**A meeting of the Aneurin Bevan University Health Board**
**Quality and Patient Safety Committee**
**will be held on Thursday 4th April 2019, commencing at 9:30am**
**in Conference Rooms 1 & 2, Headquarters,**
**St Cadoc's Hospital, Caerleon**

**AGENDA**

| | | | | |
|---|---|---|---|---|
| **Preliminary Matters** | | **Attachment** | | **9:30** |
| 1.1 | **Welcome and Introductions** | Verbal | **Chair** | **15 mins** |
| 1.2 | **Apologies for Absence** | Verbal | **Chair** | |
| 1.3 | **Declarations of Interest** | Verbal | **Chair** | |
| 1.4 | **Draft Minutes of the Committee held on 7th February 2019** | Attachment | **Chair** | |
| 1.5 | **Action Sheet of the Committee held on 7th February 2019** | Attachment | **Chair** | |
| **Presentations** | | | | **9:45** |
| 2.1 | **Outpatient - Delayed Follow Up and Reported Outcomes** | Attachment | **Dr Paul Buss** | **15 mins** |
| 2.2 | **Learning from Cwm Taf Maternity Services Report** | Attachment | **Deb Jackson** | **10 mins** |
| **For Consideration** | | | | **10:10** |
| 3.1 | **Quality, Safety and Performance Overview**<br>• Fractured Neck of Femur – proposed way forward to improve outcomes | Attachment<br>Verbal | **Dr Paul Buss/ Martine Price**<br>**Dr Paul Buss** | **15 mins** |
| 3.2 | **Risk Assessment Overview**<br>• Risk Register<br>• Patient Experience Risk | Attachment<br>Verbal | **Chair**<br>**Martine Price** | **15 mins** |
| 3.3 | **The Healthcare Inspectorate Wales Report:** Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W.<br>• Health Board response to recommendations | Attachments | **Lin Slater** | **15 mins** |
| 3.4 | **ABUHB RRAILS Acute Deterioration Report** | Attachment | **Kate Hooton** | **10 mins** |
| **Break (10 mins)** | | | | **11:05** |

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|---|---|---|---|---|
| **Items for Quality Assurance** | | | | **11:15** |
| 4.1 | • **QPSOG Assurance Report from Meeting held on 19th March 2019** | Attachment | **Peter Carr** | **10 mins** |
| 4.2 | **Independent Member Quarterly Visits Report** – Actions and Way Forward for Independent Member Visits | Attachment | **Chair/Director of Primary, Community and Mental Health** | **15 mins** |
| 4.3 | **Quality, Safety, Value, Innovation and Performance** | Verbal | **Dr Paul Buss** | **10 mins** |
| **Final Matters/For Information** | | | | **11:50** |
| 5.1 | **Items for Board Consideration** To agree items for Board consideration and decision | Verbal | **Chair** | **5 mins** |
| **Date of Next Meeting** | | | | |
| Wednesday 12th June 2019, 1:00pm, Conference Room 4, ABUHB Headquarters, St Cadoc's Hospital | | | | **Chair** |

Quality and Patient Safety Committee
Thursday 4 April 2019
Agenda Item: 1.4

# Aneurin Bevan University Health Board
# Minutes of the Quality and Patient Safety Committee held on Thursday 7 February 2019

**Present:**

| | | |
|---|---|---|
| Prof Dianne Watkins | - | Chair, Independent Member (University) |

**In Attendance:**

| | | |
|---|---|---|
| Paul Buss | - | Medical Director |
| Phil Robson | - | Special Adviser to the Board |
| Martine Price | - | Interim Director of Nursing |
| Claire Birchall | - | Director of Operations |
| Jayne Beasley | - | Assistant Head of Midwifery and Gynaecology Nursing |
| Kate Hooton | - | Associate Director, Patient Quality and Safety |
| James Quance | - | Observer, Internal Audit |
| David Thomas | - | Assistant Director, ABCi |
| Martin Lane | - | Interim Assistant Director of Organisational Learning |
| Claire Barry | - | Committee Secretariat |

**Apologies:**

| | | |
|---|---|---|
| Judith Paget | - | Chief Executive |
| Peter Carr | - | Deputy Director of Therapies and Health Sciences |
| Frances Taylor | - | Independent Member |
| Jemma McHale | - | Community Health Council |
| Cllr Richard Clark | - | Independent Member of Local Government |

**QPSC 0702/01 Welcome and Introductions**

The Chair welcomed members and officers to the meeting, and in particular welcomed guests and observers who were attending.

It was explained that the meeting was not quorate. It was agreed therefore that decisions would be deferred to the next meeting or an additional meeting would be arranged in advance of the next scheduled Committee meeting.

**QPSC 0702/02 Declarations of Interest**

There were no Declarations of Interest made relating to items on the agenda.

**QPSC 0702/03 Minutes of the Meeting held on 21 November 2018**

The minutes of the meeting held on 21 November 2018 were agreed as a true and accurate record of the meeting.

**QPSC 0702/04 Action Sheet – 21 November 2018**

The Committee considered the Action Sheet from the meeting held on the 21 November 2018 and noted that all actions had been completed or were progressing.

**QPSC 2111/04 Learning Disabilities Audit (QPSC 1209/06)** – It was noted to the Committee that Penny Gordon, was still the Learning Disabilities Project Lead.

**QPSC 0702/05 Maternity Services Board**

Jayne Beasley gave a presentation on the key issues for the Maternity Services Board as requested at the last Committee meeting.

It was reported that the total number of incidents across the three hospitals, Nevill Hall Hospital, Ysbyty Ystrad Fawr and Royal Gwent Hospital was 728 for 2017/18. It was noted that the majority of incidents were at the Royal Gwent Hospital with a total of 471. It was suggested that this was the reflection of the increased births and high acuity that was currently in this area.

It was explained to the Committee that the Governance structure was that all incidents were reported back to the Maternity Services Board and any serious incidents were reviewed at their quarterly meetings. It was highlighted that the Maternity Board considered how the Maternity Services Service could improve the service by research, engaging with patients and staff and providing support for staff through risk study sessions.

The Committee discussed the issues that had occurred within the Maternity Service and was assured by the learning and action plans that had now been put in place to improve the level of care provided.

The Committee noted the publication of the HIW report of Cwm Taf Health Board and requested that the recommendations were reviewed and mapped against Aneurin Bevan University Health Board's position. **ACTION: Martine Price/Deb Jackson/Jayne Beasley**

The Committee thanked Jayne Beasley for such a well detailed presentation.

Jayne Beasley left the meeting.

**QPSC 0702/06 Winter Plan Progress Update**

Claire Birchall gave a presentation to update the Committee on the Winter Plan Progress.

It was highlighted to the Committee that this time of year there were different changes in the level of demand.

In relation to Primary Care Out Of Hours Service (OOH), although numbers of contacts had not risen, the number of serious cases and referral into ED had increased. Thus demand in acute services had increased by 658 cases from 13,166 to 13,824 over the same period of time last year, with the majority being seen as 'major' and complex cases requiring increased levels of care. Ambulance handovers remained problematic due to the large number of major cases and there was a continuing focus on trying to reduce this. Where ambulances are waiting to hand over patients, triage takes place immediately the ambulance arrives at the hospital and those required immediate care are admitted into ED. The number of patients waiting longer than 12 hours in ED has improved with compliance at 95% compared to 94.4% in January 2018. Numbers being seen within the 4 hour window had slightly decreased with 76.2% compliance for January 2019 compared to 76.7% in January 2018.

It was explained to the Committee that even though admissions had increased, elective work was still being undertaken during the first weeks of January. This had reduced during the latter part of the month due to the flow and volume of patients.

It was reported that Community Health Care (CHC) feedback was positive, patients were satisfied with the level of comfort when they were in beds, trolleys or waiting areas. Patients commented that the Health Board's nursing staff were rated as good at communicating with patients and treating them with dignity and afforded privacy when required. It was reported that nearly all patients knew where to get refreshments, and where this hasn't been the

case the CHC had reported it and Senior Nurses had ensured this had been addressed immediately.

It was highlighted that learning going forward for winter planning 2019/20 was to:

- Plan Early
- Try to make sites more resilient with Senior Management and Governance around communication.
- Safety Huddles
- Advanced Paramedic Practitioners
- Focus on Quality and Patient Safety Feedback
- Work with the Community and Frailty
- Staff Wellbeing

The Committee commended the Team on the work that had been done around winter planning and felt assured that the position this year had much improved compared with the same time last year.

Claire Birchall left the meeting.

**QPSC 0702/07 Quality, Safety and Performance Overview**

The Committee reviewed the report, noted the progress that was being made in many areas and highlighted the issues.

It was reported that over the past three years there had been a significant reduction in crude mortality, despite increasing pressures and more complex cases.

It was highlighted that there had been significant improvements at RGH regarding Fractured Neck of Femur mortality, but it still remained a concern at NHH and it had only improved in 5 out of the 20 of the parameters in the National Audit. Learning from RGH was currently being implemented into NHH.

It was noted at the meeting that the Medical Examiner Role would be going live April 2019, this would work alongside the bereavement service and hopefully reduce the number of complaints received regarding bereavement. It was reported that a plan around piloting the bereavement service was in place at Ysbyty Ystrad Fawr (YYF) and was going through the Patient Experience Committee as well as End of Life Board. This had now been extended to the Royal Gwent Hospital. There was a plan of to support this and

funding had been secured from the End of Life funding National Board. One of the issues going forward was continuing funding for this service and a business case had been developed.

It was highlighted to the Committee the issues around sepsis at YYF. It was noted that a Senior Nurse working with deteriorating patients was in place which was helping to address these issues. The pioneering of Vital Pac had been rolled out smoothly across Nevill Hall Hospital.

The Committee received the report.

**QPSC 0702/08 Risk Assessment Overview - Risk Register**

The Committee received the risk register and noted that there were no changes in overall risk scores. At the last meeting the Committee asked for clarity that risk regarding poor patient experience and quality of care in hospital and community settings due to staff shortages and increasing acuity of patients be reviewed.

Martine Price outlined that following meetings with the Medical Director, Director of Therapies and Director of Workforce, the risk was reviewed and it was proposed it was updated to reflect all of services which could impact on patient experience and outcomes. The actions to mitigate would be updated and owner would include the Medical Director.

The Committee discussed the Patient Experience risk and agreed with the proposed update, and this would come to the next meeting. **ACTION: Martine Price**

**QPSC 0702/09 Risk Assessment Overview – QPSOG Assurance Report**

The Committee received the assurance report from the Quality and Patient Safety Operational Group (QPSOG) meeting which was held on 10 December 2018.

It was reported that there were no other issues raised by the QPSOG that needed to be escalated to the Quality and Patient Safety Committee.

The Committee was assured by the report.

**Overview of Health Care Standards Audit 2018-19**

The Health Care Standards for Wales was published in April 2015, combining the previous quality frameworks such as

the Standards for Health Service and the Fundamentals of Care Standards.

The Health Care Standards for Wales provide an updated and integrated framework of standards aimed at helping people in Wales to understand what to expect when they access health services and what part they themselves can play in promoting their own health and wellbeing.

There were seven themes of the NHS Outcomes and Delivery Framework and the Health Care Standards had been designed to fit these themes:

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

Since the launch in 2015, the focus for Aneurin Bevan University Health Board had been very much on embedding the standards within the Divisions and then into the Directorates and Teams. These standards were being used on a continuous basis by the Divisions to quality check services, identify gaps and risks and to make improvements where needed in order to improve the services provided.

It was noted by the Committee that the following progress that had been made overall in 2018-19:

- The Terms of Reference for the Health Care Standards Group had been updated.
- The Health Care Standards Assurance and Self Assessment Improving Planning Guidance's had been reviewed and was being developed to provide assurance against the Health Care Standards within the Quality Assurance Framework, as well as identifying good practice and areas for improvement.
- The driver diagrams had now been updated. Three had been highlighted as needing an alternative process as they cover such a broad area: Timely Care, Communicating Effectively and Planning Care to Promote Independence.
- The driver diagram guidance for Health Care Standards had also been reviewed.

- The intranet site for Health Care Standards had been reviewed and updated.
- The Health Care Standards Implementation Plan had been revised so that it separated out the actions that were needed to be undertaken annually, and the actions that are one-offs.
- Information on Health Care Standards had been provided to include in the recruitment pack.

The Committee received the report.

**QPSC 0702/10 Putting Things Right Report/Ombudsman Response**

Martin Lane provided the Committee with an update on actions that are ongoing to improve the quality and performance through implementation of the Putting Things Right Organisational Learning Service Improvement Programme and Action Plan.

It was reported that the principle of the Putting Things Right Team (PTR) was when concerns were raised about treatment and care, whether this was through a complaint, claim or clinical incidents. Those involved could expect to be dealt with openly and honestly and would receive a thorough appropriate investigation, a prompt acknowledgement and response on how the matter was to be taken forward.

It was highlighted that significant work was underway to improve performance and the quality in handling the concerns, complaints and cases referred to the office of the Public Services Ombusdman.

The Chair commented that it was great to receive the action plan as it gave the Committee the level of assurance required, that the issues around complaints are being taken seriously and that the PTR Team are trying to address these issues in an appropriate and timely manner.

The Committee received the report.

**QPSC 0702/11 Items for Board Consideration**

There were no items for Board Consideration.

**QPSC 0702/12 Date of Next Meeting**

The next meeting will be held on Thursday 4 April 2019 at 9.30am in Conference Rooms 1 & 2, ABUHB Headquarters, St Cadoc's Hospital, Caerleon.

Quality and Patient Safety Committee
Thursday 4 April 2019
Agenda Item: 1.5

# Quality & Patient Safety Committee
# Thursday 7 February 2019

## 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 – Thursday 7 February 2019

| Minute Reference | Agreed Action | Lead | Progress/ Completed |
|---|---|---|---|
| **QPSC 0702/05** | **Maternity Service Board**<br>The Committee noted the publication of the HIW report of Cwm Taf Health Board and requested that the recommendations were reviewed and mapped against Aneurin Bevan University Health Board's (ABUHB) position. | **Martine Price/ Deb Jackson/ Jayne Beasley** | An assessment of the recommendations arising from the Cwm Taf HIW report against ABUHB had been undertaken. Paper to come to QPSC. |
| **QPSC 0702/08** | **Risk Assessment Overview – Risk Register**<br>Patient Experience risk to be updated and come to the next Committee meeting. | **Martine Price** | Update undertaken to come to the next Committee meeting. |

| | |
|---|---|
| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol<br>Aneurin Bevan<br>University Health Board | Quality and Patient Safety Committee<br>Thursday 4 April 2019<br>Agenda Item: 2.1 |

2.1

# Aneurin Bevan University Health Board

## Management of delayed follow-up outpatients in ABUHB


**Executive Summary**

This paper provides a briefing for the Quality and Patient Safety Committee with regard to the management of follow-up outpatients, particularly those who are delayed.

This report seeks to emphasise that the Health Board had a long standing and continuing commitment to reduce its delayed follow-up appointment profile, and had been successful in doing so year or year. Progress against the target in 2018/19 had been slower than the Health Board would have expected, but this had not lessened the commitment of the Health Board to achieve improvement in 2019/20.

A recent review of risk associated with delayed follow up appointments shows that there is no evidence that delays are causing levels of concern or risk for patients, but there are improvements we can make to ensure high risk patients are seen in a timely way.


| **The Quality and Patient Safety 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: Claire Birchall, Director of Operations**

**Report Author: Claire Birchall, Director of Operations, Dr Paul Buss, Medical Director**

**Report Received consideration and supported by :**

| | | | |
|---|---|---|---|
| **Executive Team** | | **Committee of the Board [Committee Name]** | **Quality and Patient Safety Committee** |

**Date of the Report: 1 April 2019**

**Supplementary Papers Attached: NONE**

**Purpose of the Report**

This report will provide an overview of the work that has been undertaken to date and outlines further improvement initiatives and future planning for the delivery of timely follow-up appointments in the interests of patients and the provision of high quality services for the population we serve. The report provides assurance that delayed follow ups are not causing harm or high levels of risk or concerns.

**Background and Context**

The Auditor General for Wales examined arrangements for managing follow-up outpatient appointments in Health Boards in Wales in 2015/6. The Welsh Audit Office (WAO) Report highlighted a number of key points and recommendations:

- Large numbers of patients were on waiting lists for follow-up appointments and were not being effectively assessed.
- Health Boards' arrangements for reviewing outpatient follow-up performance was generally underdeveloped.
- Reporting requirements to Welsh Government were generally not being fully achieved.
- Actions to improve outpatient services were mostly delivering short-term solutions.

In 2017/18, the Auditor General undertook further work in order to assess the local and national level progress in response to the challenges and issues identified in the 2015 work. The report illustrated a number of detailed findings regarding good management of follow-up appointments:

- Exploiting opportunities to use technology allowing patients to self-manage their condition.
- Adoption of see-on symptom and virtual clinic approaches.
- Transforming the service model and pathway, by developing community and primary care based services which reduce reliance on hospital based models.

Aneurin Bevan University Health Board (ABUHB) has had clear focus on this area of our services for a number of years and has had a programme of action in place which pre-dates the WAO work, to proactively address these issues.

This long standing commitment of the Health Board to reduce delayed follow-ups had seen the Health Board achieve a significant reduction in the delayed follow-up of out-patient appointments as a consequence. Since commencing reporting of this measure the Health Board had reduced the number of patients overdue their appointment past their target date from 35,333 in April 2015 to 19,603 at the end of January 2019. This was a reduction of 15,730 which represents an improvement of 44.52%.

However, in 2018/19 the Health Board had not seen the continuing level of reduction that had been achieved in previous years, even with the range of developments and measures that were in place. Nevertheless, the Health Board would continue to focus on an improved position year on year and expect to see a return to a trajectory of continuing reduction in the 2019/20 financial year.

The Health Board continues to be actively engaged in a range of partnerships such as the Regional Partnership Board (Social Services and Well Being Act) and also the five Public Service Boards (Well Being of Future Generations Act). As part of these partnership discussions there are clear commitments for increasingly providing care closer to home and avoiding the need for traditional hospital based follow-up appointments. This was also a key priority in "A Healthier Wales" and features in our partnerships plans and the Health

Board's Integrated Medium Term Plan. Therefore, services designed for and around patients, which avoid expensive, time-consuming travel to and from clinics and was an important objective for the Health Board, particularly for older patients or those from rural areas where there are issues of access and especially for those unable to drive or have difficulty accessing public transport.

**Current Position**

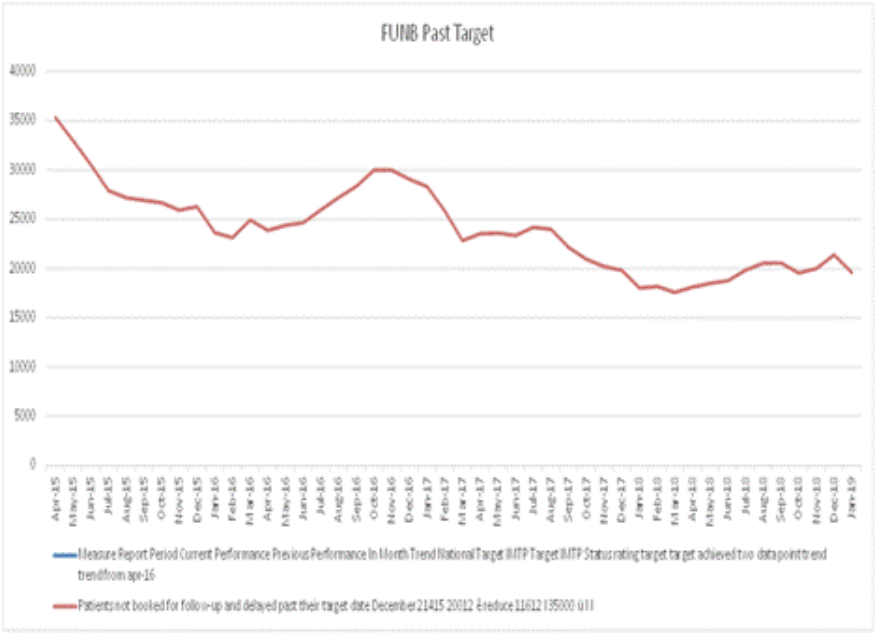
The reasons for a follow-up appointment include, but are not limited to a review after surgery, management or maintenance of chronic conditions, or monitoring for signs of deterioration, prior to intervention. However, it is recognised that delayed follow-ups are more difficult to define.

The Health Board reports a monthly position to Welsh Government on those patients in the various categories of follow-up. An example is shown below of the January 2019 position for the Health Board.

| **Total number of patients waiting for follow-up who are delayed past their target date – NOT BOOKED** | | | | |
|---|---|---|---|---|
| **0% up to 25% delay** | **Over 26 up to 50% delay** | **Over 50% up to 100% delay** | **Over 100% delay** | **Total NOT BOOKED** |
| 6,617 | 3,358 | 3,619 | 6,009 | 19,603 |

ABUHB continues to have some of the lower numbers of delayed follow-ups when compared to other Health Boards in Wales.

The graph below shows the volume of patients reported in that category since the Health Board had been required to report in this way, which clearly demonstrates this had nearly halved since reporting commenced.




**Action Taken**

Prior to the Auditor General's 2015 Report, the Health Board had already developed a Performance Management and Improvement Forum to support the delayed follow-up appointment process, with the intention of developing and delivering good practice,

reviewing administrative booking processes and ensuring clinical engagement and ownership to improve the experience and services the Health Board provides to patients.

Over recent years, the Health Board had, as indicated, delivered a significant improvement in this position. The next phase of this work is now underway, which focusses upon change to complex long term care pathways and building upon the good work that had already been achieved through the refocusing of care identified within the Care Closer to Home Strategy.

Each of the Health Board's Clinical Divisions owns an improvement target and reports progress on a monthly basis. Performance is also picked up through a series of Divisional Assurance meetings, scrutinised through the Health Board's Executive Team, Finance and Performance Committee and reported to the Board via a Performance Dashboard.

The Integrated Medium Term Plan 2019/20 forecasts a follow-up position of 12,000 delayed follow-up patients by the end of the year. In order to achieve this ambitious plan a number of further initiatives are already in place and with positive results expected in 2019/20:

- The Health Board's Clinical Futures Programme care pathways are developing through clinical leadership in line with best practice.
- The use of digital technology through the Dr-Doctor platform and use of skype consultations are planned for 2019/20.
- The use of more virtual follow-up outpatient clinics.
- Clinical Divisions are prioritising follow-up outpatient appointments that are better suited to delivery closer to home. Services for the care of older people was the first service area to be taking this forward as a priority.

Current plans and further initiatives are outlined below:

**Theme: Care Closer to Home**

**Glaucoma**

The current Welsh Government target for glaucoma follow-up appointments is 75% of patients reviewed by non-medical workforce. The Health Board has a compliance rate of 78%, which demonstrates that the on-going work being undertaken through Ophthalmic Diagnostic and Treatment Centres (ODTC) had provided the opportunity to increase the number of follow-up appointments and this approach was having a positive impact.

In 2016, the Health Board was the first to develop the service utilising six optician practices across Gwent to deliver the follow-up service closer to home. This ensured that senior medical time was spent on the more complex procedures that can only be delivered within a hospital setting.

Likewise, a further service has been developed within Newport, specifically to deliver follow-up appointments for Wet AMD, the first of its kind in Wales. This initiative has increased the capacity for review of follow-up patients and provides care for patients within a community setting. Patient feedback for both services had been extremely positive, indicating a preferred choice to be seen within a community setting.

The volumes seen through ODTCs are shown below:

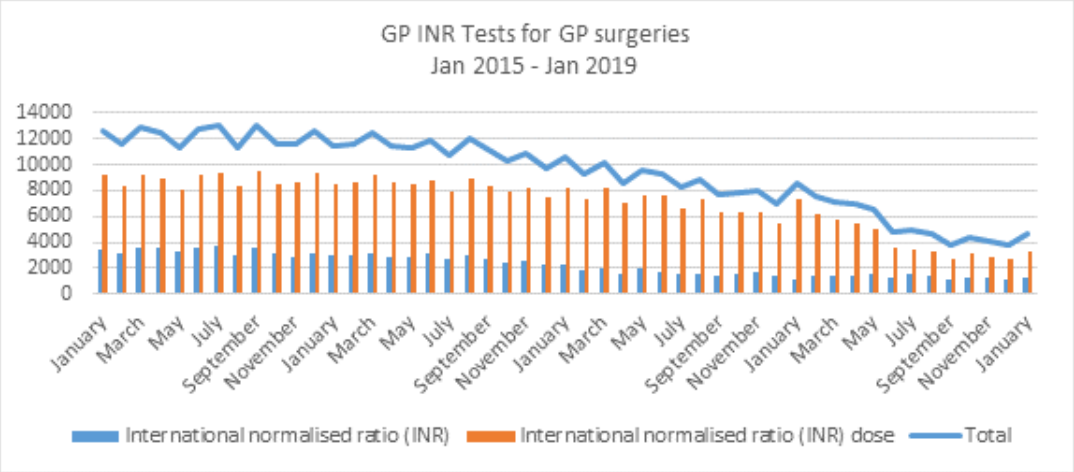
**Activity within ODTCs between April 2016 and January 2019**

| Follow ups | Total Assessed |
|---|---|
| April 2016 – March 2017 | 1843 |
| April 2017 – March 2018 | 2337 |
| April 218 – January 2019 | 2906 |

**Cataracts** – in relation to cataract surgery, the Health Board on average undertakes 4,100 cataract operations per year. All of these patients are now followed-up by optician practices in the community.

**INR (International Normalised Ratio) Anticoagulation Services**
The INR follow-up service is provided within 60 GP services across Gwent and a service hub was located in Newport. The service offers follow-up appointments and has reduced the length of time patients wait for their results from 2-days to 10 minutes through the use of handheld testing devices.

The service shift had seen 12,000 appointments a month delivered outside a hospital setting. Feedback from patients and clinical staff alike was extremely positive. District Nursing teams were also providing this service to house bound patients, reducing the requirement for house calls for GPs.




The above illustrates the reduction in the number of patients that are being reviewed as follow-up appointments within secondary care.

**Primary Care Audiology**
This pilot is being delivered in Blaenau Gwent Primary Care Services. The service navigates patients for first appointment and follow-up appointment audiology services delivered within primary care. Patients are no longer required to be referred by GPs to gain access to the service, the direct access service ensures an appointment with an audiologist within 1 week.

The pilot has been operation for 6 months with 225 patients being treated closer to home, 25% of patients discharged after first appointment, 25% received a second appointment and were discharged, 40% of patients were referred directly into secondary care audiology and 10% required an appointment with a GP for non-related hearing issues.

The roll out of the direct access service across Gwent will be undertaken over a 2 year period. The model was in line with the development of community wellbeing hubs across Gwent, as set out within the Health Board's Clinical Futures service model.

**Theme: See on Symptoms**

**Follow-up of ENT Patients**
The Health Board's follow-up protocol which illustrates the patients who should be routinely followed-up had been in place for a number of years. The success of the protocol in safely and appropriately reducing the number of patients requiring follow-up appointments, had enabled the service to see patients that require follow-up for more complex medical conditions quickly. ABUHB's work was proposed as an area of positive practice and was being adopted across other Health Boards in Wales.

The Health Board's ENT service provides a see on symptom (SOS) pathway. This work was currently undertaken by one nurse practitioner with a plan to extend this further during 2019/20. This had meant that instead of a patient being followed-up routinely within a set period of time, the patient was empowered to initiate their care base on their symptoms and was able to ask to be seen by a clinician.

In total there had been 1,136 patients registered with the SOS approach for ENT over the period and there had been a corresponding decrease of 1,180 patients on the follow-up waiting list between the period April 2016 and December 2018.

**Theme: Use of Technology**

**Virtual Review – Tele-dermatology**
Tele-dermatology had made a significant difference to the way that care was provided, ensuring that patients received the best and most appropriate care, more quickly and efficiently. Currently the Health Board's approach to tele-dermatology brings together the diagnosis and treatment of skin disorders with modern telecommunication technologies and frees up clinical capacity to enable an increased focus on any required delayed follow-up activity in dermatology.

Patients were seen by a medical photographer and a photograph of the affected skin was taken and sent directly to the consultant in secondary care. The consultant was then able to diagnose the condition from the photograph and advise appropriate treatment. Apart from a better patient pathway, medical staff had capacity to see more quickly a greater number of patients with more complex needs. The service had seen significant expansion due to its success and it was expected that over 5,000 patients would be seen in 2019/20 via this pathway.

Tele-dermatology was also beginning to be used for follow-up appointments with approximately 5-6 patients per week now followed up via this approach.

**Theme: Looking at the Future**

**Urology Prostate specific Antigen Self-Management**
Approximately 40% of patients with a raised Prostate Specific Antigen (PSA) could safely self-manage their care and follow-up, if supported by the appropriate tool. The tool

needed to be accessible and patient friendly with a clear protocol and thresholds for when to access care from the GP or from the Urology Service. The Health Board was seeking to secure the 'Patient Knows Best' self-management system. The capacity released by utilising a self-care management tool can then be used for follow-up appointments for those patients with complex conditions.

**Value Based Healthcare and Patient Experience**
The Value Based Healthcare Team was also supporting the improvement agenda for follow-up management as part of their unique approach to the implementation of Value Based Healthcare.

The approach enables patients who would traditionally attend routine follow-ups to be seen based on their current state of symptoms, rather than just as routine. It also better enables the clinicians to manage their follow-up demand focusing more on those with the greatest need first, and avoids following up patients unnecessarily through the use and understanding of outcomes. The Health Board is currently piloting the Dr-Doctor functionality in Heart Failure, Psoriasis and Ankylosing Spondylitis where it is anticipated that around 25-30% of the follow-up appointments could be followed up using an alternative method, making the process more efficient and effective and ensure appropriate timely access for patients.

The Health Board had been using the Dr-Doctor SMS and email reminder service and online patient portal for the outpatient clinic appointments for a number of years. During this time Do Not Attend (DNA) rates had reduced by almost half from the starting point of 9.7%. Dr-Doctor had also been recently introduced into our therapies services. Of the patients that used Dr-Doctor, 97% of these patients recommended the service.

There is additional functionality within Dr-Doctor which can allow for patients to communicate with the service whilst they are waiting for their appointment. As part of this year's improvement work, we intend to explore the use of this functionality so that we can better communicate with patients who are waiting and understand their experience when this is delayed, as well as address and concerns or risks.

**Risk Management and Governance**
The delayed follow-up outpatient position should form a regular part of the agenda for the Health Board's Quality and Patient Safety Committee, in order to discuss areas of potential patient risk and provide assurance to the Board relating to the ongoing work being undertaken within the work stream.

For those high risk patients whose delayed follow-ups should not be cancelled, and to ensure that higher risk patients are booked in when they needed to be seen, a flagging system is used on Myrddin – the patient administration system. Patients can be red flagged by the clinician through competing an appointment directive on Myrddin. Work continues across the Health Board to ensure that this clinical tool is fully optimised as to date only a small proportion have been flagged with a future appointment directive indicating that the patient should not to be cancelled or must been seen within a number of weeks of the specified target for follow-up.

**Risk Registers**
Each Clinical Division within the Health Board has a mechanism to identify and review the patients that appear on the delayed follow-up waiting list. The process receives clinical assurance by regular clinical review at sub-specialty level.

The area of greatest risk for the Health Board remains within the Ophthalmology service, however as detailed within the document mitigation and further action for this service had taken place and a plan had been implemented to further improve waiting times for these follow-up patients. There are currently 259 patients within Ophthalmology who are a year past their target date. It is important to note that none of these patients were in the high risk Wet AMD or Glaucoma category. The majority of these patients have retina conditions and as a consequence a review of the entire retina pathway was currently underway to determine the most appropriate clinical pathway for each patient.

All clinical incidents, near misses and serious incidents were investigated and discussed in local Directorate Quality and Patient Safety Meetings and reported through the Health Board's governance structures. Serious incidents associated with Ophthalmology were also discussed and reported at the Gwent Eye Care Group on a quarterly basis.

**Redress and Legal Claims Related to delays in Follow-up Care**
Data was analysed for Redress and Legal Claims (Litigation) that were considered/closed over the last 2 years (January 2017 – March 2019)

19 of the incidents were associated with a follow-up delay and 4 occurred in Ophthalmology. 17 incidents were closed and showed no evidence of harm and 2 remain under investigation.

144 cases were considered by Redress Panel during the period 01/01/2017 to 04/03/2019. Of these only 4 involved waiting times relating to appointments leading to a delay in diagnosis where it was agreed that there was a qualifying liability in tort i.e. there had been a breach of duty of care which had led to harm being suffered by a patient.

Of the 110 settled claims which closed during this period, 9 are directly attributable to waiting time delays.

| **Claims (Closed Cases) Attributable to Waiting Time Delay January 2017– March 2019** | | | |
|---|---|---|---|
| **By Directorate**: | | **By Incident date:** | |
| Cardiology | 1 | 2000 | 1 ENT |
| ENT | 1 | 2011 | 4 (1 cardiology 3 T&O) |
| Gastroenterology | 1 | 2012 | 2 Gastro; General Surgery |
| General surgery | 1 | 2013 | 1 Ophthalmology |
| Ophthalmology | 1 | Date not recorded | 1 T&O |
| Orthopaedics | 4 | | |

The above data should give the Quality and Patient safety Committee a perspective and assurance on the position regarding harm caused by follow-up delays compared to the overall number of cases recorded as an adverse event and case numbers overall considered through redress and legal processes at ABUHB. From a notified legal claim perspective, the historical nature of claim dates may suggest an improving picture as apart from a few cases identified and dealt with at Redress panel in 2017, there is nothing of this category for 2018 or 2019 to date. However, there is a need to accurately code complaints and incidents, revisiting the original coding of the complaint once they have been investigated to reflect the issues which actually arose during the complaint investigation, in addition to an accurate/updated description of what the complaint is about on the front screen of Datix.

## Assessment and Conclusion

This paper had sought to illustrate that the Health Board was committed to continuing to reduce its delayed follow-up appointment profile to build on the successful approaches that had been implemented over recent years. Whilst progress against the target in 2018/19 had been slower that the Health Board would have expected, but this has not lessened the organisation's commitment to further improve and for future compliance with targets in 2019/20.

This report highlights the work undertaken to date and offers assurance the further initiatives and future planning to improve delivery of timely follow-up appointments in the interest of patients and the provision of high quality services.

The report indicates there is no evidence that delay in follow up care is causing harm to patients, nor high levels of concerns. However, there is a commitment that there is more work required to understand the impact of delays on patient experience and to improve data accuracy and quality in the capture and coding of complaints and incidents.

## Recommendation

The Committee is asked to note the content of the paper;

- Current status of delayed follow ups and work done to date,
- Work planned to address delayed follow ups,
- Assurance that patients are not coming to harm as a result of delayed follow ups,
- Aspiration to understand the experience of patients waiting in the follow up cycle.
- Note the work to be undertaken to improve complaints and serious incident data through the PTR/Organisational Learning Quality Improvement Programme

## Supporting Assessment and Additional Information

| | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The delayed follow-up outpatient position should form a regular part of the agenda for the Health Board's Quality and Patient Safety Committee, in order to discuss areas of potential patient risk and provide assurance to the Board relating to the ongoing work being undertaken within the work stream. |

| | |
|---|---|
| ***Financial Assessment, including Value for Money*** | Complaints and serious incidents related to follow-up delay have a potential financial impact to the Health Board |
| ***Quality, Safety and Patient Experience Assessment*** | The report is focussed on improving quality and safety and therefore the overall patient experience. Services designed for and around patients, which avoid expensive, time-consuming travel to and from clinics are an important objective for the Health Board. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | Not specifically relevant to this report as it is not a proposal for service change. |
| **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** | An enhanced focus on efficiency, productivity and value based care with specific reference to clinical variation, theatre productivity and outpatient based projects including reduction in delayed follow ups is a specific priority area in the Integrated Medium Term Plan |
| **The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working** | **Long Term –** Improving the safety and quality including timeliness of follow-up services will help meet the long term needs of the population and the organisation. |
| | **Integration** –As we develop more care in the Community, good quality, timely follow-up care will become increasingly relevant to integrated services |
| | **Involvement** – High-quality follow up care requires patient and service user involvement and participation |
| | **Collaboration** – A collaborative approach is essential to the success of the quality improvement work mentioned in the paper |
| | **Prevention –** High quality and timely follow up care can significantly contribute to primary and secondary prevention. |
| **Glossary of New Terms** | NONE |
| **Public Interest** | There is no reason why this document cannot be made public. |

2.2

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Hospital Inspection (Unannounced)

## Cwm Taf University Health Board/ The Royal Glamorgan Hospital / Maternity Services

Inspection date: 15 - 17 October 2018

Publication date: 21 January 2019

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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In writing:

**Communications Manager**

**Healthcare Inspectorate Wales**
**Welsh Government**

**Rhydycar Business Park**

**Merthyr Tydfil**

**CF48 1UZ**

Or via

**Phone:** **0300 062 8163**

**Email:** **hiw@gov.wales**

**Fax:** **0300 062 8387**
**Website:** **www.hiw.org.uk**

Digital ISBN 978-1-78964-658-0

## Contents

# Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

## Our purpose

To check that people in Wales are receiving good care.

## Our values

- Patient-centred: we place patients, service users and public experience at the heart of what we do
- Integrity: we are open and honest in the way we operate
- Independent: we act and make objective judgements based on what we see
- Collaborative: we build effective partnerships internally and externally
- Professional: we act efficiently, effectively and proportionately in our approach.

## Our priorities

Through our work we aim to:

| | |
|---|---|
| Provide assurance: | Provide an independent view on the quality of care. |
| Promote improvement: | Encourage improvement through reporting and sharing of good practice. |
| Influence policy and standards: | Use what we find to influence policy, standards and practice. |

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of maternity services within Cwm Taf University Health Board on the 15, 16 and 17 October 2018. The inspection was in response to a number of concerns highlighted regarding the provision of safe care, staffing issues, incident reporting and the stability of the service.

The following hospital sites and wards were visited during this inspection:

The Royal Glamorgan Hospital

- Ward 10
- Ward 11
- Labour ward.

Our team, for the inspection comprised of two HIW Inspectors (an inspection lead and clinical director), a clinical peer reviewer and lay reviewer.

The inspection commenced the evening of the 15 October, and continued over the following two days.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

# 2. Summary of our inspection

Overall, we had concerns about the sustainability, resilience and the ability of the service to provide care and treatment in a safe and effective way.

Despite the best efforts and dedication of staff working very hard on the wards, we found that the service had significant staffing issues. This impacted on the delivery of safe and effective care in a number of ways, including

- Staffing issues adversely impacting upon the health, safety, morale and well-being of staff
- Staff responsible for reviewing incidents and concerns told us they were often unable to do this in a timely manner
- Staff were often unable to attend mandatory training to ensure they maintained the skills and knowledge to carry out their roles
- Essential duties, such as on ward audits, were not being carried out.

Whilst staff told us that they felt supported by their direct line managers, it was concerning to find that many described the working environment as difficult. Many did not feel action would be taken by the organisation to address or learn from incidents and concerns.

We found that there was a disconnect between a number of professional groups across the service, which impacted on effective multidisciplinary working.

As a result of our findings, we were not assured that there were sufficient governance processes and oversight in place to ensure that activities such as audit were being undertaken in order to

improve the service or take action where there were issues.

We recognised that the health board had attempted to make changes to improve staffing, culture, training and governance of the service. However, any changes were in their infancy and yet to be fully embedded.

For the health and well-being of staff, and to ensure the service is able to provide safe and effective care to patients, the health board is required, as a priority to take action to address these issues.

This is what we found the service did well:

- Patients told us that staff were kind and sensitive when carrying out care and treatment
- We observed care and treatment being delivered in a dignified way protecting patient privacy
- Staff were working hard to deliver patient centred care in very difficult and challenging circumstances.

Our findings in relation to some areas of concern resulted in HIW issuing an immediate assurance letter. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. The health board had seven days to provide HIW with full and satisfactory information about any action taken or planned, to address the concerns described. A brief summary of the issues included:

- Inability of the service to consistently staff all shifts with sufficient qualified and non-qualified staff
- Staff working long hours and extra shifts to cover staff shortages
- Skill mix of staff on shifts being potentially compromised due to staff being brought in from non-acute maternity services, with often different skills and experience, when covering shortages on shifts
- Inability of staff to complete mandatory training, review incidents, and complete ward audits due to staffing issues and clinical priorities
- Concerns relating to the sustainability of the service and the health and well-being of staff

- Checks on drugs and equipment used in a patient emergency not being checked regularly.

In addition to the issues set out in our immediate assurance letter, we also made recommendations for areas of improvement as outlined below:

- Availability of information for patients about the complaint process and advocacy services
- Security arrangements for access to the wards
- Ensuring adequate stock levels of personal protective equipment
- Some arrangements for the safe storage and checking of drugs
- Staff access to sufficient numbers of equipment such as sonicaids[1], cardiotocography[2] (CTG) monitors and blood pressure monitoring machines
- Communication with staff, in particular reference to service delivery changes
- Feedback to staff regarding concerns and complaints
- Ability of staff to review incident reports in a timely manner
- Audits on the wards and the governance arrangements for this activity
- Concerns around culture in relation to effective team working and staff health and well-being
- Training and supervision for staff.

Full details of the improvements identified during our inspection can be found in Appendix C of this report.

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[1] A hand-held device for fetal monitoring

[2] A machine used to record the fetal heartbeat

# 3. What we found

## Background of the service

Cwm Taf Health Board was established in October 2009 and achieved University status in July 2013. The health board provides primary, community, hospital and mental health services to people living in Merthyr Tydfil, Rhondda Cynon Taf and surrounding areas. The health board is also responsible for the provision of child and adolescent mental health services for south Wales and is the host body for Welsh Health Specialised Services and the Emergency Ambulance Services Committee.

The Royal Glamorgan Hospital provides acute emergency and elective medical and surgical services together with a range of diagnostic facilities.

The maternity service at The Royal Glamorgan Hospital consists of a delivery suite made up of five labour rooms. There is also an Alongside Midwifery Unit (AMU) providing midwife led care with two birthing rooms one having a birth pool.

Ward 10 has 22 beds (in a combination of bays and side rooms), providing both postnatal and antenatal care.

Ward 11 has five beds dedicated to providing high care to mothers who need extra support following birth and medical interventions such as caesarean sections. There is also a bay with six beds dedicated to providing triage services to patients, including providing care to patients who have had their labour induced.

Ward 11 also has a day assessment unit, which consists of five beds, where patients are able to access the service for day appointments, such as foetal monitoring and iron infusions. This area of ward 11 was not considered in detail during the inspection.

Maternity services at The Royal Glamorgan Hospital also comprise of an antenatal clinic, providing regular antenatal checks and scanning services. This area was not included during the inspection.

The health board recently confirmed that maternity services provided at The Royal Glamorgan Hospital will change with effect from March 2019[3]. The hospital will no longer provide consultant-led maternity services at The Royal Glamorgan Hospital, meaning that women in need of this service would be cared for at Prince Charles Hospital, Merthyr Tydfil.

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[3] http://cwmtaf.wales/update-on-changes-to-maternity-and-childrens-inpatient-services-at-royal-glamorgan-hospital/

## Quality of patient experience

*We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.*

We found a team committed to providing care and treatment to patients with dignity and respect. We observed staff being compassionate and protecting the privacy and dignity of patients and their families.

The ward environments were well maintained and generally uncluttered.

During the inspection we obtained patient views about the care and treatment received, by speaking directly with them and through completed HIW questionnaires. Patient comments included the following:

> *"The staff have been very supportive and caring"*
>
> *"I have chosen to transfer my care from (another hospital). My experience has been great and I am pleased to be here again"*

Discussions with patients and information collated in the questionnaires indicated that patients were positive about the care and treatment provided to them by staff.

### Staying healthy

We found that there was information displayed on the wards providing information to patients about how to stay healthy, including smoking in pregnancy and healthy eating.

### Dignified care

Patients were asked in the questionnaires whether they agreed or disagreed with a number of statements about the hospital staff. All patients agreed that

staff were always polite and listened, both to them and to their friends and family. All patients told us that staff called them by their preferred name.

We observed patient care being delivered sensitively, and where appropriate doors and curtains were closed to protect patient privacy and dignity.

The labour ward had individual rooms with shared bathroom facilities between two rooms. Ward 10 consisted of a mixture of single rooms and small bays with both en-suite and shared bathroom facilities.

Ward 11 was made up of two bays with patients having access to shared bathroom facilities.

There was a feeding room available for patient use, which provided patients with a private room should they wish to feed their baby away from other patients/visitors.

Sensitive support could be provided at a difficult time, when parents were grieving the death of a baby. A private room with double sleeping arrangements and fairly comfortable surroundings was available, where parents could spend as much time as they required with their baby during the bereavement process. The health board told us that they were in the process of appointing a specialist bereavement midwife to support parents through this difficult time.

Patients who required emergency surgical intervention (such as caesarean section) were transferred to maternity theatres which were situated next to the labour ward.

We received some comments from birthing partners who raised an issue regarding the lack of toilet facilities whilst supporting their partner during labour. The nearest facilities were on the ground floor of the hospital. Birthing partners commented that this meant their partners could possibly be left without family support during labour. Staff told us that such facilities previously existed, but they had been removed to allow room for the Alongside Midwifery Unit.

Improvement needed

The health board should consider appropriate toilet facilities for birthing partners during labour.

### Patient information

We found that there was some information available for patients on the ward, displayed on notice boards. Information included both antenatal and postnatal advice. We also saw information provided in a postnatal pack given to patients as they leave the ward.

### Communicating effectively

Patients confirmed in the questionnaires that they were given the option to communicate with staff in the language of their choice. There was a loop system for patients with hearing difficulties.

We saw that the wards had Patient Safety at a Glace Boards[4], which were not visible to visitors.

Patients who completed a questionnaire told us that staff had talked to them about their care to help them understand what was happening to them.

We spoke to a newly appointed consultant midwife who appeared to be enthusiastic, motivated and knowledgeable and was employed to improve communication between midwifery and obstetric staff teams across the health board, and promote best practice and support midwifery colleagues. The full impact of this role was yet to be determined, however, the feedback from staff was that it was a positive role in engaging staff across all areas to encourage multidisciplinary working.

## Timely care

We spoke to a number of staff during the inspection and received eight completed staff questionnaires. Many staff told us that whilst they were committed to providing timely care, they were often unable to meet all the conflicting demands on their time at work. Further details regarding staffing and resources is explored within a number of sections within the report.

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[4] The Patient Status At A Glance board is a clear and consistent way of displaying patient information to staff within hospital wards.

Two patients we spoke to told us that they had to wait some time after requesting pain relief, but explained they understood that staff were busy with other patients. This meant that some patients, due to staff availability, may not have received pain medication in a timely way.

## Individual care

### Planning care to promote independence

Patients and their partners told us that they were fully involved in all the decisions regarding their baby's birth and the immediate after care of their baby. We observed that the AMU offered a birthing pool, which was an area of good practice.

### People's rights

### Listening and learning from feedback

The NHS Wales Putting Things Right[5] process was not displayed for patients, neither were there contact details for the Community Health Council for those patients who may wish to have support to raise a concern or complaint about their care and treatment.

We saw that patient experiences were obtained and shared with staff through a monthly newsletter. We found this provided staff with a patient perspective of their experience.

Staff we spoke to confirmed that they would aim to deal with any complaints received from patients whilst on the ward, to help resolve any issues quickly. Senior staff told us that any formal complaints received would be dealt with via the Putting Things Right Process.

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[5] Putting Things Right are the arrangements for managing concerns (complaints) about NHS care and treatment in Wales.

Improvement needed

The health board must display information regarding Putting Things Right, to support patients who may wish to raise a concern or complaint, including displaying the contact details for the Community Health Council.

## Delivery of safe and effective care

*We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.*

Whilst we identified that staff were working hard to prioritise patient care, we were not assured that the service could be sustained in a safe way. This was because significant staffing pressures were impacting on the ability of staff to carry out essential duties such as audits, incident reviews and mandatory training.

The health board is required to address a number of issues to ensure it is able to provide a safe and effective service for patients, and to support the health and wellbeing of staff.

### Safe care

#### Managing risk and promoting health and safety

Entry onto wards 10 and 11 was gained via an intercom system. The labour ward had its own intercom system for patients to allow access directly into this area. We observed staff politely asking visitors the reason for their visit before allowing them to proceed. It was a concern that during our inspection we were left unattended for a period of time after initially being granted access to wards 10 and 11, and staff did not challenge our presence.

We saw that there were some areas where equipment had been left in corridors, such as trolleys outside the theatres. Whilst this did not inhibit safe movement, it meant that the corridors were cluttered. We also found mats on the floor of the AMU that could potentially be a trip hazard as they were not safely secured. There was also no clear secure entry for women into and out of the birthing pool.

We saw that relevant risk assessments had been completed as part of the patient admission process to hospital.

Improvement needed

The health board must ensure that access to the wards is securely maintained for the protection of staff and patients.

The health board should ensure that the mats within the birthing suite in the AMU are not a trip hazard to both staff and patients.

The health board should ensure that the entrance into and out of the birthing pool is safe and secure.

## Infection prevention and control

We found that the clinical areas were clean and tidy. Patients who completed an HIW questionnaire and patients we spoke to told us that they thought the wards were clean and tidy.

We saw that personal protective equipment (PPE) was available in all areas; however, we noted that there was low stock on ward 11.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. We observed staff washing their hands appropriately and using gloves when needed. We also observed that patient beds were cleaned and wiped down after each patient use.

We saw that a health board infection control audit had been carried out in September 2018 which highlighted a number of areas for improvement. We noted that some of these improvements had been addressed and some remained outstanding. However, an action plan was in place to address the remaining actions.

We did not see any evidence of local ward based infection control audits or checks being undertaken. Staff told us that such audits, which included hand hygiene and environmental checks, had been carried out by ward staff previously, but had not been completed since the beginning of the year. We were told that there was an expectation that these should be completed on a weekly basis. Staff told us that due to staffing pressures and time constraints, patient care was prioritised. As a consequence there was no information for patients regarding infection control rates, or compliance with best practice hand hygiene, as this information had not been collated. A recommendation is made

about this within the Quality of Management and Leadership section of the report.

Not all staff who completed a HIW questionnaire had received infection control training within the past 12 months. Staff we spoke with told us that accessing training proved to be difficult due to staffing pressures, meaning that they would often be taken off training courses, or courses would be cancelled due to clinical care taking priority. A recommendation about this is made within the Quality of Management and Leadership section of the report.

Improvement needed

The health board must ensure that personal protective equipment stock levels are maintained sufficiently at all times to support staff in undertaking their roles.

### Nutrition and hydration

Patients who completed a questionnaire, and those who spoke to us, told us that they had time to eat their food at their own pace and that they had access to water. The ward staff also had food tokens to obtain hot food for women when it was unavailable on the wards. This, along with the provision of sandwiches, gave patients some element of choice when requiring meals out of normal meal service times.

### Medicines management

Overall, we found arrangements in place for the safe management of medicines used in the clinical areas we visited.

We saw that most medicines were being correctly and securely stored. However, we found that the fridges for storing medicines were not lockable in any clinical area. The refrigerator temperature was also not checked and monitored daily to ensure the optimum temperature was maintained for the storage of refrigerated medicines.

We observed that the storage of controlled drugs was secure, as were the drug trolleys. Whilst we saw that checks had been carried out and recorded correctly with regards to the controlled drugs, they were not conducted consistently on a daily basis.

We looked at a sample of medication records and saw these had been completed correctly. We observed part of a medication round on ward 10 and

found that appropriate checks had been carried out by staff to support safe administration of medicines.

Improvement needed

The health board must ensure that medication fridges are lockable and are kept locked when not in use, and that staff record the temperature of the fridges on a daily basis.

The health board must ensure that controlled drug medication checks are carried out consistently on a daily basis.

## Safeguarding children and adults at risk

As described earlier, security measures were in place to protect patients within the ward/units. We saw that babies were fitted with tags whilst on the ward for their protection.

Staff had access to a safeguarding lead who could provide advice and support on safeguarding issues. The safeguarding process was described in detail, demonstrating a multidisciplinary approach between services when dealing with safeguarding issues.

## Medical devices, equipment and diagnostic systems

Staff reported that there was a lack of some equipment to enable them to carry out their duties in a timely manner. Such items included sonicaids[6], cardiotocography[7] (CTG) monitors and blood pressure monitoring machines. We observed, and staff told us, that they often spent time looking for equipment which decreased the amount of time they were able to be spent with patients.

The inspection team considered the arrangements for the checking of resuscitation equipment on ward 10, ward 11 and labour ward.

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[6] A hand-held device for fetal monitoring

[7] A machine used to record the fetal heartbeat

We found that records had been maintained of checks carried out by staff on the equipment to be used in a patient emergency i.e. resuscitation trolleys. However, we found that these had not always been carried out on a daily basis as required. The lack of regular, consistent checks meant that there was a risk of the resuscitation trolleys not being sufficiently stocked with equipment/medication for use in the event of a patient emergency. It was disappointing to find that this specific issue had also been highlighted during a recent HIW inspection in the same hospital, and that the learning had not been shared to ensure that appropriate measures had been put in place.

Our concerns regarding this issue were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board must ensure that there is sufficient equipment available to staff to allow them to carry out their duties in a timely manner.

## Effective care

### Safe and clinically effective care

We found a committed and dedicated team of staff who, under considerable pressure, had to prioritise the direct and immediate needs of patients over other practice areas.

On the basis of discussions with a number of staff across the directorate and evidence collated, we were concerned about the ability of staff to deliver care in a safe and effective way as a result of staffing issues.

We found that the directorate was unable to consistently staff all shifts with the required number of both qualified and non-qualified staff. Staff were often working long hours over and above normal shifts to help cover these shortages. Concerns were also raised as to whether there was always the appropriate mix of skills and experience available during all shifts due to the availability of staff.

Whilst we observed staff effectively prioritising clinical need and patient care, we found that this had a potential impact on the sustainability of the service. Examples included the inability of staff to complete identified training, ability of

staff to appropriately review incidents and concerns (via Datix[8]) in a timely manner, and local ward audits not being carried out due to clinical priorities.

We also had concerns about the sustainability of working arrangements within the service, and the impact that these arrangements may have on the health and well-being of all staff. During the inspection a number of staff presented to the inspection team concerned about their ability to provide care and treatment to patients in a safe manner. This was as a result of long term staffing issues, including both staff shortages and a reliance on the willingness of staff to work hours above and beyond normal working shifts, which has the potential for judgements to be impaired in staff who are fatigued. We also noted that a number of staff presented to the inspection team in a highly emotional and fragile way, emphasising our concerns for their health and well-being.

We were concerned about the potential risk to the safety of patients. This is because we did not feel that the resilience of the maternity department, specifically ward 10, ward 11 and labour ward, was sufficient to maintain patient safety if action was not taken to address the above issues.

Our concerns regarding the above were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

### Quality improvement, research and innovation

We found that the maternity service was in the middle of substantial change. Maternity services across the health board were in the final stages of being reconfigured. From March 2019 The Royal Glamorgan Hospital is to provide midwife lead care only, with consultant lead care being provided at Prince Charles Hospital. As a consequence of the reconfiguration the health board were recruiting into a variety of new posts, such as a bereavement midwife, a risk and governance midwife and consultant midwife. These appointments were being made with a view to improving the patient experience, but to also improve processes and procedures for the safety and wellbeing of staff and patients. We found that the health board was at the start of a change programme, and new processes were currently being embedded.

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[8] An electronic management system for recording and reporting incidents and concerns.

### Information governance and communications technology

We saw that patient records were kept securely to help prevent unauthorised access.

### Record keeping

Overall we found patient records had been well maintained, were clear and completed in a timely manner.

We considered a sample of five postnatal patient records on ward 10. We saw that pain management had been scored and action taken and escalated where necessary. Appropriate risk assessments, including those for deep vein thrombosis, had been completed.

We found, however, in some patient records where dates had not always been included on every page, and some pages where patient identification stickers were not always used.

Improvement needed

The health board must ensure that patient records include appropriate patient identification labels and dates on each page.

## Quality of management and leadership

*We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.*

We were concerned to find that there were issues requiring improvement spanning across the service with regards to communication, culture, training, leadership, staffing and multidisciplinary engagement.

A significant concern was that most staff felt that the organisation would not take action following an incident or concern being raised, and lessons would not be learned or shared across the service.

We recognised, however, that the health board had very recently implemented a new governance process around reporting and investigating concerns, and this was at an early stage of being embedded.

A robust governance process regarding ward audits must be demonstrated by the health board, to support the delivery of safe and effective care.

We found that the significant staffing issues were linked to a variety of concerns in respect of the service being able to provide safe and effective care in a consistent manner.

For the health and well-being of staff, and to ensure the service is able to provide safe and effective care to patients, the health board is required, as a priority to take action to address these issues.

### Governance, leadership and accountability

It was clear during the inspection that maternity services across the health board were under significant pressure, with concerns and incidents having

being highlighted publically. The directorate had made some recent appointments to strengthen and support changes within the service, but most changes to processes and procedures were at an initial stage and yet to be fully embedded.

## Governance

We saw that the service was in the process of implementing a number of regular meetings to support newly embedded processes and procedures, with a view to improving services and to strengthen governance arrangements. Such meetings included a maternity assurance group, which met on a weekly basis. We saw an action plan relating to the maternity service which highlighted areas for improvement including workforce, training, incident reporting, organisational design and service improvements. Ratings were applied to improvements to highlight where action needed to be taken as a priority, and we saw timescales were applied for completion of targets.

We also saw a maternity monthly score card which had information relating to clinical performance. We were told that this information was provided to the health board's quality and patient safety committee on a quarterly basis, which would inform the health board's risk register. A dedicated maternity risk register was in the process of being developed. However, the evidence captured during our inspection, including discussions with staff, did not provide assurance that themes and trends across the directorate were being identified and addressed.

## Communication

We found there was good, visible leadership directly on the wards, and staff told us they felt supported by the ward managers and shift co-ordinators. Midwifery staff also told us that there was good interaction between the ward staff and the anaesthetic team who were actively engaging in multidisciplinary work and supporting the ongoing changes to the service.

Staff who completed an HIW questionnaire described communication between senior managers and staff as being sometimes, or never effective. Staff we spoke to during the inspection provided examples of where they had found out about service redesign through social media or from colleagues outside of the directorate.

We found that the service was attempting to make changes and improve communication with a monthly newsletter, which provided both clinical and non-clinical information to staff. We also saw the first edition of a weekly update to staff providing information and feedback, including a section on 'you said, we did', to reach out to staff to help inform them of changes they were making in

response to staff suggestions. However, based on the feedback from staff, we found that communication was in need of further improvement, especially with regards to the significant changes and high levels of pressure currently affecting the service.

## Incident reporting and learning

Whilst the health board had used Datix for around 10 years, they had recently implemented a new governance process for the reporting of incidents though the system. This was with the intention of ensuring that all incidents and concerns are dealt with appropriately, including having a level of scrutiny to ensure that lessons are learned and shared with staff to prevent any similar incidents reoccurring. The health board had recently appointed a new person in the role of risk and governance midwife to lead the process. The process included appropriate steps that needed to be taken to address and review any incidents or complaints raised, and the allocation of timescales for actions to be completed.

Whilst staff either agreed, or strongly agreed that the organisation encouraged them to report near misses or incidents, the response as to whether they believed the organisation would take action to ensure they did not happen again was mixed, with some disagreeing that any action would be taken. It was also of concern that five staff who completed a questionnaire told us that they either agreed or strongly agreed that the organisation blames or punishes people who are involved in errors, near misses or incidents, with only one person agreeing that the organisation would take action. Staff we spoke to echoed these responses, with some reporting there to be a blame culture resulting in individuals being apportioned fault.

We received a similar response from staff in relation to learning from incidents. Staff we spoke to told us that they did not receive any feedback from incidents that occurred across the service with a view to sharing learning. Staff told us that whilst they received feedback when they had been directly involved in an incident, they felt this was more of a punitive process, rather than as a way to improve.

Staff also told us that as part of the new process they would be allocated Datix incidents to review. Depending on their seriousness, some of these would be allocated to senior members of the ward staff. The new process had allocated timescales for completion of these reviews. Staff told us that they found it very difficult to be able to complete these within the timescales due to staffing pressures. We were told that some staff did not have any non-clinical time, and therefore were unable to complete these reviews within a normal working shift.

This is an important part of the review process, to help identify how and why incidents or complaints have occurred, with a view to learning and prevention to support the delivery of safe and effective care.

### Audit activity

With the exception of the health board annual infection control audit, we were unable to see that any audits on the ward had been carried out. Staff we spoke to told us that audits such as hand hygiene, ward round compliance, environment, baby band monitors and induction of labour used to be completed, however, these had not been undertaken for a number of months. Staff explained that this was due to staffing pressures and the need to prioritise patient care.

It was unclear what processes were in place to ensure the health board had oversight of audit activity carried out on the ward. Consequentially, it was therefore unclear what action had, or had not been taken by the health board to address that these had not been undertaken. We were concerned about the overall governance arrangements in ensuring regular and meaningful audit activity is carried out, in supporting the delivery of a safe and effective service.

### Working environment

During our inspection we had the opportunity to speak to a number of staff across the directorate, employed in a variety of roles. We were concerned to find that there was an overall disconnect between professional disciplines within the workforce. We did not find that this was isolated to one particular area, level of seniority, or part of the workforce. It was clear from our discussions that there was a lack of trust, poor communication and lack of confidence in senior leadership. Staff told us that they felt undervalued and unappreciated and as previously mentioned, commented that they believed they were working in a punitive environment. As a consequence, we found that staff morale was very low. Senior members of staff we spoke to told us they were aware of the concerns, and were working hard to address these issues. They gave one example of organising multidisciplinary training events to encourage positive team working across the service.

Whilst we received positive comments from staff about the support and engagement from the anaesthetic team with the midwifery team, comments provided by staff about some obstetric staff engagement was less positive. We were told that there was not always a willingness to take part in multidisciplinary events, such as training and meetings. It was positive to note, however, that some obstetric staff had engaged positively with the newly appointed consultant midwife in supporting patient reviews.

We also had sight of the obstetrics and gynaecology consultants meeting minutes produced in September. It was disappointing to find that there was limited reference to the action plan identified as part of the overall service improvements, neither was there any real reference to clinical risks within the service. It is unclear where this information is discussed and actions appropriately taken.

Improvement needed

The health board is required to provide HIW with details of the action taken/to be taken to ensure that communication channels are clearly defined so staff are fully informed about information or changes that impact on them and their work.

The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate support and feedback is provided to staff in the aftermath of any concerns/issues raised, in relation to the delivery of safe and effective care to patients.

The health board is required to provide HIW with details of the action taken/to be taken to ensure that staff responsible for reviewing Datix incidents have the time and resources to be able to do so within agreed timescales.

The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate audits are undertaken on the wards to support the delivery of safe and effective care to patients.

The health board is required to provide HIW with details of the action taken/to be taken to ensure multidisciplinary working is embedded for the well-being of staff and patients.

## Staff and resources

### Workforce

As previously mentioned within the report, we found that the service had significant staffing issues. A review of staff rotas leading up to, and post the inspection, demonstrated that the service was unable to meet the required number of staff on every shift on a regular basis. Staff told us that this was, and had been ongoing for a long period of time. Staff who completed a questionnaire and those we spoke to told us that there was only sometimes, or never enough staff to enable them to do their jobs properly.

Discussions with senior managers demonstrated that they were very much aware of the staffing issues, and were attempting to address the problem, including taking the following actions:

- Rolling programme of recruitment of midwives
- Paying overtime to staff to encourage them to work additional shifts
- Midwives being brought in from non acute areas, such as antenatal clinics and the community, to support the acute areas
- Staff from Prince Charles Hospital being asked to cover shifts at The Royal Glamorgan Hospital.

However, we felt that the limited availability of staff had the potential to impact on the ability of the service to continue to provide safe and effective care. Our concerns regarding the sustainability of the service were dealt with under our immediate assurance process, as outlined in the safe and effective care section of the report. Details of the immediate improvements we identified are provided in Appendix B.

### Appraisal and supervision

Senior managers and ward staff confirmed that there was a staff appraisal process in place which assisted with determining ongoing training needs. We found that a large number of these had been completed this year.

We found that the health board did not have in place a sufficient number of supervisors to provide clinical supervision for midwives. We were told that the health board was in the process of trying to embed a new model for clinical supervision, to provide support and guidance to staff. The health board must ensure that the arrangements for providing clinical supervision to midwives are sufficient to meet the needs of staff.

### Training

Staff training records were maintained by the practice development midwife. Whilst we found that the practice development midwife was working very hard to collate this information and manage, co-ordinate and monitor staff training,

the information was limited and we were not assured that all staff had received the relevant mandatory training. We also found that staff were not always able to be released from their clinical duties to attend mandatory/other relevant training due to staffing issues. We were told that PROMTP[9] training had been cancelled on a number of occasions due to staffing pressures. We also found poor compliance with cardiotocography (CTG) training. Whilst the practice development midwife had put together a programme of training for staff, staffing pressures often meant that staff had been unable to attend. The training programme put in place meant that a majority of staff should receive the mandatory cardiotocography training by February 2019, dependent upon staff availability.

Senior managers told us that they were in the process of collating an all staff training matrix to determine the training needs of staff, and that this was ongoing. It is crucial that the directorate has a thorough understanding of the knowledge, skills and competencies of their workforce to ensure they are able to provide safe and effective care.

We recognised the work carried out by the practice development midwife in supporting newly qualified midwives into the service, including the development of the prep to practice programme passport. This supported newly qualified midwives in their first year of practice by developing and underpinning the competencies gained during training. We found this an area of noteworthy practice.

Improvement needed

The health board is required to describe how it will ensure that its workforce:

- Maintains and develops competencies to meet patients' needs
- Attends induction and mandatory training programmes

The health board must ensure that the provision of clinical supervision is

[9] PROMPT (Practical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working

appropriate to the number and need of their workforce.

# 4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

**The improvement plan, once agreed, will be published on HIW's website.**

# 5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

## Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

| Immediate concerns identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| No concerns were identified on the inspection that were required to be addressed immediately. | | | |

## Appendix B – Immediate improvement plan

**Hospital:** The Royal Glamorgan Hospital

**Ward/department:** Ward 10, ward 11 and labour ward

**Date of inspection:** 15 - 17 October

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The health board is required to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is always available and safe to use in the event of a patient emergency on Ward 10, Ward 11 and Labour Ward.<br><br>The health board is required to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is always available and safe to use across all other wards and departments across the health board. | Standard 2.6 and 2.9 | Feedback meeting held with staff including support staff the following day<br><br>Notes of the meeting taken & shared with all staff via e mail.<br><br>Review of current process to check equipment undertaken by Senior Midwife, Ward Manager and clinical midwife.<br><br>Process stream lined. Band 7 Coordinator identified as the person responsible on Labour Ward to | Senior Midwife<br><br>Band 7 Co coordinators | 18 October 2018<br><br>22 October 2018 |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | ensure all resuscitation equipment has been checked on a daily basis. Ward Manager identified as the person responsible for Ward 10 & 11 | V Box Ward Manager | 22 October 2018 |
| | | Senior Midwife to be provided on a weekly basis evidence of 100% compliance with daily checks | V Box Ward Manager | 29 October 2018 |
| | | Fortnightly on the spot audit to be undertaken by the Ward Manager to ensure new process is embedded. | V Box Ward Manager | 5 November 2018 |
| | | Audit findings to be reported to monthly clinical Governance meeting. | V Box Ward Manager | 19 November 2018 |
| | | Discuss actions taken with Jane Phillips HoM Support ABMU to ensure actions taken are shared & implemented in PCH | Senior Midwife | 24 October 2018 |
| The health board is required to provide HIW with the actions it intends to take to safeguard the sustainability of the service. | Standard 2.1 and 7.1 | Safety Huddles are held at shift handover where potential risks, staffing levels and actions being taken, to maintain safe, effective services are shared with the | Assistant Director Surgery/Maternity Services | 29 March 2019 |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The health board is required to provide HIW with details of the actions it intends to take to ensure the health and wellbeing of staff is maintained and protected. | | multidisciplinary teams, with clarity on the mitigating actions being taken.<br><br>Assurance meetings regarding the safety of the service are held weekly, included within which are with Senior Midwives, Clinicians, Directorate Managers and Patient Safety team members.<br><br>Each month divides into the following governance arrangements. Weeks 1 & 2 the Maternity Services Operational Group meets where issues including safe staffing levels, locum usage is monitored.<br><br>There is a contingency plan in place, supported by escalation procedures, when staffing levels are impacted upon, either because of staff absences or as a result of high patient acuity levels. Services are limited in accordance with the Escalation Policy when safe staffing levels are not achieved, including | | |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | support from neighbouring Health Boards to accept patient flows on a case by case basis. | DoN | |
| | | Week 3 Executive Maternity Assurance Group, Chaired by the Executive Lead for Maternity, Professor Angela Hopkins. Next meeting 30th October 2018 | | 30th October 2018 |
| | | Week 4 Strategic Maternity Improvement Board, with external stakeholders, including WG, DU and invitation extended to HIW. Chaired by a former Executive Nurse Director in NHS Wales, Denise Llewellyn. Inaugural meeting November 6th 2018. | Retire Ex Nurse Director<br>Senior Midwife | 6 November 2018 |
| | | The new graduate midwives 8.8wte commenced work, preceptorship period of 6 weeks ongoing. | Senior Midwife | 8 October 2018 |
| | | After a robust induction process these midwives will commence clinical duties. | Senior Midwife | 19 November 2018 |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | A further 4.84 wte Band 6 midwives have been recruited and after Pre Employment checks and an induction period will commence clinical duties. | Senior Midwife<br><br>Senior Midwife | 3 December 2018 |
| | | Further interviews for midwives took place on 24 October 2018 with an additional 1.64 wte Band 6 midwives appointed | HoM Support ABMU | 3 December 2018 |
| | | There continues to be a rolling advert on NHS for midwives. | Senior Midwife/ HR Business Partner | March 2019 |
| | | From 19 November 2018 there is a plan to offer both graduate and experienced midwives to be re deployed to RGH | | 19 November 2018 |
| | | Staffing levels have improved in RGH over the past 2 weeks due to a reduction in the sickness rate. Sickness levels are being analysed to identify trends in both short and long term sickness. There ongoing sickness management and support available to encourage staff back to | DoN<br><br>Senior Midwife | 22 October 2018 |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | work | | |
| | | The Health Board have agreed to pay double pay for an 8 week period to all staff who work overtime shifts. This is being closely monitored with agreed criteria to ensure risks are minimised for staff to work excessive hours. | Senior Midwife Community | 1 October 2018 |
| | | Health Board have agreed to provide 24/7 Ward Clerk cover to assist in non-clinical activities previously being undertaken by clinical staff | Deputy Directorate Manager<br>Executive Team | 30 November 2018 |
| | | Two wte midwives have been temporarily redeployed from the Community to work in RGH Antenatal clinic staff are providing Day Assessment cover until further notice. | | 24 September 2018 |
| | | When necessary Tier 1locum doctor cover by night is obtained to release the Senior Clinical Midwife to work as a clinical Midwife. | DoN | 24 October 2018 |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | The Health and Wellbeing of staff is being taken seriously. The Executive team and Directorate Team including HR visit the clinical area on a weekly basis.<br><br>Chief Executive Officer has held meetings where all members of the multidisciplinary team are invited to attend<br><br>The Executive Nurse Director holds two weekly meetings where all members of the multidisciplinary team are invited to attend.<br><br>Communication updates are provided to all staff on a weekly basis including "You said, We Did" following suggestions from the Lead Executive for maternity services.<br><br>Occupational Health have agreed to expedite maternity staff in both recruitment process and sickness management. | Deputy Directorate Manger<br><br>HR Business Partner<br><br>Clinical Psychologist.<br><br>Deputy Directorate Manager | Weekly<br><br>Weekly |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | There is a plan to direct any member of staff to a Clinical Psychologist if they wish to discuss any issues both professionally and personally. | Clinical Director | |
| | | Where appropriate staff from neighbouring Health Boards have been recruited in for additional support. | Clinical Director | |
| | | RCM providing regular site visits | Clinical Director | |
| | | Locum advert for locum Consultant posts – Interviews 26th October 2018 | | 26th October 2018 |
| | | Permanent Consultant posts being submitted to RCOG for approval | | 9th November 2018 |
| | | Associate Clinical Director posts being advertised and appointed for labour ward and gynaecology | | 9th November 2018 |

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | Lead roles within the department to be agreed within Consultant team | | 26th October |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

**Service representative:**

**Name (print): Angela Hopkins**

**Job role: Executive Director of Nursing, Midwifery and Patient Care**

**Date: 26 October 2018**

## Appendix C – Improvement plan

**Hospital:** The Royal Glamorgan Hospital
**Ward/department:** Ward 10, ward 11 and labour ward
**Date of inspection:** 15 - 17 October 2018

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Quality of the patient experience** | | | | |
| The health board should consider appropriate toilet facilities for birthing partners during labour. | 4.1 Dignified Care | The service will review the facilities in and around the birthing areas to identify a suitable toilet.<br>Currently the only toilets available are actually in the ward – which would seem an important consideration re: Dignity of other women on the ward. Partners will be offered to use the facilities in the delivery room areas if birth is imminent. The nearest facilities will be explained to | Senior Midwife for RGH | 30 April 2019 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | birthing partners when they are in the unit.<br><br>In March 2019 when the services move to Prince Charles Hospital, the birthing centre in Royal Glamorgan will have additional facilities for birthing partners due to the freeing up of the current clinical areas.<br><br>The women's experience midwife will ensure that there is opportunity for all who use the service to comment on the environment of care and facilities provided. all feedback will form part of the information shared via the directorate governance meetings | | |
| The health board must display information regarding Putting Things Right, to support patients who may wish to raise a concern or complaint, including displaying the contact details for the Community Health Council. | 6.3 Listening and Learning from feedback | Information will be placed in every ward and clinic advising women and their families how they can raise a concern.<br><br>Information about the community health council and leaflets advertising the services provided will be displayed alongside 'Putting Things Right'<br><br>The recently employed specialist | Women's experience midwife | December 31 2019<br><br>December 31 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | midwife for Women's Experience will be responsible for ensuring women's experience both positive and negative is obtained and subsequently acted upon.<br><br>The Health Board has a Patient Advice and Liaison Service (PALS) team who will provide additional support and visibility in the maternity wards to gain 'real time' feedback from women & their families.<br><br>Feedback currently being monitored via social media will be shared with the maternity team. | | 2018<br><br>Completed Nov 2018<br><br>Commenced December 17 2018<br><br>December 14 2018 |
| **Delivery of safe and effective care** | | | | |
| The health board must ensure that access to the wards is securely maintained for the protection of staff and patients.<br><br>The health board should ensure that the mats within the birthing suite in the AMU are not a trip hazard to both staff and patients.<br><br>The health board should ensure that the entrance into and out of the birthing pool is safe | 2.1 Managing risk and promoting health and safety | The unit has twin sets of double safety doors at the entrances, with an air lock area between. One twin set of doors closes and locks, before the second twin set of doors can be released, thereby, providing a safe entry and egress from the wards. New signage has been placed at the entrance and exits to advise all visitors not to allow other | Senior Midwife for RGH | Completed December 12 2018 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| and secure. | | visitors to enter the ward without using the visitor's intercom system to gain permission to enter and for the first set of doors to be released from within the maternity unit. A safety drill will be undertaken to test the system, the outcome of the drill will be fed back to all staff. | Senior Midwife for RGH | 31 December 2018 |
| | | The birthing mats have been removed and will be accessed as and when required. | Senior Midwife for RGH | Completed December 12 2018 |
| | | Staff have been reminded to ensure that, in addition to closure of the curtains into the MLU area and the pool room, that the door into the pool room is also closed when in use to maintain the highest level of privacy. This will be continually monitored by the labour ward sister and the senior midwife and practice challenged where compliance is not achieved. | AMU lead / Senior Midwife for RGH | Completed December 12 2018 |
| | | Measures already in place: | | |
| | | Anti-slip flooring for use in areas where | | |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | there is likely to be water underfoot – similar to changing rooms in swimming pools<br><br>Women use a slip proof step to get into the pool aided by their birthing partners and their midwife<br><br>To exit the pool the women step from the pool onto the seat in the pool and onto the step assisted by the midwife and birthing partner<br><br>All staff providing care are trained in the use of the pool including safety of the women and emergency evacuation from the pool<br><br>In addition, the service will explore the option of using a step which has a handle attached to it. | | |
| The health board must ensure that personal protective equipment stock levels are maintained sufficiently at all times to support | 2.4 Infection Prevention and Control (IPC) and | Additional personal protective equipment stocks have been ordered for all areas and staff have been reminded | Senior Midwife | Completed December 12 2018 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| staff in undertaking their roles. | Decontamination | of the importance of wearing these during procedures.<br>Daily checking process introduced to include ensuring stock levels of the equipment are maintained<br>Staff have been made aware that additional supplies of personal protective equipment is available from the hospital bed managers. | Ward sisters<br>Senior Midwife for RGH | Completed December 12 2018 |
| The health board must ensure that medication fridges are lockable and are kept locked when not in use, and that staff record the temperature of the fridges on a daily basis.<br>The health board must ensure that controlled drug medication checks are carried out consistently on a daily basis. | 2.6 Medicines Management | The ward staff have been requested to ensure medication fridges are locked at all times.<br>This will be included in the senior midwives monthly assurance audits.<br>The daily recording of the temperature of the drug fridges has been included on the daily checking record sheet. In addition, the fridges are also fitted with an alarm for when the temperature goes above the appropriate level to alert staff.<br>The protocol for escalation should this | Ward sisters<br>Senior Midwives | Completed December 12 2018<br>January 31st 2019<br>Completed December 12 2018 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | issue arise is being recirculated to staff. | | |
| The health board must ensure that there is sufficient equipment available to staff to allow them to carry out their duties in a timely manner. | 2.9 Medical devices, equipment and diagnostic systems | Equipment requirements have been obtained from all clinical areas and orders placed. Early delivery has been requested to address this issue.<br><br>The responsibility and process for reporting and replacing broken equipment has been communicated again to the ward sisters. | Head of Midwifery<br><br>Ward sisters | Delivery dates within the coming weeks, completion likely February 2019<br><br>Completed December 12 2018 |
| The health board must ensure that patient records include appropriate patient identification labels and dates on each page. | 3.5 Record keeping | Staff have been reminded that to support safe care and meet NMC requirements patient record labels must be used on every piece of documentation that relates to the patient.<br>This will be monitored via the monthly assurance audits, which the midwives | Head of Midwifery | Completed 13 December 2018<br><br>1st audit completed January 31 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | will be engaging in as part of a learning and peer review process, and this will also be included within the annual record keeping audit.<br><br>Findings of the audits will be used in feedback to staff in order to maintain standards of record keeping. These will be reported at the midwifery professional forum and audit meetings in 2019. | | 2019<br><br>End of December 2019 |
| **Quality of management and leadership** | | | | |
| The health board is required to provide HIW with details of the action taken/to be taken to ensure that communication channels are clearly defined so staff are fully informed about information or changes that impact on them and their work.<br><br>The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate support and feedback is provided to staff in the aftermath of any concerns/issues raised, in relation to the delivery of safe and effective care to patients. | Governance, Leadership and Accountability | Weekly staff briefing sent out from the Directors to ensure all communication is shared. This includes feedback on the actions taken by the UHB following the monthly staff briefings or during visits to the unit where staff raise issues or advise on solutions. Use of the 'You Said: We Did' attachment to the weekly written communications from the Director of Nursing, Midwifery and Patient Care has proved very useful in identifying progress and resolution on | | Completed December 7 2018 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The health board is required to provide HIW with details of the action taken/to be taken to ensure that staff responsible for reviewing Datix incidents have the time and resources to be able to do so within agreed timescales.<br><br>The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate audits are undertaken on the wards to support the delivery of safe and effective care to patients.<br><br>The health board is required to provide HIW with details of the action taken/to be taken to ensure multidisciplinary working is embedded for the well-being of staff and patients. | | issues raised.<br><br>The UHB has ensured there are regular face to face meetings with the Board members, which includes visiting staff out of hours and when the executive is on call for the whole Health Board.<br><br>Occupational Health services have provided easy access for wellbeing support mechanisms. Clinical psychology support is available and open to all staff – this has been communicated via managers.<br><br>The senior midwives will monitor the incidents in their units. The senior midwives have received training and support to manage these.<br><br>Additional support to manage the backlog of incidents has been given with assistance of a member of staff on | Senior Midwives<br><br>Senior Midwives<br><br>Head of Midwifery | Completed October 31 2018<br><br>Completed October 2018<br><br>March 31 2019 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | secondment from another Health board until the end of the financial year. | | |
| | | A new assurance audit tool has been developed with a requirement to undertake monthly assurance audits in each of the clinical areas. | Senior Midwives | To commence January 31 2019 |
| | | The findings will be shared at the monthly professional forums and via audit in relation to any medical findings requiring sharing. | | January 2019 |
| | | The UHB has introduced PROMPT and is well ahead of the Welsh Risk Pool expected timescale for implementation. | PROMPT lead for Health Board | Review in January 2019 |
| | | The Senior Midwifery team are attending multidisciplinary handover meetings to gain assurances that the handovers include the necessary information to support safety and management of activity for the shift. This will continue on a regular basis throughout the year. Findings of the | Senior Midwives | |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | observation's will be shared at the audit and midwifery professional meeting<br><br>The Health Board has funded and supported the attendance of senior clinical midwives, consultants from obstetrics and anaesthetics to attend the Royal College of Midwives - Labour Ward leadership programme in Dublin. This has evaluated well and the team have returned to the UHB with a planned quality improvement initiative. | Directorate team | Completed December 6 2018 |
| | | Maternity services have reviewed the current Quality & Safety structure and have developed a new reporting structure which includes the multidisciplinary team which will ensure robust mechanisms are in place to support Multidisciplinary Team working in the future. This structure was approved at the Maternity assurance Board with Welsh Government | Head of Midwifery | Completed December 4 2018 |
| The health board is required to describe how it | 7.1 Workforce | Training levels are being monitored and | Practice | To |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| will ensure that its workforce:<br>• Maintains and develops competencies to meet patients' needs<br>• Attends induction and mandatory training programmes<br>The health board must ensure that the provision of clinical supervision is appropriate to the number and need of their workforce. | | a new training & education forum is being established to ensure there are multi-disciplinary training programmes which reflect the clinical requirement of the service.<br>A training database is now in place for medical, midwifery and support staff training. This ensures up to date monitoring of compliance to achieve 100% standard of completion.<br>Maternity services have just appointed one Clinical Supervisor of Midwives (CSfM) and expressions of interest have been received from other midwives, which will ensure the Welsh Government ratio of CSfM's to midwives is achieved . | Development midwife & Directorate manager<br>Head of Midwifery | commence February 2019<br>March 2019<br>January 31 2019 |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

**Service representative**

**Name (print): Jane Phillips**

**Job role: Support Head of Midwifery Date: 13th December 2018**

LT – 1.2.19

**ABUHB maternity services review of HIW report of Royal Glamorgan Hospital, Cwm Taf University Health Board**

| Improvement required in Cwm Taf | HIW standard | ABUHB RAG rating | Action required by ABUHB | Responsible person and timescale |
|---|---|---|---|---|
| Ensure that resuscitation equipment/medication is always available and safe to use in the event of a patient emergency | Standard 2.6 and 2.9 | | The is checked daily as part of the ward audit | Lead midwife within the areas |
| Ensure that resuscitation equipment/medication is always available and safe to use across all wards and departments across the health board | | | The is checked daily as part of the ward audit | |
| To safeguard the sustainability of the service. | Standard 2.1 and 7.1 | | All policy and procedures in place.<br><br>Staff train to provide appropriate maternity care<br><br>Clear recruitment and retention process in place to maintain birth rate plus requirements and RCOG requirements for labour ward cover<br><br>Clear governance framework in place for maternity services and directly reports to the maternity service board chaired by the director of Nursing | |

LT – 1.2.19



| | | | | |
|---|---|---|---|---|
| | | | and the Quality and patient safety committee. | |
| Ensure the health and wellbeing of staff is maintained and protected | | | Health and wellbeing supported by Supervisors in group supervision and forms part of annual PADR for all staff | |
| Consider appropriately located toilet facilities for birthing partners during labour | Standard 4.1 | | All available for partners use | |
| Display information regarding Putting Things Right, to support patients who may wish to raise a concern or complaint, including displaying the contact details for the Community Health Council | Standard 6.3 | Information leaflets are available to patients and families, however, this information is not openly displayed in clinical areas in the form of posters | Putting Things Right team to be contacted for suitable posters for displaying in clinical areas | Lead Midwife for Complaints<br><br>End of April<br><br>Awaiting poster from PTR team |
| access to the wards is securely maintained for the protection of staff and patients | Standard 2.1 | | Baby tag system in place across Maternity | |
| ensure that the mats within the birthing suite in the AMU are not a trip hazard to both staff and patients | | | Not applicable as there are no mats in our birthing rooms in the birth centre. | |
| ensure that the entrance into and out of the birthing pool is safe and secure | | | Aids to support safe entrance and exit of the birthing pools are available as required | |

LT – 1.2.19



| | | | | |
|---|---|---|---|---|
| The health board must ensure that personal protective equipment stock levels are maintained sufficiently at all times to support staff in undertaking their roles | Standard 2.4 | | All PPE are available to maintain staff and patient safety | |
| ensure that medication fridges are lockable and are kept locked when not in use, and that staff record the temperature of the fridges on a daily basis | Standard 2.6 | | This is audited in line with health board policy to ensure compliance | |
| ensure that controlled drug medication checks are carried out consistently on a daily basis | | | This is audited in line with health board policy to ensure compliance | |
| ensure that there is sufficient equipment available to staff to allow them to carry out their duties in a timely manner | Standard 2.9 | | Midwifery Equipment is audited by the supervisors on an annual basis<br><br>All hospital based equipment meet the standards and are replace as per life span | |
| ensure that patient records include appropriate patient identification labels and dates on each page | Standard 3.5 | | Women carry their own maternity records<br><br>Medical notes audit undertaken annual by the clinical supervisor for midwives | |
| ensure that communication channels are clearly defined so staff are fully informed about information or changes | Governance, leadership and accountability | | All staff have NHS emails<br><br>Utilisation of team meeting | |

LT – 1.2.19



| | | | | |
|---|---|---|---|---|
| that impact on them and their work | | | Multi disciplinary forums to cascade information | |
| ensure that appropriate support and feedback is provided to staff in the aftermath of any concerns/issues raised, in relation to the delivery of safe and effective care to patients | | | Debriefing and review sessions are undertaken<br><br>Divison also support the sage and time strategy for support<br><br>All SUI's are feedback through multi disciplinary forums, supervision and team meeting | |
| ensure that staff responsible for reviewing Datix incidents have the time and resources to be able to do so within agreed timescales | | | Full time Clinical governance midwife who works in collaboration with the multidisciplinary team to ensure compliance | |
| ensure that appropriate audits are undertaken on the wards to support the delivery of safe and effective care to patients | | | Ward audits are undertaken as per Health board programme | |
| ensure multidisciplinary working is embedded for the well-being of staff and patients | | | Maternity is a multi disciplinary care provision. This is Embedded within ABUHB maternity services and further developed with the Training PROMPT | |
| ensure that its workforce:<br>• Maintains and develops | Standard 7.1 | | All staff attend statutory and mandatory | |

LT – 1.2.19



| | | | | |
|---|---|---|---|---|
| competencies to meet patients' needs<br>• Attends induction and mandatory training programmes | | | training Multi professional<br><br>medical and midwifery mandatory training days<br><br>All new members of staff have corporate induction<br><br>Midwives have a full preceptorship year with competencies to be achieved. | |
| ensure that the provision of clinical supervision is appropriate to the number and need of their workforce | | | Medical supervision through education and consultant support as per deanery requirements<br><br>Midwives have a clear supervision framework and KPI's. clear performance indicators reviewed annual by WG | |

| | |
|---|---|
| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | Quality & Patient Safety Committee<br>4th April 2019<br>Agenda Item: 3.1 |

3.1

# Aneurin Bevan University Health Board

QUALITY AND PATIENT SAFETY REPORT
APRIL 2019

## Executive Summary

**Summary of Key Points**

The number of deaths and mortality rate have risen going into winter, but this is the usual seasonal pattern. (section 1.1.).

An overview of participation in NCAs is provided. The results of the Annual Report of the National Emergency Laparotomy Audit are given in section 2.2. The Team are attending an All Wales Collaborative to improve the results across Wales from this NCA.

The feedback from the Peer Review of Acute Deterioration at ABUHB has been received and is very positive. An action plan has been developed to address the recommendations. (section 3.1.).

The numbers of cases of C. diff per month have now reduced from last year, but are now above the levels required to meet the target in 2018-19. (section 3.2.1.).

A pressure ulcer reduction collaborative is in place targeting wards on the Royal Gwent Hospital site. Altogether, the average reduction of HAPUs across the collaborative wards is about 45%. (section 3.4)

There was an increase in the number of in-patient falls in January, but no associated rise in the number of long bone fractures.

| **The Quality and 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: Dr Paul Buss, Medical Director** | | | |
| **Report Author: Kate Hooton, Assistant Director** | | | |
| **Report Received consideration and supported by :** | | | |
| **Executive Team** | | **Committee of the Board [Quality and Patient Safety Committee]** | **X** |
| **Date of the Report: 25th March 2019** | | | |
| **Supplementary Papers Attached:** | | | |

Bwrdd Iechyd Aneurin Bevan Health Board

*Quality and Patient Safety Report*
*Quality and Patient Safety Committee*
*Agenda Item: 3.1*

3.1

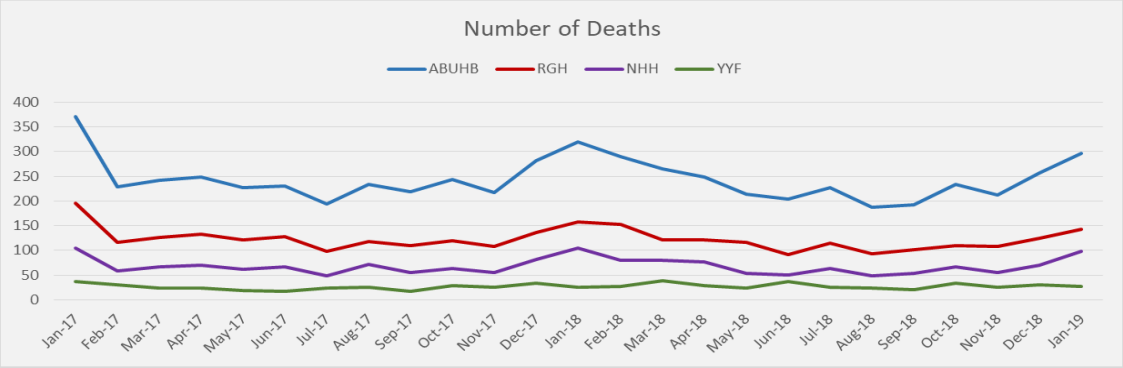
| **Purpose of the Report** |
| --- |
| The Quality and Patient Safety Report for the Quality and Patient Safety Committee provides information on the ABUHB main priorities in this area, as set out in the Integrated Medium Term Plan and the Annual Quality Statement.<br><br>The Quality and Patient Safety Committee is asked to review the report, note the progress being made in many areas and highlight any issues where further information is required for assurance. |
| **Background and Context** |
| This report provides data in the following areas in relation to quality and patient safety:<br>• High level data on outcomes<br>• Surveillance and review<br>• Optimising Care Delivery<br><br>The targets used through out the report can be Welsh Government Targets, or targets set within the Health Board, where there is no Welsh Government Target. |

| **Assessment and Conclusion** |
| --- |
| The data and narrative in the report demonstrate the position of the health board in terms of performance against a number of quality and patient safety targets, and the actions that are being taken to improve or maintain performance. |

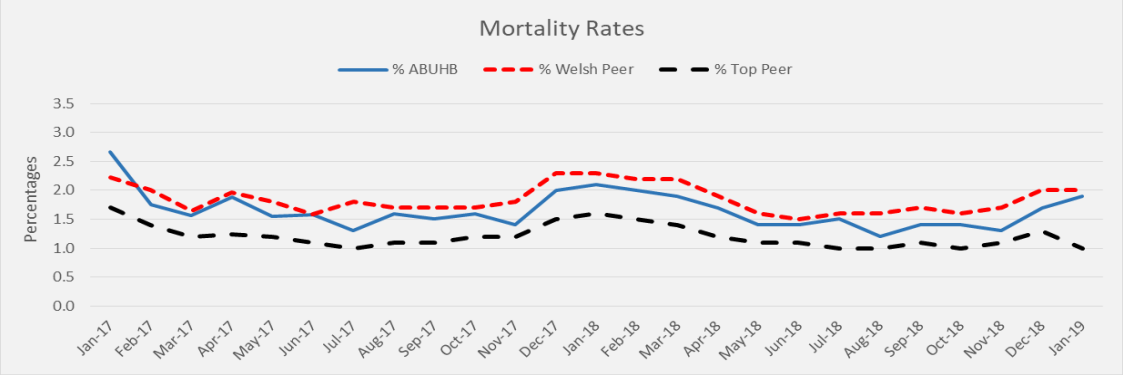
# 1. High Level Outcomes

## 1.1 Crude Mortality and Mortality Rate

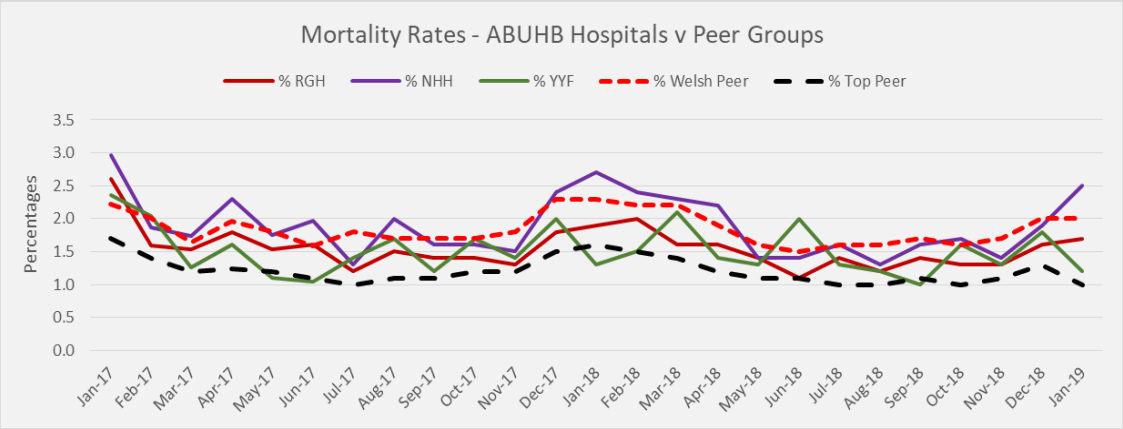
### ABUHB and Hospital Crude Mortality Jan 17 – Jan 19




### ABUHB Mortality Rate against Welsh Peer and Top Peer Jan 17-Jan 19




### Hospital Mortality Rates with Welsh Peer and Top Peer Jan 17- Jan 19



### 1.2. Narrative on Mortality Data

The line in the run charts which represents ABUHB or an ABUHB hospital, shows more variation than the line for Welsh Peer or Top Peer. This is to be expected as the Peers include much greater numbers of patients and therefore the overall variation is reduced.

The Crude mortality (number of deaths) in ABUHB and NHH and RGH has increased going into the winter period, whereas YYF has remained relatively consistent.

The ABUHB mortality rate is generally lower than the Welsh Hospitals. The mortality rate for ABUHB has been at the level expected since the last winter, and has increased going into the 2018-19 winter period, but remained below the Welsh Average.

The mortality rate for NHH has increased sharply in November and December, and in December was above the Welsh Average. The mortality reviews completed so far for December and January have not shown any concerning trends, and the number of second reviews is consistent with the usual level.

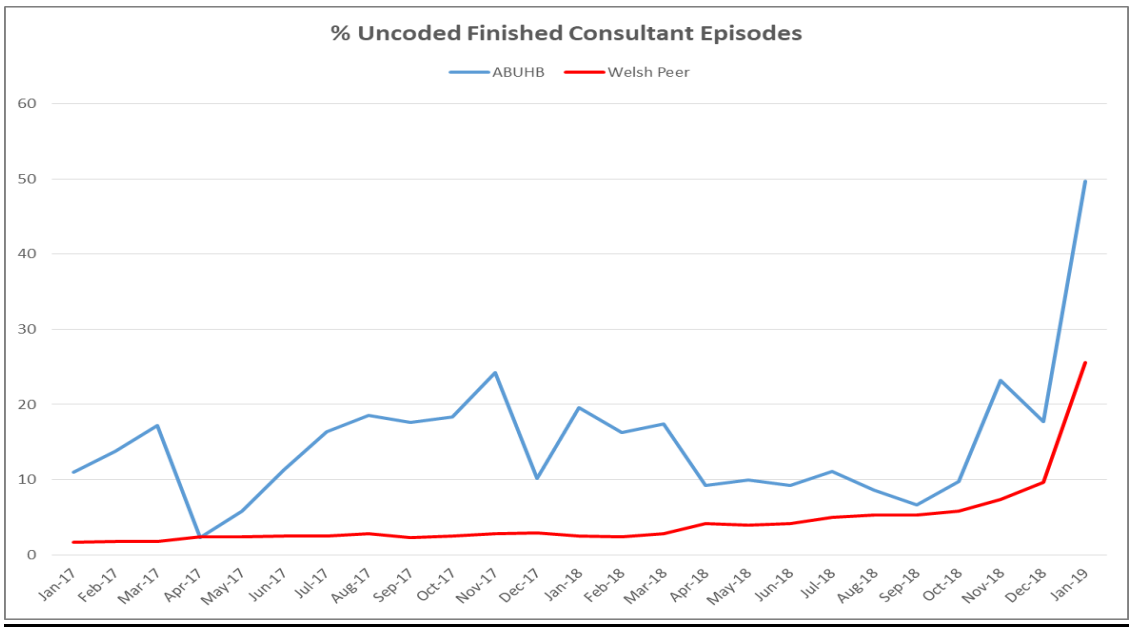
Coding completeness (p5) does not impact on the number of deaths or the mortality rate values. However, it is important for any more detailed analysis of the variation in the numbers or rates, and it impacts on the condition specific mortality rates. The Clinical Coding Department has filled its vacancies and the percentage of uncoded finished consultant episodes is decreasing, but it will be some time before the new staff are working at full effectiveness.

**Completeness of Coding**

ABUHB Coding Completeness (6 March 2019, CHKS):

| | |
|---|---|
| July 18 | 88.9% |
| Aug 18 | 91.4% |
| Sept 18 | 93.4% |
| Oct 18 | 90.2% |
| Nov 18 | 76.8% |
| Dec 18 | 82.3% |

**Uncoded Finished Consultant Episodes Nov 16 - Nov 18**




## 2. Surveillance and Review

As a Health Board we are always developing how we use clinical data to identify areas for quality improvement, in line with Professor Palmer's recommendations. The data we are currently using includes:

- National Clinical Audits, with full participation and use of the results to drive improvement year on year.
- Condition specific mortality statistics at an organisational level, such as the MI, Stroke and Fractured Neck of Femur data presented in this report (see section 4.5, 4.6 and 4.7).
- Review of clinical records of patients that die in our hospitals, following national protocols – the mortality review process.

### 2.1 Mortality Review

***Percentage Completion of Mortality Reviews –***The Welsh Government plan is that, when, in line with the recommendations of the Shipman review, the Medical Examiner role is introduced, the Medical Examiner will undertake the first level of the mortality review. This is part of their role, as they agree the cause of death with the responsible medical team and high light any concerns they have about care from their review of the clinical record. They also talk to the relatives of the deceased person to ensure that they agree with the cause of death and

were happy with the care provided. The Health Board will undertake a more in depth, second level review into any deaths that the Medical Examiner highlights. The new role will be introduced from April 2019 on a non-statutory basis for deaths in acute hospitals. It has recently been proposed that the Medical Examiners and the Medical Examiner Officers who support them, will be employed by Shared Services. The Health Board is therefore not progressing the role itself, but will ensure it will work alongside the bereavement service, as it is developed.

The Welsh Government has set the standard that 100% of the notes of patients that die in our hospitals are reviewed. In ABUHB, we have funding for 4 sessions of senior clinician time to complete mortality reviews. All 4 session have been filled, and the percentage of mortality reviews completed was increasing, particularly at NHH. However, at the end of 2018, there was a sewage leak into the room at RGH where the mortality reviews are undertaken. The room and notes have therefore been unavailable, which has meant that the reviews completed at RGH since December has been very low.

Health Boards are reporting to the Welsh Government the percentage of deaths reviewed each month and the time taken to complete the review from the death of the patient.

| | Feb 18 | Mar 18 | April 18 | May 18 | Jun 18 | July 18 | Aug 18 | Sept 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. Reviewed | 107 | 111 | 128 | 143 | 128 | 139 | 129 | 150 | 168 | 121 | 113 | 101 | 1538 |
| 2nd Stage Review | 11 | 10 | 10 | 12 | 16 | 12 | 12 | 17 | 14 | 19 | 13 | 9 | 155 |
| Total Deaths | 254 | 264 | 247 | 212 | 200 | 221 | 182 | 172 | 233 | 208 | 253 | 294 | 2740 |
| % Reviewed | 42% | 42% | 52% | 67% | 64% | 63% | 71% | 87% | 72% | 58% | 45% | 34% | 56% |

***Learning from Mortality Reviews –*** The last meeting of the Mortality and Harm Review Group identified that DNACPR forms had been completed, but the issue continues to be that the patient should not have come into hospital. Sometimes, Advance Care Plans are in place but may not be accessible out of hours.

The Group also raised the quality of the organisation of the clinical notes, which makes it hard to understand the clinical narrative. This must impact on the care given by on-call doctors. The Chair of the Group will raise "notes hygiene" and categorisation and consistent scanning via the

Head of Clinical Records and Group overseeing the transformation to digital records.

## 2.2 National Clinical Audit (NCA)

National Clinical Audits enable healthcare organisations in Wales to measure the quality of their services against consistently improving standards, and to confirm how they compare with the best performing services in the UK. National Clinical Audits also have great potential to provide information to the public about the quality of clinical care provided by NHS Health Boards.

The results of one of these National Clinical Audits are included in this report. The fourth Patient Report of the National Emergency Laparotomy Audit (NELA) is the NCA included in this report. The results of all the National Clinical Audits are now being reported to the Quality and Patient Safety Operational Group.

The Wales National Clinical Audit and Outcome Review Programme lists the National Clinical Audits that Health Boards must participate in. There are more than 40 National Clinical Audits (NCAs) on the Programme. ABUHB aims to participate fully in all the NCAs listed, but there are 3 that we do not enter any data for, and 4 that data entry is not undertaken at all hospitals, or is limited in some way.

The National Clinical Audits that ABUHB participate in from the NCAORP are:

National Joint Registry
National Emergency Laparotomy Programme
Case Mix Programme – Intensive Care
National Diabetes Inpatient Audit
National Diabetes Footcare Audit
National Pregnancy in Diabetes Audit
National Diabetes Paediatric Audit
National Asthma Audit
All Wales Audiology Audit
Stroke Audit (SSNAP)
Inpatient Falls
National Hip Fracture Database
National Dementia Audit
National Audit of Breast Cancer in Older People
National Audit for Care at the End of Life

Cardiac Rhythm Management
National Audit of Percutaneous Coronary Interventions
Myocardial Ischaemia National Audit project
National Vascular registry Audit
Cardiac Rehabilitation Audit
National Lung Cancer Audit
National Prostate Cancer Audit
National Oesophago-gastric Cancer Audit
National Neonatal Audit Programme Audit
National Maternity and Perinatal Audit
Epilepsy 12 Children and Young People NCA
National Clinical Audit of Psychosis
NCEPOD audits
Mental Health Programme
Maternal Newborn and Infant Clinical Outcome Review programme

| NCA | Case Ascertainment | Narrative | Update |
|---|---|---|---|
| Trauma Audit Research Network | No Participation | Registered for the audit and clinical staff trained for the audit but clinical staff unable to complete data entry within their working day | Other options for data entry have been considered, such as a nurse for data entry. To explore additional resource for a dedicated member of administrative staff to be trained to enter the data under close clinical supervision. |
| National Ophthalmology Audit (Adult Cataract Surgery) | No Participation | Electronic Records systems for Ophthalmology required as this uploads the audit data automatically. ABUHB has not agreed which electronic record system to use | The electronic record system in development at UHW is considered to be the best option to pursue. |
| Inflammatory Bowell Disease Registry | No Participation | Data entry ceased during 2018 due to staff resources. | Staff levels remains an issue and data entry is still on hold. |
| NACAP – National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: | Full participation at NHH. No participation at RGH and YYF | The COPD NCA has recently moved to continuous data entry and the Asthma NCA is new. The Respiratory | A process has been developed at NHH between the clinical staff and the MDST for data entry. RGH do not |

| | | | |
|---|---|---|---|
| COPD audit and Adult Asthma Audit | | Service has struggled to complete the data entry due to the high volume. | consider they have the capacity to adopt this process. Long term sickness at YYF has prevented the process being implemented there. |
| Heart Failure | Full Participation at NHH. Intermittent participation at RGH and YYF. | Established process at NHH, although reliant on one Nurse Specialist. Good engagement with Specialist Nurses at RGH and YYF, and process with MDST support agreed. However, staff sickness and change of staff has hindered consistent data entry. | The number of cases needing to be entered per nurse per week for RGH and YYF to meet the requirement has been calculated to provide clarity for the specialist nurses. |
| Early Inflammatory Arthritis | Limited participation | Process agreed between the Consultants and MDST | Two vacancies in the Consultant Team have limited participation. |
| Fracture Liaison Service | Limited Participation | ABUHB has just registered for this NCA. Process to initiate data entry agreed between service and MDST | Data entry has just started and will be monitored |

**National Emergency Laparotomy Audit Dec 2016 – Nov 2017**

This is the fourth Patient Report of the National Emergency Laparotomy Audit (NELA), commissioned by the Healthcare Quality Improvement Partnership, which is an ongoing clinical audit of adult patients having emergency bowel surgery. This 'state of the nation' report which is funded by NHS England and the Welsh Government, presents information about the care received by 23,929 patients (22,173 located in England and 1,756 in Wales) who had surgery between 1 December 2016 and 30 November 2017. This represents around 83% of all patients that underwent this surgery in 179 hospitals.

NELA is committed to supporting clinical teams and managers to apply quality improvement methods to improve care for patients undergoing emergency laparotomy. !000 Lives plus are currently running an Emergency Laparotomy Collaborative for the NHS in Wales in order to improve the results of Welsh Health Boards. ABUHB is participating fully in this collaborative.

**Results - Patient outcomes UK wide**

- 30-day postoperative mortality has improved from 11.8% when the audit started in 2013, to 9.5%, representing around 700 lives now saved each year in comparison with 2013.
- One hospital was identified as having unexpectedly high risk-adjusted mortality rates.
- Longer-term patient survival is reported for the first time. Overall mortality rates were 23% at 1-year after surgery, 29% at 2 years, and 34% at 3 years following surgery, but were substantially higher in high risk groups.
- Average length of stay has fallen further to 15.6 days. This fall from 19.2 days in Year 1 represents an annual saving to acute hospitals of £34million.
- 6.3% of all emergency laparotomy patients had their surgery for a complication of a recent elective procedure within the same admission, 6.0% of all emergency laparotomy patients had an unplanned return to theatre after initial emergency laparotomy and 3.4% of patients had an unplanned admission to critical care, with variation seen between hospitals.

**Improvement has been seen in the following areas in the UK:**

- 75% of patients now receive an assessment of risk (up from 71% last year, and 56% in Year 1)
- 95% of patients had input from a consultant surgeon and 86% had input from a consultant anaesthetist prior to surgery
- consultant presence during surgery is at its highest level since the audit commenced; for high and highest risk patients, a consultant surgeon is present during surgery 92% of the time, a consultant anaesthetist 88%, and both consultants 83% of the time
- 87% of highest risk patients are admitted to critical care following surgery.

**There are some areas that have shown little improvement over four years across the UK. NELA is calling for urgent action to address these areas:**

- only a quarter of patients suspected of sepsis on admission received antibiotics within the recommended 60 minutes
- more patients are now receiving a CT scan before surgery. Of those that had a CT scan, preoperative reporting by an in-house consultant was 73% (64% of all emergency laparotomy patients). This year's report also presents new information on accuracy of reporting of CT scans for emergency laparotomy. This varied between hospitals from 100% to 78%

- the proportion of patients arriving in the operating theatre within appropriate timeframes has remained static at 82% (almost unchanged since Year 1). Of greater concern is that the figure for the most urgent patients (requiring surgery within two hours) has fallen from 76% to 73%
- while intraoperative consultant presence is at its highest level overall, out-of-hours presence remains lower. This is particularly concerning given that a greater proportion of high risk and highest risk patients have surgery between 6.00pm and 8.00am
- emergency laparotomy remains a procedure that is associated with increasing age, but only 23% of patients aged over 70 received elderly care input
- the data quality for some hospitals remains relatively poor and this is likely to hinder attempts to improve care. Some hospitals were able to provide data on timeliness of interventions for only 23% of their patients.

There is hospital / site breakdown of data relating to the nine key standards currently subject to RAG-Rating format. Nevill Hall's case ascertainment was low for this year which may have impacted on some of the results. RGH case ascertainment was high. As both hospitals are participating in the improvement collaborative in Wales, case ascertainment is now good.

| Region | Hospital code | Trust/health boards | Hospital name | Adjusted mortality rate (%) | 99.8% upper limit (%) | 95% upper limit (%) | 99.8% lower limit (%) | 95% lower limit (%) | Total number of cases in Year 4 | Final Case Ascertainment | CT reported before surgery | Discrepancy between surgical findings and CT report | Risk documented preoperatively | Arrived in theatre in timescale appropriate to urgency | Preoperative input by a consultant surgeon and anaesthetist when risk of death >=5% (P-POSSUM) | Preoperative input by a consultant surgeon when risk of death >=5% (P-POSSUM) | Preoperative input by a consultant anaesthetist when risk of death >=5% (P-POSSUM) | Preoperative input by a consultant intensivist when risk of death >=5% (P-POSSUM) | Consultant surgeon present in theatre when risk of death >=5% (P-POSSUM) | Consultant surgeon present in theatre when risk of death <5% (P-POSSUM) | Consultant anaesthetist present in theatre when risk of death >=5% (P-POSSUM) | Admitted to critical care post-op when risk of death >=5% (P-POSSUM) | Admitted to critical care post-op when risk of death 5-10% (P-POSSUM) | Admitted to critical care post-op when risk of death >10% (P-POSSUM) | Assessment by elderly medicine specialist in patients >70 years | Median post-op length of stay in patients surviving to hospital discharge (days) | Proportion returning to theatre after emergency laparotomy (%) | Proportion with unexpected critical care admission from the ward < 7 days post-op (%) | Quartile (based on total number of hospitals) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| South - South West | MPH | Taunton and Somerset NHS Foundation Trust | Musgrove Park Hospital | 10.4 | 11.7 | 14.6 | 2.7 | 4.9 | 168 | 92.9 | 91.6 | 5.5 | 82.9 | 78.4 | 82.6 | 99.0 | 83.6 | 80.4 | 96.6 | 100.0 | 96.6 | 83.9 | 75.6 | 91.7 | 77.8 | 9.6 | 6.3 | 1.3 | 3 |
| South - South West | NDO | Northern Devon Healthcare NHS Trust | North Devon District Hospital | 6.4 | 23.9 | 18.6 | 0.0 | 1.9 | 59 | 62.8 | 81.4 | 17.2 | 98.3 | 69.6 | 100.0 | 100.0 | 100.0 | 94.1 | 92.9 | 100.0 | 92.9 | 84.0 | 75.0 | 88.2 | 57.7 | 7.6 | 17 | 0.0 | 1 |
| South - South West | PGH | Poole Hospital NHS Foundation Trust | Poole Hospital | 10.6 | 20.5 | 16.3 | 1.1 | 3.5 | 96 | 85.7 | 85.4 | 4.5 | 89.6 | 78.1 | 91.4 | 100.0 | 91.4 | 80.6 | 76.8 | 98.2 | 76.8 | 79.7 | 55.6 | 90.2 | 53.7 | 13.1 | 9.5 | 3.2 | 2 |
| South - South West | PLY | Plymouth Hospitals NHS Trust | Derriford Hospital | 7.2 | 15.7 | 13.4 | 4.2 | 5.9 | 266 | 84.9 | 67.7 | 5.1 | 60.0 | 76.7 | 90.9 | 99.4 | 91.6 | 64.4 | 70.5 | 90.6 | 76.5 | 55.0 | 17.9 | 79.8 | 41.1 | 9.4 | 3.0 | 0.4 | 4 |
| South - South West | RMS | Great Western Hospitals NHS Foundation Trust | The Great Western Hospital | 15.9 | 17.1 | 14.2 | 3.3 | 5.2 | 185 | 103.9 | 73.0 | 4.1 | 88.1 | 90.9 | 89.6 | 96.2 | 93.4 | 78.3 | 83.7 | 88.6 | 97.1 | 100.0 | 100.0 | 100.0 | 60.0 | 12.1 | 2.8 | 1.7 | 2 |
| South - South West | RCH | Royal Cornwall Hospitals NHS Trust | Royal Cornwall Hospital | 5.1 | 16.3 | 13.8 | 3.7 | 5.6 | 222 | 78.7 | 74.8 | 4.7 | 58.1 | 87.7 | 88.6 | 99.3 | 88.6 | 66.1 | 89.3 | 97.1 | 92.1 | 45.4 | 22.6 | 64.5 | 25.3 | 8.2 | 7.2 | 5.4 | 3 |
| South - South West | RDE | Royal Devon and Exeter NHS Foundation Trust | Royal Devon and Exeter Hospital | 9.5 | 16.9 | 14.1 | 3.3 | 5.3 | 190 | 86.4 | 60.9 | 6.6 | 64.1 | 75.9 | 96.5 | 96.5 | 100.0 | 75.7 | 89.4 | 91.2 | 97.3 | 68.7 | 52.3 | 78.9 | 40.9 | 10.4 | 8.4 | 5.3 | 4 |
| South - South West | SAL | Salisbury NHS Foundation Trust | Salisbury District Hospital | 11.7 | 22.0 | 17.2 | 0.2 | 2.8 | 76 | 78.4 | 80.3 | 3.9 | 67.1 | 93.3 | 95.3 | 100.0 | 95.3 | 75.0 | 81.8 | 93.2 | 88.6 | 72.5 | 46.2 | 83.2 | 56.3 | 9.0 | 2.6 | 1.3 | 2 |
| South - South West | SMH | North Bristol NHS Trust | Southmead Hospital | 10.9 | 16.8 | 14.1 | 3.4 | 5.3 | 196 | 88.3 | 71.8 | 6.7 | 91.8 | 84.8 | 90.4 | 97.4 | 93.0 | 81.8 | 82.3 | 96.5 | 84.1 | 84.6 | 61.8 | 94.0 | 58.0 | 8.8 | 13.9 | 1.0 | 4 |
| South - South West | TOR | South Devon Healthcare NHS Foundation Trust | Torbay District General Hospital | 11.1 | 17.2 | 14.3 | 3.1 | 5.1 | 177 | 100.6 | 55.2 | 4.8 | 70.6 | 91.1 | 81.9 | 94.7 | 83.1 | 89.7 | 77.5 | 95.5 | 82.0 | 73.5 | 51.3 | 88.1 | 52.8 | 9.5 | 5.2 | 0.6 | 3 |
| South - South West | WDH | Dorset County Hospital | Dorset County Hospital | 2.0 | 19.0 | 15.5 | 1.9 | 4.2 | 121 | 93.1 | 77.7 | 5.8 | 91.7 | 95.2 | 92.5 | 98.5 | 92.5 | 94.6 | 89.4 | 100.0 | 89.4 | 91.1 | 100.0 | 94.7 | 73.0 | 9.4 | 1.7 | 2.5 | 1 |
| South - South West | WGH | Weston Area Health NHS Trust | Weston General Hospital | 11.9 | 22.1 | 17.3 | 0.1 | 2.8 | 76 | 74.3 | 56.0 | 3.2 | 84.0 | 91.1 | 97.6 | 100.0 | 97.6 | 66.7 | 91.6 | 97.6 | 100.0 | 77.3 | 50.0 | 90.0 | 41.7 | 10.5 | 13.4 | 6.3 | 1 |
| South - South West | YEO | Yeovil District Hospital NHS Foundation Trust | Yeovil District Hospital | 4.0 | 23.3 | 17.6 | 0.1 | 2.6 | 72 | 94.7 | 83.3 | 6.3 | 61.1 | 86.1 | 69.4 | 97.2 | 72.2 | 52.8 | 63.9 | 100.0 | 63.9 | 73.7 | 57.1 | 83.3 | 58.3 | 11.4 | 5.6 | 6.9 | 1 |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wales | BIG | Hywel Dda Health Board | Bronglais General Hospital | 7.3 | 23.9 | 18.6 | 0.0 | 1.9 | 59 | 128.3 | 93.3 | 10.0 | 89.8 | 94.6 | 97.6 | 97.6 | 100.0 | 96.9 | 73.8 | 73.8 | 95.2 | 91.7 | 83.3 | 93.3 | 96.9 | 13.6 | 5.1 | 0.0 | 1 |
| Wales | CTM | Betsi Cadwaladr University Health Board | Glan Clwyd District General Hospital | 9.4 | 19.0 | 15.4 | 1.9 | 4.2 | 122 | 99.2 | 77.0 | 4.9 | 81.1 | 83.7 | 84.0 | 97.3 | 86.3 | 71.7 | 86.7 | 93.3 | 92.0 | 86.8 | 72.7 | 92.6 | 36.1 | 11.4 | 4.1 | 1.6 | 2 |
| Wales | GLG | Hywel Dda Health Board | Glangwili General Hospital | 10.9 | 18.6 | 15.2 | 2.3 | 4.4 | 132 | 141.9 | 91.9 | 9.1 | 93.4 | 83.3 | 57.5 | 67.8 | 83.1 | 59.3 | 86.2 | 89.7 | 95.4 | 90.4 | 82.6 | 93.3 | 91.9 | 13.3 | 11.5 | 7.6 | 1 |
| Wales | GWE | Aneurin Bevan Health Board | Royal Gwent Hospital | 13.0 | 16.5 | 13.9 | 3.6 | 5.5 | 213 | 144.9 | 94.3 | 0.7 | 87.8 | 79.1 | 67.7 | 83.1 | 79.0 | 63.0 | 61.0 | 74.0 | 76.4 | 83.2 | 80.0 | 84.7 | 66.1 | 11.2 | 5.7 | 1.4 | 3 |
| Wales | GWY | Betsi Cadwaladr University Health Board | Ysbyty Gwynedd Hospital | 4.8 | 19.7 | 15.9 | 1.5 | 3.9 | 108 | 109.1 | 67.6 | 2.4 | 83.3 | 83.7 | 88.3 | 98.7 | 89.6 | 62.5 | 84.4 | 96.1 | 87.0 | 75.0 | 65.0 | 79.2 | 57.9 | 12.3 | 3.7 | 8.3 | 2 |
| Wales | MOR | Abertawe Bro Morgannwg University Health Board | Morriston Hospital | 10.4 | 15.3 | 13.2 | 4.5 | 6.1 | 293 | 101.0 | 78.2 | 6.7 | 85.3 | 74.2 | 83.9 | 94.1 | 81.6 | 64.1 | 64.1 | 70.7 | 87.3 | 55.0 | 21.5 | 72.6 | 38.6 | 11.6 | 10.3 | 4.1 | 4 |
| Wales | NEV | Aneurin Bevan Health Board | Nevill Hall Hospital | 14.6 | 21.6 | 17.0 | 0.3 | 2.9 | 81 | 64.3 | 64.2 | 8.7 | 74.1 | 94.6 | 89.1 | 89.1 | 100.0 | 66.7 | 82.6 | 84.8 | 95.7 | 91.1 | 83.3 | 96.3 | 53.3 | 12.5 | 8.6 | 4.9 | 2 |
| Wales | PCH | Cwm Taf Health Board | Prince Charles Hospital | 10.6 | 21.0 | 16.7 | 0.7 | 3.3 | 88 | 107.3 | 89.8 | 8.3 | 96.6 | 82.3 | 100.0 | 100.0 | 100.0 | 82.8 | 83.7 | 91.8 | 91.8 | 78.3 | 53.3 | 90.3 | 56.3 | 8.4 | 4.6 | 2.3 | 1 |
| Wales | PCW | Abertawe Bro Morgannwg University Health Board | Princess of Wales Hospital | 11.9 | 18.7 | 15.3 | 2.1 | 4.3 | 129 | 99.2 | 62.8 | 4.7 | 82.2 | 74.2 | 84.8 | 97.5 | 86.1 | 63.3 | 78.3 | 94.9 | 82.3 | 66.2 | 40.0 | 83.0 | 49.1 | 9.2 | 8.6 | 5.5 | 1 |
| Wales | RGH | Cwm Taf Health Board | Royal Glamorgan | 8.3 | 19.0 | 15.5 | 1.9 | 4.2 | 121 | 119.8 | 82.9 | 1.0 | 90.1 | 71.0 | 95.9 | 100.0 | 95.9 | 85.1 | 91.9 | 97.3 | 91.9 | 70.4 | 45.5 | 81.6 | 46.7 | 10.2 | 9.1 | 2.5 | 1 |
| Wales | UHL | Cardiff and Vale University Health Board | University Hospital Llandough | NA | NA | NA | NA | NA | 0 | NA | NA | NA | NA | NA | 0.0 | 0.0 | 0.0 | 0.0 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Wales | UHW | Cardiff and Vale University Health Board | University Hospital of Wales | 7.5 | 15.8 | 13.5 | 4.7 | 5.9 | 255 | 102.8 | 68.2 | 6.3 | 87.5 | 58.0 | 73.1 | 96.2 | 76.3 | 70.9 | 72.3 | 87.1 | 79.4 | 52.3 | 13.5 | 71.8 | 41.1 | 10.2 | 7.5 | 3.9 | 4 |
| Wales | WRX | Betsi Cadwaladr University Health Board | Wrexham Maelor Hospital | 8.3 | 21.0 | 16.7 | 0.7 | 3.3 | 88 | 83.8 | 63.6 | 3.8 | 92.0 | 86.1 | 96.5 | 100.0 | 96.5 | 78.0 | 91.2 | 94.7 | 93.0 | 80.7 | 52.9 | 92.5 | 54.7 | 8.9 | 4.5 | 0.0 | 2 |
| Wales | WYB | Hywel Dda Health Board | Withybush General Hospital | 14.3 | 23.0 | 17.8 | 0.0 | 2.2 | 67 | 67.7 | 94.0 | 4.5 | 86.6 | 69.6 | 78.0 | 97.6 | 78.0 | 46.3 | 80.0 | 100.0 | 80.0 | 80.0 | 66.7 | 90.0 | 46.7 | 11.6 | 4.5 | 6.0 | 1 |

The following actions have been agreed by the Team attending the Emergency Laparotomy Collaborative:

| | Recommendations | Actions |
|---|---|---|
| **1** | Improved consultant presence in the operating theatre | Often difficult due to the large number of experienced surgeons not at consultant level within the HB. Advise divisional director, SCD |
| **2** | Review of deaths, particularly the early deaths | The team have reviewed the case notes of patients with high risk and low risk to identify areas of learning |
| **3** | Mortality and morbidity review as a multidisciplinary team of surgeons, anaesthetists, ED and theatres staff | Started being operational in 2019 (monthly meetings) |
| **4** | Improved data entry by identifying champions in theatres (scrub staff and ODPs) | Lead ODP and theatre champions identified |
| **5** | Death is > 20% involving MDT discussion pre-operatively if risk of ICU, surgical and anaesthetic consultants | Raising awareness to key stakeholders |
| **6** | Regular NELA group member discussions to ensure progress | Ensure multidisciplinary participation in the ELC site meetings |
| **7** | Antibiotic audit in Surgical Admissions Unit | Spot audit done in SAU.<br>Ongoing audit via Sepsis / RRAILS team |
| **8** | Dissemination of report and recommendations to all stakeholders (clinicians and health care professionals) | Dissemination at QUID meetings (audit days) |

| | | |
|---|---|---|
| **9** | Identify patient who trigger for the Sepsis 6 bundle | Data currently being analysed |

## 3. Optimising Care Delivery

### 3.1. Deteriorating Patient/Sepsis – ABC Sepsis

The Aneurin Bevan Collaborative on Sepsis (ABC Sepsis) was launched on 7th January 2015. The Collaborative is working in defined clinical areas, to improve the recognition and response to sepsis and therefore eliminate avoidable deaths and harm from sepsis. Key to this is the understanding that sepsis is a time sensitive condition – every extra hour of delay in treating sepsis means a 7.6% risk of mortality – and therefore it has to be treated as a medical emergency, like a stroke or MI. The focus has been on the front door to the Hospitals, as the report "Just Say Sepsis" identifies that 70% of sepsis cases are in the community.

The Collaborative's outcome measures are:

- the % of patients triggering with sepsis that die within 30 days of recognition, and
- the number of patients triggering with sepsis that die within 30 days of recognition.

The process measure for the collaborative is:

- Sepsis 6 compliance, which means that all 6 elements of the sepsis bundle are completed within 1 hour of recognition.

#### 3.1.1. Review of Results from ABC Sepsis

ABC Sepsis has been collecting data from the sepsis screening tools completed for patients triggering with sepsis in the Emergency Departments and now the wards in acute hospitals. The data is fed back to the wards and departments at the weekly DRIPS (Data, Review, Improvement, Plot the dots, Share) meetings and by e-mail after the meetings. This crucial role has been undertaken by the Medical Director's Support Team.

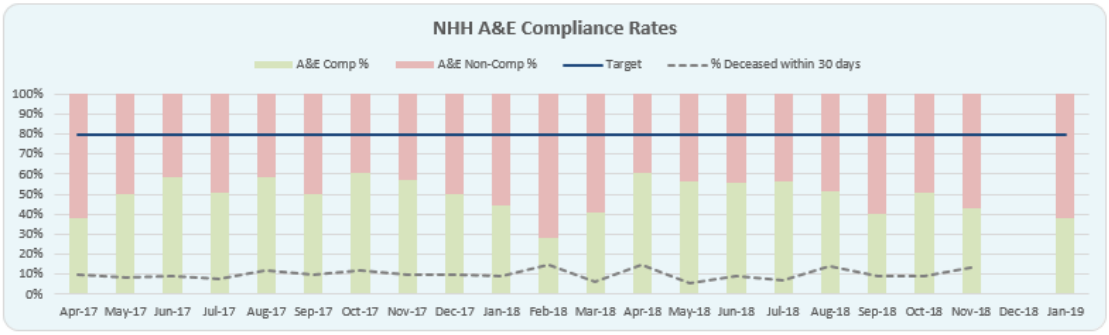
While the ABC Sepsis process is bedding in on the wards at NHH and RGH, the data for the wards is taken form the Outreach databases for NHH and RGH and from ABC Sepsis database for YYF wards.

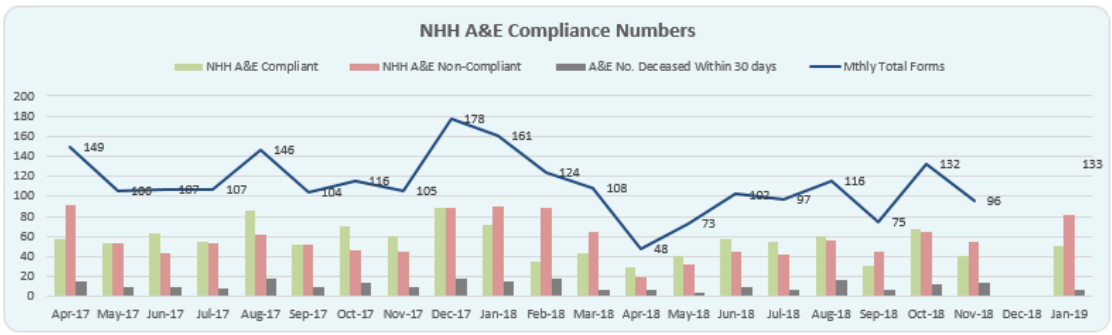
The data for the Emergency Departments is all from the ABC Sepsis database. It should be noted that ABC Sepsis applies the criteria for compliance with the sepsis 6 bundle within 1 hour robustly.

DATA ENTRY FOR NHH IS NOT COMPLETE FOR DECEMBER 18 DUE TO STAFF SICKNESS BUT THIS IS NOW BEING ADDRESSED. THE MOST RECENT DATA IS BEING ENTERED FIRST. RGH JANUARY 19 DATA IS UNRELIABLE AS ALL ELMENTS OF THE SEPSIS 6 BUNDLE HAVE NOT BEEN ENTERED.

**Emergency Departments:**

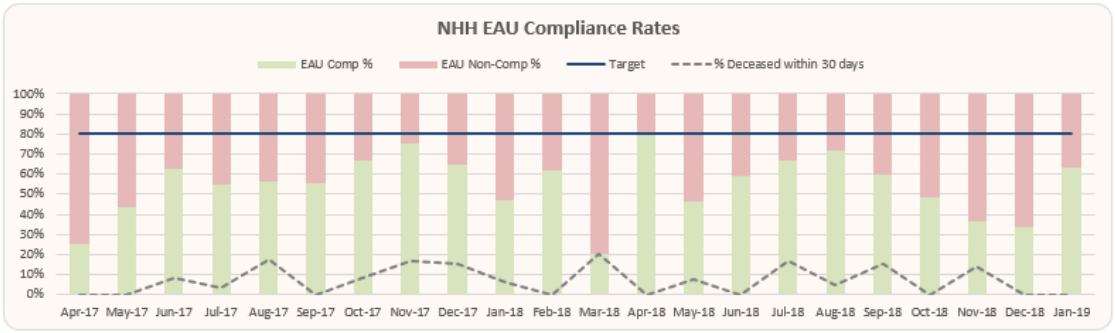
***Nevill Hall Hospital A and E*:** The number of forms at NHH has been maintained over the winter to date, but compliance has dropped off. This is being addressed within the department, through discussion with the nurses about completing the form with all the necessary information, and with the doctors about the delays in the prescribing of antibiotics.

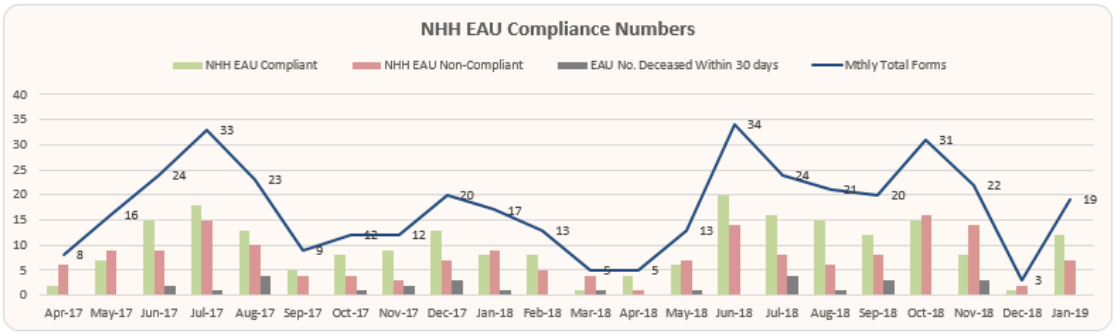


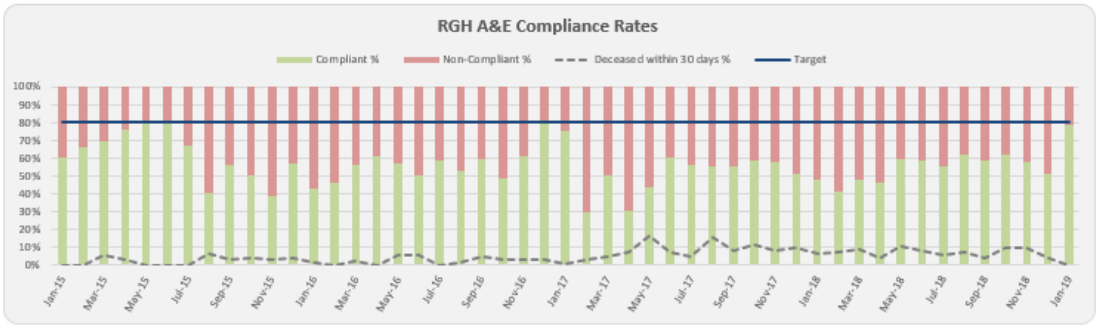

For those patients not given the sepsis 6 within 1 hour, the bundle is usually completed within 1-2 hrs, which is still good care. The factors that are barriers to the completion of the bundle vary at NHH, but it is usually a delay in the prescription of antibiotics.

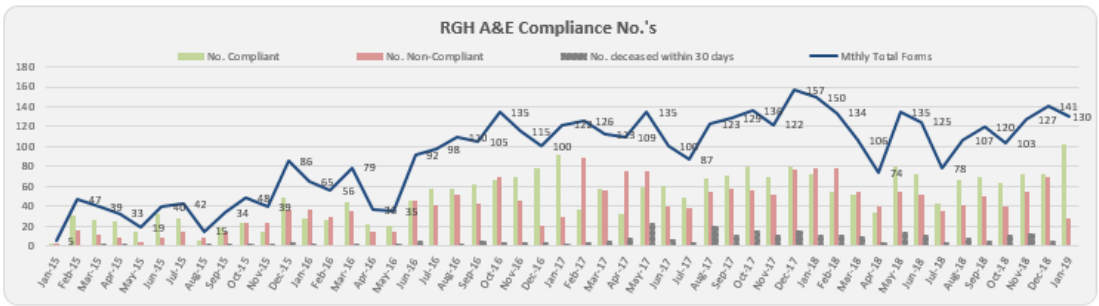
***EAU at NHH*** is now engaged with ABC sepsis. Both the recognition and response to sepsis have improved in the department, and the DRIPS meetings are well attended.



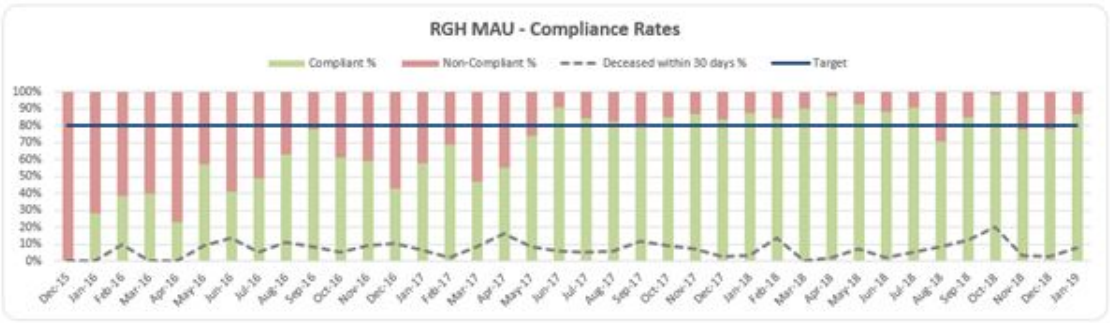



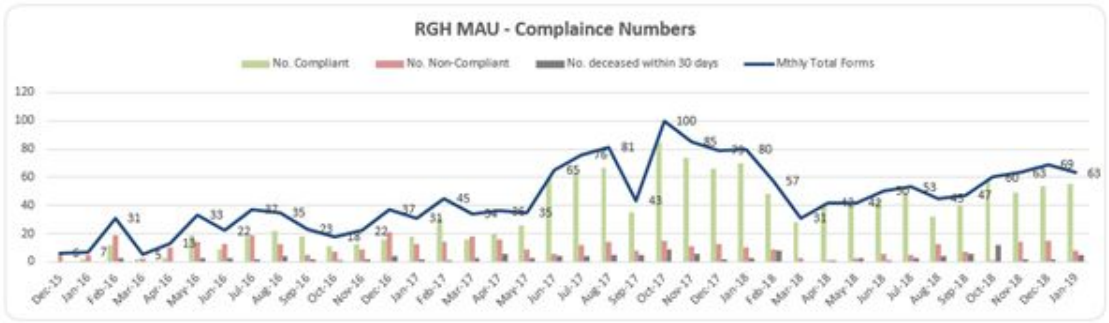

***Royal Gwent Hospital A and E*:** The number of forms from RGH A and E has been high to date over the winter, with good compliance and regular meetings, although it has not always been possible for mant front line nurses to attend the meetings.



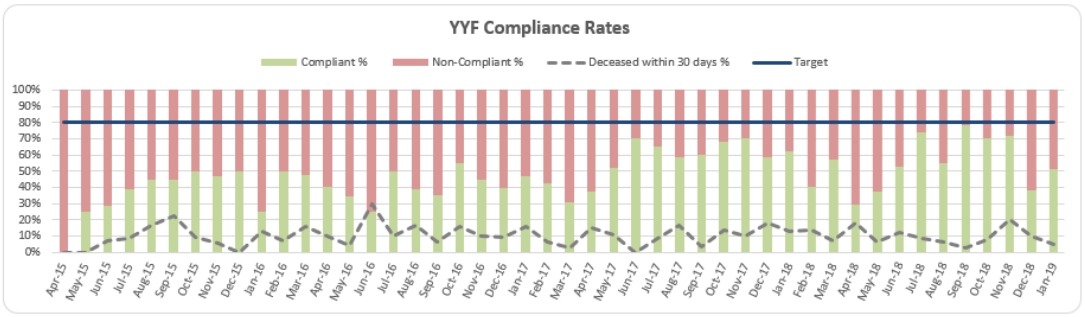



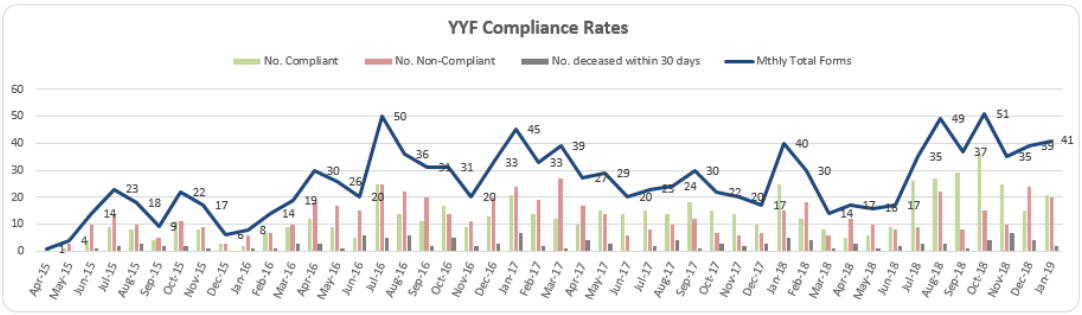
***MAU at RGH*** is fully engaged with ABC Sepsis. The number of forms completed has improved over the summer period and been maintained into the winter, and the compliance has remained high.




***Ysbyty Ystrad Fawr*:** ABC Sepsis covers the whole of YYF, wards and Emergency Department. The Vital Pac Pilot started at YYF in September 2017, and the ABC Sepsis Team have worked closely with the IT Staff so that the system supports the recognition of deteriorating patients on the wards. There have been issues with the implementation of vital pac, which the Divisions have escalated and responded to. The learning from the implementation was used to inform the roll out of vital pac at NHH.




**Community:**

Work is continuing in a range of areas within the community to implement a change in practice to use NEWS as a common language. In some areas, this has meant providing equipment to enable healthcare professionals to take observations, and doing additional training.

The 1000 Lives Team are now supporting this work, with a Wales Wide learning set in March 2019, and a number of tools to support the roll out.

**Wards at NHH and RGH:**

On the wards, the number of patients identified as triggering per ward with sepsis has been low – 1 or 2 per week. ABC Sepsis is therefore now focussing its work on the wards on the deteriorating patient generally.

The sepsis screening tool, developed by ABC sepsis with the Emergency Departments, has been rolled out to all the wards in acute hospitals from April 2017. Data taken from the Outreach databases for NHH and RGH showed that the wards were not using the screening tool on deteriorating patients, although it would support them to initiate the treatment for sepsis rapidly on the ward. The Lead Nurse for sepsis, with support from the Divisional Nurses, was meeting regularly with the wards to review the Outreach database against the sepsis screening tools completed by the wards. However, the Lead Nurse for sepsis has not been at work since

October, and as there is no clinical cover for her role in ABC Sepsis, it has not been possible to sustain this work in her absence.

3.1.2. ABC Sepsis Steering Group

The ABC Sepsis Steering Group has co-ordinated preparation for the Peer Review of Acute Deterioration in ABUHB. This took place in September and October 2018. All hospitals in Wales will be peer reviewed by the end of 2019.

The feedback from the peer review for ABUHB was very positive. It confirmed that ABUHB is the trail blazer in Wales in this area. There is good join up between the Corporate team and the front line on sepsis, which means that the whole Health Board is following one Policy on the Deteriorating Patient. ABUHB is able to provide robust data on the management of sepsis, initially from the Outreach Database, completed by the Outreach Teams at NHH and RGH, and now from the comprehensive ABC sepsis database, completed by the Medical Director's Support Team. The support from the Medical and Nursing Directors for ABC Sepsis has been crucial, from the video they made at the start of ABC Sepsis, through to attendance at workshops over the following years to encourage the work. The DRIPS meetings, held weekly in all frontline areas, with clinical leadership from Paul Mizen and Jan Barrett, have led to these being a template for the rest of Wales. There are also good links into associated streams of work, like Health Care Associated Infections and Antimicrobials.

The Peer Review Team action plan covered five areas: Structure and process to co-ordinate all the elements of acute deterioration, moving towards a Core Site Safety Team 24/7, improved focus on Acute Kidney Injury, Continued learning from vital pac and a more integrated approach to training on acute deterioration across the whole of ABUHB. The high level action plan has been developed and approved by the Executive Board.

## 3.2 Reducing C Diff and Healthcare Associated Bacteraemia

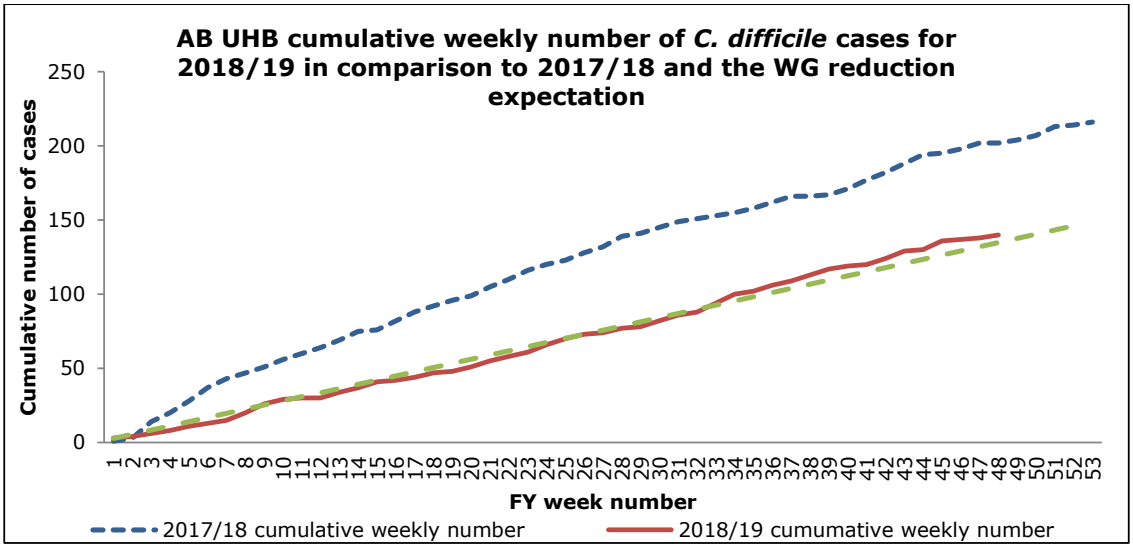
**Aim: Welsh Government 2018/19 HB reduction target for C *difficile*, Staph *aureus (MRSA and MSSA)* and E*Coli* bacteraemia are:**

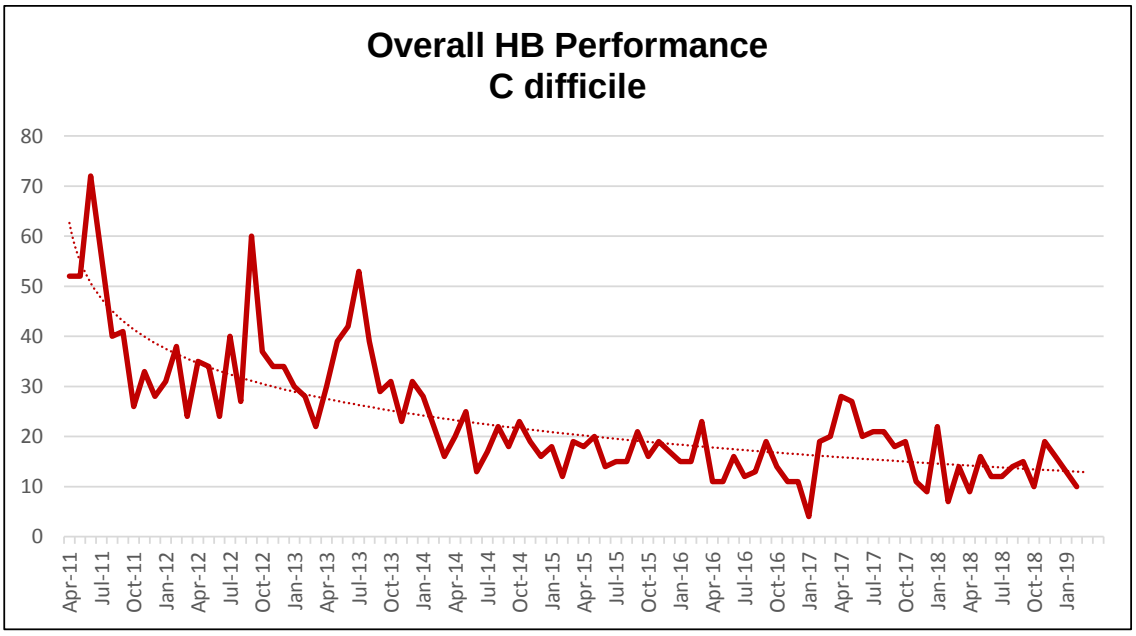
- **C difficile - 25 per 100,000 population**
- **Staph aureus – 19 per 100,000 population**
- **E Coli – 61 per 100,000 population**

**Two new targets have been added this year by Welsh Government:**

- **Klebsiella – no more than 91 cases**
- **Pseudomonas *aeruginosa* - no more than 28 cases**

### 3.2.1. Total C diff. Cases



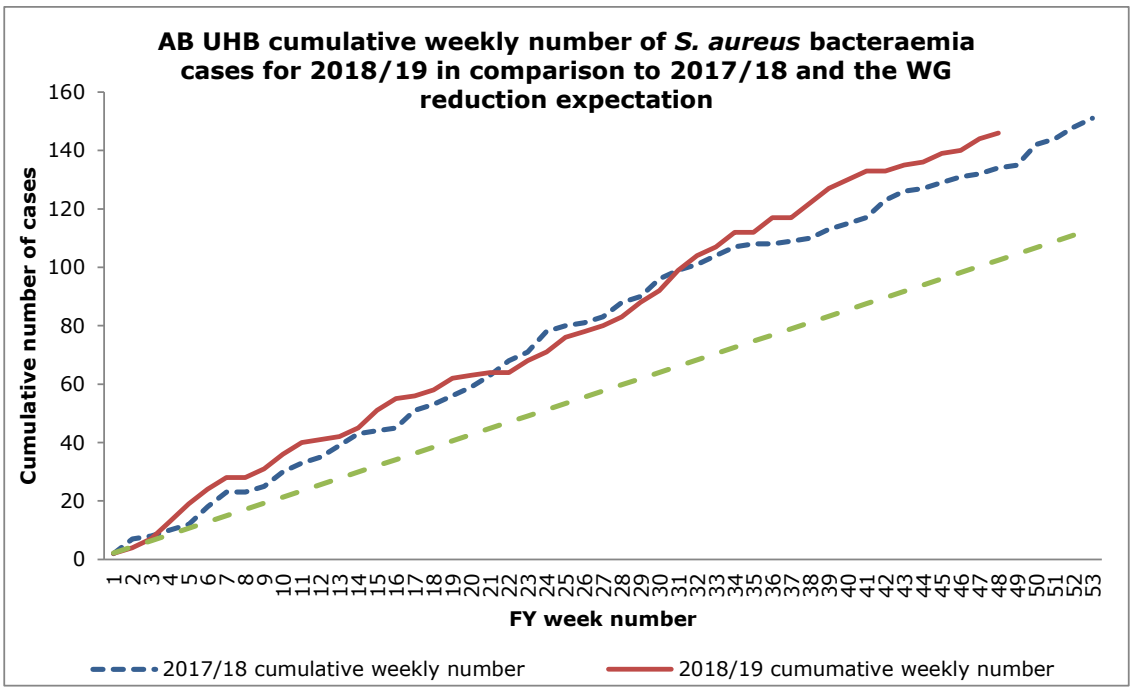

Good progress has been made in relation to C.difficile but the Health Board is just above the number of cases to achieve the required reduction (25.00 per 100K population) with a current rate of 26.77 per 100K

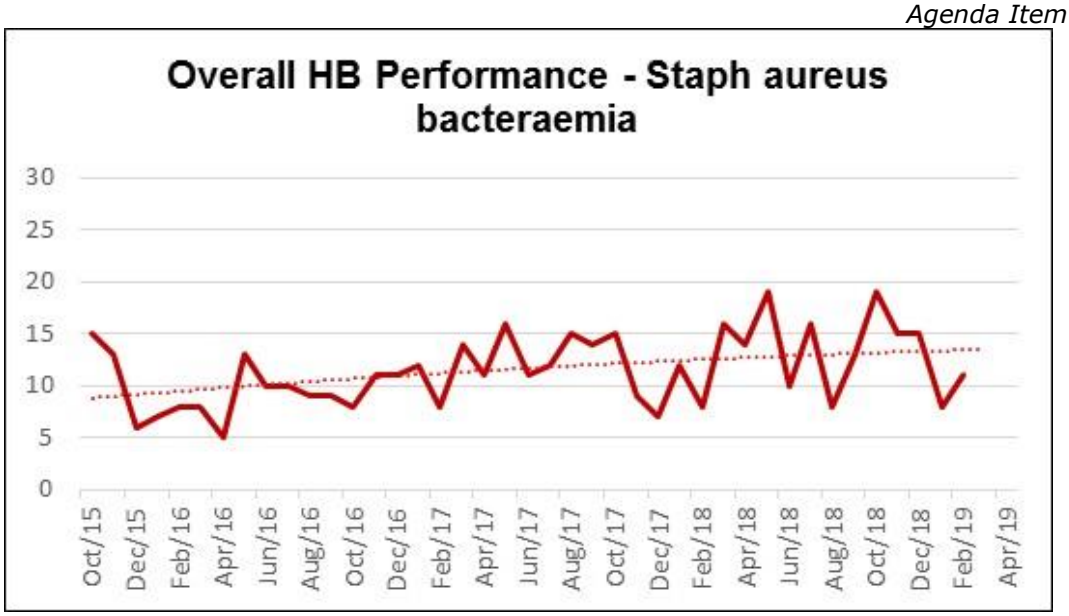
population. The Health Boards strategy to reduce cases is heavily reliant on hospital cleans using Hydrogen Peroxide Vapour (HPV).

A second important intervention relates to antibiotic guidelines. A change of guidelines utilising co-trimoxazole as the broad spectrum antibiotic of choice was introduced in Cardiff & Vale and Cwm Taff UHBs approximately 2 years ago – which may have contributed to a further reduction in *C. difficile* cases. This change in antibiotic use was discussed at ABUHB Infection Control Committee at the time but the proposal was rejected due to safety concerns around co-trimoxazole use.

Co-trimoxazole use is now being encouraged by one of the Welsh Government Tier 1 antimicrobial prescribing targets, therefore a programme of guideline review is under way by the Antimicrobial Guideline Group. Some moves to co-trimoxazole have already been made in 2017 and 2018 with further changes planned.

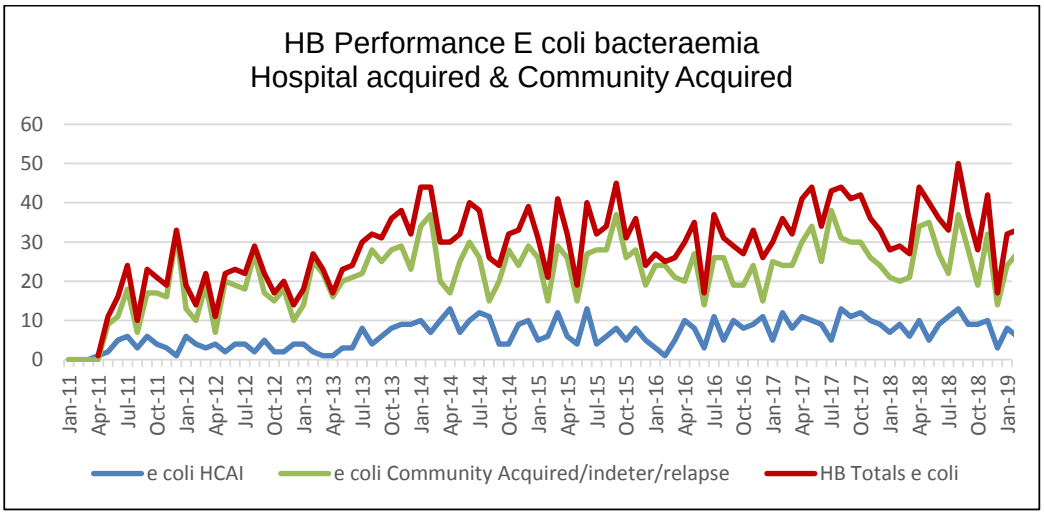
### 3.2.2. Total MRSA and MSSA Cases

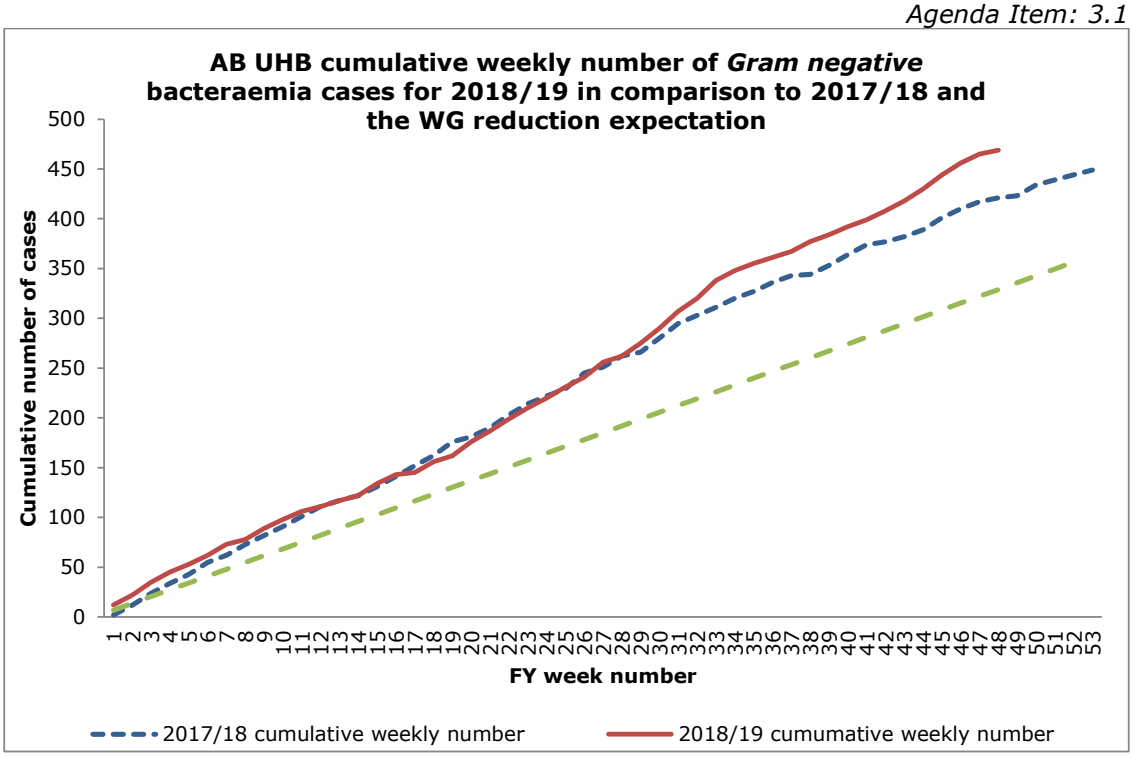





The Health Board has seen a 7% increase in staphylococcus aureus blood stream infections. This is clearly an issue cross Wales as none of the Health Boards will achieve the target this year. It is pleasing to note however that there has been a 30 % decrease in Methicillin-resistant staphylococcus aureus. ***Hospital*** acquired staph aureus blood stream infections are associated with poor IV line and urinary catheter management. High risk central lines are implicated and in light of this a business case has been approved to appoint two nurses to insert and manage such high risk lines. ***Community*** acquired staph aureus can be associated with poor ulcer management. In light of this a working group including Professor Keith Harding an expert in ulcer management will review best practice and confirm care pathways.

### 3.2.3. E Coli






EColi bloodstream infection reduction is a relatively new target with a vast majority of cases acquired in the community. EColi bloodstream infections are mostly associated with urinary tract infections although a significant amount are related to the hepatobiliary and respiratory tract.

Public Health Wales have provided comprehensive standards in relation to UTI prevention and management.

Public Health Wales is monitoring Health Boards closely for appropriate urinary tract infection and urinary catheter management in Primary Care as there is a clear evidence base in which to take this agenda forward. Antimicrobial pharmacy will play a key role in the appropriate management of urinary tract infections (UTIs) in Primary Care and the Health Board is supporting this agenda via the appointment of a Consultant Pharmacist and three further antibiotic pharmacists.

Work has commenced introducing draft all-Wales primary care UTI guidance, which was implemented locally in March ahead of national adoption.

A second important piece of work relates to the appropriate use and management of urinary catheters. A working group headed by consultant nurses for continence and infection control is developing and implementing evidence based care pathways and undertaking root cause analysis reviews when issues are identified.

Individual case reviews for EColi in hospital have commenced but not enough reviews have been undertaken to establish any common themes.

It is clear that community acquired infections need focus and scrutiny. As well as benefiting the patient, improving standards in community settings will have a positive effect in prevention secondary care admissions. In light of this a primary care infection prevention nurse has just been appointed to drive this important agenda forward.

### 3.2.4. Klebsiella – Number of cases

This is a new target and there is an expectation that the Health Board will reduce cases by 10%

*Klebsiella* species are the most frequently found agents in hospital outbreaks due to multidrug-resistant Gram-negative bacteria. *Klebsiella* species may reside in the bowel, nose, and trachea and on the skin, and are readily transmitted between patients. Contamination of gloves and gowns occurs in 14% of healthcare worker–patient interactions and the organisms survive for more than 2 hrs on hands. In the environment, *Klebsiella* species have been detected from sources such as sinks, room surfaces, door handles, thermometers and liquid soap. Factors for transmission include length of stay, urinary catheter use and high degree of dependency.

Whilst much has been written in peer review journals about this bacteria, the articles relate to hospital outbreaks.
No ABUHB hospital outbreaks have been identified – all cases are sporadic with 4 acquired in the community and one in hospital. The lack of hospital acquired cases is – in all probability- linked to infection control precautions implemented to reduce other pathogens such as C.difficile and MRSA such as hand hygiene campaigns, HPV cleaning etc.

Again, Klebsiella is associated with urinary tract infections, so the work needed in Primary Care to reduce Ecoli blood stream infection should positively impact on Klebsiella acquisition.

### 3.2.5. Pseudomonas *aeruginosa* – number of cases in

This is a new target with an expectation that the Health Board will reduce the number of cases by 10%. The Health Board is currently running at a 10% reduction.

Again, the work relating to EColi reductions in Primary Care should positively impact the numbers of cases.

### 3.2.6. Prescribing Performance

National prescribing indicators for antimicrobial stewardship support two of the Welsh Government's targets for the reduction of healthcare associated infections:

• A 50% reduction in the number of E. coli bacteraemia cases by March 2021 against a baseline rate of 2015–2016.

• An overall reduction in inappropriate prescribing of antimicrobials of 50% by 2021.

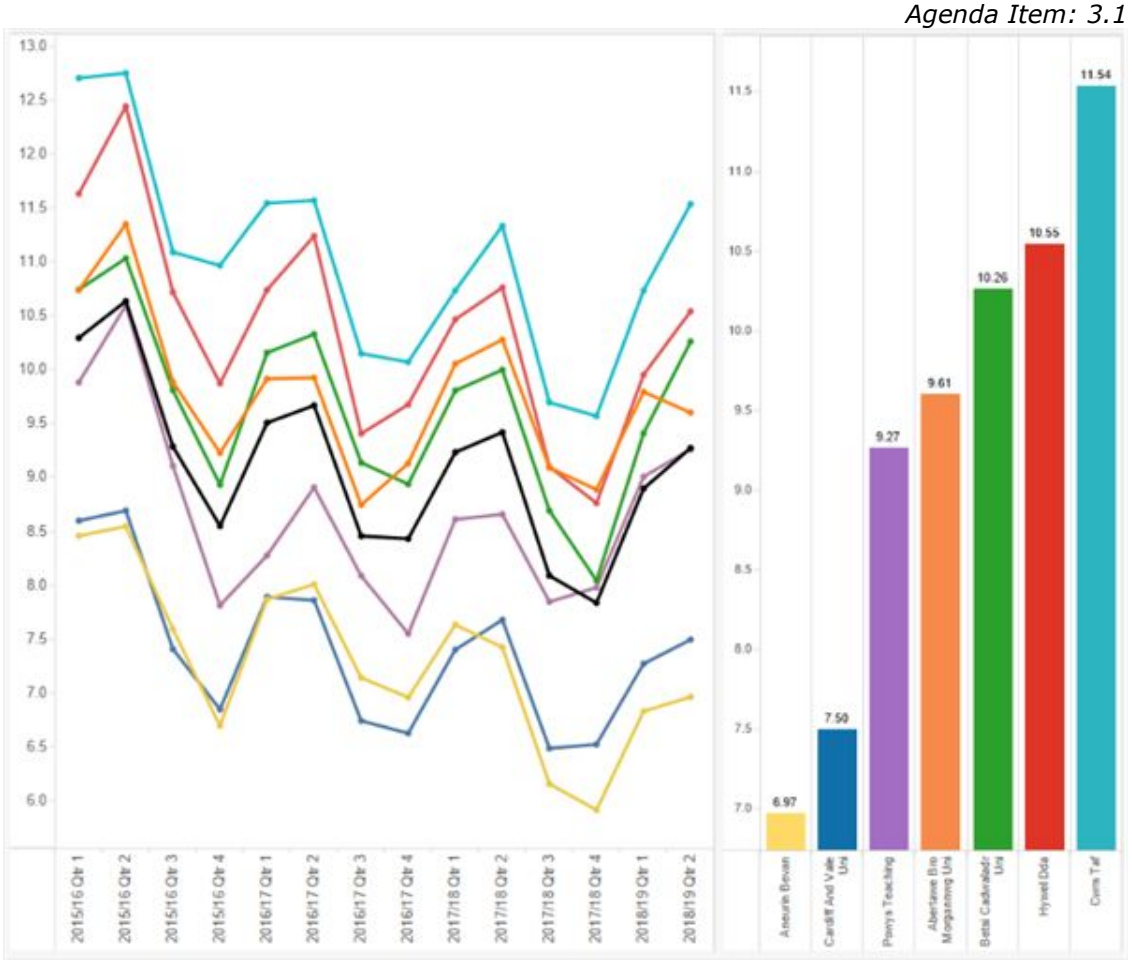
**Primary Care Prescribing**

The Delivery Framework includes a performance measure for the 4C (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin) 'high risk' antibiotics.

1. 4C antimicrobials as a % of Antibacterial Items.
   Target for 2018–2019: Absolute measure ≤7% or a proportional reduction of 10% against a baseline of data from April 2016–March 2017.

   The term '4C antimicrobials' refers collectively to four broad-spectrum antibiotics. The use of simple generic antibiotics and the avoidance of these board-spectrum antibiotics preserve them from resistance and reduce the risk of *C. difficile*, MRSA and resistant urinary tract infections.

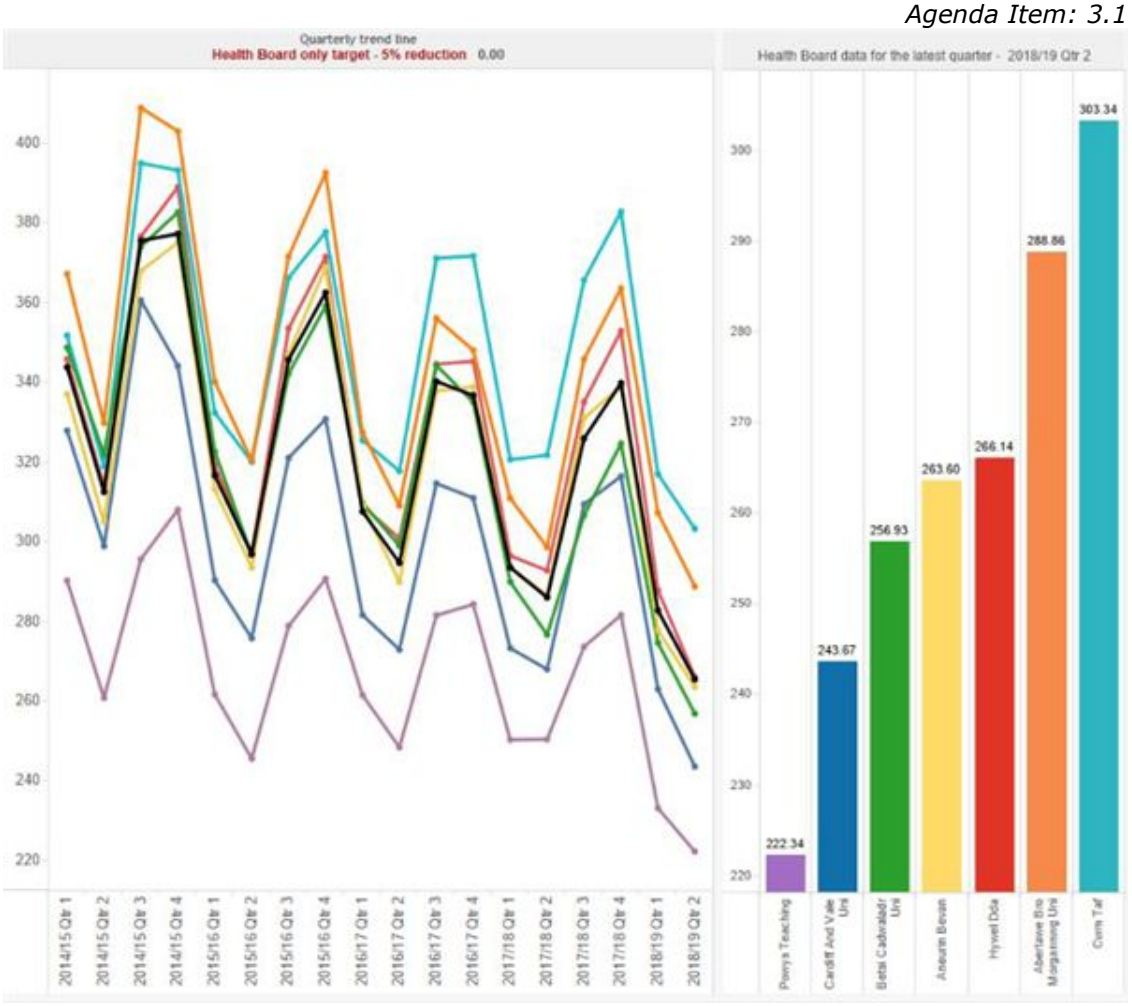
   As can be seen from the performance data for Qtr 1 below, the Health Board has the lowest use of these antibiotics in Wales and achieves the absolute target of ≤7%.



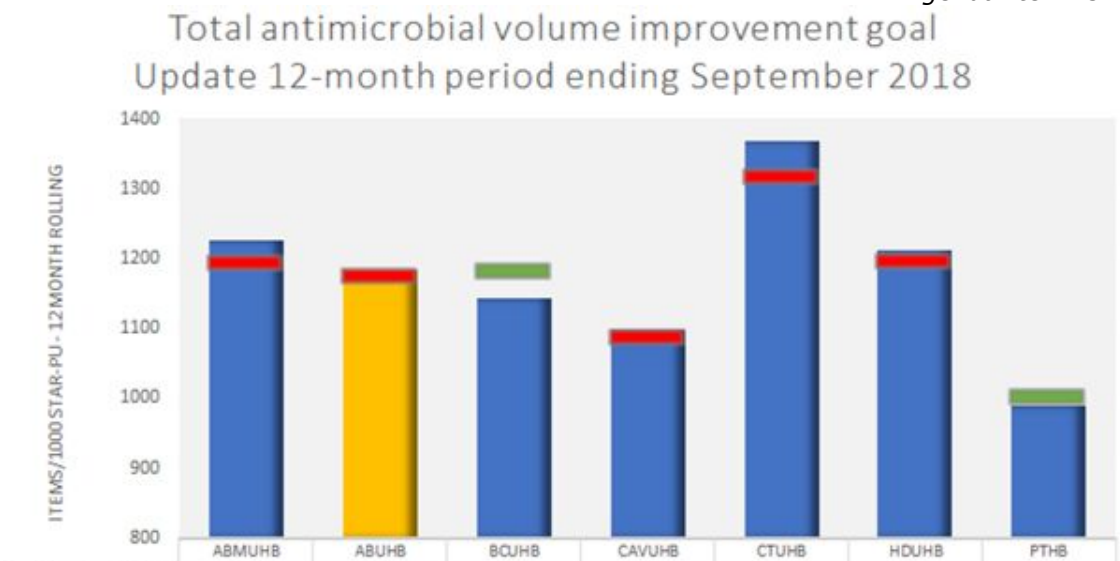

WHC 2018 (20) identifies the following performance targets.

2. Total antibacterial items per 1,000 STAR-PUs (Specific Therapeutic group Age-sex Related Prescribing Unit) Target for 2018–2019: A reduction of 5% against a baseline of data from April 2016–March 2017.

   The Health board has the fourth lowest prescribing of antibiotics in Wales. It should be noted that seasonal variation is demonstrated in the data although there is a downward trend.




Whilst the 5% reduction target is set against the annual period April 2016-March 2017, data is being reported quarterly to show progress. Public Health Wales have recently taken over reporting of these data which demonstrate a 4.3% reduction to the end of quarter 2 based on a rolling 12-month period, although concerns have been expressed around data validity.




| | ABMUHB | ABUHB | BCUHB | CAVUHB | CTUHB | HDUHB | PTHB |
|---|---|---|---|---|---|---|---|
| Period ending 09/2018 | 1227 | 1183 | 1144 | 1098 | 1369 | 1212 | 988 |
| 5% reduction target | 1191 | 1174 | 1181 | 1085 | 1315 | 1194 | 1000 |

The AWTTC SPIRA platform reports the same data and indicates 10.21% and 13.02% reductions for quarter 1 and 2 respectively compared to the same time periods in 16/17.


**Latest Qtr Achievement vs Target Period**
**4C Antibacterial Items % of all Antimicrobials**

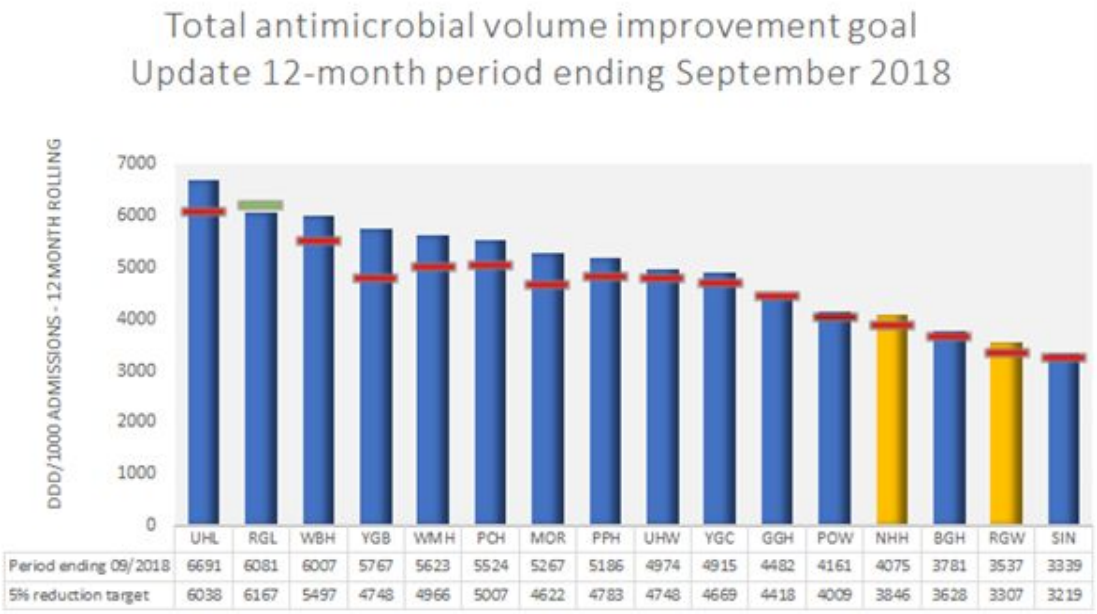
| | Abertawe Bro Morgannwg Uni | | Aneurin Bevan | | Betsi Cadwaladr Uni | | Cardiff And Vale Uni | | Cwm Taf | | Hywel Dda | | Powys Teaching | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 201609 | 201809 | 201609 | 201809 | 201609 | 201809 | 201609 | 201809 | 201609 | 201809 | 201609 | 201809 | 201609 | 201809 |
| Values | 9.93 | 9.61 | 8.01 | 6.97 | 10.33 | 10.26 | 7.87 | 7.50 | 11.57 | 11.54 | 11.24 | 10.55 | 8.91 | 9.27 |
| % Change | | -3.25% | | -13.02% | | -0.66% | | -4.64% | | -0.28% | | -6.20% | | 3.96% |

## Secondary Care Prescribing

### 1. Secondary care reduction in total volume measured as DDD/1000admissions

Public Health Wales have provided baseline data for the 2017/18 financial year to show Health Boards their baseline position. The

yellow columns in the graph below shows the estimated total antimicrobial volume for the acute hospitals in ABUHB for the financial year 2017/18. The red bars show the 5% reduction target (based on the total volume for the baseline year of 2016/17).

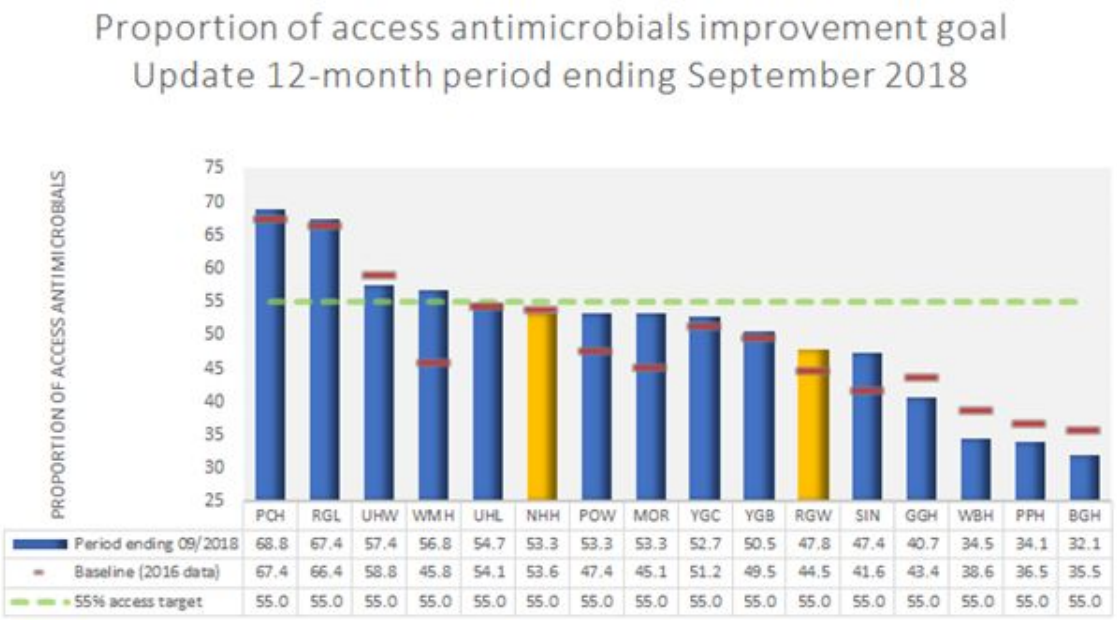



| | UHL | RGL | WBH | YGB | WMH | POH | MOR | PPH | UHW | YGC | GGH | POW | NHH | BGH | RGW | SIN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Period ending 09/2018 | 6691 | 6081 | 6007 | 5767 | 5623 | 5524 | 5267 | 5186 | 4974 | 4915 | 4482 | 4161 | 4075 | 3781 | 3537 | 3339 |
| 5% reduction target | 6038 | 6167 | 5497 | 4748 | 4966 | 5007 | 4622 | 4783 | 4748 | 4669 | 4418 | 4009 | 3846 | 3628 | 3307 | 3219 |

RGH and NHH have demonstrated 1.6% and 0.7% increases respectively. However it should be noted that similar increases in total usage have also been seen in other Health Boards when introducing guideline changes in an attempt to achieve the next target.

2. **Increase the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD) OR increase by 3% from baseline 2016 calendar year**

   The yellow columns in the graph below shows the proportion of access antimicrobial usage for the acute hospitals in ABUHB for the financial year 2017/18. The red bars shows the 2016 calendar year baseline data.




| | PCH | RGL | UHW | WMH | UHL | NHH | POW | MOR | YGC | YGB | RGW | SIN | GGH | WBH | PPH | BGH |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Period ending 09/2018 | 68.8 | 67.4 | 57.4 | 56.8 | 54.7 | 53.3 | 53.3 | 53.3 | 52.7 | 50.5 | 47.8 | 47.4 | 40.7 | 34.5 | 34.1 | 32.1 |
| Baseline (2016 data) | 67.4 | 66.4 | 58.8 | 45.8 | 54.1 | 53.6 | 47.4 | 45.1 | 51.2 | 49.5 | 44.5 | 41.6 | 43.4 | 38.6 | 36.5 | 35.5 |
| 55% access target | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 | 55.0 |

For Nevill Hall (NHH), the proportion of access antimicrobials decreased slightly from 53.6% in the baseline year to 53.3% in 2017/18 but remains near the 55% target. For Royal Gwent (RGW), the proportion of access antimicrobials increased from 44.5% in the baseline year to 47.8% in 2017/18, so has achieved the 3% increase target.

### 3.3 Hospital Acquired Thrombosis

A Hospital Acquired Thrombosis (HAT) is defined as:

> ***"Any venous thromboembolism (VTE) arising during a hospital admission and up to 90 days post discharge".***

There is no target HAT rate, as the rate in a hospital will vary according to the casemix of patients. Even if the patient is correctly risk assessed and given all the correct thromboprophylaxis, they can still develop a HAT. In these cases it is recognised that the HAT was unavoidable. The aim is that all cases of HAT will have been correctly risk assessed and given the correct thromboprophylaxis and therefore were unavoidable.

All cases of HAT that are identified are sent to the patient's Consultant for review. The number of reviews completed by the Consultants has increased greatly over the last year, through improvements to the process, which means the data is now more robust. All cases that are identified as potentially preventable, as the correct thromboprohylaxis was not given, are taken to the Thrombosis Group, to ensure that learning happens at all levels from the individual, to the team, to the

organisation. The Group sent out a HAT Newsletter across ABUHB to disseminate the data on HATs by specialty and to re-inforce the key messages about preventing VTE and correct thromboprohylaxis.

The data for the T and O HATS has been analysed by Consultant and by procedure. This data will be anonymised and sent out to all T and O Consultants. Each Consultant will know which line represents their individual data, so that they can see how they compare to other Consultants. The T and O Consultants are changing their thromboprophylaxis, in line with one of the regimens agreed by NICE. The number of HATs is being monitored to see whether this change in thromboprophylaxis impacts on the number of HATs.

The data below shows the number of cases of HAT in ABUHB in 2017/8 and 2018/19 to date. The data is derived from combining RADIS data with discharge data.

| April 2018 | May 2018 | June 2018 | July 2018 | Aug 2018 | Sept 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | 11 | 14 | 16 | 12 | 9 | 19 | 17 | 25 | 26 | | | |
| **Quarter 1 Total** | | **38** | **Quarter 2 Total** | | **37** | **Quarter 3 Total** | | **61** | **Quarter 4 Total** | | | |
| **April 2017** | **May 2017** | **June 2017** | **July 2017** | **Aug 2017** | **Sept 2017** | **Oct 2017** | **Nov 2017** | **Dec 2017** | **Jan 2018** | **Feb 2018** | **Mar 2018** | **Total** |
| 19 | 14 | 16 | 20 | 13 | 16 | 12 | 16 | 18 | 13 | 14 | 25 | **196** |
| **Quarter 1 Total** | | **49** | **Quarter 2 Total** | | **49** | **Quarter 3 Total** | | **46** | **Quarter 4 Total** | | **52** | |

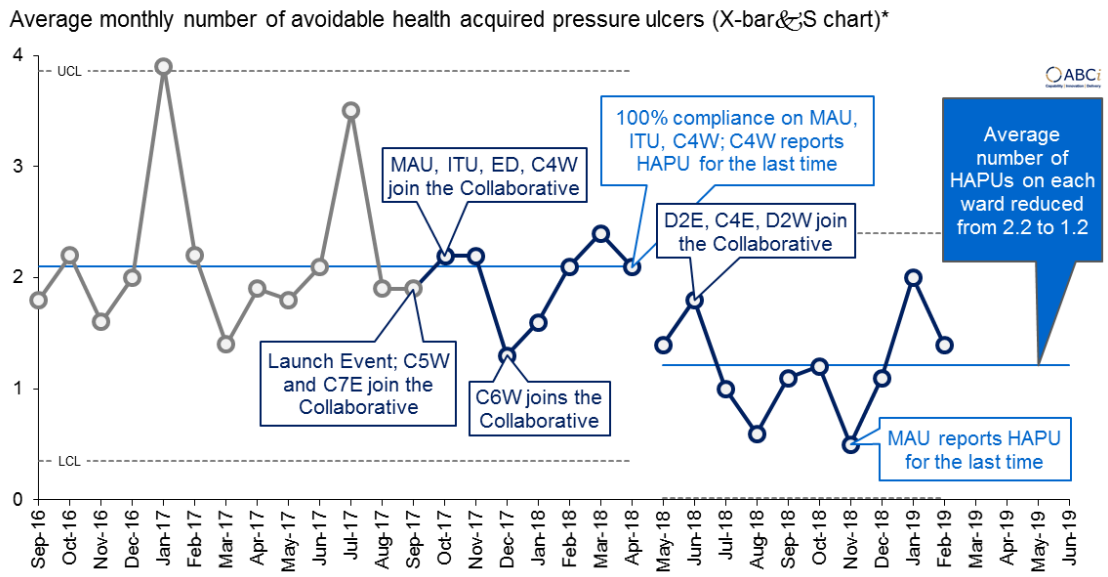
### 3.4 Pressure Damage

**Aim: Aim: Zero Tolerance, with interim targets set by the Health Board to achieve 50% reduction in hospital acquired pressure damage on wards participating in the Improvement Collaborative and 30% reduction in community settings between April 2019 and September 2020**

A pressure ulcer reduction collaborative is in place targeting wards on the Royal Gwent Hospital site. Learning sessions have focussed on PDSA

cycles based on evidence based pressure ulcer reduction guidelines. In addition to attending the pressure damage collaborative, wards participating in the programme have Nominated staff to attend two rolling training programmes on 'Coaching for Improvement' and 'Measurement for Improvement'. By March 2019, the ABCi had trained 26 ward team members as 'Improvement Coaches' and 8 staff as 'Measurement Leads' to help to further improve and sustain achievements.

As at March 2019, 12 wards at RGH have been participating on the programme for between 17 and 8 months. The different lengths of time participating in the programme mean that some wards have made bigger improvements than others, varying from 80% to 20% reduction in pressure damage. However, ward teams now have well established processes of care and assessment and were able to go through the busy winter pressures without an increase in pressure damage. **Altogether, the average reduction of HAPUs across the collaborative wards is about 45%.**




* Average taken over MAU, ED, ITU, C4W, C5W, C7E, C6W, D2E, C4E and D2W and analysed using statistical process control methods. Excluded from the computation are the 2 collaborative RGH wards who do not yet show evidence of improvement on the individual level. Note that for 83% of the collaborative wards we provide evidence of statistically significant improvement.

All grade 3 &4, and unclassified pressure damage is systematically reviewed in all settings, with learning from the review taken back to the wards/Nursing Homes. The responsibility for reviews has transferred to divisions - with oversight by Corporate Nursing.

Significant investment has been made in pressure relieving mattresses, with use monitored to ensure at risk patients receive the most appropriate mattress at the right time. It should be noted that the new pressure relieving mattresses have significant benefits when compared to older mattresses. The "hybrid" mattresses are used as "normal" mattresses until pressure ulcer risk is identified. At this point a pump is added to the mattresses converting it to an air mattress. The benefits in terms of patient comfort, prevention of back injuries and nurses time cannot be underestimated.

Data cleansing is in place to ensure that significant Pressure Ulcers are not double counted and classification is accurate. Review of access to the Tissue Viability Service now ensures that significant pressure damage is reviewed by a member of the team in all settings. The numbers of pressure ulcers (all grades) are now reported to Welsh Government on a monthly basis.

An action plan to drive the reduction of community acquired pressure damage is in place to reduce pressure damage by 30%. A pressure ulcer reduction project has commenced in Nursing Homes in collaboration with the Chief Nursing Office in Welsh Government.

**Next Steps to Maintain a reduction trajectory**.

- Increase he number of wards participating in the collaborative, including wards from NHH and YYF
- Phased approach to embed the systematic review of pressure damage across the care home sector.
- Development of new Dashboard system to make data available from the ward to the Board along with other health board quality and patient safety metrics.
- The use of technology using hand held scanners to assess a patients risk from pressure damage
- Review of Tissue Viability Education across the Care Home sector
- Continue to identify funding to extend the number of hybrid mattresses across the organisation

## 3.5 Stroke Care - Stroke 30 day mortality against Top Peer

**Acute Stroke Quality Improvement Measures Summary February 2019**

| 72 Hour Pathway Quality Improvement Measures | Aspiration | Aneurin Bevan | Abertawe Bro Morgannwg | | Betsi Cadwaladr | | | Cardiff & Vale | Cwm Taf | Hywel Dda | | | | All Wales |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Royal Gwent | Morriston | Princess of Wales | Bangor | Glan Clwyd | Wrexham Maelor | UHW | Prince Charles | Bronglais | Withybush | Glangwili | Prince Philip | |
| **1. < 4 Hours Care Performance Indicator** | 95% | 59.6% | 70.3% | 14.3% | 55.6% | 44.0% | 52.3% | 41.0% | 40.0% | 100.0% | 76.5% | 80.0% | 100.0% | 54.7% |
| 1a - Direct Admission to Acute Stroke Unit | 95% | 61.7% | 75.0% | 14.3% | 53.8% | 44.0% | 52.3% | 44.7% | 38.8% | 100.0% | 66.7% | 76.9% | 100.0% | 53.7% |
| 1b - Swallow Screening | 95% | 82.2% | 81.1% | 80.0% | 96.0% | 87.5% | 82.1% | 51.3% | 75.0% | 100.0% | 100.0% | 100.0% | 100.0% | 81.2% |
| **2. < 12 Hours Care Performance Indicator** | 95% | 100.0% | 100.0% | 95.2% | 100.0% | 92.0% | 97.7% | 94.9% | 98.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% |
| 2a - CT Scan | 95% | 100.0% | 100.0% | 95.2% | 100.0% | 92.0% | 97.7% | 94.9% | 98.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% |
| **3. < 24 Hours Care Performance Indicator** | 95% | 97.9% | 86.5% | 52.4% | 81.5% | 68.0% | 75.0% | 66.7% | 60.0% | 75.0% | 70.6% | 80.0% | 58.3% | 74.3% |
| 3a - Assessed by Stroke Consultant | 95% | 97.9% | 89.2% | 52.4% | 88.9% | 68.0% | 75.0% | 74.4% | 70.0% | 75.0% | 100.0% | 100.0% | 75.0% | 80.4% |
| 3b - Assessed by Stroke Nurse | 95% | 100.0% | 100.0% | 95.2% | 92.6% | 100.0% | 97.7% | 87.2% | 84.0% | 100.0% | 88.2% | 93.3% | 100.0% | 94.2% |
| 3c - Assessed by One of OT, PT, SALT | 95% | 100.0% | 94.6% | 95.2% | 92.6% | 100.0% | 95.5% | 87.2% | 62.0% | 87.5% | 82.4% | 80.0% | 75.0% | 88.0% |
| **4. < 72 Hours Care Performance Indicators** | 95% | 97.9% | 97.3% | 100.0% | 96.3% | 100.0% | 95.5% | 92.3% | 90.0% | 100.0% | 100.0% | 80.0% | 58.3% | 93.9% |
| 4a - Formal Swallow Assessment | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 87.5% | 87.0% | 82.4% | 100.0% | 100.0% | 100.0% | 100.0% | 93.2% |
| 4b - OT Assessment | 95% | 97.5% | 96.9% | 100.0% | 100.0% | 100.0% | 97.7% | 97.3% | 95.9% | 100.0% | 100.0% | 78.6% | 66.7% | 96.1% |
| 4c - Physiotherapy Assessment | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.4% | 98.0% | 100.0% | 100.0% | 93.3% | 75.0% | 98.4% |
| 4d - SALT Communication Assessment | 95% | 100.0% | 100.0% | 100.0% | 93.3% | 100.0% | 94.7% | 96.4% | 89.6% | 100.0% | 100.0% | 100.0% | 71.4% | 95.3% |

>= Target  Within 10% below target  More than 10% below taget

**Acute Stroke Quality Improvement Measures Summary February 2019**

| Thrombolysis Quality Improvement Measures | Aspiration | Aneurin Bevan | Abertawe Bro Morgannwg | | Betsi Cadwaladr | | | Cardiff & Vale | Cwm Taf | Hywel Dda | | | | All Wales |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Royal Gwent | Morriston | Princess of Wales | Bangor | Glan Clwyd | Wrexham Maelor | UHW | Prince Charles | Bronglais | Withybush | Glangwili | Prince Philip | |
| **1. Access** | | | | | | | | | | | | | | |
| 1a - Percentage of All Strokes Thrombolysed | N/A | 14.9% | 37.8% | 4.8% | 14.8% | 4.0% | 11.4% | 12.8% | 16.0% | 25.0% | 23.5% | 20.0% | 16.7% | 16.4% |
| 2b - Percentage of Eligible Patients Thrombolysed | 100% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| **2. Time** | | | | | | | | | | | | | | |
| 1a - Thrombolysed Patients with Door-to-Needle <= 30 mins | 50% | 28.6% | 0.0% | 0.0% | 0.0% | 0.0% | 20.0% | 0.0% | 12.5% | 0.0% | 25.0% | 0.0% | 0.0% | 8.9% |
| 2b - Thrombolysed Patients with Door-to-Needle <= 45 mins | 90% | 71.4% | 14.3% | 100.0% | 25.0% | 0.0% | 40.0% | 0.0% | 37.5% | 100.0% | 25.0% | 33.3% | 50.0% | 33.9% |
| 3c - Thrombolysed Patients with Onset-to-Needle <= 90 mins | N/A | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 20.0% | 0.0% | 0.0% | 0.0% | 25.0% | 0.0% | 50.0% | 5.4% |
| 4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score | 100% | 100.0% | 92.9% | 100.0% | 100.0% | 100.0% | 100.0% | 80.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 96.4% |

>= Target  Within 10% below target  More than 10% below taget

Bwrdd Iechyd Aneurin Bevan Health Board

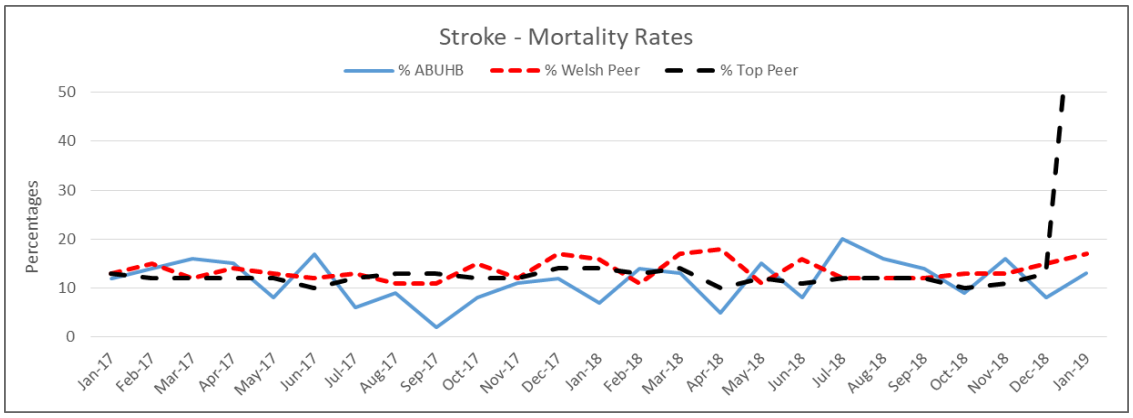
*Quality and Patient Safety Report*
*Quality and Patient Safety Committee*
*Agenda Item: 3.1*

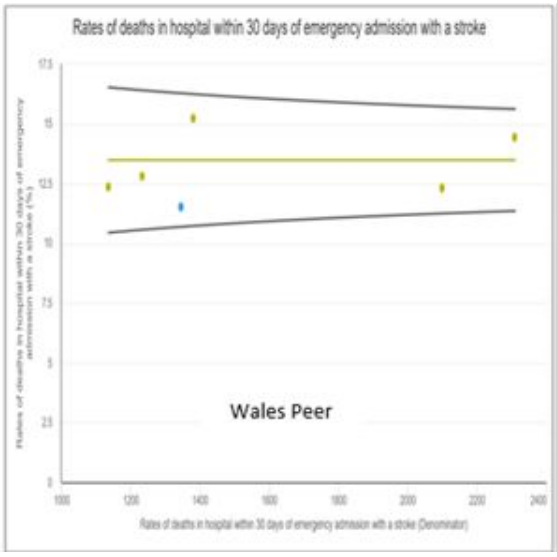
3.1

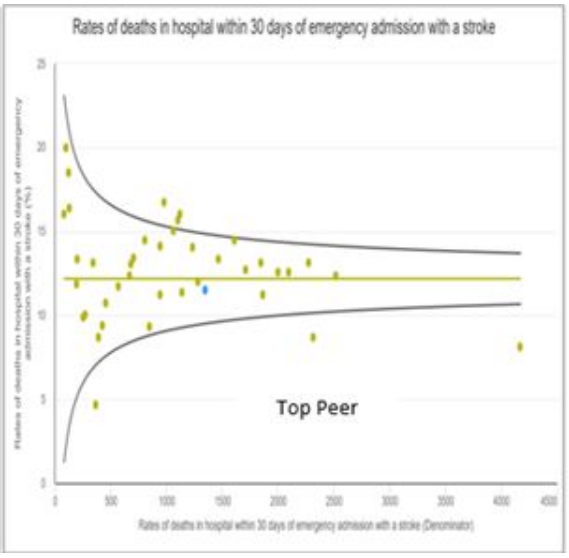
## Acute Stroke Quality Improvement Measures Summary February 2019



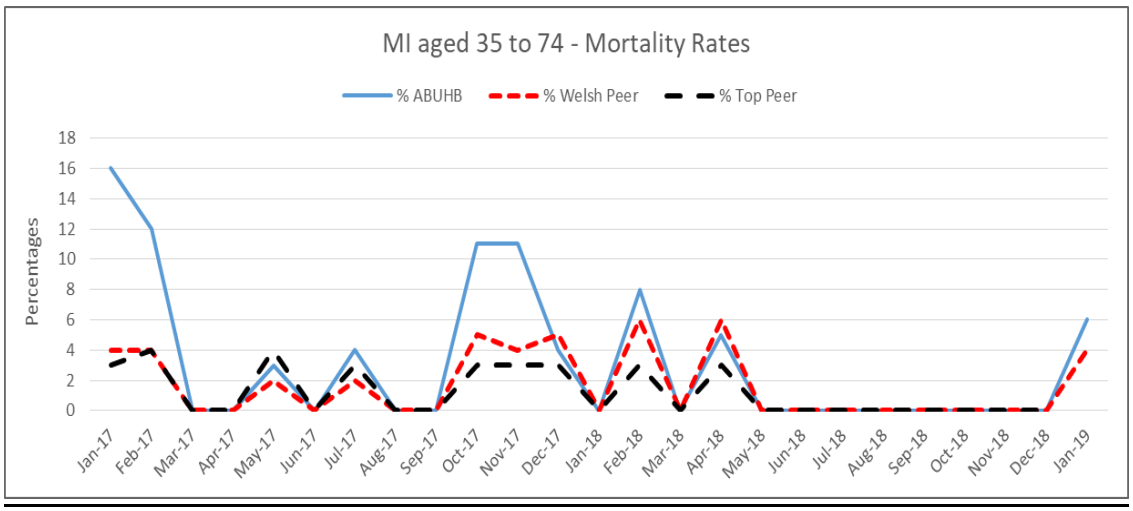


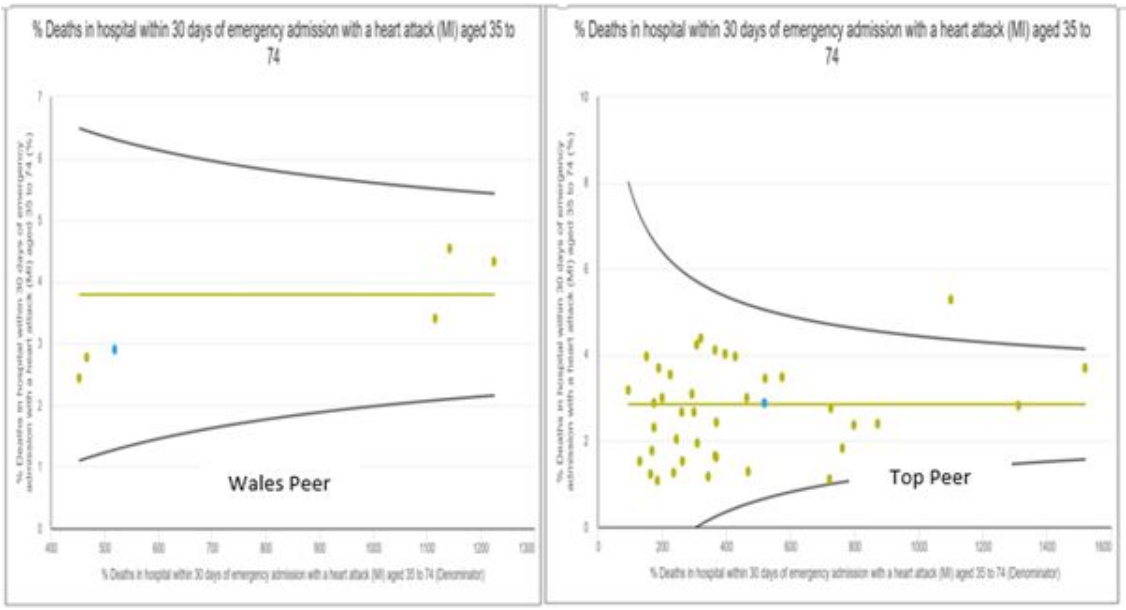


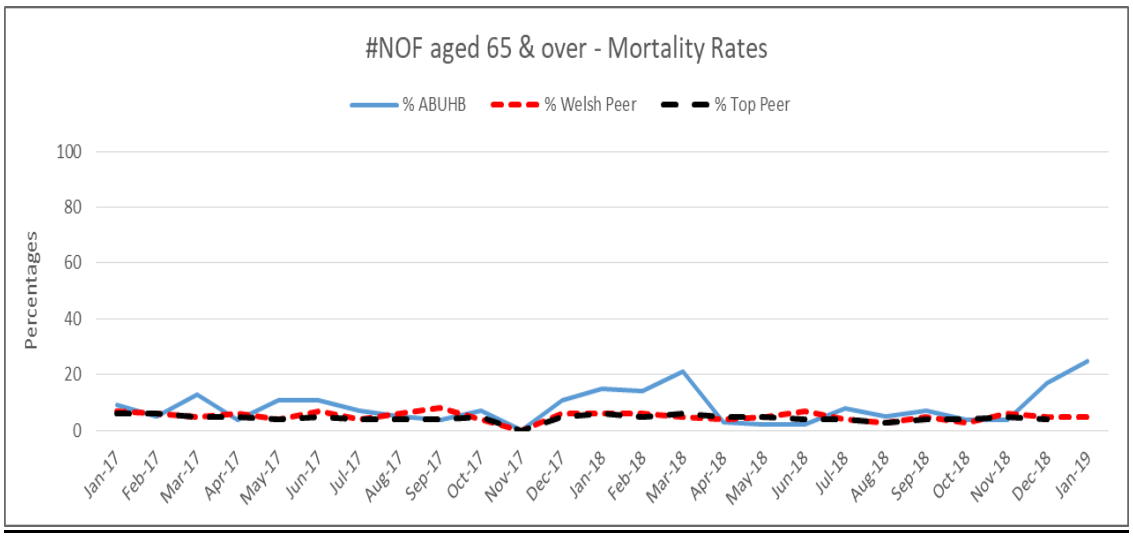
## 3.6 Myocardial Infarction 30 Day Mortality Ages 35-74 against Top Peer

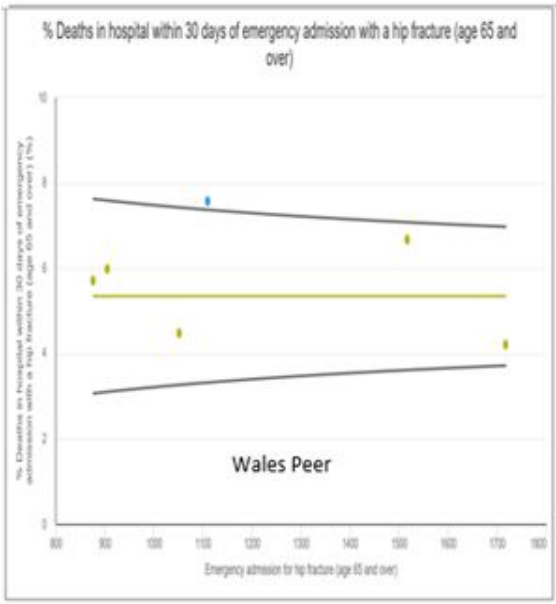


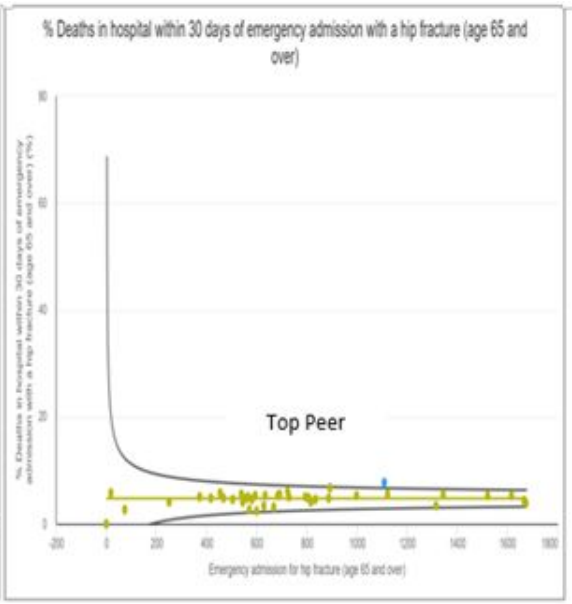




The CHKS data for this measure is under review because of the 6 month period with no deaths. It will therefore either be corrected or another measure substituted in the next report.

## 3.7 Fractured Neck of Femur 30 Day Mortality against Top Peer




The above data is taken from CHKS, and uses the coded data. As deaths are coded as a priority, and our overall coding completeness is lower than it should be, the higher % mortality recently is in part due to a lower denominator (admissions with a fractured neck of femur).

The RGH Adjusted Mortality Rate has been highlighted as an outlier in the 2018 annual report on the 2017 data in the National Hip Fracture Database. The adjustment increases the mortality rate for RGH from 9.2% to 10.8%. A number of changes have been made to the structure of the service and the fractured neck of femur process during late 2017 and early 2018 and more recent data is showing a reduction in the mortality rate at RGH. This

will be monitored on a monthly basis. If the improvement is not sustained, then ABUHB will ask for an external review of the fractured neck of femur service.

The detailed results of the NHFD for RGH and NHH in the Annual Report for 2018, based on 2017 data were included in the report to the February 2019 Committee Meeting. Generally, Welsh Services as a whole compare poorly with the UK averages for the NHFD. This has been the case for a number of years, and to address this in ABUHB actions have been taken to improve the care and outcome for patients with a fractured neck of femur at RGH and NHH, these include:

- Appointment of Orthogeriatricians, Specialist Advanced Nurse Practitioners and Flow Co-ordinators at the acute sites.
- Dedicated fractured neck of femur wards, or designated beds at both sites
- Changes to the trauma list process have been put in place to ensure patients with a fractured neck of femur at RGH get to theatre sooner

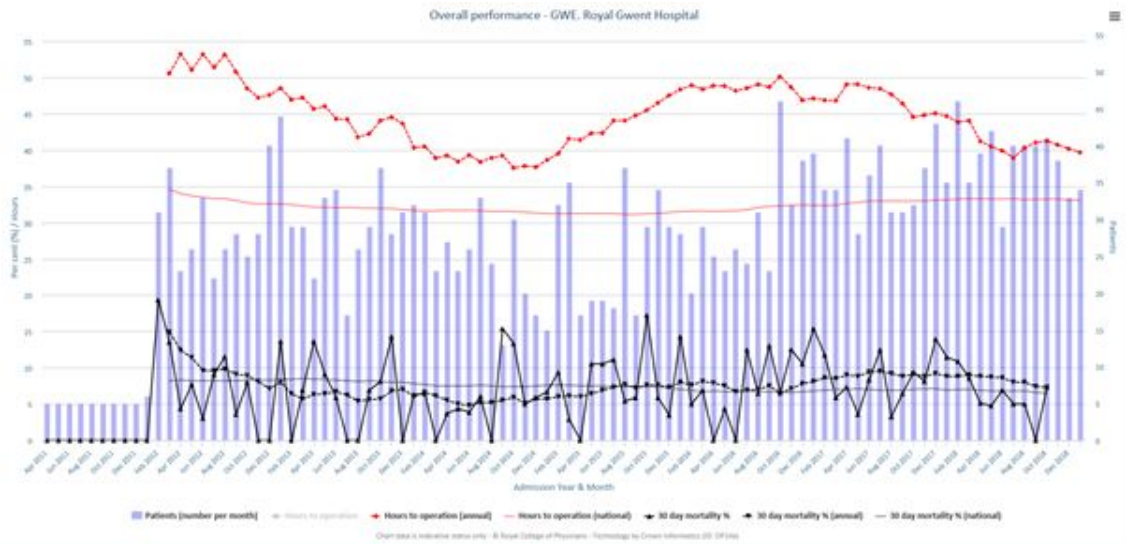
Much of the improvement at the RGH has come from the appointment of an orthogeriatrician for the fractured neck of femur service, which has driven improvements in the ward based assessments. There has been an orthogeriatrician in post at NHH for a number of years, and therefore the improvements to these processes had already been made.

Further actions being taken forward at NHH to improve the care include:

- A robust weekend watch list and out of hours handover for continuity of care
- Advice from the medical team out of hours and at the weekend
- An anaesthetic pathway to improve post-operative care from recovery to the ward
- Careful monitoring of fluid balance and haematological indices by nursing staff and duty orthopaedic medical staff
- Extension of the job plan of the hip fracture service registrars to cover the weekends as this is the period when there has been a lower level of medical cover of these patients

Current data for both RGH and NHH are shown in the following run charts and summary of Key Performance Indicators. This shows that RGH has overall sustained its reduction in the 30 day mortality rate for patients with a fractured neck of femur. The mortality rate for NHH is more variable. RGH is currently performing above the UK average in 4 out of the 6 KPIs and NHH in 5 out of the 6 KPIs.

## RGH National Hip Fracture Database Results



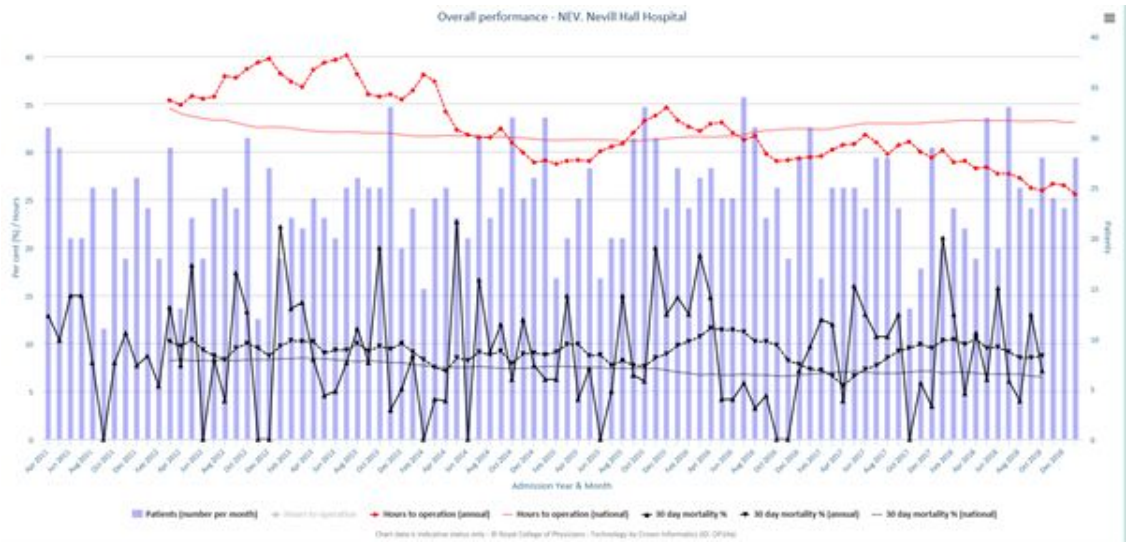

## KPI overview: GWE. Royal Gwent Hospital

*Annualised values based on 451 cases averaged over 12 months to the end of January 2019.*

| 1. Prompt orthogeriatric review | 2. Prompt surgery | 3. NICE compliant surgery |
|---|---|---|
| 95% | 50% | 79% |
| NHFD overall: 90% | NHFD overall: 69% | NHFD overall: 75% |

| 4. Prompt mobilisation | 5. Not delirious post-op | 6. Return to original residence |
|---|---|---|
| 76% | 78% | 76% |
| NHFD overall: 81% | NHFD overall: 70% | NHFD overall: 71% |

## NHH National Hip Fracture Database Results




### KPI overview: NEV. Nevill Hall Hospital

*Annualised values based on 294 cases averaged over 12 months to the end of January 2019.*

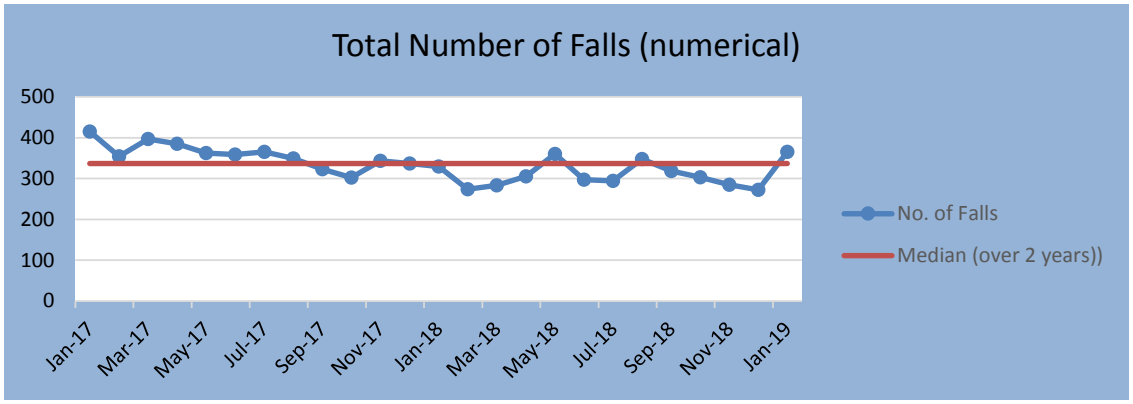
| 1. Prompt orthogeriatric review | 2. Prompt surgery | 3. NICE compliant surgery |
|---|---|---|
| 96% | 79% | 72% |
| NHFD overall: 90% | NHFD overall: 69% | NHFD overall: 75% |

| 4. Prompt mobilisation | 5. Not delirious post-op | 6. Return to original residence |
|---|---|---|
| 82% | 74% | 75% |
| NHFD overall: 81% | NHFD overall: 70% | NHFD overall: 71% |

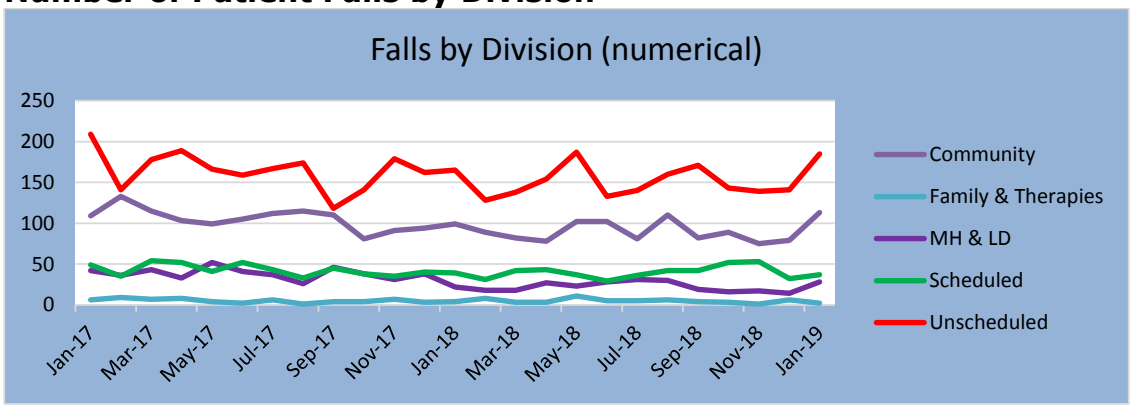
## 3.8. Preventing Falls

### 3.8.1. In-patient Falls Data

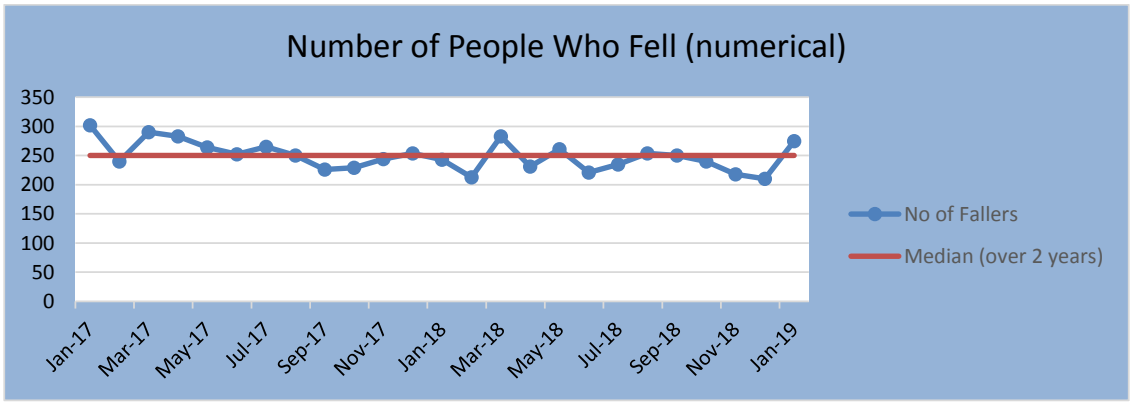
**ABUHB Total Number of Falls**



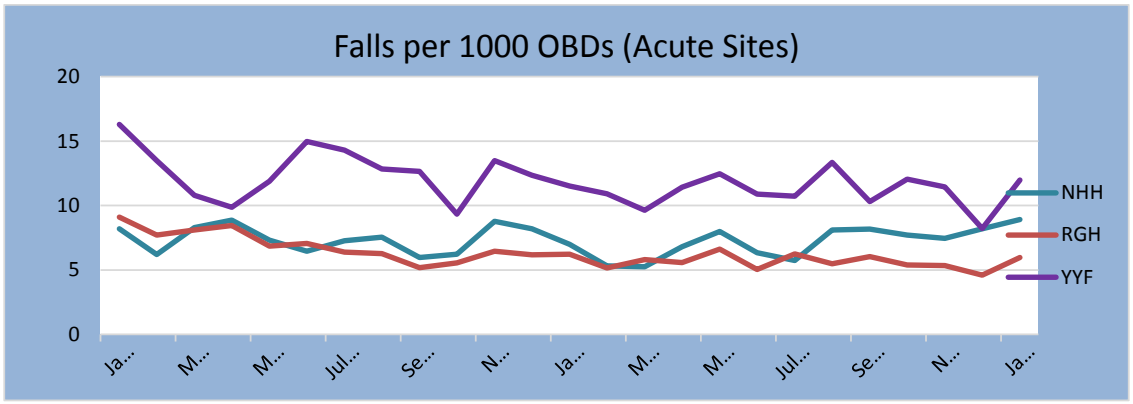

**Number of Patient Falls by Division**



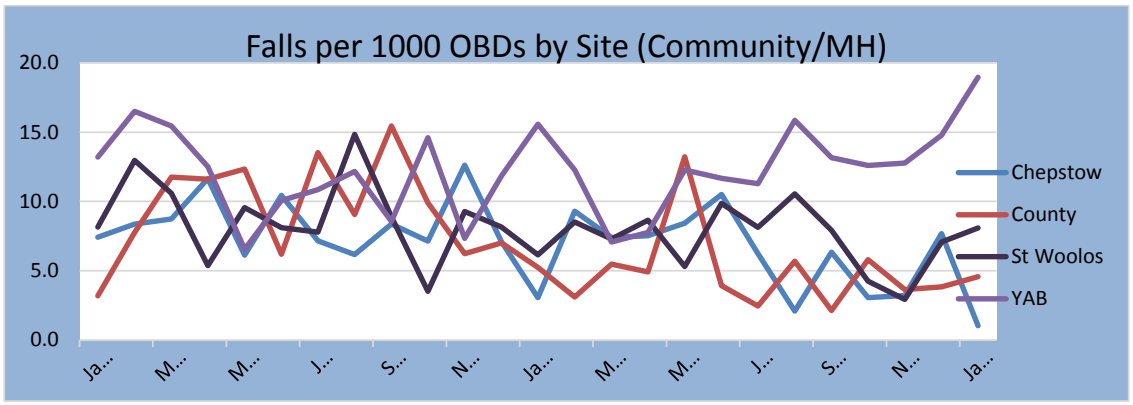

**Number of people who fell**



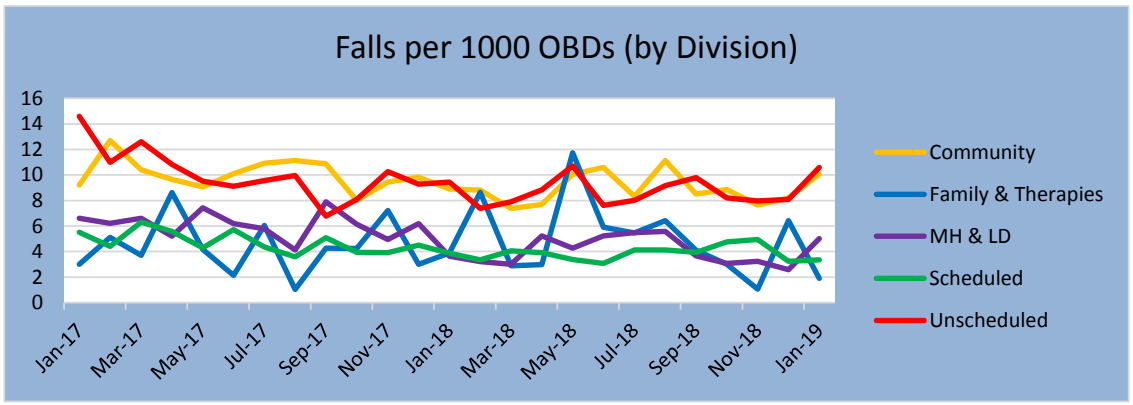
## Number of Falls per 1000 Occupied Bed Days by Acute Site



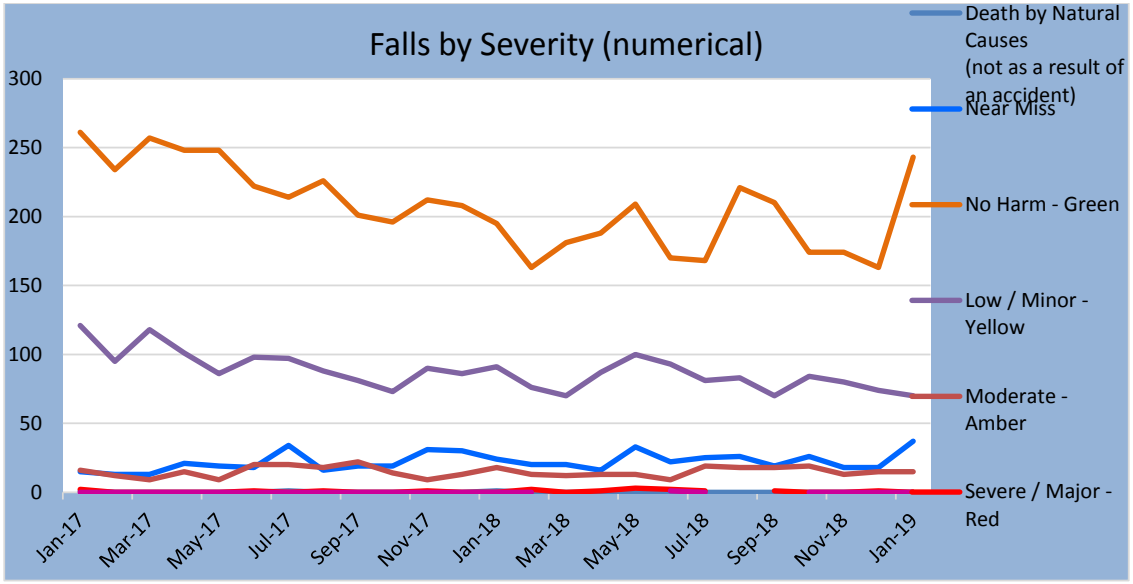

## Number of Falls per 1000 Occupied Bed Days by Community/Mental Health Site



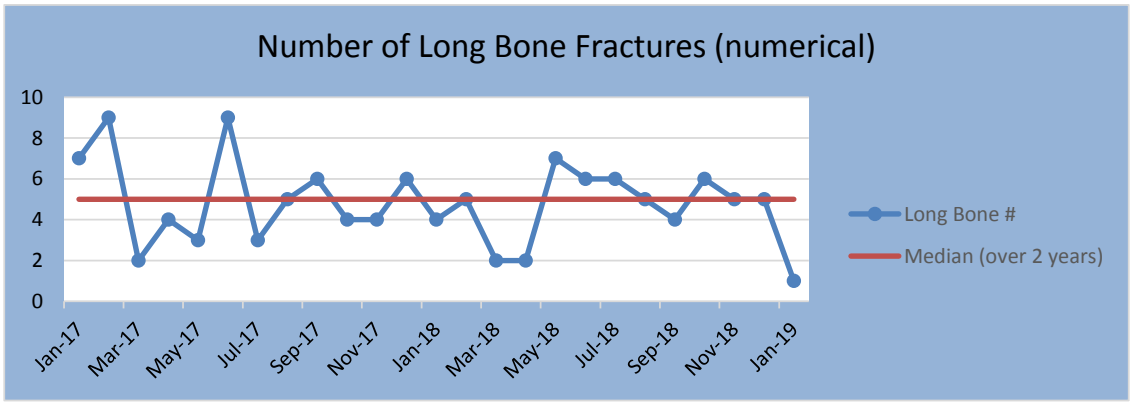

## Number of Falls per 1000 Occupied Bed Days by Division



**Number of Falls by Severity**




**Number of Long Bone Fractures**




The overall number of falls reported on datix has reduced over the last year. The majority of the reduction is in the low or no harm falls. However, the number of falls increased sharply in January. The number of long bone fractures reduced in January. The falls per 1000 occupied bed days is high at both YYF and YAB. Both areas have a frail elderly patient population, and both have wards with single rooms so that it is harder to observe patients. In January, there was one patient at YAB who fell frequently, despite close monitoring. Both hospitals have received targeted training on falls prevention

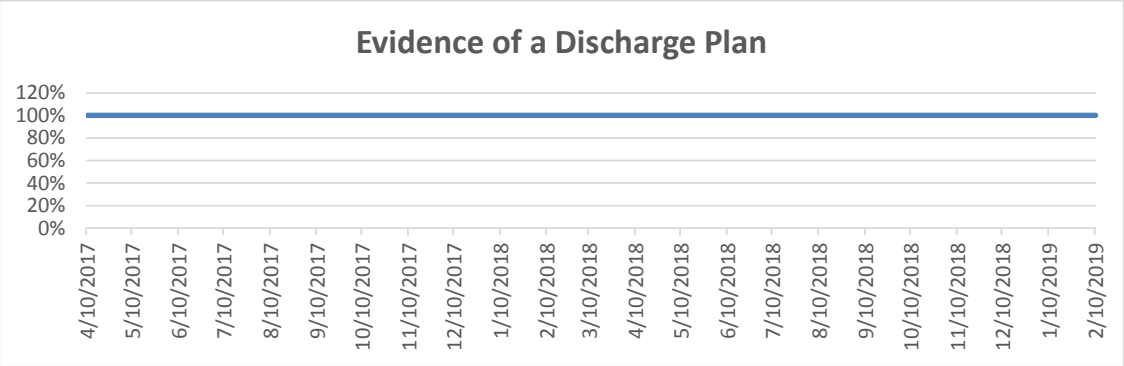
The Falls Steering Group has not met since the last QPSC.

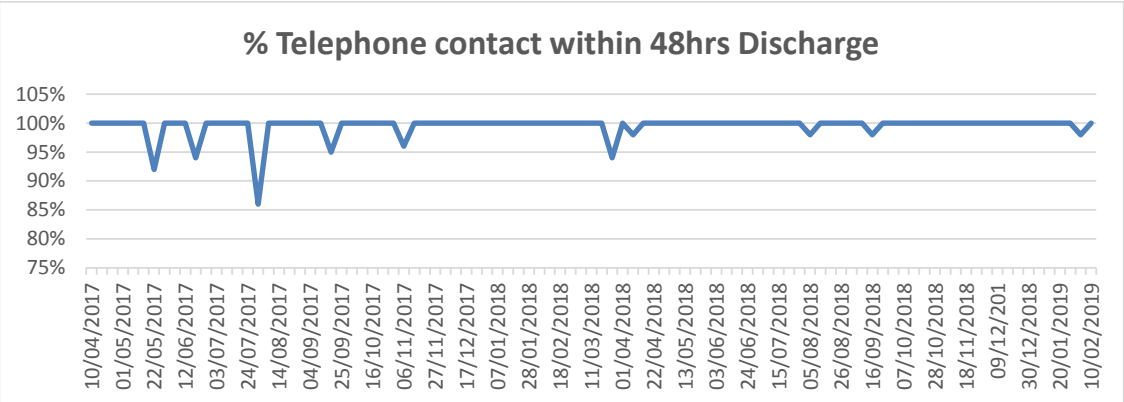
## 3.9. Mental Health – Compliance with Discharge Plans

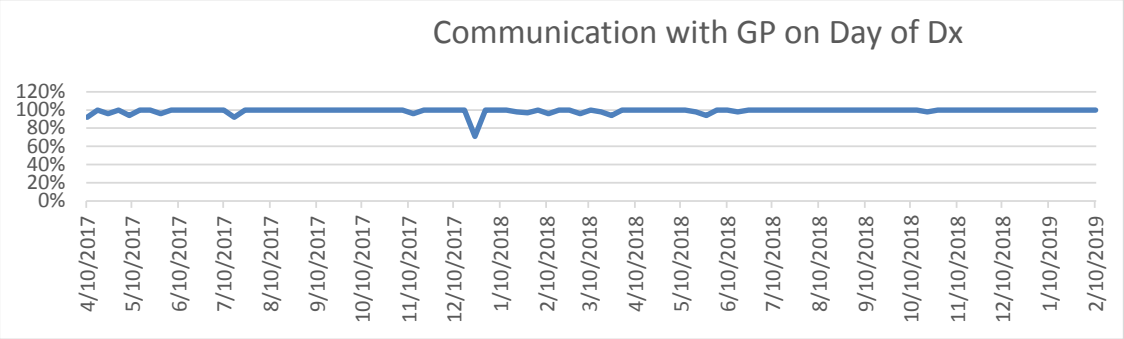
In December 2016 the Coroner issued a Regulation 28 report to the Health Board following the inquest for the death by suicide of a patient on discharge from one of the health board's acute mental health wards. These reports are issued when a Coroner believes that action should be taken to prevent future deaths. The coroner stipulated three points of learning that had to be rectified:

- Decision to discharge made without notification to or consultation with any family member
- No discharge plan or follow up support was put in place
- No contemporaneous notification to her GP of the discharge or the assessment leading to discharge

When a patient is discharged from an acute ward, they are at highest risk of committing suicide in the first 2 weeks after discharge. It is therefore important to ensure that they have a discharge plan, that they are contacted by telephone within 48hrs of discharge, and that the patient's GP is told of the discharge on the same day. The Executive Team huddle monitor compliance on a weekly basis.






The Mental Health Division monitors all three elements very closely, and follows up on each instance where the standard is not met.

## 3.10. Primary Care – Referrals to Secondary Care

One key patient safety issue for Primary care is to ensure that patients are looked after proactively in the community, so the need for them to contact the Out of Hours service or go to Accident and Emergency is reduced. Some initial primary care data by NCN on A and E attendances, GP referrals to Assessment Units and Emergency Medical Admissions is given below. This will be refined over the coming months.

| Objective | Measure | | Latest data | Latest period | Target | Tolerance | Trend - last 24 months |
|---|---|---|---|---|---|---|---|
| **Secondary Care Demand** | | | | | | | |
| ABUHB A&E Activity | New A&E Attendances - Patients Aged >65 Years | Grand Total | 1283 | Feb 2019 | 1,080 | 1,136 | |
| | | Blaenau Gwent East | 104 | | 89 | 94 | |
| | | Blaenau Gwent West | 121 | | 101 | 106 | |
| | | Caerphilly East | 161 | | 134 | 141 | |
| | | Caerphilly North | 79 | | 63 | 66 | |
| | | Caerphilly South | 110 | | 86 | 90 | |
| | | Monmouthshire North | 129 | | 100 | 105 | |
| | | Monmouthshire South | 65 | | 63 | 66 | |
| | | Newport East | 93 | | 82 | 86 | |
| | | Newport North | 108 | | 87 | 92 | |
| | | Newport West | 106 | | 70 | 74 | |
| | | Torfaen North | 118 | | 126 | 133 | |
| | | Torfaen South | 89 | | 79 | 83 | |
| A&E Attendances: The latest reported position as at Feb 2019 was reported as 1283 which is a variance of 147 compared to the same period the previous year which equates to an Increase of 12.9%. For NCN benchmarking please see table at foot of this report. | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ABUHB Assessment Unit Activity | GP Referrals to Assessment Units | Grand Total | 3481 | Feb 2019 | 3,039 | 3,199 | |
| | | Blaenau Gwent East | 174 | | 169 | 178 | |
| | | Blaenau Gwent West | 216 | | 197 | 207 | |
| | | Caerphilly East | 453 | | 366 | 385 | |
| | | Caerphilly North | 258 | | 251 | 264 | |
| | | Caerphilly South | 282 | | 290 | 305 | |
| | | Monmouthshire North | 206 | | 151 | 159 | |
| | | Monmouthshire South | 213 | | 200 | 210 | |
| | | Newport East | 327 | | 271 | 285 | |
| | | Newport North | 343 | | 304 | 320 | |
| | | Newport West | 400 | | 323 | 340 | |
| | | Torfaen North | 279 | | 287 | 302 | |
| | | Torfaen South | 330 | | 232 | 244 | |

| Objective | Measure | | Latest data | Latest period | Target | Tolerance | Trend - last 24 months |
|---|---|---|---|---|---|---|---|
| ABUHB Emergency Admissions | Emergency Medical Admissions to ABUHB - Patients Aged > 65 years | Grand Total | 1773 | Feb 2019 | 1,637 | 1,723 | |
| | | Blaenau Gwent East | 110 | | 116 | 122 | |
| | | Blaenau Gwent West | 142 | | 125 | 132 | |
| | | Caerphilly East | 196 | | 174 | 183 | |
| | | Caerphilly North | 73 | | 74 | 78 | |
| | | Caerphilly South | 134 | | 127 | 134 | |
| | | Monmouthshire North | 169 | | 155 | 163 | |
| | | Monmouthshire South | 128 | | 102 | 107 | |
| | | Newport East | 146 | | 135 | 142 | |
| | | Newport North | 183 | | 159 | 167 | |
| | | Newport West | 184 | | 145 | 153 | |
| | | Torfaen North | 142 | | 182 | 192 | |
| | | Torfaen South | 166 | | 143 | 150 | |

Assessment Units: The latest reported position as at Feb 2019 was reported as 3481 which is a variance of 282 compared to the same period the previous year which equates to an Increase of 8.8%.

Admissions: The latest reported position as at Feb 2019 was reported as 1773 which is a variance of 50 compared to the same period the previous year which equates to an Increase of 2.9%.
For NCN benchmarking please see table at foot of this report.

**The Table opposite shows the NCN benchmarking of variance to the reported position for the same period the previous year:**

| ABUHB Provider Data | A&E (>65Yrs) Attendances | Assessments (>65Yrs) | Admissions (>65Yrs) | Prescribing | OOHs |
|---|---|---|---|---|---|
| Grand Total | 13% | 9% | 3% | 0.2% | 13.8% |
| Blaenau Gwent East | 11% | -2% | -10% | 0.9% | 10.2% |
| Blaenau Gwent West | 14% | 4% | 8% | -0.2% | 13.2% |
| Caerphilly East | 14% | 18% | 7% | 0.8% | 13.0% |
| Caerphilly North | 20% | -2% | -6% | -0.1% | 14.3% |
| Caerphilly South | 22% | -8% | 0% | 0.4% | 10.5% |
| Monmouthshire North | 23% | 30% | 4% | 0.4% | 19.3% |
| Monmouthshire South | -2% | 1% | 20% | 0.6% | 12.5% |
| Newport East | 8% | 15% | 3% | -1.5% | 17.2% |
| Newport North | 17% | 7% | 10% | -0.6% | 15.0% |
| Newport West | 43% | 18% | 20% | 0.7% | 12.2% |
| Torfaen North | -11% | -8% | -26% | 1.1% | 17.7% |
| Torfaen South | 7% | 35% | 11% | 0.1% | 9.5% |

## Out of Hours demand

| Objective | Measure | | Latest data | Latest period | Target | Tolerance | Trend - last 24 months |
|---|---|---|---|---|---|---|---|
| GP Urgent OOHs Service | | | | | | | |
| Ensure that patients accessing Primary Care OOH are advised in line with tier 1 targets | % Triaged Within Limit (Reception) (Combined Urgent & Routine Measure) | Grand Total | 70.7% | Feb 2019 | 98% | 85% | |
| | | Blaenau Gwent East | 70.7% | | | | |
| | | Blaenau Gwent West | 68.7% | | | | |
| | | Caerphilly East | 72.1% | | | | |
| | | Caerphilly North | 71.2% | | | | |
| | | Caerphilly South | 69.0% | | | | |
| | | Monmouthshire North | 78.1% | | | | |
| | | Monmouthshire South | 69.6% | | | | |
| | | Newport East | 71.0% | | | | |
| | | Newport North | 68.6% | | | | |
| | | Newport West | 69.2% | | | | |
| | | Torfaen North | 72.2% | | | | |
| | | Torfaen South | 69.3% | | | | |
| OOHs: The latest reported position as at Feb 2019 was reported as 70.7% which is a variance of 13.8% compared to the same period the previous year. For NCN benchmarking please see table at foot of this report. | | | | | | | |

## Recommendation

The Quality and Patient Safety Committee is asked to review the report, note the progress being made in many areas and highlight any issues where further information is required for assurance.

| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The initial section of 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<br>Issues are part of Divisional risk registers where they are seen as a particular risk for the Division. |
| ***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** | The terms are all used routinely in the report, which is presented at every meeting. |
| **Public Interest** | |

| | |
|---|---|
| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol<br>Aneurin Bevan<br>University Health Board | Quality and Patient Safety Committee<br>Thursday 4th April 2019<br>Agenda Item: 3.2 |

3.2

# Aneurin Bevan University Health Board

## STRATEGIC RISK REPORT

| **Executive Summary** | | | |
|---|---|---|---|
| This paper provides an overview of the profile of the current risks for which the Quality and Patient Safety Committee is responsible for monitoring, at the end of February 2019. The risk profile of the Health Board is continuing to be revised and reworked. Further rationalisation and redevelopment work continues and will further developed prior to the next Committee meeting.<br><br>This report is provided for assurance purposes for the Quality and Patient Safety Committee. | | | |
| **The Quality and Patient Safety 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: Paul Buss, Medical Director, Peter Carr, Director of Therapies and Health Science, Martine Price, Interim Director of Nursing** | | | |
| **Report Author: Danielle O'Leary, Committee Secretariat** | | | |
| **Report Received consideration and supported by :** | | | |
| **Executive Team** | N/A | **Quality and Patient Safety Operational Group** | ✓ |
| **Date of the Report:** 27 March 2019 | | | |
| **Supplementary Papers Attached:**<br>Risk Dashboard | | | |

| **Purpose of the Report** |
|---|
| This report is provided for assurance purposes to highlight to the Quality and Patient Safety Committee the risks that are assessed as the key risks to the Health Board's successful achievement of our strategic objectives within the IMTP. |
| **Background and Context** |
| **1. Background**<br><br>Risk management is a process to ensure that the Health Board is focusing on and managing risks that might arise in the future. Also, situations where there are continuing levels of inherent risk within current issues within the organisation or in our partnership work. |

Active risk management is happening every day throughout all sites and services of the Health Board. Nevertheless, the Health Board's risk management system and reporting also seeks to ensure that the Board is aware, engaged and assured about the ways in which risks are being identified, managed and responded to across the organisation and our areas of responsibility.

The risks referenced within this report have been identified through work by the Board, Committees, Executive Team and items reported through the Health Board's management structures with regard to the implementation of the IMTP, for which the Finance and Performance Committee have oversight.

***Table from the updated Risk Management Strategy – January 2017.***

| **Consequence Score** | **Likelihood Score** | | | | |
|---|---|---|---|---|---|
| | **1 Rare** | **2 Unlikely** | **3 Possible** | **4 Likely** | **5 Almost certain** |
| **5 - Catastrophic** | 5 | 10 | 15 | 20 | 25 |
| **4 - Major** | 4 | 8 | 12 | 16 | 20 |
| **3 - Moderate** | 3 | 6 | 9 | 12 | 15 |
| **2 - Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 - Negligible** | 1 | 2 | 3 | 4 | 5 |

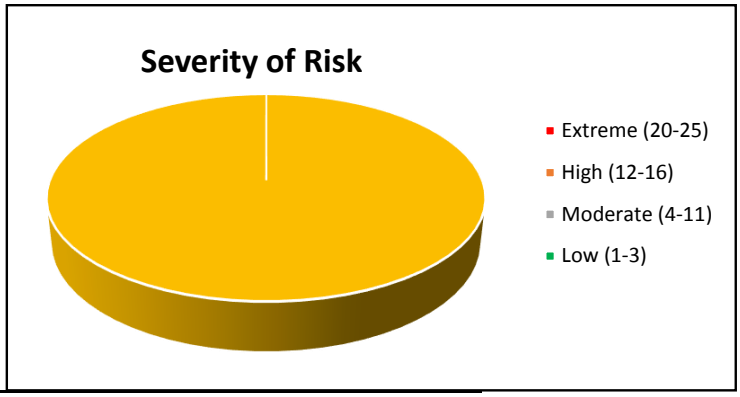
## 2. Corporate Risk Register and Dashboard Report

The dashboard reports are generated from the Health Board's Corporate Risk Register. The reports seek to provide in-overview:

- The key risks for which the Quality and Patient Safety Committee has responsibility;
- The current profile of risks in that strategic objective area and their potential impact;
- Whether risks have worsened, remained unchanged or had been mitigated since the last assessment;
- Historical context of each risk i.e. how long it has been at its level on the Corporate Risk Register;
- The report will also show any risks that have been withdrawn in the last reporting period or whether there are new risks.

The risks for the purposes of the dashboards have been summarised to make them more accessible to the Committee. The detail of the risks, their assessment, controls and mitigating actions continue to be expressed within the full Corporate Risk Register, which is presented to the Audit Committee at each meeting.
There are currently 7 risks on the Quality and Patient Safety Risk Register. These are broken down by the following levels of risk severity.

| Risk By Severity | |
|---|---|
| Extreme (20-25) | 0 |
| High (12-16) | 6 |
| Moderate (4-11) | 1 |
| Low (1-3) | 0 |




There has been 1 additional risk added to the Quality and Patient Safety risk register since the last meeting which has been assessed as 9, moderate risk. Further details on the specific risks are outlined at the Risk Dashboard which is appended to this report.

| **Assessment and Conclusion** |
|---|
| This paper provides an overview of risks as at the end of February 2019. Further development work is underway and will be reported in June 2019. |

| **Recommendation** |
|---|
| The Quality and Patient Safety Committee is asked to consider this report and note the identified risks as the current quality and patient safety risks for the Health Board as at February 2019. |

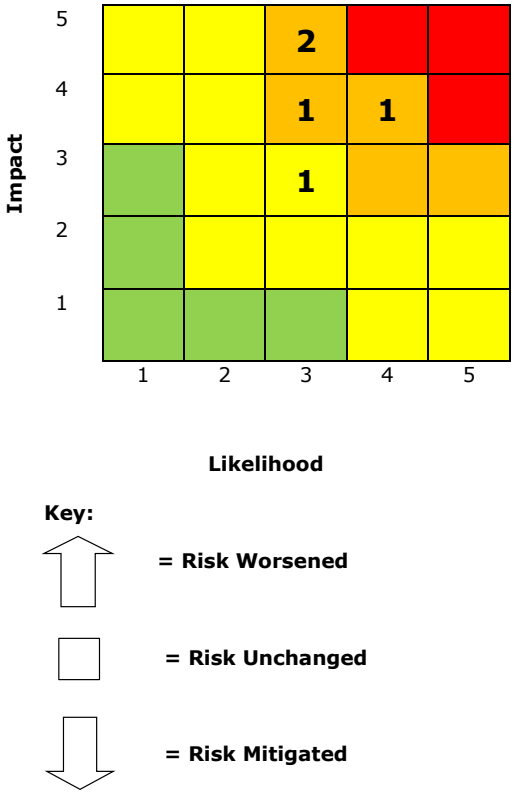
| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework. |
| ***Financial Assessment, including Value for Money*** | There may be financial consequences of individual risks however there is no direct financial impact associated with this report. |
| ***Quality, Safety and Patient Experience Assessment*** | Impact on quality, safety and patient experience are highlighted within the individual risks contained within this report. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | There are no specific equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the risks outlined in the register. |
| **Health and Care Standards** | This report would contribute to the good governance elements of the Health and Care Standards for Wales. |

| | |
|---|---|
| **Link to Integrated Medium Term Plan/Corporate Objectives** | The risks against delivery of key priorities in the IMTP, will be outlined as specific risks on the risk register. |
| **The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working** | Not applicable to this specific report, however WBFGA considerations are included within the consideration of individual risks |
| **Glossary of New Terms** | None |
| **Public Interest** | Report to be published |

## Quality and Patient Safety Committee Risk Dashboard Report as at end of February 2019

| IMTP STRATEGIC OBJECTIVE: | Enabler Risks Associated with Delivery of IMTP |
|---|---|
| KEY THEME ACTIONS: | • No specific SCPs – these areas overarch and underpin the IMTP |
| These areas are not directly associated with SCPs, but will if mitigated, facilitate the delivery of the plan. | |

**RISK PROFILE REPORT**




**Key:**

= Risk Worsened

= Risk Unchanged

= Risk Mitigated

**Description of Risk and Action and if Risk Mitigated, Unchanged or Worsened Since Last Assessment**

**16**

**Since July 2018**

**RISK**: Poor patient experience, deterioration of patient outcomes and quality of care in hospital and community settings due to staff shortages and patients not able to access services on a timely way in both primary and secondary care.
**IMPACT**: Deteriorating patient experience/outcomes and quality of care.
**ACTION**: Workforce planning, planned use of temporary staffing and recruitment strategies in place with regular review. Monitoring of quality measures are in place via Quality and Patient Safety Committee. Patient experience is being monitored and specific spot checks are being undertaken.
Key quality indicators are in place with monitoring and improvement approaches e.g. pressure ulcer collaborative launched and ED turnaround. Continuous monitoring of HIW/CHC/Complaints/incidents to identify any areas of concern/trends. These are reported to Executive Team and Quality and Patient Safety Committee, along with lessons learned.
**OWNER**: Acting Director of Nursing, Medical Director
**OVERSIGHT**: Quality and Patient Safety Committee and Patient Experience Committee.

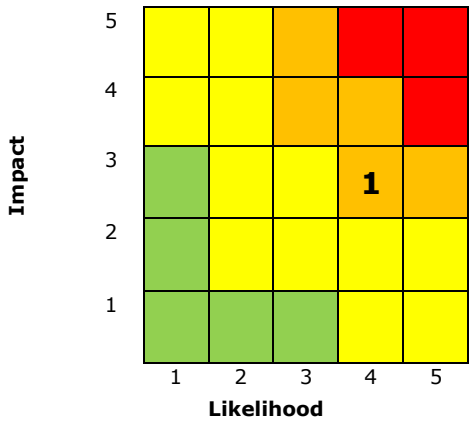
## Quality and Patient Safety Committee Risk Dashboard Report as at end of February 2019

| | |
|---|---|
| | **15**<br>**Since July 2018**<br><br>**RISK**: Failure to reduce Healthcare Associated Infections<br>**IMPACT**: Increase in Healthcare Associated Infections, in hospital and community, placing patients at risk and increasing costs and reducing quality of care.<br>**ACTION:** There is an annual programme of HPV cleaning for all clinical areas and a ward refurbishment programme is in place. Root cause analysis undertaken for all HCAIs. Deep Dive carried out for primary and community acquired infection have been undertaken and an action plan is in place. Further investment in antimicrobial pharmacy agreed. Investment in new HPV equipment agreed.<br>**OWNER**: Acting Director of Nursing<br>**OVERSIGHT**: Quality and Patient Safety Committee<br><br>**15**<br>**Since Dec 2017**<br><br>**RISK**: Inadequate falls prevention on in-patient wards<br>**IMPACT**: Failing to protect patients and risk of increased fractures and harm.<br>**ACTION:** 'Prevention and Management of Inpatient Falls' Policy has been updated and disseminated widely across the Health Board. Training ongoing on wards/sites targeting hot spot areas in the first instance. The Falls Steering Group is exploring resources for consistent delivery of falls prevention training for all inpatient areas. Monthly Falls Scrutiny Panel review and learning from all inpatient falls resulting in a fracture. Numbers of fractures from inpatient falls is reducing.<br>**OWNER:** Director of Therapies and Health Science<br>OVERSIGHT: Quality and Patient Safety Committee<br><br>**12**<br>**Since March 2017**<br><br>**RISK**: Compliance rates of statutory and mandatory training of staff<br>**IMPACT:** Risk of undermining the quality and safety of services.<br>**ACTION**: Compliance monitored by the Health and Safety Committee. Access to on-line training has been simplified via ESR and training compliance rates are steadily improving. Each Division has received latest data and produce improvement plans. |

**Quality and Patient Safety Committee Risk Dashboard Report as at end of February 2019**

| | |
|---|---|
| | **OWNER**: Director of Therapies and Health Science<br>**OVERSIGHT**: Quality and Patient Safety Committee<br><br>**9**<br>**New Risk**<br><br>**RISK:** Resources may not be used in the most effective way to optimise achievement of the Health Board's priorities.<br>**IMPACT:** The Health Board would not achieve its identified priorities in the most effective way.<br>**ACTION:** The Health Board has an approved IMTP, which identifies the key priorities regarding the improvement of health for its population and the allocation of resources to support this.<br>Budgets are delegated through the organisation based on the priorities set out in the IMTP.<br>Key IMTP delivery risks, including service, workforce and financial performance are scrutinised at the Finance & Performance Committee. The Finance & Performance Committee will also periodically review the allocation and shift in resources to support the Health Board's priorities. The Executive Board/Team and monthly Divisional assurance meetings monitor delivery and progress against key risks, including service, quality/safety, workforce and financial performance. The Health Board's Value Based Health Care Programme aims to improve outcomes for patients making best use of available resources (improving value). This Programme reports to the Quality Patient Safety Committee.<br>**OWNER:** Director of Finance & Performance<br>**OVERSIGHT:** Board, Finance & Performance Committee and Quality & Patient Safety Committee |

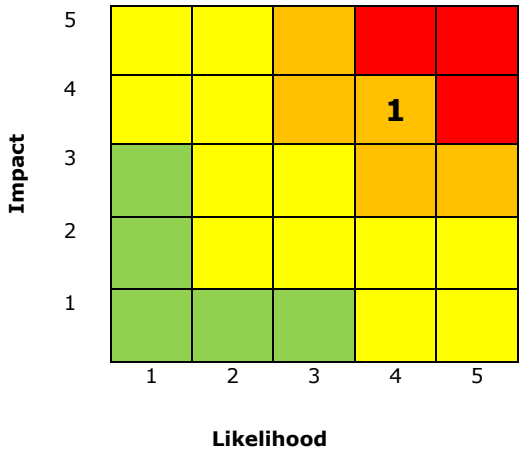
**Quality and Patient Safety Committee Risk Dashboard Report as at end of February 2019**

| **IMTP STRATEGIC OBJECTIVE:** | **Supporting a further shift of services closer to home through building a NCN foundation for delivery of care (SCPs 2, 3 and 4)** |
|---|---|
| **KEY THEME ACTIONS:** | • SCP 2 – Care Closer to Home<br>• SCP 3 – Management of Major Health Conditions<br>• SCP 4 – Mental Health and Learning Disabilities |
| The overall aim of these Service Change Plans (SCP) is to facilitate the development and sustainability of service improvement models that support the delivery of care closer to home. It also aims to deliver more systemic and proactive management of chronic disease to improve health outcomes, reduce inappropriate use of hospital services and have a significant impact on reducing health inequalities. The Mental Health and Learning Disabilities SCP seeks to provide an integrated, whole system model of care that improves the mental health and well being of our population. | |
| **RISK PROFILE REPORT**<br>  <br> | **12**<br>**Since Nov 2017**<br>**RISK:** Crisis services in Mental Health will not meet the needs of our population.<br>**IMPACT:** Risk to patient safety if services are appropriately not staffed and resourced.<br>**ACTION**: Gwent 'Whole Person, Whole System' Acute and Crisis Model being developed to support people with a mental health need who present in crisis. This will remodel the service to better meet local needs.<br>**OWNER**: Director of Primary, Community and Mental Health<br>**OVERSIGHT**: Quality and Patient Safety Committee |

## Quality and Patient Safety Committee Risk Dashboard Report as at end of February 2019

| IMTP STRATEGIC OBJECTIVE: | Improving access and flow and reducing waits (SCP 5 & 6) |
|---|---|
| KEY THEME ACTIONS: | • SCP 5 – Urgent and Emergency Care<br>• SCP 6 – Planned Care |
| To develop coherent, co-ordinated, high quality urgent and emergency care that works seven days a week, and where possible 24 hours a day. In accordance with patient expectations whilst delivering the best clinical outcomes. To secure improvements in efficiency and productivity that in combination with prudent healthcare, will improve access and deliver high quality, affordable and sustainable services. | |

**RISK PROFILE REPORT**




**16**

**Since May 2018**

**RISK**: Unsustainable model of care in Primary Care GP services
**IMPACT**: Patients will not be able to access the level and quality of services they require in a timely way.
**ACTION**: Widening skill mix (both managed and independent practices appointing to new roles). This will be tested at scale via pacesetter project backed by Welsh Government funding. Welsh Government announcement of solution for state backed indemnity in primary care. Ongoing discussions at NCN and individual practice level in relation to sustainability challenges. Work in relation to consolidating practice distribution through supported mergers and managed redistribution of patients to alternative practices.
**OWNER**: Director of Primary, Community and Mental Health
**OVERSIGHT**: Quality and Patient Safety Committee

| | |
|---|---|
| GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | Quality and Patient Safety Committee<br>4th April 2019<br>Agenda Item: 3.3 |

3.3

**Aneurin Bevan University Health Board**
**Quality and Patient Safety Committee**

# The Healthcare Inspectorate Wales Report: Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W.

## Executive Summary

In January 2019, at the request of Welsh Government, Healthcare Inspectorate Wales, published their independent report of their review of the events concerning allegations of sexual abuse of patients by a member of staff employed by Abertawe Bro Morgannwg University Health Board. The review included the handling of the allegations made by the patients and the Health Boards subsequent disciplinary process. The case highlights the importance of consistent and robust safeguarding and governance processes as essential in contributing to effective safeguarding for adults at risk. The recommendations for Abertawe Bro Morgannwg University Health Board and Welsh Government have relevance for all health boards. This paper describes the actions taken and planned by Aneurin Bevan University Health Board.

| **The Board 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: Martine Price – Interim Director Nursing**

**Report Author: Lin Slater - Deputy Director of Nursing**

| | | | |
|---|---|---|---|
| **Executive Team** | | **Committee of the Board** | **Quality and Patient Safety Committee** |

**Date of the Report: 22nd March 2019**

**Supplementary Papers Attached:**

- The Healthcare Inspectorate Wales Report: Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W.
- Summary of Health Board Actions.

## Purpose of the Report

To provide assurance to the Committee of the Health Boards consideration of the report findings and recommendations; to inform of the Health Boards current position against each of the recommendations and the actions taken and planned by the Health Board.

## Report summary and findings

Between 2011-2013 three female patients within the learning disability directorate of Abertawe Bro Morgannwg University Health Board (ABMU) made separate allegations of sexual abuse against the same member of staff, Mr W a HCSW. Mr W had been employed in an IT capacity prior to being redeployed as a HCSW. His redeployment subsequently came under scrutiny and it was noted that he had not had a CRB or DBS check. Following the first allegation, Mr W was placed on 'special leave'. A subsequent police investigation and disciplinary review concluded that no further action would be taken and he returned to his role. Two further separate allegations of sexual abuse were made and Mr W was formerly suspended. Following a police investigation the matter was referred to the Crown Prosecution Service but a decision was made that he should not be charged.

In 2016, Mr W murdered his neighbour. At the time of his arrest he was still an employee of the health board but suspended from practice since 2012 pending the outcome of the health board's disciplinary investigations. Mr W was dismissed by the Health Board in April 2016 on the grounds of Gross Misconduct as on the balance of probability, inappropriate behaviour had taken place.

The Health Board carried out an internal review and having identified some shortcomings in its processes established an action plan for improvement. It concluded that in regard to Mr Ws charge of murder that as the actions were outside of his employment these actions could not have been 'predicted or prevented' .Learning from the internal review was shared by ABMU Health Board with other Welsh Health Boards including Aneurin Bevan. This was considered at the Safeguarding Committee on 23 January 2018 and a briefing was prepared and shared across all divisions and departments of the Health Board.

HIW was asked by Welsh Government to carry out an independent review of the ABMU internal review and its action specifically to consider whether:

- The ABMU Health Boards internal review was sufficiently thorough
- The Health Boards conclusions were appropriate in light of those conclusions
- The actions that the Health Board took in light of its conclusions adequate to ensure patient safety.
- On the basis of additional evidence during this (HIW) review, are there additional or different conclusions.

The review focussed on:

- Staff recruitment and employment
- Incident reporting
- Adult safeguarding
- Governance and culture

In its conclusions, the review highlighted areas of learning relevant to the NHS in Wales.
Of particular interest on a national basis it identified the need for:

- Up–to-date DBS checks for staff ( both retrospective and renewal of checks)
- Updated Safeguarding procedures
- Robust mechanism for sharing learning across Wales
- Improved systems of triangulation of information of concerns, incidents and claims
- Robust governance and board oversight in relation to quality and safety.

ABUHB welcomes this report and the opportunity to consider the findings and recommendations to identify the internal actions required for improvement.

| **Recommendation 1** | **The Health Board must ensure the redeployment policy is consistently followed.** |
|---|---|
| **ABUHB Current Position** | |
| All staff redeployments are managed centrally through a redeployment register that is maintained by Workforce & OD.<br><br>A Redeployment Policy is in place to support managers and staff who require redeployment outside of the Organisational Change Policy. This would include staff seeking redeployment due to capability or health issues.<br><br>A review of DBS checks over the last 12 months demonstrates that appropriate DBS checks have been made for staff moving roles. This also includes staff transferring into the HB from other NHS organisations. | |

| Further Actions Planned |
| --- |
| Workforce & OD will update current Redeployment Policy to expressly state the requirements for pre-employment checks, including DBS where appropriate - April 2019. |

| Recommendation 2 | The Health Board needs to consider how Occupational Health advice can be more clearly communicated to management staff, in order to accommodate the needs of the employee concerned. |
| --- | --- |
| **ABUHB Current Position** | |
| Occupational Health Fitness to work assessment and the provision of impartial professional advice during absenteeism to support staff to return to work and to advise on potential work-related ill health issues is provided following management referral to the service. Advice on 'fitness for role' will be based on both the information gathered in the consultation with the patient and the specific advice requested by the manager. Following the consultation, the letter containing advice is agreed as factually accurate with the employee concerned prior to being emailed to the referring manager.<br><br>KPIs are in place and are regularly monitored with regards to waiting times. Current waiting times are within KPIs. These are published and shared across the HB. | |
| **Further Actions Planned** | |
| Continue to review and monitor OH provision and KPIs-monthly by Workforce & OD. | |

| Recommendation 3 | The Health Board must ensure the suspension and special leave policies are applied consistently and all staff are clear about their correct use in relation to staff members under investigation. |
| --- | --- |
| **ABUHB Current Position** | |
| Special leave is never used instead of suspension. Suspension is applied where appropriate in line with the All Wales Disciplinary Policy. It is used as a last resort where the nature of the incident is serious enough to warrant removal from the workplace.<br><br>Suspensions are monitored and reviewed regularly by Workforce & OD. In addition, regular meetings are undertaken with employees on suspension.<br><br>Suspensions and employee relations data are captured and reported to Executive Team and Board. | |
| **Further Actions Planned** | |
| Workforce & OD will continue to review suspensions on a monthly basis and will monitor use of special leave- quarterly. | |

| Recommendation 4 | The Health Board must identify and provide sufficient resources for disciplinary investigations to ensure their timely completion. |
| --- | --- |
| **ABUHB Current Position** | |
| Alternative options to appoint investigating officers are being developed to support timely completion of investigations. | |

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|---|
| This includes appointment of investigating officers on the ABUHB resource bank. Appropriate training, pre-engagement checks and statutory and mandatory training will be embedded in the process. Consideration will also be given to requirements for clinical/professional knowledge depending on the nature of the allegation(s). |
| **Further Actions Planned** |
| Workforce & OD will appoint investigating officers via resource bank - May 2019 and review the effectiveness of this approach over next 6 months. |

| **Recommendation 5** | **The Health Board must ensure there is relevant and timely clinical input to support the understanding of evidence from vulnerable patients within disciplinary proceedings.** |
|---|---|
| **ABUHB Current Position** | |
| Where appropriate, investigations that are of a clinical nature are supported or managed by a clinician. Where relevant an independent clinician will also be present on any disciplinary panel to provide professional advice to the disciplining manager in order that evidence from patients or colleagues can be appropriately considered. | |
| **Further Actions Planned** | |
| Workforce & OD will continue to ensure that the current practice of appointing appropriate clinical investigating officers and professional clinical advice to disciplinary/grievance hearing panels as and when appropriate is maintained. | |

| **Recommendation 6** | **Welsh Government, through its work with the Safeguarding Boards, needs to ensure that national safeguarding processes enable consistency of reporting to facilitate benchmarking and information sharing across Wales.** |
|---|---|

| **Recommendation 7** | **The Health Board should ensure that there is consistency between the safeguarding strategic plan and safeguarding policies to ensure aims are clearly reflected in all documents.** |
|---|---|
| **ABUHB Current Position** | |
| The ABUHB Strategic Plan for Safeguarding, Keeping People Safe 2016-2019, is aligned to Welsh safeguarding policies and strategic plans and to those of the Regional Safeguarding Boards.<br><br>The Public Health Wales Safeguarding Team have co-produced with health boards a quality self-assessment tool, the Maturity Matrix. This assurance process has been piloting and will be in use as annual self- assessment from 2019. | |
| **Further Actions Planned** | |
| The Health Board Strategy will be reviewed and updated in July 2019. | |

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| **Recommendation 8** | **Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.** |

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| **Recommendation 9** | **The Health Board must ensure all staff, where required by their role, receive a DBS check and address the following: -**<br>• As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check<br>• The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role<br>• The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff<br>• The responsibility for conducting DBS checks for redeployed staff and volunteers is clarified within Health Board policies |

**ABUHB Current Position**

DBS checks are made to relevant posts for new starters to the Health Board and when appropriate on promotion or change of role if there has been no check in the last 3 years of the correct level. This includes any staff that join the ABUHB Resource Bank.

Within the Bank, ABUHB DBS check everyone we recruit externally (Standard for Clerical and Enhanced for all others) as they may work on children wards or with vulnerable adults. Where relevant, DBS status is considered in disciplinary processes.

Workforce & OD will continue to contribute to the All Wales discussions and agreements regarding DBS and other pre-employment checks.

**Further Actions Planned**

Workforce & OD will carry out analysis of staff without a DBS check to identify where appropriate checks are or are not required in line with job roles commencing with MH&LD in March 2019.

| | |
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| **Recommendation 10** | **The Health Board must consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training** |

**ABUHB Current Position**

Safeguarding training is provided to all staff on induction to the Health Board.

An All Wales online training package provides levels of safeguarding training for all health staff. The Health Board Safeguarding Team deliver bespoke sessions for staff when requested to do so.

A programme of multi-agency face-to-face training is provided by the safeguarding boards and is promoted on the safeguarding intranet pages and is accessible for all health professionals.

The Intercollegiate Competency Document (ICD) for Safeguarding (Adults & Children) has recently been agreed in Wales.

| Further Actions Planned |
|---|
| The Health Boards Safeguarding Training Strategy will be updated to reflect the new intercollegiate guidance. |

| Recommendation 11 | The Health Board must ensure there are clear pathways within and across delivery units to share learning and good practice from safeguarding cases, including whether learning from Unit A has been shared with other units |
|---|---|

| ABUHB Current Position |
|---|
| The Health Board Safeguarding Committee disseminates learning on safeguarding matters across the Health Board. The use of 7 minute briefings enables wider dissemination of learning to staff.<br><br>Where there has been serious harm or concerns raised about the handling of safeguarding matters, these are referred to the Regional Safeguarding Boards Case Review Group for consideration of wider learning. The Serious Incident Process runs parallel and contributes to case practice reviews undertaken by the Safeguarding Boards. Learning is disseminated through the Health Board Safeguarding Committee and through the Quality and Patient Safety Committee where this is required.<br><br>Learning from cases managed outside of the area and thematic findings from reviews, audits and inspections are considered similarly.<br><br>Learning is incorporated into training and used to influence policy development. |

| Further Actions Planned |
|---|
| Further consideration to be given to how learning across the organisation can be improved.<br><br>Further analysis of the learning from allegations of abuse and neglect made against health Board staff is required to support practice and improvements where necessary. |

| Recommendation 12 | The Health Board needs to consider the arrangements to evaluate the effectiveness of training and supervision for DLMs. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance. |
|---|---|

| ABUHB Current Position |
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| Designated Lead Manager training (to lead safeguarding investigations) has been provided by the Safeguarding Team. |

| Further Actions Planned |
|---|
| The Safeguarding Team will set up x2 yearly training day for DLMs commencing May 2019.<br><br>The Safeguarding Team to develop and implement a programme of supervision for DLMs and supporting Policy.<br><br>The safeguarding to team to undertake annual audit of safeguarding investigations and practice. |

| Recommendation 13 | The Health Board must review its processes to ensure all relevant safeguarding agencies are invited to strategy meetings and are facilitated to attend, either remotely or in person. |
|---|---|
| **ABUHB Current Position** | |
| Local Authorities delegate responsibility to investigate concerns about safeguarding concerns within NHS healthcare settings and concerning health care staff to the Health Board. This is overseen by the corporate safeguarding team.<br><br>DLMs lead on the investigation and currently invite the police and local authority to strategy meetings where this is required.<br><br>This HIW report and its findings has been presented to the Gwent-wide Adult Safeguarding Board and to the Safeguarding Childrens Board, with the request for support in meeting this recommendation across the five local authority areas. | |
| **Further Actions Planned** | |
| Prospective audit of documentation to ensure safeguarding agencies are invited to strategy meetings and reasons for non- attendance is documented. | |

| Recommendation 14 | The Health Board needs to implement an effective way of checking the completion of the outcome actions when a safeguarding case is closed. |
|---|---|
| **ABUHB Current Position** | |
| Documentation concerning safeguarding investigations are managed via DATIX and minutes and reports are uploaded. The Safeguarding Team are responsible for closing completed investigations and will not close unless the minutes and reports are available and uploaded. | |
| **Further Actions Planned** | |
| Process of closure to be reviewed to ensure that outcome actions are either completed before closure or there is a mechanism for ensuring this within the division. | |

| Recommendation 15 | The Health Board must ensure there is signposting to advocacy and support for the individuals and families affected by incidents within any of its service delivery units. |
|---|---|
| **ABUHB Current Position** | |
| The use of advocacy is recorded on the Data Collection Form. | |
| **Further Actions Planned** | |
| Planned training updates for DLMs will reinforce the importance of the access to advocacy where this is required.<br><br>Prospective audit to ensure that the offer of advocacy is documented at the enquiry stage. | |

| Recommendation 16 | The Health Board must ensure there is effective and timely communication with individuals and families (where appropriate) affected by incidents throughout the safeguarding process. |
|---|---|
| **ABUHB Current Position** | |
| Contact with the victim or their family is always requested at the enquiry stage. | |
| **Further Actions Planned** | |
| Prospective audit to ensure that patients and their families views (where appropriate) are considered and documented at the enquiry stage. A method for updates must be agreed and contact documented. | |

| Recommendation 17 | The Health Board must ensure staff understand that anyone raising a safeguarding allegation should be treated seriously in all cases. |
|---|---|
| **ABUHB Current Position** | |
| This is reinforced through training; and the advice and guidance provided centrally by the Health Board Safeguarding Team and the DLMs within the divisions. | |

| Recommendation 18 | The Health Board should consider the formal support available for any members of staff who may be affected by adverse incidents, including for staff who are the alleged perpetrators of abuse. Furthermore, the Health Board should consider how it enables staff to feed in to improvements to practice. |
|---|---|
| **ABUHB Current Position** | |
| All staff in these circumstances are referred to the well-being service. Additional support is provided by local management team with HR support within the constraints of the safeguarding process. A member of the safeguarding team is available to support staff required to provide witness statements and to attend court. | |
| **Further Actions Planned** | |
| Consideration will be given to how staff are supported in providing feedback in these circumstances to support practice. | |

| Recommendation 19 | The Health Board (ABMU) is required to provide HIW with an update on the actions it has taken in response to the NHS Delivery Unit report, including where actions are incomplete or ongoing. |
|---|---|

| Recommendation 20 | **The Health Board must rapidly improve its governance and reporting/escalation structures (including ward to Board governance) around quality, safety and clinical governance.** |
|---|---|
| **ABUHB Current Position** | |
| All safeguarding matters requiring escalation are reported through the Safeguarding Committee to the Quality and Patient Safety Committee. All urgent matters are escalated to the Executive Team.<br><br>An internal audit of safeguarding practice undertaken by NHS Wales Shared Service Partnership in 2017 provided reasonable assurance in safeguarding policies within ABUHB. | |

| Recommendation 21 | **The Health Board must ensure there are effective arrangements and information systems in place to triangulate:**<br><br>• Workforce issues relevant to safeguarding, such as staff suspension, with its safeguarding processes.<br>• Information from claims, concerns and incidents to highlight areas of concern. |
|---|---|
| **ABUHB Current Position** | |
| The Safeguarding team reviews concerns highlighted by the Putting Things Right Team. | |
| **Further Actions Planned** | |
| Further exploration required to consider how information systems can be triangulated in a meaningful way and how any resultant data managed. | |

| Recommendation 22 | **The Health Board must ensure there are clear and effective pathways for sharing learning from safeguarding and incidents throughout the Health Board.** |
|---|---|
| **ABUHB Current Position** | |
| See Recommendation 11 | |

| **Conclusion** |
|---|
| Aneurin Bevan University Health Board has welcomed the opportunity to undertake this benchmarking activity against the recommendations made by Healthcare Inspectorate Wales. It is recognised that there has been significant activity to support improvement to processes to ensure public safety and protect patients from abuse. There is also acknowledgement that much further improvements are required. A summary of actions has been planned is attached. Implementation will be overseen by the Safeguarding Committee. |

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|---|---|
| **Risk Assessment (including links to Risk Register**) | Reputational risk to the Health Board in not meeting statutory responsibilities. |
| ***Financial Assessment, including Value for Money*** | Financial risks to the Health Board associated with the implementation of Court of Protection applications for DoLS in supported living or family home settings.<br><br>There is currently no corporate or divisional allocation of budget for training and support for MCA and DoLs. |
| ***Quality, Safety and Patient Experience Assessment*** | Will enhance the delivery of Quality, Safety and Patient Experience |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | Addresses statutory responsibilities for safeguarding children and adults at risk. |
| **Health and Care Standards** | Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff – March 2014 3rd Edition;<br>Social Services & Well-being (Wales) Act 2014;<br>All Wales Interim Adult Protection Policy and Procedures in Wales (2010) updated (2012);<br>Doing Well, Doing Better (2010), Health Care Standards 11 & 22;<br>NSF, Health Inspectorate Wales, Vulnerable Groups Act (2006), NICE 16, Standard 13 (Vulnerable Groups);<br>In Safe Hands (2000);<br>Deprivation of Liberty Standards (DOLS) (2007), Supreme High Court Judgement (March 2014) and Mental Capacity Act (MCA) (2005);<br>Dignified Care: Two Years On (2014): Older Peoples<br>Violence Against Women, Domestic abuse and Sexual Violence (Wales) Act (2015) |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | Fully linked to IMTP |
| **The Well-being of Future Generations (Wales) Act 2015 –<br>5 ways of working** | Fully compliant with the 5 ways of working. |
| **Public Interest** | Yes, Protection of public safety |

| Appendix 2 | Summary of Actions the Healthcare Inspectorate Wales Report: Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. |
|---|---|

| Action Required | | Lead | When |
|---|---|---|---|
| **1** | Workforce & OD will update current Redeployment Policy to expressly state the requirements for pre-employment checks, including DBS where appropriate. | Workforce & OD Division | April 2019 |
| **2** | Workforce & OD will continue to review suspensions on a monthly basis and will monitor use of special leave- quarterly. Reporting arrangements will be further considered. | Workforce & OD Division | Ongoing |
| **3** | Workforce & OD will appoint investigating officers via resource bank and review the effectiveness of this approach over next 6 months. | Workforce & OD Division | May 2019<br>Nov 2019 |
| **4** | Review and update ABUHB Safeguarding Strategy. | Safeguarding Committee | July 2019 |
| **5** | Workforce & OD will carry out analysis of staff without a DBS check to identify where appropriate checks are or are not required in line with job roles commencing with MH&LD. | Workforce & OD Division | March 2019 |
| **6** | The Health Boards Safeguarding Training Strategy will be updated to reflect the new intercollegiate guidance. | Safeguarding Committee | September 2019 |
| **7** | The Safeguarding Team will set up x2 yearly training day for DLMs. | | May 2019 |
| **8** | An analysis of the learning from allegations of abuse and neglect made against health Board staff will be undertaken to support practice and improvements where necessary. | Safeguarding Committee | July 2019 |

Action plan summary. Version 1 27.03.19 RM

| Appendix 2 | Summary of Actions the Healthcare Inspectorate Wales Report: Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. |
|---|---|

| Action Required | | Lead | When |
|---|---|---|---|
| **9** | The Safeguarding Team to develop and implement a programme of supervision for DLMs and supporting Policy. | Safeguarding Committee | July 2019 |
| **10** | The safeguarding to team to undertake annual audit of safeguarding investigations and practice undertaken by the Health Board. This will be a prospective audit and include:<br>• Audit of documentation to ensure safeguarding agencies are invited to strategy meetings and reasons for non- attendance is documented.<br>• Patients and their families' views (where appropriate) are considered and documented at the enquiry stage. A method for updates must be agreed and contact documented.<br>• The offer of advocacy is documented at the enquiry stage. | Safeguarding Committee | December 2019 |
| **11** | Further exploration required to consider how information systems can be triangulated in a meaningful way and how any resultant data managed. | Safeguarding Committee | July 2019 |

Action plan summary. Version 1 27.03.19 RM

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Special Review

## Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W

Review date: 2018

Publication date: 29 January 2019

**EMBARGOED UNTIL PUBLICATION 29 JANUARY 2019**

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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**Communications Manager**

**Healthcare Inspectorate Wales**
**Welsh Government**

**Rhydycar Business Park**

**Merthyr Tydfil**

**CF48 1UZ**

Or via

**Phone:** **0300 062 8163**

**Email:** **hiw@gov.wales**

**Fax:** **0300 062 8387**
**Website: www.hiw.org.uk**

Digital ISBN 978-1-78964-676-4

## Contents

# Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

## Our purpose

**To check that people in Wales receive good quality healthcare**

## Our values

**We place patients at the heart of what we do. We are:**

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

## Our priorities

**Through our work we aim to:**

| | |
|---|---|
| **Provide assurance:** | **Provide an independent view on the quality of care** |
| **Promote improvement:** | **Encourage improvement through reporting and sharing of good practice** |
| **Influence policy and standards:** | **Use what we find to influence policy, standards and practice** |

# 1. Foreword

Between 2011 and 2013 three female patients within the learning disability directorate of Abertawe Bro Morgannwg University Health Board ("the health board") made allegations of sexual abuse against the same member of staff ("Mr W"). Mr W was subsequently arrested and convicted of murder in 2016. At the time of his arrest, he was still an employee of the health board but not working with patients due to his suspension. He had been suspended from work since 2012 pending the outcome of the health board's disciplinary investigation following the abuse allegations. The health board carried out an internal review of the events to look at how it had handled the allegations made by its patients and the subsequent disciplinary process. The health board's review found some shortcomings in its processes and established an action plan for improvement.

HIW was asked by Welsh Government to carry out an independent review of the health board's actions.

HIW's review focused on the following areas in relation to the events in this case:

- Staff recruitment and employment
- Incident reporting
- Adult safeguarding
- Governance and culture.

Specifically, HIW's review considered whether:

- The health board's internal review was sufficiently thorough
- The health board's conclusions were appropriate on the basis of the evidence considered
- The actions taken by the health board in light of those conclusions were adequate to ensure patient safety
- Additional or different conclusions should be reached on the basis of additional evidence considered during this review
- There was any wider additional learning for the NHS in Wales.

The review did not look at the actions of the police or the Crown Prosecution Service (CPS) as this is outside HIW's statutory remit.

We are grateful to former and current members of the health board staff, to the police for their co-operation, and to all the interested parties who took time to contribute to this review. We are particularly thankful to the three patients and their families/representatives who were able to give information to this review.

# 2. Summary

Between 2011 and 2013 three patients within the Learning Disability (LD) directorate of Abertawe Bro Morgannwg University Health Board made allegations of sexual abuse against the same member of staff (Mr W). In 2016, towards the end of the disciplinary process addressing the allegations of abuse, Mr W was arrested and convicted of murder. At the time of his arrest, he was still an employee of the health board. He had been suspended from work since 2012 pending the outcome of the health board's disciplinary investigation following the abuse allegations. The health board decided to carry out an internal review of documentary evidence (desktop review), which concluded in July 2017, to look at how it had handled the allegations made by its patients and the subsequent disciplinary process. The health board's review found shortcomings in its processes and established an action plan for improvement. The areas of concern identified were safeguarding processes, incident reporting, recruitment practices and governance and culture. It also concluded that Mr W's actions could not have been 'predicted or prevented'.

HIW's independent review of the health board's actions found that the decision to undertake a review that only considered documentary evidence meant that the effectiveness of the review was limited. Documentary reviews tend to focus on the actions of a few frontline staff and often miss the wider context of events. Whilst the health board's conclusions were not unreasonable, based on the limited evidence considered, the conclusion that Mr W's actions outside of his employment could not have been predicted or prevented is not based on evidence to either support or refute it. What we can say, having considered a wider range of evidence, is that there was nothing in Mr W's training, supervision or occupational health records that would have indicated that he was unsuitable to work in a care setting.

The review considered how the allegations against Mr W were handled. The fact that the first allegation was not initially recognised as a safeguarding incident despite being repeated to staff highlights the importance of listening to patients. There was also a delay in removing Mr W from clinical duties. The other allegations were recognised and reported as such. Whilst the safeguarding procedures were followed, multi-agency involvement is vital if the safeguarding process is to be robust. In the latter part of the safeguarding process in Mr W's case, there was often no social services presence at strategy meetings. All the agencies involved in safeguarding have a responsibility to facilitate multi-agency involvement in meetings, either in person or remotely.

A criminal investigation was undertaken into all three allegations but the CPS took the decision that there was insufficient evidence to secure a conviction.

The health board therefore investigated the allegations under its disciplinary process. However, the process took an excessively long time because the health board did not provide any additional resources to support the disciplinary investigation.

HIW identified weaknesses in the quality and safety governance arrangements at the health board. These have been highlighted previously in other national reports (including Trusted to Care in 2014). The health board has made changes to improve its governance and reporting structure, both in terms of the escalation of concerns to Board level and the sharing of learning at an operational level throughout the health board. However, it is of concern that progress has been slow in this area and the governance structures within the health board relating to quality and safety are still not clear. HIW is concerned this does not give assurance about the quality of current processes within the health board for scrutinising safeguarding concerns and that the Board may not be sufficiently sighted on what is happening at operational level.

HIW also noted that Mr W did not have a Disclosure and Barring Service (DBS) check when he was employed. We also found that there were a number of employees within the mental health and learning disability directorate who do not have a DBS check because their employment had predated the requirement for those checks. DBS checks are also not updated on a regular basis. This is an unacceptable safeguarding risk.

The Wales Safeguarding Procedures are currently under review and this is an important piece of work. However, this work needs to progress quickly to ensure that Wales has an effective and consistent approach to adult safeguarding.

The weaknesses identified in the health board's handling of this case strongly suggest that senior health board staff did not appreciate the seriousness or complexity of the allegations at the time. Whilst we found the health board has made improvements to its governance arrangements following the Trusted to Care and desktop reviews, we are disappointed to find that significant work is still needed in this area to ensure there are robust systems to effectively identify areas of concern, manage risk and share learning across the health board.

# 3. What we did

## Scoping and initial information gathering

We spoke with interested parties and looked at the documentary evidence considered by the health board's review in order to determine the scope of the review. The terms of reference for the review were published in February 2018. These are set out in Appendix B.

## Review team

The review was led by a Review Manager from HIW. We established a small team of peer reviewers to provide the range of skills and knowledge required. The peer review team consisted of:

- Consultant Learning Disabilities Forensic Psychiatrist (NHS Trust in England)
- Former Head of Nursing (Health Board in Wales)
- Learning Disability Advocate (third sector organisation)
- Chief Nurse (NHS Trust in England).

## Document review

We considered a range of documentary evidence to inform this review. These included:

- The documents considered by the health board's desktop review team, including:
    - Mr W's HR records
    - Disciplinary investigation documents for the allegations against Mr W
    - Electronic safeguarding records for the three allegations
    - Police statements taken during the investigation of all three allegations.
- Additional records requested by HIW, including:
    - Mr W's supervision and training records
    - Mr W's occupational health records

- Relevant payroll records for Mr W
- Email correspondence and additional records supplied by individuals who were interviewed
- The health board's policies and procedures relevant to this review
- Records of action taken by the health board following its desktop review
- Electronic Police records in relation to the three allegations.

## We did not consider:

- Mr W's medical records (other than those which formed part of his occupational health records held by the health board)
- CPS documentation (this was not made available to us)
- Paper Protection of Vulnerable Adults (POVA) files (these were not located by the health board and we accessed the electronic records only).

## Interviews

We spoke with a number of interested parties to inform this review.

Where possible, we spoke with the women who made the allegations. Where this was not possible, we contacted their representatives or members of their family.

We contacted key current and former members of health board staff. All were willing to speak with the review team. Members of the review team interviewed over 40 current and former members of staff. These included:

- Former senior management staff within the LD Directorate
- Former senior clinicians within the LD Directorate
- Current senior management staff within Mental Health and Learning Disability (MHLD) service delivery unit
- Former executive Board members
- A selection of current staff at learning disability Unit A, including longstanding staff members who had worked with Mr W and those who had been employed since his dismissal in 2016.

We also visited Unit A and spoke with representatives of Cardiff and Vale University Health Board and Cwm Taf University Health Board.

## Report

HIW's conclusions, and the evidence on which these are based, are set out in this report.

It is not the intention that this report should include every detail that has been considered during the course of this review. The report covers the relevant significant events and evidence.

HIW is mindful of its responsibility to maintain confidentiality for those involved and the wording of the report reflects this. The report has been anonymised throughout using letters as opposed to names. Details which may cause certain individuals to be identifiable have been omitted as far as possible. Staff are referred to by their titles only.

Throughout the report reference is made to relevant legislation, policies and national standards.

# 4. Brief summary of the background events

## The health board's learning disability directorate

At the time, the health board's LD directorate provided specialist health services for people with learning disabilities covering three health board areas in South Wales (Abertawe Bro Morgannwg, Cwm Taf and Cardiff and Vale) and includes seven separate local authority areas.

In 2015, as part of restructuring at the health board, the LD directorate was merged with the health board's mental health directorate to form a new mental health and learning disability service delivery unit. The service delivery unit continues to provide specialist learning disability health services to the three health board areas.

## The events that led to this review

Mr W is the son of the former Clinical Director of the health board's LD directorate.

Mr W was first employed by the health board in its IT department. At that point he was studying for an IT degree and completed a six month paid student placement at the health board between March and September 2001 as a trainee systems developer. He continued to complete a piece of IT work on an unpaid basis as part of his final year degree project. On completing his degree, he was reemployed by the health board's IT department on a permanent basis.

In July 2004, Mr W went on sick leave. In October 2004, he remained absent from work on sickness grounds and his sick pay entitlement had been exhausted. A meeting was arranged with the IT service manager to discuss the situation. Options discussed included termination of his employment or redeployment as it had been suggested that working with screens may be contributing to his ill health. He was referred to the health board's occupational health department in November 2004 for advice on his suitability for redeployment. Occupational health supported Mr W's move to the LD directorate. Mr W started work as a nursing assistant at one of the health board's Acute Assessment and Treatment Units (Unit A) on 17 December 2004.

In December 2011, one of the residents of Unit A (Ms X) made several allegations to staff that Mr W had inappropriately touched and sexually assaulted her. These allegations were recorded in the care records. In January 2012, the care manager was reviewing Ms X's case records and noted these

entries. The allegations were then reported as a safeguarding concern. Mr W was placed on special leave. A police investigation and then subsequently an initial review under the health board's disciplinary policy concluded that there should be no further action. Mr W returned to work on 4 April 2012 in a different residential setting (Unit B).

In October 2012, a former resident of Unit A (Ms Y) made an allegation that Mr W had sexually assaulted her whilst she had been an inpatient at Unit A in 2011. Mr W was again placed on special leave while the allegation was investigated by the police. A third allegation of sexual assault was made in February 2013 by another resident of Unit A (Ms Z). Her allegation related to events in 2010. This allegation was also investigated by the police. In 2014, the police confirmed that whilst they had put the case to CPS, the CPS had determined that it did not meet the evidential test to proceed to prosecution. The health board therefore started its own disciplinary process under its disciplinary policy. An investigating officer was appointed and the investigation report was completed in early 2015. It concluded that there was a case to answer and the matter proceeded to disciplinary hearing. The disciplinary hearing took place in December 2015. It was determined that additional supporting evidence should be sought. Mr W remained suspended from work throughout this period. A dismissal letter was sent to Mr W on 21 April 2016 stating that the health board was terminating his employment for gross misconduct. The letter noted the three allegations made against him, the nature of these allegations and suggested that, on the balance of probability, inappropriate behaviour had taken place. It concluded that it would be too great a risk to allow him back to the health to return to his role or any other healthcare post.

However, by this point, Mr W was being held on remand, having been arrested on 7 March 2016 on suspicion of the murder of Ms J, one of his neighbours. He was convicted of her murder in September 2016.

The health board undertook an internal review of the circumstances around the handling of the allegations against Mr W to ascertain whether additional action could have been taken. The review entailed consideration of documentary evidence in relation to Mr W's employment and the allegations made against him (known as the desktop review). The lead investigator was the then head of the health board's serious incident review team. The desktop review process

concluded in July 2017. Its report[1] identified a number of process issues relating to governance, recruitment and safeguarding. The main conclusions of the desktop review were that:

- There was a delay in recognising the first allegation as a safeguarding incident and reporting it as such
- No DBS check was done on Mr W's redeployment to the LD directorate
- The disciplinary process took too long to reach the final dismissal decision
- There was a suggestion that the individuals making the allegations may not have been believed, referring to the delay in reporting the first allegation and the wording of the disciplinary report.

However, the desktop review report noted that all three allegations had been escalated to the Police and social services under safeguarding processes and investigated by the Police and referred to the CPS for a prosecution decision. It concluded that Mr W's future conduct and behaviour outside of his employment could not have been predicted or prevented.

A health board action plan was compiled, based on the issues identified in the report. This included:

- Relationship policy for health board employees
- Designated Lead Manager (DLM)[2] numbers had been reduced to ensure level of training was up to date. The health board also introduced a system for peer supervision for DLMs
- Creation of a centralised team to assist with disciplinary investigations to ensure investigations are adequately resourced and completed in a timely way.

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[1] Health Board Lessons Learned Desk Top Review (ABMUHB) August 2017 http://www.wales.nhs.uk/sitesplus/documents/863/4.3%20desktop%20review%20and%20lessons%20learned%20report.pdf

[2] Designated Lead Managers are senior workers (usually team managers or senior practitioners) who are responsible for the delivery of safeguarding work within their organisation.

The action plan also noted actions that had already been taken since the events in question in 2012:

- Recruitment was now completed through a centralised process (managed by the NHS Shared Services Partnership) rather than within each directorate
- Work on organisational culture. This included work on the health board's values; the 'See it, Say it' initiative; the 'Family and Friends test', the 15 Step challenge and 'In your shoes'
- Datix recording (of incidents and safeguarding) was now a web based system
- Reorganisation of the directorates into six service delivery units.

## General context

It is important to set out the general context in relation to learning disability services and safeguarding at the time that the allegations in this report were made and investigated (2011 onwards).

The high profile case of institutional abuse of residents in a private learning disability setting at Winterbourne View was highlighted in the media in 2011. The case resulted in staff being convicted for the abuse and started considerable debate about how to ensure that vulnerable patients were effectively safeguarded. A report looking into the circumstances of the actions of staff and the abuse of patients was produced in 2012[3] with recommended actions pertinent to all learning disability settings. Similarly a report into how Jimmy Savile was able to abuse children and patients in a variety of settings (including hospitals) caused widespread concern[4]. A Police investigation started in 2012. The extent of the allegations made prompted a review of safeguarding processes in many public sector care settings, including hospitals.

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[3] Winterbourne View Hospital, A serious case review (South Gloucestershire Adult Safeguarding Board); Margaret Flynn 2012. http://sites.southglos.gov.uk/safeguarding/adults/i-am-a-carerrelative/winterbourne-view/

[4] Jimmy Savile NHS investigations: Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile; Department of Health 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480059/lessons-response.pdf

In 2013, a teenage patient with autism drowned at a care setting in England having had an epileptic seizure whilst in the bath unsupervised. This focussed attention on the culture of care environments and the standard of care and treatment available to people with learning disabilities.[5]

The Social Services and Well-being (Wales) Act 2014 received royal assent on 1 May 2104 and came into force on 6 April 2016. Before this, there was no specific legal provision for safeguarding adults in Wales. There were non-statutory procedures in place for reporting and investigating safeguarding incidents involving adults at risk. The introduction of the Act put the safeguarding of adults on a statutory footing to bring it into line with the safeguarding of children. The Welsh Government has published statutory guidance for adults to accompany the provisions of the Act[6]. Work to update the Wales Safeguarding Procedures is being undertaken by Cardiff and Vale Safeguarding Board on behalf of all Safeguarding Boards in Wales. This work is intended to be completed in July 2019. Therefore, agencies are still using the previous safeguarding adults (POVA) procedures in the interim.

## Context - Abertawe Bro Morgannwg University health board

It should be noted that the events of this case span a 15 year period encompassing the existence of the former Bro Morgannwg NHS Trust and Swansea NHS Trust, prior to their merger in 2008 to become Abertawe Bro Morgannwg University NHS Trust. In 2009, Abertawe Bro Morgannwg University NHS Trust formally merged with the local health boards of Swansea, Neath Port Talbot and Bridgend to become Abertawe Bro Morgannwg University Health Board.

It may also be helpful to set out two important and high profile events that were happening at a similar time to the events described in this report.

A review of care concerns at Princess of Wales Hospital and Neath Port Talbot Hospitals took place in 2013. It was commissioned in response to complaints about an unacceptable standard of care being provided to elderly and

[5] Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk; Verita, October 2015 https://www.england.nhs.uk/wp-content/uploads/2015/10/indpndnt-rev-connor-sparrowhawk.pdf

[6] Welsh Government codes of practice and statutory guidance in relation to the Social Services and Well-being (Wales) Act 2014 https://gov.wales/topics/health/socialcare/act/code-of-practice/?lang=en

vulnerable patients. The resulting report 'Trusted to Care'[7] was published in May 2014. It highlighted issues about the culture and values within healthcare settings. As a result of Trusted to Care, the health board implemented a behaviours and values framework and a number of 'values-based' initiatives to promote a more positive patient-centred care culture within the health board's hospitals. All health boards in Wales were also required to consider and respond to the findings outlined in the report. A follow-up report to look at the improvements made was written in 2015.

In 2013, discrepancies in some blood glucose readings taken by nursing staff at Princess of Wales Hospital were discovered. As a result, a significant number of nursing staff were suspended and some were eventually convicted of falsifying blood glucose measurement records. The criminal process took some time to complete, but after its conclusion, the health board commissioned a report to identify any learning and improvement to prevent any recurrence. The report was completed and considered by the health board in 2016.[8]

[7] Trusted to Care, An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board; May 2014 Professor June Andrews and Mark Butler.
https://gov.wales/topics/health/publications/health/reports/care/?lang=en

[8] Commissioned Review, June to September 2016. Review of the Blood Glucometry Investigations in Abertawe Bro Morgannwg University Health Board. Establishing lessons learned. Professor Angela Hopkins.
http://www.wales.nhs.uk/sitesplus/documents/863/4.5%20Blood%20Glucometry.pdf

# 5. What we found

## Recruitment and employment

Mr W's redeployment did not follow the health board's redeployment policy.

The redeployment policy is not clear about who is responsible for DBS checks when a member of staff is redeployed.

Mr W's supervision and training records did not indicate any concerns with his performance.

Mr W's occupational health records did not indicate he was unsuitable to work in a healthcare setting.

Mr W should have been formally suspended from work at a much earlier stage, as opposed to remaining on special leave.

As a result of lack of resources being provided by the heath board, the disciplinary process took far too long.

Occupational health involvement was offered to Mr W throughout his employment.

### Mr W's redeployment to the learning disability directorate

***The redeployment policy was not followed. There was no evidence that a specific permanent vacancy existed at learning disability Unit A prior to Mr W starting work in December 2004. Mr W had previous experience of working in a care setting and positive references on his HR file about this employment.***

The former Bro Morgannwg NHS Trust's redeployment policy[9] sets out the process for redeploying staff who are not able to continue in their current roles to other vacancies within the health board. It gives current staff on the redeployment register preference in applying for vacancies that have arisen within the health board. Relevant extracts from the policy are set out in Appendix D. The process entails comparing the health board's vacancy list each week against the list of staff on the redeployment register to identify any suitable vacancies. Staff on the redeployment register who meet all the minimum criteria for the vacancy will be offered it[10].

A meeting with Mr W's managers in the IT department in October 2004 indicated that Mr W had, at that point, been absent on sickness grounds since July 2004 and it was noted that he had exhausted his sick pay entitlement on 13 October 2004. The health board said that it was not able to support the continued employment of an employee once their sick pay had been exhausted, though it agreed to Mr W continuing to be on unpaid leave pending an upcoming occupational health appointment.

At that appointment (30 November 2004), as well as assessing Mr W's general fitness for work, the occupational health consultant noted that he would 'fully support' Mr W's redeployment to a nursing assistant post within the LD directorate, although recommended that he avoid night shifts for the first three months. The consultant recorded that he was 'optimistic' that Mr W would be generally fit to provide regular and effective service in this area of work in the long term. A letter from the occupational health consultant confirming this is dated 9 December 2004.

Mr W started work at learning disability Unit A on 17 December 2004[11]. The Vacancy Requisition Form (VF1) was completed and signed by three members of management staff on 10 January 2005. All three signatures have the same date. The VF1 form referred to a new, permanent, full-time nursing assistant vacancy at Unit A 'because additional funds had been made available by Cardiff and Vale University Health Board'. The form also indicated that the post was 'to be filled from redeployment register'.

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[9] Redeployment Policy 2003 (the former Bro Morgannwg NHS Trust) which was in use at the time of Mr W's redeployment. The current version of the redeployment Policy dates from 2016

[10] Section 5.2 and Appendix 2 of the Redeployment Policy 2003

[11] Payroll records and absence records

An undated redeployment counselling form completed by Mr W stated that the change would give him a break from computer screen work which was felt to be exacerbating his sleep problems.

Evidence from staff interviews suggested that there was no vacancy at Unit A at the time of Mr W's redeployment. A contrary view was that additional funds had been made available by Cardiff and Vale University Health Board (as stated on the VF1 form). This was due to a specific resident who required a higher level of support being admitted for a period of assessment to Unit A, prior to moving on to a permanent residential placement. There was no documentary evidence in relation to this but the availability of additional funds for the duration of the placement was corroborated by a Cardiff and Vale University Health Board staff member. This resident's placement at Unit A had started in April 2004 and was a temporary assessment placement which lasted for around a year. It is difficult to see why this placement resulted in a permanent full-time vacancy arising at Unit A in December 2004 when Mr W required redeployment.

Mr W had already started working at Unit A three weeks before the VF1 was completed and signed. The process did not follow the one set out in the health board's redeployment policy. This may in part explain why no DBS check was completed for Mr W. The subject of DBS checks is dealt with in the 'Safeguarding' section of this report.

However, Mr W did have previous experience working in a learning disability care setting (for an independent care provider). There were two positive references on his HR file in relation to this employment[12]. There was no documentary evidence to indicate that, at this point, he would have been unable to secure a position within a care environment.

The redeployment policy[13] did not state where the responsibility for carrying out DBS checks lies for redeployed staff. The current version of the policy (2016) does not clarify this either. HIW's recommendations regarding DBS checks are included within the 'Safeguarding' section of this report.

[12] These were the references provided when Mr W was first employed by the health board in 2001 within the IT department

[13] Redeployment Policy 2003 (for the former Bro Morgannwg NHS Trust)

Recommendation 1

The health board must ensure the redeployment policy is consistently followed.

## Training and supervision

***Mr W completed training relevant to the role. There were no concerns about his performance from his supervision records (other than sickness absence). Staff who worked with Mr W did not notice anything of concern about his interaction with patients.***

Mr W's training records indicated that he completed all required mandatory training, including training in positive behavioural management techniques and safeguarding. He had also started a National Vocational Qualification Level 3 in Health and Social care.

Supervision records from February 2005 stated that Mr W had settled in well to his new role and there were no concerns about his performance. The supervision records HIW reviewed cover a number of years of Mr W's employment, but not the entire employment period. The records did not suggest any concerns about Mr W's performance other than his level of sickness absence and the fact that working predominantly night shifts impacted on the experience he gained of working with patients. Staff who worked with Mr W at Unit A, and those who managed him, told us they had no concerns about his interaction with patients at the time.

## Sickness absence and occupational health

***Occupational health support was available to Mr W throughout his employment. Mr W was working late afternoon and night shifts as a result of occupational health advice. However, managers felt that the occupational health advice given to them about Mr W was unclear. There was nothing in Mr W's occupational health records to suggest he was unsuitable to work in a healthcare setting or with adults at risk.***

In the first year following his redeployment to the nursing assistant post, Mr W took three days of sick leave. In subsequent years his sickness absence increased, but was not sufficient to trigger the health board's sickness absence policy until May 2011. At that point, a letter was sent to Mr W informing him that his sickness absence was being dealt with formally under the health board's sickness policy.

The role of the occupational health department is to support employees to ensure they are able to fulfil their employment role and to assist management in facilitating this. HIW looked at Mr W's occupational health records as part of this review. However, it should be stressed that this is not a review of Mr W's clinical status or care. The occupational health records formed part of HIW's review because they are pertinent to the health board's management of Mr W's employment and indicate any concerns that the health board may have been aware of at the time.

Mr W attended a total of 14 appointments with the occupational health department during his employment with the LD directorate. These were either at Mr W's request (self-referral) or via referral by Mr W's managers for occupational health review when there were concerns about his level of sickness absence. Based on occupational health advice, there was an agreement that Mr W should work a mixture of late afternoon and night shifts. This was a compromise following the occupational health advice for night shift working. Management staff indicated that no staff worked night shifts only as the operational needs of the unit required staff to work different shifts for training, cover and to ensure they are aware of patient needs.

Mr W's occupational health records did not note any health condition to indicate Mr W was unsuitable to work in a healthcare setting or with adults at risk.

The evidence from staff interviews indicates that there was a lack of clarity for managers about the occupational health reasons for the request for night shift working only. Staff acknowledgement there would always be tension between the needs of an individual employee and the needs of the service as a whole. However, management staff felt unsupported by the nature of the occupational health advice given in this case. Clear advice is important to identify and agree the best way to accommodate both the needs of the employee and the operational requirements of the service.

Recommendation 2

The health board needs to consider how occupational health advice can be more clearly communicated to management staff, in order to accommodate the needs of the employee concerned.

## Disciplinary process

### Suspension vs. special leave

***Mr W was inappropriately left on special leave as opposed to being suspended or working in a non-clinical role. Whilst this had the same result, in that Mr W was removed from any contact with patients and***

***remained on full pay, it created a suspicion amongst staff that he was being treated differently and meant that his suspension was not reported as such as part of the health board's figures.***

The health board's policies[14] on suspension and special leave are clear. Where allegations are made against staff, authorised absence is to be used as a short term measure only to remove someone from the clinical environment while facts are being initially established to determine how to proceed. Once a decision is made to proceed with an investigation either under the disciplinary policy or safeguarding procedures, suspension on full pay or temporary reassignment to a non-clinical role should be considered. The policy states that suspension is a 'no fault' option and is to protect both the member of staff and the patient. Suspending a member of nursing staff requires permission from a senior HR staff member and the executive director of nursing. The option to place someone on long-term special leave for disciplinary reasons was outside of the health board's procedures. The special leave policy outlines the specific instances where special leave is granted. These include bereavement, public duties and emergency leave. The policy states that any absence due to illness or disciplinary reasons should be dealt with under the sickness absence or disciplinary policies.

Although staff told us Mr W was placed on special leave due to concerns for his health, this was not in line with the health board's policies and no formal justification was given for why Mr W was placed on special leave as opposed to suspension. Evidence from interviews indicated there was inconsistency in the use of special leave and suspension amongst managers. A view expressed by staff was that the result of both special leave and suspension was the same (that is, removal from work on full pay), though they felt that suspension seemed a harsher way of dealing with this, and staff felt more comfortable using the term 'special leave'. However, differences in practice create suspicion that staff are being treated differently. The disciplinary policy is clear that suspension is a 'no blame' measure, and should be viewed by all staff as such. Incorrectly, or inconsistently using 'authorised absence' or 'special leave' on a longer term basis, as opposed to suspension, also means that absences for disciplinary reasons are not adequately recorded or monitored in the health board's performance figures.

[14] Disciplinary policy 2011 and 2017; Special Leave policy 2014

Mr W was offered a temporary move to a non-clinical role but he declined this because it would mean working day shifts as opposed to the late afternoon and night shift pattern in his nursing assistant role.

Recommendation 3

The health board must ensure the suspension and special leave policies are applied consistently and all staff are clear about their correct use in relation to staff members under investigation.

## Disciplinary investigation and hearing

***The disciplinary process took far too long. This was a complex and sensitive case, which was evidentially difficult as there was no independent witness evidence. No additional resources were offered or provided to the investigating officer. This was a shortcoming and was in contravention of the health board's own disciplinary policy. This also strongly suggests that senior health board staff did not appreciate the seriousness or complexity of the allegations.***

Following the CPS decision not to proceed with prosecution, a POVA strategy meeting was held on 22 January 2014.

The decision of this meeting was to proceed with the disciplinary process against Mr W. The health board's disciplinary policy[15] outlines the disciplinary process. This involves investigation by an investigating officer. On the basis of that investigation, a recommendation is made to the disciplining officer as to whether there is a case to answer, the case is proven or that there should be a disciplinary hearing. The case is then passed to the disciplining officer to make the decision as to how to proceed.

Mr W was informed about the disciplinary investigation at a meeting on 6 February 2014. An investigating officer was appointed from outside the LD directorate. As the former Clinical Director of the LD directorate was also the father of Mr W, we explored their involvement in respect of the disciplinary investigation due to the potential conflict of interest. The investigating officer

[15] Disciplinary Policy and Procedure 2011, (this was revised in 2014 and in 2017 – the current version)

confirmed to HIW that she did not know the former Clinical Director or have any contact from him during the disciplinary process. Evidence from interviews also indicated there was no contact between investigating officer or disciplining officer and the former Clinical Director throughout the disciplinary process. The former Clinical Director did attend on the day of the disciplinary hearing, but this was after he had left the health board's employment. From staff interviews, there was no indication of any direct influence on the disciplinary process by the Clinical Director.

The investigating officer completed her report in February 2015 and was forwarded to the HR department. The report stated that there was evidence to support a disciplinary hearing so that a panel could hear the evidence. No additional resources (either administrative support or time) were made available to the investigating officer to support the investigation. As a result, the investigating officer completed the investigation on top of her normal duties. A disciplinary hearing scheduled for 30 July 2015 was postponed at the request of Mr W's representatives. The hearing finally took place on 2 December 2015. Mr W was dismissed on 21 April 2016.

The investigating officer and the disciplinary panel had access to all the police statements for the three allegations so were aware of the evidence provided by the three women involved. It would have been helpful to have input from clinicians with knowledge of the abilities of the individual patients in the disciplinary process. This would have assisted the investigating and disciplinary panel to fully understand the evidence and any limitations within that evidence which may have arisen due to their learning disabilities. The disciplining officer stated that he had approached the three clinicians involved following representations made at the disciplinary hearing by Mr W's representative. One clinician raised concerns about the need for up-to-date consent from the patient concerned before sharing information as part of the disciplinary process. The clinicians were therefore not contacted again for information about their specific clients and this avenue was not pursued further. It should have been, and at an earlier stage. This would have led to a better understanding of the evidence given by the women when it was considered by the investigating officer and subsequently presented to the disciplinary panel. General evidence was provided to the disciplining officer by one of the clinicians, but evidence specific to the abilities of the three women individually to explain their evidence would have been much more helpful in the process.

It is HIW's view that the disciplinary investigation was hampered by limited resources and clinical input. HIW notes that one of the outcome actions following the health board's desktop review was to fund a specific team to support disciplinary investigations, but this action is yet to be completed.

### Recommendations 4-5

The health board must identify and provide sufficient resources for disciplinary investigations to ensure their timely completion.

The health board must ensure there is relevant and timely clinical input to support the understanding of evidence from vulnerable patients within disciplinary proceedings.

## Safeguarding

There are staff whose employment started prior to the requirement for Criminal Records Bureau (CRB)/DBS checks who have never had a CRB or DBS check.

DBS checks are now completed centrally as part of the recruitment process, but the health board's policies are unclear about the responsibility for checks for staff who are redeployed or for volunteers.

There was an unacceptable delay in recognising and reporting the first allegation as a safeguarding issue.

All allegations were dealt with via multi-disciplinary strategy meetings in line with the safeguarding process (involving the police and social services).

The safeguarding process was managed by a Designated Lead Manager (DLM) outside of the LD directorate from 2013 onwards. All allegations should have been overseen by a DLM from outside the directorate from the outset because of the family relationship between Mr W and the LD Clinical Director.

The outcome actions at the conclusion of the safeguarding process were not completed. The health board does not have a mechanism to properly check this.

Safeguarding encompasses a number of measures which together help to provide reporting, information sharing and learning to ensure that children and adults at risk are protected and to minimise any risk of harm. Safeguarding has been recently described as an 'imperfect art'[16]. Effective safeguarding requires constant vigilance, learning and adherence to safeguarding processes for any system to be able to minimise the risk of harm to adults at risk.

[16] Presentation by Margaret Flynn, Chair of the National Independent Safeguarding Board. https://bromley.mylifeportal.co.uk/media/19694/02_margaret.pdf

The Welsh Government has published statutory guidance[17] for adults to accompany the provisions of the Social Services and Wellbeing (Wales) Act[18]. Work to update the Wales Safeguarding Procedures following the introduction of the Act is being undertaken by Cardiff and Vale Safeguarding Board on behalf of all safeguarding boards in Wales. The result of this is expected in July 2019. In the interim, the health board, along with many other agencies in Wales, is still using the previous 'POVA'[19] procedures. A recent report by the Older Peoples Commissioner for Wales highlighted the lack of consistency of safeguarding practice across the different health boards[20]. This results in inconsistency of reporting thresholds, investigation processes, information collection and sharing, and patient involvement throughout Wales. Whilst its findings relate to the needs of older people in hospital, some of its conclusions in respect of safeguarding practice are equally applicable to other adult patients.

An audit[21] of its POVA processes, completed by the health board in 2015, highlighted that there were policies which were out of date. The health board noted that the safeguarding adult processes were being reviewed nationally, but renewed its POVA policy by referring it to the safeguarding committee. The health board's previous safeguarding adults strategy dated from 2009. The health board have confirmed this has now been replaced by a strategic work plan for safeguarding. The health board said that it measures its safeguarding performance by benchmarking to national standards and priorities.

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[17] Welsh Government codes of practice and statutory guidance in relation to the Social Services and Well-being (Wales) Act 2014 https://gov.wales/topics/health/socialcare/act/code-of-practice/?lang=en

[18] Social Services and Well-being (Wales) Act 2014 http://www.legislation.gov.uk/anaw/2014/4/contents

[19] Interim Procedures for the Protection of Vulnerable Adults Procedures 2010 (amended 2013) https://socialcare.wales/research-and-data/research-on-care-finder/wales-interim-policy-and-procedures-for-the-protection-of-vulnerable-adults-from-abuse

[20] Safeguarding in Hospitals in Wales: Review of the Actions which Health Boards are taking to ensure that older people who are hospital in-patients are safeguarded from harm in line with the requirements of the Social Services and Wellbeing (Wales) Act 2014 Sections 7 and 10. March 2018; Older Peoples Commissioner for Wales. http://www.wales.nhs.uk/sitesplus/documents/863/8b.%20Appendix%20Safeguarding%20in%20Hospitals%20Report1.pdf

[21] ABM Protection of Vulnerable Adults Audit 2015 – ABM-1516-038 (NHS Wales Shared Services Partnership Audit and Assurance Service)

Recommendations 6-7

Welsh Government, through its work with the safeguarding boards, needs to ensure that national safeguarding processes enable consistency of reporting to facilitate benchmarking, and information sharing across Wales.

The health board should ensure that there is consistency between the safeguarding strategic plan and safeguarding policies to ensure aims are clearly reflected in all documents.

## DBS checks

***Mr W did not have a CRB/DBS check in place. In addition, a number of longstanding members of MHLD directorate staff have never had CRB/DBS checks as there has never been a national requirement to carry out these checks retrospectively. DBS checks are now conducted centrally at the health board as part of recruitment and staff are not allowed patient contact prior to completion of these checks. However, it is unclear whether this centralised system covers redeployed staff or volunteers.***

The Disclosure and Barring Service was formed in 2012. Checks under the DBS scheme replaced the previous CRB checks. DBS checks can either be standard or enhanced depending on the requirements of the post. Clinical roles, where there is contact with patients, will generally require enhanced checks.

A staff view expressed during interviews was that the DBS check is “only as good as the day it is done”. This is a common view amongst many employers and staff within caring sectors, and is to some extent true. However, this is not a reason to conclude that it is not important. It is one of a number of measures that exist to promote patient safety and if any one of these measures is not robustly followed, it compromises the safeguarding system as a whole.

In Mr W’s case, as previously stated, no CRB, or latterly DBS, check was ever completed either when he was first employed or during his employment. Although later evidence from the police showed that no concerns would have been identified had Mr W received a DBS on his redeployment, the health

board does not appear to have been recognised or reviewed Mr W's DBS status after the allegations were made against him.

The health board has a DBS policy[22] which states that all required DBS checks must be completed before an employee starts work. The health board has stated that this process is now managed centrally (alongside its central recruitment process), and therefore such an omission could not recur. Interview evidence also confirmed that newly recruited staff would not be allowed to start work in a clinical environment until the DBS checks had been completed. One member of staff also described the induction process in place for all new health care support workers which must be completed before they are allowed onto the ward. This is in line with national guidance[23].

However, it is not clear to HIW that the centralised recruitment process is used by the health board for those who are redeployed under its redeployment policy. Interview evidence suggested that the responsibility for this remains with each delivery unit, rather than centrally. However, as previously stated, the redeployment policy does not specify where the responsibility for undertaking DBS checks for redeployed staff lies. The DBS policy is also unclear about the responsibility for DBS checks for volunteers.

An additional concern is that there are staff in post who were employed prior to the requirement to undertake either CRB or DBS checks. Learning disabilities has a relatively static workforce and a number of long standing staff members, whose employment predated this requirement, have never had a DBS check. There was no requirement in Wales to perform these checks retrospectively and it was never done by the health board. This is reflected in the evidence HIW obtained from staff at interview including confirmation of a recent audit within the MHLD service delivery unit which identified 142 members of staff who did not have a CRB/DBS check in place. Staff interviewed told us that the health board was relying on the contractual obligation for employees to notify them (as the employer) of any changes which may affect their employment. This is inadequate for safeguarding purposes and represents an unacceptable risk.

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[22] ABMUHB Disclosure and Barring (DBS) Policy 2018

[23] Code of Conduct for Healthcare Support Workers in Wales; 2015, Welsh Government. http://www.wales.nhs.uk/nhswalescodeofconductandcodeofpractice

The health board does not currently renew DBS checks for staff who work with adults at risk. Whilst there is no national requirement to do so, it is a matter of good practice to update these checks regularly. In a previous response to HIW on this issue in 2014[24], the health board noted it was committed to following NHS Wales policy regarding the three year renewal of DBS checks, but that this commitment is being managed on an all Wales basis due to the scale of the exercise and burden there would be on DBS services if there was no coordinated approach across NHS Wales. However, it is unclear what progress has been made regarding this.

The facility is also available to have 'ongoing' DBS registration and this tends to be used by staff who move jobs within the NHS frequently (such as doctors on rotation).

In order to promote a culture where safeguarding is a priority, updating of DBS checks should be considered on a national basis.

### Recommendations 8-9

Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.

The health board must ensure all staff, where required by their role, receive a DBS check and address the following:

- As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check
- The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role
- The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff
- The responsibility for conducting DBS checks for redeployed staff and volunteers is clarified within health board policies.

[24] Action plan in response to unannounced inspection report of Cefn Coed Hospital November 17-20 2014 https://gov.wales/docs/hiw/inspectionreports/Mental%20Health%20Learning%20Disability%20Inspection%20-%20Cefn%20Coed%20Hospital%20-%2017-20%20November%202014.pdf

## Safeguarding training and learning

***Face-to-face scenario-based safeguarding training, in addition to the online statutory mandatory training, is beneficial for staff to feel confident in properly recognising and reporting safeguarding issues. We found the pathway for sharing learning on safeguarding at operational level is unclear.***

There is a statutory requirement for health professionals to receive safeguarding training. The statutory mandatory training for staff (level 2) is delivered via online training. However, staff we spoke to felt that online training cannot replace the effectiveness of face-to-face training particularly in areas such as safeguarding which involve a number of complex factors. Interviews with staff indicated that the health board has piloted some sessions of face-to-face scenario based safeguarding training for staff. This can be helpful in all areas of practice, but particularly within mental health and learning disabilities, where there are high incident levels and potentially challenging safeguarding issues. Interview evidence indicated that the feedback from staff to this training was positive, however, it was unclear whether resources would be available to repeat or extend this training to other areas of mental health and learning disabilities, or other areas of the health board.

Documentary and interview evidence suggested that staff at operational level within the delivery units felt there is no clear pathway for sharing learning and good practice from safeguarding cases.

During interviews with current staff, we were told about how the learning from the Mr W case had been adopted at Unit A. This included adapting staff handover meetings to cover information from the last three shifts (24 hours) to ensure any emerging issues are identified. We were also told that Unit A now have combined multi-disciplinary care notes to ensure information relating to the care of individuals is kept together and easy to review. However, it is unclear from staff we spoke to whether this learning has been shared with other units across the heath board.

The health board has stated that, since the events detailed in this report, it has improved training and access to peer supervision for DLMs. This is a positive step, though there was no evidence available to HIW to assess how effective

the supervision is in practice or whether it meets the standards set out in the safeguarding supervision guidance[25].

Recommendations 10-12

The health board must consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training.

The health board must ensure there are clear pathways within and across delivery units to share learning and good practice from safeguarding cases, including whether learning from Unit A has been shared with other units.

The health board needs to consider the arrangements to evaluate the effectiveness of training and supervision for DLMs. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance.

## Safeguarding process

***In relation to the allegations made against Mr W, the first allegation should have been recognised and reported as a safeguarding incident. Each allegation against Mr W was reported to social services and investigated by the police. The police considered the three allegations together and submitted them to the CPS for a prosecution decision. We found the POVA multi-agency process was followed, but there was no social services involvement after 2013. This compromised the robustness of the multi-agency process and limited external scrutiny.***

HIW looked at the electronic safeguarding documentation in relation to the three cases central to this review. Interview evidence indicated that there were paper safeguarding files kept for each allegation by both the DLMs throughout the safeguarding process, until its completion in 2016. However, these paper files have not been located by the health board and so were not available to HIW. The content of these files has not been transferred to the Datix system as it should have been. These files would likely have included copies of correspondence (written and verbal), non strategy meeting notes, threshold

[25] All Wales Safeguarding Best Practice Supervision Guidance June 2017 http://www.wales.nhs.uk/sitesplus/888/page/91797

assessments for reporting incidents, amongst other information which (in addition to statutory reporting forms and strategy meeting minutes) would have provided more detail about what happened during the process. The documents viewed by HIW were those that were available electronically on the Datix system[26], in addition to email correspondence and information provided directly by those interviewed.

The safeguarding process is a multi-agency one consisting of strategy meetings where different agencies, including the police and social services are present. The strategy meetings will determine the most appropriate course of action to promote safeguarding.

### Allegation 1

There was a delay in reporting the first allegation as a safeguarding incident. It is documented in the care records that Ms X first made an allegation against Mr W on 21 December 2011. Three further occasions are documented in the care records (22, 24 December and 6 January) when she referred to this allegation against Mr W. However, it was only on 13 January 2012 when the care manager reviewed the notes that this was recognised as a safeguarding issue. Throughout this time, Mr W remained at work in Unit A. This delay is recognised in the health board's desktop review report.

When the allegation was formally reported on 13 January 2012, the standard safeguarding processes in place at the time were followed. The Head of Nursing for the LD directorate was the DLM with responsibility for overseeing the safeguarding process. The DLM alerted the police and social services (in the area of Unit A) immediately. A multi-agency strategy meeting was convened on 16 January 2012 with representatives from Ms X's care team, (care manager and consultant psychiatrist), the health board's HR and safeguarding teams, and social services. The outcome of the strategy meeting was that the police would investigate. A further strategy meeting took place on 23 January (no minutes of this meeting were available to HIW). The police interviewed Ms X, Mr W and members of staff as part of their enquiries. The police decided there was insufficient evidence to proceed with the criminal investigation. The allegation was therefore passed back to the health board to consider under its disciplinary procedures. The health board's initial assessment under the

[26] Vulnerable Adult Case Management Records (known as VA1, VA2 and VA4 forms), minutes of strategy meetings, Serious incident reports (where completed).

disciplinary policy[27] was presented to a final strategy meeting in March 2012 and the decision was that there was insufficient evidence to take the matter further.

Mr W returned to work on April 2012. He was placed at Unit B. The reason for this was documented to be because Ms X was still a resident at Unit A. In addition, evidence from interviews indicated that Unit B was a residential setting with only three full time residents and there was no requirement for staff to provide personal care to any of those residents.

### Allegation 2

On 2 October 2012, Ms Y made an allegation via text message to one of her care team that a student nurse (with the same first name as Mr W) had assaulted her whilst she had been an inpatient in Unit A. The police and social services were notified the following day. The allegation was reported as a safeguarding incident. Arrangements were made to visit Ms Y on 8 October to obtain some further information.

A strategy meeting was held on 12 October. Members of the care team, Ms Y's consultant and representatives from the police, social services and the health board's safeguarding team all attended. The decision was made for the police to investigate. Mr W was not in work on the day of the strategy meeting but he was contacted and placed on special leave the following day when he was due back on shift (13 October).

Police interviewed Ms Y and Mr W, and took statements from relevant staff. The police submitted the case to the CPS on 20 November 2012. The CPS decision, on 5 December, was that the matter should not proceed to prosecution. The police notified Ms Y and the health board of this decision the following day.

A strategy meeting was held on 20 December. The outcome of this was that the matter should be considered under the health board's disciplinary policy.

The initial assessment report about Ms Y's allegations under the health board's disciplinary process was completed in February 2013. This report concluded

[27] Para 9.2, Disciplinary Policy 2014. The Initial Assessment is a fact finding process under the Disciplinary Policy to establish how to proceed with the investigation. Possible outcomes include: no further action, proceed to disciplinary investigation or hearing, or proceeding under a different policy (e.g. capability)

that a full investigation under the disciplinary policy would not uncover any additional evidence to that identified during the police investigation. However, by that point, the third allegation had been made and the police were investigating all three allegations together.

### Allegation 3

On 2 February 2013, an inpatient at Unit A reported to staff that she had been sexually assaulted by Mr W between May and June 2011 during a previous admission at Unit A. It was reported as a safeguarding incident (on the adult protection case management record, known as VA1 form, dated 8 February 2013) and the police and social services alerted.

During this time, Mr W was still on special leave pending the outcome of the previous disciplinary investigation.

On 6 February 2013, a second DLM was appointed from outside the LD directorate. This appears to have resulted from a complaint letter from the family of one of the women who had made a previous allegation. The complaint related to the investigation being overseen by someone within the LD directorate due to the family relationship between the clinical director and Mr W.

On 11 February 2013, the first strategy meeting to discuss the third allegation was held. The previous two allegations were noted and the decision was taken that the police should start an investigation of the third allegation (and would consider all three allegations together).

On 26 February 2013, the second DLM sought permission from the health board's Executive Director of Nursing for Mr W to be formally suspended. This was actioned on the 7 March 2013.

During March and April 2013, the police investigated the third allegation, including conducting interviews with Ms Z and Mr W, and taking statements from staff.

On 12 April 2013, a second strategy meeting was held. The police confirmed that they were nearing the end of their investigations and would be submitting a file to CPS relating to all three allegations. The police confirmed that the HB's internal investigations could commence.

The police forwarded the case file to the CPS in May 2013. The CPS response requested that further enquiries should be made.

A third strategy meeting was scheduled for 19 August 2013 but was postponed. The reasons for this delay are unclear, but may have related to further enquiries requested by the CPS.

It is recorded on 24 September 2013 that the police had passed the file back to the CPS for a charging decision. The CPS decision was not to proceed to prosecution on the basis of the evidence. The police requested a review of the CPS decision in January 2014, but the decision not to prosecute was upheld.

The third strategy meeting finally took place on 22 January 2014. At this meeting, the police fed back the decision that the CPS would not be taking matters further as the evidence did not support proceeding with the case. The minutes of that meeting state that the police still had considerable concerns about Mr W returning to that setting. In light of the CPS decision not to prosecute, the matter was left with the health board to address under its disciplinary procedures. The police agreed to provide their evidence to the health board to facilitate this. It should be noted that the burden of proof is different for the different processes. In criminal cases, the case must be proved 'beyond reasonable doubt'. In civil cases (such as disciplinary cases) there is a lower burden of proof, 'on the balance of probability'. The matter therefore proceeded in line with the health board's disciplinary policy.

The process initially followed in each of the three cases involved decisions being made by multi-agency strategy meetings with social services, police and clinical input. This is in line with the safeguarding processes at the time. There was no social services representative at the strategy meeting in January 2014 at which the police confirmed the CPS decision not to proceed with prosecution. This was a point when external scrutiny and input in the form of a view from social services would have been helpful.

Following the strategy meeting in January 2014 there are no further documented strategy meetings until the final strategy meeting in 2016, after Mr W's dismissal. There was no social services input into that meeting. It is not clear whether social services did not attend these meetings because they were unable to attend, or were not invited, but their absence compromised the security that the multi-agency safeguarding approach provides.

It is important that attendance of external agencies is facilitated at strategy meetings, either in person, or via phone/video conferencing, to enable multi-agency input into the safeguarding process.

When safeguarding incidents have taken place within the health board, the safeguarding process and investigation is overseen by a DLM. This is usually a senior member of nursing staff. In this case, it was initially the Head of Nursing for the LD directorate. The Head of Nursing was managed professionally by the health board's Executive Director of Nursing, but was line managed by the LD directorate's Clinical Director. A view expressed during the interviews was that the safeguarding process is a multi-agency one where decisions are made collectively through multi-disciplinary meetings. All attendees have to sign up to

the actions from those meetings and therefore the process is a safe and robust one. This is an entirely reasonable view and there was no suggestion that different actions would have resulted from a different DLM being in place. However, given the family relationship between the Clinical Director of the LD directorate and Mr W, HIW is concerned that not only did this put the Head of Nursing, and to some extent the Clinical Director, in a difficult position, but also had the potential to affect public confidence in the safeguarding process because of the perception of a conflict of interest.

It is HIW's view that a person outside of the LD directorate should have been appointed to lead the safeguarding process from the outset, rather than only once a complaint from an involved family was received.

Recommendations 13-14

The health board must review its processes to ensure all relevant safeguarding agencies are invited to strategy meetings and are facilitated to attend, either remotely or in person.

The health board needs to implement an effective way of checking the completion of the outcome actions when a safeguarding case is closed.

## Support for people during safeguarding processes

***Support was provided to the women making the allegations against Mr W through the police interview process by trained intermediaries. This is in line with guidance. However, no professional independent advocacy support was offered.***

***Occupational health support was available to Mr W throughout the investigation and attempts were made to keep in contact with him throughout the disciplinary process. No formal support was provided to Mr W's former colleagues by the health board.***

The three women had access to clinical support from staff and to professional intermediaries (as part of the police interview process). There does not appear to have been any independent professional advocacy made available to the women, either at an early stage or on an ongoing basis.

There were some concerns raised by one family about a lack of information about the allegation and inclusion in the police interview process. There are issues of confidentiality in what can be fed back to families but they should be kept informed of events, where this is appropriate, and they should receive an

explanation as to why they cannot be involved in the process if this is the case. Another family also felt that the health board had not kept them informed during the process and it was always up to them to chase responses from the health board, as opposed to the health board proactively keeping in contact with them to update them.

In two cases, concern was expressed about whether the women had been believed. In one case, this related to whether health board staff had believed her; in another case, the police process and the outcome of the police investigation resulted in the feeling of not being believed.

Those interviewed confirmed that the police decision on their case was explained to them and, whilst they may or may not have agreed with that decision, they understood why the cases were not being taken further. The fact that the health board had assisted them in following the 'PTR'[28] process was described as helpful by one family, including the visit at the end of that process from the then Chief Executive in 2017.

One of the families raised concerns about the detrimental nature of reminders of the events from ongoing media attention. It is clear from speaking with the women and their families that they continue to be affected by what happened to them.

Whilst the focus in such cases should be on the welfare of those making the allegations, the health board as an employer also has a duty of care to its employees. This includes both the member of staff who is the alleged perpetrator of abuse and other staff members who may be affected by what has happened.

Mr W was given the option of an alternative non-clinical role (afternoons only) to keep him in a work environment whilst the allegations were investigated. However, he declined this. There is evidence that contact with Mr W whilst he was away from work was difficult. Despite this, staff did make frequent attempts to keep in touch with him via letter and text message at his request. He had access to occupational health support throughout the period of suspension and also the Wellbeing through Work Counselling Service was suggested to him.

[28] Putting Things Right (PTR) is the statutory process for managing concerns in the NHS in Wales. http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright

Whilst not part of the safeguarding process, it seems reasonable to include in this section the support provided to staff who worked with Mr W. After Mr W's arrest and conviction, staff noted that there was informal support available to them from the unit managers. However, staff clearly remained affected by the events, questioning whether they had missed something at the time and concerned about the level of adverse media coverage about Unit A, which continues to have an effect on the confidence of current patients and their families, as well as the morale of staff.

### Recommendations 15-18

The health board must ensure there is signposting to advocacy and support for the individuals and families affected by incidents within any of its service delivery units.

The health board must ensure there is effective and timely communication with individuals and families affected by incidents (where appropriate) throughout the safeguarding process.

The health board must ensure staff understand that anyone raising a safeguarding allegation should be treated seriously in all cases.

The health board should consider the formal support available for any members of staff who may be affected by adverse incidents, including for staff who are the alleged perpetrators of abuse. Furthermore, the health board should consider how it enables staff to feed in to improvements to practice.

## Incident reporting

There is evidence of a good level of awareness of the need for incident reporting at Unit A, that staff are encouraged to do so and feedback is provided regularly.

The way in which serious incidents are investigated in the health board is inconsistent.

The health board needs to improve its processes for 'joining up' data from incidents, concerns and claims to provide a robust system for identifying any areas of concern and managing risk.

Incident reporting is a means for staff to highlight areas of concern which may affect the provision of health board services. This is vital so that any concerns about health board services can be identified and addressed. There is also a requirement for health boards to report serious incidents (that is, those where harm is or may be caused) to Welsh Government.

Serious incident forms were completed for the first two allegations. All serious incident forms have to be signed by the health board's Chief Executive or an executive member of staff and this is done centrally before the form is forwarded to Welsh Government. As noted in the desktop review, the form for the second allegation, whilst it was completed, does not appear to have been submitted. This suggests a shortcoming in the central systems at the health board which resulted in a failure to forward on the relevant form after it was completed. It is unclear why a serious incident form was not received by Welsh Government in relation to the third allegation.

All the current staff at Unit A interviewed as part of this review were aware of the procedures for reporting incidents. Staff also said that they received feedback about incidents which had been reported. This indicates a positive culture of reporting incidents at Unit A.

Both DLMs interviewed stated that they worked hard to encourage incident reporting within their respective directorates at that time. This is supported by a

governance review of the LD directorate in 2012[29] which recorded a high level of incident reporting within the LD directorate.

The health board has also stated it encourages reporting of incidents across the health board and this was one of the recommended actions of the desktop review. The health board now has a serious incident investigation team but this team only has capacity to investigate a proportion of serious incidents. It has provided training staff in the delivery units to assist with consistency of incident investigations.

In February 2018, the NHS Delivery Unit carried out a review of the health board's processes for managing serious incidents[30]. The review resulted from two specific areas of concern, not related to learning disabilities, but its findings on serious incident reporting are relevant to all areas of the health board. Of relevance to this case, the NHS Delivery Unit review highlighted key areas needing improvement:

- The Board was insufficiently sighted on serious incidents and the associated risks
- There was a lack of strategic direction to deliver consistency in the health board's management of concerns, including inconsistency in the investigation methodology for serious incidents and operational risk management processes, and reporting and sharing of information from frontline services to the Board
- There are significant variations in approach across the service delivery units which adversely impacts on Board assurance, risk management and the health board's ability to learn lessons and make improvements to improve patient safety
- There was a lack of consistency of monitoring arrangements due to the limited corporate oversight and the difference in practice between delivery units in managing and learning from concerns.

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[29] Directorate Governance Review: Learning Disabilities; Internal Audit Report 006/2012. September 2012

[30] Intervention into systems and processes for the management of serious incidents at Abertawe Bro Morgannwg Health Board; NHS Delivery Unit, February 2018, and:

Follow-up report Summarising Progress, NHS Delivery Unit, November 2018

Follow up work by the Delivery Unit in November 2018 demonstrated improvement in these assurance systems, but reiterated that there were still improvements to be made. Of particular relevance to this review, the recommendations included:

- There were still inconsistencies in the quality of some investigations of serious incidents. A specific area of concern was cited as the MHLD service delivery unit
- Further and ongoing action to improve the systems for sharing learning across the health board.

The NHS Delivery Unit is continuing to work with the health board to monitor the above issues.

Recommendation 19

The health board is required to provide HIW with an update on the actions it has taken in response to the NHS Delivery Unit report, including where actions are incomplete or ongoing.

## Governance and culture

Some executive Board members were individually aware of the details of the allegations against Mr W throughout the investigation. Whist there was individual awareness by members of the Board, this case was never formally reported to the Board.

The reporting structure for quality and safety remains unclear. There is no clear mapped route for escalation and scrutiny of safeguarding events through the quality and safety structure to Board level, or for effective dissemination of learning back to delivery unit level.

The issue of the line of sight between the Board and operational services has been a recurrent theme since 2014.

It has not been the purpose of this review to specifically look at the governance of the former LD directorate. However, the review team has looked at evidence related to concerns about the governance of the directorate which were presented at interview.

Interviews with longstanding and former staff revealed governance concerns within the LD directorate at the time of the allegations. Staff used phrases such as “corridor management” to describe the management style and that meetings were often not minuted. Documentary evidence refers to the partnership working within the directorate as ‘informal’[31]. The report of an internal governance audit in September 2012 (which was completed for all directorates within the health board) indicated an ‘amber’ assurance rating (that is, limited assurance) for governance in the LD directorate. Actions arising from that audit were improved regular recording of meetings, with agreed decisions and actions. This indicates that at the time these were not being routinely done.

Of greater concern is that interviewees, almost without exception, described a significant dispute between two very senior members of directorate staff. This became evident from around 2011 onwards, but deteriorated over subsequent years, including a grievance process which resulted in mediation. Staff expressed the view that this dispute affected the running of the directorate at a

[31] Letter from the former Clinical Director dated 28 September 2012

management level but it did not affect the day to day care provided to patients because of the systems and good partnerships in place between staff at operational level. It is a concern that so much energy was put into managing the effects of this one poor relationship. This included the involvement of members of the Board, specifically the Interim Medical Director and the Chief Operating Officer, and then in 2014, the then Chief Executive. The Chief Executive asked the former Board Secretary to review the governance processes within the directorate in early 2015. We saw no evidence of the outcome of this review. It should also be noted that by this point, the reorganisation of the directorate into the service delivery units had been planned.

Whilst there is no evidence to suggest that this dispute impacted on the handling of the case of Mr W, HIW has no doubt that a dispute between such senior members of staff affected the strategic management of the LD directorate more widely. It diverted a considerable amount of energy and time away from planning the future progress and direction of the learning disability service. This issue of a lack of a clear strategy for learning disability services within the health board was also a key finding from the reviews of learning disability services in 2015-16 conducted by HIW and Care Inspectorate Wales[32].

Interview evidence indicates that there were regular performance reviews between executive Board staff and senior directorate staff. The individual members of the Board who were aware of the concerns within the directorate had no concerns about the performance of the directorate as a whole. Due to its size and good reputation it was able to recruit and keep quality staff and had greater resources available to it (in terms of expertise, flexibility of care provision and in terms of budgets) than a smaller unit would have had. The performance indicators that were pressing at the time were much more applicable to acute health board departments (such as waiting list times, bed occupancy rates and delayed discharge). These measures did not apply to learning disability patients given the specific nature of the need of those patients. There were no operational or budgetary concerns about the

[32] HIW review of learning disability services 2015-16

http://hiw.org.uk/reports/natthem/2016/learningdiasbilityreview/?lang=en

National inspection of care and support for people with learning disabilities 2016

https://careinspectorate.wales/national-inspection-care-and-support-people-learning-disabilities

directorate's performance and it was very much left to run itself with minimal intervention from the health board.

By virtue of their positions, some executive Board members were aware individually about Mr W's case. Specifically, the Executive Director of Nursing and the Chief Operating Officer were fully aware of the allegations against Mr W and the progress of the investigation. Email correspondence from the DLM in charge of the safeguarding process showed that regular updates were provided to both these executive Board members during the latter part of the police investigation and throughout the disciplinary process. Areas of concern were highlighted, including the suggestion for an external investigator to undertake the disciplinary investigation. However, Mr W's case was never formally reported to the Board until after his arrest.

Updates were given from the safeguarding committee to the health board's quality and safety committee about Mr W's suspension. However, whilst these updated indicated that the investigation was ongoing, they were inadequate in their level of detail to enable any effective scrutiny and did not mention timescales.

During interviews, staff explained that there were a number of high profile issues for the health board at that time. In particular, health board's focus had been on addressing concerns about the standard of care at Princess of Wales Hospital (which resulted in the 'Trusted to Care' report and police investigations of nursing staff). As a result, there were a significant number of nursing staff suspended because of police investigations; therefore the suspension of a healthcare support worker would not have stood out amongst the multiple suspensions (over 20 nursing staff) at that time.

It was also noted that the health board was undergoing significant reorganisation during this time with the creation of its service delivery units.

## Current arrangements

***It is clear that the health board has done considerable work to improve its quality and safety systems (such as the implementation of the quality and safety forum). However, the fact that this review of governance processes is still ongoing indicates that progress in this area has been very slow. There still remains a question over whether the escalating and reporting systems in place within the health board's governance framework give the Board effective oversight of areas of concern.***

The health board's current Executive Director of Nursing gave a written response to HIW to clarify some of the governance processes for safeguarding. He confirmed that each service delivery unit reports suspensions as part of their

performance reviews. Suspensions and allegations are also reported on a monthly basis through the senior workforce team to the Director of Workforce and Organisation Development. Suspensions are also reported to Welsh Government.

All discussions in relation to proposed nurse suspensions would initially be with the relevant Unit Nurse Director and a discussion would then take place with the Director of Nursing and Patient Experience or Interim Deputy Director of Nursing and Patient Experience. Service delivery units are required to provide updates on the progress of cases involving such situations to the health board's safeguarding committee (meeting every two months). All cases are closely monitored by the corporate safeguarding team and any concerns regarding delays escalated.

The Director of Nursing and Patient Experience is the chair of the health board's safeguarding committee. The committee receives all the service delivery unit safeguarding reports as part of the committee agenda. Case outcomes are also reported by service delivery units in their reports to the committee and these now include any lessons learned. Cases are also monitored by the corporate safeguarding team, who will provide additional updates on an individual case basis.

Operationally, each unit has its own quality and safety committee, where incidents, serious incidents, concerns, POVA (adults at risk) and never event figures are reported and reviewed. Each service delivery unit is required to submit a quality and safety report to every quality and safety committee**.** At a corporate level, a search is undertaken before any new entry in added to the Datix system to establish any links between incidents/ serious incidents, POVA and never events.

There is no current formal (computerised) system for identifying incidents involving specific staff members. However, service delivery units and their HR leads are aware of all concerns involving staff within their units and will highlight where previous concerns have been raised about specific staff members.

As part of the safeguarding bi-annual report, themes and trends are monitored across the service delivery units. This paper is submitted twice yearly to quality and safety committee.

All safeguarding cases are reported to the health board's safeguarding committee as part of the service delivery unit's performance reports. High risk safeguarding cases are escalated from the health board's safeguarding committee to the quality and safety committee. A high risk safeguarding case would be any adult or child concern, where there has been formal police enquires/investigations and/or referrals to professional bodies.

Board minutes from December 2016 note the intention to review what is reported to the quality and safety committee because of the volume of information presented there. A quality and safety forum was created and considers operational aspects of quality and safety and reports into the quality and safety committee. This should allow the quality and safety committee to concentrate on more strategic aspects of the health board's quality and safety performance. Review of current health board minutes indicates that this process is still ongoing.

The Trusted to Care report in 2014 stated that current assurance processes at the time were not fit for purpose[33] and referred to the disconnect between the Board and service provision. The NHS Delivery Unit report in 2018 also refers to the Board not being sighted on serious incidents and there is concern about the lack of governance assurance.

Due to the size of the health board, it will always be a challenge to ensure that the Board is fully apprised of what is going on at operational level. However, this is more reason to have clear and robust governance structures in place. The health board's current reporting and escalating structures are not sufficiently robust to underpin assurance mechanisms throughout the organisation.

Recommendations 20-23

The health board must rapidly improve its governance and reporting/escalation structures (including ward to Board governance) around quality, safety and clinical governance.

The health board must ensure there are effective arrangements and information systems in place to triangulate:

- Workforce issues relevant to safeguarding, such as staff suspension, with its safeguarding processes.
- Information from claims, concerns and incidents to highlight areas of concern.

The heath board must ensure there are clear and effective pathways for sharing

[33] Trusted to Care Professor June Andrews and Mark Butler, 2014 Para 3.79 https://gov.wales/topics/health/publications/health/reports/care/?lang=en

learning from safeguarding and incidents throughout the health board.

Welsh Government should consider how a more robust mechanism for sharing safeguarding learning can be developed across Wales.

## Desktop review

Senior health board staff chose a documentary review format to consider Mr W's case after consideration of a number of factors.

In the main, the conclusions of the desktop review were not unreasonable based on the information that was considered within the review.

The conclusion that Mr W's actions outside of his employment could not have been predicted or prevented is not evidence based as there is no evidence in the desktop review report to either support or refute it.

In looking at limited documentary evidence only, the desktop review focused on the actions of frontline individuals only, as opposed to considering wider issues relevant to this case, such as governance and reporting structures.

There were gaps in the documentary evidence available to the desktop review team. Records including Mr W's supervision, training and occupational health records were not made available.

Much of the desktop review action plan referred to actions already implemented as a result of the Trusted to Care report, rather than specific to the events of this case.

Following Mr W's arrest, the health board decided it needed to review the circumstances of his employment and suspension. The review took the form of a desktop review based on available documentary evidence. No interviews with staff were conducted.

No documentary evidence has been provided by the health board about the rationale for its decision to use a document review format. The interview evidence from those involved in this decision noted this was a decision made collectively by executive health board staff after detailed consideration. There appear to have been several factors that influenced the decision to undertake a desktop review:

- The aim of the review was to establish facts and to identify any learning from the events

- Given the length of time from the events in question, a document review would be completed more quickly so that the facts, and any learning points arising from the review could be actioned sooner
- There was concern that conducting interviews would be stressful and a large number of staff involved had already left the organisation.

It was noted that not conducting interviews would limit the breadth of evidence available to the review, but weighing up the above factors, the health board decided that a document review was the most appropriate way forward.

It was also highlighted by some interviewees that the review format and scope, including that it would be conducted internally by the health board, had been shared and agreed with the Welsh Government in advance of the review.

Unfortunately, the desktop review team did not have access to all the documentary evidence held by the health board. Interviews with staff would have given some context to the documentary evidence. That said, there does not appear to be anything inherently inaccurate or wrong with the review team's factual conclusions on the basis of the available evidence. The only exception to this is the statement that Mr W's actions outside of his employment could not have been predicted or prevented[34]. This is not evidence based as there is no evidence cited in the report which either supports or refutes this statement. This statement appears to rely on the involvement and actions of the police rather than any specific evidence cited in the report about the actions the health board took.

At interview, some staff expressed concern that the report had commented on their actions without their input. Some of the key staff involved did not know that the desktop review had been undertaken until the final report and the action plan was circulated around the health board. HIW acknowledges the health board's concern about stress to staff of conducting interviews. Many of the staff we spoke with acknowledged that it was stressful to be interviewed by HIW about events but appreciated being involved in the process and being given the opportunity to contribute what they knew about events. The health board also

[34] Executive summary and paragraph 6.3 ; Health Board Lessons Learned Desktop review, August 2016

http://www.wales.nhs.uk/sitesplus/documents/863/4.3%20Desktop%20Review%20and%20Lessons%20Learned%20Report.pdf

missed an important opportunity to identify further learning and areas of practice improvement but by not involving staff within its review.

The action plan from the review is a generic, health board wide action plan. HIW understands that each directorate within the health board was required to identify actions relevant to their own directorate arising from the health board wide action plan. At interview, a number of staff were critical of the content of the action plan. The most prevalent view was that many of the actions outlined in the action plan had already been carried out and were a result of the previous 'Trusted to Care' report in 2014[35] as opposed to resulting from the specific events of this case. Looking at the actions from the report, it is clear to HIW why staff have formed this view.

The nature of a review of documentary evidence only is that it tends to concentrate on the specific actions of those front line staff that are responsible for completing documentation. It therefore often misses out details of the wider context of the processes, culture and management within a service. Interviewing staff could have provided key additional evidence to give a broader view of events and fill in evidential gaps.

[35] Trusted to Care; Professor June Andrews and Mark Butler 2014 https://gov.wales/topics/health/publications/health/reports/care/?lang=en

## Commissioning arrangements

There is no formal commissioning arrangement between the health board and Cardiff and Vale and Cwm Taf University Health Boards in relation to the provision of learning disabilities services in their areas.

Despite there being longstanding agreement that the health board provides LD services for both Cardiff and Vale and Cwm Taf University Health Boards, there has never been a formal agreement about those services between the health boards and interaction between all the parties has been limited and informal. Historically, this has been due to funding arrangements where the health board received funding directly from Welsh Government and there was no financial transaction between Abertawe Bro Morgannwg University Health Board and Cardiff and Vale and Cwm Taf University Health Boards.

In this case, those health boards were not notified where the allegations may have involved patients resident within their geographic areas.

A formal service agreement would assist with:

- Effective planning of services in the respective health board areas
- Ensuring the services were meeting the needs of patients in the respective health board areas
- Engagement of all parties in the provision of those services
- Promoting information sharing between the health boards about the services in their area and their patients
- Performance monitoring.

The lack of formal agreement has previously been raised with all three health boards following HIW's review of Learning Disability Services in 2015-16[36]. It

[36] **Learning Disability Services** Thematic Report 2015-16; Healthcare Inspectorate Wales

http://hiw.org.uk/reports/natthem/2016/learningdiasbilityreview/?lang=en

was included as part of the actions required following that review, but the response from the health boards has lacked sufficient detail around this issue.

It was noted at interview that there was now dialogue between the three health boards and discussions about the needs of each health board for learning disability service provision and how this can best be provided. Whilst there is still no service agreement, and progress with these discussions has been slow, agreement is now being pursued through a joint commissioning group.

Recommendation 24

The health board must progress a formal commissioning arrangement, across the three health board areas, regarding the provision, planning and performance monitoring of learning disability services provided.

# 6. Conclusions

## The questions that the review sought to answer:

### Was the health board's internal review sufficiently thorough?

The health board was aware of the limitations of conducting a review based on documents alone and gave consideration to a number of factors in reaching this decision. However, the absence of input from staff who were involved in the events in question was a missed opportunity to gather evidence not only about the specific events but also the wider context of the health board's processes.

In addition, there was documentary evidence which was not made available to the review. This compromised the robustness and clarity of its findings. Therefore, HIW cannot conclude that the internal review was sufficiently thorough.

### Were the health board's conclusions appropriate on the basis of the evidence considered?

In the main, based on the documentary evidence available to the desktop review team, the conclusions reached were not inappropriate. The exception to this is the conclusions that Mr W's actions outside of his employment could not have been 'predicted or prevented'. This conclusion was not reasonable because it was not based on evidence cited within the report. This statement appears to rely on the involvement and actions of the police rather than any specific evidence cited in the report about the actions the health board took.

### Were the actions that the health board took in light of its conclusions adequate to ensure patient safety?

The health board has taken some positive actions in light of the evidence in this case. It has carried out most of the actions recommended by the desktop review report. The exception to this is the central team to undertake disciplinary investigations (similar to the serious incident investigation team which already exists within the health board). The health board has confirmed they have approved funding for three disciplinary officer posts but are yet to create the disciplinary investigation team; therefore the factors which contributed to the lengthy disciplinary process in this case remain unaddressed.

Furthermore, the shortcomings in the desktop review methodology meant that governance issues within the health board were not adequately considered, particularly in relation to reporting and escalating of safeguarding concerns. We found the governance structures within the health board are still unclear relating to quality and safety, in terms of the committee structure for reporting of

incidents and also dissemination of learning back to operational level. HIW is concerned this does not provide assurance about current processes within the health board for effective scrutiny of safeguarding concerns and to ensure the Board is sufficiently sighted on what is happening at operational level. It is also of concern that issues about the Board being 'properly sighted' were highlighted in the Trusted to Care report in 2014 and attempts to address this are still ongoing. This has taken far too long and must be prioritised as a matter of urgency.

### On the basis of additional evidence considered during this review, are there additional or different conclusions?

As stated previously, based on the evidence considered by the desktop review the conclusions reached are not unreasonable, with the exception that the actions of Mr W outside of his employment could not have been 'predicted or prevented'. However, the evidence available to the desktop review team was limited since the team did not see all the evidence and did not interview staff members involved in the events in question. This additional evidence would have provided further context to the circumstances surrounding the events in question.

### Does this review highlight wider learning for the NHS in Wales?

This review highlights areas of learning which are of relevance to the NHS in Wales. We expect all health boards to consider the findings within this report and the recommendations in Appendix A. Of particular interest on a national basis is the need for:

- Up-to-date DBS checks for staff (both retrospective and renewal of checks)
- Updated Wales Safeguarding Procedures (through all safeguarding boards) to ensure consistency practice and reporting, and benchmarking, throughout the NHS in Wales
- Robust mechanism for sharing safeguarding learning across Wales
- Improved systems for triangulation of information from concerns, incidents and claims
- Robust governance and board oversight in relation to quality and safety.

This case also highlights some positive areas, including:

- The changes to the handover process in learning disability Unit A to cover shifts in the last 24 hours as a result of this case to ensure the information shared is more robust
- A general increase in awareness and reporting of incidents throughout the health board
- The pilot of some sessions of face to face scenario based safeguarding training for staff, in addition to the statutory online learning. This can be helpful in all areas of practice, but particularly within mental health and learning disabilities, where there are high incident levels and potentially challenging safeguarding issues
- The 'values-based' initiatives to promote a more positive patient-centred care culture within the health board's hospitals resulting from the 'Trusted to Care' report. This included encouraging staff to report incidents and view care from the perspectives of patients, families and carers.

# 7. What next?

This case highlights the importance of consistent and robust safeguarding and governance processes which are an essential part in contributing to effective safeguarding for adults at risk. The robustness of these processes are intrinsic to the confidence that patients and their families can have in the safeguarding system as a whole. This is why the review of the Wales Safeguarding Procedures through safeguarding boards is so important. HIW hopes that the content and learning from this review will be helpful in informing that process, as well as highlighting the need for the new safeguarding guidance to be delivered in a timely way.

The recommendations for Abertawe Bro Morgannwg University Health Board and Welsh Government are detailed in the following section but they have relevance for all health boards in Wales.

# Appendix A – Recommendations

As a result of the findings from this review, HIW has made the following overarching recommendations which should be addressed by Abertawe Bro Morgannwg University Health Board, Welsh Government and considered by all health boards in Wales.

The following recommendations relate to Health and Care Standards 2015[37].

| No. | Recommendations | Related Health and Care Standard |
|---|---|---|
| 1 | The health board must ensure the redeployment policy is consistently followed. | Standard 7.1 Workforce |
| 2 | The health board needs to consider how occupational health advice can be more clearly communicated to management staff, in order to accommodate the needs of the employee concerned | Standard 7.1 Workforce |
| 3 | The health board must ensure the suspension and special leave policies are applied consistently and all staff are clear about their correct use in relation to staff members under investigation. | Standard 7.1 Workforce |
| 4 | The health board must identify and provide sufficient resources for disciplinary investigations to ensure their timely completion. | Standard 7.1 Workforce |
| 5 | The health board must ensure there is relevant and timely clinical input to support the understanding of evidence from vulnerable patients within disciplinary proceedings. | Standard 7.1 Workforce<br><br>Standard 6.3 Listening and Learning from |

[37] Health and Care Standards 2015 https://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en

| No. | Recommendations | Related Health and Care Standard |
|---|---|---|
| | | Feedback |
| 6 | Welsh Government, through its work with safeguarding boards, needs to ensure that national safeguarding processes enable consistency of reporting to facilitate benchmarking, and information sharing across Wales. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 7 | The health board should ensure there is consistency between the safeguarding strategic plan and safeguarding policies to ensure aims are clearly reflected in all documents. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 8 | Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 9 | The health board must ensure all staff, where required by their role, receive a DBS check and address the following:<br>• As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check<br>• The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role<br>• The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff<br>• The responsibility for conducting DBS checks for redeployed staff and volunteers is clarified within health board | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |

| No. | Recommendations | Related Health and Care Standard |
|---|---|---|
| | policies. | |
| 10 | The health board must consider the robustness of safeguarding training for staff, including the benefits of face-to-face and scenario-based training. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk<br><br>Standard 7.1 Workforce |
| 11 | The health board must ensure there are clear pathways within and across delivery units to share learning and good practice from safeguarding cases. This should include whether learning from Unit A has been shared with other units. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 12 | The health board needs to consider the arrangements to evaluate the effectiveness of training and supervision for DLMs. Furthermore, to ensure supervision is provided in line with the All Wales Safeguarding Best Practice Supervision Guidance. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk<br><br>Standard 7.1 Workforce |
| 13 | The health board must review its processes to ensure all relevant safeguarding agencies are invited to strategy meetings and are facilitated to attend, either remotely or in person. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 14 | The health board needs to implement an effective way of checking the completion of the outcome actions when a safeguarding case is closed. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 15 | The health board must ensure there is signposting to advocacy and support for the individuals and families affected by incidents within any of its service delivery units. | Standard 6.3 Listening and Learning from Feedback |

| No. | Recommendations | Related Health and Care Standard |
|---|---|---|
| 16 | The health board must ensure there is effective and timely communication with individuals and families (where appropriate) affected by incidents throughout the safeguarding process. | Standard 6.3 Listening and Learning from Feedback |
| 17 | The health board must ensure staff understand that anyone raising a safeguarding allegation should be treated seriously in all cases. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 18 | The health board should consider the formal support available for any members of staff who may be affected by adverse incidents, including for staff who are the alleged perpetrators of abuse. Furthermore, the health board should consider how it enables staff to feed in to improvements to practice. | Standard 7.1 Workforce<br><br>Standard 6.3 Listening and Learning from Feedback |
| 19 | The health board is required to provide HIW with an update on the actions it has taken in response to the NHS Delivery Unit report, including where actions are incomplete or ongoing. | Governance, leadership and accountability |
| 20 | The health board must rapidly improve its governance and reporting/escalation structures (including ward to Board governance) around quality, safety and clinical governance. | Governance, leadership and accountability |
| 21 | The health board must ensure there are effective arrangements and information systems in place to triangulate:<br><br>• Workforce issues relevant to safeguarding, such as staff suspension, with its safeguarding processes.<br><br>• Information from claims, concerns and incidents to highlight areas of concern. | Governance, leadership and accountability<br><br>Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk<br><br>Standard 3.4 |

| No. | Recommendations | Related Health and Care Standard |
|---|---|---|
| | | Information Governance and Communications Technology |
| 22 | The heath board must ensure there are clear and effective pathways for sharing learning from safeguarding and incidents throughout the health board. | Governance, leadership and accountability<br><br>Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 23 | Welsh Government should consider how a more robust mechanism for sharing safeguarding learning can be developed across Wales. | Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk |
| 24 | The health board must progress a formal commissioning arrangement, across the three health board areas, regarding the provision, planning and performance monitoring of learning disability services provided. | Governance, leadership and accountability |

# Appendix B – Terms of reference

## Background

HIW has been asked by Welsh Government to undertake an independent review of how Abertawe Bro Morgannwg University Health Board handled the employment of and allegations made against Mr W.

In 2016, Mr W was convicted of the murder of Mrs J. At the time of the offence, Mr W was employed by the health board as a care assistant, but had already been suspended from work pending the investigation of three separate sexual assault allegations made against him by individual patients. He worked in a learning disabilities setting run by the health board.

The health board undertook an internal review looking into the management of Mr W's employment and the handling of the three separate allegations made against him. This was an internal, desktop review, undertaken by senior individuals within the health board who were independent of the learning disability directorate.

The health board's internal review identified a number of significant issues of concern and procedural weaknesses relating to governance, recruitment, adult safeguarding, incident reporting and culture within the health board. It highlighted several areas for learning and improvement. An improvement plan outlining actions taken to date has been published alongside the report. The health board's review concluded that Mr W's future conduct and behaviour outside of his employment could not have been predicted or prevented.

In order to be satisfied that appropriate actions had been identified by the health board and that its action plan for improvement is sufficiently robust, Welsh Government has asked HIW to undertake an independent assessment to determine whether the learning and actions as a result of that review were appropriate.

In requesting the review, Welsh Government suggested a number of broad parameters. HIW has taken time to consider these views and the views of others in order to develop its own terms of reference for the independent review. This consisted of initial consideration of the documentary evidence on which the health board's review was based, and inviting discussions with other interested parties.

HIW's review methodology will consist of thorough examination and analysis of the documentary evidence. We will also collect evidence from interviews. There will be discussion and engagement with other key individuals throughout the process, and independent professional input from peer reviewers.

It is anticipated that this review will be concluded by December 2018. A report will be published at the end of the review process.

## Sources of information to inform the HIW review

In order to ensure a robust and independent review, HIW will consider a wide range of information and evidence. During the course of the review, we will:

- Speak with key stakeholders and other interested parties
- Interview relevant individuals
- Examine and analyse documentation held by the health board, and other key stakeholders, pertinent to the review
- Obtain input from relevant independent peer reviewers
- Produce a public report at the end of the review detailing HIW's findings.

## What the review will consider

The independent review will determine whether:

- The health board's internal review was sufficiently thorough
- The health board's conclusions were appropriate on the basis of the evidence considered
- The action that the health board has taken in light of those conclusions is adequate to ensure patient safety
- Additional or different conclusions should be reached on the basis of additional evidence considered during this review
- There is any wider additional learning for the NHS in Wales.

The areas and processes within the health board that HIW will be considering in relation to this case include:

- Staff recruitment and employment
- Incident reporting
- Adult safeguarding
- Governance and culture.

What the review will not consider:

The decisions or actions of the police or Crown Prosecution Service will not form part of this review. This is not within the remit of HIW as it is only able to investigate matters in connection with the provision of healthcare services. However, we will be seeking the co-operation of and information from South Wales Police which may assist us in our consideration of the health board's actions.

# Appendix C – Extracts from health board policies

## Extract from Disciplinary Policy (March 2011)

### 8. Procedure for Dealing with Alleged Misconduct

8.1 Where the manager becomes aware that an incident or misconduct has apparently occurred, the following procedure should be followed. It is expected that the employee will be afforded due courtesy and sensitivity at all stages, and that the procedure will be followed with appropriate promptness.

### 8.2 Initial Assessment

The purpose of the initial assessment is for the manager to determine, on the information available at that time, what the next appropriate course of action might be. This fact finding assessment may involve discussing the alleged incident/misconduct with the employee as well as obtaining other, preliminary pieces of information as necessary. Following the assessment, the manager may decide that:

- No further action is necessary because there is no evidence to support the allegation that an incident or misconduct occurred.
- Given the minor nature of the misconduct, counselling is a more appropriate measure than formal disciplinary action. (Paras 6.1 to 6.5 refer).
- The Fast Track Disciplinary process may be appropriate because the individual has admitted misconduct or where prima facie evidence exists. Fast tracking can only occur in incidents where it appears that the nature of the misconduct would only warrant a verbal or first written warning.
- A formal investigation will be required, with due consideration given to the need to suspend the employee without prejudice or redeploy him/her whilst the investigation is ongoing.

### 8.3 Fast Track Disciplinary Process

8.3.1 The Fast Track disciplinary process allows for cases to be dealt with in a timely manner, within one month of the initial assessment unless there are exceptional circumstances. There will not be any need for a formal investigation report although a thorough examination of the known facts will take place. An investigating officer will not, therefore need to be appointed.

8.3.2 Those situations where fast tracking may be suitable are as follows:-

- Incidents that are regarded as ‘Misconduct’ which would normally result in either a verbal or first written warning.

- The employee against whom the allegations are made has admitted to them in full.
- Where the employee does not admit to the allegation but there is factual evidence which the employee cannot refute, i.e. there is indisputable prima facie evidence, fast tracking may take place.

8.3.3 If the manager feels that the fast track approach is appropriate, they must, in the first instance, discuss this with the HR adviser. A review of the information will be undertaken in conjunction with the manager, the employee and his/her representative and a decision taken as to whether the fast track process should be adopted. This must be agreed by all parties.

8.3.4 If the decision has been made to Fast Track then the following process should be followed:

- The manager will ensure (if not done already) that there is a written statement from the individual who reported the incident and also from the employee involved, together with any supporting information gathered.
- The Disciplining Officer will write to the employee involved asking them to attend the fast track Disciplinary Hearing, and will provide a copy of all information gathered. The employee will be given the right to be accompanied if they so wish.
- The Disciplining Officer will be supported by, an HR Advisor and professional adviser where appropriate. The employee and their representative will also be present. No witnesses will be called from either side.

8.4 The procedure for the fast track Hearing is as follows:

- Introductions are made.
- The Disciplining officer outlines the nature of the allegation(s) and advises that it (they) may result in disciplinary action.
- The Disciplining Officer confirms with the individual that he/she admits to the allegations previously stated or confirms the evidence available.
- The employee or Staff Side Representative will have the right to put forward any comments or statements relating to the incident (including any mitigation).
- The Hearing Panel may wish to question the employee.
- The Hearing Panel will adjourn briefly to discuss the outcome of the Disciplinary Hearing.
- The Disciplining Officer will then communicate the decision of the Hearing to the employee and their representative. The penalty should not exceed a verbal or first written warning.
- The Disciplining Officer will send a letter confirming the decision of the Hearing to the employee, advising them of their right of appeal. The record of any warning will be kept on the employee's personal file.

## 9. Formal Investigation

9.1 Where the case is not suitable for a fast track hearing, an Investigating Officer should be appointed to undertake a full investigation. The Manager must ensure that the Investigating Officer is provided with sufficient support in terms of time, administrative facilities and reallocation of their work responsibilities to be able to carry out a careful and thorough investigation in a timely manner.

Regular verbal updates on progress will be provided by the Investigating Officer to the manager and the employee and his/ her representative.

9.2 The investigation is commissioned by and conducted on behalf of the employee's manager.

9.3 The Investigating Officer will produce a factual report, and draw on his/her findings to determine whether there appears to be evidence to support the allegations being made against the employee concerned. It is not the role of the Investigating Officer to make any judgement about the case.

9.4 The report will be considered by the Manager who will make a decision about the appropriate course of action.

9.5 Where a disabled employee is subject to a formal investigation, the duty to consider reasonable adjustments should be taken into account in the context of the arrangements for conducting the investigation and, where relevant, the issues under investigation. Advice from an HR Advisor may be sought if necessary.

9.6 The Investigating Officer should normally be appointed from a different department to that in which the employee works. In certain cases it may be necessary for an Investigating Officer with specialist skills and/or knowledge to be appointed or made available for advice.

9.7 The employee must be made aware of all the allegations made against them and be interviewed as part of the investigation process. They may be accompanied by their representative at this meeting, the aim of which is to establish, impartially, all the key points pertinent to the investigation that can be provided by the employee. The employee should be allowed to offer any information that they feel is relevant during this interview as it may affect the decision about whether to proceed with a disciplinary hearing. A written record of the interview should be made and signed by the employee as an accurate record. The investigation will also make enquiries of relevant witnesses and collect documentary evidence as necessary. Such evidence must be copied to the employee and their representative.

9.8 If an employee becomes unwell during the disciplinary process, the investigation may continue, albeit in a sensitive and considerate manner. Advice from the occupational health department may be sought, if appropriate.

9.9 The Investigating Officer will be given advice on the process by an HR advisor who would not then be part of a disciplinary panel. Where the Investigating Officer requires secretarial support, then the Manager must take this into account when instigating the investigation. However, disciplinary matters require high standards of confidentiality and the number of staff involved must be the absolute minimum to deliver a comprehensive report within a reasonable timescale.

9.10 The Investigating Officer will attend the disciplinary hearing to present his/her report and to answer any points of clarification required.

9.11 Once the investigation is complete the Investigating Officer will prepare a report of their findings, providing documentary evidence of the facts, and any witness statements and concluding whether there appears to be evidence that the alleged misconduct occurred. On receiving the Investigating Officer's report, the Manager will determine, within 10 calendar days what further action should be taken. i.e:

- no case to answer
- to proceed to a disciplinary hearing
- to proceed through an alternative procedure (for example, capability)

Where a decision is made to proceed to a disciplinary hearing, this should take place as soon as possible after the decision is made.

9.12 Where the allegation is of a potentially serious nature, in the interests of minimising unnecessary delay it may be advantageous to arrange, a provisional date for a disciplinary hearing at the outset of an investigation.

This is a practical measure that does not, in any way, attempt to prejudge whether such a disciplinary hearing will be deemed necessary.

**9.13 Witnesses**

9.13.1 All employees of the ABMU Health Board have a duty to co-operate with management in disciplinary proceedings. Witnesses who have provided statements should be advised of the fact that a hearing may take place and of their being required to attend.

9.13.2 The employee or their representative must make the Disciplining Officer aware of those staff they wish to call as witnesses.

9.13.3 The Disciplining Officer will arrange to call all witnesses required after having discussed and agreed these with the employee and his/her representative.

9.13.4 Witnesses are obliged to attend if requested to do so by the Disciplining Officer.

9.13.5 Arrangements will be made for witnesses to be released from their duties to enable them to attend the hearing. They may bring a representative or colleague with them for personal support if desired.

9.13.6 People not directly employed by ABMU Health Board may be invited to attend the hearing as a witness but cannot be compelled to do so.

**10. Suspension from the Workplace**

10.1 In some circumstances it may be appropriate to suspend the employee or to transfer the employee to another post/work pattern or to another work place on a temporary basis. Where alternatives to suspension are being considered, this would only be done following consultation with the employee and their Representative and would take into account its reasonableness in all the circumstances. LCFS / CFS Wales should always be advised of any decision to suspend or transfer an employee when the employee is under investigation by the LCFS/ CFS Wales.

10.2 Suspension is not a disciplinary penalty and is without prejudice Suspension from the workplace will be with pay, in accordance with Paragraph 10.4.1 of this Policy. Suspension may be considered appropriate where keeping the employee in the workplace after the incident/ misconduct may:

- Compound the offence.
- Interfere with or prejudice the investigation.
- Jeopardise the safety or well being of patients or employees.

10.3 If the decision to suspend is taken by the manager (in consultation with a senior HR Advisor or, where not available, another manager of equivalent seniority) the employee should be told of this decision immediately. Where possible the employee should be given the opportunity to be accompanied at the meeting when they are informed of their suspension if they wish.

10.3.1 Unavailability of a preferred representative or colleague may not, however, delay the meeting from taking place.

10.3.2 The employee should be given information regarding the support available to them e.g. Occupational Health, via the ABMU Health board's Occupational Health Service and Stress Counselling Service by their manager and their representative.

10.4 During suspension the employee must not (unless as a patient or to access sources of help e.g. to meet with their Representative) enter ABMU Health Board premises or their normal place of work without the express permission of their manager. Details of the suspension will be confirmed in writing giving the reason(s) for this course of action by the manager.

10.4.1 Pay during suspension will be calculated according to the normal duty roster worked by the employee and during this period the employee will be recorded as paid leave of absence in order to maintain confidentiality.

10.4.2 Employees who are suspended must make themselves available to attend meetings and interviews as part of the disciplinary process.

10.4.3 Where alternatives to suspension are being considered, this would only be done following consultation with the employee and their Representative and would take into account its reasonableness in all the circumstances.

10.5 If an incident occurs, or is reported out of hours and an employee's manager or an appropriate member of the HR Department is not available, an appropriate senior member of staff can make a decision to send an employee home on the basis that there is a risk to themselves and/or others if they were to stay in work. The individual will be asked to report to their manager on a specified day. This decision will not constitute suspension but is required in order that the facts of the case are reviewed as soon as reasonably possible. The employee will be recorded as on special leave and paid as per their normal shift.

10.6 The manager must ensure that the period of suspension is kept to a minimum and that the investigation takes place as swiftly as possible. The manager should review fortnightly the period of suspension, and any that continue beyond four months should be reported, together with information on the expected completion of the investigation to the Board of ABMU Health Board

Regular reports should be made to every Board detailing current suspensions and their duration. Information identifying individual members of staff should not, however, be presented in the open Board meeting.

10.7 If an employee wishes to book annual leave during the period of their suspension they must apply to the manager giving due notice. Such applications will be considered sympathetically but may reasonably be refused if the leave would delay the resolution of the disciplinary matter. Annual Leave booked prior to the suspension will be honoured and will be deducted from the employees total annual leave entitlement.

11. Procedure for reporting staff to the Independent Safeguarding Authority/appropriate professional body

11.1 All organisations, with effect from 12th October 2009, will have a legal duty to refer any information about individuals who could pose a risk of harm to children and adults at risk to the ISA who will assess the information and make a barring decision. Such referrals will include when an incident comes to light, when a member of staff has been dismissed, or resigned before dismissal.

11.2 'Harm' is stated as being physical, sexual, emotional, neglect or financial. Neglect could include a failure to act or an omission.

11.3 It will be the responsibility of the HR Advisor dealing with each individual case, or an appropriate senior manager, to report staff to the ISA. Where such a referral is made, the Head of Profession should be notified.

11.4 It will be the responsibility of the Head of Profession to contact the appropriate professional regulatory body at the point at which it is decided that there is some evidence of a concern relating to fitness to practice. The decision on when this occurs should be taken in discussion with the appropriate regulatory body.

11.5 During a period of suspension, the employee is prohibited from working in another NHS organisation without the express written permission of their manager. Where the alleged offence relates to the protection of children and adults at risk, further restrictions on employment in other sectors may be imposed by the Independent Safeguarding Authority. The employer will take advice from ISA should this be the case.

## Extract from Redeployment Policy (2003)

Scope of Policy

2.1. The policy applies to all staff who are employed on a permanent contract with the Trust whose current or future role is no longer tenable because of:-

a) **changes in the provision of service delivery.** This includes changes to skill mix, the contraction or cessation of a service or other organisational change which results in a reduction to the number of employees required. The policy also covers employees who are the subject of a TUPE transfer out of the NHS who wish to retain their NHS terms and conditions. TUPE transfers within the NHS do not fall within the scope of this policy

b) **capability issues arising from health problems.** This includes any employee who, on medical advice, is unable to remain in their current position due to a health related problem.

Reference should be made to the NHS Injury Benefits Scheme if the employee is suffering from an injury, disease or condition sustained during NHS employment.

To comply with the principles of the Disability Discrimination Act (DDA), priority consideration (including consideration of reasonable adjustments) will be given to staff whose disability, as defined by the Act, results in their continued employment in their current post becoming untenable.

c) **capability issues arising from poor performance.** Where it has been determined under the scope of the Trust's Capability policy that an employee should be redeployed into an alternative post although there is no automatic right for an employee under these circumstances to be considered for redeployment.

2.2 The policy is not intended to cover the needs which may arise as a result of market testing of services in accordance with 'Best Value' principles.

**3. Staff consultation**

3.1 The Trust is committed to full negotiations and to consult with staff side representatives over changes in service delivery and then to consult individually with all affected employees and their representatives throughout the application of this policy.

3.2 Staff are entitled to be accompanied by a trade union representative, work colleague or friend not acting in a legal capacity at any stage in this process.

3.3 Where a long term service change, such as a retraction or closure of a service, has been identified, agreement will be reached in consultation with staff side representatives to determine precise timescales for implementing this policy. This will include identification of the date of entry onto the Redeployment Register from when the active search by both parties for suitable alternative employment must commence. This period will not exceed four years.

**4 Entry onto the Redeployment Register**

4.1 Subject to paragraph 3.3 above, staff who are judged to fall under the scope of this policy will be placed on the Redeployment Register as soon as it is identified that their employment in their current post is no longer tenable due to one of the reasons detailed in section 2 above. Any search for suitable alternative employment within the employee's current Directorate will occur simultaneously with their entry onto the Redeployment Register and will take place under the terms of this policy.

4.2 Staff whose employment in their current post is no longer tenable due to health related issues will only be placed on the register on the advice of Occupational Health in accordance with the Trust's Sickness Absence Policy. Where it is known following Occupational Health advice that an employee will not be able to return to work in any capacity, they will have no entitlement to be considered for redeployment.

4.3 "At risk" staff are defined as "those staff whose post(s) cease to exist or whose post(s) are substantially altered as a result of service changes".

4.4 Any member of staff identified as "at risk" will be individually counselled by his/her line manager and a member of the Personnel Department where requested. The member of staff may be accompanied by a Trade Union representative, colleague or friend not acting in a legal capacity should they wish. The purpose of the counselling session(s) will be to discuss the reasons

for the redeployment and to explain the purpose of the Redeployment Policy and to determine the individual's circumstances.

4.5 During the counselling session the employee will be assisted in the completion of an application to the Register (appendix1). This form should be supported with a letter from a relevant specialist adviser (e.g. Occupational Health) where appropriate, together with any other information which will assist in the matching process.

4.6 Under the requirements of the DDA, managers are required to provide details of any adjustments which may need to be considered as part of the redeployment process. Such details should be attached to the application to the Register if appropriate.

4.7 The completed form and attachments should then be forwarded to the appropriate Group Personnel Manager who will ensure that the employee does fall within the scope of this procedure. The form will then be forwarded to the Redeployment Co-ordinator.

4.8 Where there is a major reconfiguration, retraction or closure of a service which affects a group of staff, the Personnel Manager will complete a summary of the details of those 'at risk'. This summary will be sent to the Redeployment Co-ordinator.

4.9 The Redeployment Co-ordinator will compare the Trust's vacancies (proposed and advertised) against the details of staff held on the Register on a weekly basis.

**5 Informal Interview**

5.1 Once an initial match has been made, an informal interview should take place involving the line manager and the employee. The Personnel Manager will advise the employee's representative of the interview arrangements but the employee's representative will not be present at the interview itself. A Personnel Manager from the Directorate in which the vacancy has occurred should either be present or their advice sought prior to any decision being made.

5.2 The purpose of the interview will be to ensure that the employee meets the minimum criteria for the job, as determined by the Person Specification, or that they will be able to meet these criteria within a reasonable timescale if provided with appropriate training.

5.3 Where the employee is being redeployed as a result of a health related issue, advice must be sought from the Occupational Health department on the suitability of the post.

5.4 Unless either the manager or the employee can clearly justify that the post is not suitable, an offer of employment will be made subject to a 28 day trial period. Any extension to the trial period will be subject to agreement by both parties.

5.5 During the trial period, the employee will be provided with appropriate support and the relevant training to enable them to undertake the role. The provision

of support and training will be the responsibility of the new line manager where the trial is being undertaken.

5.6 During the trial period, the employee will be paid by the department in which the trial period is being undertaken. The receiving department will also fund any additional training required.

5.7 Where an employee is redeployed successfully and is subsequently entitled to protection of earnings, arrangements will be made to ensure that the receiving department does not suffer a financial disadvantage.

**6. Identification of Suitable Alternative Employment**

6.1 Where a group of employees is affected by an organisational change, a list of posts which may be suitable alternative employment will be drawn up jointly by management and staff organisations and sent to the redeployment Co-ordinator. All posts on the list which become vacant will automatically be held for consideration. (See appendix 2).

6.2 In other cases, the search for suitable alternative employment will be undertaken by the Group Personnel Department and by the Redeployment Co-ordinator. On a weekly basis the requirements of individuals on the register will be reviewed against all vacancies which have become available across the Trust prior to advertisement. This will be done by checking the VF1 forms submitted for advertisement. In addition, the Trust will ensure that each edition of the Trust's internal recruitment bulletin is made available to employees on the Register.

6.3 Should a vacancy occur which is a potential match, the vacancy will be held from advertisement for further investigation of suitability. Where a vacancy is a potential match for more than one employee on the register, the Directorate in which the vacancy has occurred will be responsible for interviewing all such candidates to select the best employee based on the candidates' suitability against the criteria laid down in the Person Specification. Where the manager is unable to determine who the 'best' candidate is following the interview, length of service may be used as a justifiable criteria to separate two evenly matched applicants. (For the purposes of length of service, staff who have taken formal career breaks will be able to have their break included in their service provided that they undertook their two week training during each year of the career break).

6.4 Employees with a disability which falls within the scope of the DDA will be given preferential consideration including the consideration of reasonable adjustments. In all other cases, the principles of the Trust's Equal Opportunities policy will apply.

6.5 In all other cases, the 'matching process' will be conducted as detailed in the framework illustrated in Appendix 3. The responsibility for co-ordinating the matching process will be with the Group Personnel department from whom the employee originates.

6.6 Should a vacancy be identified which has already been advertised, the recruitment process will be suspended and the matching process conducted as in 5.3 above unless the interviews have already been arranged and shortlisted candidates informed. Where the interviews have already been arranged, the employee will be considered on the same terms as other shortlisted candidates provided that they meet the minimum criteria laid down in the Person Specification.

6.7 The definition of suitable alternative employment will be:

- Located within six miles of the employee's home or it involves no additional travelling expenses. If the new post is at a greater distance, the fact that assistance will be given with extra travelling expenses will normally outweigh any added difficulties in travel in line with Whitley.
- Where possible at the same grade as the employee's substantive post and should carry broadly similar levels of responsibility. However, suitable alternative employment may be offered at a different grade when salary protection is offered and the individual's qualifications and ability to perform have been considered.

6.8 Protection of salary and terms and conditions of service will apply on the following basis:

In cases where the employee's job is "at risk" as a result of organisational change the Trust's Protection arrangements will be applicable.

In cases where the redeployment has resulted from an incapacity to continue in the current role due to either ill health or performance, there will be no protection of salary. However, where the ill-health is as a result of an industrial injury which has been appropriately reported and documented, protection may apply.

Where, following discussion with staff side representatives, it has been agreed that staff falling within the scope of a TUPE transfer may be placed on the Redeployment Register, as per paragraph 2.1.a. above, there will be no entitlement to protection of salary. However, where it has become apparent that an individual does not have an identified position to transfer into, protection may be granted following discussion between senior management and staff organisations.

6.9 Should an employee unreasonably refuse the offer of suitable alternative employment on three occasions, they will be removed from the Register and will not be considered for any other suitable alternatives. In such cases, the employee's employment will be terminated with appropriate notice (see section 8 below). This decision to remove an employee from the Register will only be taken after full consideration of all the relevant factors following advice from the Group Personnel Manager. Where the employee is "at risk" due to organisational change (other than a TUPE transfer), this may result in a loss of entitlement to any redundancy payment.

6.10 Where an employee disagrees with the manager that the employment offered is suitable, the employee will have a right of appeal using the Trust's Individual Grievance Procedure.

## 7. Evaluation of trial period

7.1 It is vital the employee is fully supported during the trial period. This will include the provision of an adequate induction and appropriate on the job training. Progress must be actively reviewed through out the trial period.

7.2 Where there is concern by either party that the post may not be suitable for the employee, this must be discussed prior to the conclusion of the trial. All reasonable attempts should be made to ensure that the trial is successful, including the provision of additional training where necessary.

7.3 On conclusion of the trial, if successful, the employee will be confirmed in the post on a permanent basis. Where the trial has been unsuccessful and it is agreed that the post is not suitable, the employee will return to the Register subject to the agreed length of time (see section 8 below). The Group Personnel Manager must ensure that the Redeployment Co-ordinator is informed promptly of any re-entry to the Register.

## 8 Length of time on the Register

8.1 Where an employee has been placed on the Register due to a health related capability issue, they will remain on the register for the duration of their pay, subject to paragraph 6.9 above. Should the search for alternative employment prove unsuccessful, the employment will be terminated on the grounds of incapacity due to ill-health. The employee's notice period will run concurrently with the period of half pay.

Only in very exceptional circumstances, at the discretion of the Director of Personnel and Operations, may an individual may be permitted to remain on the register after their pay has been exhausted.

## Appendix D – Interviews

The following current and former members of the health board's staff were interviewed.

Current staff (MHLD delivery unit):

- Service Director
- Nurse Director
- Head of Psychology and Therapies
- Head of Specialist Services
- Head of Nursing (Locality)
- Service Manager (Acute Assessment and Treatment Units)
- Unit Manager (Unit A)
- Quality and Safety Manager
- 11 members of staff from Unit A (registered nursing staff x3 and unregistered nursing staff)

Other current staff:

- Assistant Director of Workforce and Organisational Development
- Workforce Manager (POWH)
- Workforce Manager (MHLD)
- Assistant Director of Nursing (with responsibility for safeguarding)
- Deputy Head of Safeguarding, Corporate Safeguarding Team
- Safeguarding Specialist, Corporate Safeguarding Team
- Nurse Director (Morriston Hospital)
- Investigating officer for Mr W's case
- Disciplinary officer for Mr W's case
- Authors of the internal desktop review report (x2)

Former staff:

- Clinical Director (LD directorate)
- Directorate General Manager (LD directorate)
- Head of Nursing (LD directorate)
- Head of Nursing (Mental Health Directorate)
- Consultant Psychiatrist – Lead Clinician (LD directorate)
- Associate Clinical Director – Tier 2 Services (LD directorate)
- Associate Clinical Director – Tier 3 Services (LD directorate)
- Service Development Consultant – Tier 2 Services (LD directorate)

Former Executive Board members (ABMUHB):

- Chief Executive
- Chief Operating Officer
- Executive Director of Nursing and Patient Experience
- Medical Director
- Interim and Deputy Medical Director.

Cwm Taf University Health Board and Cardiff and Vale University Health Board staff:

- Director of Nursing (until Summer 2018: Cwm Taf University Health Board)
- Assistant Director Patient Safety and Quality; Lead Nurse (Cardiff and Vale University Health Board).

## Appendix E – Outline chronology of events

**March 2001** – Mr W started work in the health board's IT department

**July - December 2004** – Mr W was on sick leave

**17 Dec 2004** – Mr W started work at the LD directorate (unit A)

**2005 – 2012** – Mr W worked as a care assistant based at Unit A

**21 Dec 2011** –It is recorded in the care notes that Ms X became physically and verbally aggressive towards staff and made allegations of inappropriate contact by Mr W.

**22 Dec 2011** – It is recorded in the care notes that Ms X that Mr W had inappropriately touched her.

**24 Dec 2011** – It is recorded in the care notes that Ms X became verbally aggressive making allegations of inappropriate conduct against Mr W

**Jan 2012** – It is recorded in the care notes that Ms X referred to her previous allegations against a 'male member of staff' and said that she was upset that no-one believes her.

**13 Jan 2012** – Ms X's care manager was reviewing the care plans and escalated the documented allegations of abuse to Unit Manager. A VA1 form was completed and the HON (LD directorate) was informed.

**17 Jan 2012** – 1st POVA strategy meeting (allegation 1) took place

**19 Jan 2012** – Mr W was placed on special leave

**24 Jan 2012** – 2nd POVA strategy meeting (allegation1) took place. The police started a criminal investigation.

**16 Feb 2012** – The police completed interviews with 6 members of staff and Ms X. She later withdrew her allegation. The decision was made to proceed to non-criminal investigation by the health board.

**12 March 2012** – An initial assessment report (under the health board's disciplinary procedures) found no evidence additional to that identified by the police.

**13 March 2012** – A Final POVA Strategy meeting (allegation 1) was held. The decision was that there was insufficient evidence to proceed with an investigation under the disciplinary procedures.

**4 April 2012** – Mr W returned to work at Unit B.

**2 Oct 2012** – A second allegation was made against Mr W by Ms Y, a former patient at Unit A. This allegation related to events which took place during June-July 2010.

**8 Oct 2012** Staff visited Ms Y to discuss the allegations. A VA1 form was completed.

**12 Oct 2012** – 1st POVA strategy meeting (allegation 2) was held. The police started a criminal investigation.

**13 Oct 2012** – Mr W was advised about the allegation and placed on special leave until further notice.

**6 Dec 2012** – Having concluded the criminal investigation, the police notified the health board that the CPS would not be taking the matter further.

**20 Dec 2012** – 2nd POVA strategy meeting (allegation 2) was held and noted the decision concerning the criminal investigation. The health board would undertake an initial assessment under its disciplinary policy.

**2 Feb 2013** – A third allegation against Mr W was made by Ms Z during a previous inpatient stay at Unit A between May and June 2011. A VA1 form was completed.

**6 Feb 2013** – A second DLM was appointed from outside the LD directorate.

**11 Feb 2013** – 1st POVA strategy meeting (allegation 3) was held.

**20 Feb 2013** – The Initial Assessment report under the disciplinary policy about allegation 2 concluded that full investigation would not achieve anything further.

**26 Feb 2013** – The second DLM sought permission for Mr W to be formally suspended.

**7 March 2013** – Mr W was formally suspended pending the outcome of the investigation.

**12 April 2013** – 2nd POVA strategy meeting (allegation 3) was held. The police confirmed that they were nearing the end of their investigations and would be submitting a file to the CPS relating to all three allegations. The police confirmed that the health board's internal investigations could commence.

**19 Aug 2013** –3rd POVA strategy meeting (allegation 3) was postponed pending outcome of the CPS decision.

**22 Jan 2014** – 3rd POVA strategy meeting (allegation 3) was held. The police confirmed that the file on the allegations had been passed to the CPS but their decision was not to proceed to prosecution. The police confirmed that they had significant concerns about KW. Mr W remained suspended and the health board would investigate under its own disciplinary procedures.

**5 Feb 2014** – It was decided that someone external to LD and MH Directorate would undertake the disciplinary investigation into the incidents.

**10 Feb 2014** – The police confirmed that they would release all interview records and statements to be used in the health board's disciplinary investigation.

**14 August 2014** – A Senior Manager external to the LD directorate was appointed as the Investigating Officer for the case.

**2 Feb 2015** – The Investigating officer forwarded the draft investigation report to the health board's HR department.

**25 March 2015** – The finalised version of the investigation report was available.

**June 2015** – The agreed date for the disciplinary hearing was 30 July.

**22 July 2015** – A representative for Mr W requested deferment of the hearing due to Mr W's ill health.

**Sept 2015** – An occupational health assessment took place. It confirmed that Mr W was fit to attend a hearing but not to attend work.

**2 Dec 2015** – **The disciplinary hearing took place**. There was an adjournment to seek additional information about points raised by Mr W's representative during the hearing. It was planned to reconvene on 10 December but this was deferred the day before due to the need for additional enquiries.

There were subsequent difficulties in arranging a time for the continuation of the hearing when all witnesses were available to attend.

**7 March 2016** – Mr W was arrested on suspicion of murder. The Disciplinary process was still to be concluded.

**30 March 2016** – The Disciplinary Panel met to consider the evidence. A decision of gross misconduct was made.

**21 April 2016** – A letter was sent to Mr W informing him of the outcome of the disciplinary hearing and formally terminating his employment.

**27 April 2016** – A final POVA strategy meeting was held; the outcome was that all three allegations were found to be 'proven'.

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|---|---|
| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | Quality and Patient Safety Committee<br>4th April 2019<br>Agenda Item: 3.4 |

3.4

# Aneurin Bevan University Health Board
# Quality and Patient Safety Committee

FEEDBACK FROM THE PEER REVIEW OF ABUHB ACUTE DETERIORATION SERVICES AND DRAFT ACTION PLAN

## Executive Summary

The All Wales Rapid Response to Acute Illness Learning Set (RRAILS) Steering Group set up a review of how well Welsh Health Boards and Trusts respond to the challenge of the acutely ill and deteriorating patient and whether our existing arrangements are working. Where good practice and innovation is identified, it will be shared across Wales to reduce variation and drive up standards of care. The peer review combines self assessment and independent peer review carried out by members of the RRAILS Steering Group.

This report provides the Quality and Patient Safety Committee with the Feedback on the Peer Review of Acute Deterioration Services in ABUHB, which took place across the 3 acute sites on 26th and 27th September 2018 (RGH and NHH) and 4th October 2018 (YYF). The Peer Review Team provided initial feedback on the 3 sites in November 2018, and the draft feedback report (see Appendix 1) was presented to a meeting with key staff from ABUHB on 21 December 2018. The feedback from the Peer Review Team was extremely positive, with ABUHB acknowledged as the trail blazer for Wales in this area.

It also provides the ABUHB draft action plan in response to the feedback and recommendations, which has been developed by the Aneurin Bevan Collaborative (ABC) Sepsis Team.

The Executive Board has considered the report and approved the action plan. The Quality and Patient Safety Committee is asked to approve the report.

| **The Executive Board is asked to:** (please tick as appropriate) | |
|---|---|
| Approve the Report | X |
| Discuss and Provide Views | |
| Receive the Report for Assurance/Compliance | |
| Note the Report for Information Only | |
| **Executive Sponsor: Dr Paul Buss – Medical Director** | |
| **Report Author: Kate Hooton – Assistant Director – Quality and Patient Safety** | |
| **Report Received consideration and supported by :** | |

| Executive Team | | Committee of the Board [Committee Name] | Executive Board |
|---|---|---|---|
| **Date of the Report: March 2019** | | | |
| **Supplementary Papers Attached: Feedback on the Peer Review of Acute Deterioration Services and ABUHB Draft Action Plan** | | | |



## Purpose of the Report

This report provides the Quality and Patient Safety Committee with the Feedback for ABUHB on the Peer Review of Acute Deterioration Services, which took place across the 3 acute sites on 26th and 27th September 2018 (RGH and NHH) and 4th October 2018 (YYF). It also provides the ABUHB draft action plan in response to the feedback that has been developed by the Aneurin Bevan Collaborative (ABC) Sepsis Team.

## Background and Context

Unrecognised and untreated acute deterioration has long been recognised as the cause of a significant amount of avoidable harm and death in all healthcare settings, although quantification of this has been difficult and problematic. It has only been relatively recently appreciated that two syndromes, Sepsis and Acute Kidney Injury (AKI), are associated with, or are a major cause of most cases of acute deterioration in hospital.

The vehicle for driving recognition and treatment of acute deterioration in Wales is the Rapid Response to Acute Illness Learning Set (RRAILS).This is a national improvement initiative, which started in 2011 as part of the 1000 Lives Campaign, and the RRAILS Steering Group brings together representatives from all Health Boards and Trusts and senior doctors and Nurses, managers, Critical Care Outreach Teams (CCOTs) and Resuscitation Officers.

The RRAILS Steering Group set up a review of how well Welsh Health Boards and Trusts respond to the challenge of the acutely ill and deteriorating patient and whether our existing arrangements are working. Where good practice and innovation is identified, it will be shared across Wales to reduce variation and drive up standards of care. The peer review combines self assessment and independent peer review carried out by members of the RRAILS Steering Group.

The Peer Review of Acute Deterioration Services in ABUHB took place across the 3 acute sites on 26th and 27th September 2018 (RGH and NHH) and 4th October 2018 (YYF). The RRAILS team included Chris Hancock, Lead for Acute Deterioration Programme 1000 lives; Dr Richard Jones, Clinical Lead for Acute Deterioration Programme 1000 lives; Lisa Fabb, Service Improvement and Development Manager Acute Deterioration 1000 lives; David Wastell, Service Improvement and Development Manager Acute Deterioration 1000 lives. Peers were Dr Lisa Williams- Gastroenterologist & hospital lead for AD at ABMUHB, Mark Dawson- Lead for resuscitation ABMUHB & Tina Howell- Advanced Nurse Practitioner ABMUHB. The review team fed back that they were welcomed in ABUHB and staff gave reviewers an open and honest reception.

The Peer Review Team provided initial feedback on the 3 sites in November 2018, and the draft feedback report, which was extremely positive, was presented to a meeting

with key staff from ABUHB on 21 December 2018. This draft report is attached as Appendix 1.



**Assessment and Conclusion**

The feedback at the meeting with the Peer Review Team on 21 December 2018 was extremely positive. The Team found it hard to review ABUHB as ABUHB is a trail blazer in Wales for sepsis. The Peer Review Team particularly noted the join up between Senior Levels and the front line within ABUHB, with long term support for the sepsis work in particular from the Medical and Nursing Director. There are also good links to and support from associated streams of work, like Health Care Associated Infections. ABUHB is also notable as it is able to evidence measurement at all points, initially through the take up of the Outreach database by the CCOTs, and more recently through the comprehensive ABC Sepsis database. ABUHB worked with the 1000 Lives and Public Health Wales to set up ABC Sepsis, and test and then spread the DRIPS meetings and Sepsis trigger tool to all receiving units. This has now become the template for sepsis work in the rest of Wales. There is more work to be done on acute wards, as the process for collecting and feeding back sepsis data in this setting is not as robust as in the receiving units.

The AKI guidance, which originated in ABUHB, has been adopted as the All Wales AKI Guidance. The RGH has piloted an AKI response bundle for AKI e-alerts. However, the peer review team found there was no systematic response to AKI in place in the acute hospitals.

The draft Feedback report has 5 recommendations that have been included in a suggested action plan. However, the next step in the peer review process is for the Health Board to review the suggested actions and collaborate with the 1000 Lives Improvement RRAILS Team to finalise the action plan. When finalised, the action plan will be published for wider dissemination and will be shared with Welsh Government.

The suggested action plan for ABUHB contains high level actions, as we have a well established process in place across all acute areas in the Health Board. The ABC Sepsis Team has worked with others to amend the suggested action plan to reflect the approach being taken within ABUHB. This draft action plan is provided in Appendix 2.

Once finalised, the action plan will be monitored through to completion. This will be undertaken by a Group in the Quality and Patient Safety Assurance structure and which Group will be determined as part of the review of governance for acute deterioration, which is the first action in the action plan.

**Recommendation**

The Executive Board has considered the report and approved the action plan. The Quality and Patient Safety Committee is asked to approve the report.

| Supporting Assessment and Additional Information | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | Unrecognised and untreated Acute Deterioration is a major cause of avoidable harm and death. However, the feedback on the acute deterioration services in ABUHB is positive, but the Health Board needs to continue its focus on sepsis through ABC Sepsis, and take forward the actions resulting from the recommendations to maintain this position. |
| ***Financial Assessment, including Value for Money*** | There will be some financial implications from the action plan, but these will be assessed through the process of implementation |
| ***Quality, Safety and Patient Experience Assessment*** | Implementing the action plan form the recommendations in the peer review will improve quality and patient safety, and the patient experience. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | Advice will be obtained from the Workforce and OD Directorate. |
| **Health and Care Standards** | Recognising and Responding to acute deterioration is core to providing safe care. |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | ABC Sepsis and acute deterioration is one of the aims within the Quality appendix for 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 –** Recognising and responding to sepsis and AKI early prevents long term problems for patients and therefore the population. |
| | **Integration** – It is about preventing harm and avoidable mortality. |
| | **Involvement** – The work involves people across the health board, increasingly in the community. |
| | **Collaboration** – We are working with partners in the community, such as nursing homes and residential homes, to spot deterioration in the community. |
| | **Prevention –** Recognising and responding to sepsis and AKI early prevents long term problems for patients and therefore the population. |
| **Glossary of New Terms** | RRAILS Rapid Response to Acute Illness Learning Set<br>CCOT Critical Care Outreach Teams<br>DRIPS Data, Review, Improvement, Plot the dots, Share |
| **Public Interest** | This report can be made public. |

**Appendix 1**



Aneurin Bevan University Health Board

# Feedback on the Peer Review of Acute Deterioration Services

November 2018

1000 LIVES i O FYWYDAU

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

# Contents



# Appendices

# 1 Introduction

The following report is the penultimate part in the improvement cycle for the review of acute deterioration services in Aneurin Bevan University Health Board (ABUHB). It is intended for use in the development, with the support of the national 1000 Lives Acute Deterioration Programme team, of an action plan to improve processes and outcomes for patients in the three acute ABUHB hospitals.

The Framework for Peer Review of Acute Deterioration Services in NHS Wales was agreed by the Rapid Response to Acute illness Learning Set (RRAILS) Steering Group with the purpose of reviewing how Welsh Health Boards (HB) respond to the challenge of the acutely ill and deteriorating patient. During the visits, the review team saw examples of good practice and effective systems as well as some opportunities to develop further.

The Peer Review is both a quality assurance and quality improvement process that assesses the quality of the service being delivered by multi-disciplinary teams and local health boards and Trusts in Wales. This assessment is set against a framework of local and national guidelines and Patient Safety Alerts and the overall Health and Care Standards for Wales and is underpinned by the principles of Prudent Healthcare.

The team was very pleased to see that the self-assessment and initial feedback has already galvanised staff into reviewing and adapting their practices around acute deterioration in ABUHB. The evolution of an action plan over the next few months with the support of the 1000 lives national Acute Deterioration Programme team should strengthen the response to the acutely deteriorating patient.

## 2 ABUHB Peer Review process

The Review framework comprises four elements:

1. Internally validated self assessments
2. Externally verified self assessments
3. Review visits
4. Collaborative Action plan


The RRAILS team included Chris Hancock, Lead for Acute Deterioration Programme 1000 lives; Dr Richard Jones, Clinical Lead for Acute Deterioration Programme 1000 lives; Lisa Fabb, Service Improvement and Development Manager Acute Deterioration 1000 lives; David Wastell, Service Improvement and Development Manager Acute Deterioration 1000 lives. Peers were Dr Lisa Williams- Gastroenterologist & hospital lead for AD at ABMUHB, Mark Dawson- Lead for resuscitation ABMUHB & Tina Howell- Advanced Nurse Practitioner ABMUHB. The review team were welcomed in ABU HB and staff gave reviewers an open and honest reception.

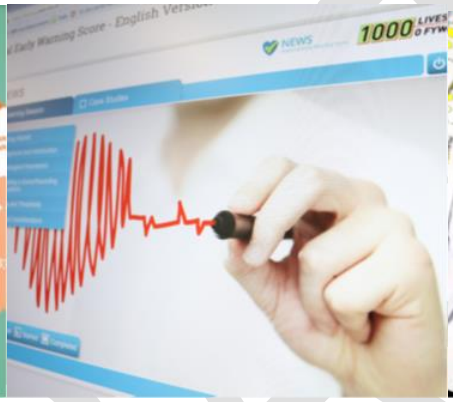
Preliminary reports were provided to each hospital within three months of each visit, see appendix 1-4. ABUHB's Dr Paul Mizen and Jan Barrett have supported the peer reviews around Wales from the outset. The process of HB's supporting staff to

review other HB's has been agreed by Welsh Government. We hope the team can continue to support the process.

## 3 Action Planning Process

This is the report summarising the findings and recommendations of the Review panel. This will be sent to the Health Board for accuracy checking of the findings and followed by the final report, which will be issued to the Chief Executive and Medical Director of the organisation responsible for the delivery of the service. The recommendations will provide the basis for the action plan that the HB will be expected to publish online.

Alongside the HB reports the Acute Deterioration team will produce a report for Welsh Government, summarising the key findings of the review visits.




# 4 Alignment with Patient Safety Alerts and RRAILS Programme Aims

| | |
|---|---|
| **Implementing the National Early Warning Score (NEWS) as Standard in all clinical areas in all acute hospitals.** | • All areas are using NEWS (with the exception of maternity and paediatric areas).<br>• An escalation protocol based upon NEWS is standard in all three sites reviewed. |
| **Quantifying the incidence of sepsis, AKI and acute deterioration in the non Critical Care setting.** | • Data on in-hospital incidence of positive sepsis screening and bundle compliance is collected via DRIPS meetings and collated at local and HB level.<br>• ED data collected via carbon copy forms in RGH, NHH and YYF receiving units Unit.<br>• There was no data collected on AKI incidence. |
| **Improving reliability of systems for identification, escalation and treatment of sepsis and AKI.** | • Carbon copy sepsis screening forms exist in all areas.<br>• Sepsis trolleys in existence on all receiving units.<br>• Weekly DRIPS meeting occurred in all receiving units and data was shared from ward to board. |
| **Supporting the introduction of care bundles, Standard Operating Procedures and tools based upon the guidance from NICE, NCEPOD and the Surviving Sepsis Campaign.** | • Acute deterioration and sepsis Standard Operating Procedure is well defined, evidence based and well publicised.<br>• Sepsis 6 care bundle is widely recognised as the standard treatment protocol throughout the HB.<br>• All hospitals use the all Wales consensus sepsis-screening threshold of a NEWS of 3 or greater and signs of infection.<br>• These protocols appeared to be understood in most clinical areas but clinical judgment was often reported to be used to identify deterioration rather than NEWS in YYF. |
| **Enabling measurement of compliance with these bundles and use of feedback and the model for improvement to improve reliability in the process of recognising and responding to the acutely ill.** | • All receiving units have weekly DRIPS meetings; this was exemplary practice and will be recommended to other HBs.<br>• The use of VitalPAC in YYF and NHH has allowed a regular review of the wards' NEW scores by 'nurse in charge' at the beginning of every shift. |
| **Working with LHBs and Trusts to** | • NEWS, sepsis screening and treatment with the sepsis 6 bundle were apparently part of the life |

| | |
|---|---|
| **develop training in recognition & response to acute deterioration.** | support skills training that the HB provides and which is mandatory for clinicians.<br>• The various CCOT members considered education to be part of their roles.<br>• We recommend that the HB should investigate how to combine the various sources of training (possibly including the local Schools of Health Science) to ensure greater efficiency in delivering training. |
| **Supporting LHBs & Trusts to improve the reliability of sepsis metrics reporting to Welsh Government** | • The HB has been exemplary in the submission of data on positive sepsis screening numbers and sepsis 6 compliance for all hospitals to WG on a monthly basis.<br>• This data has been used to inform practice from ward to board. |
| **Expanding reporting to incorporate measure of AKI** | • The HB has appointed an AKI lead.<br>• There did not appear to be a plan to measure the burden of AKI.<br>• There was no AKI bundle in use in any of the hospitals visited.<br>• A standardised set of metrics, for AKI, should be developed across all sites |
| **Supporting LHBs and Trusts to achieve the actions set out in the Patient Safety Alerts** | • All parts of Patient Safety Alert PS002 2014 on Sepsis have been achieved or are being actioned.<br>• We recommend that the HB review its response to Patient Safety Alert PSN029 2016 on AKI. |

# 6 Summary of Findings (please see appendices for detailed findings)

## 6.1 Governance

6.1.1 ABUHB has a single HB wide acute deterioration steering group with oversight of standards, procedure and practice in the three hospitals. There is also the ABC Sepsis group.

6.1.2 The single HB group appears to work well, however YYF feel that they would benefit from a local AD group as communication structures are different as it is smaller.

6.1.3 The ABC Sepsis group has had a great impact on the care of patients with suspected sepsis. Jan's role visiting all clinical areas has been key in this work. Inevitably there is some cross over into acute deterioration particularly in the assessment of patients using NEWS.

6.1.4 Leadership of ABC Sepsis has been very good, the support from other members of the senior executive team in the HB has been outstanding. The attendance of the members of the executive team at Sepsis events and through videos appears to have had a huge impact on the work.

6.1.5 The implementation of NEWS, sepsis screening and standardisation of response to acute deterioration that has been achieved throughout ABUHB. It is reassuring that these procedures appear to be understood from ward to board.

6.1.6 The Quality and Patient Safety Operational Group appear to have an appropriate wide and diverse membership.

6.1.7 Membership of and participation in the national RRAILS steering group from ABUHB has been excellent.

## 6.2 Structure

**Leadership and Coordination**

6.2.1 The HB structure appears to work well in the areas where the Sepsis Lead has been able to cascade information. A representative for YYF may improve communication in the future for clinical areas at this site.

6.2.2 CCOT and Sepsis Lead appear to coordinate services at ward level.

6.2.3 CCOT and Sepsis Lead take on much of the education role.

**Critical Care Outreach Team (CCOT)**

6.2.4 The CCOT are valued by medical and nursing staff of all specialties in NHH and RGH.

6.2.5 CCOT provision was variable across the HB. YYF hospital had no CCOT although the ANP took on aspects of this role. However, ward staff were unclear exactly what these roles encompassed.

6.2.6 The CCOT did not cover nights throughout the HB, although the Out of hours teams on all sites tended to appoint one member of staff to take on the CCOT function. It would be useful for these roles to be more closely aligned for education, qualifications and grade.

6.2.7 CCOT staffing levels do not allow reliable seven day a week cover. It was noted that an additional two CCOT members were about to be appointed in NHH to this end.

6.2.8 The review team noted that that many ward staff on all sites felt that it was not expedient to call CCOT between 9am and 5pm on Monday to Friday as there were doctors based on the ward.

6.2.9 Ideally the CCOT service should be enhanced with team expansion and role redesign to form the basis of a reliable 24/7 Rapid Response System.

**Huddles**

6.2.10 The daily patient flow meeting, observed in RGH, focussed on patient flow but offer an opportunity for real time ownership of patient safety problems and rapid response involving the entire hospital system.

**Standard Operating Procedures (SOPs)**

6.2.11 Hospitals within ABUHB have implemented various tools and operating procedures including NEWS, sepsis screening tools, 2 minute safety briefing, Patient Status at a Glance (PSAG) boards and an antibiotic formulary.

6.2.12 The tools appear to be embedded in practice in all areas visited.

6.2.13 This SOP was not followed in all areas. Although some areas were able to quote jump policy and delegation pathways (NHH), in other areas (YYF), nursing staff felt NEWS was a guide, not a SOP.

6.2.14 PSAG boards were in use on all wards and most were kept up to date. They were used as the focus for Board rounds where these were carried out.

6.2.15 The review team were impressed to see SOP attached to the NEW score on the PSAG board in some areas (NHH).

6.2.16 Vital PAC meant that NEW scores were not always seen on PSAG boards. The inclusion of both of these as part of a 'visual management system' would be an effective method for improving patient safety.

6.2.17 Although it was felt that 'board rounds' or '2 minute safety briefing' held at the PSAG board was an example of good practice, it was not clear how the data was used or fed back to clinical teams (medical and nursing).

6.2.18 Safety data derived from the board rounds could be developed and integrated with that collected by the CCOT to provide a patient safety dashboard and, if possible, should be integrated with the hospital Huddle.

**Sepsis boxes and trolleys**

6.2.19 ABUHB has a variety of Sepsis boxes and trolleys in use. These ranged from purpose built manufactured trollies to adapted 'Tupperware' boxes. All appeared to be safe and compliant with appropriate guidance.

## 6.3 Processes and measures

6.3.1 ABUHB provides data to Welsh Government on a monthly basis representing the numbers of positive sepsis screens and Sepsis 6 bundle compliance

6.3.2 This data is fed back to staff through DRIPS meetings in all receiving units throughout the HB. This ABC sepsis methodology has been adopted by various HB's and recommended as the gold standard by the 1000 Lives AD team.

6.3.3 In-patient wards also collect and feedback sepsis data; though this system did not appear to be as robust and the Sepsis team felt that there were missed opportunities to screen for sepsis. There may be an opportunity to

develop the other acute deterioration measures alongside sepsis data in these areas.

6.3.4 ABU HB has a culture of sepsis data collection that informs decision making in the provision of services.

**CCOT database**

6.3.5 The CCOT database is a potential source of extremely valuable information detailing; time of calls, average NEWS on referral and at 24 hours, the incidence of positive sepsis screening and associated treatment compliance and the ability to 'cut' the data to illustrate demand at particular times of day.

6.3.6 In order for this information to be used to inform service provision we would strongly recommended that a set of metrics from CCOT database is used to provide regular feedback sessions to local and HB wide quality and safety meetings.

**AKI**

6.3.7 The AKI guidance, which originated in ABUHB, has been adopted as the all Wales AKI guidance.

6.3.8 RGH had piloted an AKI response bundle for AKI e-alerts.

6.3.9 There was no systematic response to AKI in place in any of the hospitals visited.

**Sepsis Treatment and Metrics**

6.3.10 Use of the HB sepsis screening forms was consistent in receiving units; however this was inconsistent in other in-patient areas.

6.3.11 Welsh hospitals that are sucessfully managing sepsis at the front door are seeing less sepsis on inpatient wards. As a result staff caring for in patients will see less sepsis which reduces awareness of sepsis. This may be impacting on ABC Sepsis' ability to engage ward staff.

6.3.12 The review team were told that occasionally, personal judgement and discretion was used to identify sepsis cases, rather than NEWS or the SOP.

6.3.13 There did not appear to be any data available on the frequency sepsis boxes or trollies were used, and the related outcomes after use.

6.3.14 The utilisation of NEWS by WAST was reported both by paramedics and ED clinicians to be reliable and of a consistent quality.

## 6.4 Training and education

6.4.1 It was appeared that NEWS, sepsis screening and treatment were included in the life support skills and ALERT training which is mandatory for clinicians.

6.4.2 The Sepsis teams, CCOT and the resuscitation training departments have an important role in training and education in acute deterioration and although the message delivered by both sets of trainers was the same it appeared that there was significant duplication of effort.

6.4.3 Resuscitation training team were not available at peer review meetings to explain training plans.

6.4.4 The use of RRAILS Online was not yet widespread but this may be due to it still being a relatively new resource.

6.4.5 We recommend that the HB should investigate how to combine the various sources of training (possibly including the local Schools of Health Science) to ensure greater efficiency in delivering training.

6.4.6 It is recommended that the uptake of RRAILS Online modules be encouraged and that the numbers and professional identity of staff who have completed the modules be included in the standard metrics reviewed by the ABU HB Acute Deterioration Steering Group

6.4.7 HCSW record vital signs and during the implementation of VitalPAC in NHH it became apparent that HCSW did not always have the required skill set. Being the first step in the acute deterioration process, it is essential that they have the skills and supported to do this through training and assessment.

# 7 Key Recommendations

1. **Identify an Acute Deterioration Programme lead (similar role as current band 7 sepsis) under the direction of the ABUHB RRAILS steering group to coordinate activity, training and measurement in all ABUHB sites. (sec. 6.1, 6.2)**

   The current band 7 sepsis role has had a wide reaching impact on practice, training and data collection across the three hospitals. Although this role has had some impact on acute deterioration, it is sepsis focussed and person dependant.

   This role would benefit from working closely with the ABCi team. This would support the individual with quality improvement resources necessary to implement change effectively.

   Analysis of the RRAILS Acute Deterioration programme during the last eight years has repeatedly shown that HBs that appoint a single individual or team to coordinate work in this area rapidly experience improvements in clinician engagement, system reliability and patient outcome.

2. **The CCOT services are appreciated and should be preserved during times of staffing pressures elsewhere. Ideally the CCOT service should be enhanced with team expansion for 24/7 cover. (sec. 6.2)**

   The CCOT, and ANPs in YYF, are valued by medical and nursing staff. They are integral to escalation SOPs for deteriorating patients, the response to emergencies and follow-up of the hospitals' high-risk ward patients.

   Current CCOT staffing levels do not allow a reliable 12 hr cover. The review team were frequently told that the CCOT are more likely to be required out of hours, 5pm-9am on Monday to Friday, as well as weekends. The CCOT database may inform any changes needed to core hours worked and therefore service provision.

   YYF's ANPs were viewed as an Outreach type service but clarity is needed on this as some staff where unclear on the ANPs role.

   The CCOT had an integral role in the provision of ALERT and acute deterioration training, this should be protected.

   There is an All Wales Critical Care Outreach Group currently reviewing outreach provision in Wales, senior representation on the group will ensure services are in line with services elsewhere in Wales.

   Ideally the CCOT service should be enhanced and integrated with ANP and H@N services to provide the basis of a 24/7 Rapid Response System.

3. **Roll out a consistent approach to generating and responding to AKI e-alerts to all sites. (sec. 6.3)**

   The national e-alerts system is still in early development. RGH CCOT have piloted a response to e-alerts with stickers in notes and direct communication of AKI to the clinical team (nursing or medical).

   The lessons learnt from the pilot should inform the roll out across the HB and metrics monitored.

It is essential that both the metrics and the response be standardised. As there is no all Wales list generating system this aspect should be addressed in house.

4. **The implementation of VitalPAC has identified some issues in existing assessment and reporting of NEW score and acute deterioration. ABUHB should continue to safely implement the system with careful monitoring and report their experience to all-Wales forums.**

   ABUHB was one of the first HB's to introduce some effective low tech initiatives to enhance patient safety i.e. PSAG boards, 2 minute safety briefings. It is essential that some of these systems remain to enhance an electronic system. Building in redundancy in this way will ensure reliability.

   The focus on acute deterioration that the introduction of VitalPAC has provided has resulted in a useful insight into acute deterioration systems. The lessons learnt in the process are useful not only for ABUHB, but for all of Wales with regards to digital implementation.

   The focus on acute deterioration has also provided valuable lessons that are not solely linked to digital systems.

5. **Various sources and providers of training should be combined and online resources developed to ensure greater efficiency and functionality in acute deterioration training. (sec. 6.5)**

   It is apparent that some of the clinical education on acute deterioration is carried out by CCOT, who already find it difficult to maintain the required clinical service. Both the CCOT and the resuscitation training departments have an important role in training and education in acute deterioration and although the message delivered by both sets of trainers was the same, it appeared that there was significant duplication of effort.

   The review team are aware that as in most hospital the HCSW do most of the recording of vital signs, assurance is needed that all HCSW are competent to do this and systems are in record levels of compliance. Although training is key in this process, assessment of competency in the clinical setting is necessary.

   The review team recommend that the HB should investigate how to combine the various sources of training (possibly including the local Schools of Health Science) to ensure greater efficiency in delivering training.

   It is also recommended that the uptake of RRAILS Online modules be encouraged and that the numbers and professional identity of staff who have completed the modules be included in the standard metrics reviewed by the ABUHB Acute Deterioration Steering Group.

## 8 Suggested Action Plan

| Action | Suggested timeline | Support |
|---|---|---|
| 1 Identify an Acute Deterioration Programme lead under the direction of the ABUHB RRAILS steering group to coordinate activity, training and measurement in all ABUHB sites. | Within 6 months | Induction support from national Acute Deterioration Programme team.<br>Weekly phone call from national Acute Deterioration Programme team.<br>Inclusion on national RRAILS Steering Group and at national events. |
| 2 The CCOT services are appreciated and should be preserved during times of staffing pressures elsewhere. Ideally the CCOT service should be enhanced with team expansion for 24/7 cover. | Within 6 months | Chris Hancock, Acute Deterioration Programme Lead, 1000 Lives Improvement provides Welsh representation on the National Outreach Forum (NOrF) Executive Board.<br>Representation on the all Wales Critical Care Outreach group. |
| 3 Roll out a consistent approach to responding to AKI e-alerts to all sites. | Within 6 months | Links with NWIS, LIMS and all Wales National Outreach Forum group. |
| 4 The implementation of VitalPAC has identified some issues. ABUHB should continue to safely implement the system with careful monitoring and report their experience to all wales forums. | Within 6 months | The roll-out of the system has naturally been cautious although it is crucial that the second phase of roll-out, namely the alerting side of an E-observation system is followed through on to improve the response. |
| 5 Various sources and providers of training should be combined with online resources to ensure greater efficiency and effectiveness in acute deterioration training. | Within 6 months | RRAILS Online e-learning |

# APPENDICES

## Appendix 1 RRAILS Peer Review Preliminary Feedback for Royal Gwent Hospital

Site visit carried out 26 Oct 2018

Royal Gwent Hospital, Aneurin Bevan Health Board

Attendance.

Peer review team

Richard Jones- RRAILS clinical lead

David Wastell

Lisa Fabb

Lisa Williams

Mark Dawson

Local Team

Kate Hooton – Assistant Director Quality and Patient Safety

Jan Barrett – Lead nurse ABCSEPSIS

Paul Mizen – Consultant Acute Physician, Clinical lead ABCSEPSIS

Nirmala Parma-Hopkins- MDST

Chris Bradley – MDST

Laura Thomson – Senior nurse scheduled care

Tracey Rich – Senior nurse scheduled care

Lynne Sutton – Consultant ED

Donna Bielski Morgan – Band 7 – ED

ED DR – waiting for name

Ceri Philips –Antimicrobial pharmacist

Moira Bevan – Lead IPCT

Dr Mohammad Abrishami – Microbiologist

Dr Vinod Marthrani – Consultant physician acute medicine

The ABC Sepsis team should be applauded for their engagement with the 1000 lives RRAILS programme in all its forms over the past 10 years. In particular Jan Barrett's influence across the HB at a grass roots level has probably had the greatest impact.

We would also like to thank Kate Hooton for providing us with extensive evidence and organised itineraries for the visits. Our first meeting in the acute deterioration (AD) peer review process was very well attended, this demonstrated the great engagement ABUHB has with the AD agenda.

It is worth noting at the outset that there is a strong focus on Sepsis within ABUHB. The ABCsepsis group occasionally cover aspects of acute deterioration. There is also a LHB acute deterioration group.

Governance

There is a clear, health board wide, governance structure with policies and procedures appearing to be standard on all sites visited.

The review team were concerned that this might mean the lack of forums to share concerns at a site level. On discussion with clinical staff this did not seem to be a problem and they felt there were processes to discuss AD issues and were confident that they were shared at senior level.

The membership of the Deteriorating Patient group is wide-reaching and there is also the ABC Sepsis group that addresses some aspects of AD.

Structure

Structures, standard operating procedures and lines of responsibility appear clear and ward staff understood these structures. Dissemination of this information had been achieved through discussion and education from Jan Barrett.

The AKI champion is Dr Gareth Roberts however the Dr Vinod Marthrani was present in the meeting and clearly has an interest in the area.

As mentioned earlier Jan Barrett's role is fundamental in embedding policy and process from ward to board. Some responsibility for DRIPS meetings have been shared but some succession planning for Jan's role would be prudent as it is currently person dependant.

Critical care outreach team (CCOT) are often the safety engines of a hospital and their work is appreciated by the ward staff. The Outreach at RGH work during normal working hours. We were often told that 'we do not use Outreach much as doctors are here in the daytime'. One ward visited said they did not use outreach at all.

The CCOT resource is long standing and there has been a long-standing business case to increase their numbers to provide 12/7 cover. We felt the long-established CCOT database could help inform the case for service expansion.

Although there was a handover between the CCOT and ITU team there was no handover with the medical team on-call with responsibility for the rest of the hospital although there was an informal opportunity to communicate when the resuscitation team met for the test call.

The review team did not get any sense of an effective collaborative approach between outreach/ITU/Sepsis leads.

Process

The same NEWS chart and sepsis screening tool were used in all areas reviewed. The return of the sepsis screening forms is not as reliable on the wards as it is in admitting units despite Jan Barratt's attempts to engage wards. The data would suggest that the success of sepsis recognition at the front door has resulted in less sepsis on the wards. It may be worth considering another sepsis recognition model such as AD stickers or a SBAR form.

The respiratory ward used an adapted NEWS system, at the time of the visit there was no evaluation of this available.

Although the escalation SOP appeared to be one of the most complex the review team have seen evidence that staff seemed to understand it and it was embedded into practice.

The review team were impressed with the use of NEWS in the MAU as a tool for early triage, allowing a quick and simple assessment of the patient to rule out any serious concerns in a time stretched service. This safety measure had been achieved without investment and was embedded into admission processes.

There was no clear process for identifying and acting on AKI. MAU had a trial system where AKI alerts were reported by the admitting consultant team but this was not consistent.

Outcomes

The ABC Sepsis team have a culture of data collection and monitoring and data appears to be used to inform services. This is seen in DRIPS meetings and the Deteriorating Patients Group's Terms of Reference.

The ABC Sepsis team had used innovative ideas, such as a competition, to involve teams that were previously difficult to engage.

Auditing of the use of NEWS in the clinical area seemed inconsistent. Although some wards were aware of it one ward denied it took place at all. It may be beneficial to see how this data is being shared in RGH.

The use of a screening tool and the data collection was well established. It was good to see that feedback of the results was considered to be a vital part of the process. This also seemed to be well received by the clinical areas that were keen to improve their performance. The process functioned effectively because of a well-constructed support structure; Jan Barrett, data collection, audit department and feedback.

The question of succession planning was raised on a few occasions Jan Barrett is the cornerstone of the process. Sustainability might be questionable without her input.

Training & Education

The CCOT and Jan Barrett provide informal education in the clinical areas on Sepsis and AD, as well as occasional awareness days.

There was no representative of the Resuscitation Service available to outline how they contribute to this type of training. Others present reported training via ILS (mandated) & ALS, but it was not possible to judge the extent of the "managing deterioration" element within training. ALERT course were mentioned, however these were not considered mandatory and were "once only". It is hard to see how this would make a measurable contribution.

Doctors' sepsis training was regularly captured by Paul Mizen on the induction programme.

HCSWs in RGH have a clinical induction.

Outreach contributed to education at the bedside ie: face to face education opportunistically when responding to calls. It was frequently suggested that an increase in funding for outreach services would improve education and that would undoubtedly be true in the clinical setting.

26 Oct 2018

Nevill Hall Hospital, Aneurin Bevan Health Board

Attendance.

Peer review team

Richard Jones- RRAILS clinical lead

Christopher Hancock

David Wastell

Lisa Fabb

Lisa Williams

Mark Dawson

Local Team

Kate Hooton – Assistant Director Quality + Patient Safety

Jan Barrett – Lead nurse ABC SEPSIS

Deputy medical Director- Dr Steve Edwards

Ceri Phillips

Lisa

Natalie

The ABC Sepsis team should be applauded for their engagement with the 1000 lives RRAILS programme in all its forms over the past 10 years. In particular Jan Barrett's influence across the HB at a grass roots level has probably had the greatest impact.

We would also like to thank Kate Hooton for providing us with extensive evidence and organised itineraries for the visits. Our first meeting in the acute deterioration (AD) peer review process was very well attended, this demonstrated the great engagement ABUHB has with the AD agenda.

It is worth noting at the outset that there is a strong focus on Sepsis within ABUHB. The ABC Sepsis group occasionally cover aspects of acute deterioration. There is also a LHB acute deterioration group.

Governance

There is a clear health board wide governance structure through divisional structures with policies and procedures appearing to be standard on all sites visited.

As with other hospitals in the HB there is no local AD meeting. Staff did not feel this to be a problem as reporting structures appeared effective.

Nevill Hall had implemented the VitalPAC observation system and the implementation group provided a useful focus for the recording and escalation of vital signs and associated processes.

Structure

Most of the lead roles are HB wide. As previously mentioned Jan Barrett's role as lead nurse for Sepsis appears to be influential as it permeates all tiers from ward to board.

ABUHB has a strong presence at the all-Wales level, on the RRAILS steering group.

Although there had been a pilot of an AKI bundle with the outreach team in RGH there was no clear plan for AKI E-alerts at NHH.

NHH has a small Outreach team. They are awaiting appointment of a further 2 nurses to provide a 7 day cover.

Staff in NHH said they appreciated the work of the outreach although it was suggested that as outreach worked 9-5 ward staff would have doctors based on the ward at this time. One ward manager reported that they occasionally called outreach to ensure they are compliant with audit of escalation pathway.

There appeared to be good engagement from the sepsis champions on wards and admitting units.

Process

Sepsis is clearly a priority. There is a strong presence of posters and reminders in clinical areas. Despite this, wards are not screening as many patients as expected. Data would suggest that since the success of sepsis screening in the admitting units there are less cases of sepsis on the wards. The low frequency of sepsis would reduce the ward staffs' awareness of sepsis.

DRIPS meeting appeared to be embedded in the admitting units and appear to have had an impact. Missing forms were an issue and despite a review of the form collection process some were still lost.

The Jump call policy appears to be well established and nurses in NHH regularly quoted it.

ABUHB were one of the first HBs to embed confusion into the AVPU section of NEWS chart although it deviates from national guidance (as in ABUHB confusion scores a 2 not a 3).

Respiratory ward used a 'NEWS sticker' which appeared to be effective communication tool.

The review team did not get a sense of a co-coordinated/collaborative approach between outreach/ITU/Sepsis leads.

VitalPAC

VitalPAC is a significant part the recognition of acute deterioration process and brings with it some unique issues, we have therefore dedicated a section to its impact. In NHH it had only been introduced for a matter of months but the team were using the lessons learnt in YYF to guide implementation.

The introduction of VitalPAC has highlighted some issues around the recording of vital signs. These have been addressed through training of HCSW. It is unclear if registered nurses are struggling with similar issues.

Outreach and other roles encompassing a whole hospital responsibility said they found the ability to remotely review NEW scores for the entire hospital very useful.

There are still clinical areas that are not totally comfortable with the functionality of the VitalPAC system. One ward struggled to show us an observation chart.

The peer review team were reassured that all 'nurses in charge' reviewed the ward's NEW scores at the beginning of every shift. This seemed to be effective use of an electronic system that would not be available in a paper system.

The peer review team were told of a safety-net question that pops up when NEWS is >3 – 'Are you concerned about this patient?' This question is for registered nurses to answer, however we only felt assured that this was answered by registered nurses on one of the wards visited. This could occur using paper NEWS charts but this can be reviewed in the VitalPAC system.

VitalPAC provides the opportunity to collect a large amount of data. This is being scrutinised in the introduction period. We would recommend that VitalPAC implementation team choose a set of metrics that can be presented to the quality and safety meeting on a regular basis in the future.

Outcome

As with other ABUHB hospitals there is a culture of data collection and the data is effectively shared at ward level in displays and in DRIPS meetings, board meetings and local senior nurses meetings.

Two minute safety briefing appeared to be in use in many areas, the review team feel there is an opportunity to collect some data from this. In particular on antibiotic review as this was discussed at board rounds but not documented.

The use of a screening tool and data collection was well established. It was good to see that feedback of the results was considered to be a vital part of the process. This also seemed to be well received by the clinical areas that were keen to improve their performance. The process functioned effectively because of a well-constructed support structure i.e.: through Jan Barrett, data collection, the audit dept. and feedback.

Education

There appeared to be some excellent incidental ward based training from Sepsis team and the Outreach. Outreach contributed to education at the bedside via face to face education opportunistically when responding to calls. It was frequently suggested that an increase in funding for outreach services would improve education. This would undoubtedly be true in the clinical setting however there was no suggestion of how additional resources were being planned for this.

VitalPAC had highlighted issues around HCSW recording observations and communicating NEWS to registered staff. This had been addressed locally. There may be some benefit in working with the HCSW clinical induction team to ensure the issue is addressed on induction.

There was no representative of the Resuscitation Service available to outline how they contribute to this type of training. Others present reported training via ILS (mandated) & ALS, but it was not possible to judge the extent of the "managing deterioration" element within training. ALERT course were mentioned, however these were not considered mandatory and were "once only". It is hard to see how this would make a measurable contribution.

In general there did not seem to a co-ordinated approach to education around deterioration. Jan Barrett makes a significant contribution on the sepsis side but there did not seem to be same emphasis on NEWS etc.

It was unclear how education and support is provided for NEWS other than ILS.

VitalPAC highlighted issues with HCSW that were undoubtedly present before its introduction.

Peer review of Acute Deterioration services

26 Oct 2018

Ysbyty Ystrad Fawr, Aneurin Bevan Health Board

Attendance.

Peer review team

Chris Hancock

David Wastell

Lisa Fabb

Tina Howells

Mark Dawson

Local Team

Kate Hooton – Assistant Director Quality +Patient Safety

Jan Barrett – Lead Nurse ABC Sepsis

Phil Hill

Head nurse

Medical lead

Managerial lead

The ABC Sepsis team should be applauded for their engagement with the 1000 lives RRAILS programme in all its forms over the past 10 years. In particular Jan Barrett's influence across the HB at a grass roots level has probably had the greatest impact.

We would also like to thank Kate Hooton for providing us with extensive evidence and organised itineraries for the visits. Our first meeting in the Acute Deterioration (AD) peer review process was very well attended, this demonstrated the great engagement ABUHB has with the AD agenda.

It is worth noting at the outset that there is a strong focus on Sepsis within ABUHB. The ABC sepsis group occasionally cover aspects of acute deterioration. There is also a LHB acute deterioration group.

Governance

There is a clear LHB wide governance structure that feeds into the AD group from divisional structures.

The Acute Deterioration group's policies & procedures appear to be standard on all sites visited.

Due to the size of YYF, communication appears to be often informal. Feedback from those at the meeting suggested that divisional structures hindered communication at a hospital level.

As with other hospitals in the HB there is no local AD group. Again the YYF senior team feel they would benefit from a local AD group.

Structure

As with all hospitals in the LHB responsibility lies with the LHB leads for AKI, AD & Sepsis.

Jan Barret bases herself in YYF one day a week and is recognised by ward staff as the expert and she leads on education for Sepsis.

It was suggested that the Advanced Nurse Practitioners have an outreach type role in the preliminary meeting, however discussion with the ward staff suggested they weren't necessarily the clinicians called when a patient deteriorated.

Process

NEW Scoring was used throughout YYF and VitalPAC had been used in the hospital for a year. This had provided a spotlight on monitoring of vital signs and the related escalation procedures.

VitalPAC also provides an opportunity to review the frequency of observation both retrospectively and in real time. Phil Hill discussed his role monitoring and responding to increasing NEW scores.

The admitting unit uses a paediatric Early Warning Score to help risk stratify the care of paediatric patients.

Use of the standardised Sepsis screening tool throughout the hospital was impressive. Nursing staff knew when to screen for sepsis on all wards visited. The feeling of the ABC sepsis team is that ward staff are not screening for sepsis frequently enough.

The Medical Admission Unit (MAU) holds regular DRIPS meetings, they appeared to be well established.

The staff in YYF appeared less familiar than other HB staff with the standard operating procedure for escalating acutely deteriorating patients. Some of the staff we spoke to suggested they used personal judgment.

On discussion with medical staff they expressed concern around the lack of TPR/NEWS chart for each patient. They felt that VitalPAC did not allow the same opportunity for a timely review of the patient's vital signs at the bedside that a traditional paper chart provides. They also felt that subtle deterioration that may be incidentally picked up on a 'review of the charts' could be missed. Although they felt VitalPAC does allow remote review of the patient through the hospital overview system, which was useful when on call.

Outcome

There appears to be a robust reporting system of sepsis cases and compliance with the sepsis 6. This is fed back to staff through DRIPS meetings.

The Co-ordinators in Quality and patient safety team are key in the data collection and feedback process. They have also developed skills and deputise for Jan in DRIPS meetings in her absence.

Education & Training

It was unclear what aspects of recording vital signs & NEWS were covered in the HCSW clinical induction. All Wales Support worker competency was seen in clinical areas suggesting it was in use.

There was no representative of the Resuscitation Service available to outline how they contribute to this type of training. Others present reported training via ILS (mandated) & ALS, but it was not possible to judge the extent of the "managing deterioration" element within training. ALERT courses were mentioned, however these were not considered mandatory and were "once only". It is hard to see how this would make a measurable contribution.

Doctors had training on Sepsis on induction.

**ABUHB ACUTE DETERIORATION PEER REVIEW ACTION PLAN – DRAFT 2**

**Appendix 2**

| Recommendation | Actions | Timescale | Lead | Update |
|---|---|---|---|---|
| Review the structure for the governance of acute deterioration and consider Identifying an acute deterioration lead under the direction of the ABUHB Clinical Effectiveness Group, to co-ordinate activity, training and measurement in all ABUHB sites | 1. Review Structure for governance, including:<br>• Main issues within acute deterioration<br>• Policy Framework<br>• Steering Group<br>• Co-ordination<br>• Training<br>• Measurement and vitalpac<br>2. Consider identifying a lead for acute deterioration | 1. By Dec 19<br>2. By March 20 | AMD Clinical Effectiveness with Assistant Director - QPS | |
| To develop the Critical Care Outreach Team to a 24/7 Core Site Safety Team across the acute sites before the opening of the Grange University Hospital | 1.Implement first step business case, bringing together the Outreach Team and Resuss Team to provide 12/7 support for acute deterioration across RGH and NHH<br>2. Develop second step business case for the hospital at night service across the acute sites<br>3. Bring together the 12/7 acute deterioration service and the hospital at night service into a core site safety service across the acute sites | By Dec 2020 | Divisional Director, Scheduled Care and Clinical Futures Programme Board | |
| Roll out a consistent approach to responding to AKI e-alerts and data/measurement on all sites | 1.Meet with Clinical Leads for AKI at RGH and NHH and agree a consistent approach to responding to AKI alerts and consider ABCi involvement to test and spread the response<br>2.Develop an approach to data collection and measurement across the acute sites (local process data and Nationally collected outcome data) | 1. September 2019<br>2. December 2019 | ADD Unscheduled Care with Assistant Director - QPS | |
| To continue the implementation of vital pac (modules) in 2019 and clarify and address the issues in clinical practice that it has | 1.Ensure that outputs from vital pac are reported to the Steering group for Acute Deterioration | 1. September 19<br>2. ongoing | Deputy Medical Director | |

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| highlighted, and learn how to use the data in vitalpac to improve the recognition and response to acute deterioration. Ensure the learning is taken forward into the National Procurement Programme | 2.Continue meetings to ensure governance arrangement and evaluate clinical impact of vital pac | | | |
| Various sources and providers of training should be combined with online resources to ensure greater efficiency and effectiveness in acute deterioration training | 1.Complete mapping of current training provision for acute deterioration<br>2.Complete training requirements overview<br>3.Develop training strategy for acute deterioration across ABUHB services, acute and community | By December 19 | Assistant Nurse Director and Senior Nurse, Resuss Service | |
| Work with the Start Smart and focus programme to test how the principles can be built into the ABC Sepsis approach in A and E and MAU | 1.Meet with 1000 Lives lead to agree the way forward<br>2. Set up Pilot for RGH A and E and MAU, integrating “start smart and focus” principles into the ABC Sepsis 6 hour and 24hr/48hr review | September 2019 | ABC Sepsis Steering Group | |

Quality and Patient Safety Committee
4th April 2019
Agenda Item: 4.1



**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:** | 19th March 2019 |

**Summary of Key Matters Considered by QPSOG:**

**Divisional Risk Registers/Concerns**

The QPSOG received the Divisional reports and Divisional Quality and Patient Safety leads were given the opportunity to flag any significant areas of concern. These are included in the Divisional risk registers with information detailing mitigating action being taken to ensure quality and patient safety. A common theme across Divisions in terms of high risk was sustainability of the workforce (medical and nursing). Unscheduled Care also identified emergency pressures and flow in their top risks. The Complex Care team also raised nursing home and domiciliary care fragility as a high risk.

During the March QPSOG meeting, the Chair invited discussion about the way that Divisional risks and concerns are shared, scrutinised and escalated in the QPSOG, with a view to improving the established approach. It was noted that QPSOG is well attended by all Divisional Quality and Patient Safety leads and all are using a consistent template to capture and present the risks and concerns and these are shared at each QPSOG. It was noted that both the Family & Therapies Division and Facilities Division are currently piloting the Datix risk module that is anticipated to further improve the collation of risks at a Divisional level. It was agreed that QPSOG is the appropriate forum for sharing Divisional risks and concerns, for awareness raising, monitoring, providing assurance on mitigation, and an opportunity to seek help or escalate. It was felt that this part of QPSOG is often rushed at the end of the meeting, leaving little time for the risks and concerns to be discussed in any depth between Divisions. It was also agreed that QPSOG has an important role in ensuring quality and patient safety risks are accurately translated in the Corporate risk register. As a result of the discussion the Chair agreed to move the agenda item about Divisional risks and concerns to the start of the QPSOG meeting and allow more time for this item in future.

**Quality, Safety and Performance Report**
The draft report was presented and comments invited ahead of its presentation to the QPSC meeting in April 2019.

**Risks Around Hospital At Night**
Dr Edwards distributed a paper for the QPSOG members and invited comments. This will be reviewed at future QPSOG meetings.

**Putting Things Right (PTR)/ Organisational Learning Report**
QPSOG received the bimonthly PTR report (for Jan / Feb 2019). The report included information about formal and informal complaints received, Ombudsman cases and serious incidents notified in January and February 2019. The report also provided the QPSOG with an update on performance and actions underway to improve quality and performance through implementation of a Putting Things Right / Organisational Learning Service Improvement Programme and Action Plan. This report will be presented to the QPSC in April 2019.

QPSOG were also updated on staff changes within the PTR team.

**Health Board Wide Clinical Audit Plan**
QPSOG members were invited to suggest topics for future Health Board wide clinical audits that should be undertaken in 2019-20, specifically to address major clinical risks identified. This request is in part, to respond to a high priority recommendation from the Internal Audit Report 2016-17 on Clinical Audit about the content of the Health Board wide clinical audit programme.

The 2018-19 Health Board wide clinical audit programme was noted by QPSOG. As there is no Clinical Effectiveness Group currently, the results of the Health Board wide clinical audits will be reported to QPSOG.

**Feedback on the Peer Review of Acute Deterioration Services**
The QPSOG received and discussed the peer review report and noted the related ABUHB action plan. This report will be presented to Executive Board and then QPSC.

**Matters Requiring QPSC Level Consideration:**

- Quality, Safety and Performance Report (scheduled for QPSC meeting in April 2019)

- Putting Things Right (PTR)/ Organisational Learning Report for the period Jan – Feb 2019 (scheduled for QPSC meeting in April 2019)

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| • Feedback on the Peer Review of Acute Deterioration Services (scheduled for QPSC – to be confirmed) |
| **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:** 21st May 2019 |

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| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | Quality and Patient Safety Committee<br>4th April 2019<br>Agenda Item: 4.2 |

4.2

**Quality and Patient Safety Committee**
**Independent Member Quarterly Visit Reports**

| **Executive Summary** |
|---|
| The Health Board introduced in 2018 an additional structured programme of visits for Independent Members in addition to the well establish Patient Safety Walkarounds. This additional programme of visits is organised on a quarterly basis, each quarter focusing on a different themed area of the services and business of the Health Board in line with our key strategic plans. The first quarterly programme of visits between July and September focused on mental health and learning disability services. Each Independent Member following their visit was asked to complete a report. This report provides copies of the reports from the visits undertaken and a response from the Health Board's services to the issues and concerns highlighted within the visit reports. The responses made are provided at Appendix 1 and the visit report are provided at Appendix 2. |

| **The Quality and Patient Safety 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 Bevan, Board Secretary and Nick Wood, Director of Primary, Community and Mental Health | | | |
| **Report Author:** Richard Bevan, Board Secretary and Nick Wood, Director of Primary, Community and Mental Health | | | |
| **Report Received consideration and supported by :** | | | |
| **Executive Team** | | **Committee of the Board [Committee Name]** | |
| **Date of the Report:** 1st April 2019 | | | |
| **Supplementary Papers Attached:**<br>Appendix 1 – Organisational Response<br>Appendix 2 - IM Visit reports for Quarter 1 of the visiting programme. | | | |

| **Purpose of the Report** |
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| The report is designed to provide and update on the visits undertaken by Independent Members and to outline the responses made and the progress reported following the issues highlighted. |

| **Background and Context** |
| --- |
| The Health Board introduced in 2018 an additional structured programme of visits for Independent Members in addition to the well establish Patient Safety Walkarounds. This additional programme of visits is organised on a quarterly basis, each quarter focusing on a different themed area of the services and business of the Health Board in line with our key strategic plans. The first quarterly programme of visits between July and September focused on mental health and learning disability services. Each Independent Member following their visit was asked to complete a report. This report provides copies of the reports from the visits undertaken and a response from the Health Board's services to the issues and concerns highlighted within the visit reports. The responses made are provided at Appendix 1 and the visit report are provided at Appendix 2.<br><br>Further rounds of visits are taking place with regard to Older Adult Services and also engagement with Managed GP Practices. These reports will be submitted to the next Committee. |

| **Recommendation** |
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| The Committee is asked to note the contents of the report. |

## Appendix 1 – Organisational Response

| **Talygarn Ward – 31st July 2018** | |
|---|---|
| **Reported Issue:** | **Response/Progress:** |
| **Access to Maintenance and Facilities Support:** It was reported that there was some difficulty in accessing facilities/maintenance support for some activities e.g. mural project and allotment project. | The ward now has access to a handy man who responds promptly. He takes ownership for the work requested and is flexible to the needs of the ward. Minor Works input is more challenging and the process requires regular follow-up to ensure the work is completed.<br><br>The Division has established a fortnightly meeting with representation from Works and Estates in order to enable service areas to escalate concerns, seek resolution and monitor outstanding work. |
| **Water Cooler:** Permanently fixing-down the water cooler, which is seen as a health and safety issue – linked to number 1. | This has been completed. |
| **Kitchen Water Heater:** Permanently fixing-down the water heater in the kitchen, which is seen as a health and safety issue – linked to number 1. | This has been completed. Patients now have access to this area throughout the day, which has a positive outcome. |
| **Outdoor Fixed Lighter:** This a safety and time issue in that patients are required to smoke outside, but do not have access to matches and lighters. Staff time is taken supporting patients with this activity. | This was originally planned to have been completed by the end of March 2019. Unfortunately this is outstanding and the Division has received assurance from Works and Estates that the work will be completed by mid-April. |
| **Late Admission – Admission Process:** The space for the admission/assessment process is small and therefore inadequate.<br><br>Also, many patients do not require admission following assessment. Therefore, could this be undertaken in a different way, perhaps at first point of contact, avoiding the necessity for transportation? | In 2016, the operational hours of the Crisis Resolution Home Treatment Teams (CRHTTs) were extended to enable more individuals to be assessed and treated at home, where possible. The Division acknowledges this does not address the system wide issues on a long term basis and a re-design of CRHTT and acute in-patient services across ABUHB is required. This is a key work stream within the Whole Person Whole System Crisis Support Transformation Programme. The work stream aims to deliver a 24 hour crisis |

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| | assessment service and enhanced home treatment.<br>Other work streams continue to focus on the development of alternatives to admission including Shared Lives and the development of a Crisis House. As part of the programme, work is also due to commence on a Single Point of Contact with the aim of ensuring that individuals who present in crisis and their carers can access the right level of support 24 hours a day, 7 days a week, within a stepped care model of crisis support.<br><br>At present after 10pm Talygarn continues to the dedicated admission ward across ABUHB. The number of individuals assessed after 10pm is relatively small, for example, during the month of December 2018, 65 people were assessed and of those 29 individuals were admitted. This function is currently being reviewed as part of the work stream described above.<br><br>In order to maintain the safety of both patients and staff after 10pm, assessments are undertaken on the ward (as opposed to the upstairs of the building). One area of the Health Board's Estate Strategy is to review and develop high quality, fit for purpose mental health estate and this will be considered as part of that approach. |

| **Annwylfan Ward, Ysbyty Ystrad Fawr – 17th August 2018** | |
|---|---|
| **Reported Issue:** | **Response/Progress:** |
| **Sensory Garden:** A capital bid to develop a sensory garden had been submitted for approx. £8,000. | A £12k bid to access Charitable Funds to support the development of a sensory garden was submitted and approved in Feb 2019. Work will commence in April 2019. |
| **Continuing Healthcare Funding Delaying Discharges:** Reported differences in health and social care criteria/assessment and delays in approval of funding, which delays discharge. | There has been one Delayed Transfer of Care (DToC) within the ward in the last six months.<br><br>The concerns raised within the visit were largely related to the provision of aftercare for those subject to Section 117. The Mental Health and Learning Disability Strategic Partnership has commissioned a Task and Finish group to review the challenges and make recommendations regarding the development of a multi-agency agreed process. |

| **Chepstow CMHT – 28th September 2018** | |
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| **Reported Issue:** | **Response/Progress:** |
| **Standard of the Facilities Environment:** Concerns with regard to the general standard of the site and environment. | Internal Community Environmental Health Environmental Board (HEB) visits now take place in all Mental Health Community bases. A site visit took place to Hywel Dda Ward on the 20th June 2018 attended by the Lead Nurse, Service Improvement Manager, Health and Safety representative and Infection Control and an action Plan has been agreed.<br><br>A further visit is scheduled to take place on 15th November 2019 to assess progress.<br><br>New equipment has recently been ordered for the Occupational Therapy department in Hywel Dda Ward to further enable Activities for Daily Living interventions. This includes gardening and kitchen equipment. |

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| **CMHT Integration:** Reported that there appeared to be a lack of integration of the CMHT. This included leadership and IT systems. | The Mental Health and Learning Disabilities Division are due to upgrade their patient informatics system to replace Epex. The new All Wales integrated system (called WCCIS) will be utilised by Mental Health staff and Local Authority. All staff who see patients outside of their base will be provided with smart tablets so that they can update and access the patient record remotely.<br><br>The system was due to 'go live' in ABUHB in July this year. This has been delayed due to notification issues by the provider, Care Works. The Health Board is currently in the process of re-planning to confirm the go live date and Hywel Dda Ward will be included in this. |
| **Accommodation:** Reported uncertainty with regard to the future accommodation for the CMHT and a proposed move to Chepstow Hospital. | In order to explore any potential benefits and challenges of relocating the service to Chepstow Community Hospital an initial mapping of the usage of Hywel Dda Ward has been undertaken (completed March 2019). This will now be considered at a meeting with the Health Board's Strategic Capital and Estates Programme Director. |
| **Psychology Waiting List:** Reported concern with regard to the length of the waiting list (two years) to see a psychologist. | Improving access to psychological therapies is a key priority for the Mental Health and Learning Disability Division's IMTP and the Health Board has received additional monies from Welsh Government to support this.<br><br>One of the posts within Monmouthshire was a split post cross the South and North Monmouthshire CMHTs and it has been difficult to recruit to this post. The service has now been restructured and a specific post will shortly be advertised that addresses this issue.<br><br>In relation to waiting times as of March 2019, 27 individuals across Monmouthshire have been waiting for over 12 months to access a |

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| | psychological intervention. Long waiting times can occur when a particular approach is needed (for example specialist input from a senior psychologist), but many people referred for psychology are seen far more rapidly. If a group intervention is required and a programme is starting the following week, waiting times may be less than a week. People are also prioritised based on a range of reasons including risk, so the longest waiting time is not representative of the waiting times that people generally experience. |
| **Split Site Working:** The impact on the team of team members having to cover both Chepstow and Abergavenny sites. | The current service model within Monmouthshire comprises two Community Mental Health Teams (one in the north based at Maindiff Court Hospital and one in the South based in Chepstow). In addition to this there is an Assertive Outreach Team (AOT) that covers all of the Boroughs which accepts referrals from both CMHTs. Whilst CMHTs work with significant number of individuals the role of the AOT is very specialist working intensively with a small number of service users who do not engage well with traditional services and the model of delivery is quite different from that provided by the CMHT.<br><br>There are regular meetings between the Team Leaders of the North CMHT and AOT and the South CMHT Team Leader. |

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| **Clarity on the Role of Teams:** Reported that GPs have difficulty distinguishing between the role of the primary mental healthcare team and the CMHT. | There are occasions when it can be unclear as to whether or not a patient should be referred to the Primary Care Mental Health Support Service (PCMHSS) or secondary Mental Health services. On such occasions colleagues within primary care discuss a potential referral with either service.<br><br>The Division is also undertaking some work to re-design both its intranet and internet pages and one aim of this will be to provide better information for those potentially wishing to refer to the service. |
| **Data on Length of Stay:** The Team was not aware of the data on average length of stay. | The Health Board has recently adopted a new computerised system called 'Qlik Sense'. This system pulls information from the Mental Health patient database (Epex) and displays in a dashboard, which is easily accessible by staff. Training is due to take place in regard to the Qlik system and the Adult Mental Health Directorate have made enquiries to ask whether or not length of stay can be included in one of the reports.<br><br>In addition to the above on an individual practitioner level all team members' access caseload supervision and this provides an opportunity to reflect on therapeutic goals and when these have been achieved as part of an individual's recovery journey. |
| **Patient/User Experience:** Reported that there was not a system for gathering patient experience and satisfaction feedback. | Some of the interventions delivered by the CMHT are monitored via the use of intervention specific PROMs and PREMS although this is not as yet systematically embedded across all areas of the work undertaken by the CMHT. The Mental Health and Learning Disability Division is currently participating in the national roll out of the mental health "Outcomes Framework" and when embedded this will systematically consider (i) well-being and quality of life (ii) personalise goals (iii) experience and satisfaction. The intention is that the recording and |

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| | analysis of these outcomes will be embedded within WCCIS. |
| **Staff Doctor Role:** Reported that there was a problem with the continuity of the staff doctor role and a reliance on locums. | A Specialty Doctor post for South Monmouthshire Adult Mental Health services has been advertised on a number of occasions. Last time interviews occurred on 22nd March and an offer of appointment has been made and accepted. In the meantime this post is being covered by agency. |

**Appendix 2 IM Visit reports for Quarter 1 of the visiting programme**

**Reports received from Independent Members for First Quarter Visits to Mental Health and LD services and sites**

**Report One:**

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|---|---|
| **Independent Member:** | Pippa Britton |
| **Location/Service Visited:** | Hafan Deg Ward, Ty Siriol Unit |
| **Date:** | 31st July 2018 |
| **Overview Comments:** | |
| The staff at Hafan Deg seemed committed and extremely knowledgeable. The staff make up has changed slightly with staff moving from Chepstow but they seemed very happy with the move. The whole environment of this ward seems incredibly supportive and I was keen to hear of the collaborative work with the 3rd sector that this ward is doing. | |
| **Issues/Matters Arising From Staff Engagement:** | |
| 1. I am looking forwarded to seeing the progress of the memory clinic.<br>2. Special mention should be given to the staff engagement with local community volunteers who have done tremendous work in the garden area and beyond in making this environment as inviting as possible. | |
| **Issues/Matters Arising From Patient Engagement:** | |
| There was limited opportunity for patient engagement at this visit. | |

**Report Two:**

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|---|---|
| **Independent Member:** | Pippa Britton |
| **Location/Service Visited:** | Talygarn Ward Acute Adult County Hospital |
| **Date:** | 31st July 2018 |
| **Overview Comments:** | |
| The staff at Talygarn Ward appear to be focussed on providing the best level of individual patient care whilst working well as a team. There are several really creative and innovative ideas (murals, the allotment etc.) but it seems that sometimes these are hampered by access to facility or maintenance support.<br><br>There are also some challenges around the admissions and assessment process that staff are doing their best to work around (see second section) and this should be considered in the wider context of mental health assessment across the Health Board. | |
| **Issues/Matters Arising From Staff Engagement:** | |
| 1. The water cooler in the corridor is not fixed down. This has apparently been knocked over on several occasions when patients | |

have had violent episodes and is a simple 'fix'. The challenge is getting maintenance or facilities support to attend in a timely manner.
2. A similar issue is fixing down of a water heater in a kitchen space. This would enable patients and their families to have a private space which is not a bedroom to have a cup of tea or quiet chat. At present the furniture and the water heater is in this room, but the door is locked because of an extended wait for this piece of work. This may have a direct impact on patient care and staff time, since at present if a patient wants a drink it has to be made by a member of staff.
3. Many of these vulnerable patients smoke. There is a smoking area, but at present members of staff have to go outside to light cigarettes for patients as they cannot have matches or lighters. This is not pleasant for staff and is not a productive use of their time. An outdoor fixed lighter could be installed but the wait for this equipment has taken a long time despite the negative impact on staff.
4. The assessment process for late admissions needs to be reviewed. The waiting area is small and 3 or 4 patients are regularly brought in, often late at night, from outside the immediate area. The first issue is that these patients have to be transported to the ward, but once in the ward, they have no suitable space to do the assessments. The current room is right next door to the bedrooms and it seems to me that this could be very disruptive to those trying to sleep. Many of the patients assessed do not require admission which raises the question of assessments being done at first point of contact i.e. before transportation and assessment at the ward. If staff support could be used in this way, this would have positive advantages for patient care in terms of transport, time and better, less disruptive care for existing patients on the ward.

| **Issues/Matters Arising From Patient Engagement:** |
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| There was limited opportunity for patient engagement at this visit. |

**Report Three:**

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| **Independent Member:** | Professor Dianne Watkins |
| **Location/Service Visited:** | Ysbyty Ystrad Fawr, Annwylfan Ward |
| **Date:** | 17th August 2018 |
| **Overview Comments:** | |
| The welcome received on this ward was outstanding, signage was excellent within the ward environment and parking at the venue (YYF) would score 10/10. The cleanliness in the ward dining room in which our meeting took place was average.<br><br>I met with the ward manager James Robinson and the senior nurse for Caerphilly Older Adult Services. Both were extremely professional and provided an excellent background on the services provided by the ward, which deals with acute mental health/ dementia patients, admitted due to a break down in community/nursing home/ carers ability to cope with challenging patients. | |

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| There is no shortage of staff on this ward and the staffing compliment is good, comprising of 14 qualified nurses, 6 Occupational therapists, admin and healthcare assistants. This seems excessive for the 16-18 beds available within the ward environment, although cases referred are complex, often spanning physical and health issues, with a level of dementia not able to be managed anywhere else in the vicinity. It is likely this need will increase given the demographic trends.<br>The impressive elements to the visit included the dementia training delivered in house; dementia champions and the involvement of a psychologist. Excellent links with local communities have been established, examples given included links with 'Woodchips' who work with patients to develop woodwork and gardening skills, and with the local college from which students visit and talk to patients. The senior nurse also meets with care home managers and runs 'hot clinics' for staff to advise and teach them on how to care for patients with dementia and challenging behaviour. Great enthusiasm for helping dementia patients was observed in the senior nurse and the ward manager, who have been involved in fundraising to raise funds to develop a sensory garden outside the ward area. A capitol bid has been submitted to ABUHB for £7/8k to assist with this.<br><br>One of the most problematic issues raised by the staff I met related to problems with CHC funding and the differences in health and social care funding. The criteria are not clear and from assessment to a place/ services funded in the community can take up to 4 weeks, thus delaying discharge from the ward. |
| **Issues/Matters Arising From Staff Engagement:** |
| The ward manager should be praised for the way in which he has changed the culture and positively influenced quality and safety issues since commencing in the role 2 years ago. For example there has been a dramatic reduction in patient falls, staff absenteeism and a positive effect on recruitment and retention of staff. The ward environment was clean and safe with sensory areas beneficial to the care of patients with dementia. I would have no concerns regarding this ward. |
| **Issues/Matters Arising From Patient Engagement:** |
| Patients looked comfortable and at ease, considering their health issues. I observed an OT working with a patient in a reassuring and empathetic manner. |

**Report Four:**

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| **Independent Member:** | Shelley Bosson and Catherine Brown |
| **Location/Service Visited:** | Chepstow CMHT |
| **Date:** | 28th September 2018 |
| **Overview Comments:** | |
| It was very interesting and useful to have the chance to visit this site and meet the team and hear about the service. The site, although it was old and grotty, had a friendly ambience. There was a lovely display of thank you cards in the team kitchen. There was good evidence of collaborative working with the third sector. Mind and others run group sessions in the centre, and hold meetings there, and make places available on their courses for some of the CMHT service users. | |

Issues which arose included:

A lack of integration in the "integrated CMHT". The notional manager of the team in fact only manages the nurses and admin staff. This leads to issues with annual leave and rotas which we heard about at our other CMHT visit too.

Of even more concern, the social workers are using a completely different IT system to keep their client records, which are therefore inaccessible to the other members of the team or other mental health teams - should a patient appear in A&E or at the crisis team, the staff there may be unaware that they are already being treated by the CMHT. The team manager at Chepstow was unaware if Monmouthshire had agreed to use WCCIS in the future (due implementation in 9 months) or if even after implementation of that the split would continue.

Uncertainty was expressed about a possible move for the service to Chepstow Hospital. It was thought the accommodation there was unsuitable for the needs of the CMHT and their patients.

2 year waiting list for psychologist individual treatment for those assessed as needing it. This is aggravated by a loss of funding and considerable uncertainty over the role of the psychology assistant who runs the group sessions. It was explained that it was hard to recruit and retain the other psychologist role because it was split across two sites and people didn't want to have to spend 3 days in Chepstow and 2 days in Abergavenny.

Lack of clarity about the different roles of different mental health teams - apparently the GPs have difficulty distinguishing between the role of the primary mental healthcare team and the CMHT. There also seems to be a question as to the relationships between the "assertive outreach team" based in Abergavenny and the CMHT - is it cost effective for staff to be travelling from Abergavenny to see clients in Chepstow who could be cared for by the CMHT in Chepstow?

Clinical supervision - optional and no way of checking who had and had not received supervision.

No data on average lengths of treatment for people on the case load. They thought that people were on the caseload for between 6 and 12 months, mainly, but there was no systematic analysis of this.

A lack of focus on patient/user satisfaction - we were told that there hadn't been any systematic seeking of feedback for about a year but that something was planned.

They were very happy with their consultant and the current locum staff doctor, but have a constant problem with continuity in the staff doctor role. It was explained that medical staffing was managed by the

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| consultant, but it was understood that the pay rate was unattractive, so more expensive locums were used.<br><br>Despite the fact that the team felt that they were very busy and under pressure, they had found time to introduce physical health checks for mental health patients, which they believe is best practice as GPs do not currently provide these services, as in their view they should. This raises the question if this is really a higher priority for clients in this service than the provision of a psychology assistant to facilitate group psychology sessions (which would be the only psychology many of them will be able to access given the 2 year wait for individual services). However, an overall manager of the service needs to be identified to consider the re-profiling of the budget in real time to address these kinds of issues. |
| **Issues/Matters Arising From Staff Engagement:** |
| Issues from staff engagement |
| **Issues from Patient engagement** |
| no patient engagement took place |