - Nine reported that relate to nursing

Complaints - x1 open related in part to nursing, not reportable

Symbiotix - cleaning averaging above 90%. S&M Training - 86% to 93% with a plan to improve further so all above 85%. PADR's - 70% identified area for improving.

Vacancies = Band 5 = 0 Band 2 = 0

Quality Indicators

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatient wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Number of closed incidents/ complaints during current year September 1st 2023 - 5th April 2024	Total number of incidents/ complaints not closed and to be reported on/during the next year	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)	**0**	**0**	**0**	**0**
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	**0**	**0**	**0**	**0**
Medication errors never events	**0**	**0**	**0**	**0**
Any complaints about nursing care	0	0	0	**0**

Outcome Summary

To supppprt the changes with C4 (increase in respiratory footprint), 8 beds will become part of the C4 footprint and to supppprt this the budget for 5.69 WTE Band 5 and 5.69 WTE Band 2 HCSW transfer directly from B4 to C4 roster and the line managemnet will move to sit under C4. Divisional Nurse to Divisional Nurse discussions planned re shared budget and roster.

Person(s) informing the calculation	**Ward Sister / Charge Nurse**	Febe Palmer	**Senior Nurse / Matron**	Lynsey Hook	**Divisional Nurse / Head of Nursing**	Natalie Skyrme / Karen Collins
Authorising person	**Designated Person (e.g. Exceutive Director of Nursing)**		**Date Calculation made by person(s) informing the calculation**	**04.11.2024**	**Date Presented to Board**	
					Date to be reviewed (latest date)	

Nurse Staffing Levels (Wales) Operational Guideance. Refer to Appendix 5: Factors which must be considered during the calculation process

This template states the minimum dataset / information that is required and has been agreed nationally

Health board / trust	ABUHB	Site	Nevill Hall Hospital	Ward Name	Ward 4/4	Period Reviewe	from 31 September 2024	to 04 November 2024

Staff Nyrsio Nurse Staffing

Current Roster

35.15 WTE

Headcount per shift			Mon	Tue	Wed	Thu	Fri	Sat	Sun
		Beds	26	26	26	26	26	26	26
	Early (LD) Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	Early (LD) Duration	HCSW	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	Late Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	Late Duration	HCSW	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	Night (LN) Shift	RN	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	Night (LN) Duration	HCSW	2.00	2.00	2.00	2.00	2.00	2.00	2.00

Band 7 1.00 | Band 6 2.00 | Band 5 18.17 | Band 4 0.00 | Band 3 0.00 | Band 2 13.98

Total No. Staff WTE: 35.15

Inclusive of uplift

Proposed Roster (after review)

37.99 WTE

Headcount per shift			Mon	Tue	Wed	Thu	Fri	Sat	Sun
		Beds	26	26	26	26	26	26	26
	Early (LD) Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	Early (LD) Duration	HCSW	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	Late Shift	RN	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	Late Duration	HCSW	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	Night (LN) Shift	RN	2.00	2.00	2.00	2.00	2.00	2.00	2.00
	Night (LN) Duration	HCSW	4.00	4.00	4.00	4.00	4.00	4.00	4.00

Band 7 1.00 | Band 6 2.00 | Band 5 15.32 | Band 4 0.00 | Band 3 0.00 | Band 2 19.58

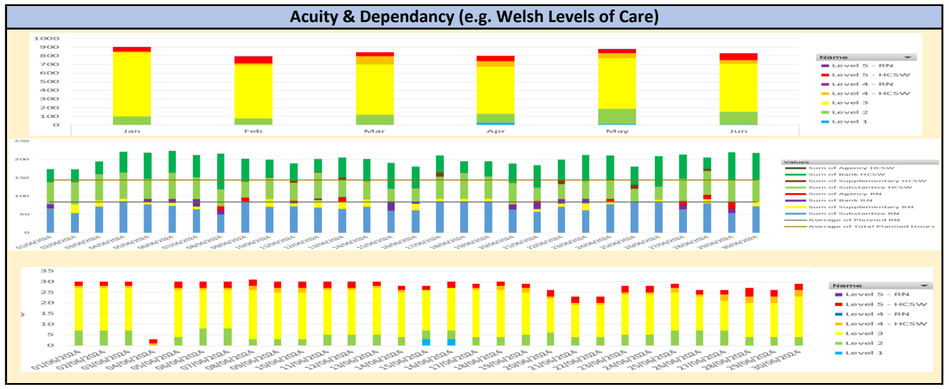
Total No. Staff WTE: 37.99

Inclusive of uplift

Ward Shift Types

12 hour shifts

Acuity & Dependancy (e.g. Welsh Levels of Care)



Professional Judgement

A deep dive was undertaken of 4/4 which is a 26 bedded ward, ability to surge up to 30 beds which are in constant use. Previously higher RN ratio due to NIV step up pathway. Present during the meeting was the Ward Manager, Head of Nursing, Senior Nurse a member of Finance and E-Rostering team and Senior Nurse for professional practice. Professional discussions were undertaken using the triangulated approach. T

HAPU's - Nil avoidable

Falls- x1 fracture not staffimg related

Med errors - none relating to nursing.

S&M training for Fire Safety showed 97%, Health & Safety 94%, Violence & Aggression 97% and Manual Handling 60%. Plans have been put in place to increase compliance. PADR is 93%.

Vacancies if changes agreed RN B5 +0.5 WTE Band 2 4.34 WTE

Safe care compliance 81.67%.

Quality Indicators

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatient wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Number of closed incidents/ complaints during current year (1st March - 31st August 2024)	Total number of incidents/ complaints not closed and to be reported on/during the next year	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)	0	0	0	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	0	0	0	0
Medication errors never events	0	0	0	0
Any complaints about nursing care	0	0	0	0

Outcome Summary

Due to the changes in the respiratory pathway, 4.4 will no longer be the respiratory step down ward and will no longer be required to commence NIV therapy on patients prior to step up to GUH, therefore they will no longer require 3 RN by night, plan to convert to 2 RN by night. Follwoing a review of the acuity data and in line with the planned respiratory changes plan to increase from 2 HCSW by night to 4 HCSW by night. Impact of changes RN B5 -2.85 WTE and HCSW B2 + 5.6 WTE. The finacial impact of this change is £90,665, this will support with some reducation in variable pay. The variable pay costings from May to October 2024 for enhanced care was £122, 480.

Person(s) informing the calculation	Ward Sister / Charge Nurse	Helen Golding	Senior Nurse / Matron	Rachel Pritchard	Divisional Nurse / Head of Nursing	Natalie Skyrme / Karen Collins
Authorising person	Designated Person (e.g. Exceutive Director of Nursing)		Date Calculation made by person(s) informing the calculation		Date Presented to Board	
					Date to be reviewed (latest date)	

Nurse Staffing Levels (Wales) Operational Guideance. Refer to Appendix 5: Factors which must be considered during the calculation process

This template states the minimum dataset / information that is required and has been agreed nationally

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 January 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer Head of Corporate Governance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report as Appendix 1.

The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

The Forward Work Programme Plan is designed to assist the Committee in the review of its programme of business. It captures the timing of report submissions, identifies items that have been deferred, and captures new requests for reports. The plan also allows the Committee to monitor and review its business at each meeting.

During the period of November to January the following requests and changes to the Forward Work Plan have been included:

Items deferred on the Forward Work Programme:

- Development of Committee Annual Programme of Business 2025/26 deferred to March's meeting;
- Annual Review of Committee Terms of Reference 2024/25 deferred to March's meeting;
- Annual Review of Committee Effectiveness 2024/25 deferred to March's meeting;
- Committee Annual Report 2024/25 deferred to March's meeting;
- Commissioning Outcomes Report deferred to March's meeting;
- Quality Assurance Framework Annual Review and Evaluation of Progress deferred to March's meeting;
- Medical Devices Annual Report deferred to March's meeting;
- Nutrition and Hydration Committee Update Report deferred to March's meeting.

Additions to the Forward Work Programme:

- Standard operating procedure on Deep Dives to be reported on in January's Meeting.
- Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Macken Ward) to be reported on in January's meeting.
- Mental Health Act Monitoring Report to be reported on in January's meeting.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Patient Quality, Safety and Outcomes Committee Forward Work Plan as provided in **Appendix 1**.

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

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2024-25

Patient, Quality, Safety and Outcomes Committee

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

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

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

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

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	QTR 1		QTR 2	QTR 3		QTR 4
			30th April	4th June	30th July	2nd Sept	12th Nov	20th Jan
Attendance and Apologies	Chair	SI	√	√	√	√	√	√
Declarations of Interest	All members	SI	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN					**√D**	**√D**
Review of Committee Programme of Business 2024/25	Chair	SI	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN					**√D**	**√D**
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN					**√D**	**√D**
Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN						**√D**
Committee Annual Report 2023/24	Chair & DOCG	AN	√					

Committee Annual Report 2024/25	Chair & DOCG	AN						**√D**
Committee Risk Report	DOCG	SI	**√**	**√**	**√**	**√**	**√**	**√**
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	**√**	**√**	**√**	**√**	**√**	**√**
Pharmacy Robot Risk Assessment	DOCG	Action			**√** (incl. in risk report)			
Quality Strategy - Quality Outcome framework	DoN	Quarterly			**√**		**√**	
Quality Annual Report 2023/24	DoN	AN				**√**		
Quality Assurance Framework Annual Review and Evaluation of Progress (Deferred to March)	Clinical Executives	AN						**√D**
Primary Care Quality Report	COO	Bi-AN				**√D**	**√**	
Performance Report on the Pillars of Quality, to include:- • Patient experience and stories • Incident reporting - falls/ pressure ulcers medicines management and mortality • Healthcare Inspectorate Wales Operational Plan • Complaint, concerns and compliments • Health Safety and Security • Infection Prevention and Control • Safeguarding	DoN /MD & DOTHS	Quarterly		**√**	**√**		**√**	**√**

• Clinical Negligence Claims and Coroners Inquests Report
• Quality & Engagement (Wales) Act, Preparedness and Implementation
• Tracking of Improvement Actions Arising from Inspections and Reviews
• Cleaning Standards Annual Report
• Infection Prevention and Control
• MCA & DOLs
• Child and Adolescent Mental Health Quality Outcomes Report, including self-harm and suicide
• Clinical Audit
• Mental health and learning disabilities assurance
• Listening and Learning Framework Outcomes
• Never Event Incidents
• Clinical Effectiveness and Standards Committee Report (January Meeting)
• Closure of incident dates Sbar
• Operational Quality updates on:
  ○ Cancer
  ○ U&EC
  ○ Planned Care								

Pillars of Quality Interim Report	DoN	Bi-Annual	√			√		
Healthcare Inspectorate Wales Annual Report	DoN	AN	√					
Commissioning Assurance Framework, Development, and Implementation	Clinical Executives	AN		**√D**	√			
Commissioning Outcomes Report (deferred to March)	Clinical Executives	Bi-An				**√D**	**√D**	**√D**
Putting Things Right Annual Report 2023/24	DoN	AN				√		
Maternity Services: Organisational Improvement and Action Plan	DoN	Bi-An			√			√
Learning from Death Report	MD	Bi-AN	√				**√D**	√
Listening and Learning Framework	DoN	AN	√					
Listening & Learning Forum Minutes	DoN	SI	√	√	√	√	√	√
IPC and Cleaning Standards	DoN	AN		**√D**	√			
Annual Volunteering Report	DoN	AN		√				
Mortuary Incident Action Plan	DoT&HS	AN		**√D**	√			

Covid-19 Nosocomial Investigations Report	DoN	AN		**√D**	**√ D**	**√**		
Challenges in securing improvements within the Mental Health & Learning Disabilities	DoN	Action				**√**		
Clinical Advisory Committee Minutes	DoN	SI	**√**	**√**	**√**	**√**	**√D**	**√**
Protocol for patients presenting with Sepsis **PQSOC 3007/07**	DoN	Action					**√**	
Report on time closure of patient safety incidents **PQSOC 3007/07**	DoN	Action					**√**	
Serious Incident Learning Report	DoN	AN					**√**	
Medical Devices Annual Report (Deferred to March)	DoT&HS	AN					**√D**	**√D**
Radiation Protection Committee Report	DoT&HS	AN					**√D**	**√**
Falls and Bone Health Management Annual Report • Deep Dive on Falls **PQSOC 3007/07**	DoT&HS	AN		**√D**	**√D**	**√D**	**√**	
Health and Safety Compliance Annual Report	DoT&HS	AN			**√D**	**√D**	**√**	
Human Tissue Act Group Annual Report	DoT&HS	AN				**√**		

Pharmacy and Medicines Management Annual Report	MD	AN			√			√
Safeguarding Annual Report	DoN	AN			√			
GP Engagement and Child Protection Report **PQSOC30/07 3.4**	DoN Action	AN				√		
Update Optimal Antimicrobial Prescribing **PQSOC 3007/14 & PQSOC 0209/2.8**	MD Action	AN					√	
Ward Accreditation Report	DoN	AN					√	
Nurse Staffing Levels (Wales) Act 3-year report	DoN	AN					√	
Nurse Staffing Levels Wales Act Recalculations	DoN	AN				√ **D**	√	
Update on Staff Members wearing cameras while working policy. **PQSOC 0209/2.8**	DoT&HS	Action					√	
Research and Development Annual Report	MD	AN				√		
Hospital Transfusion Committee Annual Report	MD	AN			√			
Organ Donation Annual Report	MD	AN				√		
Annual Report on Clinical Audit Activity 2023 – 2024	MD	AN		√				

Nutrition and Hydration Committee Update Report	DoT&HS	AN					**√D**	**√D**
Review of neurodevelopmental service for U18s	DoN	AN			**√**			
Children's Rights & Participation Forum	DoN	Bi-AN			**√**			**√**
Dementia Care Annual Report	DoN	AN				**√**		
Children and Young Peoples Board Minutes	DoN	SI				**√D**	**√**	**√**
SOP Deep Dives **PQSOC 1211/08**	DoN	Action						**√**
Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Machen Ward) **PQSOC 1211/17**	DoN	Action						**√**
Mental Health Act Monitoring Report	COO	Action						**√**

Lead Officer	

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

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Reporting Committee	**Quality and Patient Safety Committee (QPSC)**
Chaired by	**Ian Green**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**4th November 2024**

Summary of key matters considered by the Committee and any related decisions made

1. PATIENT STORY

Members received a video of a patient and donor's experience whist undergoing a Bone Marrow Transplant. The service is commissioned from Cardiff & Vale University Health Board in the South and The Christie in the North. The video demonstrated the needs for a whole team approach and the support the patients receive during and after the transplant. As well as outlining the process the Lead clinician spoke about the need to increase the bank of donors. A member of the Joint Commissioning Committee (JCC) Quality Team attended a celebration event when the donor visited Wales to be reunited with the recipient one year after his transplant.

2. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the Welsh Kidney Network (WKN) and a summary of risk register was provided. Concerns were raised regarding the importance of early intervention and the role of public health going forward. The Committee were reassured that the appointment of a Public Health Advisor was progressing within the JCC and an update would be provided at the next meeting.

3. COMMISSIONING TEAM AND NETWORK UPDATES

Reports from individual Commissioning Teams were received and taken by exception. Members noted the information presented and a summary of the services in escalation as attached. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

4.1 Cancer & Blood
Plastic Surgery

It was noted that the JCC had agreed additional funding that will achieve the Key Performance Indicators (KPI) for identified higher priority patients (including

paediatric patients and patients waiting for Deep Inferior Epigastric Perforator (DIEP) reconstruction after cancer surgery) awaiting plastic surgery. The trajectory is currently being finalised however, the committee requested that in the meantime any direct harm to paediatric patients needed to be considered and escalated appropriately.

Neuroendocrine Tumours
Cardiff & Vale University Health Board received confirmation from the European auditors on the 3rd October that following submission of their annual return data they have maintained the European Neuroendocrine Tumour Society (ENETS) certificate for another year. This maintains accreditation status as a European Centre of Excellence.

4.2 Cardiac
Obesity Surgery Waiting Times
It was reported that there had been no improvement in the waiting list positon for Salford which was resulting in an inequity of service provision between the North and South Wales obesity services. As a result the JCC Senior Leadership Team endorsed a proposal submitted by the Commissioning Team for a portion of the resource allocated to SBUHB to be used to support the recruitment of an additional dietician. This will enable the Welsh Institute of Metabolic and Obesity Surgery (WIMOS) to undertake a number of additional procedures for BCHUB and North Powys patients. The Committee asked if the NHS England service needed to be placed into escalation as a direct result and it was agreed that the Commissioning Team would now consider this as a matter of urgency.

Cardiac Surgery
Cardiff and Vale Cardiac Surgery Service was de-escalated from Level 2 to Level 1 of the Escalation Framework in May 2024. The JCC team have been informed that the Health Board are undertaking an internal review of cardiac services following a number of incidents. The team will request the Terms of Reference and ensure that the JCC are fully sighted on the timescales of the review and its findings.

4.3 Neurosciences and Long-Term Conditions
Deep Brain Stimulation
It was noted that significant progress had been made with North Bristol to secure the pathway for South Wales patients and will monitored over the coming months.

4.3 Women & Children
Children's Hospital For Wales
A reset meeting took place on the 18th September to consider the services in escalation and undertake a collaborative approach to agreeing the way forward. Further work was required to agree the data set for monitoring and the next

escalation meeting is scheduled for 25th November. A detailed update with actions is provided in the escalation table.

Wales Fertility Institute
Members noted the significant work that had been undertaken to improve the service. The risk score has been reduced from 15 to 8, following receipt of 3 months comprehensive dataset received from the provider. The Commissioning Team reviewed the evidence and the level of escalation has been reduced from three to one as a result. Quarterly meetings will continue to be held and data submissions will be required in order to ensure the service remains at an appropriate level of service provision with reduced risks. A Letter has been sent to provider to inform them of the decision to reduce the level of escalation.

Infection Prevention & Control Issues
The committee were given an update on the two Methicillin-resistant Staphylococcus aureus (MRSA) outbreaks in the neonatal units in SBUHB and CVUHB. The JCC Quality team we part of the outbreak meetings and will continue to provide support into the units. Welsh Government are aware of the position. Further work will need to be undertaken to fully understand if the units are outliers and what actions are required to prevent further outbreaks and transmission.

4.4 Mental Health
High Secure Services
The service at Rampton High Secure Unit remains in enhanced monitoring via NHS England & the Care Quality Commissioning (CQC) due to significant staffing issues. There are beds available but all admissions are managed via this process. There is one Welsh patient awaiting admission. The Commissioning Team continue to have oversight of commissioning of high secure services via the National Oversight Group (NOG) which include fortnightly SITREP's, site visits and Bi Monthly Strategic Executive Information System (StEIS) meetings.

4.5 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio.

5.0 OTHER REPORTS RECEIVED

Members received reports on the following.

5.1 Services in Escalation Summary
Members noted that there were a number of examples given where services had been in escalation for a considerable length of time and in some instances this was due to a lack of data being submitted in a timely fashion by the provider.

The committee requested that any delays were escalated to the JCC Senior Leadership team and the provider Health Bards made aware at Executive Level.

A copy of each of the services in escalation is attached to the report at **Appendix 1.**

5.2 Quality and Safety Report - Ambulance and 111

A report providing an update on quality and safety matters for the Ambulance and 111 commissioned services was received. The committee received a copy of the Quality Dashboard which has been produced in line with the requirements of the Duty of Candour and the Duty of Quality and reports around the Six Quality Domains.

Regulation 28

The committee was informed that it had recently received a regulation 28 order as a result of a delay of an ambulance getting to a patient. This would need to be considered in a system wide approach and joint working with the NHS Executive and WAST was required. A further update would be provided at a future meeting.

5.3 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to JCC and the actions taken for assurance. This excluded both Mental Health and Ambulance as they were included within their separate reports. Work is planned to align the processes going forward.

5.4 Joint Commissioning Committee Risk Register

The risk register for the JCC was presented to the committee, which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former EASC, NCCU and WHSSC predecessor organisation risk registers. This Risk Register was approved by the JCC in September 2024, and considered by the CTM Hosted Bodies Audit and Risk Committee (ARC) in August October. Members noted the significant amount of work done to bring this together, mindful there was still a lot of work to be done with scores and assessing risks to ensure consistency across the range of NWJCC services.

A summary of the risks related to the Ambulance and 111 service was presented to the Committee and a paper was due to be received by the JCC next week.

5.5 Policy Group Report

Members received an update on activity and output from the JCC Policy Group during the period 01 July 2024 – 30 September 2024 together with an updated overview of all JCC policies and service specifications including those published during the current financial year. The Committee acknowledged the significant work that had been undertaken.

6. ANY OTHER BUSINESS

QUALITY SAFETY AND OUTCOMES SUB COMMITTEE (QSOSC) Terms of Reference & Operating Arrangements (Schedule 3.1 of the Standing Orders)

A discussion took place regarding the Terms of Reference for the new Quality Safety and Outcomes Committee and the changes to the membership following the appointment of Independent Members for the JCC. The Chair assured the Committee that the JCC would continue to work with the Health Board Board Secretaries to ensure that a Chairs Report would still be made available to the Health Boards QPS for assurance purposes. As the meetings would be held in public the papers would be readily available and anyone could attend as an observer.

It was noted that the Director of Nursing wrote the Health Board QPSC members on the 25th October outlining progress and changes in establishing the new Joint Commissioning Committee (JCC) Quality, Safety and Outcomes (QSOSC) sub-committee and thanked them for their significant contribution and commitment to the Committee. The Chair also took the opportunity to thank them personally at the meeting.

Key risks and issues/matters of concern and any mitigating actions

- Confirmation of appointment of Public Health expertise into the JCC
- Assurance on any harm resulting in delays in plastic service for paediatrics to be confirmed
- Note position of obesity pathway and consider if the service for North Wales patients' needs to go into the escalation process.
- Escalation objectives to be agreed for services in escalation in Childrens Hospital for Wales
- Risks relating to ambulance services will be considered by the JCC next week
- Continue to input into the MRSA outbreaks within the neonatal units and provide an update to the next meeting

Summary of services in Escalation

- Attached (**Appendix 1**)
- Escalation to SLT if delay in data information received into JCC

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	TBC

Executive Director Lead: Carole Bell
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

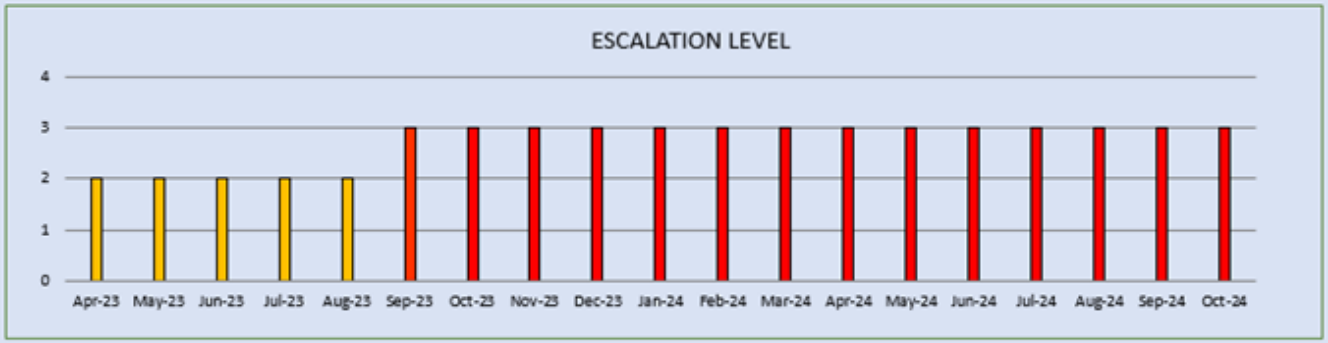
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ OCT 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	2
September 2023 – Increased level from 2 to 3	3

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of JCC through various routes including HiW and the daily SITREP.

JCC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	-	17th July 2024
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024

Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. JCC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC. The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. Actions/Objectives agreed on the 18th September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25th November to monitor progress.	Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	25th November 2024
Issues/Risks:				

Executive Director Lead: Carole Bell
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

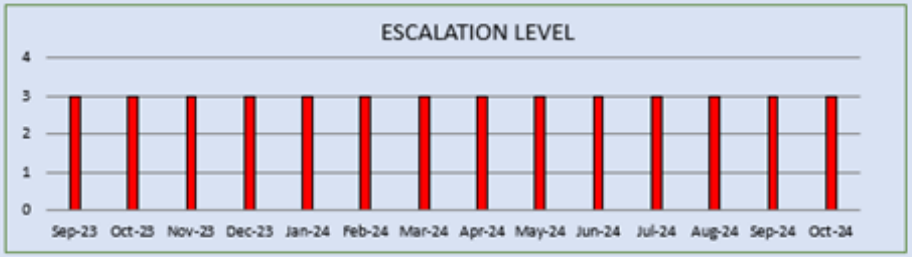
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ OCT 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Ratio Plot Area **Escalation Status :**

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

NWJCC assurance and confidence level in developments:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC.

The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	25th November 2024

objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. Actions/Objectives agreed on the 18th September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25th November to monitor progress. Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live – Phase 1 implementation paper to be taken to management group on 28th November to recommend a way forward to progress with the implementation of the new baseline.	
Issues/Risks: March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered. May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.	

JCC assurance and confidence level in developments:	14th March 2024

Executive Director Lead: Iolo Doull
Commissioning Lead:

Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24, 13/06/24, 18/07/24, 08/08/24, 12/09/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

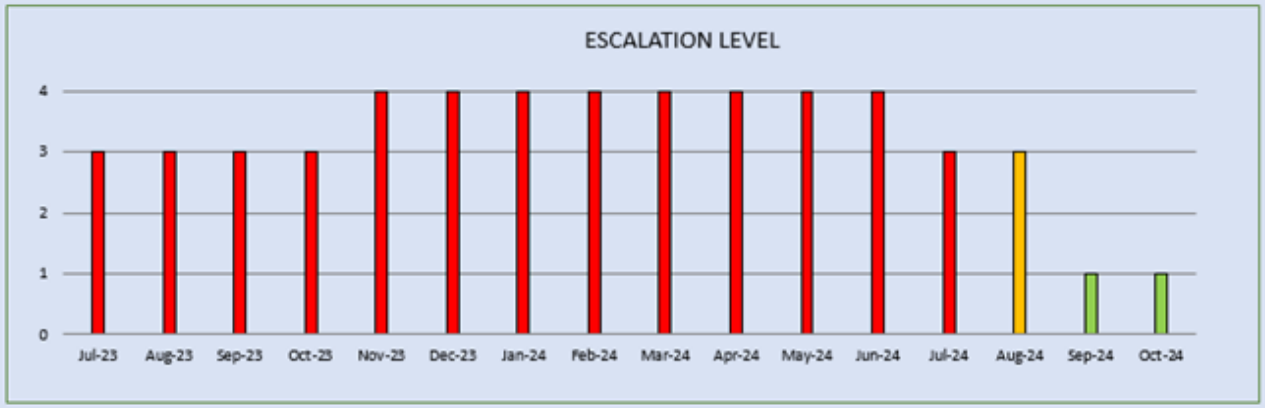
Service in Escalation: Wales Fertility Institute

Current Escalation Level 1

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ SEPT 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – JCC escalation	3
November 2023 – JCC escalation	4
July 2024 – JCC escalation	3
September 2024 - JCC escalation	1

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the JCC contract monitoring data submission; adherence to JCC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, JCC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Actions:

Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024	Assistant Specialised Planner	Monthly	13 June 2024