Quality and Patient Safety Committee

Tue 13 April 2021, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:40
10 min

1. Preliminary Matters

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Draft Minutes of the Committee held on 11th February 2021

Attachment *Chair*

1.4 Minutes QPSC 1102202.pdf (13 pages)

1.4.1. Action Sheet of the Committee held on 11th February 2021

Attachment *Chair*

1.4.2 Action Sheet QPSC 11022021.pdf (2 pages)

09:40 - 09:55
15 min

2. Governance

2.1. 09:40 - 09:55 Annual Review of Committee Terms of Reference

Attachment *Chair*

2.1 Review of Committee ToR.pdf (3 pages)

2.1.1. Quality and Patient Safety Committee Terms of Reference

2.1.1 T of R draft - QPS Committee.pdf (13 pages)

09:55 - 10:30
35 min

3. Presentations/Reports for Assurance

3.1. 09:55 - 10:05 Update on actions following a Serious Incident in Mental Health Services

Verbal *Rhiannon Jones*

3.1 Talygarn SI.pdf (5 pages)

3.2. 10:05 - 10.15 The Brithdir Inquests - outcome of the Coroner's Inquest

Verbal *Rhiannon Jones*

3.2 Brithdir Inquests.pdf (5 pages)

3.3. 10:15 - 10:30 Update on Prevention and Management of Injurious Patient Falls

Attachment *Peter Carr*

3.3 Report on Injurous Inpatient Falls.pdf (9 pages)

3.3.1. Inpatient Falls Action Plan

Attachment

3.3.1 Inpatient Falls Action Plan April 2021.pdf (8 pages)

10:30 - 11:30
60 min

4. For Consideration

4.1. 10:30 - 10:50 Safety Dashboard

Attachment *Clinical Executives*

4.1 Quality and Patient Safety dashboard.pdf (6 pages)

4.2. 10:50 - 11:10 Quality and Safety Performance Report

Attachment *Clinical Executives*

4.2 Quality and Patient Safety Perfromance Report.pdf (33 pages)

4.3. 11:10 - 11:20 Annual Programme of Committee Business - A Proposed Approach

Attachment *Rhiannon Jones*

4.3 Annual Programme of Committee Business_Proposed Approach .pdf (3 pages)

4.4. 11:20 - 11:30 Quality and Safety Risks

Verbal *Richard Howells*

11:30 - 11:50
20 min

5. Items for Quality Assurance

5.1. 11:30 - 11:40 CHC/ABUHB Patient Experience Buddying Pilot

Attachment *Rhiannon Jones*

5.1 Facetime Buddying Project Cover Report.pdf (4 pages)

5.1.1. Buddying Project Inpatient Engagement

Attachment

5.1.1 Aneurin Bevan CHC - Facetime “Buddying” Project - Inpatient Engagement d....pdf (39 pages)

5.1.2. Buddying Action Plan

Attachment

5.1.2 DRAFT CHC Buddying Action Plan.pdf (7 pages)

5.2. 11:40 - 11:50 New Dementia Standards and Revised ABUHB Plan

Attachment *Rhiannon Jones*

5.2 Refreshed Dementia Action Plan.pdf (5 pages)

11:50 - 12:15
25 min

6. For Information

6.1. 11:50 - 12:00 Highlight Reports - Quality and patient Safety Operational Group

Attachment *Peter Carr*

6.1 QPSOG report from 23 03 21.pdf (2 pages)

6.2. 12:00 - 12:15 Putting Things Right Annual Report

Attachment *Rhiannon Jones*

6.2 PTR Annual Report 2019-20.pdf (30 pages)

6.3. 12:10 - 12:15 Items for Board Consideration

To agree items for Board consideration and decision

12:15 - 12:15
0 min

7. Date of Next meeting

Tuesday 15th June at 09:30
Microsoft Teams

Aneurin Bevan University Health Board

Quality and Patient Safety Committee

Minutes of the Meeting of the Quality and Patient Safety Committee held on Thursday, 11th February 2021, via Microsoft Teams

Present:

Emrys Elias	-	Chair, Vice Chair
Pippa Britton	-	Independent Member
Louise Wright	-	Independent Member

In attendance:

Sarah Aitken	-	Director Public Health & Strategic Partnerships (left 2.30 pm)
Sue Bale	-	Research & Development Director
Shelley Bosson	-	Observer, Independent Member
James Calvert	-	Medical Director
Paul Deneen	-	Observer, Independent Member
Katija Dew	-	Observer, Independent Member
Richard Howells	-	Interim Board Secretary
Rhiannon Jones	-	Director of Nursing
Chris Koehli	-	Observer, Independent Member
Ann Lloyd	-	Observer, Chair (left at 3.30 pm)
Jemma McHale	-	Community Health Council
Danielle O'Leary	-	Head of Corporate Services, Risk and Assurance
James Quance	-	Observer, Head of Internal Audit
Judith Paget	-	Chief Executive (left at 2.00 pm)
Tracey Partridge-Wilson	-	Observer, Assistant Director, Nursing
Alexandra Scott	-	Observer, Assistant Director, Quality & Patient Safety
Gabrielle Smith	-	Observer, Wales Audit Office
Suzanne Webb	-	Committee Secretariat

Guests:

Cynthia Henderson	-	Head of Health Records
Jonathan Sims	-	Clinical Director of Pharmacy

Apologies:

Peter Carr	-	Director of Therapies and Health Sciences
Helen Sweetland	-	Observer, Independent Member
David Thomas	-	Assistant Director, ABCi

QPSC 1102/01 Welcome and Introductions

The Chair welcomed everyone to the meeting.

The Committee was happy for the meeting to be recorded via Microsoft Teams.

The Committee did not receive any written questions prior to the meeting.

QPSC 1102/02 Apologies for Absence

The apologies for absence were noted.

QPSC 1102/03 Declarations of Interest

There were no declarations made of potential conflicts of interest by those attending the meeting.

QPSC 1102/04 Draft Minutes of the Meeting held on 13th January 2020

The draft minutes of the meeting held on 13th January 2021 were considered by the Committee and agreed as an accurate record.

QPSC 1102/05 Action Sheet

No actions reported.

QPSC 1102/06 COVID-19 Update (pertinent issues/challenges /progress)

Supported by a presentation, the Medical Director provided an update on the current COVID-19 pertinent issues, challenges and progress undertaken, nationally and by the Health Board.

Key points included:

- Within the Health Board area Monmouthshire currently had the lowest case rate of 68 per 100,000 cases with Torfaen the highest prevalence of 146 case per 100,000.
- The Kent variant was 70% more infectious than the original COVID-19 strain and was currently presenting in 82% of cases.
- A decrease in community cases had resulted in 30 cases per day being recorded at Emergency Departments which equated to a 25% reduction.
- A reduction in staff sickness was noted from 11% to 9% although this was higher in critical care areas at 14%.

- Over 121,000 people had now been vaccinated and protocols were in place to administer any spare doses.

In response to questions raised the Committee received assurance on a number of concerns:

- Lessons had been learned from the first and second pandemic waves. Development work was being undertaken to ensure that a sustainable and dynamic approach to workforce would be applied in future.

- Different delivery models to triage patients including the use of digital ways of working.

- The well-being of staff was a key priority for the Health Board including:
  - All Wales national guidance had been implemented to enable staff to carry over annual leave over the next two years.
  - The Health Board's lead psychologist was working closely with Divisions across the Health Board.
  - Funding had been approved to develop a centre of well-being excellence at the Grange University Hospital site.
  - A national review of military support was underway, the results of which were awaited and will be shared.

The committee thanked the Medical Director for the update.

QPSC 1102/07 Quality and Safety Performance and Outcomes Report

The Medical Director presented a detailed overview of the Quality and Safety Performance report. The Committee received the report and noted:

- Medication Management – the Health Board participated in the All Wales Medicines Safety Thermometer Audit in September 2020.

  It was confirmed that the medication of all patients was scrutinised upon admission to hospital.

As part of the programme monthly audits were undertaken on each ward and included:
- Venous Thromboembolism (VTE) risk assessment
- Prescribing of thromboprophylaxis
- Recording of allergies
- Reconciliation of medication
- Omitted doses and critical time omitted doses

It was noted that feedback from the audits informed the agenda of the relevant working groups and any targeted deep dives required.

- Mortality – The Committee was advised that the clinical notes of each patient who deceased under the Health Board's care is subject to level 1 and a proportion level 2 scrutiny, as part of national learning guidance. This process will be operationalised as part of the Medical Examiner's system roll-out. In November 2020 the South East Wales Medical Examiner service commenced, initially undertaking level 1 mortality reviews in Ysbyty Ystrad Fawr.
- Hospital Acquired Thrombosis - All hospital associated thrombosis (HAT) were subject to a process of reviews facilitated by the Haematology Department and undertaken by the lead consultant for each patient. During COVID an increase had been reported.
- Sepsis Compliance – Since the opening of the GUH and the single siting of the Emergency Department there had been a marked decrease in the number of sepsis proforma completed. It was reported digital solutions will strengthen compliance with Sepsis 6 flagging tools.
- The national audit of Breast Concern in Older People was discussed. It was reported as good, however, further improvements including a 'one stop shop' to enable patients to have their mammograms and clinical management plan would be developed.
- National Audit of Lung Cancer – based on 2018 data indicated good performance in diagnosis and treatment outcomes.
- National Audit of Chronic Obstructive Airways Disease (COPD) is part of the respiratory quality improvement programme. Variation in relation to participation in the audit across the Health Board had been reported.

- National Audit of Care at the End of Life (NACEL) – compliance was variable across the Health Board and this has been exaggerated during COVID restrictions. Strengthening communication processes needed to be developed with patients and their families.
- Intensive Care National Audit and Research Centre (ICNARC). Health Board practices differed from the previous norms due to high numbers of COVID patients who presented at RGH and NHH.
- National Vascular Registry – The Health Board met the target in 56% of cases.
- Elective Care – systems were in place to triage patients to improve waiting lists and reduce harm.
- Diagnostic access – reduced diagnostic activity during the pandemic had resulted in a significant increase in waiting times. Supported by an innovative pathway, Endoscopy activity had increased.
- A key priority was to improve Unscheduled Care access – Four hour wait and ambulance handovers performance. The Health Board had undertaken a case based approach reviewing individual patient long waits; flow through COVID wards; and times decisions were made. The position had improved following interventions.

The Committee requested assurance that the notable increase in the number of reported grade 1 and grade 2 hospital pressure ulcers and patient falls indicated in the 'patient journey' dashboard were being addressed.

The Medical Director explained a great deal of work had been undertaken to reduce pressure ulcers and the number of falls. The Director of Nursing highlighted the impact of operating in a pandemic with increased staff challenges including the need to use agency staff, managing the acuity of patients, insufficient bed capacity and increased surge plans. It was emphasised that staff had provided optimal care in the environment in which they were currently operating.

It was noted that with COVID pressure slowly reducing patient outcomes and experience should improve.

The Director of Nursing also brought the infection control indicators to the Committee's attention outlining the performance outcomes demonstrated levels of good

cleaning standards and antibiotic care.

The Committee noted the positive progress undertaken in Children and Mental Health Services (CAMHS) with 97.1% of patients waiting less than 28 days for their first appointment.

The Director of Nursing highlighted the 5 Never Events with no common theme and provided assurance that action and learning plans had been developed and were being implemented.

The Chair acknowledged the significant development and improvement in the quality of the overview report.

The Chair also acknowledged the challenging circumstances clinicians and practitioners were currently experiencing, whilst continuing to deliver the safest patient care possible.

The Committee thanked the Medical Director and Director of Nursing for their helpful overview. The Director of Nursing acknowledged the contribution of the teams in developing the report, whilst recognising this continues to be work in progress.

QPSC 1102/08 QPS Risk Register

The Interim Board Secretary provided an overview and summary of the risks reflecting the challenges of the COVID pandemic. The following key risks were outlined:

Two risks had an extreme severity score of 20 – 25 (red zone):
CRR011 – poor patient experience
CRR013 – nosocomial transmissions

Two risks remained at a high severity score of 15 (amber zone):
CRR010 – falls
CRR022 – governance in relation to the COVID response

The Committee noted that CRR010 falls had now reached its target risk score.

It was noted a workshop with the Executive Team to review the COVID Risk Register and Corporate Risk Register was planned for 18 February 2021.

The Interim Board Secretary indicated that there will be a review of the risk framework working closely with Divisions and the Planning department aligning objectives and threat identification. Metrics would be developed and provide assurance that targets were being met.

The Committee noted the proposals to the revised Risk Management approach and welcomed an update in due course.

QPSC 1102/09 Plan going forward for QPSC

The Chair provided a short message.

The Chair noted the work currently in development to further enhance internal quality systems with a focus on lessons learned; assessing quality and implementing measures on new service models of care.

The Chair informed the Committee that the national meeting of QPSC Chairs recommended quality indicators to be reported differently.

The Committee noted the work that had already been undertaken to implement this recommendation as evidenced by the reports received at the meeting.

QPSC 1102/10 Patient Experience Report

The Director of Nursing provided a synopsis of the patient experiences during the last quarter and the actions undertaken to address concerns raised.

Key responses included:

- Feedback suggested that patient experience had been negatively impacted by restricted visiting (family and volunteers) during the pandemic.

- Some relatives complained that they were unable to get through to wards via the telephone.

In response to the complaints the Health Board introduced an interim solution whereby Telephony Officers started in mid-January 2021 working 7 days a

week from 8.00 am till 8.00 pm. Relatives were encouraged to dial the ward but if there was no response then they could dial a dedicated line and the Telephony Officers will act as a go between to provide feedback. This service had been well received by families and relatives and positive feedback had been noted, together with a reduction in complaints on this subject.

In response to the enquiry to expand the service the Director of Nursing confirmed the appointment of ward assistants may be able to support this function going forward. A review of the telephony support was being undertaken.

It was noted that patients in all hospitals are able to use mobile phones, if desirable and posters highlighting how to use the Cloud were in place. The 'Messages from Home' service was still supporting families.

- It was noted that volunteering, locally and nationally, has recommenced following appropriate risk assessments. The support of the Red Cross had been reinstated in ED and a call for additional volunteers made.

  A family liaison pilot supported by the Chaplains Team had been positively received and continued to be rolled out.

- To improve the process of capturing patient experiences the Health Board was exploring the functionality within the existing Once for Wales Concerns Management System to enable patient surveys. A working group had been set-up and a bid was being developed.

- It was noted the Health Board had engaged with the CHC on a buddying pilot to enable the CHC to extrapolate views from patients on their experiences using Facetime. 101 patients had been contacted. The CHC is undertaking a similar approach to the buddying pilot with the Complex Care Team. It was agreed that the results of the Buddying Pilot would be presented to the next meeting.
  Action: Director of Nursing.

It was noted the CHC's national report 'Feeling Forgotten: Hearing from people waiting for NHS care and treatment during the Coronavirus pandemic' had highlighted the experiences of both the public and patients during the first and second waves of the pandemic. The report identified the actions that NHS Bodies and Welsh Government had to undertake when responding to the 'worries' people experience. A report had been prepared for Executive Team and a response provided for the CHC. This will be shared with the Committee members.
Action: Director of Nursing

The Health Board has recently purchased digital reminiscence therapy units to support patients with Dementia. 87 units, funded from the Charitable Funds had been purchased and distributed across the Health Board

The Health Board acknowledged the support of the CHC.

The Chair thanked the Director of Nursing and CHC colleagues for their work to ensure reporting of patient experience.

QPSC 1102/11 Pharmacy and Medicines Management Annual Report

The Clinical Director for Pharmacy provided an overview of the 2019 report developed in response to Audit Wales recommendations. A letter from the Deputy Chief Medical Officer to Health Board Chief Executives received in January 2020 supported the recommendations.

The following recommendations were highlighted:

- Storage of bulk fluids at RGH was identified as an issue with close proximity to public areas and issues around temperature monitoring.
  Status - Plan to relocate the bulk store in the refurbishment of the Pharmacy Unit along with the new robot in the next financial year.
- Preparation of high risk injectable medicines.
  Status - Audit undertaken and areas addressed.

- Non-medical prescribing register.
  Status - Single register for all professions completed.

The following areas of work were deferred due to staff supporting the COVID pandemic:

- Patient safety notice issued in October 2020 identified the need to have increased governance structures in place to provide high tech medicines at home.
- Develop a process for providing home care records at GP surgeries.
- Develop a mechanism to report performance indicators and identify how compare within Boroughs and wider benchmarking with England.

The Chair thanked the Clinical Director of Pharmacy and the team for the work undertaken and look forward to receiving how future actions are progressing.

QPSC 1102/12 HIW Phase One National Review of Maternity Services

The Director of Nursing provided an overview of the progress and actions undertaken following the national review of maternity services.

The Committee noted that Healthcare Inspectorate Wales (HIW) conducted a phase 1 review, providing a national view of maternity services triggered by issues associated with Cwm Taf University Health Board and the follow-up report by the Royal College of Obstetricians and Royal College of Midwifery identifying serious failings in care.

During November 2020 the Health Board received a composite national report. The report identified 32 Health Board and 5 Welsh Government recommendations. The Committee noted 20 recommendations had been addressed following the HIW inspections undertaken in 2019/2020 and good progress made in the remaining 12 recommendations. Rapid work had been undertaken in relation to the recommendation on female genital mutilation.

The Health Board's response, approved by the Executive Team, will be sent to HIW w/c 15 February 2021.

The Committee received assurance that each of the

recommendations was supported by a file of evidence to demonstrate the work undertaken.

The Director of Nursing acknowledged the hard work of colleagues in addressing the recommendations.

QPSC 1102/13 Clinical Audit Update

The Medical Director provided an overview of the 35 national clinical audit set and highlighted key actions.

- Each Division to have a named medical lead for quality and patient safety.
- A standardised operating procedure and agreed job description for each directorate was being developed to ensure a consistent approach.
- A structured approach was needed to triangulate with other sources of information, for example complaints.
- A review of ICT solutions to present an annual review supported by a quality improvement plan for each of the Divisions.

The Chair thanked the Medical Director for the overview.

QPSC 1102/14 The Safeguarding Committee

The Director of Nursing provided an overview of the recent Safeguarding Committee meeting, highlighting salient points:

- The Terms of Reference, training compliance and committee representation had been reviewed.
- The programme of work included the development of a robust approach to the safeguarding risk register, and a focus on domestic abuse.
- A Board development session regarding Safeguarding is proposed.

The Chair thanked the Director of Nursing for the update.

QPSC 1102/15 Quality and Patient Safety Operational Group

A Highlight report was not provided.

The Chair requested an update on activities to be presented at the next meeting.
Action: Director of Therapies and Health Sciences

The Chair requested a plan outlining the business cycle is provided at the next meeting.
Action: Clinical Executives & Board Secretary

A risk related to ligature issues in paediatrics at the Grange University Hospital was noted and the Director of Nursing agreed to source an update and inform the Chair.
Action: Director of Nursing

QPSC 1102/16 Public Service Ombudsman Wales Annual Letter

The Director of Nursing provided assurance regarding the actions being undertaken to improve complaint handling:

- Training events undertaken to ensure complaints are handled correctly minimising referrals to the Public Service Ombudsman Wales office.
- Gaps in staffing addressed with the aim of improving turnaround and compliance rates.

The Chair thanked the Director of Nursing for the update.

QPSC 1102/17 Data Protection Act Subject Access Requests Update

The Interim Board Secretary and Head of Health Records provided an update on Subject Access Reports.

As part of statutory legislation the Health Board was obliged to report Subject Access Reports. The Interim Board Secretary suggested the fora should be the Quality Patient Safety Committee, considering alignment to patient care with a report presented to the Audit Committee.

The Chair suggested a separate discussion outside of the meeting.
Action: Chair/Interim Board Secretary

The Head of Health Records provided a brief overview of current activities including:

- Total of 1555 received with compliance 94% with no significant concerns.
- Delays recorded in primary and community care areas.

The Chair thanked the Interim Board Secretary and Head of Health Records for the update.

QPSC 1102/18 Items for Board Consideration

No specific items discussed.

QPSC 1102/19 Any Other Business

There was no other business to report.

QPSC 1102/20 Date of the Next Meeting

It was confirmed that the next meeting of the Committee would be held on Tuesday, 13 April 2021 via Microsoft Teams.

Quality & Patient Safety Committee
Thursday 11th February 2021

Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Quality & Patient Safety Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Quality & Patient Safety Committee these actions will be taken off the rolling action sheet.)

Agreed Actions:

Minute Reference	Agreed Action	Lead	Progress/ Completed
QPSC 1102/10	**Patient Experience Report** Results of the Buddying Pilot to be presented to the next meeting.	**Director of Nursing**	For QPSC agenda. It has been presented to Executive Team.
	The Health Board has reviewed the CHC national report 'Feeling Forgotten: Hearing from people waiting for NHS care and treatment during the Coronavirus pandemic'. A paper has been presented to Executive Team and a response will be provided to the CHC. This will be shared with the Committee Chair.	**Director of Nursing**	
QPSC 1102/15	**Quality and Patient Safety Operational Group** An update on the work of the QPSOG to be presented to the next meeting.	**Director of Therapies and Health Sciences**	On the Agenda.
	Present a draft plan at the next meeting on the QPSC business cycle.	**Clinical Executives & Interim Board Secretary**	On the Agenda.

Minute Reference	Agreed Action	Lead	Progress/ Completed
	Progress on ligature risks in paediatric wards to be circulated to the Chair of the Committee.	**Director of Nursing**	Update provided to the Chair.
QPSC 1102/17	**Data Protection Act Subject Access Requests Update** Discuss the appropriate fora for Subject Access Requests.	**Chair/Interim Board Secretary**	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Tuesday 13th April 2021 Agenda Item: 2.1

Aneurin Bevan University Health Board

Review of Terms of Reference for Health Board's Committees

Purpose of the Report

This paper seeks the approval of the Committee for the reviewed and revised terms of reference for the Quality, Patient Safety and Performance Committee.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Richard Howells, Interim Board Secretary

Report Author: Bryony Codd, Head of Corporate Governance

Report Received consideration and supported by :

Executive Team		**Committee of the Board Quality and Patient Safety Committee**	Members of the Committee

Date of the Report: 13th April 2021

Supplementary Papers Attached: Terms of Reference

Executive Summary

The Board, at its meeting in December 2020, approved a revised Committee Structure as part of 'Resetting Governance' which promoted a leaner structure whilst maintaining effective scrutiny and assurance around the Health Boards strategic decision making, financial accountability and patient outcomes.

It was agreed that the changes would take effect from 1st April 2021, when the current adjusted governance structures end.

As a result of this revised Structure, and in line with the good governance principles, the Terms of Reference for each Committee have been reviewed and were presented to the Board for approval on 24th March 2021.

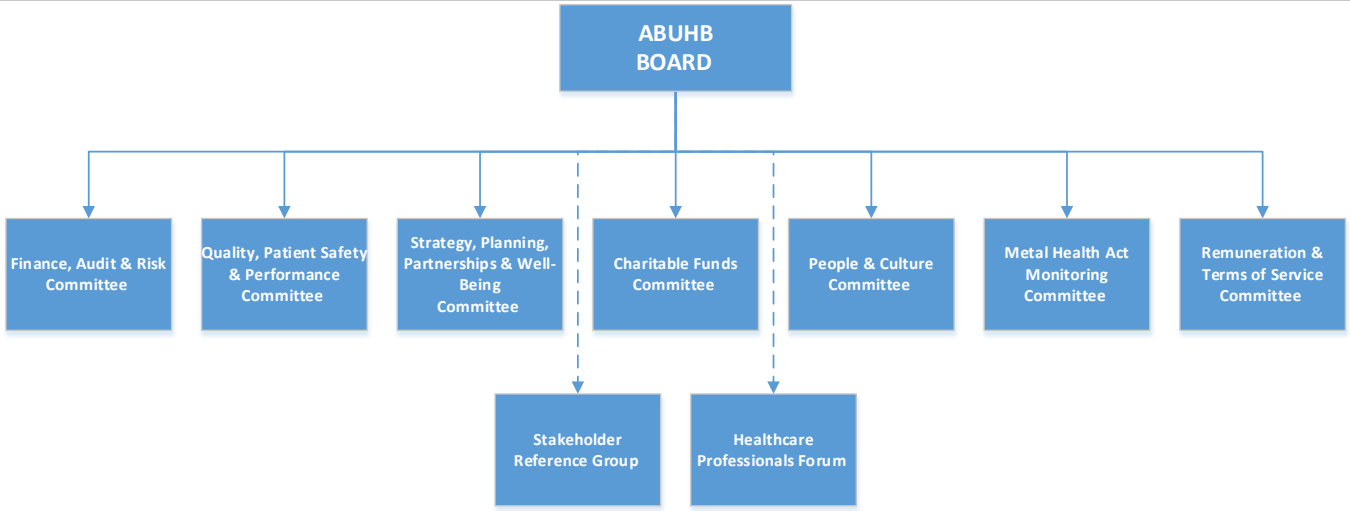
Membership of Health Board Committees for 2021/22 will be provided at a later date.

Background and Context

1. Review of Terms of Reference

The Board, at its meeting in December 2020, approved a revised Committee Structure which promoted a leaner structure whilst maintaining effective scrutiny and assurance around the Health Boards strategic decision making, financial accountability and patient outcomes.

It was agreed that the changes would take effect from 1st April 2021.



As a result of this revised Structure, and in line with the good governance principles, the Terms of Reference for Quality, Patient Safety and Performance Committee have been reviewed by the Board Secretary and were presented to the Board for approval.

The Board provisionally approved the Terms of Reference pending review by the respective Committee.

2. Committee Membership

The Chair is currently undertaking a review of the membership of the revised Committee Structure and is discussing this review with members of the Board. The proposed membership of Health Board Committees for 2021/22 will be provided upon conclusion of this review.

Assessment and Conclusion
In approving this report, the Health Board will comply with the organisation's Standing Orders and good governance principles.
Recommendation
The Committee is asked to approve the revised and updated Terms of Reference.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	In approving terms of reference the Health Board will comply and further support the organisation's Standing Orders and good governance principles.
Financial Assessment, including Value for Money	There are no financial implications for this report.
Quality, Safety and Patient Experience Assessment	There is no direct association to quality, safety and patient experience with this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality or child impact issues associated with this report as this is a required process for the purposes of legal authentication.

Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to Plan associated with this report.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Not applicable to this report
	Integration –Not applicable to this report
	Involvement –Not applicable to this report
	Collaboration – Not applicable to this report
	Prevention – Not applicable to this report
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Quality, Patient Safety and Performance Committee Terms of Reference – 2021/22

Version: Draft

Date: 15/03/2021

Document Title:	Quality, Patient Safety and Performance Committee Terms of Reference – 2021/22
Date of Document:	15/03/2021
Version:	Draft (For approval)
Previous version:	October 2019
Approved by:	
Review date:	March 2022

Contents

1. Introduction

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

In line with standing orders and the Health Board's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Quality, Patient Safety and Performance Committee.

The Committee is formed of Independent Members of the Health Board and has no executive powers, other than those specifically delegated to it by the Board as outlined in these Terms of Reference.

The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out in this document.

2. Purpose of the Committee

The purpose of the Quality, Patient Safety and Performance Committee ("the Committee") is to:

Advise and ***assure*** the Board and Accountable Officer by critically reviewing the Health Board's arrangements and activities to discharge its responsibilities to:

- ensure the safeguarding of staff, patients and citizens on Health Board premises;
- protect vulnerable people

  and
- improve the quality of services provided as part of person centred care.

It will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer (Chief Executive) on where and how its system of governance and assurance may be strengthened and further developed.

3. Delegated Powers and Authority

3.1. Governance & Assurance

The Committee will scrutinise, measure and monitor the quality of clinical safety and care to the citizens using the Health Boards services.

The Committee will seek assurances that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Board's activities in line with the Health Board's system of governance and assurance.

The Committee will ensure that decisions taken are based upon valid, accurate, complete and timely data and information and that there is continuous improvement in the standard of quality and safety across the whole organisation. This will be guided through the use of national and professional standards and in line with regulatory frameworks and that there is an effective clinical audit and quality improvement function in place that meets the standards set for the NHS in Wales and provides appropriate assurance to the Committee that actions are in place and learning has been undertaken.

The Committee will provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance used are reliable.

The Committee will support the development of public disclosure statements that flow from the assurance processes, including the Accountability Report, the Annual Governance Statement and the Annual Quality Statement (in association with other Committees of the Board).

3.2. Authority

The Committee is authorised by the Board to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board and primary care practitioners relevant to the Committee's remit (ensuring patient, service user, client and staff confidentiality, as appropriate). It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee);

and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

The Committee will focus on all aspects of Health Board functions aimed at achieving the highest quality and safety of healthcare, including activities traditionally referred to as 'clinical governance'.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outside representatives with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

As part of its role in advising the Board on the overall quality and safety of services the Committee will seek assurance from other Committees of the Board, as appropriate, about the adequacy of the ways in which that Committee discharges its responsibilities as part of the overall system of governance and assurance.

The Committee may act on any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.3. Sub-Committees

The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

4. Function and Work Programme

4.1. Governance and Assurance

The Committee's work will provide assessment and assurance of the Health Board's:

- ability to achieve its objectives and the provision of high quality, safe healthcare for its citizens;
- compliance with relevant regulatory requirements, standards (including Health and Care Standards), quality and service delivery requirements and other directions and requirements set by the Welsh Government and others;
- effectiveness of its patient experience framework;
- efficiency, effectiveness and economic use of resources and the extent to which the safeguards and protects all assets, including its people (in association with the other relevant Committees)
- application of the care planned or provided across the breadth of the organisation's functions (including corporate/directorate/ division/clinical and those provided by the independent or third sector) are consistent, based on sound evidence, clinically effective

and meet agreed standards;

- development and delivery of the Health Board's corporate strategies e.g. Integrated Medium Term Plan and plans or those of its stakeholders and partners, including those arising from any Joint (sub) Committees of the Board, considers the implications for quality and safety;
- compliance with Standing Orders, (including associated framework documents, as appropriate), Scheme of Delegation and receipt of regular reports with regard to quality and safety;
- planned activity and results of internal audit, external audit (Audit Wales) and clinical audit;
- adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity and to monitor outcomes;
- compliance with the statutory reporting requirements of the Data Protection Act (2018);
- reliability, integrity, safety and security of the information collected and used (in association with the other relevant Committees);
- proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations;

In performing this work the Committee will scrutinise, measure and monitor aspects of quality and safety in order that:

- the Health Board has a person centred approach, putting citizens safety, experience, well-being and safeguarding above all other considerations;
- it can advise the Board on the adoption and continued development of a set of key indicators of quality of care against which the Board's performance will be regularly assessed and reported;
- it can advise the Board on the compliance with regulatory requirements and standards for the NHS in Wales such as, the Health and Care Standards;
- it can monitor compliance and response to audit and regulatory inspection arrangements, including Healthcare Inspectorate Wales (HIW), Audit Wales, Internal Audit and the Community Health Council;
- there is an ethos of continual quality improvement and that there are regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation

- lessons are learned from patient safety incidents, complaints and claims and that these, together with good practice are shared across the organisation and that the impact is measured and shared;
- there are appropriate risk and control related disclosure statements, in particular, the Accountability Report, the Annual Governance Statement and the Annual Quality Statement (devised by the Quality and Patient Safety Committee);
- there is an appropriate Clinical Policies Framework in place for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.
- the underlying assurance processes indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements;

To assist it the Committee will utilise the work of scrutiny and other assurance services including NHS Wales Internal Audit and Audit Wales, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.2. Risk Management

The Committee will seek assurance that there is an effective framework for the identification and management of clinical risks at all levels of the Health Board.

4.3. Effective Assurance

The Committee's programme of work will be designed to provide assurance that:

- There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer.
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees.
- The work carried out by key sources of external assurance, in particular, but not limited to the Health Board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity supports and informs (but does not replace) internal assurance activity.

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

  and that

- The results of audit and assurance work specific to the Health Board, and the implications of the findings of wider audit and assurance activity relevant to the Health Board's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

4.4. Access

The Head of Internal Audit and the Auditor General and his representatives shall have unrestricted and confidential access to the Chair of the Committee at any time, and vice versa.

The Committee will meet with relevant auditors and the nominated representative of Clinical Audit (including Health Inspectorate Wales as appropriate) without the presence of officials on at least one occasion each year.

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant staff (including primary care practitioners), other Committees and Groups deemed appropriate for the Committee's business.

5. Membership

5.1. Members

The Committee shall comprise of five (5) members:

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

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

5.2. Attendees

Other officers of the Health Board will attend:

- Chief Executive (as Accountable Officer)
- Director of Finance and Performance
- Director of Nursing
- Director of Therapies and Health Science
- Medical Director

(Deputies will be allowed by agreement with the Chair)

Others by invitation

The Committee Chair may invite any other Health Board officials and / or any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter. The invites may include Trades Union representation, partner organisations, public and patient involvement organisations and Internal Audit and clinical audit representation.

5.3. Member Appointments

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

Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office.

During their period of appointment a member may resign or be removed by the Board.

6. Support

6.1. Secretariat

Secretariat arrangements will be determined and arranged by the Board Secretary.

6.2. Advice and Member Support

The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role;

  and

- Ensure the provision of a programme of organisational development for committee members as part of the Health Board's overall OD programme developed by the Director of Workforce and Organisational Development.

7. Committee Meetings

7.1. Quorum

At least two of the selected members must be present to ensure the quorum of the Committee, one of whom must be the Committee Chair or Vice Chair.

7.2. Frequency of Meetings

Meetings will be held bi-monthly and otherwise as the Chair of the Committee deems necessary – consistent with the Health Boards plan of Board business.

7.3. Withdrawal of individuals in attendance

The Chairman may ask any or all of those who normally attend but who are not members of the Committee to withdraw to facilitate open and frank discussion of particular matters (an In Committee meeting).

7.4. Record of the Committee Meeting

A record of the meeting will be presented as notes and action points.

7.5. Public Meetings

The Committee will routinely meet in public**.**

8. Relationship and Accountabilities with the Board and its Committees

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for assuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

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

The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business and
- Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. Reporting and Assurance Arrangements

The Committee Chair shall:

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

The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Accountability Report, the Annual Governance Statement and the Annual Quality Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

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

The Board Secretary, on behalf of the Board, shall oversee a process of annual self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

10. Applicability of Standing Orders to Committee Business

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

- Quorum

11. Review

These terms of reference shall be reviewed annually by the Committee with reference to the Board.

Quality and Safety Committee

Progress and Learning from the Talygarn Serious Incident

Executive Summary

This is a sensitive case and has been subject to media and press coverage. It is subject to Coroner's Inquest (scheduled for November 2021).

It has been thoroughly investigated via ABUHB Red 1 (Executive led) Serious Incident process.

A patient (patient X) had been admitted to Talygarn in December 2018 due to escalating suicidal risks and was detained under Section 3 of the Mental Health Act (MHA). During this admission, patient X had spent time at Ty Skirrid on Section 17 leave from Talygarn. The patient had been taking regular periods of escorted and unescorted leave from both the adult acute mental health ward Talygarn and Ty Skirrid forensic rehabilitation unit.

On the morning of Monday 22/07/19 patient X requested to take 2 hours unescorted leave to have a walk along the canal and purchase an ice cream, prior to a planned ward round. Prior to leaving the ward patient X was advised of the ward round time slot of 14:30hrs. Staff were not concerned about the patient's demeanour.

The patient died in an explosion in a garage at the property of the mothers' partner whilst detained on Section 3 and on Section 17 Leave.

The investigation identified multiple areas of concern and failings in care which were subsequently managed through the PTR Redress process. There has been significant Divisional engagement, learning and action planning to seek to prevent future deaths of this nature, including formal Learning Events. The Health Board has sought to support and include the patients' mother throughout these matters, as the surviving next of kin.

Board Members have previously been appraised of this Serious Incident. This paper is to provide an update on progress and learning, for assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	**X**
Note the Report for Information Only	
Executive Sponsor: Executive Director of Nursing	
Report Author: Garvin Jones - Senior Manager, Legal Services and Tanya Strange – Assistant Director of Nursing, Person Centred Care	
Date of the Report: 24 March 2021	
Supplementary Papers Attached: Nil	

Purpose of the Report
To provide a summary of the case, investigation outcome, current status and progress report for the Committee.

Background and Context

Serious Incident investigation

The police raised a Duty to Report (DTR) following concerns from the family that Patient X had been allowed out of hospital unsupervised. They were not happy with this due to the patients' mental state. No safeguarding concerns were identified, however, a Serious Incident investigation was initiated as per Health Board policy. A formal concern on behalf of the family was raised via their Assembly Member. All parties were notified that this incident would be subject to SI investigation, with the outcomes shared fully and openly with the family.

- The SI investigation was undertaken by an experienced Assistant Director of Nursing, with Executive oversight and Chaired by the Executive Director of Nursing (EDoN).

- The investigation included the review and analysis of exhaustive documentation, medical records, policies and guidelines. Interviews were conducted with 28 members of staff.

- Support has been provided to staff throughout, with initial debriefing sessions held immediately following the incident.

- The family has received a dedicated point of contact and were visited at home by senior staff including the EDoN.

- Arrangements were made to meet with the family to discuss the investigation findings.

Summary of Key Failings:

The Serious Incident investigation identified significant failings in the care, management and treatment of the patient, with non-compliance with ABUHB policy requirements, namely:

- Therapeutic Engagement and Observation Policy
- Responsible Clinician (RC) and Approved Clinician (AC) Policy
- Mental Health Act 2007 Procedure for S17 and S18 Leave of Absence
- Multi- Agency Policy within Gwent for Care and Treatment Planning
- Multi-Agency Guidance with Gwent for Consulting and Informing Nearest Relative
- Allocation of Responsible Clinician
- Involving Nearest Relatives

In addition, there was:

- No formal allocation of a Responsible Clinician (RC) on transfer to Talygarn

- Failure to invalidate the existing Section 17 Leave forms
- Lack of clinical escalation
- Failure to handover, consider and enact the recommendations of the Fire Risk Assessment and S-RAMM
- Failure to upload risk assessments on the clinical system
- Failure to reference above risk assessments and non-recording of historical risks within the WARRN
- Non-recording of Risk Reference Panel advice and recommendations
- Failure to convene a Professionals Meeting for MDT consideration of presenting and escalating risks
- Failure to refer to Clinical Psychology on return to Talygarn
- Poor handover processes during transfer from Ty Skirrid to Talygarn
- Lack of robust recording of MDT discussions/decisions
- Failure to consider risk assessment recommendations when reinstating Section 17 Leave on return to Talygarn
- The Section 17 Leave form used to grant the final unescorted leave was invalid

Overall conclusion

The overall conclusion of the Health Board's investigation was that there were multiple failings in care, management and treatment, with the patient identified as having a very high risk of completing suicide.

Had the patients care been to an acceptable standard, principally where the recommendations within the fire and suicide risk assessments were considered, together with changing and escalating risks being formally and thoroughly contemplated by the MDT in Talygarn Ward, Patient X may either have not been granted Section 17 Leave on the 22nd of July or there may have been restrictions where leave was supervised.

But for these failings, and based on the balance of probability, it is deemed likely that Patient X would not have taken their life at that time.

Failings in care, treatment and management have directly or materially contributed to the catastrophic outcome.

The investigation has concluded there has been a breach of duty of care with resulting catastrophic harm.

PTR Redress

In light of the SI findings it was right and appropriate to refer this matter to the Health Board's Redress Panel for formal determination as to any legal liability, and to consider Redress if appropriate. This approach was welcomed by the family. Following presentation to Panel a Qualifying Liability was confirmed and an offer of financial compensation made following legal advice. A substantive letter from CEO followed. The family wish to await the outcome of the pending inquest before considering Redress further.

Learning & Assurance

A comprehensive and detailed suite of recommendations came out of the Health Board's investigations.

The Mental Health & Learning Disabilities Division has taken forward the required learning and recommendations through a substantial Divisional Action Plan, to ensure implementation, ongoing monitoring and audit.

The Division has been, understandably, off schedule in terms of the progression of some of the original intended timeframes due to the Covid-19 pandemic.
There have been various updates and iterations of the plan, as actions have progressed. These have been communicated to the Coroner and for updating to the patient's family.

A number of 'Learning Events' have taken place, to share and disseminate the key findings and learning, to build and enhance the actions and improvements for prevention of future patient harm. These events have included a significant debrief session for core staff involved in the care and the SI investigation. The patients' family were invited to the events.

On 21 December 2020 a MH&LD Serious Incident Learning Event was held. There was widespread Multidisciplinary attendance and engagement and the events were supported by the EDoN and the Vice Chair of the Board. These were facilitated safe sessions to enable participants to fully and openly reflect, discuss and consider learning from the events and what could be done differently going forwards.

There are also wider discussions being held on an All Wales basis in which MH&LD senior representatives are engaged. ABUHB has also had a meeting with representatives from Welsh Government Quality Unit to discuss the case.

Coroner Inquest

Ahead remains the Coroner's inquest. This is currently listed to proceed over the course of 10 days from 15th - 26th November. As Patient X was sectioned at the time of death it means they died whilst 'detained in state custody'. As a result it requires the Coroner to sit with a public Jury. It also means that the 'scope' of the inquest will also consider Article 2: Right to Life issues, not just reviewing how the patient came to die, but the wider circumstances surrounding the death.

17 members of Health Board staff are currently required to attend the inquest later this year.
Those staff were interviewed in October 2019 as part of the SI investigation. Throughout March 2021 the ABUHB Legal Team has again been meeting with each of the staff to prepare their formal statements for the Inquest – these have been requested. Full support is being provided to these staff from legal service colleagues. This matter is highly likely to attract further media interest and the ABUHB Communications Team will be fully briefed.

Assessment and Conclusion

This was a significant incident, revealing concerning and multiple failings in care and treatment of a young patient, resulting in catastrophic outcome and death. The patient had a very close relationship with their mother. The impact on the family unit has been immense and ongoing. Staff were very close and cared for the patient deeply, resulting in traumatic and long lasting impact on staff.

ABUHB has investigated fully and diligently, at great length. We have done so with openness and candour in line with PTR principles 'Investigate Once Investigate Well'. This has resulted in a suite of recommendations and subsequent actions from which to learn and improve patient safety. Learning Events have been at the heart of our wider dissemination and sharing of learning. This work continues.

We have complied with all ABUHB and national requirements to include Welsh Government Reporting, Serious Incident investigation and application of PTR Redress.

The Coroner Inquest remains outstanding. We are and will be fully prepared to further assist the family and coroner through this next stage. It will undoubtedly remain a difficult and challenging time for the patients' family and all involved.

Recommendation

For the Quality and Patient Safety Committee to receive the briefing as assurance of actions being taken to minimise the risks of such an event re-occurring.

Quality and Patient Safety Committee

The Brithdir Inquests

Executive Summary

The 'Brithdir Inquests' touching the deaths of 6 residents commenced on 18.1.2021 in the Riverfront Centre, Newport. Gwent. The inquests concluded on 16th March having lasted 8 weeks. ABUHB has been preparing for these inquests since August 2019. This has necessitated exhaustive collation and review of copious material, including extensive meetings and support to staff, both current and long retired.

The deaths that the Coroner has investigated occurred between 2003-2005 following residency in the Brithdir Nursing home, located within Caerphilly County Borough. Brithdir was owned by GP's Dr Prana Das (now deceased) and his wife, Dr Nishebita Das, who also owned a number of other nursing and residential homes in Wales.

The local health board at the index time was Caerphilly LHB. CLHB, together with the 4 other Gwent LHB's, became part of the newly constituted Aneurin Bevan Health Board in 2009. ABUHB, along with other State Agencies, to include the Care Inspectorate Wales (CIW) and Caerphilly County Borough Council (CCBC) were all Interested Persons in the Inquests, to assist the Coroner with his investigations.

These matters have been the subject of an extensive investigation undertaken by Gwent Police. 'Operation Jasmine' was established in October 2005 to investigate the death of a resident who was categorised Elderly Mentally Infirm (EMI) at a nursing home in Newbridge. Gwent Police liaised with other partner agencies and soon established a pattern of concerns linked to other deaths in other care homes within Gwent. Operation Jasmine widened its parameters to include Brithdir Nursing home. Despite many years of investigation, ultimately there was no criminal prosecution of Dr Das, or his company Puretruce Health Care. Dr Das was deemed to have lost his mental capacity and not fit to stand trial.

The families of the 6 patients have waited a very long time for the Inquests to be heard. ABUHB has fully supported the families' wish for a full and independent investigation of the deaths of their loved ones who were residents at the Brithdir Nursing Home, Caerphilly County Borough, between 2003 and 2006.

During the course of the inquests the Coroner heard evidence from the state agencies – ABUHB/CIW/CCBC – outlining the significant changes to health and social care practice that have occurred since the index time.

Final formal conclusions as to cause of death of the 6 residents
The Coroner found:

- that 5 of the 6 deaths were contributed to by 'neglect at the hands of the Brithdir staff' – the 6th death was by natural causes
- No findings of unlawful killing
- No findings of 'neglect' by State Agencies
- No findings of Corporate manslaughter by State Agencies

Specifically with regard to the role of the State Agencies, the Coroner stated –

I find all employees of the state agencies worked in good faith to the very best of their abilities. The state agencies and their staff were largely hampered by the regulations and statutory framework in place at that time'. I make no personal blame of those staff'

Regulation 28 Report - Prevention of Future Deaths report

ABUHB was not requested to provide a Prevention of Future Deaths report.
The Coroner was fully satisfied and assured as to everything he had heard with regard to our systems in place and the work undertaken over last 15 years

"*I am satisfied all in place to obviate any need for a Regulation 28 report'.*

Note for awareness

We have an entirely separate 3 week inquest in May 2021 about the death of a resident at Grosvenor Nursing home, within the former Blaenau Gwent LHB. This currently involves at least 3 staff who will need support, 2 of whom are currently employed by ABUHB.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	**x**
Executive Sponsor: Executive Director of Nursing	
Report Author: Garvin Jones, Senior Manager, Legal Services	
Date of the Report: 24 March 2021	
Supplementary Papers Attached: Nil	

Purpose of the Report

To provide summary of the 'Brithdir Inquests', their relevance to ABUHB, outcomes and the learning.

Background and Context

The 'Brithdir inquests' - how these came about

In 2019, following years of investigation and a failed criminal prosecution, Gwent Police referred the matter to the Coroner for consideration of open public inquests into the deaths of residents investigated under Operation Jasmine. From that emerged the

'Brithdir Inquests'. There have been 6 inquests all running together for the 6 residents who died following residency at Brithdir Nursing Home between 2003-2006.

3 of the families were represented by the law firm 'Hogan Lovells' – Hgan Lovells specialise in high profile public interest cases, often involving actions against Government and state agencies (e.g. wounded soldiers returning from Iraq). The 3 remaining families chose not to participate.

In summer 2019 Gwent Police informed the Health Board that a Pre-inquest Review was to be held and ABUHB was required to attend as a potential 'Interested Party'. Our first Pre-inquest Review hearing took place in September 2019. We, along with 2 other State Agencies (CSIW – Care Standards Inspectorate Wales and CCBC – Caerphilly County Borough Council), were formally joined as 'Interested Persons' in the intended 'Brithdir' inquests.

Over the course of the subsequent 18 months we have been preparing for these inquests. This has involved exhaustive searches and review of copious documents, evidence, statements, expert reports and transcripts. It has also necessitated locating and interviewing numerous staff, many now aged and retired, from the 5 former Gwent Local Health Boards. Those Health Boards, created in 2003, became part of the newly constituted ABUHB on its creation in 2009, and hence our current involvement and legacy to index events.

Whilst not all staff of the former Health Boards went on to become employees of the ABUHB, we have sought throughout, unless conflicted, to do all that we could to support and help them.
For all involved it has been a very difficult and traumatic time, and especially challenging with the passage of time.

The role that ABUHB has already played in Operation Jasmine – learning and support to families affected

It should be noted that ABUHB was approached by Gwent Police to support 'Operation Jasmine' at its inception which we have done in a positive way. A senior member of staff was appointed as a dedicated resource to assist Gwent Police, leading to significant support and contributions from the Health Board.

Following the collapse of the criminal proceedings the then First Minister of the Welsh Government, Carwyn Jones, ordered an independent review of the whole matter. In 2015 Dr Margaret Flynn published her independent review (the *Flynn report)* which considered all aspects of Operation Jasmine including, the workings of the various homes, the actions of the Police and HSE and the state agencies which had some responsibility for the regulation of care and nursing homes in South Wales. ABUHB fully participated in the work by Dr Flynn to the extent that the Health Board and its staff were formally acknowledged and thanked within the report for all of their help and positive contributions.

At the same time the Health Board organised and delivered a number of learning events, attended by Dr Flynn and the families of patients. These were regarded as a significant and successful contribution by the Health Board.

Assessment and Conclusion

Our management and approach to the Brithdir Inquests

With the death of Dr Das, and the failure to have secured any criminal prosecution, the families have waited a long time for their 'day in court' and the inquests have been akin to a public inquiry.

ABUHB has fully supported the families wish for a full and independent investigation of the deaths of their loved ones. ABUHB has played its part, openly and collaboratively, with the families, Gwent Police, the Coroner and other state agencies since approached in summer 2019 to facilitate and support these public inquests.

Whilst ABUHB did not exist as an organisation when these deaths occurred it has been important for it to participate in the inquest process – not only to provide information as to what happened, but also to set out the substantial changes made in subsequent years in the contractual and statutory frameworks to protect residents in care homes. These changes, together with an enhanced degree of collaborative working between the Health Board, Local Authorities, Care Inspectorate Wales and the care homes themselves, mean that any deficiencies in care are rapidly identified and addressed.

It was clear from the outset that the Inquests would tell the full story of the events surrounding Brithdir. Whilst ABUHB could not change those events, it was clear that we would be assessed by our conduct and response to the Inquests.

Through our evidence and witnesses we were presented with a real opportunity to bring clarity and context to the landscape of the time, the very different status and abilities of the then CLHB, compared to the ABUHB of today, and to explain and evidence the significant distance we have travelled in the intervening years. To that end, we were successful, as seen in the Coroner's final conclusions and comments.

The overall consensus is that the families have finally had the comprehensive in-depth independent investigation and scrutiny into the deaths of their loved ones that they have sought for so long.

ABUHB has endeavoured to behave with integrity throughout. We played a full participatory, helping and honest supporting role throughout the duration of proceedings. ABUHB staff and witnesses have conducted themselves as exemplary ambassadors of the Health Board throughout.

Whilst an arduous and difficult journey, the overall outcome is positive for the Health Board, and one in which we feel we can take pride for the part we have played. The lack of any real media reporting or criticisms of ABUHB may be reflective of the approach and outcome.

A number of sessions are being arranged to debrief and consider the experience and outcome. In addition, whilst the Health Board can be assured of the quality and safety frameworks in place for the protection of older adults resident in care homes we need to assure ourselves that the same applies for complex care of children and clients within Mental Health and Learning Disability needs. A scoping exercise is being undertaken.

Recommendation
For the Quality and Patient Safety Committee to NOTE the outcome of the Brithdir Inquests and the further scoping work to assess the quality and safety of services for children with complex needs and clients with Mental Health & LD needs in receipt of Continuing Health Care.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Tuesday 13th April 2021 Agenda Item: 3.3

Reduction and Management of Inpatient Falls

Executive Summary

Inpatient falls continue to be the most reported clinical incident in the Health Board and the harm resulting from these falls remains a significant cause of concern. It can be reported that:

- Good progress has been achieved in better understanding the incidence of inpatient falls and related harm through improved data analysis and benchmarking comparisons, further supported by the establishment of an all-Wales Inpatient Falls Network;
- Good progress has been achieved with implementing the corporate action plan for reducing and managing inpatient falls, a comprehensive suite of action that is overseen by the Falls and Bone Health Steering Group;
- Revision of the Health Board policy for reducing and managing inpatient falls with a particular emphasis on driving multi-professional responsibility for reducing inpatient falls and related harm. The revised policy also provides improved and simplified falls assessment documentation;
- The organisation is using audit to ensure learning and action from inpatient falls incidents is embedded at ward level.

Quality, Patient Safety and Performance Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Clinical Executives	
Authors: Peter Carr, Executive Director of Therapies and Health Science Karen Hatch, Assistant Director of Therapies and Health Science	
Date of the Report: 13 April 2021	
Supplementary Papers Attached: Corporate Action Plan for the Reduction and Management of Inpatient Falls	

Purpose of the Report

To provide the Quality, Patient Safety and Performance Committee with an updated position on the incidence of inpatient falls and the related injuries, across all ward environments in the Health Board. This report also provides a summary overview of the action being taken to further reduce inpatient falls and related harm, as set out in the detailed corporate action plan (attached at Appendix 1), which is overseen by the ABUHB Falls and Bone Health Steering Group.

Background and Context

Falls and falls related injuries are a major cause of disability and the leading cause of mortality in older people in the UK. "Falls are the second leading cause of accidental or unintentional injurious deaths worldwide" (WHO 2018) and are the most frequently reported incident affecting hospital inpatients; this is true in ABUHB.

The corporate action plan (for reduction and management of inpatient falls) is overseen by the ABUHB Falls & Bone Health Steering Group, chaired by the Executive Director of Therapies and Health Science.

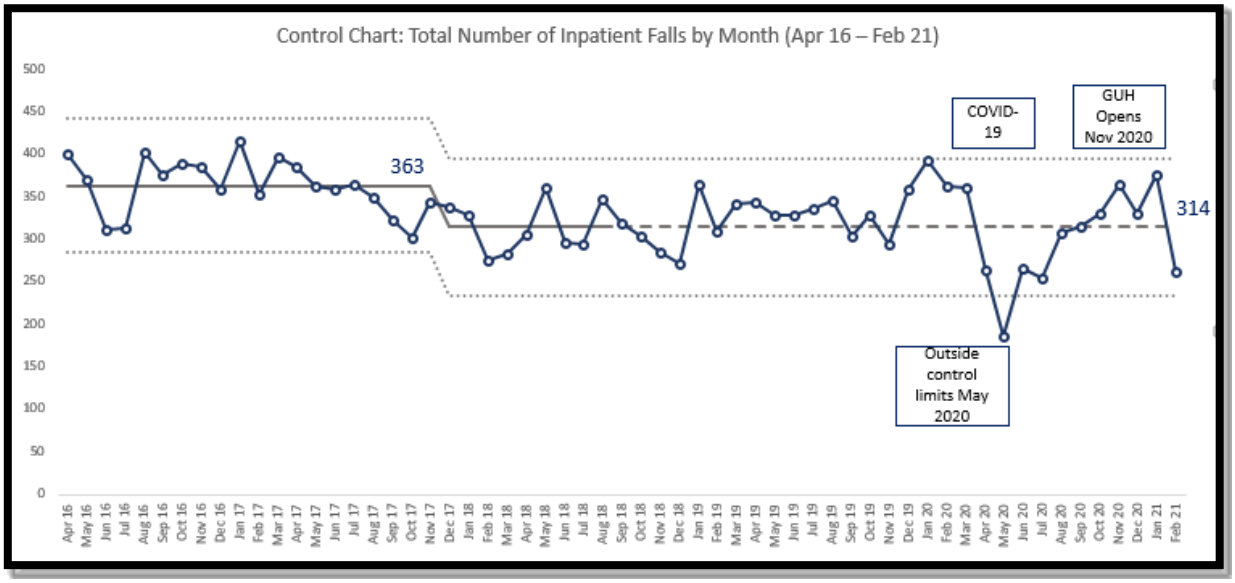
In addition, current risks and incidents associated with inpatient falls are considered and reviewed at the weekly Executive Clinical Huddle and reported to the Executive Team. The ABUHB Quality and Patient Safety Committee also receive routine reports on inpatient falls.

Assessment and Conclusion

In-patient Falls Data

The information below provides an update in relation to the total number of in-patient (IP) falls across ABUHB and associated control limits which define expected variation.

Chart One: Total Numbers of IP Falls across ABUHB per Month April 2016 - February 2021.

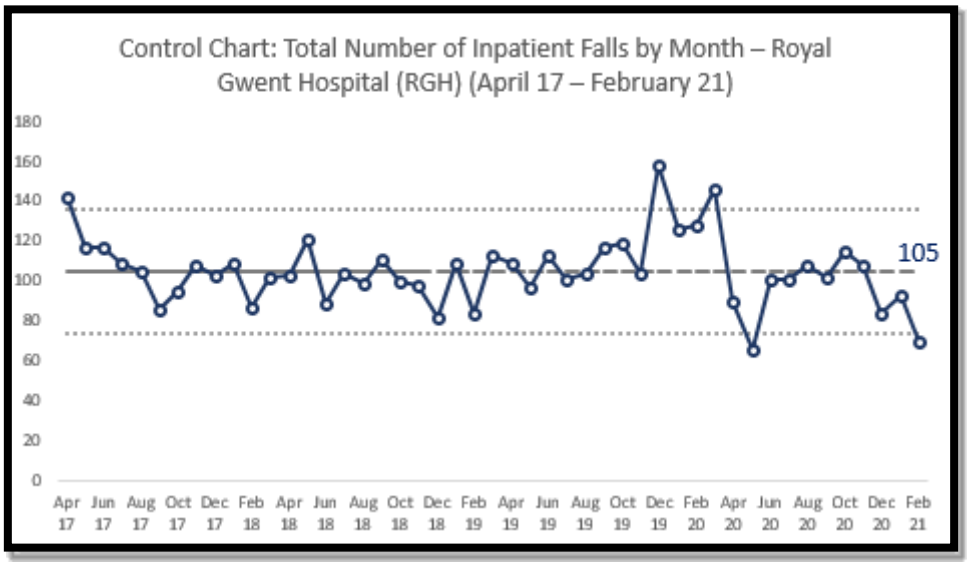


With particular reference to 2020-21 it can be seen that in May 2020 there was a significant decline in falls incidents which coincides with the first wave of the Covid-19 pandemic and the change in cohort of patients at that time. Although numbers of incidents increased up to November 2020 they remain within the identified control limits.

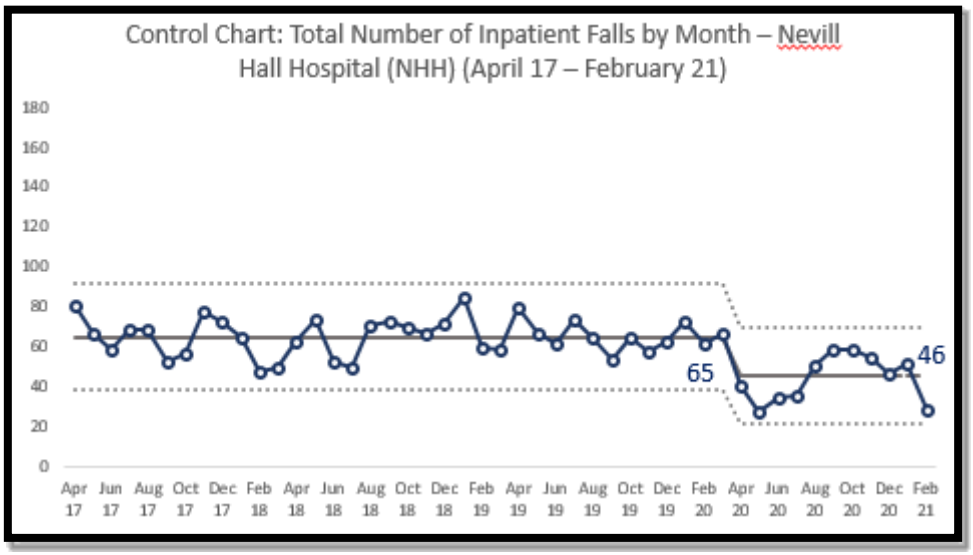
For the Quarter 4 period months - January and February there has been a positive reduction in reported falls to below the defined mean value of 314 to 262.

The charts below detail the site specific information for total numbers of IP falls with reference to the ELGH's. The data period covers April 2017 to February 2021.This places context in relation to the overall figures reported by the Health Board.

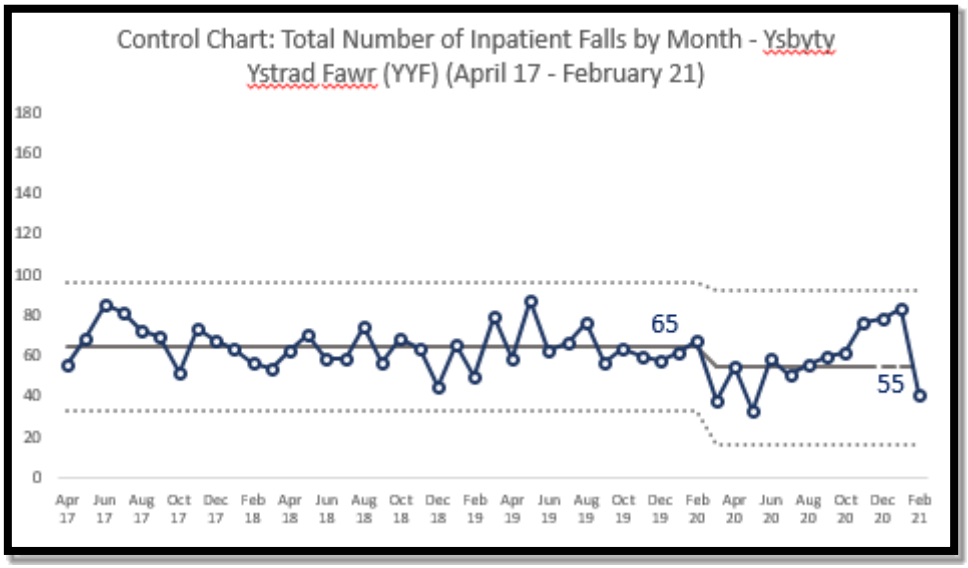
RGH – The mean number of monthly falls has remained at 105 between April 2017 and February 2020. Whilst the mean has remained the same throughout there are special cause variation (outside control limits) on four occasions. For Quarter 4 both the months of January and February see values of below the mean with the latter value contributing to being below the current control limit and is representative of the continuing downward trend in falls incidents at this site.



NHH - The mean number of monthly falls has seen a decrease since March 2020 from 65 to 46. For Quarter 4 January saw a marginal increase in numbers of reported incidents with a subsequent fall in February 2021 to 29 which is below the current mean. There are no occasions in which special cause variations have been identified.

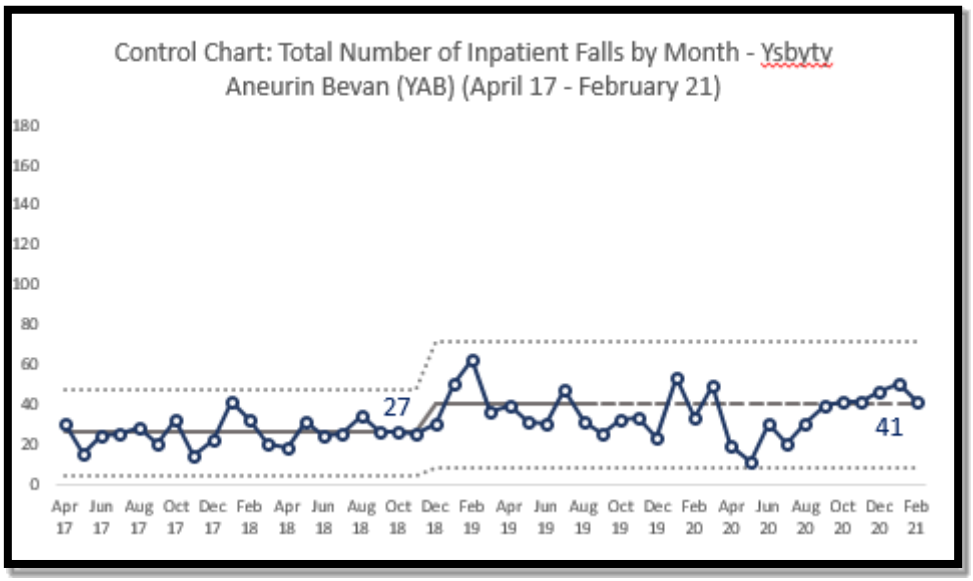


YYF - The mean number of monthly falls saw a decrease in March 2020 from 65 to 55. Since July 2020 the numbers of reported incidents have risen to the highest value in January 2021 with a subsequent significant decrease in February 2021 from 84 to 41 respectively. There are no occasions in which special cause variations have been identified.



For all other sites, with the exception of YAB, there has been only small shifts in relation to the defined mean values.

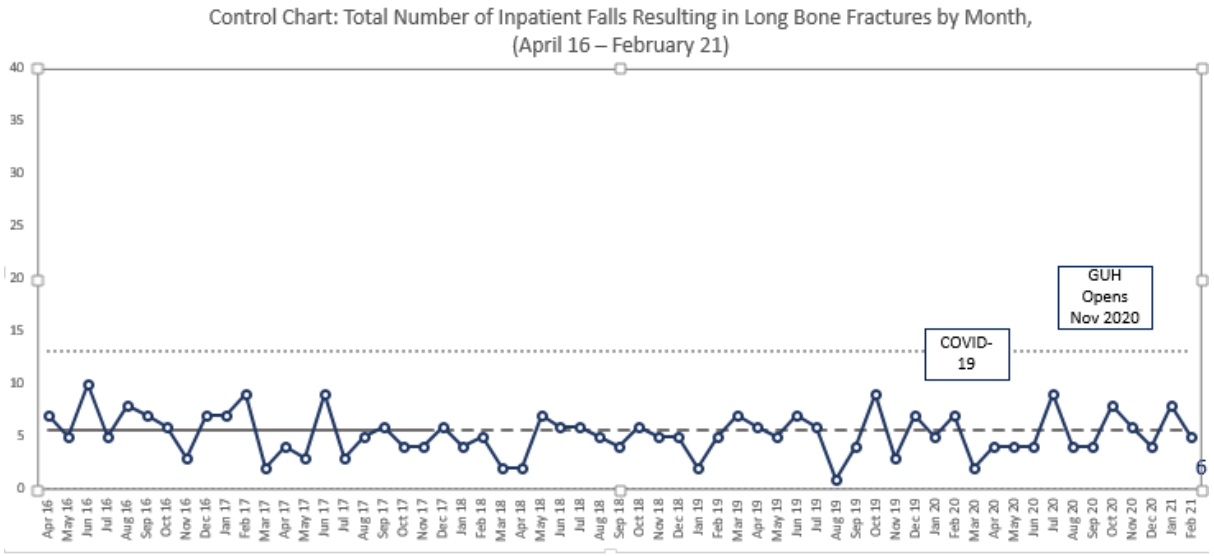
YAB - The mean number of monthly falls saw an increase from 27 to 41 in December 2018. Reported incidents have continued on an upward trajectory since May 2020. It is however important to recognise the changes associated with the patient cohorts on this site during the Covid-19 pandemic.



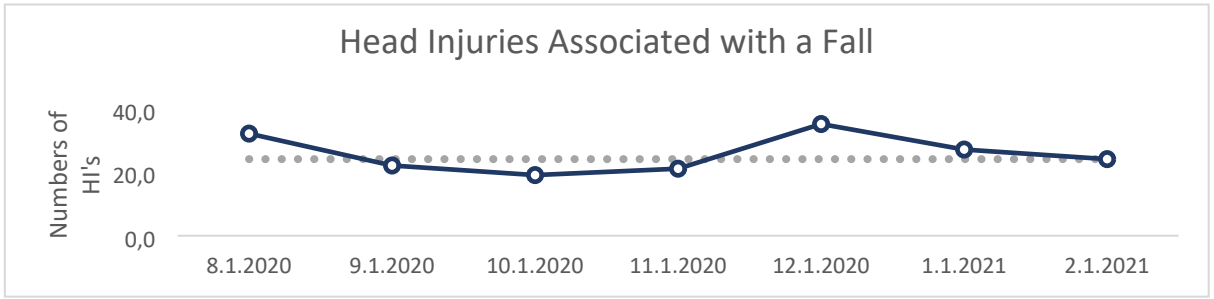
The next chart shows the total number of IP Falls resulting in an injury per Month 2016 - 2021.

The information below details IP falls with a resultant long bone fracture and shows no significant variation for the given period of data analysis. For Quarter 4 the month of February has seen a marginal reduction in the number of falls with associated fracture to just below the median value of 6.

All such incidents are discussed at the 'Falls Review Panel' at which the wards provide action plans as an assurance to manage the learning identified through the investigations. This will be supplemented by audit data to evaluate the impact of any associated change.

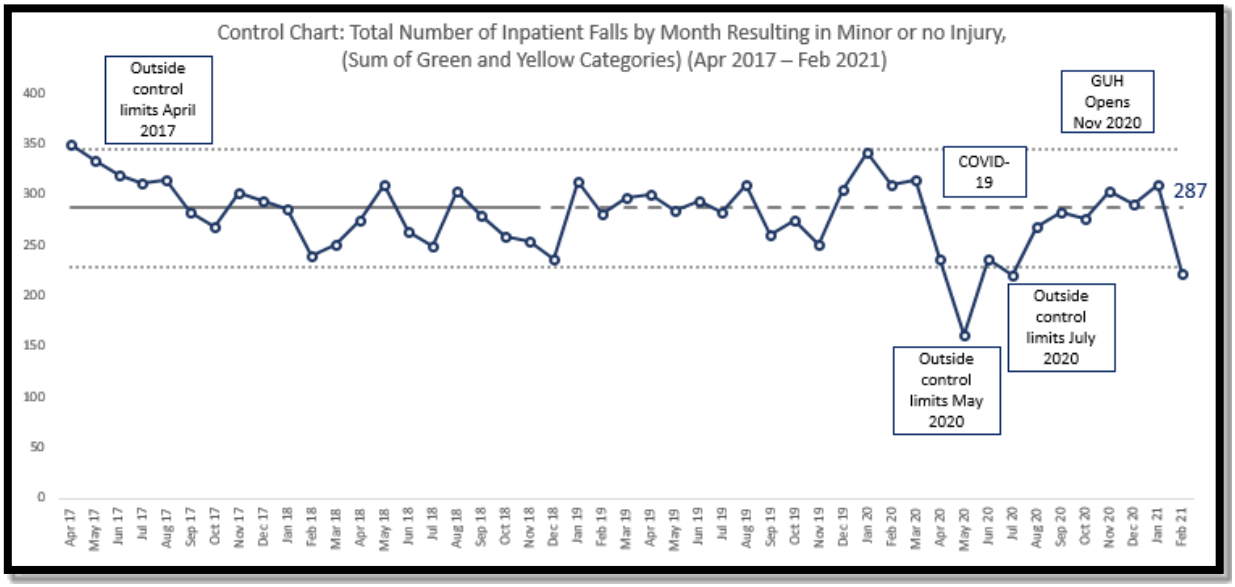


The following chart shows the total number of Head Injuries associated with a fall. The data period covered is August 2020 to February 2021.



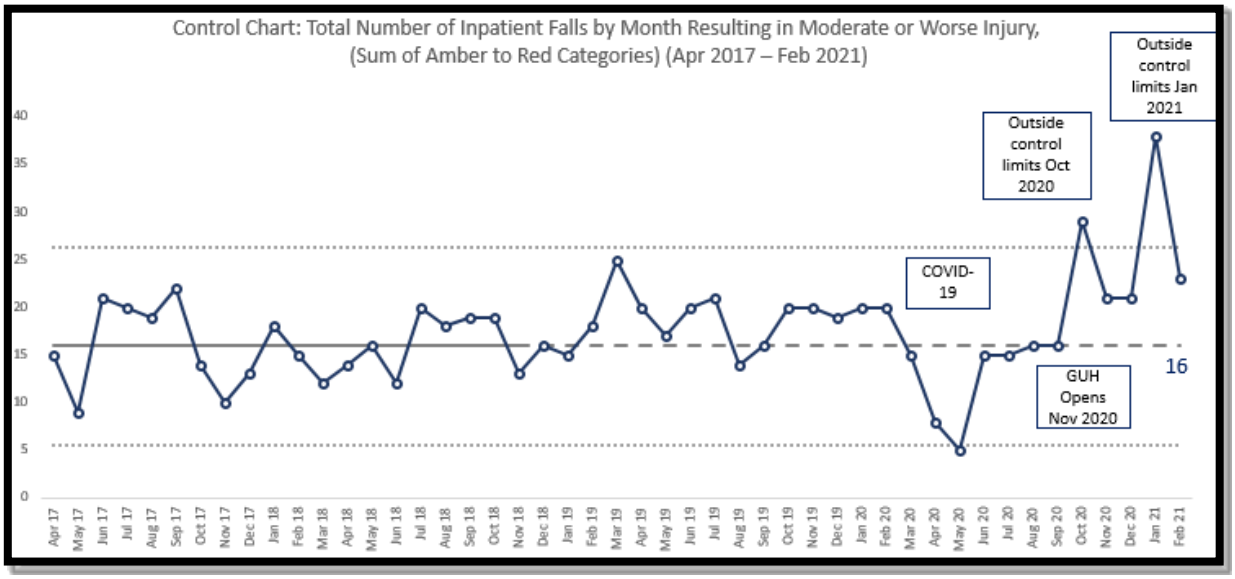
The data is reflective of head injuries sustained as a result of a fall are predominantly represented yellow when categorised in the context of harm. The defined median value is 24. There are three occasions within the six month period in which a proportion of incidents identified in the context of the DATIX reports include the terminology associated with a head injury. On the other three occasions the numbers of incidents are less than the median value.

The next chart shows the levels of severity of harm associated with injurious falls per month, 2017-2021: Green and Yellow Category incidents.



The information identifies 4 occasions outside of the defined parameters of control. Of these two are representative of the changes experienced in ABUHB associated with the Covid-19 pandemic. February 2021 has seen a reduction in the number of reported incidents categorised as minor or no harm from 309 to 222.

The following chart shows levels of severity of harm associated with injurious falls per month, 2017-2021: Red and Amber Category incidents.



For the given period the levels of reporting associated with these categories of harm provided an anticipated level of variation. However for Quarter 4, the month of January 2021, has seen a rise in numbers of incidents reported classified as red or amber with a subsequent downward trajectory identified for February 2021. This month also saw the highest total number of falls recorded since May 2020.

Programme of work to further reduce inpatient falls and related harm

Within ABUHB a comprehensive suite of work is being undertaken which informs the corporate action plan. This is monitored through the Falls & Bone Health Steering Group and has been frequently reported to the QPSC. The work is being informed by data together with that of the staff experiences in the management and prevention of patient falls.

Policy to Reduce and Manage Adult Inpatient Falls

Updating of the Policy facilitated through a robust Multi-Professional consultation process together with a review of the Enhanced Care Policy.

The revised policy has also taken account of legislative requirements and National Audit to further inform its content and the requirements to reduce the incidents of injurious falls and associated injuries within the Health Board.

The Policy includes a nationally developed Multi Factorial Falls Risk Assessment (MFRA) to support the transition to the electronic format which forms part of the All Wales Nursing documents.

In preparation for publishing the revised policy an implementation plan is being developed to raise awareness of the key changes and support the multi-professional team through training, especially with regards to the new MFRA.

Falls Review Panel and audit

The established Falls Review Panel which operates as a Multi- professional forum is working with the wards to implement their action plans and to provide outcomes evidence to reflect improvements. Audit will be used to monitor and support implementation of ward level actions identified and agreed through the Falls Review Panel and other serious incident investigations related to inpatient falls.

Falls and Bone Health Steering Group and corporate action plan

The corporate action plan (for reduction and management of inpatient falls) is overseen by the ABUHB Falls & Bone Health Steering Group, chaired by the Executive Director of Therapies and Health Science.

The Steering Group is developing a training strategy and programme for reducing inpatient falls, building on existing training programmes and considering multiple modes of delivery besides face to face, such as web based and virtual reality training. In support of publishing the revised policy, specific learning events are being planned around falls scenarios and exemplar assessment and care plan documentation and which takes learning from the Falls Review Panel and other serious incident investigations related to inpatient falls.

An external review of the incidents of falls in relation to YYF was commissioned by ABUHB as a means to further understand the challenges associated with falls management. It was completed by a Consultant Nurse for Older People from Cardiff and Vale University Health Board, who has a particularly specialist interest in falls. It outcomes, pleasingly, are consistent with the programme of activities already underway across the Health Board.

Quality Improvement Collaborative

The work associated with the reduction and management of injurious falls is being undertaken by means of quality improvements and as such is through collaborative, multi-

professional working. Wards for inclusion in the collaborative work have been agreed with work to commence on the 'radar for readiness' and charter. Progress has been subject to delays associated with the challenges of the Covid-19 pandemic.

Innovative use of technology

The steering group is leading work to explore opportunities for use of information technology, looking at existing technologies but also working in conjunction with the Health Board's Assistant Director of Innovation and TEC Cymru.

All Wales Inpatient Falls Network

ABUHB representatives are participating in the newly established 'All Wales Inpatient Falls Network'. This will provide the opportunity to utilise the data, patient and staff experiences to support shared leaning and the establishment of benchmarking standards. The work of the group will look to further inform that of the already established 'Head Injuries Task and Finish Group' and the evaluation of an already existing project to evaluate the single room environment.

Recommendation

The Quality and Patient Safety Committee is asked to:

- **Note** the Health Board position related to inpatient falls and related injury.
- **Note** the action being taken to reduce and manage inpatient falls and related harm.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Inpatient falls feature as a significant risk is both Divisional and Corporate risk registers.
Financial Assessment, including Value for Money	This paper doesn't detail any specific investment requirement. Reducing inpatient falls and related harm helps to avoid financial costs to the health and care system.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	NA
Health and Care Standards	Standard 2.3 – Falls Prevention
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP; reducing inpatient falls and related harm is a key action to ensuring quality and safety in the care we deliver.

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – The benefits of reducing inpatient falls and related harm work across acute, community and primary care.
	Involvement – Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration –action to reduce inpatient falls requires collaboration across acute, community and primary care
	Prevention – Improving patient safety and reducing inpatient falls will prevent harm within our services.
Glossary of New Terms	NA
Public Interest	Report has been written for the public domain.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD (ABUHB)
INPATIENT FALLS ACTION PLAN – updated 6TH April 2021

In the context of this plan the 'falls and bone health steering group' will look to provide a steer, advice, guidance in relation to the associated actions.

	ACTIONS REQUIRED	RESPONSIBLE PERSON		STATUS	TARGET COMPLETION DATE	MONITORING ARRANGEMENTS	COMMENTS AND ACTIONS COMPLETED TO DATE
		DIVISIONAL/ OPERATIONAL LEAD	CORPERATE LEAD				
1	**Update Policy for the 'Prevention and Management of Inpatient Adult Falls'.**		**Executive Director of Therapies and Health Sciences**			Falls & Bone Health Steering Group / QPSOG/QPS Committee DMT's	Policy to be reviewed at the Falls & Bone Health Steering Group meeting and to be subsequently taken to Clinical Policy Group.
	Implementation and monitoring of the Policy	**Divisional Management Team (DMT)**					
a.	Alignment to current legislation and guidelines.			**Completed**	May 2020		
b.	Review of roles and responsibilities.			**Completed**	July 2020		
c.	Review of the Multi-Factorial Risk Assessment (MFRA). The review forms part of the National approach to incorporating the MFRA as part of the Welsh Nursing Care Record.	Membership of Falls and Bone Health Steering Group QPS Leads Therapies Leads Senior Nurses Medical staff	Assistant Director Therapies & Health Sciences (AD T & HS)	**Completed**	March 2021		ABUHB are continuing to review its existing MFRA in order to ensure that this assessment tool meets the needs of staff in informing the establishment of patient centered care plans. **Actions Update:** Following Policy Consultation and feedback from staff training sessions updates to the MFRA have been further included to support Improved documentation and management of risks and ability to reflect more clearly the care plan. This work continues ahead of the introduction of the electronic version of the MFRA. Action Update: 'Wales Nursing Documents' MFRA to be included in Policy to support transition phase to E document. March 2021
d.	Inclusion of a falls medication specific tool within the Policy document to ensure arrangements are in place to review the appropriateness of prescribing medicines which are known to increase the risk of falls in patients who have fallen or are at risk of falls. To ensure that the work takes account of patients at high risk of Osteoporotic fractures and that they are offered appropriate therapies.			**Completed**	February 2020 November 2020		**Action: The** proposed medication review tool developed has been piloted on a number of wards at RGH. The evaluation of the pilot was presented at the Falls and Bone Health Steering Group with a view to including this as part of Policy and aligned to the completion of the MFRA. **Actions Update**: The medication tool has been included as an appendix within the policy and is referenced within the narrative.

	ACTION REQUIRED	RESPONSIBLE PERSON		STATUS	TARGET DATE	MONITORING ARRANGEMENTS	COMMENTS AND ACTIONS COMPLETED TO DATE
		DIVISIONAL LEADS	CORPORATE LEAD				
	Update Policy for the 'Prevention and Management of Inpatient Adult Falls'. **Implementation and Monitoring of the Policy**	**DMT**	**Executive Director of Therapies and Health Sciences**			**Falls & Bone Health Steering Group / QPSOG/QPS Committee DMT's**	**Policy to be reviewed at the Falls & Bone Health Steering Group meeting and to be subsequently taken to Clinical Policy Group.**
e.	Inclusion of clear guidance/ flowchart in support of the falls incidents with a suspected head injury for patients where treatment anticoagulants have been prescribed.			**Completed**	July 2020 Please see action update.		**Action Update:** A further review of the flowchart has been undertaken to reflect further agreed changes**.**
f.	To provide updated information for Patients and Families to support the reduction of risks of falls in hospitals and to establish availability of updated literature.			**Completed**	February 2020		The Policy update includes a revised version of information. National Guidance leaflets are being sought to support patients at the point of discharge.
g.	To take account of inter-ward and inter- hospital transfers in relation to impact of increased falls risks. Development of a transfer and discharge protocol.			**Completed**	July 2020		The 'Falls Review Panel' looks to capture the transfer status of patients as part of the investigation process.
				Completed	November 2020		**Actions Update:** An Adult SBAR, Patient transfer checklist has been developed which includes those factors associated with a risk of falls. This document was introduced in November 2020 and will be subject to audit to access the impact of implementation.
h.	To take account of the recommendations of the 'National Audit Inpatient Falls' report 2020.			**Completed**	July 2020 November 2020 Please see actions update.		**Actions Update**: A further inclusion within the policy makes reference to the recently published State of the Nation-Wales Report 2020 and takes account of the information provided based on the data from the National Hip Fracture Database (NHFD), Fracture Liaison Service Database (FLS-DB) and the National Audit of Inpatient Falls (NAIF).

	ACTIONS REQUIRED	RESPONSIBLE PERSON		STATUS	TARGET COMPLETION DATE	MONITORING ARRANGEMENTS	COMMENTS AND ACTIONS COMPLETED TO DATE
		DIVISIONAL/ OPERATIONAL LEAD	CORPERATE LEAD				
	Update Policy for the 'Prevention and Management of Inpatient Adult Falls'	**Divisional Management Teams (DMT)**	**Executive Director of Therapies and Health Sciences**			Falls & Bone Health Steering Group / QPSOG/PTR Teams	
i	Draft updated Policy circulated for HB Consultation via Clinical Policies Board			**Completed**	7th August 2020		
j	Evaluation of Policy consultation comments to inform changes as required.		AD T & HS	**Completed**	Please see actions update		**Actions Update** The policy consultation has been completed and all comments collated to inform the final document. The Information/ changes are supplemented by an audit trail.
k.	The updated document will be renamed the Policy to 'Reduce and Manage Adult Inpatient Falls'. Publication will be supplemented with an implementation plan to raise awareness and support the embedding of the requirements as day to day activities across the HB.		AD T & HS AD Quality & Patient Safety (AD QPS) AD Nursing	**Ongoing**	Please see action update		**Actions Update:** Establish an implementation plan aligned to Policy publication.
2.	**Falls Review Panel (FRP)**						
a.	To undertake a review of investigations post fall which have resulted in a fracture and to identify learning outcomes and any associated training needs.	Senior Nurses QPS Leads Therapies Leads Medical Staff	AD T & HS AD Quality & Patient Safety (AD QPS)	**Completed**	The FRP meets on a monthly basis.		**Actions:** The FRP has developed as action plan which captures learning and provides a means of evaluating progress of Wards to inform and demonstrate change.
b.	To work in collaboration with the wards to support the implementation of their actions plan as presented to the FRP.	Senior Nurses QPS Leads Therapies Leads Medical Staff	AD T &HS AD QPS AD Nursing	**Completed**	The FRP meets on a monthly basis Please see actions update		**Actions Update**: On review of incidents a focus of discussions relates to representatives presenting their action plan alongside discussions relating to an incident. This will be supplemented by a request for audit information to support proposed action plan.
c.	Establish a cycle of audits to ensure active monitoring and analysis of specific process measures with agreed metrics for collection e.g. Falls MFRA commenced within 6 hours of admission. Completion of assessment documentation on patient transfers. Audit to include sample testing of documentation across ABUHB and compliance with NICE CG161	Senior Nurses QPS Leads Therapies Leads	AD T &HS AD QPS AD Nursing	**Ongoing**	This will represent a cyclical audit process with individually defined completion dates	Audit outcomes will be presented in a multitude of forums maximizing the opportunity to share learning and promote change initiatives.	**Actions:** A suite of audits are being developed aligned to the Health and Care Standard 2.3 Falls Prevention. These will represent a means to promote an ongoing audit cycle alongside National audits.

	ACTIONS REQUIRED	RESPONSIBLE PERSON		STATUS	TARGET COMPLETION DATE	MONITORING ARRANGEMENTS	COMMENTS AND ACTIONS COMPLETED TO
		DIVISIONAL/ OPERATIONAL LEAD	CORPERATE LEAD				
3	**Complete a 'Thematic Review' in order to access current and emerging risks to provide the focus for detailed work to support improvements in the management of falls.**	**Divisional Management Teams (DMT)**	**Executive Director of Therapies and Health Sciences**			Falls & Bone Health Steering Group / QPSOG/PTR Teams	
a.	The thematic review is to take account of those findings identified through the work of the 'Falls Review Panel' and 'Putting Things Right' in conjunction with QPS Divisional reviews.	DMT/Senior Nurses / QPS Leads PTR	Assistant Director Organisational Learning (AD OL) AD T& H AD QPS	**Completed**	August 2020		**Actions:** Next steps are an evaluation of the themes using this to inform the work of the Collaborative.
b.	Analysis of the reviews will be used to establish learning, training and education needs to inform a quality improvement strategy for falls and to ensure an improved patient experience within the hospital setting.	DMT Senior Nurses QPS Leads PTR	AD T &HS AD QPS	**Ongoing**	Please see action update		**Actions:** This work is further informed as part of the SRE Project.
c.	Establish learning events specific to SI's with catastrophic outcomes	QPS Leads	AD OL AD T & HS	**Completed**	11th August 2020		Dates had previously been identified but were subject to postponement due to C-19 **Actions:** Feedback has been collated and will be used to inform future events (d).
d.	To evaluate the feedback from the learning event (c) to inform and support changes in falls prevention and management.	QPS Leads Putting Things Right (PTR) Team	AD OL AD T & HS	**Ongoing**			
4	**Training Strategy / Programme**						
a.	To build upon the existing training on falls prevention that has been provided to staff on Community wards whilst considering multiple means of delivery - Class Room, Virtual Reality, Webinars. Evaluation of the methods of delivery, learning feedback and impact on falls reduction.	Senior Nurses QPS Leads Therapies For Community Wards Training and Education Lead Community and Primary Care	AD T &HS AD Nursing	**Completed**	Please see actions completed and update.		**Actions:** Training for staff on Community Wards recommenced in July 2020 following postponement C-19. **Actions Update:** The feedback has been used to inform the development of a framework for training **Action Update:** The delivery of training has been adapted and remains iterative following feedback from the sessions. The training will be further updated to take account of the publication of the revised Policy – 'To reduce and Manage Inpatient Falls'.
	ACTIONS REQUIRED	RESPONSIBLE PERSON		STATUS	TARGET COMPLETION DATE	MONITORING ARRANGEMENTS	COMMENTS AND ACTIONS COMPLETED TO

		DIVISIONAL/ OPERATIONAL LEAD	**CORPERATE LEAD**				
		Divisional Management Teams (DMT)	**Executive Director of Therapies and Health Sciences**			Falls & Bone Health Steering Group / QPSOG/PTR Teams	
b.	To explore models for delivering training aligned to staff resource requirements.	Senior Nurses QPS Leads Therapies	AD T &HS AD Nursing	**Ongoing**	Please see actions completed to date.		**Actions:** Opportunities to establish Falls Champions for Wards is being explored alongside options for cascade training.
c.	To ensure training equips staff to fulfil compliance with the Policy for 'Prevention and Management of Inpatient Adult Falls', whilst adopting a MDT approach. Thereby raising awareness of the assessment documentation and required timelines for completion, associated care plans and reviews necessary to support individual patient care. Policy Rename – 'Policy to Reduce and Manage Adult Inpatient Falls'.	QPS Leads Training and Education Lead Community and Primary Care	AD T &HS AD QPS AD Nursing	**Ongoing**	Please see actions completed to date.		**Actions:** Establishing a learning event uses falls scenarios and exemplar documentation to support awareness raising and promote improvements in falls management. **Actions Update**: The documentation to support the event is being finalized.
5.	**Training Strategy / Programme**						
a	To develop a framework for training which looks to accommodate the needs of all staff groups who are responsible caring for patients who are at risk of falls.	For Community Wards Training and Education Lead Community and Primary Care QPS Lead Community and Primary Care		**Ongoing**	Please see actions update.		**Actions:** Work is being undertaken to develop a framework for the provision of falls training. This will look to take account of the varying knowledge and skills of individual staff groups and professions and the requirements to support their roles and responsibilities in relation to falls management. **Action Update**: A framework for discussion has been established
b	To develop a means to provide training for staff in the newly established GUH to support their management of falls in a Single Room Environment. The provision of training is in support of new staff unfamiliar with this environment. To progress training across Divisions.	For GUH Community Wards & ELGH settings. Training and Education Lead Community and Primary Care QPS Lead Community and Primary Care	AD T &HS AD Nursing	**Ongoing**	Please see actions completed and update.		**Action:** It is anticipated that the training will commence in February 2021 virtually. Delays have been associated due to current challenges associated with the requirements to support the management of the pandemic. **Action Update:** Training recommenced in February 2021 priority being given to supporting staff in the GUH and the transition for some to working in the single room environment. Training has also included the inclusion of wards in our ELGH setting and Community Hospitals.
	ACTIONS REQUIRED	RESPONSIBLE PERSON		**STATUS**	**TARGET COMPLETION DATE**	**MONITORING ARRANGEMENTS**	**COMMENTS AND ACTIONS COMPLETED TO**

		DIVISIONAL/ OPERATIONAL LEAD	CORPERATE LEAD				
		Divisional Management Teams (DMT)	**Executive Director of Therapies and Health Sciences**			Falls & Bone Health Steering Group / QPSOG/PTR Teams	
6.	**All Wales Network for Inpatient Falls**						
a.	Establishment of the 'Network' will allow the sharing of good practice, learning and data to support the development of common standards and approaches to the reduction and management of falls across Wales.	ABUHB MDT	Dr I Singh Appointed Clinical Lead for the Network. AD T &HS AD Nursing AD QPS	**Ongoing**	Please see action update		**Action Update:** This is a newly established forum which held its first meeting on the 30th March 2021.
7.	**Improvement Programme**						
a.	Establishment of Clinician led MDT Task and Finish (T & F) groups with a specific remit of reviewing the following:- • Falls with Head Injuries (HI) • Single room environments (SRE)	Members of Falls & Bone Health Steering Group Senior Nurses Therapies T& F group's HI's Cross Divisional and Hospital Representation QPS Lead Community and Primary Care (SRE)	Dr I Singh AD T & HS	**Ongoing**	Please see actions Completed and update.		**Actions Update:** T& F group HI Terms of Reference agreed. Data was presented to the group for one of the Community Hospitals (Chepstow). It was agreed the same methodology should be applied to evaluation falls associated HI's on all sites. A project has been initiated to review falls in the single room environment. This aims to undertake modelling and simulation work to inform falls management. **Actions Update**:- Work has progressed in relation to that associated with the SRE Lead by QPS Lead Community and Primary Care. The outcomes/ findings will be presented to Senior Leadership for the Division and subsequently to the Falls & Bone Health Steering Group. The information will be used to inform further future actions.
	ACTIONS REQUIRED	**RESPONSIBLE PERSON**		**STATUS**	**TARGET COMPLETION DATE**	**MONITORING ARRANGEMENTS**	**COMMENTS AND ACTIONS COMPLETED TO DATE**

		DIVISIONAL/ OPERATIONAL LEAD	**CORPERATE LEAD**				
8.	**Quality Improvement (QI)**	**Divisional Management Teams (DMT)**	**Executive Director of Therapies and Health Sciences**			Falls & Bone Health Steering Group / QPSOG/PTR Teams	
a.	To establish a Programme of work supported by ABCi to identify quality improvement opportunities to inform an implementation framework for falls through a collaborative.	Divisional/ Senior Nurses QPS Leads Therapies Leads Medical Staff	AD T & HS ABCI AD Nursing	**Ongoing**	Please see actions completed to date and the action update.		**Actions:** Identification of wards and associated MDT teams to participate in the initial stage of the collaborative projects. Wards utilizing QI methods (Driver Diagram) to support identification of specific areas for focus alongside thematic reviews. Improvement methodologies support being provided by ABCi **Actions Update:** Wards for inclusion in the collaborative work have been agreed with work to commence on the radar for readiness and Charter. Progress has been subject to delays associated with the management of C-19.
9.	**Innovation/ Information Technology(IT)**						.
a.	To explore the opportunities for the use of IT technology etc. by means of the ABUHB approach to innovation and its associated platforms/ strategy.		AD T & HS Assistant Director Innovation (AD Innovation)	**Ongoing**	Please see actions completed to date and action update.		**Actions:** Initial meeting established with technology company to discuss opportunities of utilizing AI (ARMED). **Actions Update**: AD T & HS attended a webinar at which the role of ARMED in supporting improvements in falls numbers. Work will be progressed in conjunction with TEC Cymru as to the options available to utilize this technology. **Action Update**: Meeting to be held 7th April 2021 to discuss the ability to use the HB's Innovation platform to support IT opportunities for falls reduction and management.

	ADDITIONAL NOTES

	Highlight reports will be presented to the Falls & Bone Health Steering Group to update on actions aligned to the Corporate plan. • Policy to reduce and Manage Adult Inpatient Falls. • Single Room Environment Project • Falls Review Panel • Training • HI T & F Group. All the above actions are to be considered in conjunction with all ABUHB Policies which support an all-inclusive approach to individualized patient care. e.g. Enhanced Care Policy, Bed Rails Assessment

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Tuesday 13th April 2021 Agenda Item: 4.1

Aneurin Bevan University Health Board

Covid Quality and Patient Safety Dashboard

Executive Summary

A Quality and Patient Safety Dashboard was developed in October 2020 to support the monitoring of quality indicators to understand the impact that Covid was exerting on care delivery. The report highlights an improving picture in relation to the impact from Covid on care delivery.

The Executive Team is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	x
Note the Report for Information Only	
Executive Sponsor: Dr James Calvert - Executive Medical Director Rhiannon Jones - Executive Director of Nursing, Peter Carr – Executive Director of Therapies and Health Sciences	
Report Author: Alexandra Scott - Assistant Director of Quality and Patient Safety	
Report Received consideration and supported by :	
Executive Team	
Date of the Report: 13 April 2021	
Supplementary Papers Attached: None	

Purpose of the Report

To assure the committee of the systems in place to monitor the quality and patient safety of care provision during the period of significant Covid activity.

Background and Context

To support the proactive monitoring of the quality and safety of service provision during the pandemic a Covid Quality and Patient Safety Dashboard has been developed providing oversight of a number of key performance measures and quality indicators aligned to the four harms associated with the impact of Covid. The dashboard is monitored on a weekly basis at the Executive Safety Huddle and facilitates the identification of issues for action and potential inclusion in the Covid risk register.

Harm from COVID itself

Harm from overwhelmed NHS and social care system

Harm from reduction in non-COVID activity

Harm from wider societal actions / lockdown

Assessment and Conclusion

Figure 1 shows a screenshot of the Covid QPS dashboard live as 29 March 2021.

Figure 1

Harm from Covid Itself

Several indicators have been utilised in monitoring harm resulting directly from Covid.

Covid related mortality in all settings has been monitored against All Wales mortality rates and historical 5 year mortality data. Health Board and All Wales all-cause mortality rose significantly higher than the 5 year average mortality in the first wave of Covid and a similar rise was noted from November 2020 as Covid cases increased. The pattern is mirrored by the numbers of deaths where Covid had been confirmed in the 28 days previously. ABUHB all-cause mortality has fallen in line with 5 year mortality rates since the beginning of February 2021 and in recent weeks has fallen below the 5 year average mortality rate.

Mortality rates of inpatients with a diagnosis of Covid peaked in late December 2020 when 46% of inpatient beds were occupied by patients with suspected or confirmed Covid or who were recovering from Covid. Level 1 mortality reviews have been prioritised for all patients who die with a diagnosis of Covid. Since January 2021 an all definite hospital acquired cases are subject to an All Wales Review to capture learning and emergent themes relating to hospital transmission. The reviews in relation to Covid-19 are complex but support the identification of key learning for dissemination at all levels of the organisation and nationally.

Nosocomial or hospital acquired Covid is defined as a positive diagnosis of Covid 14 days after admission and probable hospital acquired Covid is defined as a positive diagnosis between 7 and 14 days post admission. Probable and definite hospital acquired Covid peaked in the last week of November 2020 when there were 1764 confirmed cases of Covid across the Gwent area and 4% (n=81) of cases were identified as being possible or definite hospital acquired. During the week ending the 21 March 2021 there were 219 confirmed cases across Gwent and 3% (n=6) were hospital acquired. The reinforcement of the importance of social distancing on Health Board sites including the Aneura in a Visor campaign contributed to this improvement. In addition the recruitment of Covid safety officers have further supported this work.

Harm from Overwhelmed NHS services

The ongoing monitoring of quality indicators to gauge the impact on non Covid pathways was necessary to identify early warning signs of services under pressure.

A reliance on surge capacity meant that the numbers of occupied inpatient beds peaked during the week commencing 18 December 2021 when 1492 were occupied. Covid inpatient bed occupancy peaked in late December with 46% of all inpatient beds occupied by patients with suspected confirmed or recovering Covid. This resulted in significant pressures on staffing resources with 141.86 whole time equivalent registered nurse positions unfilled and 216.39 whole time equivalent Health Care Support Worker positions unfilled. In the week ending 28 March 2021 there were over 100 less inpatient

beds open (1386), with 7% of inpatient beds accommodating patients with suspected, confirmed or recovering Covid and the staffing position had improved.

ABUHB has Intensive Care beds capacity of 24 beds, however, as a result of increased Covid activity by mid-January 2021, it was necessary to utilise surge capacity resulting in 29 ITU beds in use and 62% of these beds occupied by patients with a diagnosis of Covid. By the end of March 2021 the reduction in Covid infections and subsequent admissions resulted in decreased pressure on the unit and on 28 March 2021 there were 19 ITU beds occupied and 11% (n 2) beds were occupied by patients with a diagnosis of Covid.

The rate of a number of bacteraemias are routinely monitored in relation to Infection Prevention and Control. These include C difficile, Staph Aureus, E coli, Klebsiella and Pseudomonas Aeruginosa. An increase in Klebsiella cases was noted in January 2021 with a number of cases identified in ITU. These cases coincided with the use of surge capacity and were associated with embedding of new practices in single room environments.

In April 2020 the Health Board reported the lowest number of pressure ulcers in four years, a likely reflection of the changes in care delivery and the numbers of inpatients during the first wave of Covid. Since then there has been a sustained increase in the numbers of pressure ulcers being reported until September 2020 when the reporting levels returned to previous rates. Occurrence in November, December and January and February continued to increase above the median with the increase associated with increasing numbers of inpatients, a frailer and more dependant inpatient population. Encouragingly the majority of pressures Ulcers being reported were grade 1 and 2 and no increase in the reporting of grade 3, 4 and ungradable pressure ulcers was noted, which suggests effective management of pressure ulcers once identified.

Inpatient falls are routinely reported as falls per 1000 bed days. A rate of 12 falls per 1000 bed days was observed during the first wave of Covid and inpatient falls peaked again during December 2021 with a rate of 12.47 per 1000 bed days observed. The change in inpatient demographics during this period, with reduced ambulant elective patients and increased unscheduled patients with significant levels of dependency will have impacted falls rates. By the end of March 2021 the rate of inpatient falls was 7.63 per 1000 bed days. In 2015 the Royal College of Physicians recorded a falls per 1000 bed day rate of 6.6 for acute settings, while the National Patient Safety Agency (NPSA) recorded a rate of 4.8 in acute hospitals, 8.4 in community hospitals and 2.1 in mental health hospitals.

Enhanced care can include a spectrum of interventions ranging from the provision of assistance to help to mobilise a patients, through to one to one nursing. Categories of enhanced care vary from level 1 to level 5. Numbers of patients requiring level 4 and level 5 enhanced care have been monitored since late October 2020 and from Christmas a sustained increase was noted a and by mid-February 2021 over 1000 patients were recorded as requiring either level 4 or level 5 enhanced care, reflecting the increased

care requirement of the inpatient population at that time as well as the pressures on nurse staffing.

Links to Nurse Staffing Welsh Levels of Care descriptors		Description	Enhanced care requirements	Resources required
Level 5	**One-to-one care** This patient requires 1 to 1 care continuous nursing supervision	Level 4 actions have not made the patient safe. Examples of care needs: At risk of harm to self or others, deteriorating, compromised condition, fall with harm has occurred, patient standing unaided, patient attempting to leave ward, severe confusion, episodes of agitation, needs continuous enhanced clinical observation / intervention.	Constant Requires 1 to 1 care continuous nursing supervision and observation for 24 hours a day. Commence patient engagement activities. Consider specialist referral / assessment: DOLS / MH / Clinical / Falls team etc. Review medication. Communicate and escalate at safety briefing.	**Additional** **Requires 1 to 1 continuous supervision / observation** Discuss with family additional family support in addition to open visiting.
Level 4	**Urgent and unstable** The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.	Level 3 actions have not made the patient safe. Examples of care needs: Cognitive impairment, at risk of falls, at least 1 fall whilst in hospital, may unintentionally wander off the ward, showing signs of attempting to stand unaided or leave ward, moderate confusion, agitated or restless, at risk of pulling out devices, patient unable to make needs known / effectively use call bell, patient acutely unwell with elevated NEWS score.	Observation of cohorted patients Cohort in bay of 4, one staff member allocated to the bay. Commence patient engagement activities. Consider specialist referral / assessment: DOLS / MH / Clinical / Falls team etc. Review medication. Communicate and escalate at safety briefing.	**Additional** Cohort in bay of 4, one staff member allocated to the bay. Discuss with family additional family support in addition to open visiting.

A number of indicators have been reported by the Putting Things Right Team, including the numbers of red 1 Serious Incidents, Never Events, No Surprises, Category 3 and 4 complaints and the numbers of patient safety incidents relating to Covid. Patient safety incidents relating to Covid peaked in December 2020 when 75 incidents were reported in 1 week and there has been a sustained reduction since that time with no Covid associated incidents reported in the week ending 28 March 2020. All Incidents were reviewed to identify emergent themes and to inform mitigating actions.

Harm from a reduction in non-Covid activity

A reduction in non-Covid hospital presentations was reported nationally during the first wave of Covid. To support identification of a similar theme during the second wave the numbers of attendance to the Emergency Unit that resulted in admission and the numbers of attendance that were discharged without requiring follow up were monitored. These two indicators are not a reflection of overall Emergency Unit attendance. There has been a sustained but gradual reduction on both of these indicators since mid-November 2020, however, this is not reflective of overall EU activity.

Harm from wider societal actions

In response to the widely reported impact of Covid on the mental health of the population, referrals to adult mental health and primary care mental health services have been monitored. A reduction in referrals was noted to both services from March 2020 but referral rates recovered to normal levels by June 2020 and have remained at this level.

Recommendation

The Committee are asked to **note** the assurance provided by the ongoing monitoring of quality indicators associated with the increase in Covid activity.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring of quality indicators has informed risk assessments and population of the Covid risk register
Financial Assessment, including Value for Money	Improving quality will reduce harm to patients and/or waste
Quality, Safety and Patient Experience Assessment	The report is focussed regular reporting and monitoring of a number of indicators pertinent to Quality and Patient Safety and Experience
Equality and Diversity Impact Assessment (including child impact assessment)	NA
Health and Care Standards	The indicators are relevant to all Health and Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Patient Safety is represented within the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements require integration across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements require collaboration across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the public domain.

Quality and Patient Safety Performance Report

Executive Summary

- An exception report has been provided that sets out the mitigation in relation to falls management. It is proposed that the overall rating is reduced from Red to Amber.
- An exception report has been provided that sets out the mitigation in relation to pressure ulcer management. It is proposed that the rating for pressure ulcers is reduced from Red to Amber
- An exception report has been provided that sets out a plan to improve Divisional wide governance in relation to Never Events.
- An Infection Control exception report has been provided that describes an improving picture in relation to Covid-19 and the Health Board position in relation to national Infection Prevention and Control (IP&C) targets. It is proposed that the rating is reduced from Red to Amber.
- A highlight report relating to claims and redress has been included.
- An exception report has been provided in relation to urgent care in the Emergency Department (ED) and Welsh Ambulance Service NHS Trust (WAST) that provides details of work underway to ensure the safe management of patients self-presenting to ABUHB Minor Injuries Units.

Quality & Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Clinical Executives	
Authors: Alexandra Scott, Assistant Director of Quality and Patient Safety Tracey Partridge-Wilson, Assistant Director of Nursing Karen Hatch, Assistant Director of Therapies and Health Science	
Date of the Report: 6 April 2021	
Supplementary Papers Attached: Nil	

Purpose of the Report

The quality and patient safety report is produced around the themes of the Health and Care Standards (HCS) and is provided for the purpose of assurance. The report highlights the current position against a range of key quality indicators, identifying emerging themes, areas of concern and mitigation, as well as good practice.

Background and Context

The report is generated using key performance indicators, information from incident reporting, concerns and complaints and includes escalation from any of the quality & safety-associated groups which report to the Quality, Patient Safety Operational Group (QPSOG) and directly to the Quality, Patient Safety Committee (QPSC).

A review of reporting arrangements for the QPSC has been undertaken by the Clinical Executives and supported via the Chair of the Committee, for discussion with Committee members (see separate paper). An annual work programme is in-development, based on the Health and Care Standards, and it is proposed that reporting against these standards is strengthened to provide greater assurance to the Board. As a result the Quality and Patient Safety Performance report presented at each QPSC has been revised to report risks through a process of RAG rating, identifying emerging themes and trends, including the work to mitigate associated risk and to drive required improvement.

The following is an 'at a glance' Red, Amber, Green (RAG) rated summary of key metrics that are regularly monitored, some of which (and notably the 'red' rated areas) are included within this report, providing an overview of the Health Board position from January – March 2021.

Assessment and Conclusion

Staying Healthy

The principle of staying healthy is to ensure that the population are well informed to manage their own health and wellbeing. Organisations and people in Wales will work together to protect and improve health and wellbeing and reduce health inequalities. People will be empowered to make decisions about their own health, behaviour and wellbeing that impact positively throughout their lives

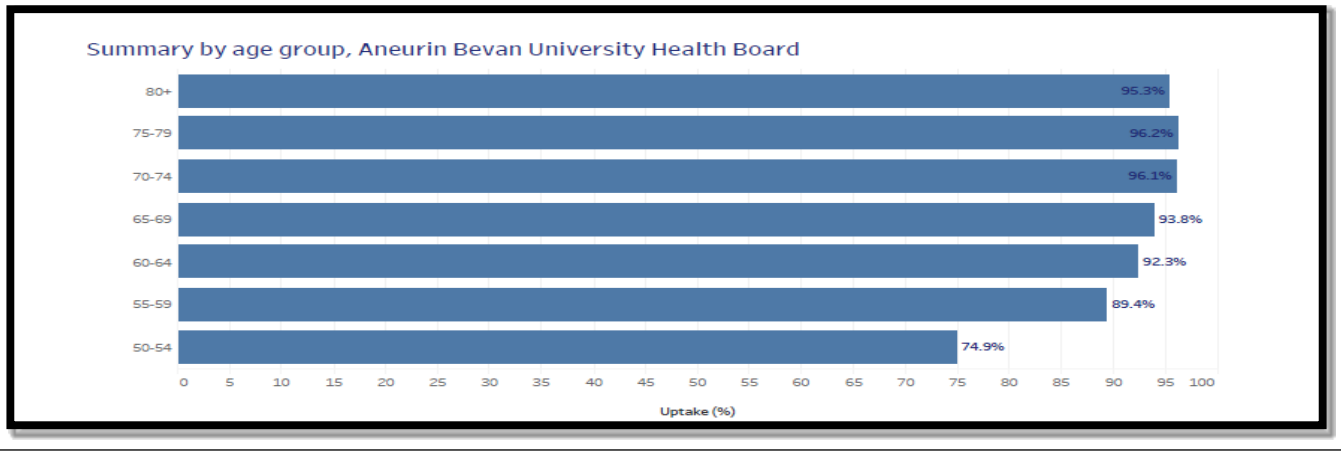
Mass Vaccination Programme
(Standard 1.1 – Health Promotion, Protection and Improvement)

The Wales National Covid-19 vaccination board requested that organisations were ready to begin mass vaccination by 5th October 2020 for specific community groups and health and social care front line staff. The current working basis is that ABUHB will receive 200,000 vaccines in phases with the assumption that each person requiring the vaccine will receive it in two doses.

The programme has delivered a total of 367,177 vaccinations between 8th December 2020 and 30th March 2021, delivering the first 100,000 vaccinations in 57 days, 24 days later a further 200,000 vaccines had been administered, and just 17 days later the total number was 300,000. Vaccine supply is the limiting factor in the programme and the team have demonstrated that they can scale the programme up and down according to varying supply.

As of 30th March 2021, 277,061 residents (over half of the HB's adult population) have now received their first dose of the Covid-19 vaccine, and a total of 90,116 residents have received their second dose.

The programme is on track to complete the offer of first doses by mid-April to the first 9 Priority Groups. The programme is achieving high coverage rates with over 95% of those aged over 70 having received their first dose; over 90% of those aged between 60 and 69 years received first dose, and exceeded WG target of 75%+ for 50-59 year group (vaccination is ongoing in these groups).



HIW have recently inspected 8 Mass Vaccination Centres (MVCs) within a sample of 4 Health Boards across Wales and provided immediate feedback and recommendations to all Health Boards. (ABUHB has not been inspected to date). HIW request that this information is reviewed internally and in particular within the quality governance structures that has been put in place for vaccine delivery.

The findings outline a summary of the 4 issues identified during HIW's inspections which required urgent remedial action to be taken in order to maintain patient safety. HIW made 4 recommendations stipulating that all Health Boards ensure:

1. Processes for vaccine delivery are in line with the National Protocol.
2. A programme of clinical and environmental audit activity is in place, and is regularly completed, reported and acted upon where necessary.
3. Risk assessments for fire regulations and security are up to date and actions taken where appropriate. All centres should have up to date evacuation procedures and all staff should be aware of what to do in an adverse event.
4. A process in place to regularly check all equipment required for a patient emergency, and ensure procedures are in line with the Resuscitation Council (UK) guidelines.

A self-assessment against the findings has been conducted, with ABUHB in a positive position. A paper outlining the position has been prepared for presentation to the Executive Team.

Safe Care

The principle of safe care is to ensure that the population are protected from harm and supported to protect themselves from known harm. The health, safety and welfare of people are a priority. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers. Although the provision of care has some associated element of risk of harm to service users, safe care identifies, prevents or minimises unnecessary or potential harm. Therefore people will be kept safe and protected from avoidable harm through appropriate care, treatment and support.

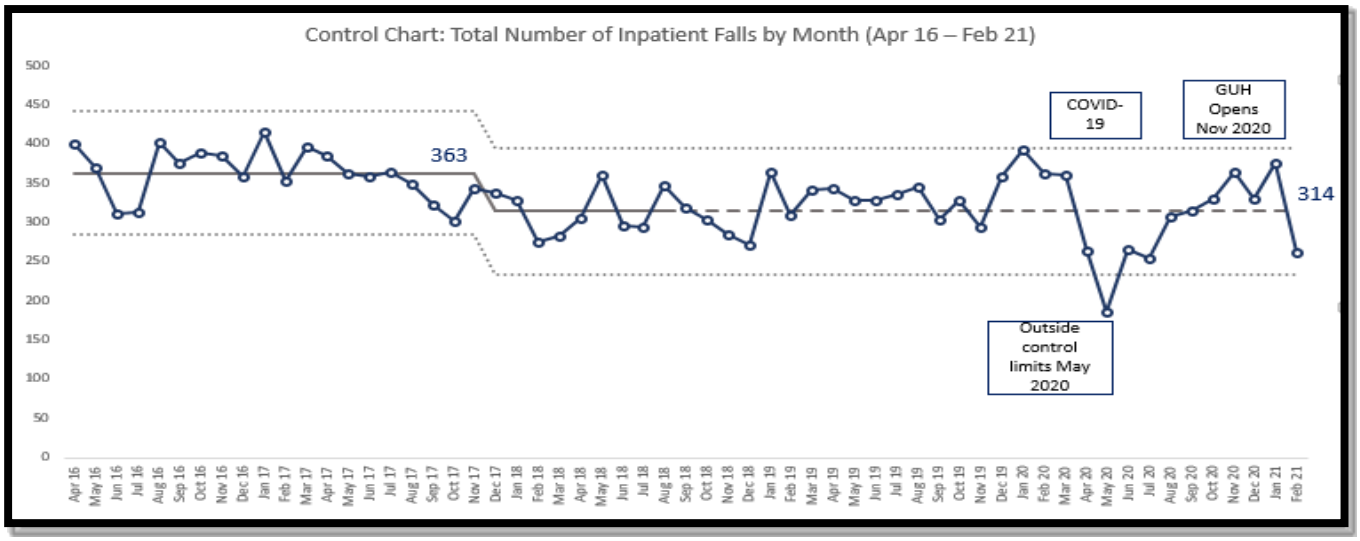
Falls (Standard 2.3 – Falls Prevention)

The information below provides an update in relation to the total number of inpatient (IP) falls across ABUHB and associated control limits which define expected variation.

Chart One: Total Numbers of IP Falls across ABUHB per Month April 2016 - February 2021.

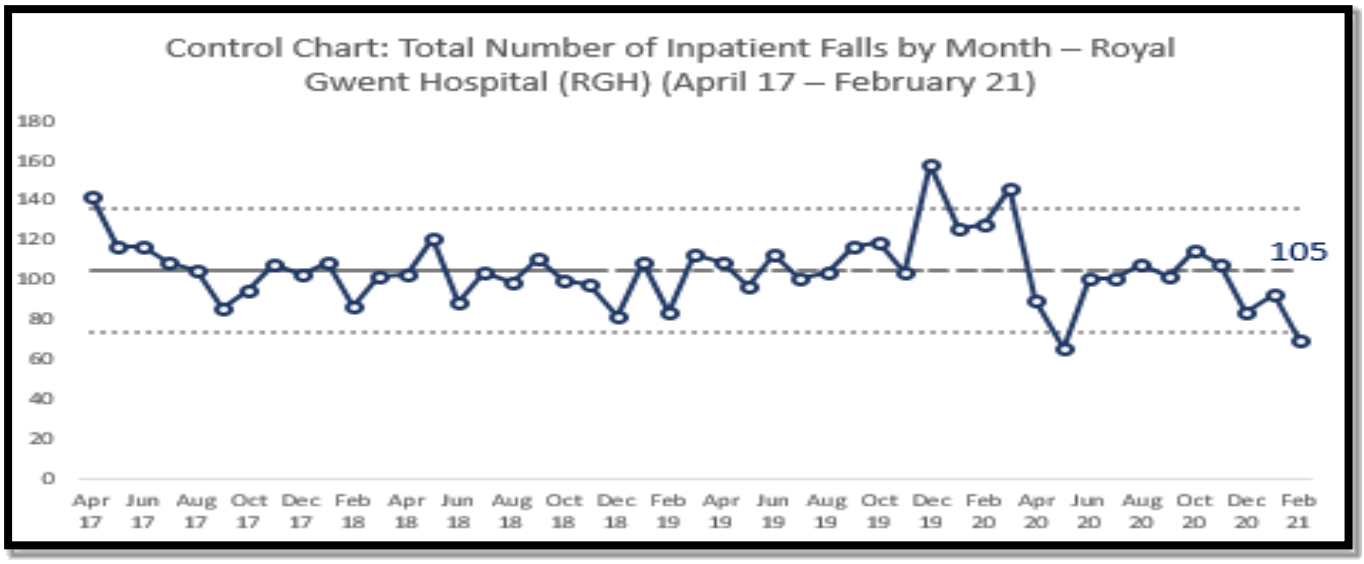
With particular reference to 2020-21 it can be seen that in May 2020 there was a significant decline in falls incidents which coincides with the first wave of the Covid-19 pandemic and the change in cohort of patients at that time. Although numbers of incidents increased up to November 2020 they remain within the identified control limits.

For the Quarter 4 period months - January and February there has been a positive reduction in reported falls to below the defined mean value of 314 to 262.

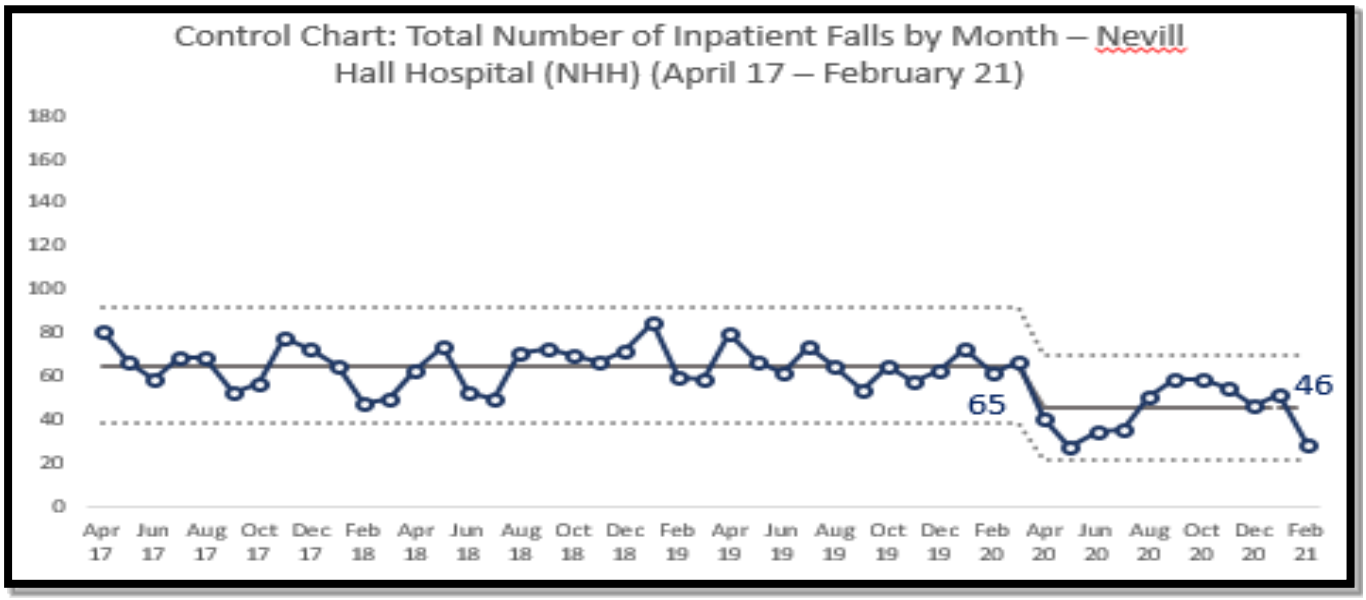


The charts below detail the site specific information for total numbers of IP falls with reference to the ELGH's. The data period covers April 2017 to February 2021.This places context in relation to the overall figures reported by the Health Board.

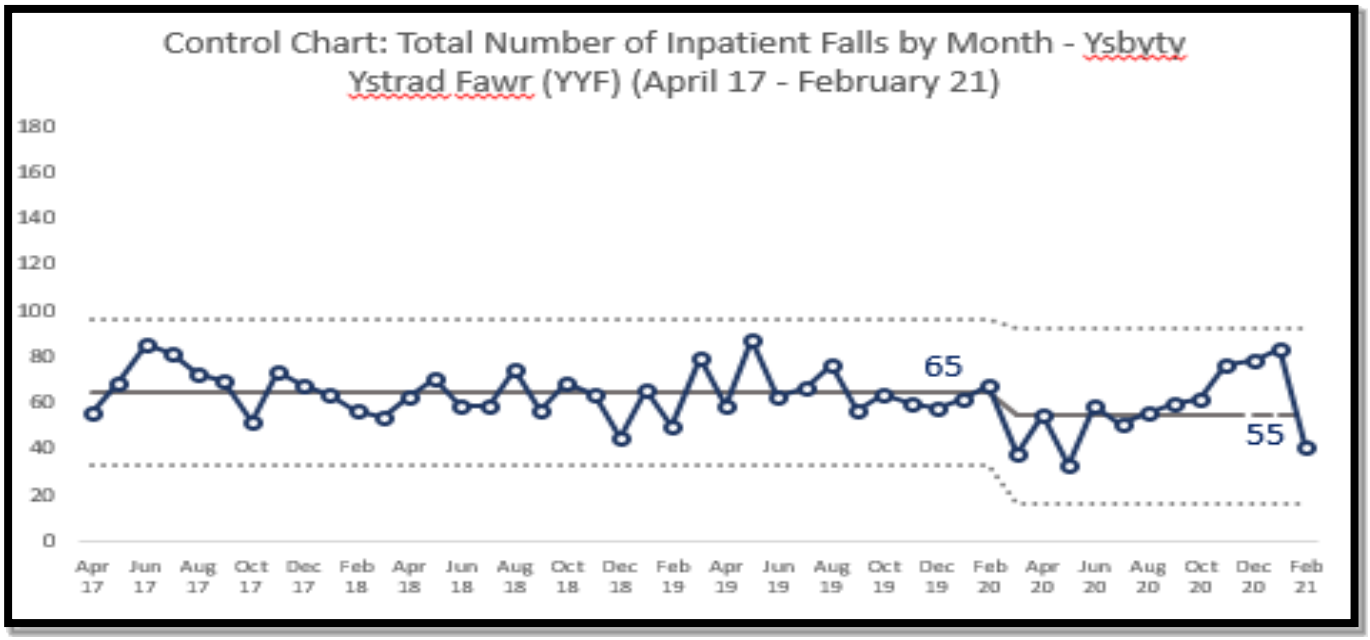
RGH – The mean average number of monthly falls has remained at 105 between April 2017 and February 2020. Whilst the mean average has remained the same throughout there are special cause variation (outside control limits) on four occasions. For Quarter 4 both the months of January and February see values of below the mean average with the latter value contributing to being below the current control limit and is representative of the continuing downward trend in falls incidents at this site.



NHH - The mean average number of monthly falls has seen a decrease since March 2020 from 65 to 46. For Quarter 4 January saw a marginal increase in numbers of reported incidents with a subsequent fall in February 2021 to 29 which is below the current mean. There are no occasions in which special cause variations have been identified.

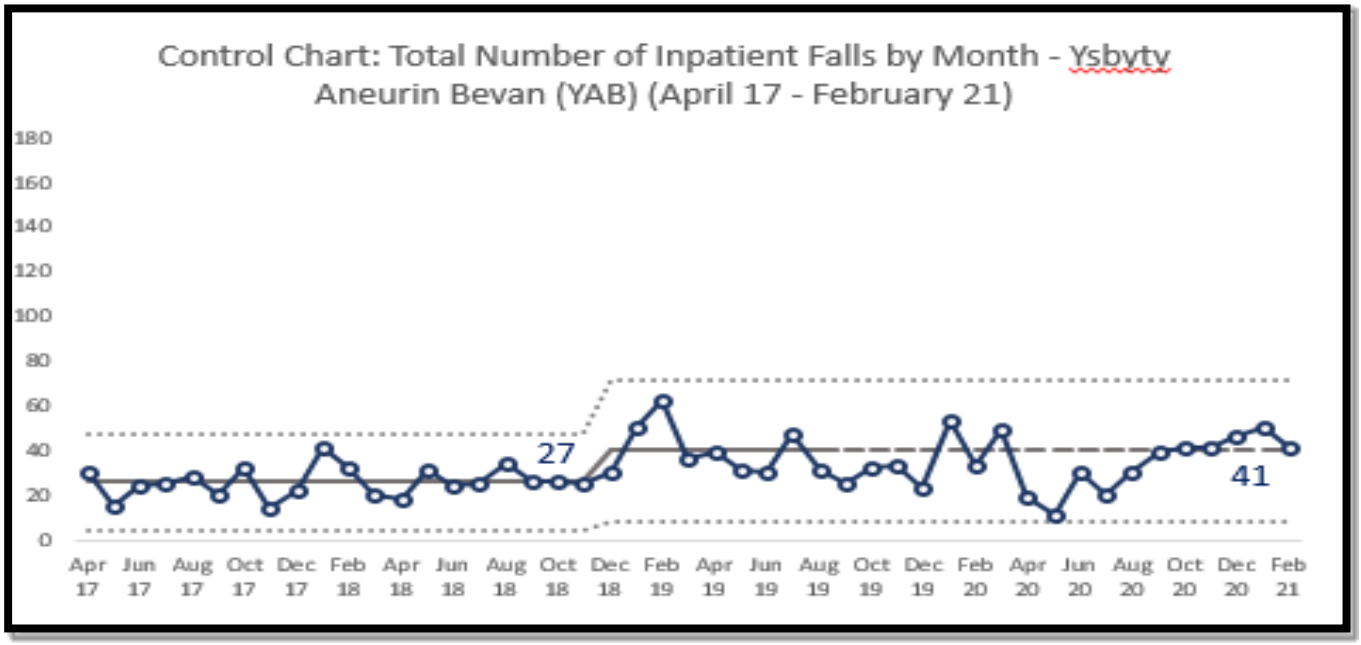


YYF - The mean average number of monthly falls saw a decrease in March 2020 from 65 to 55. Since July 2020 the numbers of reported incidents have risen to the highest value in January 2021 with a subsequent significant decrease in February 2021 from 84 to 41 respectively. There are no occasions in which special cause variations have been identified.



For all other sites, with the exception of YAB, there has been only small shifts in relation to the defined mean average values.

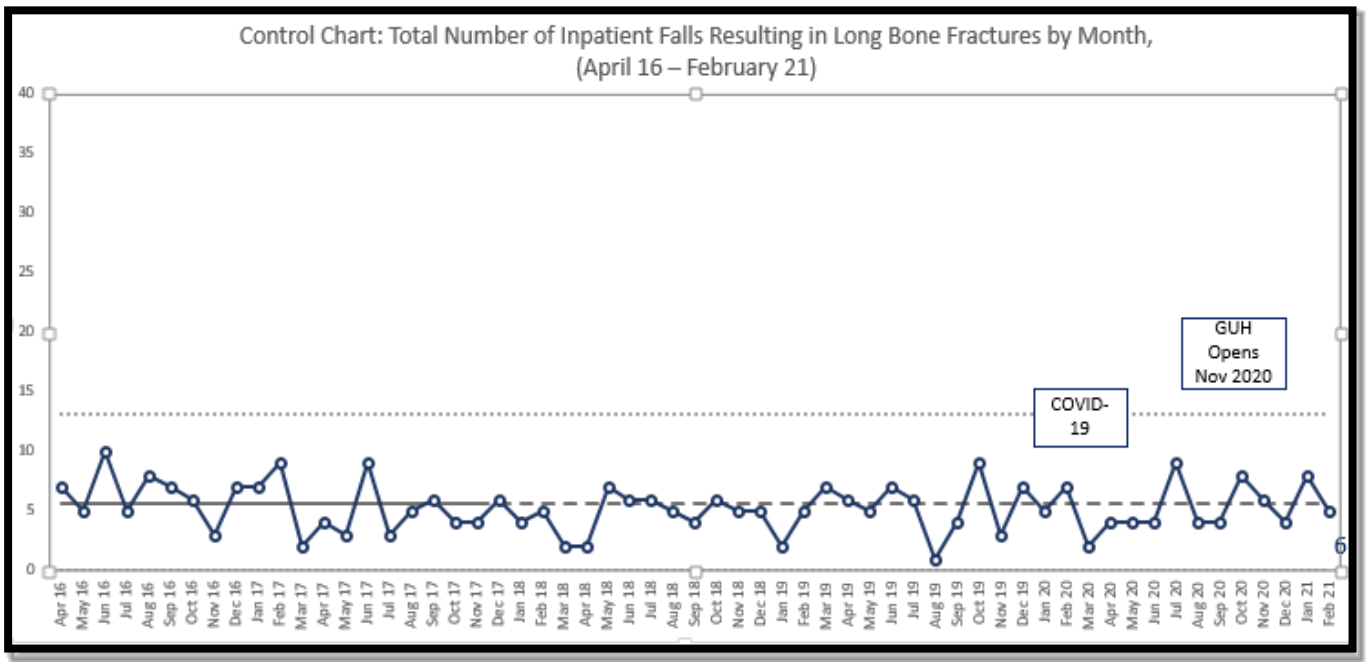
YAB - The mean average number of monthly falls saw an increase from 27 to 41 in December 2018. Reported incidents have continued on an upward trajectory since May 2020. It is however important to recognise the changes associated with the patient cohorts on this site during the Covid-19 pandemic.



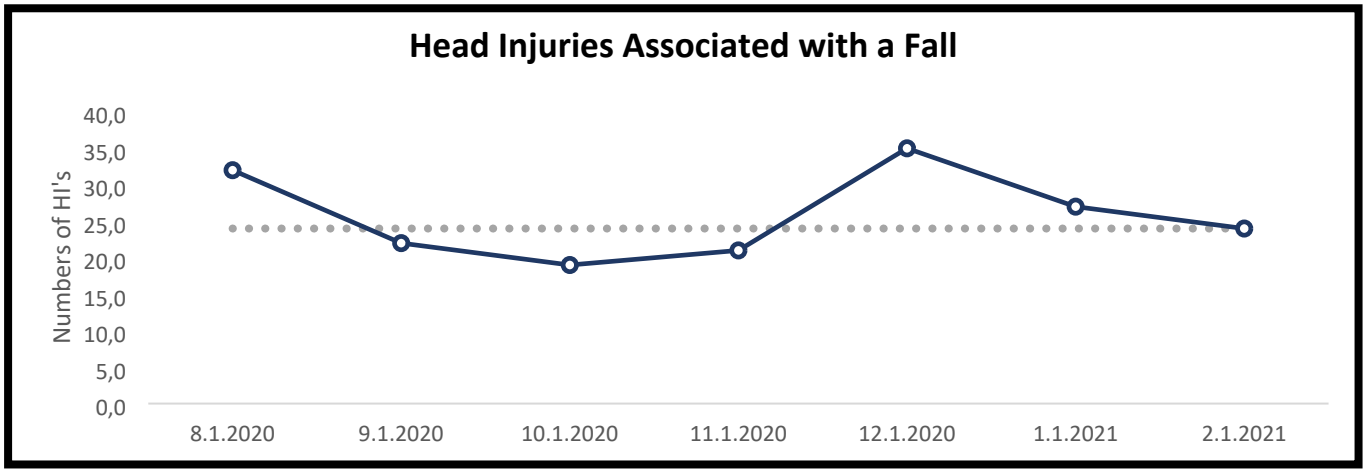
The next chart shows the total number of IP Falls resulting in an injury per Month 2016 -2021.

The information below details IP falls with a resultant long bone fracture and shows no significant variation for the given period of data analysis. For Quarter 4 the month of February has seen a marginal reduction in the number of falls with associated fracture to just below the median value of 6.

All such incidents are discussed at the 'Falls Review Panel' at which the wards provide action plans as an assurance to manage the learning identified through the investigations. This will be supplemented by audit data to evaluate the impact of any associated change.

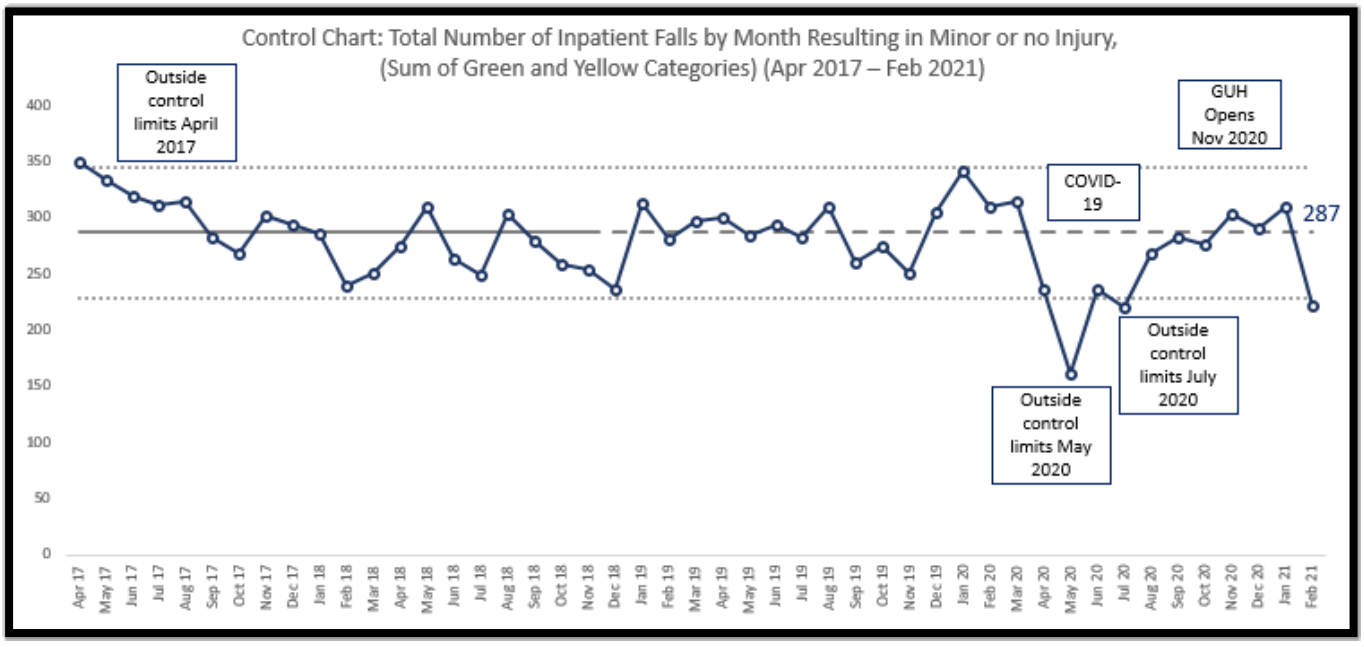


The following chart shows the total number of Head Injuries associated with a fall. The data period covered is August 2020 to February 2021.



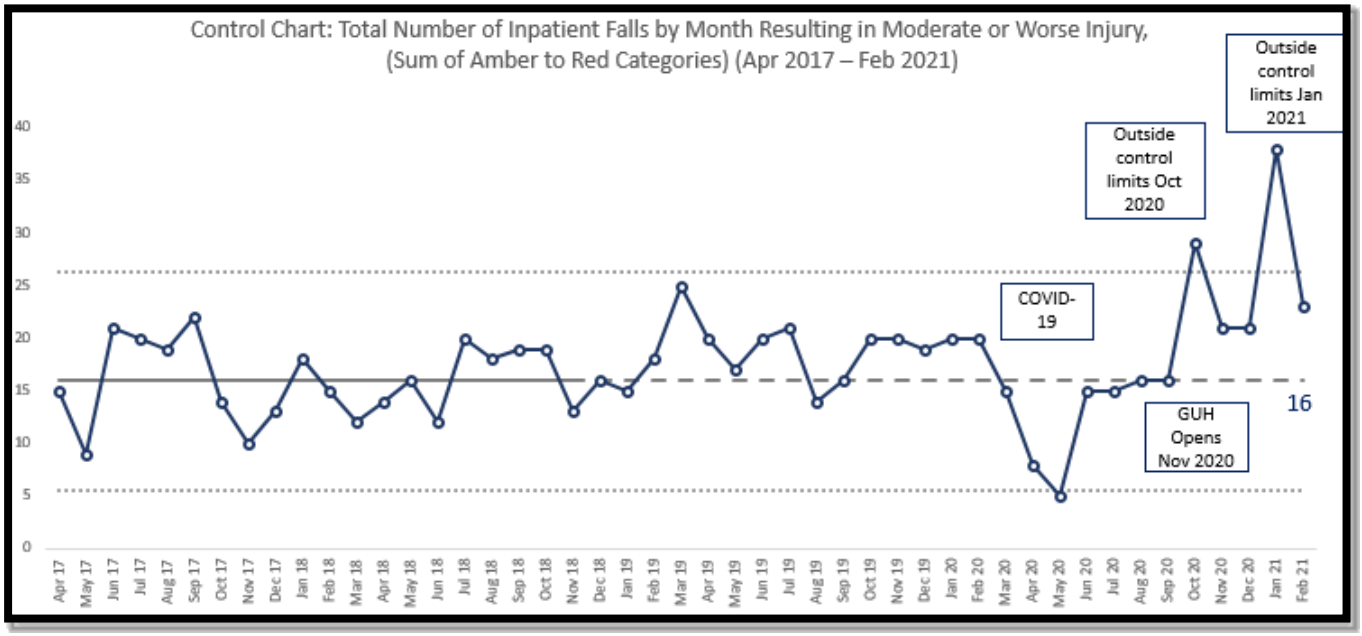
The data is reflective of head injuries sustained as a result of a fall are predominantly represented yellow when categorised in the context of harm. The defined median value is 24. There are three occasions within the six month period in which a proportion of incidents identified in the context of the DATIX reports include the terminology associated with a head injury. On the other three occasions the numbers of incidents are less than the median value.

The next chart shows the levels of severity of harm associated with injurious falls per month, 2017-2021: Green and Yellow Category incidents.



The information provided identifies 4 occasions outside of the defined parameters of control. Of these two are representative of the changes experienced in ABUHB associated with the Covid-19 pandemic. February 2021 has seen a reduction in the number of reported incidents categorised as minor or no harm from 309 to 222.

The next chart shows levels of severity of harm associated with injurious falls per month, 2017-2021: Red and Amber Category incidents.



For the given period the levels of reporting associated with these categories of harm provided an anticipated level of variation. However for Quarter 4, the month of January 2021, has seen a rise in numbers of incidents reported classified as red or amber with a subsequent downward trajectory identified for February 2021. This month also saw the highest total number of falls recorded since May 2020.

Programme of work:

Within ABUHB a comprehensive suite of work is being undertaken which informs the corporate action plan. This is monitored through the Falls & Bone Health Steering Group and has been frequently reported to the QPSC. The work is being informed by data together with that of the staff experiences in the management and prevention of patient falls.

- ABUHB representatives are participating in the newly established 'All Wales Inpatient Falls Network'. This will provide the opportunity to utilise the data, patient and staff experiences to support shared leaning and the establishment of benchmarking standards. The work of the group will look to further inform that of the already established 'Head Injuries Task and Finish Group' and the evaluation of an already existing project to evaluate the single room environment.

- Updating of the Policy for the Prevention and Management of IP Falls facilitated through a robust Multi-Professional consultation process together with a review of the Enhanced Care Policy.

  The revised policy has also taken account of legislative requirements and National Audit to further inform its content and the requirements to reduce the incidents of injurious falls and associated injuries within the Health Board.

  The Policy includes a nationally developed Multi Factorial Falls Risk Assessment (MFRA) to support the transition to the electronic format which forms part of the All Wales Nursing documents.

- The established Falls Review Panel which operates as a Multi- Disciplinary forum is working with the wards to implement their action plans and to provide outcomes evidence to reflect improvements.

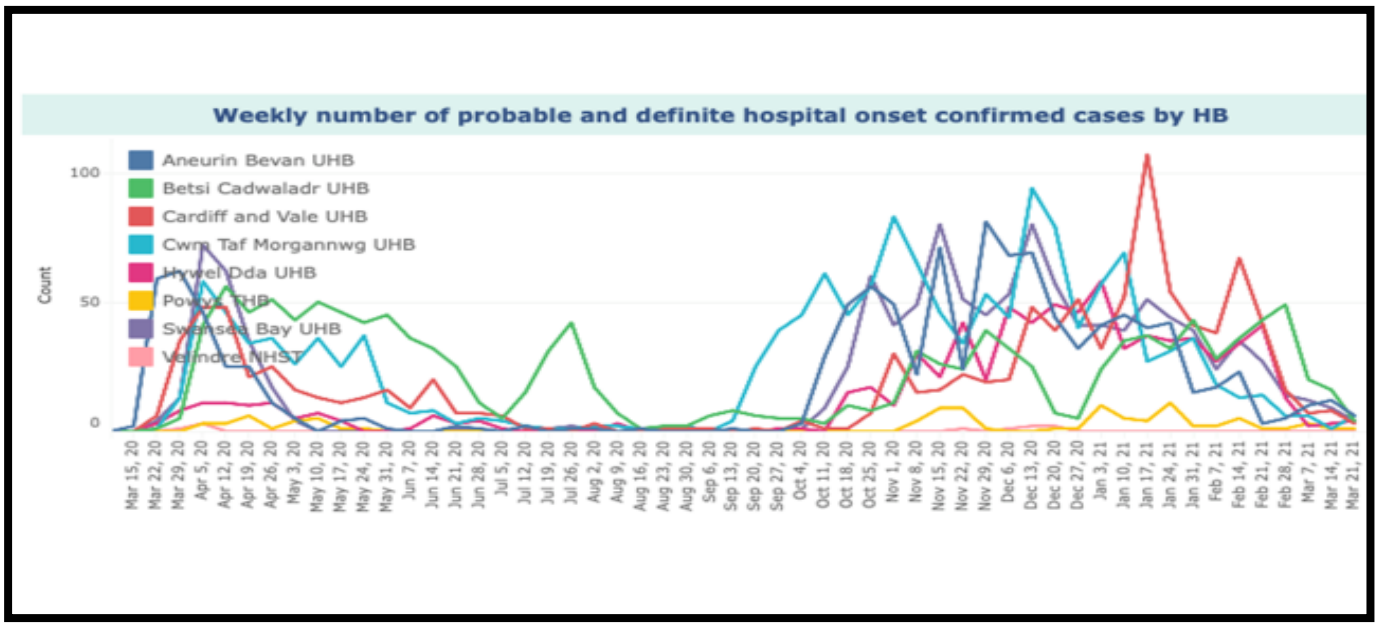
- An external review of the incidents of falls in relation to YYF was commissioned by ABUHB as a means to further understand the challenges associated with falls management. It was completed by a Consultant Nurse for Older People from Cardiff and Vale University Health Board, who has a particularly specialist interest in falls. It outcomes, pleasingly, are consistent with the programme of activities already underway across the Health Board.

- The work associated with the reduction and management of injurious falls is being undertaken by means of quality improvements and as such is through collaborative, multidisciplinary working. Work stream progress has been hampered by the challenges of the Covid-19 pandemic.

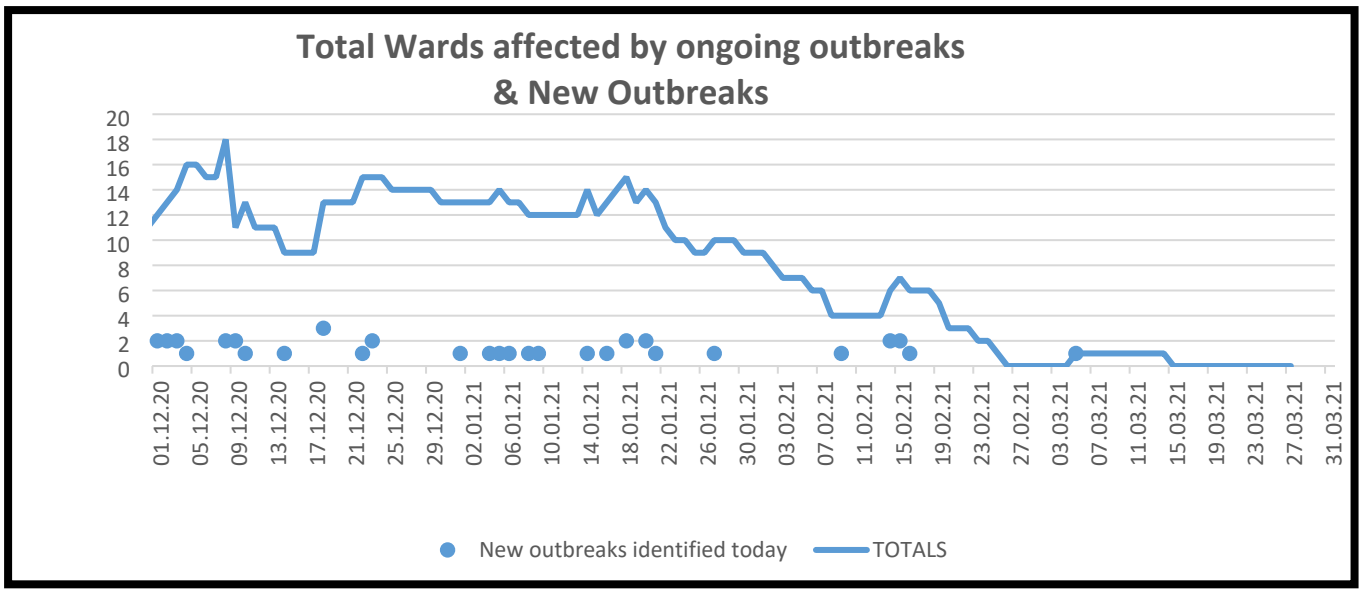
Infection Prevention and Control
(Standard 2.4 – Infection Prevention and Control)

Covid-19
Covid-19 continued to dominate the infection prevention and control agenda during quarter 4, with sustained community spread and new variants evident. The Health Board has managed a number of Covid-19 outbreaks across acute and community sites since mid-October, aligned to the significant rise in community transmission across all five local authority areas.

The All Wales nosocomial graph below clearly demonstrates the challenge of nosocomial Covid-19 across all Welsh Health Boards but it is reassuring to note the significant decline in cases, due to stringent testing and infection control measures and a reduction in community transmission as a result of lockdown and vaccination. There is an absolute need to remain vigilant in light of a possible third surge and the threat of variants of concern, such as the South African strain.



As community and hospital transmission has declined it is notable the number of reported outbreaks have significantly reduced.



Covid-19 Infection Prevention & Control measures are monitored through the Reducing Nosocomial Transmission Group where site based/divisional leadership teams present IP&C compliance data and policies/procedures are debated and agreed.

Learning from outbreak and death reviews is underway and the Health Board is currently adapting the national framework for the management of claims. A summary of the death reviews will be presented at a future QPSC.

Compliance with Welsh Government Targets

Welsh Government targets have remained "active" despite the pandemic and the following table outlines compliance based on provisional figures up to the 31st March 2021:

Organism	2020/21 Target	Current rate	All Wales comparison
C.*difficile*	A rate of no more than 25 cases per 100,000 population	24.69 **Target achieved**	Second lowest
Staph *aureus*	A rate of no more than 19 per 100,000 population	26.56 23% increase **Target not achieved**	Second highest
E*Coli*	A rate of no more than 61 per 100,000 population	49.73 - 30% fewer cases **Target achieved**	Lowest When all Gram negatives combined ABuHB is the most improved with 31+% reduction overall
Klebsiella	A 10% decrease compared to 2019/20	19.45 - 20% fewer cases **Target achieved**	
Pseudomonas Aeruginosa	A 10% decrease compared to 2019/20	4.06 - 38% fewer cases **Target achieved**	

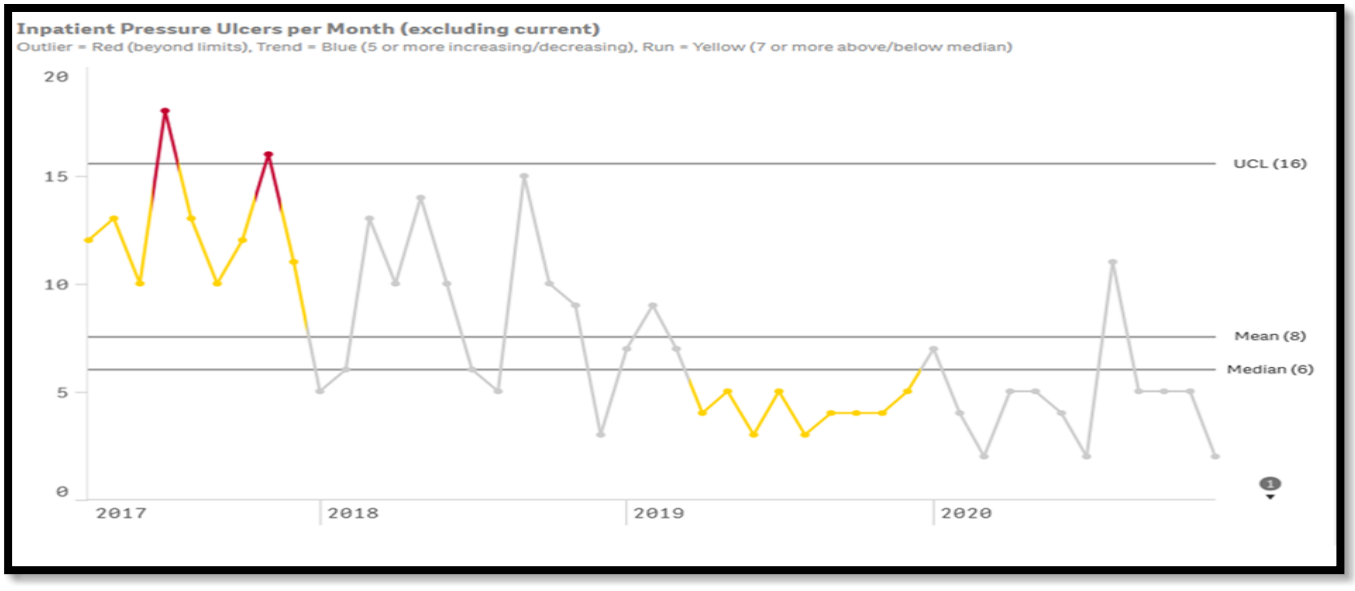
All targets were achieved with the exception of Staph Aureus (a gram positive bacterium), which will be an area of focus for 2021/'22. A reduction strategy will be developed taking into account the learning from cases identified in the community as well as hospital.

Pressure Damage (Standard 2.2 - Preventing Pressure & Tissue Damage)

In 2017, in response to high levels of pressure ulcer (PU) occurrence a PU collaborative was formed with the purpose of standardising the approach to the prevention and management of PU damage. This strategy encompassed:

- The development of accurate metrics related to pressure damage
- The strengthening of root cause analysis (RCA) reviews of serious pressure damage
- A review of the management of pressure relieving equipment.

The collaborative was successful in reducing occurrence of PU (all grades), from late 2018 and this improvement was maintained until recently. In April - May 2020 the Health Board reported the lowest number of pressure ulcers in four years, a likely reflection of the changes in care delivery and the numbers of inpatients during the first wave of Covid. Since then there has been a sustained increase in the overall PU rate until September 2020 when the reporting levels returned to previous rates. PU reporting in November, December and January and February continued to increase above the median with a vast majority of these PU being grade 1 and 2. No increase in the reporting of grade 3, 4 and ungradable Pu has been noted, which suggests effective management of PU once identified. Occurrence is reported and monitored weekly through the Executive Safety Huddle.



A review of the governance around Healthcare Standard 2.2 Preventing Pressure and Tissue Damage is currently underway, with a view to ensuring robust monitoring of the quality and safety of care provision associated with this standard.

The Tissue Viability Nurse (TVN) service is a fast paced high impact service that employs 5 TVNs that covering the entire Health Board. The service sits within the

Primary Care and Community Division, but is available to support all patients and services across the Health Board, with complex wound care management providing advice, training and education for staff. The service also works with the All Wales TVN group developing guidelines, pathways and documents.

A newly developed lower limb referral system includes a multidisciplinary team (MDT) approach will require a collective involvement from all MDT members including Podiatry, Vascular, Trauma & Orthopaedics, Diabetes & Endocrinology, Dermatology, Tissue Viability Nurses and Complex Wound Clinic. The purpose is the improving patient pathways for individuals experiencing problems with lower limb and/or foot wounds.

In addition to the TVN service, the podiatry team provide a comprehensive review of any wounds that occur below the ankle, liaising with teams in regards to pressure ulcer reporting and safeguarding. The service provides twice monthly pressure ulcer case reviews with the Care Home Governance Nurses. The team support training and development providing foot health care and diabetic foot care checks to Nursing Homes and District Nurse in line with current guidance.

In line with the Welsh Health Circular all Multiple Grade 2/3/4/Ungradable/Suspected Deep Tissue Injury (SDTI) are subject to a root cause analysis to establish causation and to identify emergent themes.

Divisions monitor pressure ulcer prevalence and incidence through their respective quality and patient safety structures, closely monitoring DATIX. The Complex Care Team monitor and review all occurrences of pressure damage that occur within Care Homes to gain assurance around standards of care provision. Pressure ulcer root cause analysis (RCA) has recommenced in all divisions. During the RCA process it has been identified that some pressure ulcer development is as a result of a delay in completing timely risk assessments and in ensuring that all mitigating actions are undertaken. One area of concern identified is the timeliness of providing patient equipment and the variation in providing pressure relieving equipment to address identified risks. As a result a task and finish group has been established to standardise protocols for the request, authorisation and provision of pressure relieving equipment.

All Wales Clinical Fora has been re-established, after a number of cancelled meetings due to the Covid-19 pandemic. This forum continues to implement the developed work plan for 2021/22. A key focus of this work will relate to the care and treatment of people with leg ulceration and the reporting/categorisation of early stage pressure damage.

Medicines Management (Standard 2.6 – Medicines Management)

The monitoring of medication incidents is undertaken by the pharmacy directorate to establish emergent themes and trends.

Medicine Safety Thermometer audits have commenced across all sites and monitor a number of quality indicators relating to the safe prescribing and administration of

medicines. A series of deep dive audits is underway to further explore emergent themes and to provide greater scrutiny.

Improvement work is currently underway in relation to the safe prescribing of Sodium Valproate. Sodium Valproate is associated with a significant risk of birth defects and developmental disorders in children born to women who take valproate during pregnancy. An action plan developed jointly between Mental Health and Primary Care Directorates to ensure the timely assessment of pregnancy prevention plans for women of child bearing age who are prescribed Sodium Valproate has been developed. The work has included a review of all women and girls prescribed Sodium Valproate in Primary Care to ensure regular review in an appropriate specialist setting, which encompasses a risk assessment and pregnancy prevention plan.

Safeguarding (Standard 2.7 – Safeguarding children & adults at risk)

Internal Audit has conducted a review of the management of safeguarding across ABUHB and allocated 'reasonable assurance'. The recommendations have been embraced with the establishment of an operational group, enabling the Safeguarding Committee to focus on strategic matters. The Terms of Reference for both the Group and Committee have been developed and for the latter amended.

The Safeguarding Operational Group will oversee delivery of the agreed work programme. A Risk Register has been developed to ensure focus on areas of key risk.

Effective Care

The principle of effective care is that people receive the right care and support as locally as possible and are enabled to contribute to making that care successful.

If people receive the right care and support they will be empowered to improve or manage their own health and wellbeing. Interventions to improve people's health must be based on best practice, derived from good quality research. Data relating to care delivery should be maintained in structured, accurate and accessible records. The ability to manage data and information and to communicate effectively will contribute to the delivery of safe and effective care.

Record keeping (Standard 3.5 – Record Keeping)

The national implementation of the Welsh Nursing Care Record (WNCR) has commenced. The digital solution will fundamentally change the way nurses admit and document the care of patients within the health board, moving from a paper based system to nursing assessments being recorded electronically. This will form part of the Health Board's ambition to be a pathfinder in the realisation of the Digital Ward.

Whilst Aneurin Bevan University Health Board had been involved in the pilot of the service in 2020 there has been a break in the engagement with the national programme as a result of the resignation of the Nursing Informatics Lead and the

impact of Covid-19. A new Chief Nursing Information Officer has joined the organisation, in late January, to provide clinical leadership and engagement for this and the wider informatics agenda. The Informatics Directorate will provide project support for the programme and there will be a band 6 Informatics Clinical Nurse Specialist appointed and funding for a technical lead provided nationally. A baseline assessment of the current position has been undertaken, engagement with the national programme established and planning commenced for the implementation of the electronic nursing record within the health board. The Digitisation Nursing Documents Programme Board has been re-established and will oversee the preparation activities and implementation of the WNCR. ABUHB will potentially be the final Health Board to implement the service due to technical issues associated with the availability of documentation within the Clinical Workstation and the establishment of the project. Once the technical work stream has been planned and a resolution date identified, preparation work will start on the implementation activities; with the proposal being The Grange as the first site commencing in quarter 3.

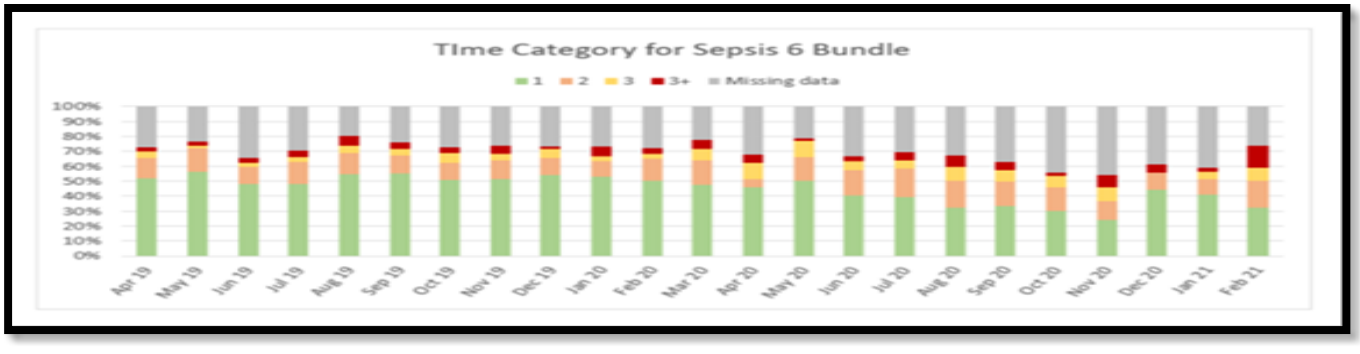
Mortality (Standard 3.1 - safe and clinically effective care)

The reporting of Universal Mortality Reviews (UMR) as a national quality indicator has now ceased as the implementation of the Medical Examiner (ME) service supersedes local UMR processes. Despite this, the Health Board continues to prioritise the completion of UMR until the ME service is working across all hospital sites and reviewing all inpatient deaths. Additional resource to support the completion of mortality reviews has been secured.

A national working group has been established to support development of a National Learning from Deaths Framework following agreement that a consistent and systematic process is needed to support organisational and national learning from all deaths on an All Wales basis.

Sepsis (Standard 3.1 - safe and clinically effective care)

The reconfiguration of the Emergency Department, and Medical Assessment Unit and opening of GUH in November 2020 led to a decline in the completion of documented Sepsis 6 intervention bundles. A previous snap shot audit had demonstrated that completion of the bundle was associated with improved completion of the 6 interventions. The graph overleaf demonstrates the delivery of the 6 components of the Sepsis bundle within 1, 2 and 3 hours for patients who receive a positive sepsis screening and for whom a sepsis bundle document is started.

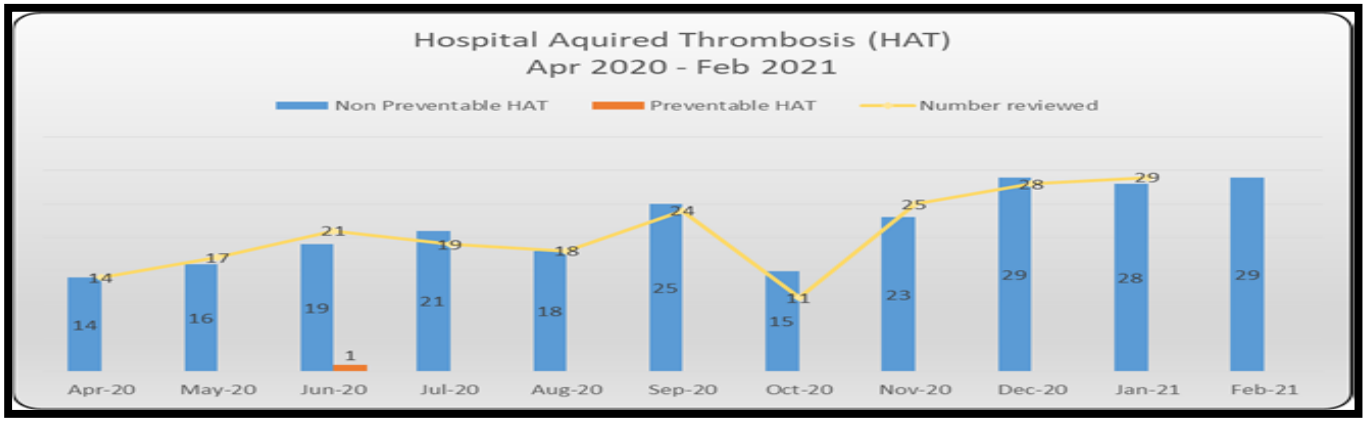


Since January 2021 compliance with completion of the proforma has increased on the GUH site. The Quality and Safety lead on the Nevill Hall site is actively working with Medical Assessment Unit staff to review processes and improve compliance. Work is underway to improve compliance on the RGH site.

The introduction of Careflow into the Emergency Department will provide a digital solution to support the completion of the Sepsis bundle and provide improved data availability to evidence performance and to drive improvement. This will be implemented later in 2021.

Hospital Acquired Thrombosis
(Standard 3.1 - safe and clinically effective care)

All Hospital Acquired thrombosis are identified and a root cause analysis undertaken to understand if there these event were preventable. Only 1 preventable thrombosis has been identified since April 2020 compared with 10 in the same period the previous year, demonstrating significant improvement, as shown in the next graph.



National Clinical Audit (Standard 3.1 - safe and clinically effective care)

Reporting of clinical audit through the Clinical Standards and Effectiveness Group has resumed to ensure Divisional oversight and monitoring of progression of associated action plans.

A revised plan of reporting to the Quality and Patient Safety Committee will mean a bi-annual Clinical Audit paper is reported for the purposes of assurance.

Individual Care

Complaints and Serious Incidents
(Standard 6.3 – listening and learning from feedback)

Each and every concern raised deserves, and is entitled, to receive an appropriate and proportionate investigation and response.

In 2019-20, ABUHB received 1658 formal complaints, 1568 complaints were closed in year, of which 995 were responded to within 30 working days, the Welsh Government target. Overall compliance for the 2019/20 was 63.5%, a significant improvement of the previous year.

The improvement noted in 2019/2020 has been sustained in 2020/2021 with 30 day compliance in February 2021 being 65%, consistent with the same month in the previous year (64%) and Serious Incidents performance was 67% slightly lower than January 2020 (73%). The Putting Things Right Team is continuing to work with the Divisions, through improved training, networking, and collaboration and sharing of best practice.

The Putting Things Right Annual Report for 2019/'20 has been presented to Executive Team and approved for submission to Welsh Government. The Report is presented to QPSC for information.

Never Events
(Standard 6.3 – listening and learning from feedback)

Never Events are defined as serious patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level have been implemented by healthcare providers (NHS Improvement 2018). The more commonly nationally reported Never Events in 2018/19 included, wrong site surgery (including wrong tooth extraction), retained foreign object and wrong implant prosthesis and these accounted for 75.4% of reported Never Events (n=374) during that period.

In the past 2 years the Health Board has reported 16 Never Events, a number of which were reported retrospectively following a review of patient safety incidents. These events have occurred across multiple Divisions and Directorates. The majority of reported Never Events correlate with the national commonly reported themes, wrong site surgery, retained foreign object and wrong implant. Each Never Event is subject to a comprehensive investigation that explores all contributing factors and identifies the root cause of the event.

In each case an action plan is developed to ensure the implementation of the necessary actions and improvements. Actions have included:

- The Implementation of 'Stop Before You Block'
- The development of amended WHO checklists delivering procedure specific prompts
- Revised guidance in relation to staffing requirements for specific procedures

In 2016 Welsh Government published the Patient Safety Notice PSN034 that required the introduction of National Safety Standards for Invasive Procedures (NatSSIPs). The standards were created to provide safer care for patients and to reduce the possibility of Never Events occurring. The NatSSIPs are based on the World Health Organisation (WHO) checklist for Surgical Safety, but develop this further and cover skills and training, scheduling of theatre lists and governance and training.

In 2017 a corporately led programme of work was undertaken to identify all invasive procedures and to support the development of Local Safety Standards for Invasive procedures (LocSSIPs). This work was undertaken in many areas, however further analysis is required to gain assurance of the completeness of the gap analysis and LocSSIPs development.

In response to the retrospective identification of Never Events (previously reported to the QPSC), a Theatre Safety Group was established to oversee an improvement plan that encompassed themes relating to incident management processes, governance and culture. This group has been successful in implementing a number of improvements and supporting the introduction and monitoring of governance measures including audit.

In addition, an internal audit of WHO checklist was undertaken and was awarded reasonable assurance. An action plan has been developed to progress the recommendation from the audit report and is being led by the Scheduled Care Division.

A strategic task and finish group with Divisional and Corporate membership is being developed to support a standardised approach across all Divisions and Directorates and to progress work relating to 4 key objectives:

- Divisional identification of all invasive procedures
- The development of LocSSIPs associated with these procedures
- A standardised programme of assurance in relation to practice in line with the LocSSIPs

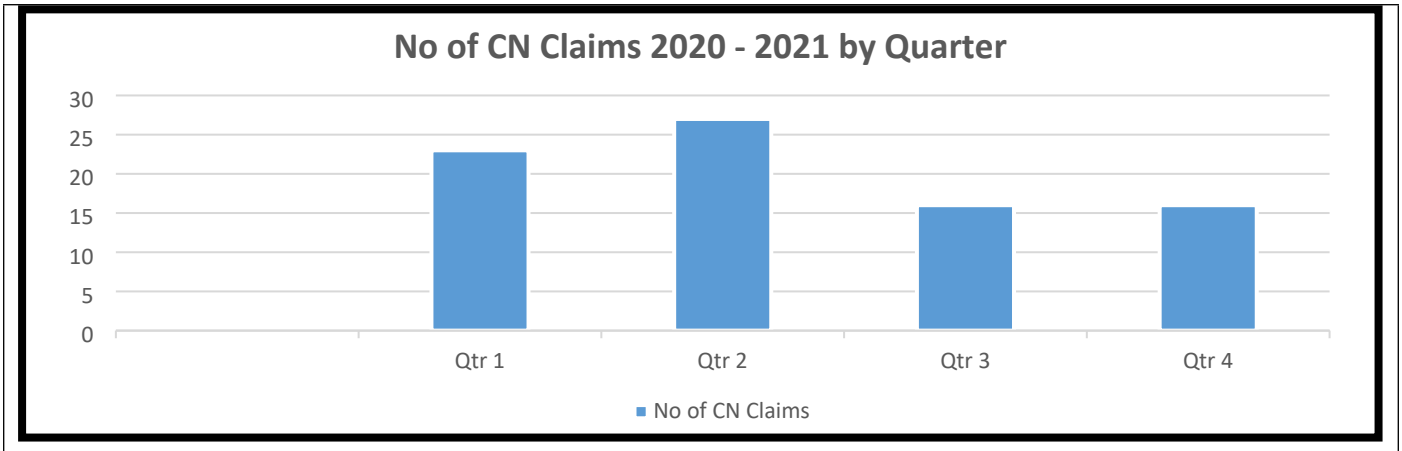
The Development of learning and education to support improved compliance and greater understanding of contributing human factors.

Claims and Redress
(Standard 6.3 – listening and learning from feedback)

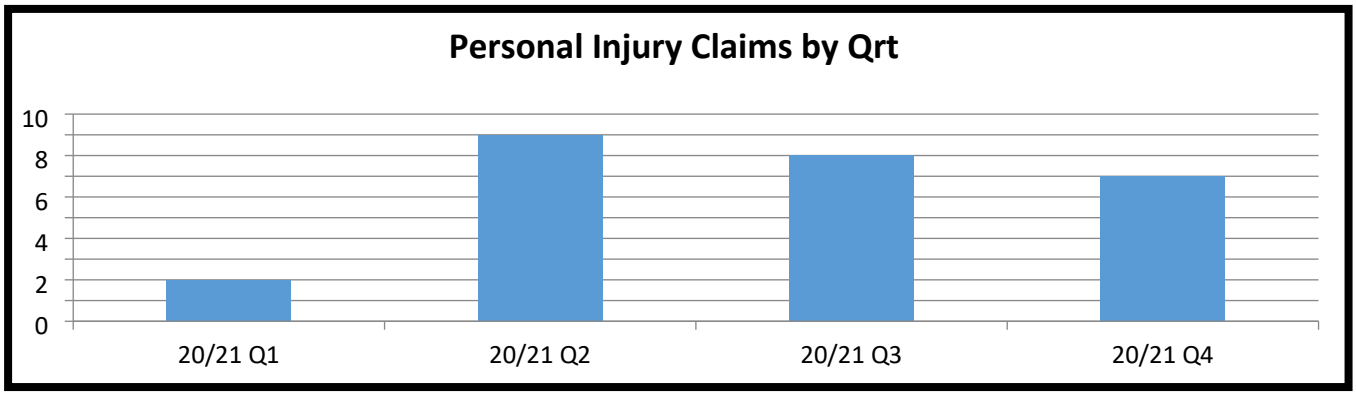
New Claims: New claims need to be seen within a wider totality of year on year patterns. External influences together with the time taken to lodge, investigate and make a formal claims are factors as to when claims are brought. They are not necessarily a reaction to events which have occurred in the immediate preceding period.

Clinical Negligence Claims: Whilst Legal Services keep a record of all potential claims which are received, only those which are formal or meet a certain criteria will be proactively investigated and Legal & Risk instructed.

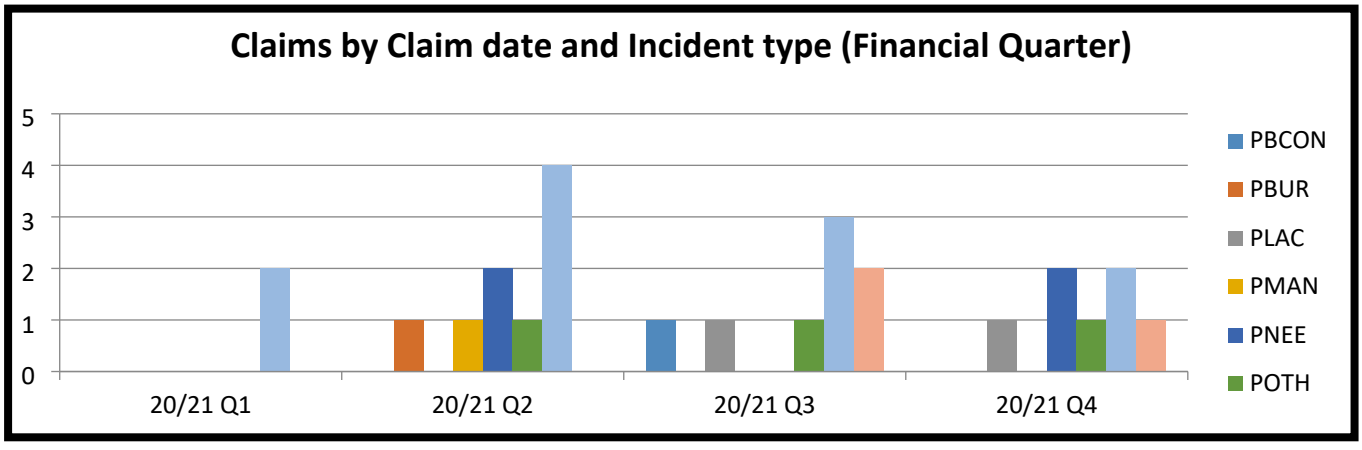
A total of 82 new formal clinical negligence claims have been received during the year where Legal & Risk have been instructed. This represents a decrease of 32% on the amount of new clinical negligence claims received during the year. 121 new claims were received in 2019/2020. 16 were received in quarter 4.



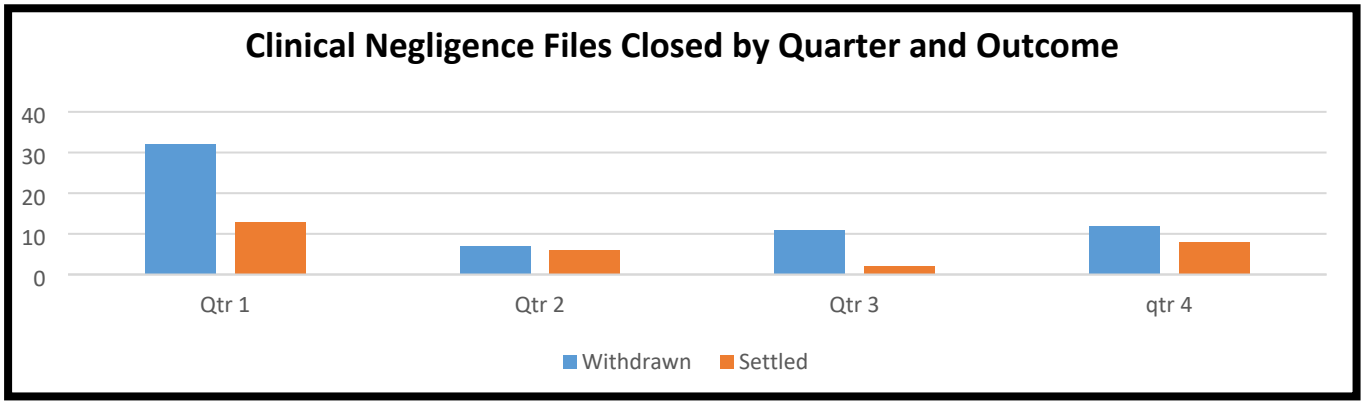
Personal Injury Claims: 27 new personal injury claims have been received for the year, this is a 41% reduction on the number of new claims received from 2019/2020 when 46 new claims were received. With the exception of quarter one, the claims have been received evenly throughout all the quarters with 7 being received in quarter 4.



Slips continue to feature as the predominant type of personal injury claim albeit that low numbers of claims have been received throughout the year and only 2 received in quarter 4.



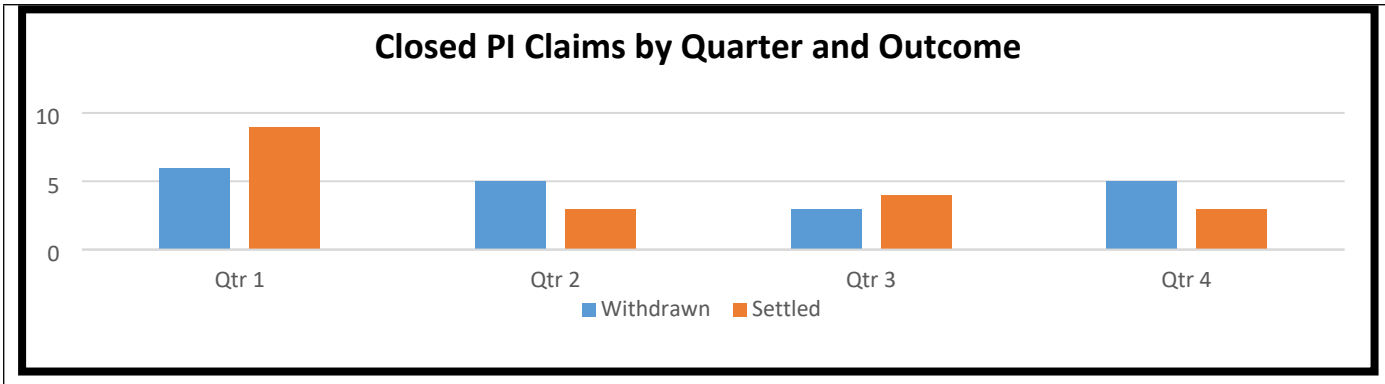
Closed Claims: Of the 91 clinical negligence claims which were closed during the year, most of the claims were closed during quarter 1. This is due not only to the changes in Welsh Risk Pool reimbursement procedures with the emphasis on learning which is required to be evidenced but also due to the change in the portfolio of the Legal Services Managers caused by the pressure due to the number of new Inquests and enquiries from the Coroner and matters being heard. See below.



Of the 20 claims which were closed during quarter 4, 8 were settled. Of the settled claims:

Directorate	Theme/Issue	Action taken
Emergency Care	Failure to diagnose - poor documentation - wound not fully exported	Reflection, case discussed with individual concerned and anonymised and shared within directorate.
Care of the Elderly	Lack of documentation 1:1 provided but nurse attending to another patient at time of incident	
General Surgery	Patient not fully consented re risks of procedure	Health Board has full programme of training on consent and provided updating lectures/presentations following index case of Montgomery.
		Case anonymised and discussed within directorate, individual reflection.
Anaesthetics	Patient suffered complication	Patient information leaflet amended to include risk of injury to lung.
		Regional anaesthesia now undertaken by specialists in this procedure if undertaken at eDGH if patient is unsuitable for general anaesthesia.
Orthopaedics	Delay in diagnosis and treatment (4)	Case anonymised and discussed within directorate, individual reflection.
	Failure to refer and arrange further investigations	Standard operation procedure introduced and implemented in respect of requesting nerve conduction studies. Updated guidance issued to secretarial staff.

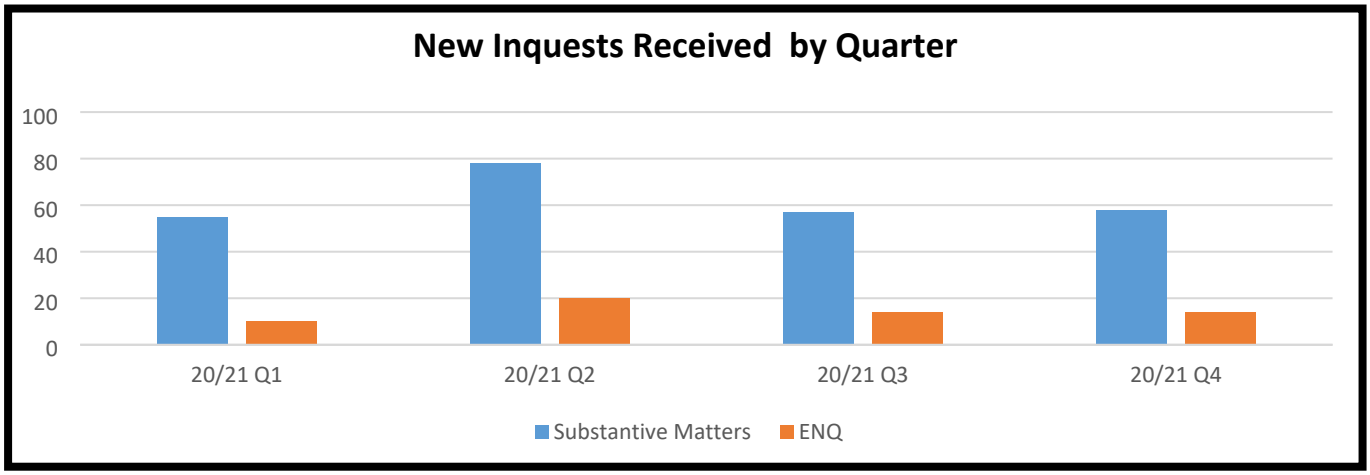
Personal Injury Claims: Similarly reflecting the pressures identified above most of personal injury claims were closed in quarter one. 36 claims have been closed during the year.



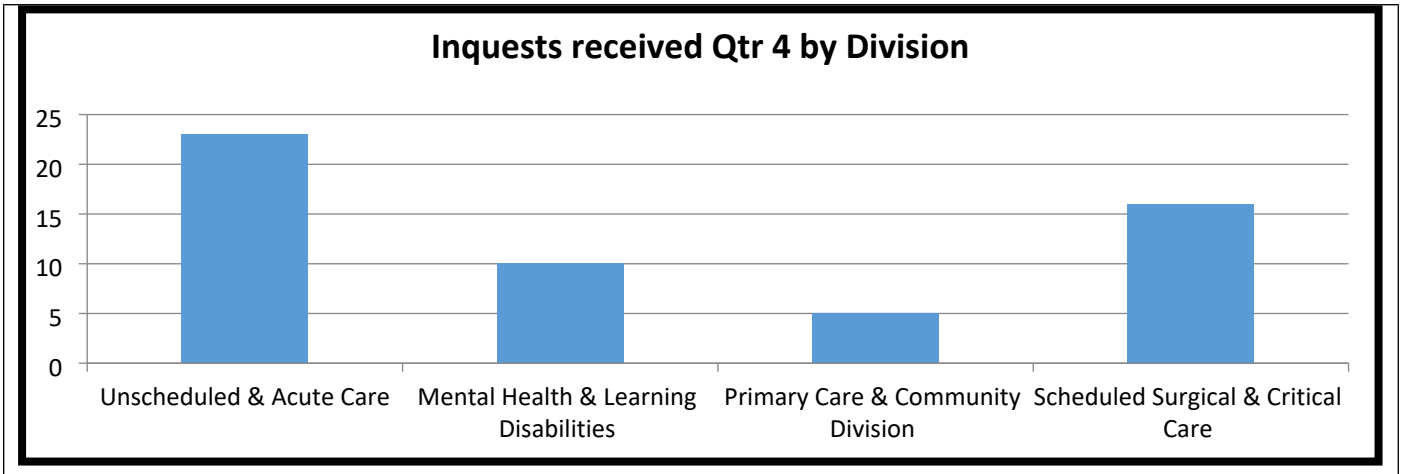
Of the eight cases closed in quarter four, three were settled.

Incident type	Remedial Action
Slip outside	Pothole repaired
Equipment – inappropriate use	Risk assessment updated to reflect risk and ensuring procedure to be undertaken during its use
Chair and flooring	Internal safety alert issued

Inquests: During the year 306 requests for information have been received from the Coroner.



A total of 72 requests were received during quarter 4. Whilst 14 related to queries from the Coroner e.g. whether a person was known to our services or requests for records, 58 new Inquest files have been opened where the Coroner is seeking statements from staff and where appropriate copies of any incident investigation undertaken.



39 matters have been closed and the Legal Services Staff have attended and supported staff at 15 Inquests during the quarter, one of which was a six week hearing involving the care provided to members at a care home and involved the death of 6 residents (to note: a separate report has been provided for the QPSC regarding this inquest).

During the quarter the Coroner has issued the Health Board with two Prevention of Future Deaths Reports. The Health Board is required to provide a response within 56 working days. Both cases relate to inpatient falls:

Case	Action Health Board is required to consider
Case 1	Steps taken to ensure a truly MDT approach is achieved to managing patients' needs when they are identified as at high risk of falls.
	A review of adequate staffing to care for at risk patients.
Case 2	Information on steps taken to address staffing levels on ward.
	Describe how the findings and learning from internal investigations are shared in a meaningful and timely manner with all grades of clinical staff.

A response to a Regulation 28 report issued in Quarter 3 was sent to the Coroner in quarter 4. The response confirmed that practices within the Mental Health Services Directorate confirmed that they had devised a process and proforma to aid the timely sharing of pertinent information and to ensure that GPs are routinely invited to participate in reviews of serious incidents. Processes are also being considered to ensure that third sector organisations are also invited to participate in such reviews when they have been involved in a person's care.

Redress: 66 concerns (complaints or patient safety incidents) have been requested by the Divisions to be considered at the Health Board's Redress Panel. Prior to a matter being considered by the Panel, the case is sifted by the Legal Services Managers to ensure that the matter is not outside the financial limits for Redress and to ensure that the Redress Panel have all the pertinent information to enable them to

consider the case and make informed decisions as to whether there is a qualifying liability.

Of the 25 cases allocated during the quarter to the managers for sifting:

7 have been heard at Redress Panel.
6 have been sent back to the Division for additional information.
2 have been precluded from Redress due to potential value and factual responses under Regulation 24 have been issued.
3 cases are waiting for further information from the Division before the matters can be sifted.
2 cases are prepared and waiting to be heard.

These figures do not include requests which are made to the managers directly.

Two Panels were held during the quarter hearing a total of 11 cases in which a qualifying liability was established in 9 cases. The decisions of the Panel are shown by directorate below.

Directorate	Qualifying Liability Established	Qualifying Liability Not Established	Further Information needed
T & O	1	1	
Caerphilly	3		
General Surgery	2		
Emergency Care	1		1
Cardiology	1		
Newport	1		

Of the cases heard where a qualifying liability was established:

Themes:

Theme	Issues	Action Taken
Pressure Damage 3 cases (1 T&O 2 General Surgery)	• Failure to provide pressure mattress • Failure to communicate to patient he was high risk • Failure to complete MUST documentation • Poor documentation • Delay in review • Delay in escalation • Lack of evidence of pressure relieving measures in place	• Action plan given to all members of staff on ward • Skin bundle documentation audits commenced • Mini improvement collaborative to be restarted Covid permitting • Pressure Ulcer collaborative quality meetings restarted.

Theme	Issues	Action Taken
Nursing care	• Failure to monitor blood sugar levels • Incomplete documentation • Did not identify deterioration • Lack of review by clinicians	
Delay in diagnosis a) Fracture	• Request for senior review as patient re-attended not undertaken	• Discussion at junior doctor and ENP teaching sessions
Medication	• Medication should not have been stopped.	• Case anonymised and discussed within directorate.
Falls (2 - Caerphilly)	• Enhanced level of care indicated not implemented • Poor documentation and care could not be evidenced • Falls equipment not provided.	• Monthly audits of inpatient falls risk assessments. • Falls compliance being audited weekly • Standard operating procedure introduced on ward for enhanced care and this is now being spread across all community wards

The aim of the Legal Services team is to send out substantive responses within three weeks of Panel being held. Of the 10 cases where decisions have been made, 5 responses were issued within this time frame and there were two cases where this was not achieved. The deadline has not been reached in three cases.

Closed Cases:

19 Redress files were closed during the quarter.

No:	Reason for Closure
2	Qualifying liability was not established
4	Cases were closed as they were above the value for consideration of redress or a claim ensued
3	Offers of redress were not taken up and/or not pursued further
10	Offers of Redress were accepted

Internal and External Inspections
(Standard 6.3 – listening and learning from feedback)

As previously reported, HIW adapted its approach to assurance and inspection as a result of the Covid-19 pandemic. From August to December 2020 HIW used a three tiered model of assurance and inspection which reduced the reliance on onsite inspection activity as their primary method of gaining assurance. These Tier 1 Quality

Checks were conducted remotely. There have been five notice of quality checks, and no immediate assurance notices were issued. All areas have completed their improvement plan.

- Redwood – HIW recommended a review of all mandatory training compliance. This has been completed and the ward are now reporting compliance of 93.4%.
- C7 West – HIW made several recommendation in relation to cleaning schedules, hand hygiene, mandatory training and information governance training. All requisite actions have been undertaken and completed.
- Adferiad Ward – HIW made several recommendations in relation to suitability of placement of Covid Patients, ligature risks, Wi-Fi, nursing skill mix and recruitment processes. Actions associated with the improvement of access to Wi-Fi and ligature risks are ongoing but within timescale and the remaining actions are complete.
- Ty Skirrid Ward – HIW made two recommendations in relation to domestic cleaning and increased compliance with PADRs. A review of domestic cleaning provision has been undertaken to address requirements. A plan has been developed to ensure scheduling of PADRs which includes monthly monitoring of compliance.
- Ty Lafant Ward – HIW made several recommendations in relation to visiting arrangements through Covid, ligature risks, risk assessments of the visibility of the garden area, mandatory training, sharing of annual health check information between Primary Care and Mental Health and Learning Disabilities services. An action plan has been developed and all actions are in train and progress is being monitored.

The HIW National Review of Maternity Service was reported to the Committee in January, the action plan has been submitted to HIW, no response has been received to date. The action plan will be subject to ongoing implementation by the Divison and review via the Maternity Services Assurance Group.

Since the coronavirus pandemic, the Community Health Council (CHC) have focused on engaging with people in different ways, This includes surveys, apps, videoconferencing and social media to hear from people directly about their views and experiences of NHS services as well as through community groups. More recently they have been conducting virtual visits where feedback has been provided to the Health Board.

A separate report detailing the Community Health Council and ABUHB Buddying Project is subject to a separate report for the Committee.

Timely Care

The principle of timely care is that people have timely access to services based on clinical need and are actively involved in decisions about their care. Not receiving timely care can have a huge impact on individuals' experience of health services and their ability to achieve the best health outcomes. To ensure the best possible outcome people's conditions should be diagnosed promptly and treated according to clinical need.

Elective Activity (Standard 5.1 – Timely Access)

Elective activity undertaken has mainly been based on the Essential Service Framework distributed by Welsh Government, where delivery was defined by the clinical prioritisation of the patient, rather than a time based approach. Services deemed as *essential* are broadly defined as services that are lifesaving or life impacting where harm would be significant or irreversible without timely intervention. Services have embraced new ways of working due to Covid-19 especially within outpatient services where the focus has been on virtual clinics and office-based decisions.

The reporting of performance measures, including RTT, has now been re-started by Welsh Government. The Royal College of Surgeons (RCS) introduced guidance on how and what pathways should be prioritised for patients waiting for treatment, as an inpatient or day case. Changes to incorporate the agreed RCS risk prioritisation on the national Welsh Patient Administration System (WPAS) has been completed and is now live.

Diagnostic Access

The over 8 week position improved in January 2021, with 10,523 waiting over 8 weeks compared with 10,788 in December. Endoscopy activity has continued to increase over recent months and provided across all sites and has recovered pre-Covid levels of activity. Plans are being developed to address the backlog and options for additional capacity with support through St Joseph's hospital.

Cancer

Cancer diagnosis from outside of primary care referral routes remains significantly down. This is most likely due to a reduction of incidental findings of cancer associated with routine workload currently not being undertaken.

The new Single Cancer Pathway performance measure was formally reported in January with a decrease in compliance of 58.9% compared with 65.8% in December. The focussed and sustained effort into recovering the cancer position is now having a noticeable effect on pathways. With a reduction in the cancer backlog of 30% and with the exception of Breast, a 13% improvement in first seen within 2 weeks since January. Similarly, diagnosis within 28 days has improved by 9% in the last month. Whilst the 62 day position for February continues to look challenging, the positive improvement in pathway metrics are suggestive of a recovering positioning the coming months.

Stroke

Since opening the Hyper Acute Stroke Unit (HASU) at GUH, the main challenge has been maintaining available bed capacity to admit patients presenting with stroke and providing timely onward transfer to the ELGHS. The Covid-19 pressures have made

it particularly difficult to ring-fence beds for patients with stroke across the entire pathway, but there is a continued emphasis on protecting these beds, as a primary mechanism to improve stroke care performance and therefore achieve the best clinical and experience outcomes for patients.

In the context of the current Covid-19 environment and constraints described, the proportion of patients with stroke directly admitted to a stroke ward improved in January 2021 with 30.8%, compared with 26.6% for the same period last year. This is a significant improvement on the December position which was 17.6%.

The percentage of patients with stroke assessed by a stroke consultant within 24 hours is high at 98.5% and has been consistently above the national target of 85.3%, throughout the pandemic. The percentage of patients receiving the required time allocation for speech and language therapy improved slightly in January with 43.3% compared with 36.7% in December 2020. A review of therapy services across the stroke service is being undertaken by the Clinical Director of Therapy Services, to ensure that there is equitable therapy provision.

Mental Health

Access to services on the CAMHS Neurodevelopmental Pathway reported 89.9% against the 80% target. The service has introduced additional decision points into the clinical model, which reduce the length of the assessment and diagnostic pathway.

Work is underway to ensure safe and dignified care of children and adolescents requiring mental care in an inpatients setting following a number incidents relating to the admission of young people to an adult mental health ward.

Patients age 16-18 who require acute admission to a mental health ward are admitted to a designated unit accommodated on an adult mental health ward. The staff on this ward have received the appropriate training to ensure the safeguarding of these young people. Where a young person age 16 or 17 requires admission to the Psychiatric Intensive Care Unit (PICU) the decision is made jointly between the Child and Adolescent Mental Health Service (CAHMS) team and Adult Mental Health directorate and is reviewed every 24 hours.

Patients under 16 who require acute admission are admitted to an acute paediatric ward and specialist CAMHS staff are sourced to provide care as appropriate, however, there are occasions where it is not possible to safely deliver the appropriate care in this environment and patients are instead admitted to an adult mental health ward. It is anticipated that more CAMHS patients will be able to be accommodated appropriately in GUH as a result of the single rooms. In addition work has been undertaken by Estates and Family and Therapies Division to minimise the ligature risk on the acute paediatric wards. Every case is risk assessed on an individual basis to ensure appropriate mitigation.

All young people under the age of 18 who are admitted are actively offered advocacy to ensure that they are involved in their care planning.

Nationally, a Specialist CAMHS Improvement Framework has been developed and is being led by the CAMHS Network to review the model of inpatient provision.

Sustained performance above the 80% target for Primary Care Mental Health Services (PCMHS) Measures for assessment within 28 days is reported, with 80.2% compliance. The position deteriorated in January for the intervention measure with 54% compared with 72.9% in December 2020. This is in part due to the service focusing on assessment, to ensure that all patients receive the initial assessment with a registered Mental Health Practitioner. This is part of an approach which aims to minimise the number of interactions with different practitioners and to direct patients to the most appropriate care and support first time. Where therapy is indicated, the aim has been to maintain care interventions with the same practitioner. This is deemed better care for individual patients, whilst acknowledging that it may initially impact on the access targets.

With regard to demand for services, referrals for adults are back to pre-Covid levels and Children and Young People (CYP) referrals are at a level that exceeds pre-pandemic referral numbers. During the pandemic, the PCMHS has been completely transformed with 100% of the service being provided remotely until very recently. Currently, 90% of the service is delivered via telephone and/or video conferencing. Microsoft Office 365 Teams is being used to provide group interventions for both adult and CYP and video conferencing for one to one therapy.

Urgent Care, ED and WAST

A small number of patient safety incidents relating to acutely unwell individuals self-presenting at the Minor Injuries Units (MIU) at the ELGHs have been reported since the opening of GUH. As a result, a review of processes to ensure the safe clinical management and timely transfer of these patients has been undertaken.

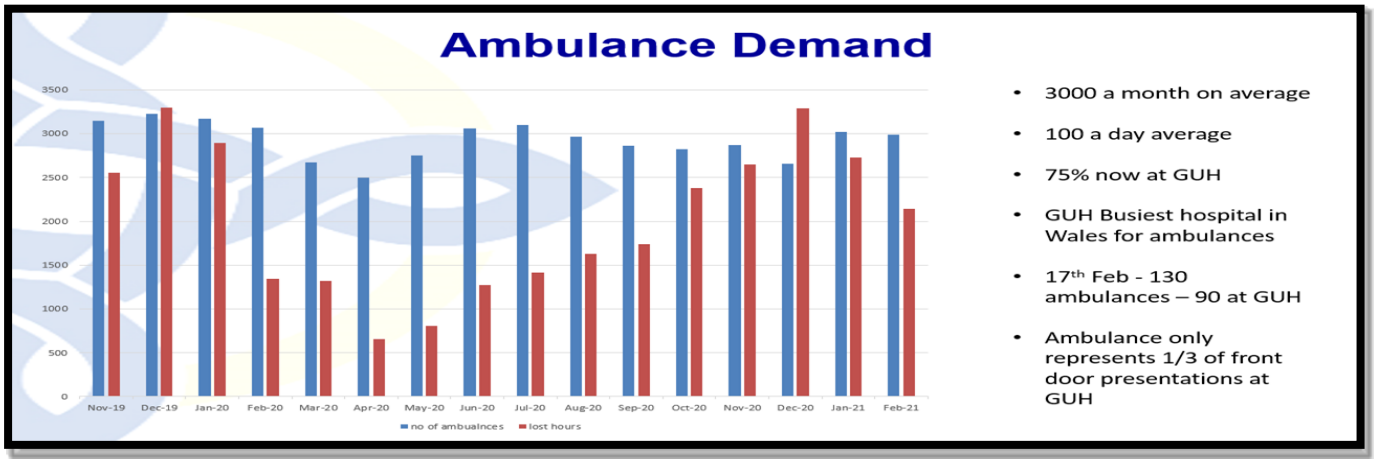
In response, a joint WAST and ABUHB Flow Centre protocol has been developed to ensure the timely and appropriate transfer of patients to the correct unit. The protocol includes a built in safeguard to ensure appropriate action regardless of whether the escalation is directed via the Flow Centre or WAST. In addition a standard operating procedure has been developed to ensure that medical personnel working in the MIU have adequate senior clinical support in the management of acutely unwell patients until they can be transferred.

The imminent implementation of Phone First, an initiative that forms part of a wider programme of work around the re-design of Urgent Care, has been identified as a priority within NHS Wales and will support presentation of patients to clinically appropriate units.

The underpinning premise is the establishment of a 24/7 clinical hub within the Health Board can provide further consultation and assessment to those patients whose call to 111 has resulted in an ED/ MIU disposition. Patients can then be directed to the most appropriate service including the offer of a booked appointment in a range of care settings including ED. It is hoped that once fully rolled out, the service will not only be a key enabler to improved urgent patient flow across the Health Board.

Since opening in November 2020 The Emergency Department have experienced a high level of ambulance demand and high numbers of self-presenting patients. This

has presented ongoing challenges in terms of timely handover of patients from ambulance personnel to ED with long waits, with significant delays observed in December.

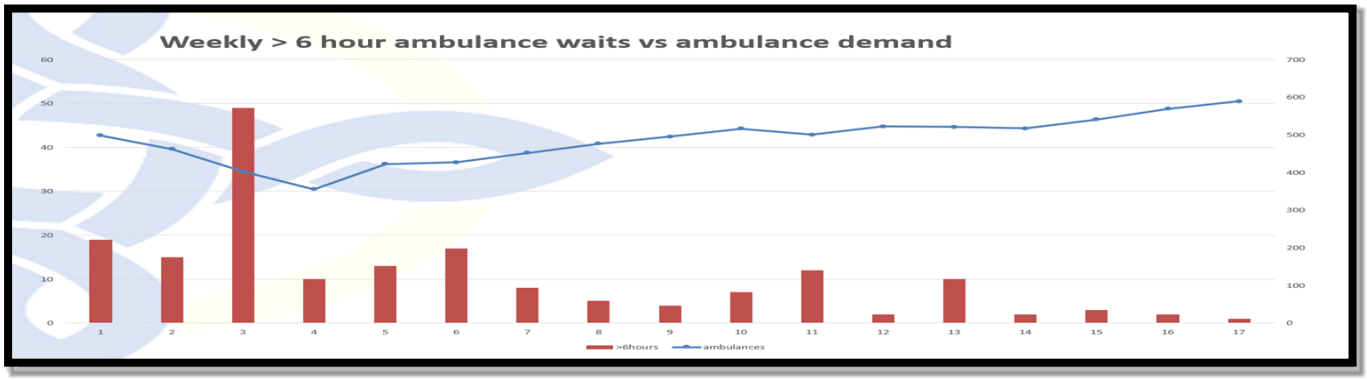


Key Challenges include:

- Covid demand across the systems
- The development of Covid pathways and separation of patients
- New Covid assessment zone, which has resulted in loss of short stay beds
- Swabbing process and delays associated with test results
- Embedding a new system including ensuring appropriate presentations and facilitation of inter-site transport
- Demand and batching of ambulances
- Workforce challenges

To mitigate associated risk and drive improvements in performance and patient experience an ambulance improvement plan and escalation process has been developed and includes the implementation of the new hospital site based leadership and a new hospital transfer protocol. The development of daily demand and capacity reviews across sites supports the identification of early indicators of escalation.

Since week one of the opening of GUH improvements in the numbers of patients waiting on the ambulances over 3 hours has decreased from 100 patients to 20 in week 14, this is despite a sustained increase in ambulance attendances (and self-presenters) noted since week 4 of GUH opening. This improvement has resulted in a decrease in the numbers of WAST ambulance crew hours lost, however more work is required.



When the GUH opened on the 15th November 2020, a new inter-site transport system was launched in collaboration with the Welsh Ambulance Service Trust (WAST) and the Non-Emergency Patient Transport Service (NEPTS). Patients are transported between hospital sites in response to the clinical need to either escalate or de-escalate their care to the most appropriate service or specialty. To ensure that these transfers are managed effectively via the inter-site transport service, new services, processes and procedures were designed for each organisation involved.

Since opening, the most prevalent inter-site transfer requested has been that for the transfer of a patient from the GUH to any other hospital site. There have been a number of issues raised throughout November and December 2020 in regards to this process, predominantly in relation to the local processes in ABUHB. The reality of the volume of these transfers required per day has created additional pressure on the ability to enact a brand new process across multiple stakeholders simultaneously.

Inter-site transfer activity during February continued to be managed within the modelled numbers (72 per day) with 4 hour (inter-site and discharge) performance improving to 88.5% and 90.2% respectively against a 90% standard. One hour (step-up) performance was at 75.6% for February 2021, again against a 90% standard.

Pick up within 30 minutes is measured against a 100% KPI (time of call to arrival in a ward or department to transfer a patient). Pick-up for patients transferring from ELGH's to GUH was reported as 58.5% and for patients transferring from GUH was 51.9%. The main identified reason for this is that the Transfer Lounges are not fully operational as per modelling assumptions with an unintended consequence that ambulance staff are spending longer on site.

The Primary Care and Community Division are working with Scheduled and Unscheduled Care Divisions to monitor the appropriateness of inter-site transfers and discharges out of hours, to ensure the wellbeing and dignity of the patient group.

Emergency Medical Service (EMS) activity showed signs of improvement as red 999 performance increased to 64.6% since January. All call categories (red, amber and green) saw lower responses than in January; conveyance rates however rose to 64% which was a 1.7% increase on the previous month. Lost hours improved by 678 hours during February to a reported 1577.4 lost hours across our key sites.

Non-Emergency Patient Transfer Service (NEPTS) activity remained stable with all areas performing well with the exception of oncology inbound performance (51.6%) and core inbound performance (68%) reported as below the required 75% standard. These areas of concern will be discussed at the Tier 2 meetings along with the number of aborted journeys and journeys booked on day by Health Board wards and departments.

Recommendation

The Quality and Patient Safety Committee is asked to:

- **Note** the Health Board position against a range of key quality and safety metrics, notably pressure ulcers, never events, falls, claims and redress and inter-site transport.

- **Agree** the revised RAG rating for Pressure Ulcers, Falls and Infection Prevention and Control.

- **Note** the continued Red RAG rating in relation to Never Events and Urgent Care: ED and WAST until the mitigation is embedded and assurance can be gained in relation to effectiveness of these measures.

- **Discuss** performance, themes and actions.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight clinical risks in the system. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a number of areas are also included within the Covid and Corporate Risk Registers.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	Advice will be obtained from the Workforce and OD Directorate about how the Impact Assessment is carried out for this report.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.

	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	See section 4.
Public Interest	Report has been written for the public domain.

Quality and Patient Safety Committee

A proposal for revised reporting arrangements

Executive Summary

A review of reporting arrangements for the Quality and Patient Safety Committee has been undertaken by the Clinical Executives in response to the recommendations from Internal Audit, the approval of the ABUHB Quality Assurance Framework and a request from the Committee Chair. An annual work programme is in-development, based on the Health and Care Standards, and it is proposed that reporting against these standards is strengthened to provide assurance to the Board.

The programme will include:

- An annual programme of Health and Care Standards assurance reports
- A bi-annual internal and external inspection report
- A bi-annual clinical audit report
- A regular Quality and Patient Safety exception report (every meeting).

Purpose of the Report

The purpose of the paper is to propose a structured annual reporting plan to the Quality and Patient Safety Committee strengthening assurance for each of the Health and Care Standards, internal and external inspections and clinical audit, together with timely and transparent exception reporting in relation to emerging themes and trends across the Health Board.

The Committee is asked to consider and approve the proposal.

Background and Context

The Quality and Patient Safety Committee provides assurance to the Board in relation to arrangements for safeguarding, the quality and safety of person-centred care, requirements and standards determined for the NHS in Wales together with compliance, clinical audit concordance and internal and external inspections.

The Health and Care Standards (HCS) were launched in 2015 and form the cornerstone of a quality assurance system within the NHS in Wales. There are 7 standards:

1. Staying Healthy
2. Safe Care
3. Effective Care
4. Dignified Care
5. Timely Care
6. Individual Care
7. Staff and Resources

By way of further illustration, under Safe Care Standard 2.8 is Blood Management. A review of the past agendas for the QPSC, over the past two years, demonstrates that no reports have been considered by the Committee regarding blood and blood products. Under Effective Care standard 3.2 relates to communicating effectively and meeting language needs. Again, the Committee has not received assurance in recent times regarding sensory loss standards.

Internal Audit completed a review of HCS in 2019/20. This included consideration for the assurance provided to the Quality and Patient Safety Committee (QPSC) through overall regular reporting and oversight of the standards. The audit awarded reasonable assurance and identified one high priority action, to strengthen governance, accountability and reporting structures and to identify escalation routes to the QPSC and Executive Leads.

In March 2020 the Board approved the ABUHB Quality Assurance Framework. The Framework comprises a range of groups each of which focuses on an aspect of quality and safety ultimately reporting to the QPSC via the Quality and Patient Safety Operational Group (QPSOG). The Framework is mapped to the HCS and incorporates themes of patient safety, clinical effectiveness, dignified care and individual care.

Assessment and Conclusion

A review of the governance around each of the HCS is currently underway, with a lens on ensuring robust monitoring of the quality and safety associated with each of the standards.

This review process is helpfully subject to an Internal Audit review and will incorporate:

- A review of the Terms of Reference of each Health Board Group / Committee that has a role in overseeing a HCS;
- A review of the evidence / information considered in each group with the purpose of providing assurance;
- A review of reporting and escalation process of each group to the Board via the Quality and Patient Safety Committee (QPSC)

An annual assurance report will be produced, using a consistent framework, for each of the 7 standards and will be reported to the QPSC, via QPSOG. The report will provide detail in terms of concordance with the standards outlining performance and practice for each Division with actions to secure improvements where necessary. These reports will be scheduled across the year.

In addition, it is proposed to produce:

- a bi-annual report providing detail of Internal and External Inspections, including findings, recommendations and progress against requisite actions.

- a bi-annual report providing details of clinical audits, including results, benchmarking and actions plans.

- a Quality and Patient Safety Performance report at each meeting, which will be risk-based RAG-rated, identifying emergent themes and trends including the work in progress to mitigate associated risk and to drive required improvements.

Recommendation
To consider and approve the proposed approach for future reporting to the Quality, Patient Safety & Performance Committee, with the aim of strengthening assurance to the Board against the national framework.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Tuesday 13th April 2021 Agenda Item: 5.1

FaceTime "Buddying Project": Inpatient Engagement during the Coronavirus Pandemic

Executive Summary

Community Health Council's (CHC's) hear from the public in many different ways. Before the Coronavirus pandemic, CHC's regularly visited NHS services to hear from people at the point they are receiving care. These visits are regularly scheduled as part of the CHC's annual engagement plans. Third party feedback from the CHC's is a rich source of independent information for the Aneurin Bevan University Health Board (ABuHB).

The CHC has engaged with the public in many different ways throughout the pandemic, including on-line surveys and social media. National guidance and restricted visiting has prevented CHC members direct attendance on the wards, meaning that they were unable to obtain face to face real time feedback from people who are in-patients. Therefore, it was agreed that a virtual patient engagement buddying pilot using FaceTime enabled i-Pads would be undertaken across in-patient services.

The attached CHC report sets out the findings of the virtual buddying programme and provides rich feedback of patient's experiences across our wards during the pandemic.

Extremely positive feedback about staff was reported. A number of recommendations contained within the report have been fed back to Divisional Teams for further discussion and action. There are also wider corporate recommendations.

QPSC is asked to note the report and provide views.

Quality, Patient Safety and Performance Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	X
Executive Sponsor: Rhiannon Jones – Executive Director of Nursing	

Date of the Report: 13 April 2021
Supplementary Papers Attached: Facetime "Buddying" Project Inpatient Engagement during the Coronavirus and Draft Action Plan

Background and Context

In August 2020, the Person Centred Care Team (PCCT) and the Aneurin Bevan CHC agreed to pilot a virtual inpatient engagement 'buddying' programme, where 2 members of the PCCT would attend the wards and connect patients to CHC officers via video calls/Facetime. In discussion with Divisional Nurses, all visits were well co-ordinated, patient consent sought and there was full adherence to infection control measures. There were initial issues in securing Facetime on i-Pads meaning there was a two week delay in starting the pilot.

A schedule of 35 ward visits were planned. However, 10 ward visits needed to be cancelled either because the wards were closed to visiting or because of the lack of Wi-Fi availability. Between September and October 2020, 25 wards were visited across 8 hospital sites and 96 patients provided feedback.

The wards at the following hospital sites were visited:

- Chepstow Community Hospital
- County Community Hospital (including Ty Siriol)
- Maindiff Court Hospital
- Nevill Hall Hospital (including paediatrics and EAU)
- Royal Gwent Hospital (including adolescent ward and MAU)
- St Cadocs Hospital
- St Woolos Hospital
- Ysbyty Ystrad Fawr Hospital

People gave overwhelmingly positive comments about staff, at all levels, about their care, approach and support. This positive theme was consistent in people's messages in nearly all cases. The CHC concluded that 'this demonstrates that staff have gone above and beyond in their duties to ensure that impatient experiences were comfortable, well informed and engaged with during this unprecedented level of disruption and demand on NHS services'.

On the whole, patients were very understanding of the impact of the pandemic on both visiting and staffing pressures. Any immediate areas of concern were escalated and actioned without delay.

Assessment and Conclusion

The CHC report outlines a number of key recommendations, many of which have common themes across the wards. These recommendations and draft action plan (see attached) have been shared with Divisions with the expectation that they discuss further and agree actions within Divisional QPS meetings. There are a number of recommendations that require corporate consideration.

Summary of Themes/Recommendations

At ward/unit level:

1. **Loneliness and isolation**- particularly in single rooms, where patients did not have visitors and could not access personal devices and/or could not connect to hospital Wi-Fi.
2. **Boredom**: There is need to further consider meaningful, person-centred activity.
3. **Restricted Visiting:** Numerous patients reported negative impact due to not being able to have visitors, the general 'disconnect' from families and friends and the need to consider 'virtual' connection and virtual visiting.
4. **Communication:** with a particular reference to those who were hard of hearing (increasing isolation and loneliness). It is recommended that further identification of patients with communication needs is reviewed with strategies in place to combat negative impact.
5. **High Risk of Isolation:** the Health Board is asked to consider how patients at high risk of isolation are identified and the measures needed to reduce negative impact.
6. **Wi-Fi connection:** this was an issue on some sites, impacting patient's ability to use their own devices to connect and preventing them for engaging in this pilot.
7. **Sleep/rest disturbance:** due to environmental noise, uncomfortable chairs.
8. **Meal choices/beverages**: feedback varied from very good to 'unpalatable' food, 'cold coffee' and long wait for snacks. It is recommended that there is a 'mealtime review'.
9. **Dignity:** Long waits to use the bathroom impacting on dignity. Where this has been identified specific actions have been suggested to the clinical areas to review staffing/support levels.
10. **Delays in Information**: in regards to medical status, diagnosis, communication on transfer (with a specific recommendation from a parent).

Corporate Recommendations:

- **Meaningful Activity**: The need to develop a person centred meaningful activity strategy that keeps patients occupied and reduces loneliness and isolation. There are ongoing discussions around this and a bid developed for consideration against any new NHS Charities monies. Additionally, volunteers are being introduced back onto the wards where it is safe to do so.
- **Meals:** Review mealtime options. It is proposed that a bespoke mealtime patient satisfaction survey be undertaken by Facilities across all inpatient areas
- **Wi-Fi/digital connection:** Assess Wi-Fi accessibility across all sites. This is already being discussed and considered.

- **Inclusion:** Review how those with communication impairment are both identified and supported. Whereas assessments will identify those at risk, more consideration is needed in regards to the identification of the support systems in place and gaps that need to be addressed.
- **Virtual Visiting:** consider strategies to ensure patients can virtually connect with families and friends during the pandemic. The Assistant Director of Nursing and IT Lead are already developing a strategy and are piloting 'virtual visiting' on wards at the Grange University Hospital.

Recommendation & Conclusions:

The Facetime Buddying Project: *Inpatient Engagement during the Coronavirus Pandemic* was very successful, particularly in regards to gaining real time third-party feedback from people receiving care on the wards and to enable the CHC to continue to undertake its statutory functions.

Phase two of the pilot where the CHC will buddy with the Complex Care at Home Team to obtain feedback from patients receiving care at home during the pandemic is about to commence.

The QPSC is asked to:

- Consider the CHC Facetime Buddying Project Report
- Discuss Divisional and Corporate recommendations

Aneurin Bevan Community Health Council

Facetime "Buddying" Project

Inpatient Engagement during the Coronavirus

January 2021

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

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Contents

1. About the Community Health Councils (CHCs)

CHCs are the independent watchdog of the National Health Service (NHS) within Wales. CHCs encourage and support people to have a voice in the design and delivery of NHS services.

CHCs work with the NHS, inspection and regulatory bodies. CHCs provide an important link between those who plan and deliver NHS services, those who inspect and regulate it and those who use it.

CHCs hear from the public in many different ways. Before the coronavirus pandemic, CHCs regularly visited NHS services to hear from people while they were receiving care and treatment. CHCs also heard from people at local community events, and through community representatives and groups.

Since the coronavirus pandemic, CHCs have focused on engaging with people in different ways.

This includes surveys, apps, videoconferencing and social media to hear from people directly about their views and experiences of NHS services as well as through community groups.

There are 7 CHCs in Wales. Each one represents the "patient and public" voice in a different part of Wales.

2. Introduction & Background

As part of the Aneurin Bevan Community Health Council's annual plan for 2020/21 we set to undertake a number of face-to-face ward visits to gain NHS experience feedback from people at the point that they were receiving care.

All Acute and Community hospitals were part of that plan for our volunteer CHC members to visit in line with a set schedule of activity. Since the coronavirus pandemic, these face-to-face ward visits were paused in line with Welsh Government restrictions.

As part of our statutory obligations, Aneurin Bevan CHC adapted these face-to-face visits and embarked on a hospital based engagement campaign in collaboration with the Aneurin Bevan University Health Board, who were key in facilitating our contact with people who were inpatients.

This collaboration was agreed through regular discussions held between the Aneurin Bevan CHC and the University Health Board's Nursing Director's office. In light of the visiting restrictions in place across all wards, it was quickly recognised that people who were at risk of boredom and isolation could suffer even further as a result of not being able to see loved ones or receive befriending support from the UHB's own volunteering services whilst they were in hospital.

This report sets out the findings for a ward based engagement campaign that took place via FaceTime (video calling) on 8 inpatient sites and 25 wards. We were able to speak to 96 people over a two-month period from September to October 2020. The original programme was to visit 35 wards, but 10 wards were cancelled for various reasons relating to COVID or Wi-Fi connection issues.

Aneurin Bevan CHC wishes to extend grateful thanks to the Aneurin Bevan University Health Board for supporting this continued need for people to be able to share their experiences with an independent body during an extremely difficult time.

3. What we did and who are we hearing from

When coordinating this exercise it was agreed early on that two members of staff from the University Health Board (UHB) would support the CHC throughout the exercise and facilitate the engagement contacts for continuity. These two members of UHB staff were current officers for coordinating volunteering services and improving patient experience opportunities.

We planned a schedule of 35 wards for the UHB staff members to visit face to face and by the end of the programme, 25 wards were visited, as 10 visits needed to cancelled for reasons relating to the pandemic or because of site access to Wi-Fi connection.

This programme was risk assessed and PPE (Personal Protective Equipment) and strict hygiene arrangements were in place for IPads to be given to people staying on a ward.

Ward schedule attached as Appendix 1. The Hospital sites visited included:

Chepstow Hospital
County Hospital
Maindiff Court
Nevill Hall Hospital
Royal Gwent Hospital
St Cadocs Hospital
St Woolos Hospital
Ysbyty Ystrad Fawr

CHC volunteer members were allocated time slots and wards over a 4-day period for 5 weeks in order for a FaceTime call to take place via IPads. The UHB staff member would approach appropriate individuals on the day of the visit and seek an individual's consent for the call to take place. The UHB staff member was provided with introduction text to explain the role and remit of the CHC and our independence from the NHS. We were able to speak to 96 people and receive their feedback and experience as an inpatient.

4. What we heard

4.1 Overall themed feedback

It was encouraging to find that across the 25 wards visited, the majority of people firstly mentioned the good or excellent care they felt they were receiving from a variety of staff in a very difficult time. People shared highly positive comments about staff being *fantastic, wonderful and amazing.* The comments for specific wards will be shared later in this report within individual ward summaries.

Visiting restrictions were mentioned numerous times and feedback about feelings of isolation or loneliness were mixed depending on the individual and the ward environment. The single room environment was attributed in some circumstances to increased feelings of isolation. Others told us that they did enjoy the quiet and ability to close a door to get meaningful rest. People understood the visiting restrictions and the pressure the pandemic appeared to be causing, but many people understandably missed friends and family. Many people were

able to keep in contact with loved ones regularly if they had their own phone or smart device with them.

We received comments that appeared to suggest people experienced increased feelings of isolation or loneliness because of a lack of access to a personal mobile phone or smart device whilst staying in hospital. This issue appeared to place these people at greater risk of experiencing loneliness and isolation.

There were a number of people who did report feeling lonely or isolated, and whilst this did not appear to be a predominant theme amongst the people we spoke to, it is still very important to acknowledge the feelings of the these individuals and highlight the issues raised above that increased people's risk of becoming more isolated.

Wi-Fi connection was raised as a particular issue on some sites and wards. A number of visits to St Cadocs Hospital were cancelled, as it transpired that the site did not have Wi-Fi available and so the FaceTime calls with people staying there could not take place. This issue was raised immediately and the CHC has received an update from the Health Board that Wi-Fi connection to the wards in St Cadocs Hospital is now progressing.

4.2 Chepstow Hospital (amber ward)

We spoke to seven people here, all those spoken to said they were very happy with the level of care they were receiving and some stated "excellent", "polite" and "caring" when referring to the approach of staff.

People here were very keen for ward activities to resume. On the day of our virtual visit, some people had had the opportunity to go outside where a dancing troupe had attended to provide some entertainment; this activity was very well received. Other people told us that relatives lived further away and so could not visit and one lady in particular missed her two grand-daughters

and found it very difficult not seeing them. Some others told us they had still been able to have some visitors periodically, one person saw their daughter with appropriate PPE in place and another had been able to see grandchildren who lived nearby.

All those spoken to said they found it easy to sleep as the hospital was quiet at night. In general, all were very complementary about they comfort levels and the meals on offer. One person would have preferred her food a little hotter.

Recommendation: The CHC would be grateful if the positive comments about staff at Chepstow Hospital could be shared with the ward teams, particularly those where safe visits could still take place for inpatients to see loved ones.

Recommendation: The CHC requests that the Health Board note the experiences of people who felt isolated.

4.3 County Hospital

Phoenix Ward

Two people spoke to us on Phoenix Ward. Both individuals told us the ward seemed short staffed but that staff were "excellent", "very helpful" and "doing everything they could to help people despite being under pressure". Both people stated that staff appeared to "work as a team" and that they enjoyed the friendly and "chatty" staff.

One person gave us an example of the toileting needs on the ward and how people are assisted in the mornings, which they felt could be improved. They explained that they were staying on this ward with eight other people and that seven individuals required some form of assistance from staff to be able to mobilise to the toilet. On a morning shift they said there is one nurse to help people with toileting needs and assistance to wash, this person felt this was not enough for seven people as some needed to wait and we were told that some people

couldn't "hang on", so the person we spoke with felt this impacted on others' dignity. This person had staying on Phoenix ward in the past and said they felt the staff was "much reduced".

One person said they felt isolated but understood the safety measures in place due to the pandemic.

One person told us that their sit out chair was a bit hard and not very comfortable, that meal choices were limited, and that they would like more meal options.

Both people referred to some disruption on the ward because of those living with Dementia, but staff assisted these people kindly. There were no "hospital noises" that would disrupt people at night-time.

Recommendation: Whilst recognising the staffing pressures the Health Board has experienced across all sites throughout the pandemic, the CHC would like the Health Board to note the comments made by people about staffing levels on this ward. The CHC seeks assurances however, that the process for supporting people to the toilet in the morning time is reviewed and any actions taken reported to the CHC please.

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes, care and behaviours could be shared as a commendation to the team.

Ty Siriol

We were able to speak with five people on the day of this FaceTime exercise.

The majority of the people spoken to told us that they were happy with the treatment and approach from staff, one person stated that staff were "as good a gold". Most were sleeping well and comfortably on the ward, one person did say that it can become noisy on the ward from very early in the morning and

that this caused a bit of sleep disruption. One person shared some dissatisfaction about not agreeing with their treatment plan but did state that staff were polite and treated them well.

Some people told us they were cold on the ward but that they were supplied with plenty of pillows and blankets.

One person told us that they had found it difficult to understand what staff were saying because of the need to wear masks and visors but that translation was also provided when needed.

People said that they had found having no visitors difficult, but that contact on the telephone with loved ones was helping.

We received mixed feedback from people about their satisfaction with meals. Some like the food provided and always liked one of the options offered and that food was always warm enough, but others did say that the meals were "average" or "terrible".

Recommendation: The CHC would be pleased if the positive comments made about staff could be shared with the ward team.

Recommendation: The CHC requests that the Health Board consider the mealtime feedback as mixed satisfaction was received.

Recommendation: The Health Board is asked to remind staff about comfortable noise levels in the early start of the morning.

Usk Ward

We spoke to six people on Usk Ward in County Hospital and all told that staff were "marvellous", "exceptional", very polite and helpful. One person did however feedback that some staff spent a noticeable time on their mobile phones.

Many people said they did not feel isolated because they enjoyed conversing with other people staying on the ward and this helped everyone. One person did say that they found it hard

to keep in touch with loved ones because they had not brought their mobile phone into hospital with them.

People told us that they were able to sleep well, even the light sleepers, and that the ward was pleasantly quiet at night.

We were told that people enjoyed their meals, were offered plenty of fresh water and that they were comfortable. Some commented that the ward was a positive and clean environment.

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes, care and behaviours could be shared as a commendation to the team.

Recommendation: The Health Board is asked to remind staff about any policies relating to use of their personal mobile phones.

4.4 Maindiff Court

Ty Skirrid

We were able to speak with four people on this ward. Most of the people staying here were long-term residents, 12 months plus in some instances.

All four people told us that they were very happy with the care and support they had received from the team on this unit. Some felt they had built good relationships with staff and felt well care for and involved.

We were told that the unit supports independent shopping and cooking and that this helped people remain independent. One person told us that they had no issues with feeling isolated because they had been able to meet family in an outside environment. Another person said that their family lived a distance away and although they did not say they experienced

isolation because of this, they were looking forward to seeing more of their family when they could.

Other people told us about the many activities that they enjoyed taking part in. For example, some people could travel to St Cadocs hospital to participate in woodwork and art programmes. Other activities included pool and quizzes. People said that they could cook their own meals throughout the week but enjoyed the Sunday lunch served each week. Regular exercise was encouraged and one person was able to access weights.

There were no issues raised in relation to comfort or sleep.

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes, care and behaviours could be shared as a commendation to the team. The CHC was particularly encouraged to learn about the independent living approach and activities available for people to become involved in.

4.5 Nevill Hall Hospital

Ward 2.3 (Paediatrics)

Ward 2.3 is an inpatient children's and young person's ward, we were able to speak with two parents during this FaceTime exercise.

The two parents spoken with gave different experiences, but both were equally complimentary about the approach of staff.

The first parent told us that staff were "amazing" and that "good" food was available. On some occasions, the child's grandmother had been permitted to bring some food in also.

The second parent also stated that staff on this ward were "wonderful and nothing is too much trouble". However, she expressed anger and disappointment towards what she felt had

been a late diagnosis for her child, and may wish to consider raising a formal concern later. The CHC member advised the mother of the Community Health Council's free and independent Advocacy Service, should she wish to seek Advocacy support with any complaint that is raised in the future.

Recommendation: The CHC would be pleased if the positive comments made about staff could be shared with the ward team.

Ward 3.3

We were able to speak to five people staying on ward 3.3 in Nevill Hall Hospital. All the people we spoke to said the staff were kind, thoughtful and fantastic.

Many commented on the positive professional approach of staff, but one person did stated that they felt the masks and visors staff needed to wear were a bit intimidating. Another person stated that their family had been able to bring in personal items for them but understands the current, difficult situation.

We received mixed feedback about people's ability to sleep well at night. Some said they slept well but others did say that "hospital noises" disturbed their sleep during the night.

We also received mixed feedback about people's experience and satisfaction with meals and drinks. A number of people enjoyed the food and choices of meals offered, one person said the food was "tolerable". Another gentleman said his only complaint was cold coffee.

No one spoken with raised any concern with feelings of loneliness. One person reported that contact with their husband and family via video call was helpful, and another person had been able to go for walks outside and see their mother.

One person explained they had a poor experience of communication from the medical team after being transferred to

the ward and had already raised concern through the correct channels.

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes, care and behaviours could be shared with the team.

Recommendation: The Health Board is asked to remind staff about comfortable noise levels during the night.

Ward 4.1

Two people spoke with us during the FaceTime calls here. Both people gave positive feedback about their experiences with staff. One person said staff were "as good as gold" and the other person stated that staff were "really good".

One person told us that the ward was comfortable and not too noisy at night. The other person said, "it can be a bit noisy at night, but that's to be expected".

Both individuals said they enjoyed the meals on offer and that food was always hot.

One lady said that she understands the reason for the visiting restrictions in place at the moment, but told us she did miss her family and that she is only able to communicate with them through the ward staff. She told us that when she needs more nightwear, the staff telephone her family for them to bring in essentials.

Recommendation: The CHC would be pleased if the positive comments made about staff could be shared with the ward team.

Recommendation: The Health Board is asked to consider how direct family contact could be supported for people at higher risk of experiencing isolation from loved ones due to not having access to mobile phones or smart devices. The CHC recognises that communication devices are personal items but would be

keen to understand how people at higher risk of isolation are identified and supported with contacting family or friends.

Ward 4.2

We were able to speak with six people on the day our calls to this ward. All the people spoken with said that staff were "fabulous", "wonderful" and that everyone was "so kind". One person stated that this was "the best hospital I've ever stayed in". Most were comfortable whilst staying on the ward.

Everyone spoken with were very complimentary about the meals they received and one-person commented that the food was like having "home cooked food", and spoke very highly of the desserts offered. Another person said, "they make a good cup of tea".

Whilst praise for the staff was very high, a few people told us that the noise at night could be very high and some staff "speak at night as if it is day time". One person said that their earplugs helped with this and suggested earplugs could be offered to others staying on the ward. Another person told us that some nights are more difficult than others, as it depends on which night staff are on duty.

Many people acknowledged the need for the visiting restrictions in place due to the pandemic, and most had access to personal devices to keep in touch with loved ones. One person commented that others on the ward "appeared bored".

Recommendation: The CHC would be pleased if the positive comments made about staff could be shared with the ward team.

Recommendation: The Health Board is asked to raise the issue of noise levels at night-time with staff and highlight the comments raised above.

Emergency Assessment Unit (EAU)

Seven people spoke with us from the EAU in Nevill Hall Hospital. All seven individuals told us that they were happy with the care and treatment they were receiving from the staff on this unit. Some told us that staff were "fabulous", respectful, polite and helped maintain their dignity.

In terms of people's comfort, some said that they were comfortable in both their bed and their available chair. One person reported that the bed was not long enough for them and that a light was directly above their bed, which they found "annoying at times"; both of these issues affected the person's comfort levels.

We were told that the meals offered are "good" or "ok" but one person reported having received cold beans on toast. Three people said the refreshments are "nice" and that access to snacks were regularly available throughout the day.

Most of the people we spoke to said they felt slightly isolated and missed family, most told us they had access to their mobile phones so they could contact friends or family by telephone. People were also grateful to be able to speak with a few others staying on the ward. One person had misplaced their phone but later confirmed a nurse has assisted them to locate their missing items. People "accepted" the reason for restricted visiting at the moment, and offered further praise to staff for the way they were being treated and cared for.

People reported that the hospital noises on the unit could disturb them at night as "people are in and out".

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes, care and behaviours could be shared with the team.

Recommendation: The CHC recognises the nature of this unit and the noise levels expected throughout the day and night. The

CHC however requests the Health Board take note of the comments made by people about some night-time disturbances.

4.6 Royal Gwent Hospital

Medical Assessment Unit (MAU)

We spoke to seven people staying on the MAU in Royal Gwent hospital. People reported that the staff were very helpful and were keen to assist people in being more comfortable. One person told us it was "marvellous here" and they felt comfortable in being able to ask staff questions because staff were "responsive" and "kind". Another person told us that staff appeared "motivated to make sure they were not in pain" and that care was "excellent".

We note that one conversation with an individual began in a very positive way, but then the individual appeared to become confused during the call and gave mixed feedback about many different topics.

All the people we were able to speak with stated they had not been on the unit for very long and so did not consider isolation to be an issue for them at that moment. Some told us they had access to mobile phones and could FaceTime family. Some were understandably anxious to return home as soon as they were able to.

We received thematic feedback that the unit was "very noisy" but that some people slept well when they were able to sleep and others found if quite difficult to sleep due to the noise on the unit.

People were very complimentary about the meals they were offered and some referred to having received "a pleasant breakfast" and having access to plenty of water.

Two people told us that their waits for a Consultant opinion or feedback had been "a bit slow". Another person commented that although they were happy with the care they were receiving, they did not know the roles of the staff members whom they were receiving information from, as staff wore many different coloured uniforms. They suggested a poster on the unit explaining the different coloured uniforms might help people's understand of staff roles.

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes, care and behaviours could be shared with the team.

Recommendation: The CHC recognises the nature of this unit and the noise levels expected throughout the day and night. The CHC however requests the Health Board take note of the comments made by people about some night-time disturbances.

Recommendation: The Health Board is asked to consider the use of uniform posters to help people understand the role and different colours of staff uniforms.

Ward B6 (Adolescents)

We were able to speak with four young people on this ward, some accompanied by a parent. All four people shared very positive feedback about the staff on this ward and how they felt they were being treated. Comments about the staff include; "*staff uplifting*", staff are "*excellent*", "*polite*", "*kind*", and "*lots of checking to see if I'm Ok*". One person told us "*Sally in A&E went above & beyond. Also Cheryl Warwick on the B6 ward, excellent!*"

No-one raised any issue with feeling isolated as they were allowed to have one parent present with them on the ward. Some commented that they missed their friends but having their mobile phones helped them keep in touch.

We received some good feedback about access to food and water but one person commented that they did need to ask for this and that there was a long wait for a sandwich.

People were comfortable in their beds and parents were able to use the bedside chairs available.

Two people commented that they were anxious due to long waits for medical advice or a "status update", two parents commented that it would be helpful to know a "rough time" for when information may be given.

Whilst everyone we spoke to were complimentary about staff care and attitude, all four people comment that staff were "*noisy at night*". One parent described the disturbances as "*staff have a house party all night long*" and another said that it was "*noisy on the changeover shift, singing and speaking in loud voices, not lowering voices to reflect the time of day*".

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes and care could be shared with the team.

Recommendation: The Health Board is asked to raise the issue of noise levels at night-time with staff and highlight the comments raised above.

Recommendation: The Health Board is asked to consider the comments about waits for food and information updates.

Ward D2 East

Two people spoke to us from D2 East in the Royal Gwent Hospital. Both individuals gave very positive feedback about the staff. One person told us they had stayed on the ward 5 or 6 times previously and that they had received "*wonderful care*" every time. The other person reported that staff are "*all very nice*" and that one nurse mentioned (Catherine) was "*brilliant*"

and that she had helped everyone throughout the previous night.

Both individuals commented on the visiting restrictions that were in place. One person was quite concerned about their wife, who was living at home with Dementia; he stated he was able to speak with her over the telephone. The other person commented that it was "*very sad*" that they were unable to have visitors but again was able to keep in touch with loved ones via their mobile phone.

When giving their views on the meals offered, one person said that the food was "Ok" but the other person stated it was "lush". Both reported that their meals were always hot enough and that they enjoyed the desserts.

We received mixed feedback about the noise levels at night; one person told us the ward isn't too noisy at night and did not raise any issues with being able to sleep at night, but the other person reported that "*sleeping on this ward isn't easy, as people are coming and going*".

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes and care could be shared with the team.

Recommendation: The Health Board is asked to raise the issue of noise levels at night-time with staff and highlight the comments raised above.

Ward D4 East

We spoke to five people during our FaceTime calls on this ward. We heard that staff are "*wonderful*", "*marvellous*" and "*as good as gold*". One person further commented that they felt they "*wouldn't be better treated even if in a palace*". Other comments included; "*Can't fault anyone, domestic staff are excellent*".

People were particularly satisfied with the meals on offer to them. We heard of the different varieties of meals and people mentioned the fish and chips. One person did comment that food "*could be warmer*" while another person stated that they enjoyed the soup but wished to have a crusty roll too.

People found it difficult not being able to receive visitors but most commented that they understood the reasons for this; one person suggested a visiting method at the door with a screen in place. None of the people spoken to commented on how they are able to keep in touch with loved ones.

One person told us that the ward alarms were not working and that staff explained there was "a fault in the whole hospital". This comment was feedback back to the Health Board at the time for investigation but no issues were identified.

We received mixed feedback from people about their ability to sleep. A few people explained it was quiet at night and had no issues with sleeping, but one person indicated that disturbances were occurring because of another patient in a six-bedded area.

Recommendation: The CHC would be grateful if the positive comments made by people about staffing attitudes and care could be shared with the team.

Recommendation: The Health Board is asked to consider how direct family contact could be supported for people at higher risk of experiencing isolation from loved ones due to not have access to mobile phones or smart devices. The CHC recognises that communication devices are personal items but would be keen to understand how people at higher risk of isolation are identified and supported with contacting family or friends.

Ward D4 West

We spoke with one person on this ward during our FaceTime calls.

As our feedback was limited to one experience, we were able to glean very useful information. We heard that staff are "really lovely" and look after the person "very well". The food appears "alright" but we were told by the individual that they do not eat much, they referred to having omelette plus potato wedges. We were told that it was "lovely away from home" and the person was still able to make contact with loved ones whilst staying in hospital. We were told it was "not too noisy at night" and no issues with sleep or comfort were raised.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the team.

Ward D7 East

We heard from two people staying on ward D7 West during our FaceTime calls. Both people told us staff were "*brilliant*", "*lovely*" and "*can not do enough*" for people. We heard further that staff are very polite and respectful and both people felt well cared for.

We were told that the beds on the ward were "*very comfortable*" and staff brought extra blankets if needed.

Both people told us that the visiting restrictions were difficult but both had access to a mobile phone and one was able to use FaceTime to support video calls. One person explained that they had been supported to see their husband whilst staying on the ward and that this was conducted "*through glass on occasions*".

We heard that the meals offered were "*ok*" or "*edible*" and so meal satisfaction appeared less positive.

One person told us that it would be beneficial to have had access to television or a radio to "break the monotony". They

also commented that the Wi-Fi signal is "very weak" so they had been unable to use their mobile phone to watch television.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the team.

Recommendation: The Health Board is asked to consider the comments made in relation to meals and consider a mealtime review to gauge overall satisfaction on this ward.

Recommendation: The CHC would be interested in receiving further information in respect of visitors being able to attend areas via a glass screen. We would be interested to know how any learning from this could be safety implemented in other areas (where appropriate) to support people at higher risk of becoming isolated.

4.7 St Cadocs Hospital

Beechwood unit

One person was able to speak with us during our FaceTime call to this unit.

We heard that; the individual was "very happy" with the care they had been receiving so far. They felt that staff treated them very well and that they got on well with the team.

We were told that the person had been in hospital for just over a week and did miss their family but understood the restrictions in place. They did not tell us how they were able to keep in touch with loved ones.

They reported that the "*accommodation is good and comfortable*" but that the meals were "average but ok". We heard that there were no issues with being able to sleep and there were "no excessive noises at night".

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the team.

Recommendation: The Health Board is asked to consider the comments made in relation to meals and consider a mealtime review to gauge overall satisfaction on this ward.

Recommendation: Whilst recognising the limited feedback the CHC was able to gather on this is unit, the Health Board is asked how direct family contact is supported for people at higher risk of experiencing isolation from loved ones due to not have access to mobile phones or smart devices. The CHC recognises that communication devices are personal items but would be keen to understand how people at higher risk of isolation are identified and supported with contacting family or friends.

4.8 St Woolos Hospital

Gwanwyn ward

We were able to speak with five people during our FaceTime calls to this ward. We were unable to speak with other people who were hard of hearing due to a low volume level for the video calls. We recognise this issue excluded a number of individuals with hearing impairments. As this issue presented itself, the CHC will learn from this issue for future engagement exercises to ensure people with any communication impairments are not excluded from our activities. Furthermore, we are eager to understand how the Health Board identifies individuals at a higher risk of isolation due to communication impairments.

During the calls to this ward, it was noted that a number of individuals appeared to be confused, but as conversations developed, we were told that staff were helpful and friendly; some commented that staff were “excellent” and one person said they were “treated well and very caring”.

All five people reported that they were satisfied with the meals they were offered, comfort levels were good and people told us they had plenty of blankets and pillows.

We were told that whilst staff were caring, and some were able to speak to family and friends, it was reported that people felt isolated, "fed up" and "too lonely".

All but one person said that they were able to sleep well at night, with one person stating they had difficulties with disturbances because of another inpatient.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the team.

Recommendation: The CHC requests further information from the Health Board about how people with communication impairments, such as hearing loss, are identified and supported to keep in touch with loved ones during times where visiting restrictions are in place.

Penhow ward

Six people were able to speak with us from this ward on the day of our FaceTime calls.

One person discussed very significant concerns with us, which involved care prior to transferring to this ward. They explained that a concern had already been submitted to the Putting Things Right team and our independent Advocacy Service details were shared with the individual should they wish to seek support with their on-going complaint. This individual did comment that they were satisfied with the care they were receiving from this ward.

A number of people commented that care on the ward was "magnificent" and "awesome". People were happy with the helpfulness of staff but some comments were made that the staff were very busy, appeared short in numbers but they were still doing their best.

We were told that some people enjoyed the meals offered to them with comments made that food was "well balanced and nutritious" but others reported that food was "ok", "not to their pallet" or that they "never seem to enjoy it".

People told us that loneliness was not an issue for them as they were able to keep in touch with loved ones via telephone or FaceTime.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the team.

Recommendation: The Health Board is asked to consider the comments made in relation to meals and consider a mealtime review to gauge overall satisfaction on this ward.

Ruperra Ward

We spoke with two people on this ward, both told us that staff were "mostly" polite and both were happy with the care they were receiving. One person commented on the manner in which one nurse had spoken to him, but when he responded firmly, her attitude improved.

One person had been staying on the ward for over a month and gave an account of their observations over this period of time. They stated that there appeared to be plenty of staff and that nurses "*spend long periods chatting… sometimes outside the 4 bedded ward door. Their major discussion seemed to who had been offered a new positon in the new hospital*". This person also described instances where they had heard "*nurses bickering or fighting*", they said "*even the dark blue uniform didn't seem to manage*".

Both people commented that they miss having visitors; one person told us they were unable to have visual contact with their daughter but that she brings items to the ward door and helps with laundry most days.

We were told that both people felt comfortable and were able to sleep well at night and that the meals offered were good.

One-person stated their only concern was timely assistance with toileting needs, they stated staff "*respond abruptly & almost always asked if he could hang on, usually returning about 30 minutes later*".

Recommendation: The CHC is concerned about the accounts relayed about staffing attitudes and responses to toileting assistance requests. We would be pleased if the UHB could review the comments and monitor the following:

- Staff attitudes and the reported arguing
- Staffing approach and timeliness of assistance to the toilet

Recommendation: The Health Board is asked how direct family contact is supported for people at higher risk of experiencing isolation from loved ones. The CHC recognises that communication devices are personal items but would be keen to understand how people at higher risk of isolation are identified and supported with contacting family or friends.

4.9 Ysbyty Ystrad Fawr

Bargoed Ward

Two people spoke with us on this ward during our FaceTime calls. Both people told us the hospital and ward was a "first class facility" and "second to none". We heard very positive comments about staff who were said to be "*great, pleasant, polite and friendly*" and "*excellent*". All staff were said to wear name badges and were also described as "*patient*". We heard positive feedback about experiences with the physiotherapy team also.

Both people told us they were very comfortable and if feeling cold then extra blankets are provided promptly. We heard that meals were "*excellent*" and that there is "*plenty of it*". When asked for meal choices, one person told us they always receive what they ask for.

One person told us they missed their loved ones and found the visiting restrictions difficult, but understood that staff were "*keeping to the virus rules*". This person also stated they missed the social interaction with other inpatients whilst staying in a single room and that they only see staff. The other person told us that not seeing anyone was "not having an effect of him" as he enjoyed his own company, but could understand why other people may become depressed. This person did state that they "*really enjoyed*" the FaceTime call with us that day.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the ward team and Physiotherapist.

Bedwas Ward

We heard from two people on Bedwas Ward during our FaceTime calls. Both told us that staff were "*excellent*" and "*Marvellous*". We heard that Doctors were quick and prompt in addressing pain with "*immediate responses*".

One people shared with us issues of concern about care in the community prior to admission to hospital and was keen to share more with the CHC about this so our contact details were provided.

We were told that meals are "really good" and that isolation was not an issue for these individuals as they had personal mobile telephones. One person told us they enjoyed looking out of the large window in their room watching the traffic and watching a local rugby match, which took place close to their hospital window.

People were able to sleep well at night and we were told by one person they felt "*really well looked after*".

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the ward team.

Oakdale Ward

We heard from three people on this ward, all three said they were very happy with the care provided, that staff here where "*excellent*". One person commented that they were initially reluctant to transfer here but then felt it was "*not so pressured*" in this hospital as in the Royal Gwent Hospital.

People were generally happy with the meals offered but did comment that is could sometimes be cold.

We heard that comfort was supported as best as it could be, but pain due to conditions made sleep difficult in some instances.

People were missing the company of loved ones but we were told people did not feel lonely, as there were people to talk to on the ward.

We were told by one person how they had felt anxious about returning home and the new adaptions that were needed in the home. To address these anxieties, the Physiotherapy and Occupational Therapy teams took photographs of the home adaption and this helped the person see what support had been put into place for them to return home safely before they were discharge.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the ward team and particularly the efforts of the Physiotherapy and Occupational Therapy teams.

Risca Ward

We spoke to 4 people on this ward during our FaceTime calls. We were told that staff were all good and caring. We heard that communication from staff was good and people felt involved in the next steps their care. One person was very anxious to return home to their husband who was living with Dementia.

We heard about increased feelings of loneliness and isolation as the people we were able to speak with had been in hospital between 1 week to 4 months. Two people referred to relatives being able to deliver culinary needs and additional comfort items to the ward and one of these people told us they could speak to their daughter through the closed ward doors. Another person told us they did feel isolated and depressed and the single room environment "doesn't help with this" but they did have a television to watch.

We heard that staff are friendly and prompt when call bell requests are made and we received good feedback about people's satisfaction with meals.

None of the people we spoke to raised any issues with being able to sleep well at night.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the ward team.

Recommendation: The Health Board is asked to consider the comments made by people about increased feelings of loneliness and isolation. We would be keen to understand how people at increased risk of isolation are identified and supported.

Ty Cyfannol ward

We spoke with four people on this ward at the time of our FaceTime calls. We heard that people were receiving "amazing care", that people felt treated with dignity, respect and that the

hospital was comfortable and clean. One person commented that their consultant was "*excellent and very understanding*".

One person expressed dissatisfaction with care they had received in the community prior to their admission to this ward and went on to give positive feedback about the ward.

People told us that meals were very good and most enjoyed the options on offer, one person felt the selections were too healthy and they would like to see more sausages and chips on the menu but others were quite happy with their meals.

We heard that activities were still available on the ward and one person had taken part in tennis. People did comment that they missed their families and wished to return home when they could, but all said they mixed well with other people staying on the ward and some had "made friends".

We received mixed feedback about people's ability to sleep well at night, but these comments showed any disturbed sleep was usual for the person's normal sleeping habits. All did however comment that the ward was quiet.

Recommendation: The CHC would be grateful if the positive comments about staffing could be shared with the ward team.

5. Learning from what we heard

In undertaking this project, the Aneurin Bevan Community Health Council has been able to maintain a level of contact with people in hospital, albeit in a new way, in lieu of our physical visits to hospital wards because of the pandemic.

The people we spoke to were able to give free and independent feedback to us about their stay and what had been positive or negative in their own experience.

In hearing people's views whilst in hospital we have learned:

- People gave overwhelmingly positive comments about staff, at all levels, about care, approach and support. This positive theme was consistent in people's messages in nearly all cases. We believe this demonstrates that staff have gone above and beyond in their duties to ensure that inpatient experiences were comfortable, well informed and engaged with during this unprecedented level of disruption and demand on NHS services.

- Increased access to communication aids is necessary for any future projects for the CHC or UHB, to ensure those who are hard of hearing or those who have hearing loss are able to engage with remote activities.

- Those in single room environments commented more on experiencing isolation and feelings of loneliness.

- People without access to their own mobile telephone or smart device reported increased feelings of isolation and loneliness from loved ones at home. This issue appeared to show these people were more likely to experience loneliness and isolation.

- Some wards require reminders about noise levels at night in order to promote restful sleep during the night.

- Wi-Fi connection was key to supporting people during this time to stay in touch with loved ones and enable them to engage with remote activity. Wi-Fi issues were raised with the Health Board at the time and is receiving attention.

- The CHC was encouraged that people were still able to give feedback about their care to an independent organisation at a time when access the hospital sites has not been possible. Those who raised concerns were able to receive information from us about access to Independent Advocacy support services.

- The CHC has been able to set appropriate recommendations for learning for each of the wards visited and highlighted good care and some areas where improvements or reviews are required.

6. Thanks

We thank everyone who took the time to share their views and experiences with us about their health and care services and to share their ideas.

We also thank the Health Board team who assisted in facilitating access to people whilst in hospital.

We hope the feedback people have taken time to share influences healthcare services to recognise and value what they do well – and take action where they need to as quickly as they can to make things better.

7. Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

If you write to us in Welsh, we will answer in Welsh. This will not lead to a delay in responding to your correspondence.

We welcome telephone calls in Welsh.

8. Contact details

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CIC Aneurin Bevan CHC

Appendix 1 – Ward Schedule

CHC Buddying Visit Dates: September to October 2020	**AM Start at 10.30 am Finish at 12.00 Midday**	**PM Start at 12.30pm (start time may differ due to travel) Finish 2.00pm**
Tues 8th	MAU (RGH)	B6 (RGH- older children)
Wed 9th	Bargoed (YYF)	Penallta (YYF)
Thurs 10th	Chepstow Hospital	**Ty Skirrid** (Maindiff Court)
Mon 14th	Ruperra (St Woolos)	**Sycamore (St Woolos)**
Wed 16th	2.3 (NHH)	3.3 (NHH)
	4.1 (NHH)	4.2 (NHH)
Thurs 17th	**Carn-y-Cefn (YAB)**	**Cedar Parc (Ysbyty Tri Cwm)**
Mon 21st	D4E (RGH)	D4W(RGH)
Tues 22nd	Bedwas (YYF)	Risca (YYF)
Wed 23rd	Ty Cyfannol (YYF)	Oakdale (YYF)
Thurs 24th	Usk (County)	Phoenix (County)
Mon 28th	D2E (RGH)	**C7W (RGH)**
Tues 29th	**Adferiad Ward (St Cadocs)**	Beechwood (St Cadocs)
Weds 30th	**Pillmawr/Lodges (St Cadocs)**	
Mon 5th October	**D7W (RGH)**	D7E (RGH)
Tues 6th	**Talygarn(County)**	Ty Siriol (County)
Wed 7th	Gwanwyn (St Woolos)	Penhow (St Woolos)
Thurs 8th	MAU (NHH)	**3.2 (NHH)**

Cancelled

Aneurin Bevan

Community Health Council

Facetime 'Buddying' Project undertaken September-October 2020
Action Plan in response to the Recommendations

Hospital	Recommendation Themes	Actions	Responsible Persons
Community Hospitals: Recommended that CHC Report is discussed at Divisional QPS and feedback of main findings is provided to staff teams.			
Chepstow Community Hospital	Ward activities	Consider resumption of ward based activities.	
	Impact of no visiting	Consider virtual visiting and patient and family digital connection.	
Phoenix Ward County Hospital	Patients needing to wait to use the bathroom (reference to staffing levels)	Review staffing levels and process for ensuring patients are able to use the bathroom when requesting. CHC wish to have written assurance.	
	Limited meal choices	Review menus with Facilities team. This was a theme in previous PREM.	
	Uncomfortable chairs	Review seating.	
	Impact of no visiting- loneliness and isolation	Consider virtual visiting and patient and family digital connection.	

Hospital	Recommendation Themes	Actions	Responsible Persons
Usk Ward, County Hospital	Staff spending time on personal phones	Remind staff of any policies relating to use of mobile phones in ward environment.	
	Contact with relatives	Assess patient's access to personal phones on admission and consider other means of digital connection whilst in patients.	
Gwanwyn Ward, St Woolos Hospital	Isolation and boredom	Consider meaningful activity.	
		Consider virtual visiting and patient and family digital connection.	
Penhow Ward, St Woolos Hospital	Numerous comments regarding dissatisfaction with food	Undertake specific meal satisfaction patient survey to inform need for mealtime review.	
Ruperra Ward, St Woolos Hospital	Staff spending long periods of time 'chatting' amongst themselves. Also Staff attitudes/ arguing.	Staff to be reminded of professional behaviours. Consider staff survey.	
	Long waits to use the bathroom	Review staffing levels. Undertake PREM.	
	Isolation and boredom	Consider meaningful activity. Consider virtual visiting and patient and family digital connection.	

Hospital	Recommendation Themes	Actions	Responsible Persons
Bargoed Ward, YYF	Boredom, loneliness and social isolation	Consider meaningful activities.	
		Consider virtual visiting and patient and family digital connection.	
Bedwas Ward, YYF	No recommendations.		
Oakdale Ward, YYF	Food sometimes cold	Asses meal temperatures	
	Missing family connections	Consider virtual visiting and patient and family digital connection	
Risca Ward, YYF	Loneliness and isolation	Consider virtual visiting and patient and family digital connection	
Mental Health and Learning Disabilities Services: Recommended that CHC Report is discussed at Divisional QPS and feedback of main findings is provided to staff teams.			
Ty Siriol, County Hospital	Noise levels early morning disrupting sleep	Review activity during early mornings to explore noise levels.	
	Environmental temperature-complaint of coldness	Review unit temperature.	
	Impact of no visiting	Consider further virtual visiting and patient and family digital connection.	
	Menus (mixed feedback)	Review menus. Consider menu patient survey.	
Ty Skirrid, Maindiff Court Hospital	No recommendations		

Hospital	Recommendation Themes	Actions	Responsible Persons
Beechwood Unit, St Cadoc's Hospital	Limited family contact due to restricted visiting	Consider virtual visiting and patient and family digital connection.	
		The CHC is requesting information on how direct family contact is supported for people who are at higher risk of isolation from family if they do not have access to personal mobile devices.	
		Please confirm how people at higher risk of isolation are identified and supported to connect with family and friends.	
Ty Cyfannol, Ysbyty Ystrad Fawr	Limited family contact due to restricted visiting	Consider virtual visiting and patient and family digital connection.	
Nevill Hall Hospital: Recommended that CHC Report is discussed at Divisional QPS and feedback of main findings is provided to staff teams.			
Ward 2.3 (Paediatrics) Feedback from parents	Concern re: late diagnosis	The ward may wish to consider whether any other concerns have been raised in regards to late diagnosis in order to inform action required (no details provided about the parent raising the concern).	
Ward 3.3	Noise disturbing sleep	Assess noise levels to maximise rest and minimise sleep disturbance.	

Hospital	Recommendation Themes	Actions	Responsible Persons
	Lack of communication from medical team on transfer	This has been raised through formal channels. Please bring this concern to the medical team's attention.	
Ward 4.1	Noise disturbing sleep	Assess noise levels to maximise rest and minimise sleep disturbance.	
	Lack of contact with relatives (restricted visiting)	Consider virtual visiting and patient and family digital connection.	
Ward 4.2	Noise disturbing sleep	Assess noise levels to maximise rest and minimise sleep disturbance.	
	Boredom	Consider meaningful activities.	
Emergency Assessment Unit	Noise disturbing rest and sleep	Assess noise levels to maximise rest and minimise sleep disturbance.	
	Communication with families	Consider virtual visiting and patient and family digital connection.	
Royal Gwent Hospital: Recommended that CHC Report is discussed at Divisional QPS and feedback of main findings is provided to staff teams.			
Medical Assessment Unit	Noise disturbing rest and sleep	Assess noise levels to maximise rest and minimise sleep disturbance.	
	Unable to identify staff roles from uniforms	Consider use of uniform posters to help people understand roles of staff.	
Ward B6 (adolescents)	Lack of timely information on 'status update'	Review patient/parent information and consider inclusion of expected timescale for status updates (recommendation from parent).	

Hospital	Recommendation Themes	Actions	Responsible Persons
	Noise levels at night affecting sleep (particularly during staff changeover)	Assess noise levels to maximise rest and minimise sleep disturbance.	
	Long waits for snacks	Consider action required to ensure more timely access to snacks.	
Ward D2 East	Lack of communication with relatives (restricted visiting)	Consider virtual visiting and patient and family digital connection.	
	Noise levels at night affecting sleep	Assess noise levels to maximise rest and minimise sleep disturbance.	
Ward D4 East	Ward alarms not working	**Note:** This was raised at the time of the buddying but no issues identified.	
	Food not hot enough	Assess food temperatures.	
	Noise levels affecting sleep and rest	Assess noise levels to maximise rest and minimise sleep disturbance.	
	Lack of contact with relatives (restricted visiting) - isolation	Consider virtual visiting and patient and family digital connection.	
Ward D4 West	No recommendations made (limited patient contact through the Buddying programme)		
Ward D7 East	Lack of entertainment (TV/Radio) resulting in boredom	Consider meaningful activities e.g. use of RITA units so patients can view films.	

Hospital	Recommendation Themes	Actions	Responsible Persons
	Weak Wi-Fi connection affecting ability to connect through personal devices	Assess Wi-Fi connectivity.	
	Allowing visiting through a 'glass screen'	The CHC are requesting additional information on this and whether shared learning has occurred.	
Overarching Corporate Themes			
Isolation, Connections, Loneliness and Meaningful Activity	Numerous comments in regards to loneliness, isolation and boredom, particularly in single rooms	Progress meaningful activity strategy.	
		Progress 'virtual visiting' strategy and digital connections.	
Wi-Fi Connection	Some patients were unable to engage in the Buddying programme due to Wi-Fi accessibility.	Ongoing discussions with IT around Wi-Fi connectivity particularly in mental health units.	

Draft action plan completed by Tanya Strange, Assistant Director of Nursing, Person Centred Care

17th February 2021

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Tuesday 13th April 2021 Agenda Item: 5.2

Refreshed dementia action plan based on new all Wales dementia care pathway standards

Executive Summary

The Dementia Action Plan for Wales (2018) sets out the Welsh Government's commitment to promoting the rights, dignity and autonomy of people living with dementia and the people who care for them. An established Regional Dementia Board has developed a Regional Strategy and Action Plan to drive forward improvement actions against the 6 key aims of the National Plan.

The COVID-19 pandemic has impacted on the lives of people with dementia and their carers. Although the partnership has taken collective action to mitigate risks to people living with dementia and those who care for them, there can be no doubt that lockdown rules and restrictions will have had a negative impact. Throughout the pandemic, the Dementia Board has continued to meet but the Steering Groups have met less often due to clinical priorities. The Dementia Board agreed a need to refocus the action plan to support adaption and recovery over the next year.

In March 2021, Improvement Cymru published the All Wales Dementia Care Pathway Standards: High Level Standard Descriptors; these Standards needed to be reflected in the Regional Dementia Strategy and Action Plan. The Standards will be subject to reporting against a 2 year Delivery Framework (2021-2023).

The Quality and Patient Safety Committee is asked to note the report, consider the refreshed high level priorities and revised dementia action plan, as assurance of focus on this important agenda (aligned to Priority 3 & 4 in the ABUHB Annual Plan).

Quality, Patient Safety and Performance Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	X
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	
Executive Sponsor: Rhiannon Jones – Executive Director of Nursing	

Date of the Report: 13 April 2021
Supplementary Papers Attached: Nil

Background and Context

The Dementia Action Plan for Wales (2018) sets out the Welsh Government's commitment to promoting the rights, dignity and autonomy of people living with dementia and the people who care for them. In setting out the strategic actions, a series of statements, produced through the work of the Dementia Action Alliance, provide a framework of best practice. We have used this framework and engaged with people living with dementia and their carers' in order to develop our own regional strategic action plan.

The regional Dementia Board helped develop the population needs assessment required under the Social Services and Well-being Act and the Board has developed strong partnerships with local groups to ensure continuous engagement. The current action plan aims to ensure that the voices and personal experience of people living with dementia help shape the regional plan.

In developing this regional strategy, our actions are aligned to the 6 key statement aims set out in the Dementia Action Plan for Wales (2018 - 2022) national plan. These are:

1. Risk Reduction and Delaying Onset
2. Raising Awareness and Understanding
3. Recognition and Identification
4. Assessment and Diagnosis
5. Living as well as possible, for as long as possible with dementia
6. The need for increased support

The Regional Dementia Board is well established and provides a forum for strategic and clinical leadership, engagement, consultation and joint decision making across the health, social care and third sector agenda for dementia care in the five local authority areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen, and the Aneurin Bevan University Health Board. The Dementia Board aligns and reports to the Regional Partnership Board (RPB).

Through its membership the Dementia Board is aligned to the work of the regional Carers Board; End of Life Care Board; Mental Health and Learning Disability Partnership Board and the Gwent Adult Strategic Partnership Board. Five Dementia Friendly Community Implementation groups are represented by each local authority. The Board aims to harness the partnership working in the region to meet the priorities identified by people living with dementia and their carers and in the Dementia Action Plan for Wales (Welsh Government 2018-2022) and associate guidance.

The Board is supported by a sub structure to take forward specific areas of work:

- Dementia Pathways and Diagnosis
- Care in General Hospitals
- Good Work -Dementia Learning and Development

- Dementia Friendly Communities Implementation Groups

Formal activity reports demonstrating partnership actions against the National Plan are provided to Welsh Government.

Although the Dementia Board has continued to meet during the pandemic, the ability of the sub groups to meet has been difficult due clinical activity and the pandemic response. This has meant that monitoring of the action plan during the pandemic has not been as robust as it was pre-pandemic.

In March 2021, Improvement Cymru published the 'All Wales Dementia Care Pathway Standards' (attached).

Dementia Standards Pathway (

These standards have been scoped over the past two years and have been informed by 1800 people, including people living with dementia. The 20 standards indicate what people believe will make a positive difference to dementia care in Wales. A two year Delivery Framework has been developed to support the regional implementation across Wales (to cover the period 2021-2023).

The 20 Standards have been 'wrapped' around the person and, with 'kindness and understanding' at its core, consist of 4 broad themes:

- Accessible
- Responsive
- Journey
- Partnerships and Relationships

Each standard applies to all people being assessed, diagnosed and living with dementia and their carers', recognising people with dementia as a vulnerable group, together with individuals with special characteristics such as Learning Disability and Black Asian and Minority Ethnic Groups. The overriding approach for implementation of the standards is one of multi-agency responsibility with the Standards supporting the Dementia Action Plan (DAP) and laying the foundation for what the National DAP will look like for the next 5 years and beyond. Currently, the Regional Dementia Strategy and Action Plan does not reflect these Standards.

Assessment

The Dementia Board has identified that the current action plan needs to be refreshed to refocus the priorities, support pandemic adaption and recovery and ensure that the All Wales Dementia Care Pathway Standards (high level standard descriptors) are adopted.

4_DEMENTIA STRATEGY HIG...

The attached refreshed action plan outlines high level priority actions under each of the 6 key aims of the National DAP. This refresh aligns to the strategic key aims and has been informed by both regional priorities and the regional needs assessment. Going forward, it will need to be further amended to reflect and address people's experiences during the pandemic.

In summary, priority actions include:

- Seek inclusive approaches to obtain and learn from peoples experiences, especially post-COVID and in the recovery phase;
- Review of all current public information to ensure it supports accessibility and COVID recovery;
- Review of advocacy services;
- Regional review of current training strategy and delivery in accordance with the principles of the MCA across all partner organisations;
- Greater focus on engagement with people and their carers', providing opportunities for their own learning to self-manage and promote choice across the life journey;
- Development of a Dementia Pathway that embedding the new Standards;
- Extend our efforts to embed dementia friendly communities and support providers to consider reasonable adjustments to enable people with dementia to lead active community life (including transport);
- Inclusion of the need for cognitive health wellbeing checks for people with Down Syndrome;
- Proposal for a dedicated 'wellbeing' subgroup to maximise people's ability to live well for as long as possible;
- Reinvigorate Johns Campaign and adoption of a Hospital Dementia Charter;
- Improved anticipatory care planning and end of life care.

A review of each of the sub groups is taking place to ensure the membership and Terms of Reference for each group is reflective of both the priority actions within the refreshed action plan and the new Standards.

It is proposed that these are the high priority actions for the coming year. During this time, the Regional Dementia Strategy will be reviewed to ensure the 20 Dementia Care Pathway Standards are adopted. The refreshed Strategy will be informed by people living with dementia, their carers' and workforce views.

Recommendation & Conclusions:

The Dementia Board has refreshed the current regional action plan to focus on the key priority actions that aim to maintain a focus on excellent dementia care and support COVID-19 adaption and recovery. Although the new Dementia Standards have been cross referenced, the Dementia Board will now review in detail the All Wales Dementia Care Pathway Standards to ensure the Standards are adopted in Sub Group Terms of Reference and subsequent action plans and are reflected in the Regional Dementia Strategy.

The Quality and Patient Safety Committee is asked to:

- CONSIDER the revised Dementia Action Plan and discuss the priority actions;
- NOTE the informal 'launch' of the revised action plan during Dementia Week (May 2021);

NOTE a review of the Regional Dementia Strategy to ensure the Dementia Standards are adopted

Aneurin Bevan University Health Board

Health Board Committee Update Report

Name of Group:	Quality and Patient Safety Operational Group (QPSOG)
Chair of Group:	Peter Carr, Executive Director of Therapies and Health Science
Reporting to:	Quality and Patient Safety Committee
Reporting Period:	From the meeting held 23rd March 2021 (held by Teams)

Summary of Key Matters Considered by QPSOG:

Divisional Risk Registers/Concerns

The Divisional Quality and Patient Safety leads presented the Division's highest risks and concerns related to quality and patient safety.

All Divisions noted the ongoing challenges and related risks in delivering safe care in the context of the COVID 19, including adhering to requirements of PPE, infection control, physical distancing and regular testing to prevent nosocomial transmission. Divisions confirmed that they have been fully supported in maintaining the necessary measures and protections.

Concern was raised across Divisions about service resource to support the Grange University Hospital, as non-COVID activity increases, of particular concern were:

- Dedicated pharmacy support to ED / MAU;
- Nutrition support teams;
- Speech and Language Therapy to respond to referrals for dysphagia assessments;

It was noted that Divisions are preparing plans / cases to address these gaps in service provision that have now become apparent.

The increased demand for enhanced care was noted by both Unscheduled Care and the Community Divisions.

Most Divisions noted the challenges with recovery and restarting elective work. All Division have plans in place but the associated risks of unmet demand and long waiting times were acknowledged.

Both the Family and Therapies and the Mental Health and Learning Disabilities Divisions noted the ongoing concern and related risk to

children and young people suffering with acute mental health issues being admitted to the adult unit. It was noted that this issue has been escalated to the Executive Team and at all-Wales level, including with WHSSC for action to address.

Injurious inpatient falls remain a high risk across all Divisions.

The Complex Care Division noted the ongoing risks associated with their limited access to care homes to undertake their routine governance visits. The Division is actively collecting data to monitor themes and risks and is progressing plans to access care homes on a risk based approach.

All the Divisional risks and concerns highlighted are included in the Divisional risk registers with information detailing the action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the highlighted risks to ensure the quality and safety of services. The risks highlighted during the QPSOG meeting are also captured on the corporate and COVID risk registers.

Quality, Patient Safety and Experience Report

A verbal report was presented and comments invited ahead of the formal report being prepared for presentation to the QPSC meeting in April 2021.

CHC Buddying Project
The group received a presentation updating on this project

RLDatix Once for Wales Concerns Management System
The group received a presentation updating on the implementation plan of the new system.

Matters Requiring QPSC Level Consideration:

- Quality, Patient Safety and Experience Report (scheduled for QPSC meeting in April 2021)

Key Risks and Issues/Matters of Concern

There were no key risks or matters of concern to note other than those already noted above.

Date of Next QPSOG Meeting: 12th May 2021

Putting Things Right Annual Report 2019 - 2020

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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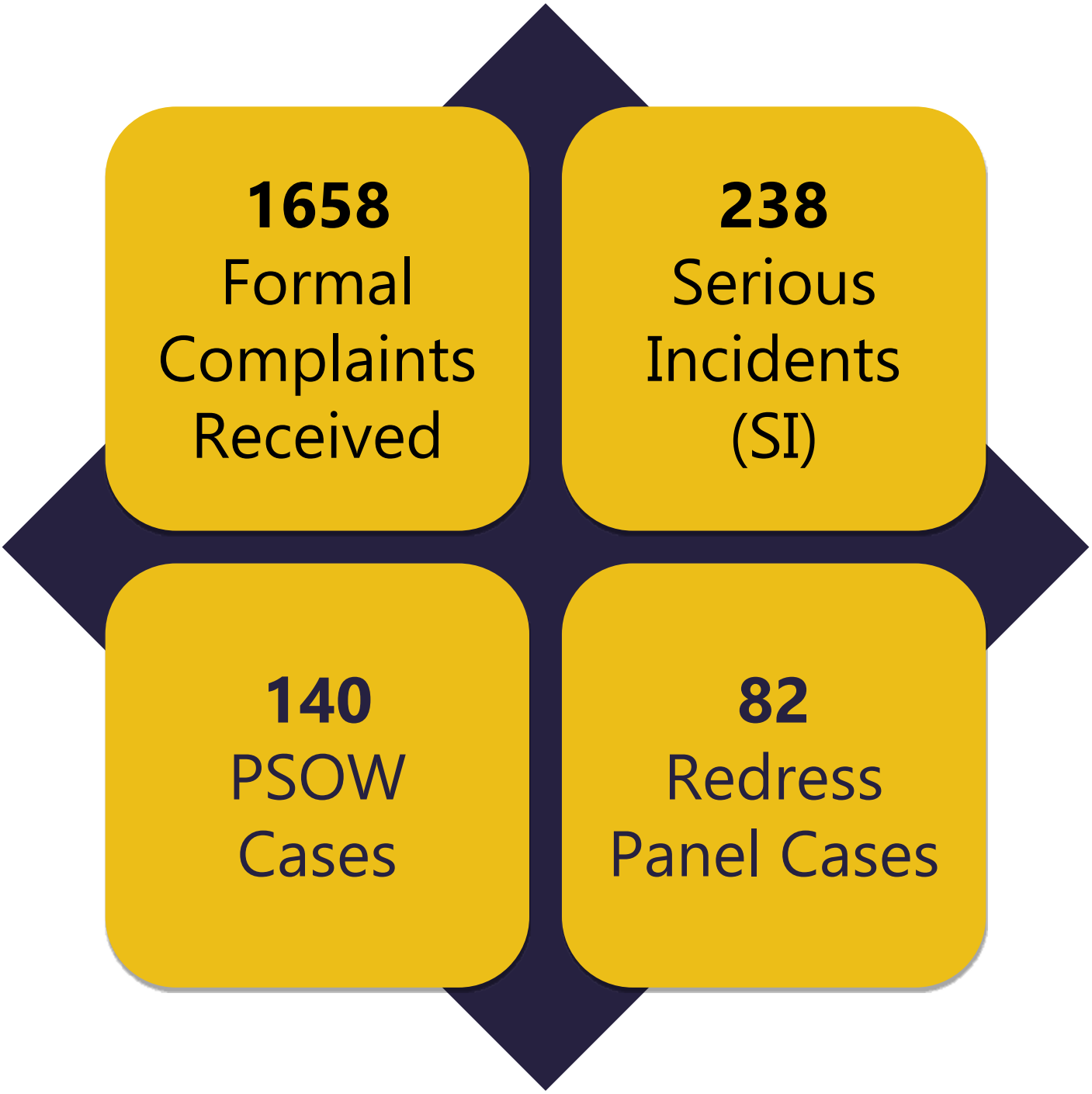
Aneurin Bevan University Health Board (ABUHB) 2019/20 in a nutshell



Introduction

Whenever concerns are raised about treatment and care, through a complaint, claim or clinical incident, those involved can expect to be dealt with openly and honestly. These will receive a thorough, appropriate and proportionate investigation, a prompt acknowledgment with a response regarding how the matter will be taken forward, and importantly will identify lessons learnt for the future. This is the underlying principle of Putting Things Right, the regulations underpinning The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

As a Health Board we are committed to responding to concerns raised by patients, service users or their representatives, with openness and transparency and, where we can, learning from the concerns raised. Whilst it is disappointing to hear our services have not met expected standards, every concern provides valuable feedback and potential learning opportunities. Concerns provide a view, from a variety of perspectives, enabling changes and improvements to the services provided.

Aneurin Bevan University Health Board is striving to be a learning organistion, encouraging staff to develop and improve.

A learning organisation promotes a culture that encourages staff to: -

- Raise concerns and offer suggestions
- Challenge current practice without fear of blame or repercussions
- Feel part of a team
- Learn together

The ABUHB Putting Things Right Service has two main parts: Concerns (complaints) and Serious Incidents. Concerns are raised by people who have received services. Whereas Serious Incidents are predominantly raised by staff working within the service through the incident reporting system (Datix), where an unintended or unexpected incident could have or did lead to harm to patients.

If a person raising concerns is not satisfied with the concern response, they can refer the complaint to the Public Service Ombudsman for Wales (PSOW), who can offer a number of ways forward and are able to separately investigate the issues raised in the complaint.

Where the appropriate standards of care have not been met, and that has led to harm to a patient, the case is referred to the Redress Panel, who determine whether there has been a breach of duty of care and whether that breach of duty of care has caused harm. Redress can then be offered. Redress can take the form of an apology, explanation of the events that occurred, reassurance about the lessons learnt or, where appropriate, financial compensation.
The Putting Things Right (PTR) Service is co-ordinated by a central Corporate Team in ABUHB, the majority of the work to investigate concerns and serious incidents, takes place within the Divisions.

The production of the 2019/20 Annual PTR report has been unavoidably delayed as a result of Covid-19.

Table 1: *illustrates progress from 2018/19*

At the end of 2018/19, the focus and priorities for the coming year were identified as:	How did we do?	
Improvement in the timeliness of responses to complaints.	*Increase* from 41% to 63.5%	
Taking forward further training in both concerns and serious incidents investigations.	Face to face training scheduled for June 2020 – delayed until October due to Covid-19.	
Improvement in the quality of complaint responses.	*Improvement* of 5.3% - cases upheld by PSOW *(2018/19 – 31/42 cases)* (2019/20 – 37/54 cases)	
Further development of the Learning Framework with an emphasis on learning and continuous improvement.	*Learning Events held* but impacted by Covid-19	

Challenges and Successes 2019/20

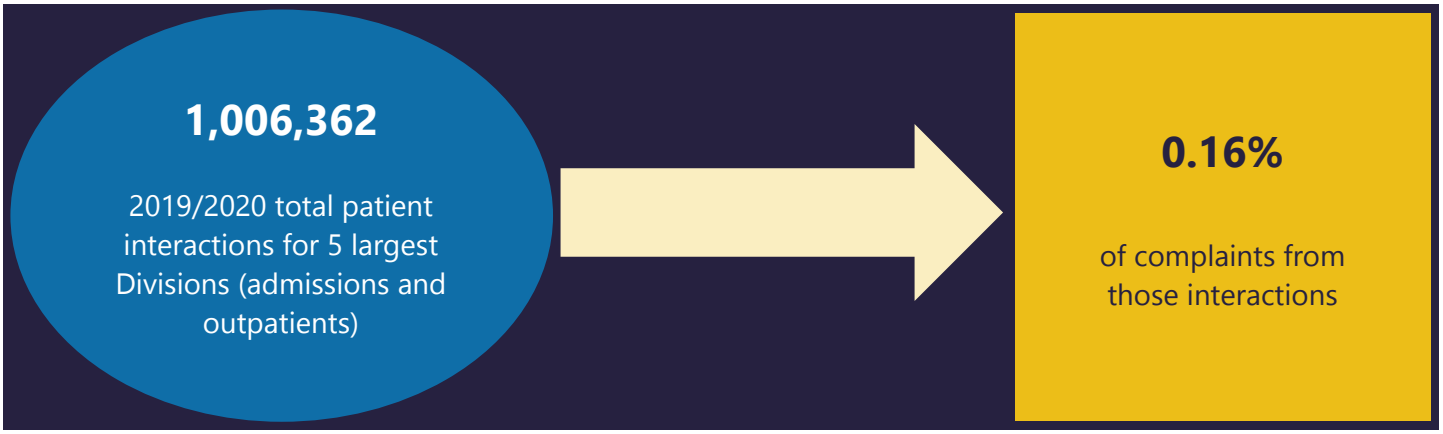
Challenges

- Consistent achievement of Welsh Government compliance target for timely concerns response.
- Quality of complaint responses.
- The majority of the PSOW upheld investigations showed dissatisfaction with the way in which the Health Board handled the complaint.
- Vacancies within the PTR team.
- Inability to deliver timely training for the Divisions regarding investigating concerns.

Successes

- PTR structure agreed and appointments made.
- Increase in Welsh Government compliance rates from 41% to 63.5%.
- PSOW reduction in payments in the last financial year.
- The development of Serious Incident Tools, which includes guidance notes for report writing, writing a Welsh Government closure summary and conducting an investigation.
- The introduction of huddles with PTR Team and Divisional Quality and Patient Safety Leads to identify any challenges and ensure that SI's and concerns are progressed seamlessly.
- Quality and Patient Safety (QPS) Leads are notified of an impending closure date 10 days prior to closure to ensure compliance.
- Improved use of technology and use of virtual meetings to reduce need for key clinical staff to travel, enabling better use of working time.
- Introduction of huddles with the Legal Team to ensure better communication around Coroners Cases/SIs.
- Quarterly meetings with the PSOW Improvement Officer, forging improved relationships.

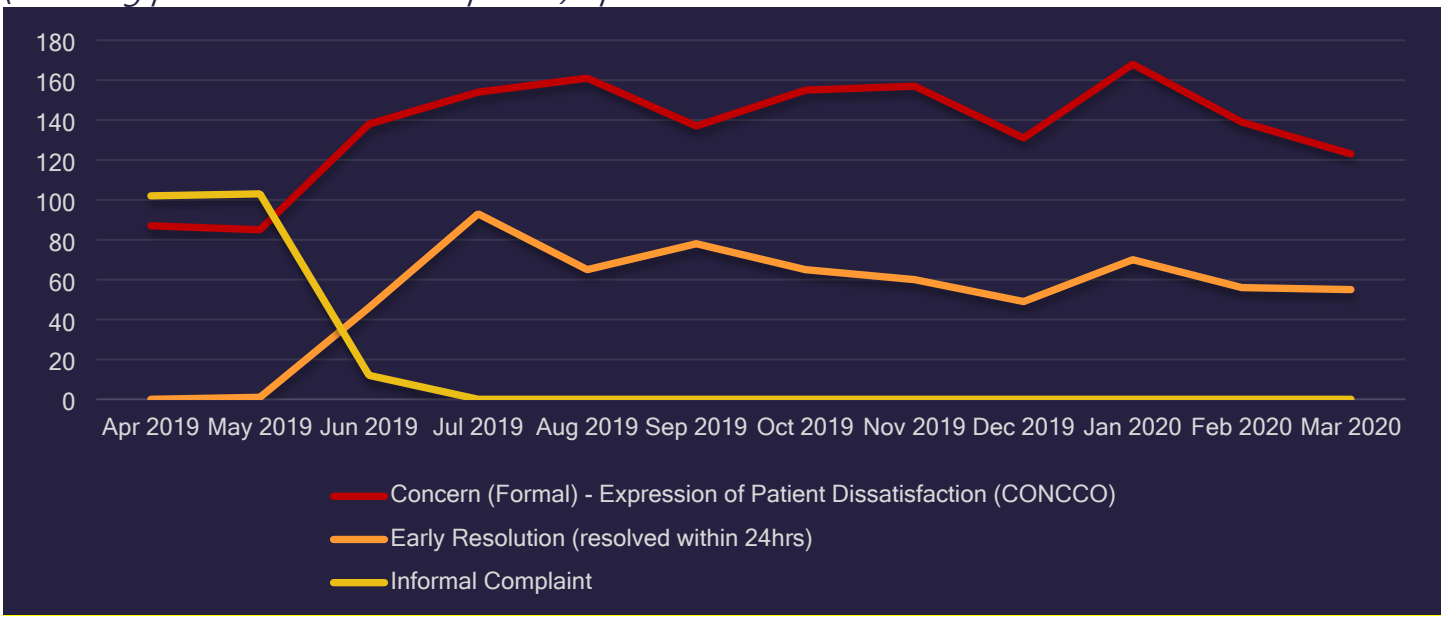
Complaints / Concerns



Each and every concern raised deserves, and is entitled, to receive an appropriate and proportionate investigation and response.

The large increase in formal complaints demonstrated in Graph 3, received from May 2019 onwards, is due to the change in the definition. Prior to this date complaints were categorised as either formal or informal complaints. The informal complaints were those, often received by telephone, resolved by the service looking at what had happened and responding within 5 days. Contact is made with the person complaining usually by phone, to explain what has happened and what is being done to address it.

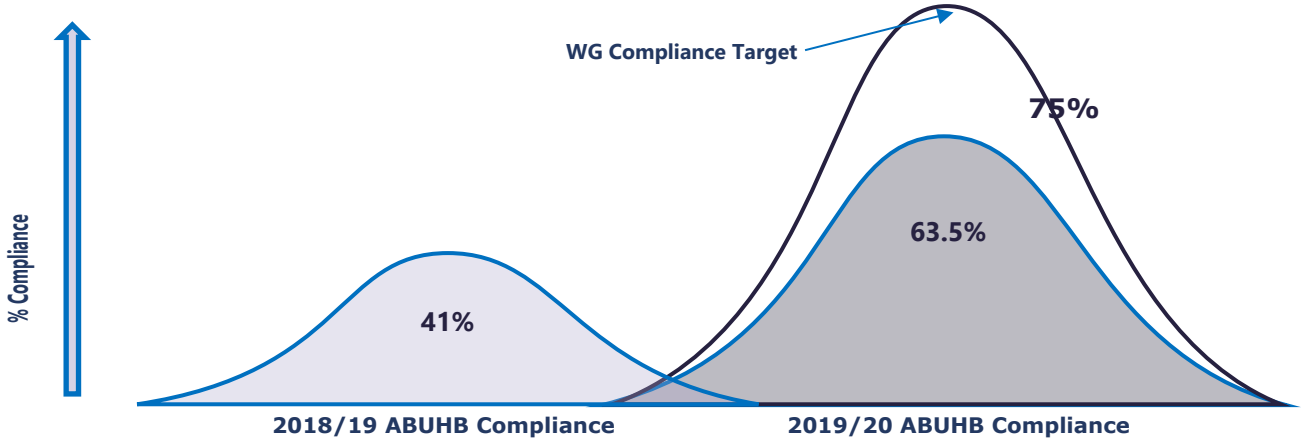
Graph 1: *Trend in formal and Early Resolution (including previous informal complaints) April 2019 – March 2020*



Compliance with Welsh Government Targets

In 2019-20, ABUHB received 1658 formal complaints, 1568 complaints were closed in year, of which 995 were responded to within 30 working days, the Welsh Government target. Overall compliance for the year = 63.5% as illustrated in Graph 2.

Graph 2:

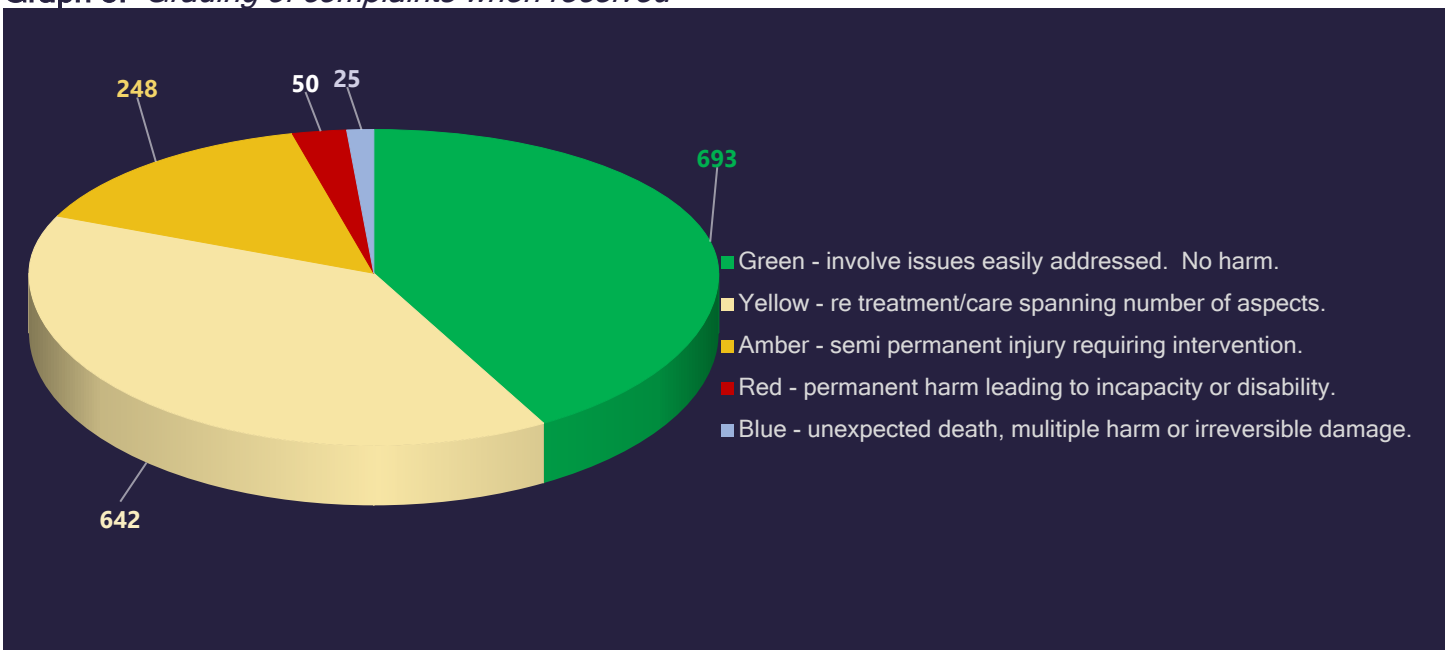


The Corporate Putting Things Right Team has worked with the Divisions, through improved training, networking, collaboration and sharing of best practice and consequently compliance has improved in comparison to 2018/19.

Table 2: *Guidance of Grading the Level or Harm in Complaints*

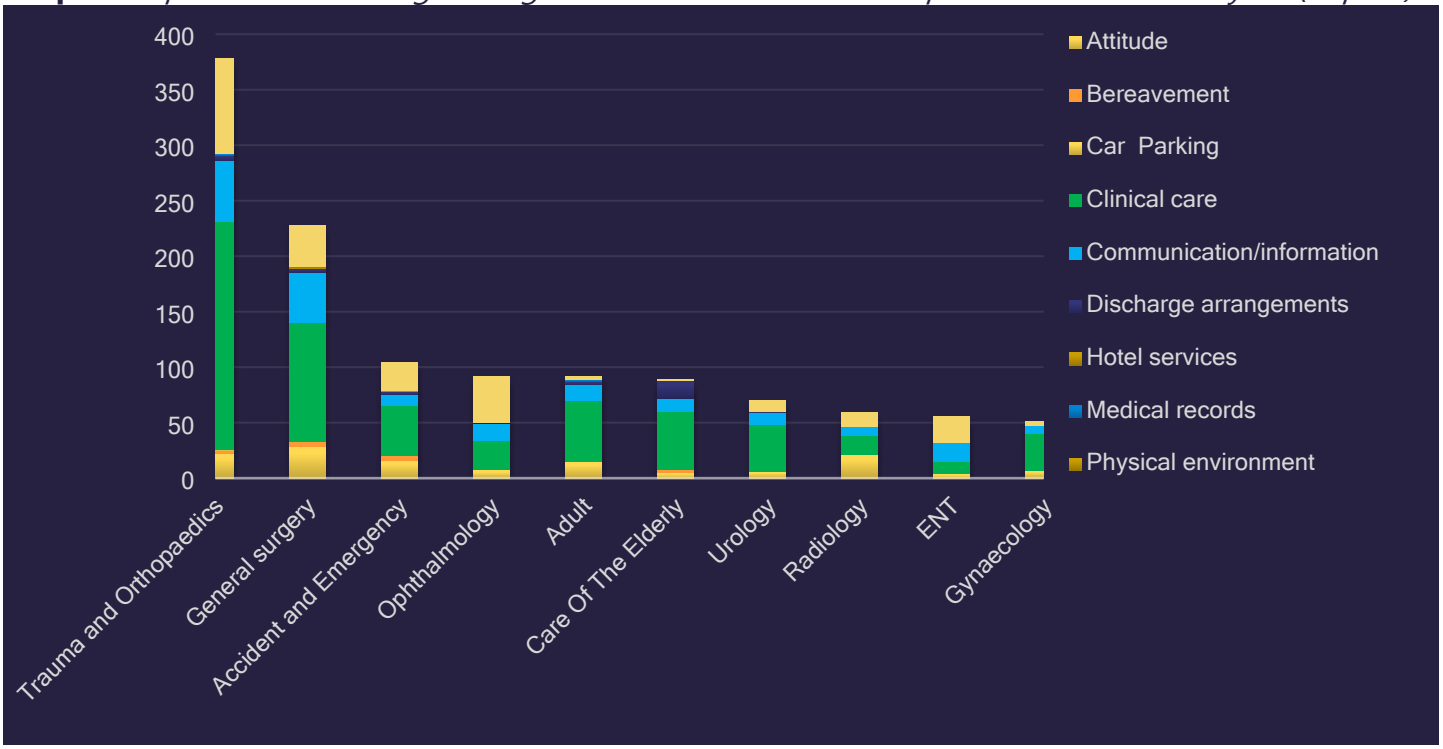
Grade 1	No Harm	No harm.
Grade 2	Low Harm	Minor implications for patient safety, patient fall requiring treatment, minor treatment.
Grade 3	Moderate Harm	Semi-permanent injury or impairment of health or damage requiring intervention, readmission, additional interventions.
Grade 4	Severe Harm	Semi-permanent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

Graph 3: *Grading of complaints when received*



Following thorough investigation, of the 75 complaints that were initially graded as a 4 or 5, only 10 remained at grades 4 and 5. Therefore 65 of the initial 75 categorised as having caused severe or catastrophic harm, were subsequently downgraded.

Graph 4: *Specialties receiving the highest number of formal complaint in the financial year (Top 10)*



Improving the timeliness and quality of complaint responses

The introduction of a Welsh Government Target and furtherance of network links and collaboration between the Corporate PTR Team and Divisions has led to a rise in compliance of more than 20% in comparison with 2018-2019. There has however been a period of time since 2018 that training in complaints handling and response delivered through PTR, due to PTR team workforce vacancies, has not happened. Bespoke training sessions have been rescheduled during 2020/21.

Even though formal training has not been undertaken learning has continued with the following examples highlighting where changes have occurred.

Learning from Complaints

End of Life Communication and Care

As a result of concerns raised regarding end of life communication, including those concerning clear treatment escalation plans/ceilings of care, a number of actions have been initiated:

- An End of Life Seminar including priorities and communication at the end of life and Advanced Care Planning was run in November 2019. This was attended by 127 staff. In addition staff have been offered communication skills training. This will enable the development of skills in engaging in difficult conversations, with both patients and their families, regarding palliative care and end of life pathways.

Documentation

- Introduction of 'One Patient - One Day' audits to provide a snapshot of total patient care and experience – devised for numerous reasons particularly to improve communication and documentation standards.
- Senior Nurses are undertaking weekly documentation audits across wards to monitor recording of patient fluid balance and food charts, as documentation standards have been identified as an issue.
- Scheduled Care Division implemented a Quality Focus Group with standardisation of documentation as an area of attention.

Mental Health and Learning Disabilities

A lack of diagnostic and aftercare services for adults with Attention Deficit Hyperactivity Disorder (ADHD), was identified and as such the person raising the complaint was invited to be part of a group developing the Health Board's service model.

Reduction in Pressure Ulcers (PU)

In response to concerns raised around healthcare acquired pressure ulcers and their management. A number of measures were introduced, which included the use of hybrid mattresses, revision of SSKIN bundles, physiotherapy engagement, PU classification training, a Pressure Ulcer poster was also displayed, which was reported favorably as good practice by the PSOW. It highlighted actions for consideration which included;

- Body map completion on arrival on the ward
- Completion of necessary documentation e.g. WATERLOW and WAASP tools

Along with ongoing care, that includes 2-4 hourly skin bundles, use of profiling bed to reposition the patients also ensuring clinical photography and referral to Tissue Viability Nurses if required.

Serious Incidents (SI)

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

All Serious Incidents are reported to Welsh Government and managed through the Serious Incident Process with a target to be reported, investigated and learning identified within 60 working days of the incident notification.

In January 2020, ABUHB changed the way in which it categorised serious incidents and divided these into two separate categories. Serious Incidents are broken down into two criteria, Red 1 and Red 2 as illustrated in the following flowchart.

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SERIOUS INCIDENT PROCESS
DO IT WELL DO IT ONCE

A serious concern occurs

Division to ensure immediate patient safety actions are addressed with pace

Division report incident via **DATIX Web 'Serious Incident'** option selected. **Corporate Serious Incident Team** to be contacted on 01633 431671/431669 or x51671/51669.

Incident reviewed by Putting Things Right Team and advice sought from Clinical Executive Director/s, if required. Incident classified as **Red 1** or **Red 2**.

Welsh Government notified of the Serious Incident c.c. Executive Directors. Closure form to be completed within **60** working days.

CRITERIA FOR RED 1

Severe harm or death as a result of patient safety incident. Examples include:

- Coroner's cases
- In-patient suicide
- Sudden unexpected death in theatre
- Significant media interest
- Never events
- Complex multi-agency incidents

CRITERIA FOR RED 2

Significant harm as a result of a patient safety incident. Examples include:

- Management of deteriorating patient
- Medication incidents with harm
- Missed investigation results with harm
- Community Suicides
- Serious complaints with actual/potential harm

Directors to receive updates on Red 1 and 2 Serious Incidents via the Executive Clinical Huddle

RED 1

- An Executive or nominated deputy is allocated who will chair the review process, with full Divisional engagement.
- An Investigating Officer is appointed.
- 3 meetings are established.
- Draft Terms of Reference for the review are developed.

PTR Team arrange 1st SI Meeting
(1 week)

Purpose of meeting:

- Review incident and secure notes
- Agree Terms of Reference
- Support for staff
- Nominate lead contact for family/patient
- Assurance that immediate patient safety actions undertaken

Investigating Officer undertakes investigation and drafts investigation report
(6 weeks)

2nd Serious Incident meeting held within 8 weeks

- Review draft investigation report
- Identify learning and develop the action plan
- If Breach of Duty and Harm consider Redress Panel

3rd and final Serious Incident Meeting held within 10 weeks

1. Agree final draft investigation report and sign-off (if Non-Exec chair, the report will need Executive sign off)
2. Agree final action plan, monitoring arrangements and ABUHB learning
3. Confirm arrangements for sharing report with staff and family/patient
4. Welsh Government closure form completed by Serious Concerns Assurance Officer
5. Approved report and Action Plan to the Coroner

RED 2

- The Division will chair the review process.
- An Investigating Officer is appointed.
- 3 meeting dates are established.
- Draft Terms of Reference for the review are developed.

Divisional Team arrange 1st SI Meeting
(1 week)

Purpose of meeting:

- Review incident and secure notes
- Agree Terms of Reference
- Support for staff
- Nominate lead contact for family/patient
- Assurance that immediate patient safety actions undertaken

Investigating Officer undertakes investigation and drafts investigation report
(6 weeks)

2nd Serious Incident meeting held within 8 weeks

- Review draft investigation report
- Identify learning and consider the action plan
- If Breach of Duty and Harm consider Redress Panel

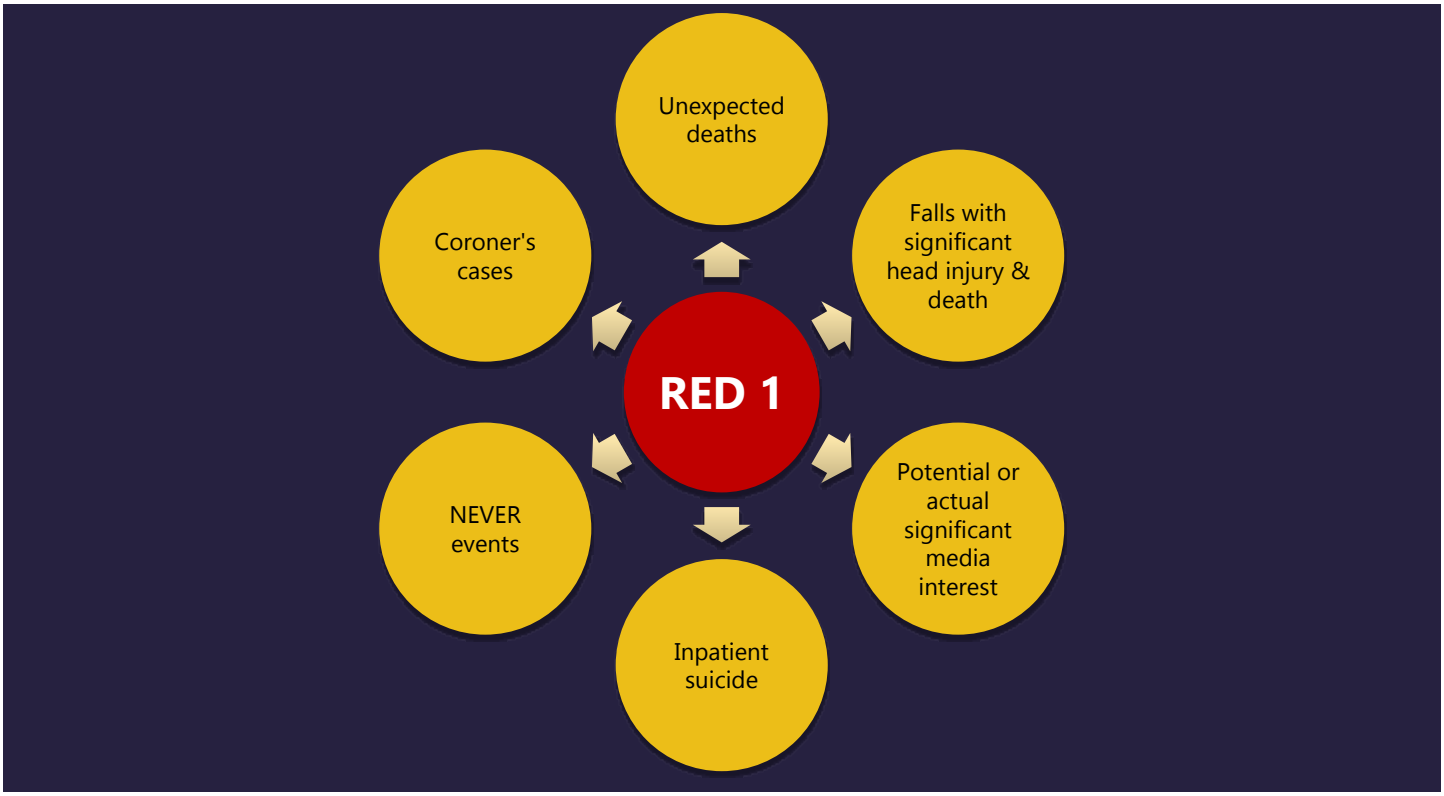
3rd and final Serious Incident Meeting held within 10 weeks

1 Agree final investigation report and arrange DD/GM/DN sign off
2 Agree final action plan, monitoring arrangements and Divisional learning
3 DD/GM/DN arrange Executive sign off via Concerns Team
4 Confirm arrangements for sharing the report with staff and family/patient
5 Case discussed at DQPS meeting
6 Welsh Government closure completed by Division and forwarded to Serious Concerns Assurance Officer

The expectation is that timescales are met and SI's are robustly, effectively and efficiently managed

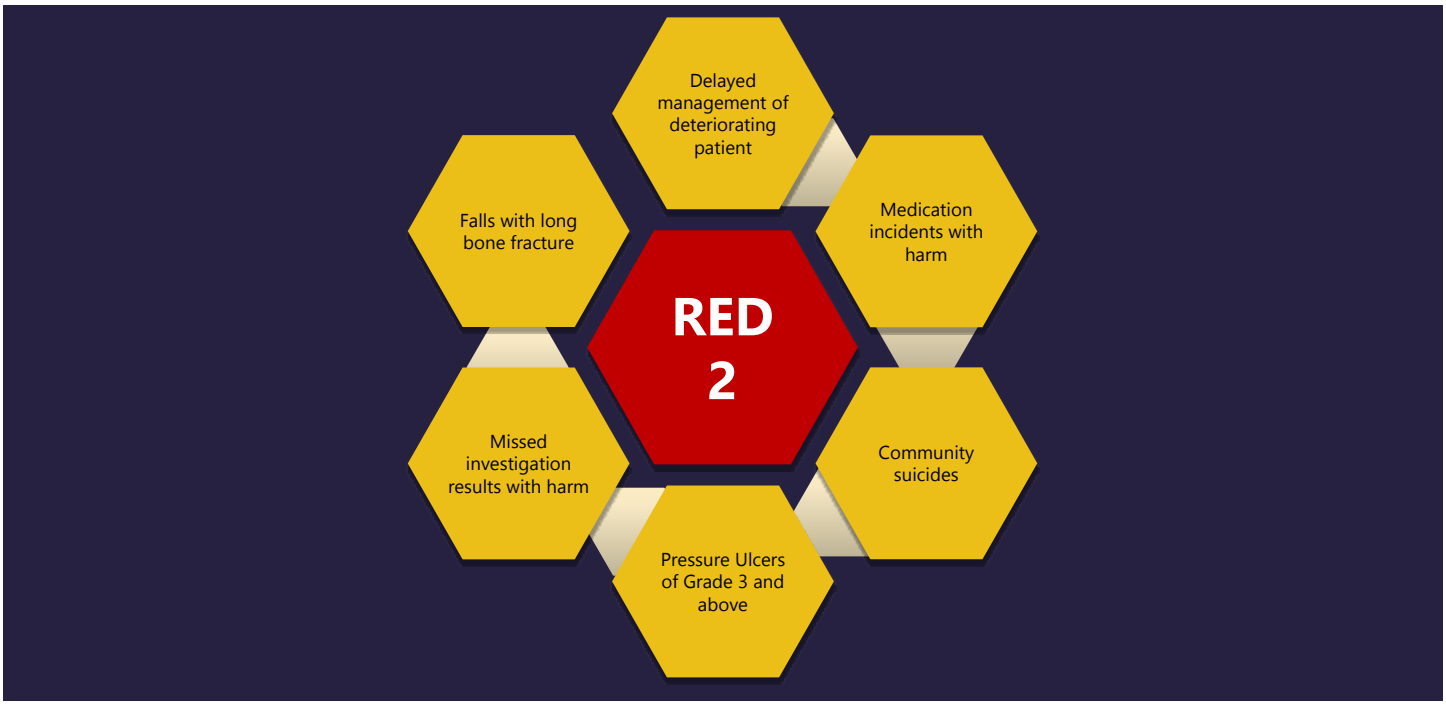
Red 1: Serious Incidents

Formally known as Corporate Serious Incidents are incidents which have resulted in severe harm or death. Examples include:



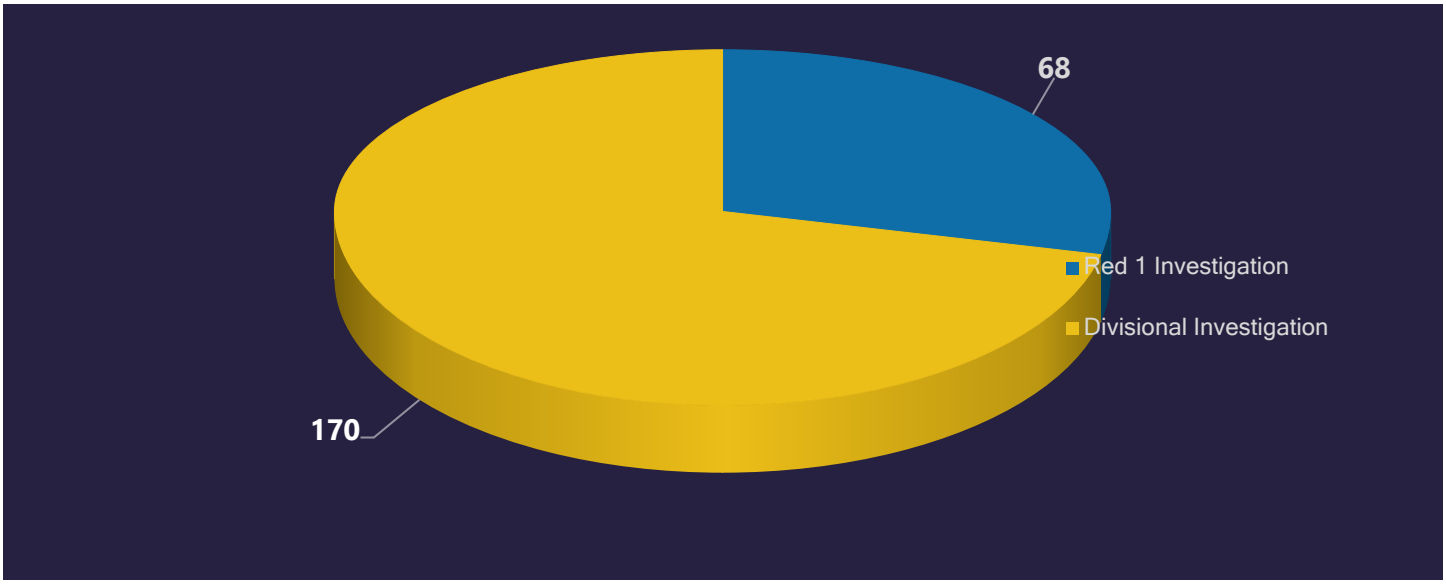
Red 2: Serious Incidents

Formally known as Divisional Serious Incidents are those that have resulted in moderate to severe harm as a result of a patient safety incident. Examples include:



The number of incidents reported to Welsh Government were either led by the Division as a Red 2 investigation or Corporate led as a Red 1. This equated to 71% and 29% respectively.

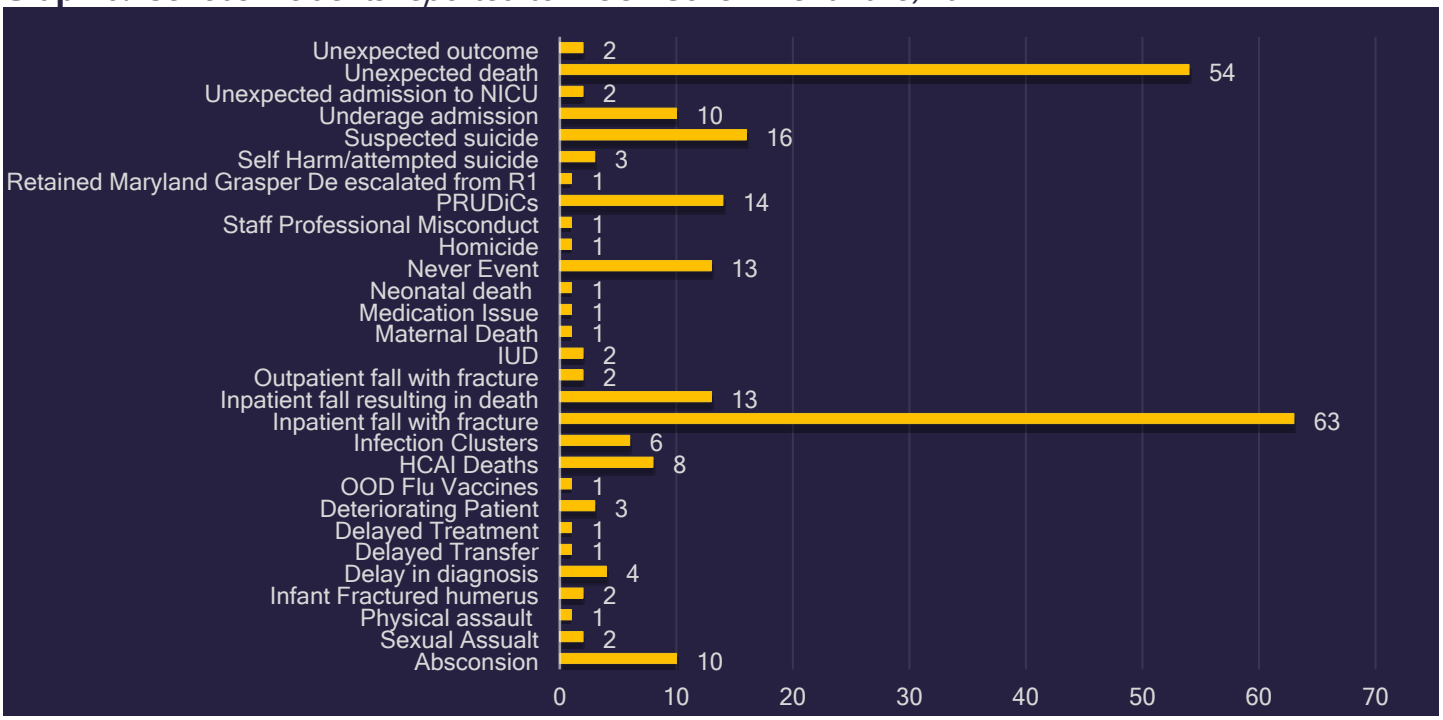
Graph 5: *Red 1 and Red 2 Investigations – 2019/20*



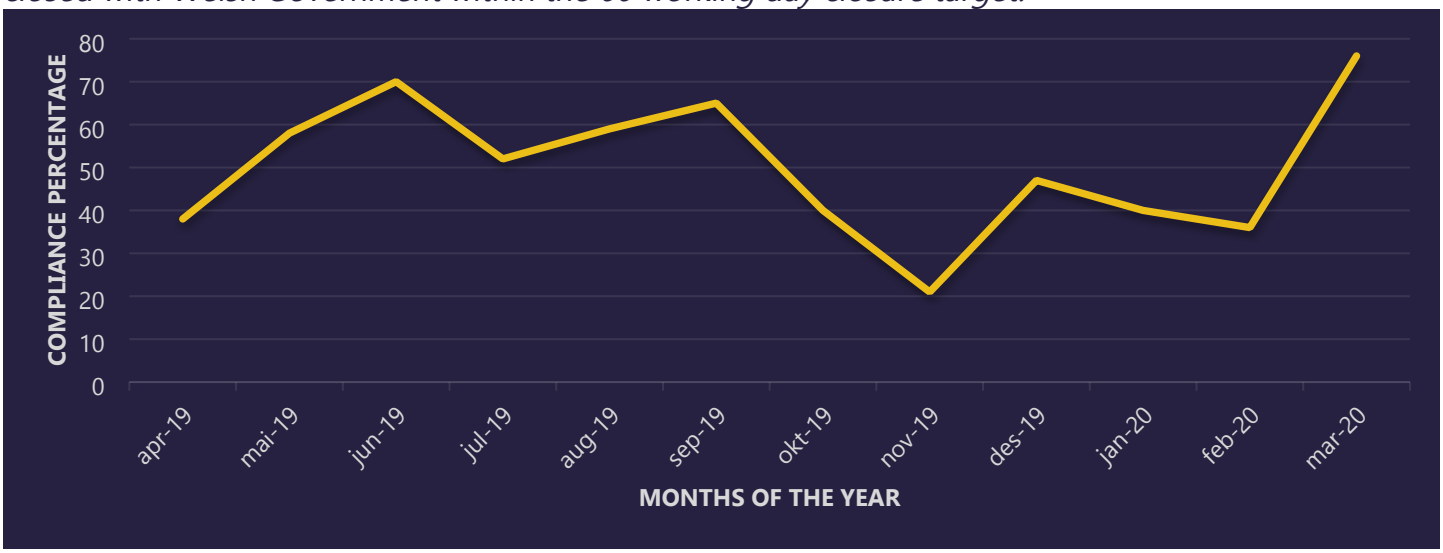
The following graph illustrates the criteria for reporting incidents, with the top three themes as follows;

1. Inpatient fall with fracture
2. Unexpected death
3. Suspected suicide

Graph 6: *Serious Incidents reported to Welsh Government 2019/20*



Graph 7: *shows the Health Boards compliance with serious incident investigations concluded and closed with Welsh Government within the 60 working day closure target.*



Serious Incidents – Falls

Inpatient Falls are reported as incidents on Datix. Many falls do not result in major physical harm for patients. A target was set in April 2017 to reduce the annual median inpatient falls by 10% over 2 years (in line with the recommendations in WHC (26) 2016). The actual median at March 2019 showed a reduction of 19% on that time period.

When comparing hospital sites, the number of inpatient falls (per 1000 bed days) is seen to be higher in those sites with single rooms i.e. YYF and YAB.

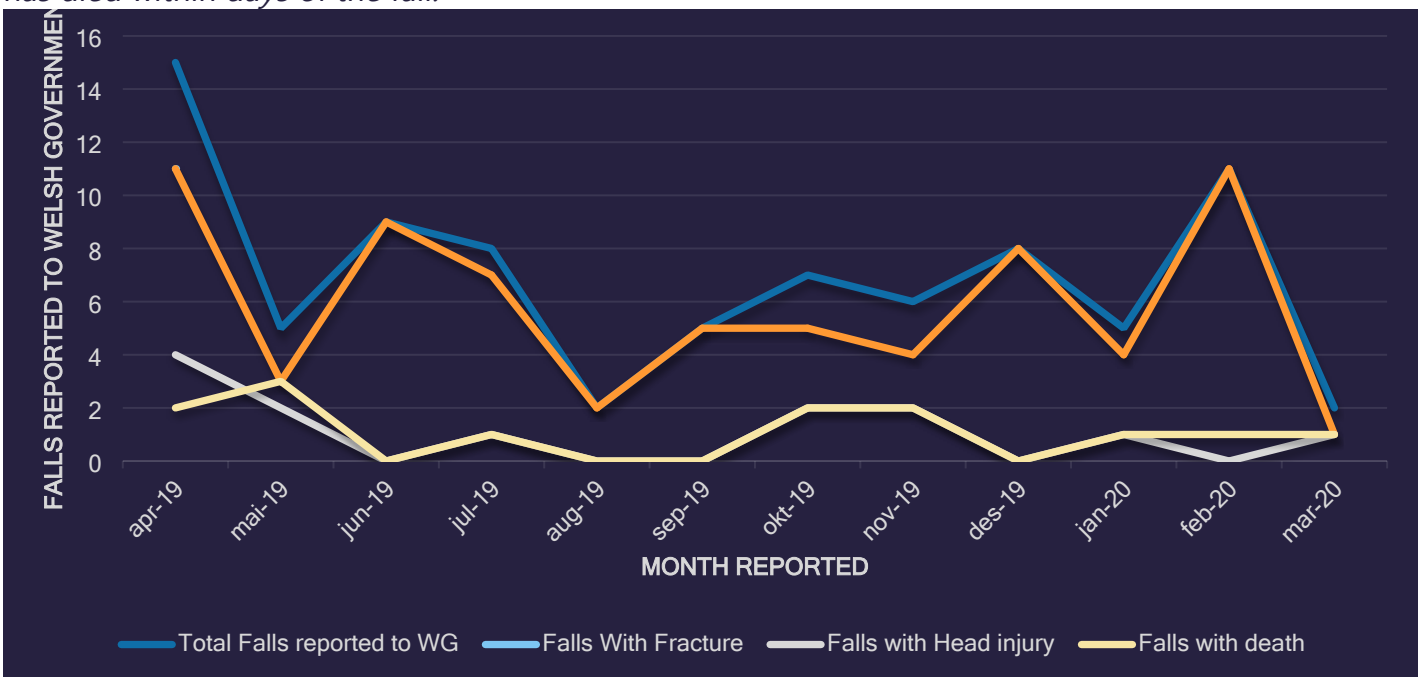
A number of falls result in a fractured bone or a head injury. Inpatient falls which result in a long bone fracture are reported to Welsh Government. An investigation is conducted and presented to the Falls Review Panel. The role of the Falls Review Panel is to review the investigation to ensure that there is learning and themes are identified and overseen by the Falls and Bone Health Steering Group.

Overall, the total number of inpatient falls is reducing, however the severity of harm (at severe and catastrophic levels) has increased in the past two years, specifically for both long bone fractures and head injuries. Whilst this severity of harm represents a very small percentage of all inpatient falls (between 0.3% - 2%), the increase is of concern.

Falls with head injury and death are referred to HM Coroner and an inquest is arranged. There have been occasions where inpatient falls have resulted in other fractures, such as spinal fractures or facial fractures. Whilst not classed as long bone fractures, the SI Team assess these on a case by case basis in terms of the level of harm for the patient and whether these are reportable.

The number of fractures or severe head injury varies from month to month, but shows normal variation.

Graph 8: *Illustrates the total number of inpatient falls reported to Welsh Government between April 2019 and March 2020. It provides detail of those that are fractures, head injuries or when the patient has died within days of the fall.*



In March 2020 due to the Covid-19 global pandemic, Welsh Government issued a national steer that mandated that only falls resulting in unexpected death, were to be reported. This is the reason for the sudden decrease in falls reported for March.

Learning from Serious Incidents

Falls

In response to a number of injurious falls, measures have been put into place in an attempt to reduce avoidable falls:

- Introduction of an ABUHB wide Falls Collaborative, with multidisciplinary membership.
- Recruitment of an Orthogeriatrician for the fractured neck of femur service at Royal Gwent Hospital (RGH), which has driven improvements in the ward based assessments.
- Also at RGH a robust weekend watch list and out of hours handover for continuity of care has been introduced. Along with an anaesthetic pathway to improve post-operative care from recovery to the ward.
- There has also been an extension of the job plan of the hip fracture service Registrars to cover the weekends.
- Launch of an improved Multi-factorial Risk Assessment Tool (MFRA) and incorporation into a booklet with other risk assessments.

- A Learning Event with multidisciplinary staff to discuss lessons learnt.
- Actively minimising the amount of inter-ward transfers for patients at risk.
- Patient falls reduction leaflets provided for patients and families.
- Appropriate use of post-fall assessment document and physiotherapy assessments following falls.
- Adjustment to ward routine i.e. stopping of early morning routine observations at 06:00.
- Improved signage on bathroom doors, to include visuals.

National Early Warning Score (NEWS) / Deteriorating Patient

In response to a number of incidents, e.g. recognition and escalation of the deteriorating patient, the CareFlow Vitals System was further rolled out across the Health Board. This system that monitors and analyses patient's vital signs, providing Clinicians with accurate, real time information for the safest possible patient care. Staff using the system enter patient's vital signs with other clinical observations and assessments at the bedside. It automatically calculates a risk score (using the nationally recognised NEWS score) based on clinical observations, immediately alerting staff of deterioration and advising on appropriate actions.

The introduction of this system highlighted voids in practice, which included inconsistences in undertaking and recording of physiological observations and calculation of the NEWS score. This was identified as having caused delay in escalating deterioration of patients. This resulted in:

- A comprehensive training and education programme rolled out to staff across hospital sites in the use of this system.
- Snap shot observational audits undertaken by Senior Nurses to monitor compliance with the system.
- An additional Senior Nurse was based on site in Ysbyty Ystrad Fawr (YYF) to support this workstream.
- A competence based assessment was introduced to monitor the practical skill of recording observations.

Improvement to Theatre Environment and Procedures

Following a number of mis-categorisations of level of harm on the Datix reporting system:

- Training has been undertaken for senior leads in all areas in order to identify how to categorise events into levels of severity, the review and mapping where the checks occur and who carries out the checks. This is supported by an ongoing audit programme by senior leader and peers.
- Anonymised staff surveys have been established for all groups to identify areas of concern, thus encouraging early escalation of concerns observed in a safe environment.

- New Epidural charts introduced to ensure administration of medication via this route are robustly escalated. Training has been provided to theatre recovery staff and ward nurses by the acute pain lead nurse.
- A significant effort has been undertaken to promote 'Stop Before You Block' and this practice is now embedded within the organisation and signage displayed in all anaesthetic areas.
- WHO checklist audits, have been conducted.

Plaster Cast Care in Trauma and Orthopaedics

- Development of a neurovascular assessment tool for Trauma and Orthopaedic (T&O) patients to reduce risk of pressure ulcer development associated with cast application.
- Specialist plaster technicians are now available for trauma lists to apply plasters.
- Information on the management of plasters and requirement to investigate joint pain within plasters has been added to the educational induction programme for T&O doctors and nursing staff.

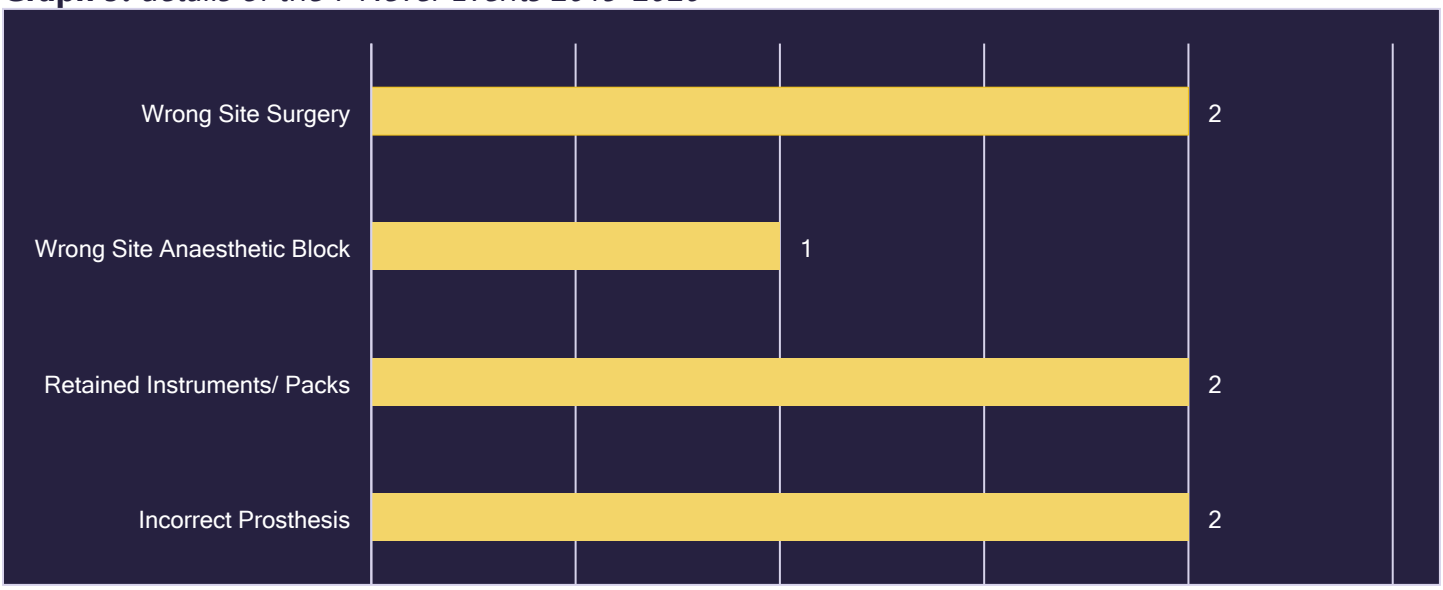
Learning from Mental Health and Learning Disabilities Division

- Findings of SI reviews have instigated the review and amendment of the Clozapine Policy – specifically in relation to the management of constipation.
- Following an incident the Therapeutic Observations and Engagement policy was updated, to include the requirement to assess a person's mental state when they are being given Section 17 leave from a Mental Health Ward, prior to the leave being granted.
- Due to the lack of a multidisciplinary team when assessing people who are in crisis, the current crisis team being uni-disciplinary (nursing), and having a multi-disciplinary team may give a different perspective on an assessment. There was development of the clinical model for acute care in mental health services, specifically the liaison model and multi-disciplinary aspect of the Crisis Resolution Home Treatment Teams.

Serious Incidents – Never Events

There were 7 Never Events occurring during 2019-20 including: wrong site surgery, wrong site anaesthetic block, retained instruments/packs and incorrect prosthesis.

Graph 9: *details of the 7 Never Events 2019-2020*



There were no real themes identified however a broad number of actions and associated learning has been undertaken to minimise recurrence. This includes an overarching Action Plan to address incidents in theatres, with improvements including;

- A monthly Safety Group meeting has been established to strengthen the governance framework.
- Processes to ensure cross divisional learning across specialities and sites were commenced – including dissemination of learning at Theatre Teams Audit days and via monthly team meetings.
- Theatre Collaborative utilised to support information sharing and improving good practice.
- Datix training for staff.
- Senior review and sign off of Datix.
- Mechanisms to feedback investigation outcomes to promote learning across all theatres.
- Incidents reviewed to monitor trends and target improvements.
- Ongoing audit programme established – with LoccSips audits undertaken in General, Gynaecology, Ophthalmology, Urology and ENT Theatres.

Learning from Never Events

In 2019/20 an internal audit of the completeness and effectiveness of the WHO Surgical Safety Checklist was undertaken. This provided reasonable assurance. The following actions were implemented to address findings in the report and subsequent learning:

- The WHO safety checklist template was adapted for application in Ophthalmology laser therapy treatments following a Never Event wrong site procedure and Never Event retention of throat pack. This checklist was formatted with relevance to other minor and invasive ophthalmic procedures.
- The Ophthalmology checklist is now completed for all patients undergoing ophthalmic surgical procedures using laser therapy. Compliance has been confirmed by live auditing for a period of one month and an audit programme is now in place to monitor compliance going forward.

- Learning and progress is effectively communicated at induction of new staff, via LocSSIP training and departmental meetings with all staff disciplines.
- The maternity pathway has been revised to include an improved version of the safety checklist to reflect the WHO template, ensuing consistence across specialities.
- A recent observation revealed inconsistencies in the interpretation of the 'sign in' section of the WHO checklist. This, in part, is due to the design and use of a Treatment room within the theatre suites in two locations. An improvement initiative to revisit the WHO checklist process is underway to confirm that practitioners of all disciplines undertake the process consistently, accurately, efficiently and in compliance with NatSIPP guidance.
- The surgeon, scrub practitioner and circulating practitioner now verbally confirm the size and type of prosthesis to be implanted, to prevent errors.

A significant effort has been undertaken to promote 'Stop Before You Block' and this practice is now embedded within the organisation and signage displayed in all anaesthetic areas.

Redress

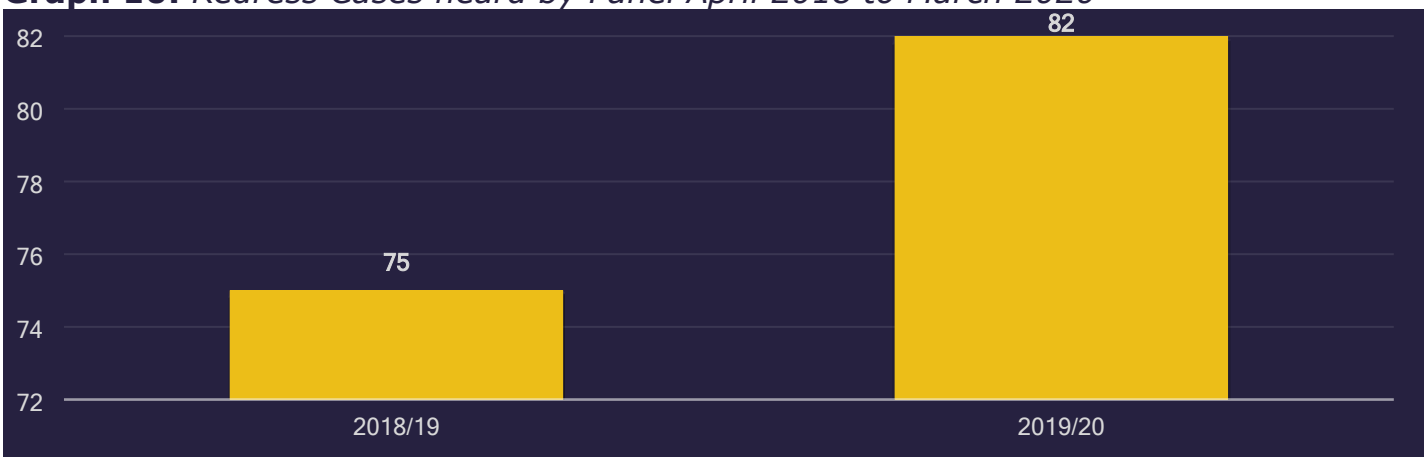
Under the framework for investigating concerns including those of patient safety incidents, there is an obligation on Health Boards where harm has occurred or is alleged to have occurred, to consider whether there is a qualifying liability in tort i.e. are there failings in care which amount to a breach of duty of care and that breach of duty led to the harm experienced or materially contributed to it. The test of a breach of duty is the same as the legal test and is based on the Bolam principles i.e. were the decisions and actions taken reasonable and appropriate as by judged by a body of "peers".

The Redress Panel

The Health Board has established a Redress Panel to make determinations in those cases where it feels there have been failings and the failings may have led to harm. Redress Panel now has a permanent chair, Assistant Medical Director (Public Health) and members include representatives of the Medical Director, Nurse Director, Director for Therapies and Health Science, Finance Director and Board Secretary. Cases are heard every three weeks. In addition to making determinations of a qualifying liability there is an increased focus by the Panel to ensuring adequate learning has taken place and whether further learning is required on a corporate/division wide basis and in some instances on a national basis.

The final Panel for 2019/2020 was suspended due to the Covid-19 pandemic. The Panel heard 82 cases during the year an increase of 7 (9%) from the previous year as illustrated on Graph 10.

Graph 10: *Redress Cases heard by Panel April 2018 to March 2020*

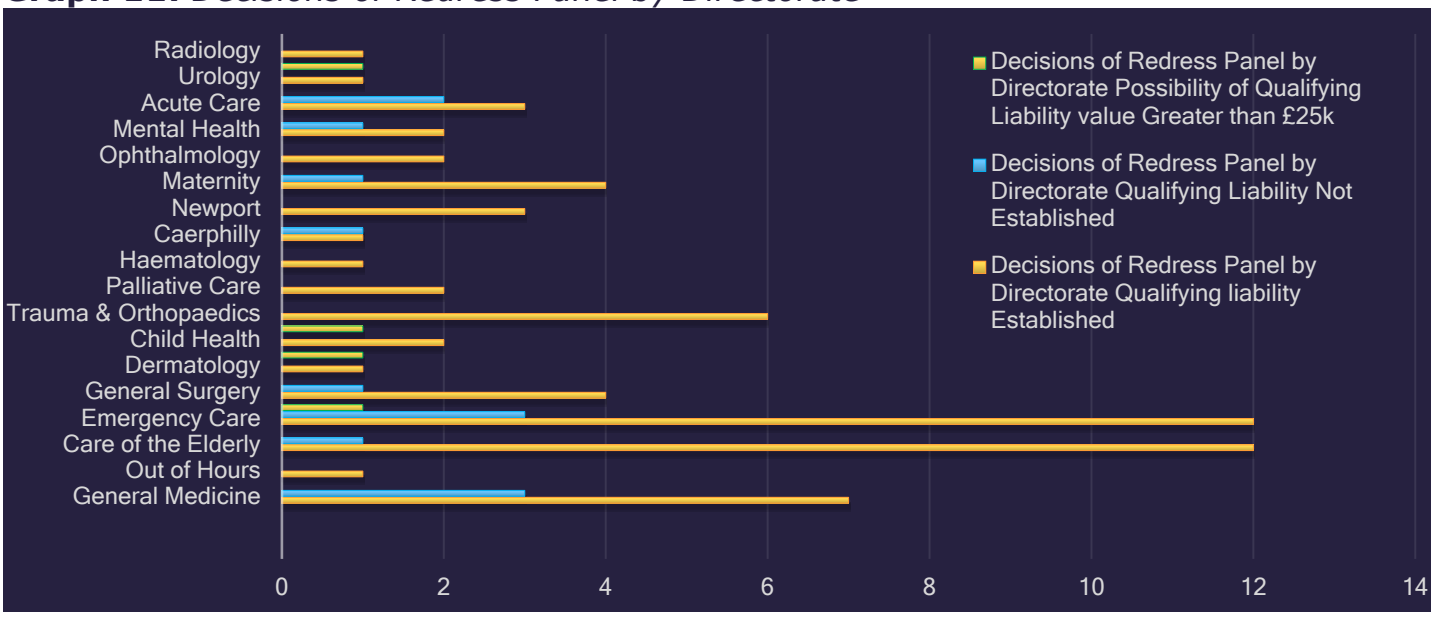


Decisions of Panel

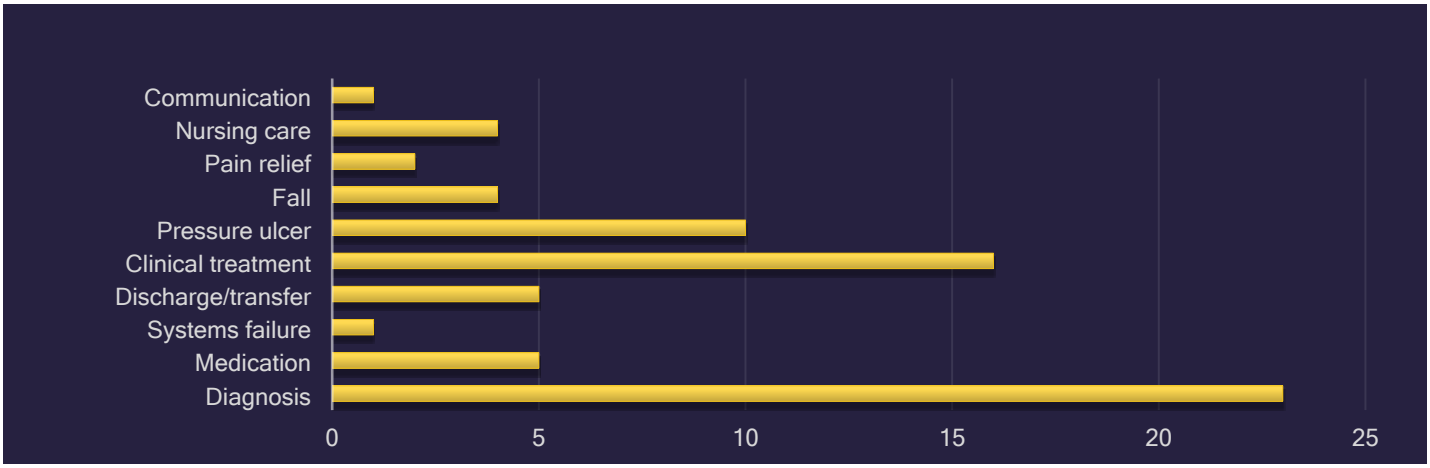
Qualifying Liability Established	65
Qualifying liability not established	13
Cases where potential of Q/L but taken out on value	4
Total number of cases heard in Panel	**82**

Cases considered by Panel do not only consider those concerns raised by patients or their representatives but also consider concerns raised by staff, either as a patient safety incident or via Safeguarding. Of these cases, 15 arose by way of patient safety incidents and 17 involved a complaint and a patient safety incident.

Graph 11: *Decisions of Redress Panel by Directorate*



Graph 12: *Themes in cases where qualifying liability established*



The main theme in cases whereby qualifying liability was established is associated with diagnosis. Lessons learnt from issues connected with the theme of diagnosis can be wide and varying as the issue can range from a failure to appreciate the subtly of a fracture via x-ray to a failure to appreciate the significance of a presenting symptom(s) to reporting errors on radiological investigations. Often the case will be anonymised and used in teaching sessions within the relevant clinical areas and the individuals concerned will be asked to reflect on the case and use this to inform their clinical practice. In other cases there may be changes to systems and processes in the care to be provided e.g. agreement between paediatric ward managers of a standard to include recording of blood pressure twice daily and completion of a full set of observations on admission to Children's Assessment Unit or ward area. In addition re-attendance guidelines have been developed and embedded across the paediatric directorate.

Lessons Learned from Redress

Two cases involving the out of hours radiology reporting system highlighted concerns with governance and indemnification. This was escalated through Redress Panel and reported to the All Wales Meeting of Directors of Therapies and Health Sciences. Consequently a meeting has been held with the out of hours reporting service and a new system of governance has been agreed with the Health Board. As a result of the concerns raised by the Health Board an All Wales investigation was undertaken.

The concerns and lack of assurance was such in two particular cases presented that they have led to the development of Learning Events. These are multi-disciplinary meetings involving not only members of the teams providing the care but also cross divisional and cross specialty personnel. The meeting discusses the care provided to the patient and the action that has been taken and needs to be taken within the ward, directorate, and division across the Health Board. As a consequence of their success they are now to be repeated on a more regular basis especially for those cases which are complex and raise multiple clinical and nursing failures.

A number of cases involving falls resulting in a fracture of a long bone have led to the Inpatient Falls Policy and the multi factorial risk assessment accompanying this to be reviewed. This in turn has led to the development of a falls learning collaborative with the assistance of ABCi in a similar vein to the pressure ulcer collaborative. The pressure ulcer collaborative has been very successful in reducing the number of inpatient acquired pressure ulcers.

Public Service Ombudsman for Wales (PSOW)

The number of complaints that are referred to the PSOW provide a marker of the quality of the Health Board's investigation and its initial responses to the complaints received.

Quarterly meetings with the PSOW Improvement Officer to discuss handling and liaison issues, alongside regular telephone contact with the Investigation Officers, have been positive. This year no concerns have been raised with regard to the Health Board's response to the PSOW when dealing with complaints that have been referred to them.

During 2019/20 good working relationships have been maintained and efficient processes are in place to ensure deadlines are met. Where delays are encountered, and the PSOW's deadline cannot be met, an escalation process has been put in place with the Executive Team.

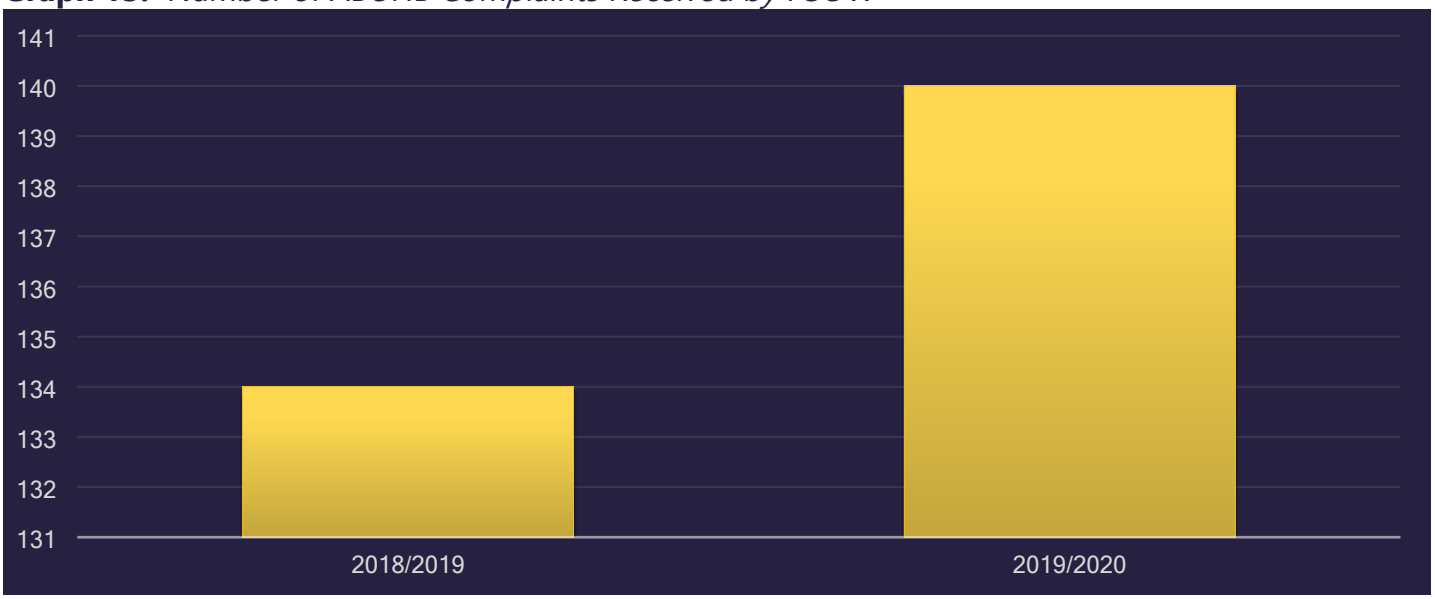
This year, the way in which PSOW cases are recorded by the Health Board has been improved through a more effective use of Datix. This enables information relating to the whole complaint, from first receipt by the Health Board to the final involvement of the PSOW, to be recorded on one electronic file.

Number of complaints received by PSOW

During 2019/2020 the PSOW received 140 complaints related to ABUHB. This represents an increase compared to 2018/19 of 4.5%.

The following chart shows the number of complaints received by the PSOW over the last three years, showing a year-on-year increase. The higher number of PSOW complaints received in 2019/20 reflects the increase in the number of overall complaints received by the Health Board during 2019/20.

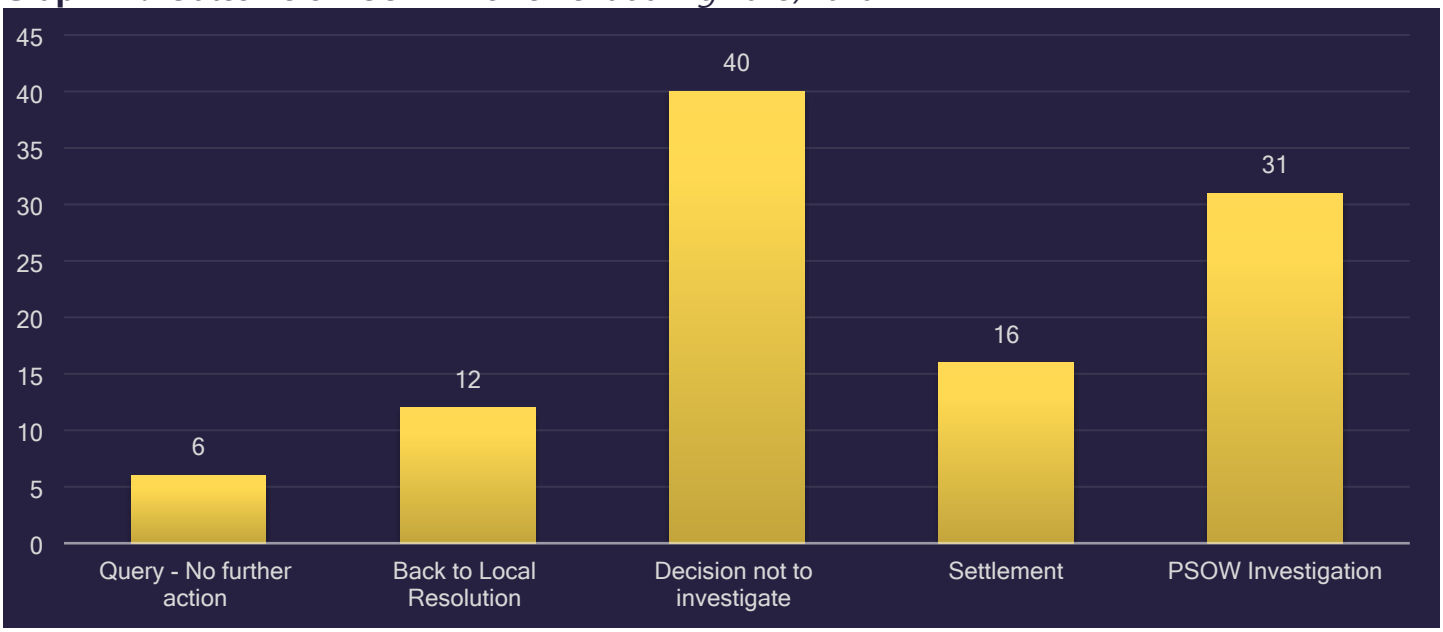
Graph 13: *Number of ABUHB Complaints Received by PSOW*



A proportion of the complaints shown in the graph would have been rejected at the outset by the PSOW and would have remained anonymous to the Health Board, meaning that numbers received by the PSOW differs from the number that require further Health Board input.

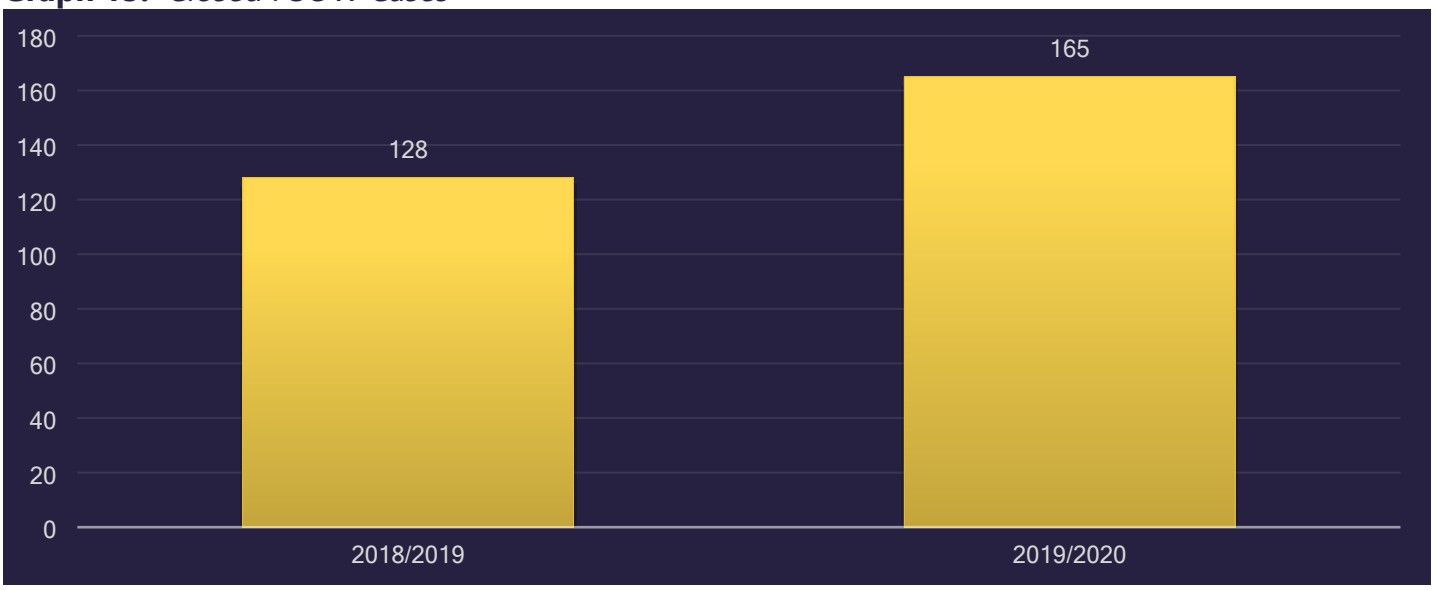
105 PSOW complaints were referred back to the Health Board for further involvement, including 39 from 2019/20 and 66 related to complaints dealt with by the Health Board in previous financial years. The outcome of PSOW cases received in 2019/2020 is shown in graph 14:

Graph 14: *Outcome of PSOW Involvement during 2019/2020*



As shown in graph 14 out of the 105 complaints dealt with, 31 required a full PSOW investigation.

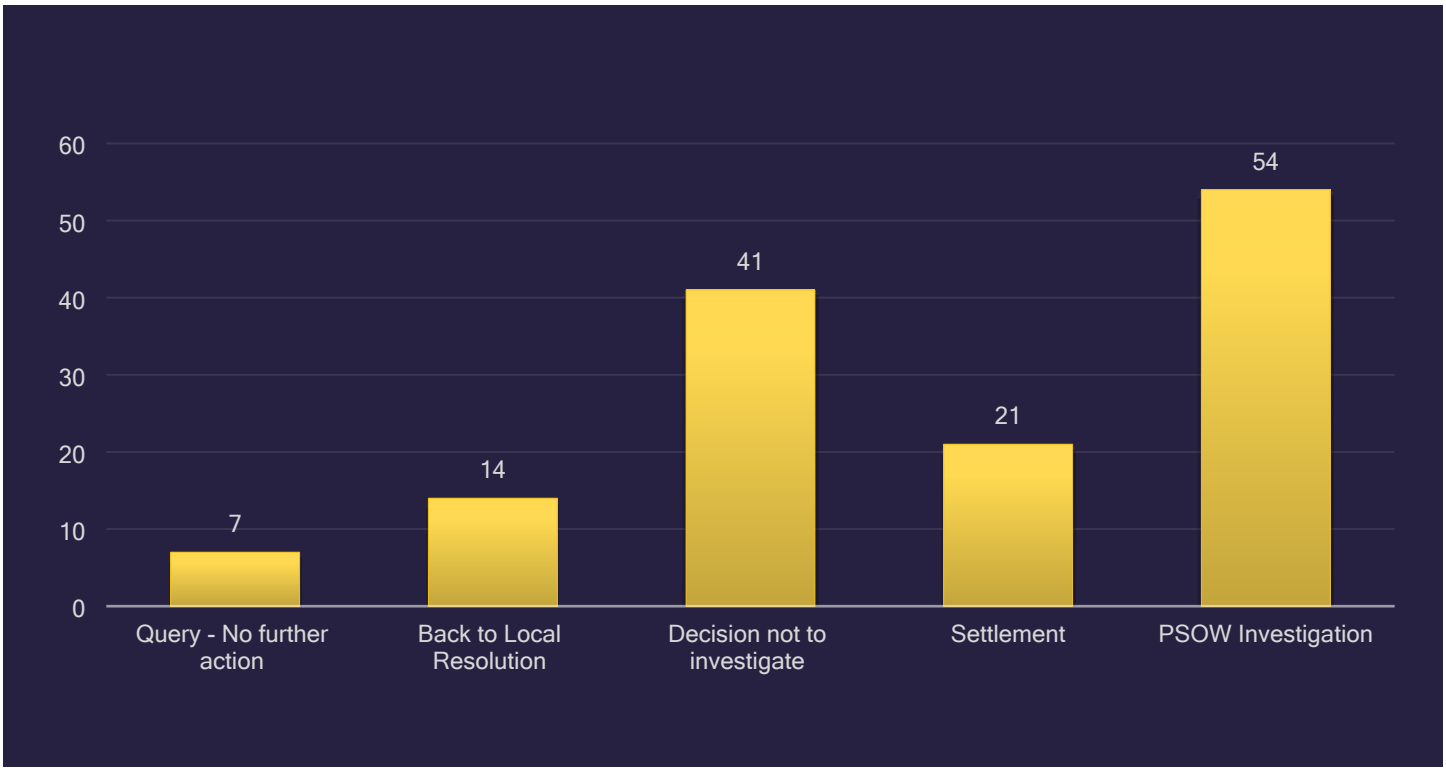
Graph 15: *Closed PSOW Cases*



Outcome of PSOW complaints closed during 2019/20

Although the PSOW closed 165 cases in 2019/20, the Health Board itself closed 137 PSOW cases. The difference of 29 can be attributed to anonymous complaints made that the Health Board does not have knowledge of. The 137 cases includes complaints received by the Health Board in previous financial years, not just complaints 2019/20.

Graph 16: *Outcome of closed complaints in 2019/2020*

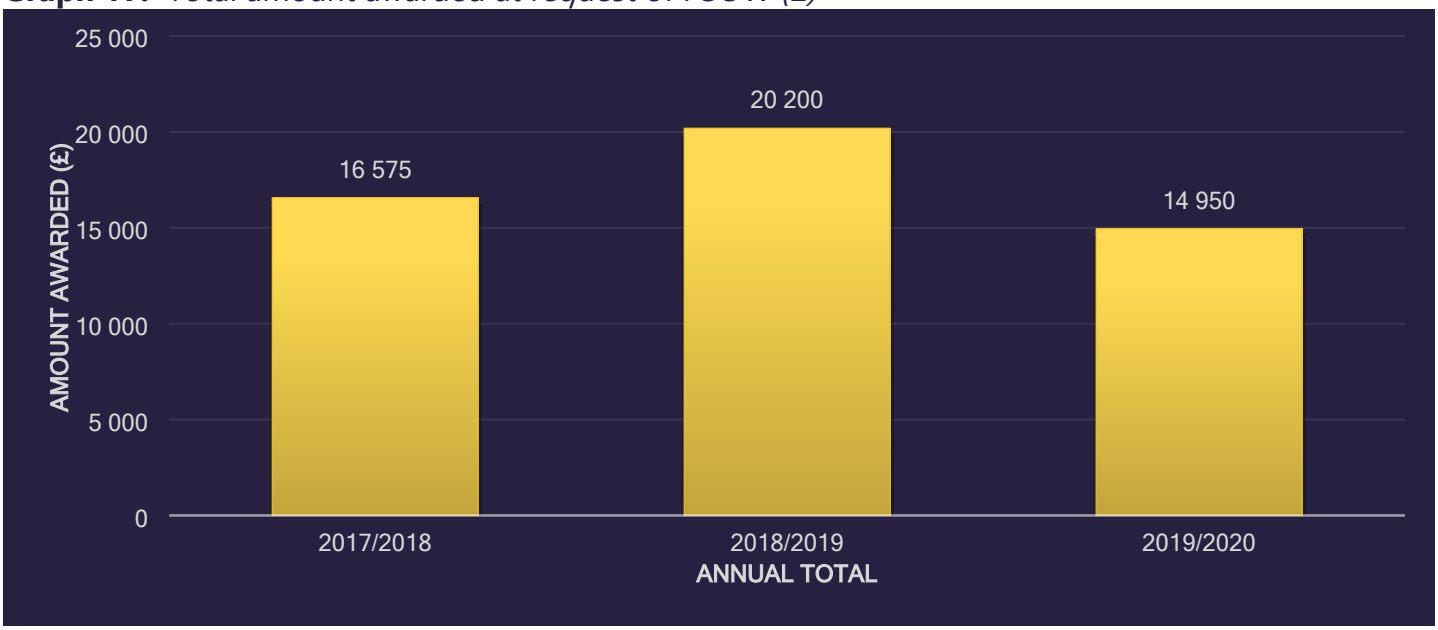


As shown in graph 16, out of the 137 closed cases, 54 were relating to PSOW investigations. 37 of these were upheld and 17 were not upheld. This represents a 68.5% figure of upheld complaints. This is compared to 73.8% of complaints upheld in 2018/19.

PSOW Financial Settlements

Where the PSOW considers there has been an injustice they are able to recommend a financial payment. This can be at any stage, i.e. as a settlement or as part of the recommendations following a full investigation. The following information shows the financial amount paid out by the Health Board at the request of the PSOW over the last three years, indicating a reduction in payments in the last financial year.

Graph 17: *Total amount awarded at request of PSOW (£)*



Learning from PSOW Cases

Medication for Patients with Parkinson's Disease

Inappropriate prescription and single dose of haloperidol, contraindicated in patients with Parkinson's disease, led to learning and inclusion of the management of Parkinson's disease being introduced into the F1 teaching programme at Nevill Hall Hospital for 2019/20. In addition, the Symptomatic Management of Parkinson's Disease was also added to the Health Board's Training App.

Lack of timely action in relation to a pressure ulcer within the Medical Assessment Unit led to an avoidable pressure ulcer. Since this patient was admitted to the Medical Assessment Unit, improvements in pressure area management have been put in place, which include:

- Comprehensive assessments are undertaken on admission to hospital. Any reason for not undertaking assessments is documented fully.
- Appropriate care is provided regardless of patient location.
- There is an embedded focus on patient safety at all the hospital bed management meetings.
- The ward is a member of the Pressure Ulcer Collaborative. This is a programme of work launched in September 2018 developed by the Health Board. The MAU team have been at the forefront of the collaborative.
- There is a Tissue Viability Nurse Champion in place.

Compliments

Compliments are useful for measuring and tracking feedback. They can show improvements in performance, and provide a baseline for measuring patient satisfaction, generating meaningful data can help drive continuous improvement. Compliments acknowledge, reward and promote desirable behaviours and practices, also providing staff with social recognition. Positive feedback is pivotal for morale and wellbeing, and reinforces what the Health Board, is striving to provide.

Historically, compliments have not been captured within ABUHB, however during 2019-20, better systems and processes have been instigated to ensure that this important feedback does not go unrecognised. Compliments are received within a variety of formats, including letters, emails, telephone calls and conversations.

Some examples are included as follows:

"Thank you for running such a great department. And thank you to all the staff who saw me with a smile."

A&E, Unscheduled Care
April 2019

"To all the staff thank you for your care".

Mental Health Team
June 2019

"You are all superb and I thank you most sincerely".

Chepstow Hospital
Primary Care & Community
October 2019

"I would like to thank the doctors and staff for an unbelievable experience with fantastic support and assistance with this minor procedure."

Dermatology, Scheduled Care
August 2019

"I wanted to let you know the tremendous difference you have made to the patient's quality of life and the gratitude had by both the patient and her daughter."

Mental Health
September 2019

"The level of care from all the Team was outstanding and we would like our grateful thanks noted and passed onto the staff."

GP Out of Hours, Primary Care & Community
May 2019

"I was in, seen, x-rayed, given advice and a splint, and discharged, all within half an hour! Can't thank the staff enough."

A&E, Unscheduled Care
November 2019

2019/20 – Learning through themes

A learning organisation is one where patient safety, quality of care and a positive experience is core. Key themes for learning include the necessity to;

Share and disseminate lessons learnt

- Development of the overall approach to learning from incidents and complaints and sharing of lessons learned and actions implemented.
- Further development of the Learning Framework and emphasis on learning and continuous improvement is required in order to foster a learning organisation that thrives through its responses to incidents and complaints, is flexible, adaptive and productive and future-focused.

Ensure a robust and comprehensive training programme

- There is a significant need for the delivery of Investigating Officer and Complaints response training in order to improve the quality of responses and organisational learning.

Continually strive to improve complaints handling

- Rapid review meetings to assign most relevant division to lead will streamline initiation of processes and define roles and responsibilities more clearly.

Ensure timeliness of investigations and quality responses

- Use of virtual meetings will enable greater flexibility in managing calendars of many senior clinicians and nursing staff, leading to timely meeting scheduling.

Streamline the serious incident investigation process and response times

- Action Plans were not being submitted alongside the investigation report and were required in order to close the incident with WG. PTR would experience many delays in receiving action plans back. In order to address this Action plans are populated throughout the SI process as discussed within the meetings. This is starting to yield improved results.

Minimise the risk of the occurrence of Never Events

- More robust systems and processes in place to address issues.

Improvement actions for 2020/21

- A suite of training modules to be delivered by the PTR team engaging stakeholder partners, focusing upon Complaints and Serious incident investigation.
- Further enhanced relationships with PSOW and officers.
- Newsletter to be introduced in order to share and promote good practice.
- Continued improvement in compliance to turnaround times for complaints and incidents, with Divisional trajectories set.
- Complaints Coordinator Forum to be established as a support network.
- More robust trend analysis of complaints/incidents to inform areas for learning and development.
- The improved use of Datix will facilitate analysis and reporting of complaints information in future. This will ensure alignment with the work that is being progressed by the 'Once for Wales Concerns Management System Programme (OfWCMS), developing a consistent approach in the use of Datix across all Health Boards. OfWCMS is a new approach to how NHS Health Boards and Trusts in Wales will report, record, monitor, track, learn and make improvements from incidents, complaints, claims, adverse outcomes, risks and events that happen in healthcare.
- Further focus on the development of learning, with evidence of improvement.