A meeting of the Aneurin Bevan University Health Board
Quality and Patient Safety Committee
will be held on Thursday 5th December 2019, commencing at 09:30am
in Conference Rooms 1 & 2, Headquarters,
St Cadoc's Hospital, Caerleon

AGENDA

Preliminary Matters		**Attachment**		**09:30**
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 16th October 2019**	Attachment	**Chair**	
1.5	**Action Sheet of the Committee held on 16th October 2019**	Attachment	**Chair**	
Governance				**09:45**
2.1	**Revised Committee Terms of Reference**	Attachment	**Chair**	**10 mins**
Presentations				**09:55**
3.1	**Patient Safety - Themes and Trends to Inform Improvements and Learning with WAST**	Presentation	**Claire Bevan/ Dr Brendan Lloyd/ Darren Panniers, WAST**	**30 mins**
3.2	**Safety and Patient Experience – Winter Plan**	Presentation	**Martine Price**	**20 mins**
3.3	**Quality & Safety in Ophthalmology**	Presentation	**Chris Blyth/Jayne Roberts/Julie Poole**	**30 mins**
Break (10 mins)				**11.15**
For Consideration				**11.25**
4.1	**Quality, Safety and Performance Overview**	Attachment	**Dr Paul Buss**	**15 mins**
4.2	**Risk Assessment Overview**	Attachment	**Chair**	**10 mins**
Items for Quality Assurance				**11.50**
5.1	**QPSOG Assurance Update from Meeting held on 28th November 2019**	Verbal	**Peter Carr**	**10 mins**

5.2	**Clinical Audit Programme**	Attachment	**Kate Hooton**	**10 mins**
5.3	**Putting Things Right Progress Against Improvement Programme**	Attachment	**Rhiannon Jones**	**10 mins**
Final Matters/For Information				**12.20**
6.1	**Any Other Business**	Verbal	**Chair**	**5 mins**
6.2	**Items for Board Consideration** To agree items for Board consideration and decision	Verbal	**Chair**	**5 mins**
Date of Next Meeting				**12.30**
Wednesday 5th February 2020, 09:00am, Executive Team, ABUHB Headquarters, St Cadoc's Hospital				**Chair**

Quality and Patient Safety Committee
Thursday 5th December 2019
Agenda Item: 1.4

Aneurin Bevan University Health Board
Minutes of the Quality and Patient Safety Committee held on Wednesday 16th October 2019

Present:

Prof Dianne Watkins	-	Chair, Independent Member (University)
Louise Wright	-	Independent Member
Emrys Elias	-	Vice Chair
Pippa Britton	-	Independent Member

In Attendance:

Judith Paget	-	Chief Executive
Paul Buss	-	Medical Director
Rhiannon Jones	-	Director of Nursing
Peter Carr	-	Director of Therapies and Health Sciences
Phil Robson	-	Special Advisor to the Board
Claire Birchall	-	Director of Operations
James Quance	-	Head of Internal Audit
Kate Hooton	-	Associate Director, Patient Quality and Safety
David Thomas	-	Assistant Director, ABCi
Deb Jackson	-	Head of Midwifery and Associate Director of Nursing
Sue Bale	-	Research and Development Director
Jemma McHale	-	Community Health Council
Gabrielle Smith	-	Performance Audit Lead, Wales Audit Office
Alexander Crawford	-	Senior Planning & Service Development Manager
Stephen Edwards	-	Deputy Medical Director
Liz Waters	-	Associate Nurse Director
Moira Bevan	-	Lead Infection Control Nurse
Ceri Phillips	-	Consultant Pharmacist - Antimicrobials
Garvin Jones	-	Senior Manager Legal Services
Jyoti Singh	-	Consultant, Obstetrics and Gynaecology
Rachel Williams	-	Committee Secretariat

Apologies:

Frances Taylor	-	Independent Member

QPSC 1610/01 Welcome and Introductions

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

QPSC 1610/02 Apologies for Absence

The apologies were noted.

QPSC 1610/03 Declarations of Interest

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

QPSC 1610/04 Minutes of the Meeting held on 12th June 2019

The minutes of the meeting held on 12th June 2019 were agreed as a true and accurate record of the meeting.

QPSC 1610/05 Action Sheet – 12th June 2019

The Committee considered the Action Sheet from the meeting held on the 12th June 2019 and noted that all actions had been completed or were progressing.

QPSC 1610/06 Revised Draft Committee Terms of Reference

The Committee was presented with the revised Terms of Reference following the recent agreed changes to the Committee structure and membership at the Board meeting in May 2019. The Terms of Reference had already been reviewed by the Chair and Executive Leads and their comments had been incorporated. The Committee reviewed and discussed the content of the document.

It was agreed that the wording of section 3.1J needed to be updated to ensure this captured the role and responsibilities of the Committee in regards to Clinical Audits. It was confirmed that the Committee would continue to receive an update on the Clinical Audit Programme twice a year, including assurance that the relevant action had been undertaken, and that any learning had been embedded within the organisation. The Committee would also address any specific concerns raised by National Clinical Audits and escalate where necessary. It was added that the Clinical Effectiveness and Strategy Group received and reviewed the results of all National Clinical Audits including the programme of risk based audits. It was noted that the Clinical Audit programme would be presented at the next Committee meeting.

ACTION: Secretariat

The Committee discussed patient experience and highlighted that this was not explicit within the Terms of Reference. It was suggested for another bullet point to be included within section 3.1 or for patient experience to be strengthened within section 3.1b. It was also agreed that the requirement for the Committee to have a work plan should be included within section 7. It was agreed for the Secretariat to discuss these changes with Richard Bevan and for the final version to

be presented at the next Committee meeting in December, following Board sign off in November 2019.
ACTION: Secretariat/Richard Bevan

QPSC 1610/07 Winter Plan – Reflections and Planning for Winter 2019/20

Claire Birchall and Alex Crawford gave a presentation on 'Safe & high quality patient care during winter & beyond 2019/20', including the current position, key themes and next steps. The following key points were noted:

- This year there had been a particular focus on integrating the Health and Social Care system to support people at home;
- Welsh Government guidance described a framework for delivery of key themes to support a whole system approach to Winter Planning and Delivery,
- The nine key themes provided the opportunity to work differently and collaboratively in partnership with the Local Authorities and 3rd sector;
- Learning from last year was essential to further improve and deliver models that worked;
- All themes would have a quality impact assessment, looking at patient safety and workforce;
- Measures had been put into place to optimise cross sector working such as increased levels of Advanced Care Planning and an increase in pharmacy late opening hours;
- National work was underway to open up more pathways for patients in crisis;
- A pilot was underway in the Emergency Department within the Royal Gwent Hospital to identify primary care demand and to help educate patients;
- Work would continue with St John Ambulance this year regarding falls to prevent unnecessary conveyance and admission;
- There were 4 national pathways to support discharge to assess;
- There had been a focus on the respiratory pathway, falls and other high risk groups;
- High level quality metrics would be regularly reported to Executive Team;
- The CHC would undertake a survey programme this winter to obtain patient feedback;
- There was a national piece of work underway to provide a centrally funded real time feedback system, with ability for alerts;

- Learning from staff experience was essential and the core care staffing work had been successful;
- Executive Team would consider the first draft of the plan on 21st October 2019 in readiness for sign off by the Board and Regional Partnership Board in November.

The Committee discussed discharge to assess and emphasised the need to continue education and supporting staff in having those conversations with families. It was noted that the 111 service would hopefully be a successful opportunity to ensure people were directed to the correct service to reduce strain on the health service. It was reported that work was ongoing with North Wales to look at available pathways and joint learning.

The Committee discussed demand and capacity planning, including the timely access to social care packages. It was emphasised that the ability for the Local Authorities to resource the demands for winter posed a huge risk. It was noted that Local Authority workforce was highlighted as a key issue at the last Regional Partnership Board meeting, despite the domiciliary care events which had taken place. The Committee discussed the supply and demand of care workers. It was reported that discussions were underway with the Local Authorities to look at alternative opportunities including an apprenticeship programme approach.

It was agreed for the Committee to receive a brief update at the next Committee meeting.
ACTION: Secretariat

QPSC 1610/08 Quality and Safety in Theatres

Liz Waters and Stephen Edwards gave a presentation on 'Quality & Safety in the Theatre Environment A Clinically-Led Review of Clinical Incidents' including the background, key themes and actions. The following key points were noted:

- In 2010 the Who Surgical Safety Checklist was introduced. Following on from this three Never Events occurred and interventions were put in place. Despite these interventions 5 further 'never events' were identified and a clinical audit was commissioned of theatre-related Datix incidents to be undertaken with pace;
- The audit examined over 700 incidents reported via Datix relating to theatres in the Royal Gwent,

Nevill Hall, St Woolos and Ysbyty Ystrad Fawr, from January 2016 to June 2019;

- Following the deep dive, a further 4 never events and 2 serious incidents were identified;
- A number of themes emerged from the review, which highlighted that a focus on theatre safety was essential;
- A number of immediate actions have been taken including an SBAR to Executive Team, a full investigation of all events and the development of a Divisional improvement plan.

It was reported that Internal Audit would be reviewing Theatres as part of their audit programme. It was recognised that a piece of work pertaining to examination of the culture within Theatres was required to consider the learning and action taken.

Rhiannon Jones explained how the DATIX incident reporting system worked, including the process for reporting and escalation. It was confirmed that the never events and serious incidents were recorded on DATIX but were not picked up through the system. It was added that an investigation was underway in relation to the 3 that had been missed. It was agreed for the learning from this review to be presented at a future Committee meeting.
ACTION: Secretariat

The Committee discussed the assurance going forward and recognised that education needed to be monitored. It was noted that outcomes would be discussed at the Theatre User Group and monitored. Staffing within Theatres was also discussed and it was recognised that human factors and culture needed focus. Assurance was received that patients had been informed of the incidents but further detail was required for some cases.

The Committee commended the team on undertaking the historical review. It was emphasised that an action plan was required to look at how to prevent this happening again in the future.

QPSC 1610/09 Quality, Safety and Performance Overview

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

Mortality Rate

The Committee was informed that since the Palmer Report mortality rates had been monitored. It was reported that the number of deaths and mortality rate had risen going into winter and exceeded the Welsh Peer at times.

The Committee discussed the hospital mortality rates between July 2017 and July 2019 which highlighted concerns for Nevill Hall Hospital. It was explained that a review was carried out, but this had not identified any clinical causation. It was added that coding completeness was an issue for the Health Board. Recruitment and retention of coders was being considered to help alleviate this problem.

Mortality reviews completed for December to March at Nevill Hall Hospital, including a targeted review of 40 deaths, had not shown any concerning trends. It was reported that the last meeting of the Mortality and Harm Review Group highlighted that the fluid balance charts were not always completed well. This concern had been raised with the Divisions through the Director of Nursing, and a further audit was being undertaken to better understand the reasons for this and how to improve. The Assistant Medical Director was also undertaking a mortality audit in hospital regarding the average age of patients dying in hospital.

The Committee discussed mortality rate data per condition. It was explained that although data was available it was questioned how robust this would be. It was noted that when the Medical Examiner role comes in, more accurate monthly data would be available. Paul Buss agreed to look at the present data in the interim.

ACTION: Paul Buss

National Clinical Audit (NCA)

The Committee received an overview of the Health Board's participation in National Clinical Audits (NCAs). It was reported that there was more than 40 NCAs on the programme and Aneurin Bevan University Health Board (ABUHB) aimed to participate fully in all of the NCA areas listed. It was noted to the Committee that there was a further 2 that ABUHB did not enter any data for, and 4 in which data

entry was not in place for all hospitals, or was limited in some way.

The Committee discussed the results of the National Audit of Intensive Care and noted that the results were discussed by the Directorate Teams and that there was a robust morbidity and mortality review process in place for ICU. In addition, changes were being made to the data entry process, since there were concerns about 'underscoring' the acuity of the patients.

Sepsis
It was reported that the front door departments had struggled to maintain compliance with the sepsis 6 bundle within one hour of recognition of sepsis during the winter, and in to the first 6 months of 2019. Compliance was normally addressed within the department through discussion with nurses about completing the form with all the necessary information, however there have been challenges due to the number of vacancies and pressure within the departments.

Hospital Acquired Thrombosis
It was noted that data was showing a decrease in the number of potentially preventable Hospital Acquired Thrombosis (HAT) in the Health Board.

Stroke
The Committee was informed that there had been an increase in the number of in-patient falls within the first 6 months of 2019, which appeared to be leading to an increase in the fractures resulting from falls. The Falls Steering Group had broadened its remit to falls and bone health, to ensure that the bone health of our population was as good as possible so that fewer people fracture a bone when they fall.

Pressure Ulcers
The Committee was advised that audits have identified that the grading of pressure ulcers was sometimes incorrectly recorded on Datix. Assurance was received that the issue was specific to pressure ulcers and is being addressed.

Fractured Neck of Femur (FNOF)
The Committee received an update on the latest position. It was explained that the rate for the Royal Gwent Hospital and Nevill Hall Hospital for FNOF was higher than the average for the UK. It was reported that meetings had taken place with the orthopaedic directorate and Divisional Director to turn

around the key indicators. As a result, the Health Board was now green for all key performance indicators although the improvement was not reflected within the mortality rate. The division was confident that this was a time lag issue and that the improved rate would be seen in the following year. The Medical Director was liaising with the Royal College of Physicians to look at the system to understand how ABUHB had a higher mortality rate than the average in the UK despite performing relatively well in the KPI. This may result in an external review, although no decisions had yet been made. The committee reinforced the need to monitor the situation.

It was identified that the performance was better in March 2018. Paul Buss agreed to look into this further to establish what worked well.
ACTION: Paul Buss

ABUHB Safeguarding Maturity Matrix
It was agreed for this item to be rescheduled for the next Committee meeting.
ACTION: Secretariat

ABUHB HIW Maternity Inspection – findings and actions
Deb Jackson gave a presentation on 'HIW Inspections of Maternity Services', including the process, findings and action taken to secure improvements.

It was reported that HIW carried out unannounced inspections of Nevill Hall Hospital (NHH), the Royal Gwent Hospital (RGH) and Ysbyty Ystrad Fawr (YYF) in July, September and August 2019 respectively. The Committee was informed of the instances which resulted in the immediate assurance notices issued at NHH:

- The security of babies due to the lack of 'tagging'
- The storage of equipment for use in a patient emergency, and associated emergency protocols
- Irregular and inconsistent checks on emergency equipment
- Irregular and inconsistent checks on fridge and freezer temperatures used to store medicines
- Management and security of confidential patient information
- Security and storage of the drugs trolley

The detail surrounding each of these notices was discussed and assurance was received that immediate action was undertaken to rectify these matters. The Committee was advised that there was a tagging system in place at NHH but the system was not being used correctly at the time of the inspection. Assurance was received that this was immediately addressed. Again it was confirmed that regular checks were being carried out on the emergency equipment, fridge and freezer temperatures, although these were not being recorded on a regular basis. Assurance was received that these were now being recorded.

The Committee was informed of the instances which resulted in the immediate assurance notices issued at RGH:

- Irregular and inconsistent checks on emergency equipment (neonatal resuscitaires)
- One issue of security of confidential information

Again, the detail surrounding each of these notices was discussed and assurance was received that immediate action was undertaken and these matters had been remedied. It was added that YYF did not receive an immediate assurance notice. The Committee discussed the criteria used by HIW for their investigations. Concerns were raised since there were a number of areas which differed to NICE guidance. It was acknowledged that this was important to feedback to HIW.

The Committee was advised of what the service did well, across all three sites, following the feedback received. This included excellent patient experience, robust processes in place for the management of clinical incidents, excellent strong leadership and multidisciplinary team working. It was highlighted that issues of poor practice identified within the Cwm Taff Health Board report, had been scrutinised as part of this investigation and gave no cause for concern for ABUHB, only areas of good practice were present.

As a result of the spot HIW audits, all issues identified across the three sites had been addressed and rectified. Assurance was received that lessons had been learnt and clear monitoring processes were now in place. It was reported that systems of monitoring and assurance had been strengthened including Divisional Risk Management and Mitigation, tracking systems for inspections and enhanced visible leadership of the Divisional Management Team. It was noted that Deb Jackson had written to all members of staff to provide

feedback following the inspection. It was highlighted that Deb Jackson required more support from Divisions during inspections.

The Committee received an update on the baby tagging system and it was noted that the system within the Royal Gwent Hospital would be replicated in Nevill Hall Hospital. It was added that the Health and Safety Team were supporting the service with practice emergency drills. It was added that preparations were underway for Phase 2 of the inspections at Ysbyty Aneurin Bevan.

The Committee praised the excellent work carried out by Deb Jackson and her team.

QPSC 1610/10 Risk Assessment Overview

The Committee received the risk register and noted that there had been one risk removed since the last meeting which related to Crisis Services in Mental Health. Emrys Elias, as Chair of the Crisis Group, provided an update on the latest position and highlighted that there had been extensive work carried out and that performance was being delivered in line with the national requirement. It was requested to seek confirmation regarding how the risk had been reduced.
ACTION: Secretariat

The Committee discussed the content of the Risk Register and noted that the risks were consistent with the Committee's work programme and that actions were in place to try and mitigate the risks.

The Committee received the report.

QPSC 1610/11 QPSOG Assurance Report

The Committee received the assurance report from the Quality and Patient Safety Operational Group (QPSOG) meetings which were held on 18th July and 6th September 2019. It was highlighted that Divisions had been given more time at the meetings to share risks and concerns with other Divisions for opportunities of learning. A dedicated slot on the agenda had been created for investigation reports to discuss and identify lessons of learning. It was added that workshop sessions were underway to look at the Quality and Patient Safety Strategy. It was agreed for this to be presented at a future Committee meeting.
ACTION: Secretariat

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

The Committee was assured by the report.

QPSC 1610/12 Women and Children's Services Sustainability

Peter Carr provided an overview of the current situation with regard to the sustainability of the medical workforce in Paediatrics, Obstetrics & Gynaecology and Neonatal Services during the transition period before the opening of the Grange University Hospital. The Committee was advised of the background, current position and the approach adopted by the Health Board in managing the situation and mitigating the associated risks. It was noted that the report was incorrectly dated as 6th October 2019 instead of 9th October 2019.

ACTION: Secretariat

The Committee received a summary of the current workforce position for each of the specialities across both Nevill Hall and Royal Gwent Hospitals. It was acknowledged that the workforce pressure points were in obstetrics and gynaecology and paediatrics where middle grade rotas were partially reliant on medical locums, which were often difficult to secure.

It was reported that in January 2019, the Health Board commissioned the Faculty of Medical Leadership and Management to undertake an independent review of the key risks related to Paediatric, Obstetric and Maternity Services. The final recommendations and observations included the following:

- There was a compelling case for prompt centralisation of neonatal practice to a single larger unit on the RGH site, with gains in both quality and safety of care;
- There was a very strong case for consolidation of obstetric and midwifery services onto a single site at RGH, with potential gains in quality, safety and sustainability of services, as soon as it was practically possible, namely whenever there is infrastructural capacity to meet additional demand;
- The policy with regard to management of very sick children prior to transfer should be reviewed by the most appropriate means either internally or externally;
- Urgent change was needed in service provision for sick children, with consolidation on the RGH site and

negotiated agreement amongst all stakeholders with regard to an interim model of care that minimises risk.

It was noted that since the review was undertaken, the Faculty of Medical Leadership and Management had been further commissioned to undertake the review of the current policy and pathways, on the two sites, for the management of the critically ill child and was expected to conclude by December 2019.

The Committee requested that a clear action plan was produced with actions/progress outlined against the recommendations made by the Faculty of Medical Leadership and Management in the independent review report of the key risks related to Paediatric, Obstetric and Maternity Services.
ACTION: Peter Carr

Assurance was received that the status of the rotas and the related impact on the service, including any clinical incidents or concerns, was closely monitored by the Family and Therapies Division, with a weekly Service Impact Assessment report being completed for Executive scrutiny. It was emphasised that although no significant issues or adverse clinical outcomes had occurred, continued monitoring of the risks and oversight of the mitigation action continued at Executive level. The Women and Children's Transition Board had also been established and weekly assurance meetings were held with the Division. It was added that in May 2019, the Clinical Futures programme appointed a Programme Manager to support the transition planning for Paediatrics, Obstetrics and Neonates. The Committee was advised that the Board and Executive Team had received regular updates during this period on a routine and exception basis. The Executive Team had also met last week for a focused meeting in relation to the transition period.

The Committee discussed the risks and issues associated with moving acute paediatrics to Royal Gwent Hospital. It was recognised that centralising paediatrics would require the centralisation of other services, which would also result in increased activity for Prince Charles Hospital. It was noted that there had not been sufficient assurance that Cwm Taff could take on this additional activity. The Committee was also advised of the staffing issues which would arise following a move to Royal Gwent Hospital. Therefore it was recognised that centralisation of the service at RGH at this present time

was not the best option and this was endorsed by the Executive Team.

The Committee raised concerns regarding the future move to the Grange Hospital following the issues raised regarding the potential temporary move to RGH. The Committee discussed recruitment and made suggestions for attracting staff to the posts. Peter Carr agreed to look at the job plans.
ACTION: Peter Carr

It was recognised that an urgent contingency plan needed to be established and different ways of working needed to be considered. It was questioned if any external support or other professionals could assist from a functional perspective. It was added that the workforce were looking at more innovative ways of working.

QPSC 1610/13 Infection Control Annual Report

The Committee received the Infection Control Annual Report and presentation which highlighted the significant programme of work, achievements and future areas of concentration. The following progress against the performance targets was noted:

- C difficile - 28% fewer cases compared to previous year;
- MRSA bacteraemia - 37% fewer cases
- MSSA bacteraemia - increase of 9%
- Combined MSSA/MRSA bacteraemia - increase of 3%
- E coli bacteraemia - 5% fewer cases
- Klebsiella bacteraemia - increase of 21%
- Pseudomonas bacteraemia - same number reported compared to the previous year
- Surgical Site Infections (SSI) - Orthopaedic primary joint 0.4% at NHH, 0% at RGH all Wales rate 0.2%
- Surgical Site Infections (SSI) - C section all Wales rate 4.01%, HB rate at NHH is 2.34% and RGH 2.89%, both sites lower than the Welsh rate;
- Ventilator Associated Pneumonia (VAP) all Wales rate 1.86% HB rate 1.51% which is lower than the Welsh rate.

It was noted that there was an additional post within the Infection Control Team and additional funding to increase cleaning in the assessment units to prevent C.difficile. It was added that collaborative work was ongoing with the Continence Team to improve gram negative performance. It

was highlighted that ABUHB was seen as a centre of excellence for VAP.

The Committee praised the excellent work, leadership and Divisional ownership. It was emphasised that primary care prescribing had made a significant impact on the progress.

QPSC 1610/14 Putting Things Right Report (PTR)

The Committee received an updated report on Concerns, Ombudsman and Serious Incidents performance during July and August 2019.

It was advised that significant work had been undertaken to improve both turnaround time performance and quality of concerns handling and responses. The Health Board responded to a total of 225 formal complaints during July and August 2019, with the overall performance against the 30 day target in July being 65% and in August 2019 70%, both of which were on or above trajectory. It was added that the majority of Divisions exceeded their trajectories for August, which was positive.

The Committee was informed that a new Assistant Director joined the team in August 2019 and a new Senior Concerns Manager had also been recruited, which would bring stable senior leadership and management to PTR.

It was reported that there had been improvements in the management and resolution of serious incidents. The performance against 60 day turnaround was just below the improvement trajectory for August at 59% against a target of 60%.

The Committee received the Public Services Ombudsman for Wales (PSOW) Annual Report 2018/19. It was reported that the Health Board had reviewed its annual letter from PSOW and provided a formal repose to the Ombudsman. During 2018/19 the Health Board was issued with two public interest reports. Both reports had been carefully considered, action taken and learning embedded. The Committee discussed the increase in the number of complaints to PSOW as a result of the new timescales. It was noted that the Health Board had an increase of 18 cases requiring PSOW intervention, compared with last year.

The Committee was advised that all divisions were focussed on improving complaint handling. ABCi had undertaken a

pathway mapping of a concern to ensure consistency and a more person centred approach to concerns handling. It was emphasised that the key message was effective and appropriate management of concerns.

It was highlighted that during 2018-19 the Ombudsman issued a thematic report "Home Safe and Sound: Effective Hospital Discharge". The Health Board had taken forward learning from complaints related to discharge and considered the themes identified in the Ombudsman thematic report on effective hospital discharge. Ensuring that people were provided with a truly seamless system of care when admitted to and discharged from hospital was one of the clear ambitions within the Gwent Area Plan. A proposal for a new and integrated model, called Home First, was in progress to provide a more seamless approach to care to facilitate more integrated planning and to deliver improved outcomes for both patients and their families. The Health Board had also revised its discharge policy and patient information to support the work and were monitoring discharge as a key indicator of quality and patient experience.

QPSC 1610/15 Any Other Business

There were no items of other business.

QPSC 1610/16 Items for Board Consideration

There were no items for Board Consideration.

QPSC 1610/17 Date of Next Meeting

The next meeting will be held on Thursday 5th December 2019 at 09:00am in Conference Rooms 1 & 2, ABUHB Headquarters, St Cadoc's Hospital, Caerleon.

Quality and Patient Safety Committee
Thursday 5th December 2019
Agenda Item: 1.5

Quality & Patient Safety Committee
Wednesday 5th December 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 – Wednesday 16th October 2019

Minute Reference	Agreed Action	Lead	Progress/ Completed
QPSC 1609/06	**Revised Draft Committee Terms of Reference** Clinical Audit programme would be presented at the next Committee meeting.	**Secretariat**	Complete – item on agenda
	Secretariat to discuss these changes with Richard Bevan and for the final version to be presented at the next Committee meeting in December, following Board sign off in November 2019.	**Secretariat/ Richard Bevan**	Complete – item on agenda
QPSC 1609/07	**Winter Plan – Reflections and Planning for Winter 2019/20** It was agreed for the Committee to receive a brief update at the next Committee meeting.	**Secretariat**	Complete – item on agenda
QPSC 1609/08	**Quality and Safety in Theatres** Learning from this review to be presented at a future Committee meeting.	**Secretariat**	Complete – item added to forward work programme

Minute Reference	Agreed Action	Lead	Progress/ Completed
	The Committee discussed mortality rate data per condition. Paul Buss agreed to have a look at the present data in the interim.	**Paul Buss**	Complete - Discussed with Royal College of Physicians (RCP) – Dr Buss informed the metrics improvement will lead to improved mortality by summer of next year.
	Fractured Neck of Femur (FNOF) - It was identified that the performance was better in March 2018. Paul Buss agreed to look into this further to establish what worked well.	**Paul Buss**	Complete – Performance has stabilised and there is an ongoing audit
	ABUHB Safeguarding Maturity Matrix **-** It was agreed for this item to be rescheduled for the next Committee meeting.	**Secretariat**	Complete – item presented at other Committee meetings
QPSC 1609/10	**Risk Assessment Overview** It was requested to seek confirmation regarding how the risk relating to Crisis Services in Mental Health had been reduced.	**Secretariat**	Complete – Risk was incorrectly recorded as removed from risk register at last meeting. Risk remains on register with risk score of 8 but is reported to the Mental Health & Learning Disabilities Committee for assurance.
QPSC 1609/11	**QPSOG Assurance Report** It was agreed for Quality and Patient Safety Strategy to be	**Secretariat**	Complete – item added to forward work programme

Minute Reference	Agreed Action	Lead	Progress/ Completed
	presented at a future Committee meeting.		
QPSC 1609/12	**Women and Children's Services Sustainability** The report was incorrectly dated as 6th October 2019 instead of 9th October 2019.	**Secretariat**	Complete – date of report amended
	Clear action plan to be produced with actions/progress outlined against the recommendations made by the Faculty of Medical Leadership and Management in the independent review report of the key risks related to Paediatric, Obstetric and Maternity Services.	**Peter Carr**	Verbal update to be provided at the meeting
	Peter Carr agreed to look at the job plans.	**Peter Carr**	Verbal update to be provided at the meeting

2.1

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance and Performance Committee Thursday 5th December 2019 Agenda Item: 2.1

Aneurin Bevan University Health Board

Quality and Patient Safety Committee Terms of Reference

Executive Summary

This report provides for the Quality and Patient Safety Committee the updated Committee Terms of Reference following the last meeting on 16th October 2019. It is good governance practice for the Terms of Reference to be reviewed annually. This review has also been undertaken as part of arrangements to renew all Health Board Terms of Reference following the updating of the Health Boards committees and membership in May 2019. The Terms of Reference were approved by the Board on 27th November 2019.

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

Executive Sponsor: Richard Bevan, Board Secretary

Report Author: Richard Bevan, Board Secretary

Report Received consideration and supported by :

Executive Team		**Committee of the Board: Quality and Patient Safety Committee**	✓

Date of the Report: 28 November 2019

Supplementary Papers Attached: Terms of Reference

Purpose of the Report

The purpose of this report is to present the updated Terms of Reference for the Quality and Patient Safety Committee.

Background and Context

The Health Board at its meeting in May 2019 agreed changes to the Committee Structure which began to take effect from the 1 July 2019. The new structure has been implemented with new membership and arrangements for committees. It was agreed at the time that new terms of reference would be developed to support enhanced interoperability of committees, specifically in response to the Wales Audit Office Structured Assessment recommendation made in early 2019.

Terms of Reference for all committees have been reviewed and updated by their respective Chairs and Lead Executives. These updated Terms of Reference have been considered by committee and approved by the Board in November 2019.

Assessment and Conclusion

The attached Terms of Reference for the Quality and Patient Safety Committee have been reviewed and a small number of suggested amendments have been made following the Committee meeting on 16th October 2019.

Recommendation	
The Committee is asked to note the Terms of Reference which were approved by the Board in November 2019.	
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	It is good governance practice to review terms of reference on an annual basis.
Financial Assessment, including Value for Money	There are no financial implications for this report.
Quality, Safety and Patient Experience Assessment	There is no direct association to quality, safety and patient experience with this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality or child impact issues associated with this report as this is a required process for the purposes of legal authentication.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/ Corporate Objectives	There is no direct link to Plan associated with this report.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Not applicable to this report
	Integration –Not applicable to this report
	Involvement –Not applicable to this report
	Collaboration – Not applicable to this report
	Prevention – Not applicable to this report
Glossary of New Terms	None
Public Interest	Report to be published in public domain

2.1

Aneurin Bevan University Health Board

Quality and Patient Safety Committee

Terms of Reference

Updated July 2019 (Revised October 2019)

QUALITY AND PATIENT SAFETY COMMITTEE TERMS OF REFERENCE

1. INTRODUCTION

1.1 The Health Board's Standing Orders provide that:-

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

1.2 In line with Standing Orders (and the Board's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Quality and Patient Safety Committee**. This Committee will focus on all aspects of Health Board functions aimed at achieving the highest quality and safety of healthcare, including activities traditionally referred to as 'clinical governance'. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality and Patient Safety Committee "the Committee" is to provide:

- evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and

- **assurance** to the Board in relation to the Health Board's arrangements for:

    - Safeguarding and improving the quality and safety of patient-centred healthcare

    - The health and safety of staff, and citizens on the Board's premises

    - The protection of vulnerable people in accordance with its stated objectives

- The requirements and standards determined for the NHS in Wales e.g. the Health and Care Standards.

- The Health Board's compliance with and response to audit and inspection arrangements from within and out of the organisation e.g. the Healthcare Inspectorate Wales, Internal Audit, Wales Audit Office and Community Health Council.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of advice and assurance to the Board have responsibility on behalf of the Board to continually scrutinise, measure and monitor to ensure that, in relation to all such aspects of quality and safety:

a) that there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

b) that the organisation, at all levels (corporate/directorate/ division/clinical) has a citizen centred approach, putting patients, patient safety, patient experience, well-being and safeguarding above all other considerations. This will include receiving assurance that the Health Board has a patient experience framework in place and that assurance is given regarding its effectiveness;

c) that the care planned or provided across the breadth of the organisation's functions (including corporate/directorate/ division/clinical and those provided by the independent or third sector) are consistently applied, based on sound evidence, are clinically effective and meet agreed standards;

d) that the Committee considers the implications for quality and safety arising from the development and delivery of the Board's corporate strategies e.g. Integrated Medium Term Plan and plans or those of its stakeholders and partners, including those arising from any Joint (sub) Committees of the Board e.g. WHSSC and EASC.

e) that the Committee considers the implications for the Board's quality and safety arrangements from review/investigation reports and actions arising from the work of external regulators;

f) that the organisation, at all levels (corporate/directorate/division/ clinical) has the right systems and processes in place to deliver, from a patients perspective - efficient, effective, timely and safe services;

g) that there is an ethos of continual quality improvement and that there are regular methods of updating the workforce in the skills

needed to demonstrate quality improvement throughout the organisation;

h) that clinical risks are actively identified and robustly managed at all levels of the organisation;

i) that decisions taken within the organisation are based upon valid, accurate, complete and timely data and information;

j) that there is continuous improvement in the standard of quality and safety across the whole organisation, which is guided and continuously monitored through the use of national and professional standards in line with regulatory frameworks.

k) there is effective action and outputs in relation to clinical audit and the quality improvement function and that an annual plan is in place that meets the standards set for the NHS in Wales and provides appropriate assurance to the Committee that actions are in place and learning has been undertaken. (The Committee will link with the Audit Committee with in relation to overall assurance regarding these functions).

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

m) that those recommendations made by internal and external reviewers are considered and acted upon appropriately and on a timely basis.

n) that lessons are learned from patient safety incidents, complaints and claims and that these, together with good practice are shared across the organisation and that the impact of learning is measured and shared.

3.2 The Committee will, in respect of its assurance role on behalf of the Board, link with the Audit Committee to seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Board's activities in line with the Health Board's system of governance and assurance.

3.3 The Committee will, in respect of its assurance role on behalf of the Board, seek assurances that there is an appropriate Framework in place for Clinical Policies and that this is regularly reviewed.

3.4 The Committee as part of its delegated responsibilities will advise

the Board on the adoption and continued development of a set of key indicators of quality of care against which the Board's performance will be regularly assessed and reported on through Annual Reports, such as the Annual Quality Statement.

Authority

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

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

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

Access

3.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Quality and Patient Safety Committee.

3.8 The Committee will meet with Internal Audit and representatives of Clinical Audit [and, as appropriate, nominated representatives of Healthcare Inspectorate Wales] without the presence of officials on at least one occasion each year.

3.9 The Chair of the Quality and Patient Safety Committee shall have reasonable access to Executive Directors and all other relevant staff, any other Committees, Sub-Committees and Groups deemed appropriate by the Committee, and to primary care practitioners.

Sub Committees

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

4. MEMBERSHIP

4.1 Members

A minimum of five members, comprising:

Chair	Independent member of the Board
Vice Chair	Independent member of the Board
Members	At least 3 other independent members of the Board, to include a member of the Health Board's Audit Committee and the Vice Chair of the Health Board. At least one member must have a clinical background.

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

4.2 Attendees

In attendance

The lead executives for this Committee will be the Medical Director, Director of Nursing and Director of Therapies and Health Science.

The Chief Executive and all Executive Directors holding portfolios containing aspects of quality and safety of care.

Other Executive Directors should attend from time to time as required by the Committee.

Nominated deputies for Executive Directors will be required to attend meetings of the Committee when the respective Director is not able to attend for valid reasons.

By invitation

The Committee Chair may extend invitations to attend Committee meetings as required to the following:

- Directors and/or Heads of Directorates/Divisions/Clinical Teams
- Representatives of Partnership organisations
- Public and Patient Involvement Representatives
- Trade Union Representatives
- Representatives of Internal Audit and Clinical Audit.

as well as others from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting.

Secretariat

Secretariat - As determined by the Board Secretary.

4.3 Member Appointments

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

4.3.2 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board. The Board should consider rotating a proportion of the Committee's membership after three or four years' service so as to ensure the Committee is continuingly refreshed whilst maintaining continuity.

4.3.4 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Board Chair {and, where appropriate, on the basis of advice from the Board's Remuneration and Terms of Service Committee}.

4.4 Support to Committee Members

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

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

5.2 Meetings shall be held no less than bi-monthly, and otherwise as the Chair of the Committee deems necessary – consistent with the Board's annual plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters, which are deemed to be not appropriate for the public domain due to issues of confidentiality.

6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, in particular the Audit Committee (in its role of providing overall assurance to the Board on the design and appropriateness of the organisation's system of governance and assurance), joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of information

in doing so, this will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall system of governance and assurance framework.

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual report;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.
- The Board Secretary, in liaison with the lead Executives for the Committee and the Chair, shall ensure that an annual work programme is in place for the Committee, aligned to the priorities of the Health Board.

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Board's Standing Orders are equally applicable to the operation of the Committee.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Thursday 5th December 2019 Agenda Item: 4.1

Aneurin Bevan University Health Board

QUALITY AND PATIENT SAFETY REPORT
DECEMBER 2019

4.1

Executive Summary

Summary of Key Points

The number of deaths has been stable over the summer 2019. The mortality rate however is now closer to the Welsh mortality rate than it has usually been. (section 1.1.).

An overview of participation in National Clinical Audits (NCAs) is provided. The results of the National Audit of Care at the End of Life are given in section 2.2. The results of the audit have been discussed at the End of Life Care Board, and a core action plan is being drafted which the Divisions will be asked to implement.

It has been challenging for the front door departments to maintain the compliance with the sepsis 6 bundle within one hour of recognition of sepsis during 2019. (section 3.1.).

Progress against this financial year's target for C difficile is good – currently running at 23.43 per 100,000 population as at 31st October 2019. See section 3.2.

There has been an increase in the number of in-patient falls per month in 2019, which appears to be leading to an increase in the fractures resulting from falls. The Falls Scrutiny Panel Terms of reference are being reviewed, in line with the recommendations in an Ombudsman report. (section 3.8)

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 Operational Group]**	**X**
Date of the Report: November 2019			
Supplementary Papers Attached:			

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.

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:

- High level data on outcomes
- Surveillance and review
- Optimising Care Delivery

The targets used included in the report are either Welsh Government Targets, or targets set within the Health Board, where there is no Welsh Government Target.

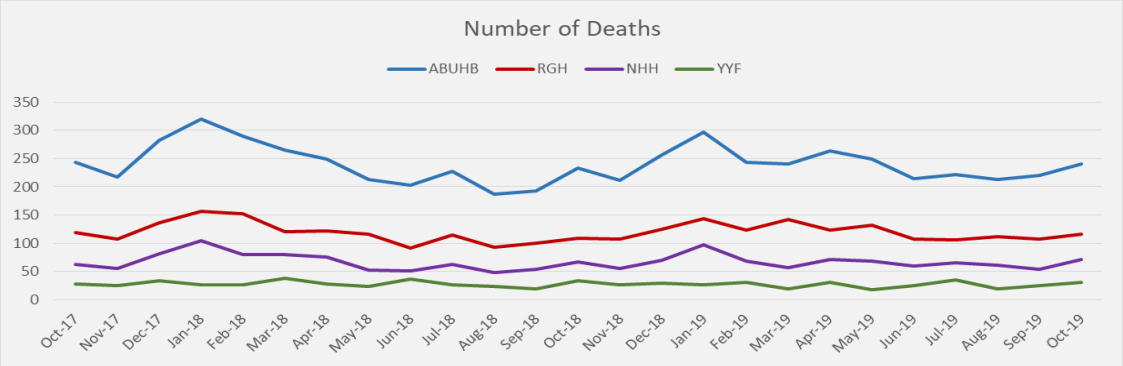
Assessment and Conclusion

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.

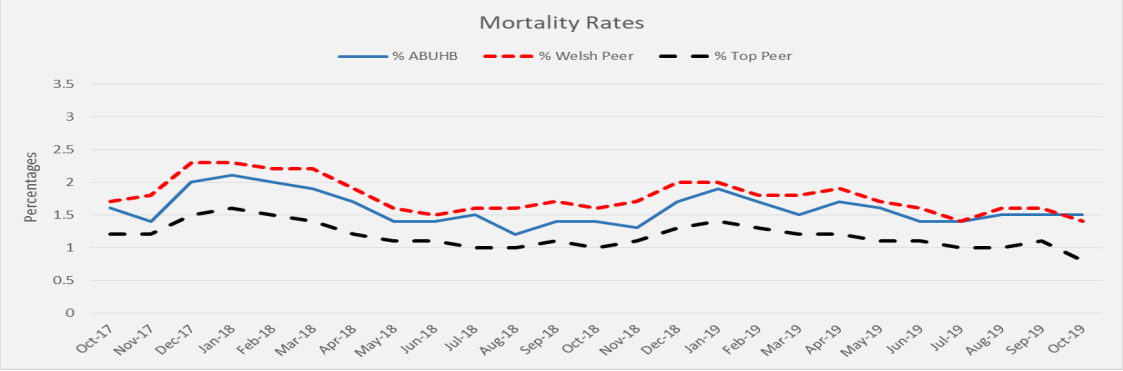
1. High Level Outcomes

1.1 Crude Mortality and Mortality Rate

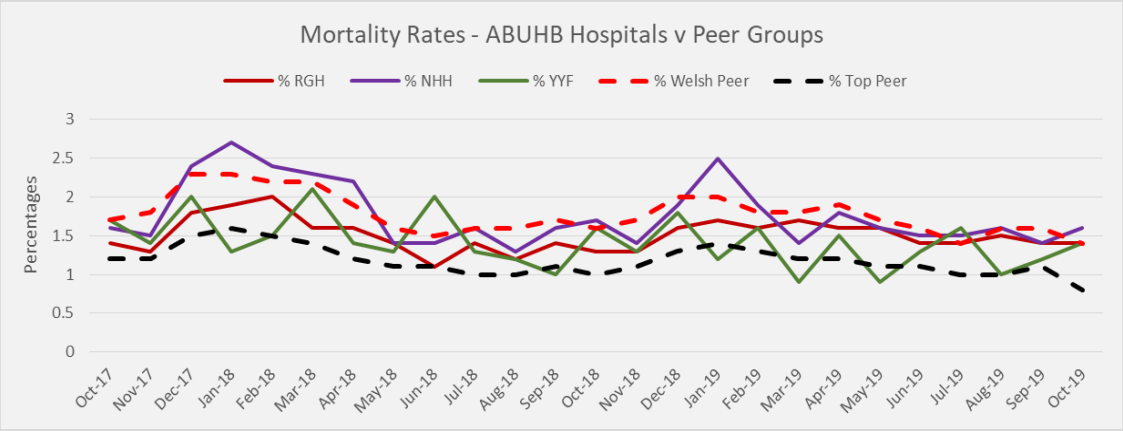
ABUHB and Hospital Crude Mortality October 17 – October 19



ABUHB Mortality Rate against Welsh Peer and Top Peer October 17- October 19



Hospital Mortality Rates with Welsh Peer and Top Peer October 17- October 19



Percentage of deaths by place of occurrence 2018

LHB Area	Home	Care Home		Hospices		Hospitals (acute or community not psychiatric)		Other communal establishments	Elsewhere
		Local Authority	Non-Local Authority	NHS	Non-NHS	NHS	Non-NHS		
Betsi Cadwaladr University	22.0%	1.3%	18.2%	0.0%	3.8%	52.4%	0.0%	0.1%	2.1%
Powys Teaching	24.5%	3.6%	15.2%	0.0%	3.1%	51.9%	0.0%	0.0%	1.7%
Hywel Dda	27.6%	1.9%	18.0%	0.0%	0.9%	49.1%	0.0%	0.1%	2.4%
Aneurin Bevan	26.1%	1.1%	14.4%	0.0%	2.0%	54.2%	0.0%	0.2%	1.8%
Cardiff and Vale University	22.7%	0.4%	16.9%	0.0%	6.5%	51.2%	0.0%	0.0%	2.2%
Cwm Taf Morgannwg	22.6%	1.3%	11.8%	1.6%	0.1%	59.2%	0.0%	0.3%	3.0%
Swansea Bay	25.0%	0.5%	18.3%	0.0%	0.1%	52.5%	0.0%	0.8%	2.9%
WALES	24.2%	1.3%	16.3%	0.2%	2.4%	53.1%	0.0%	0.2%	2.3%

Source: ONS

The above data is published by the ONS. It shows the percentage of deaths by place of occurrence in 2018 by health board in Wales. It shows that ABUHB has the second highest percentage of deaths in hospital in Wales.

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, YYF and RGH has been stable during the summer of 2019.

The ABUHB mortality rate is generally lower than the Welsh Hospitals. The mortality rate for ABUHB increased going into the 2018-19 winter period, but then decreased in the first half of the year. It is of note however, that the ABUHB mortality rate was the same as the All Wales Mortality rate in July 19. Both NHH and YYF mortality rates are above the Welsh average for July 2019 and RGH is the same. This seems to have happened again in October 2019.

The rise in the mortality rate at NHH is still of concern until it is understood and changes made if necessary. It is possible that a higher mortality rate is indicative of good practice – using the virtual ward and ambulatory care to keep the less unwell patients out of hospital, and admitting those with higher acuity. NHH has been using the virtual ward for longer than RGH, and a greater percentage of surgical presentations at NHH are managed through the virtual ward than at RGH. However,

NHH has a high proportion of registered nurse vacancies on some wards and it is difficult to see the impact of this on care in reviewing the case notes. The mortality rate at RGH also seems now to be nearer to the All Wales mortality rate than it has been.

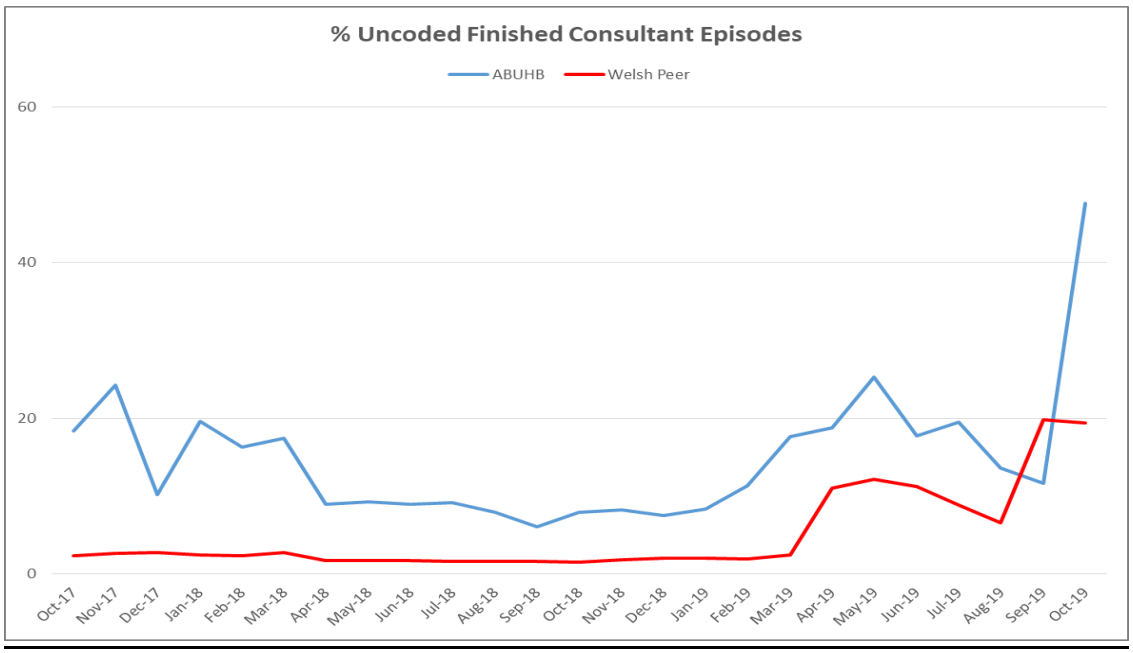
Coding completeness (p5) does not impact on the number of deaths or the mortality rate values. However, it is important for any more detailed analysis of the variation in the numbers or rates, and it impacts on the condition specific mortality rates. The Clinical Coding Department continues to fill its vacancies as they arise, but there is a regular turn over of staff and it is some time before the new staff are working at full effectiveness.

Completeness of Coding

ABUHB Coding Completeness (29 November 2019, CHKS):

April 19	81.2%
May 19	74.7%
June 19	82.3%
July 19	80.5%
Aug 19	86.4%
Sept 19	88.4%

Uncoded Finished Consultant Episodes October 17 - October 19



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 treatment and 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 satisfied with the care provided. The Health Board will undertake a more in depth, second level review into any deaths highlighted because of concerns by the Medical Examiner. The new role is being introduced from April 2019 on a non-statutory basis for deaths in acute hospitals. In Wales, the Medical Examiners (ME) and the Medical Examiner Officers (MEO) who support them, will be employed by Shared Services. The Health Board is therefore not implementing the role itself, but will ensure it will work alongside the bereavement service, as it is developed. Shared Services will now appoint to the ME and MEO roles, as the lead ME for Wales has been appointed.

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, with a focus on learning. The number of deaths is higher in the winter, and therefore even when same number of reviews are completed, the percentage of reviews completed will drop. Other HBs in Wales achieve a higher percentage of mortality review completion, as most

require their junior doctors to complete the review when they do the discharge summary, rather than a review by an impartial, senior clinician.

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.

Percentage of Mortality Reviews completed for ABUHB

	Nov 18	Dec 18	Jan 19	Feb 19	March 19	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sept 2019	Oct 2019	Total
No. Reviewed	122	125	188	168	191	216	169	159	119	121	142	126	1846
2nd Stage Review	19	13	15	11	18	25	28	29	23	14	20	12	227
Total Deaths	208	259	294	240	236	261	242	210	220	190	213	228	2801
% Reviewed	59%	48%	64%	70%	81%	83%	70%	76%	54%	64%	67%	55%	66%

Learning from Mortality Reviews – The last meeting of the Mortality and Harm Review Group highlighted that the STET fluid balance charts are not always completed well. This concern has been raised with the Divisions through the Director of nursing, and further audit is being undertaken to better understand the reasons for this, and how it can be improved. The actions are being taken forward and overseen by the Clinical Nutrition and Hydration Group.

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 first Report of the National Audit of Care at the End of Life is the NCA included in this report. The results of all the National Clinical Audits are now being reported to the Clinical Effectiveness Group.

The Wales National Clinical Audit and Outcome Review Programme (NCAORP) 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 below, but there are a further 2 that we do not enter any data for, and 4 that data entry is not in place at all hospitals, or is limited in some way.

The National Clinical Audits that ABUHB participates in on 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 Core Diabetes Audit
National Diabetes Transitions Audit
National Diabetes Paediatric Audit
Pulmonary Rehabilitation
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
National Clinical Audit of Psychosis
NCEPOD audits
Mental Health Programme
Maternal Newborn and Infant Clinical Outcome Review programme

ABUHB has no or limited data entry for the following NCAs:

NCA	Case Ascertainment	Narrative	Update
Trauma Audit Research Network	Participation started	Registered for the audit and clinical staff trained for the audit but clinical staff unable to complete data entry within their working day.	Lead administrator for NCA now trained on TARN and entering some data. A member of staff has joined the Medical Director's Support Team to enter data for this audit, and interviews for a further post will take place before Christmas.
National Ophthalmology Audit (Adult Cataract Surgery)	No Participation	Electronic Records systems for Ophthalmology required as this uploads the audit data automatically.	The procurement of an electronic medical record system for Wales is to be expedited, based on the Cardiff model. It is predicted to be ready in March 2020.
NACAP – National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: COPD audit Adult Asthma Audit Children and Young People Asthma Audit	Full participation at NHH in COPD and Adult asthma. Participation at RGH and YYF in COPD initiated, with MDST support for data entry. No participation in Children and Young People Asthma Audit	The COPD NCA has recently moved to continuous data entry and the Asthma NCAs are new. The Respiratory Service has struggled to complete the data entry due to the high volume.	A process has been developed at NHH between the clinical staff and the MDST for COPD data entry. RGH Consultant is identifying primary COPD patients and MDST administrative staff are entering the RGH data. YYF clinical staff are now entering data for COPD and Adult Asthma. Paediatricians are unable to enter data for the Asthma audit.
Heart Failure	Full Participation at NHH. Improving participation at RGH and YYF.	Process for data entry working well to date for 2019-20.	It is expected therefore that case ascertainment for ABUHB will achieve 70% in 2019-20.
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 registered for this NCA from the beginning of 2019. Process for data entry	Data entry is being monitored. It is progressing well, and the number of cases entered has recently increased.

		agreed between service and MDST	
Epilepsy 12 Children and Young People NCA	Limited participation		Participation in this audit is being discussed with the clinicians

Learning from Clinical Audits happens across all the services. One example of recent learning from the National Hip Fracture Database is that a presentation was given by an Orthogeriatrician to the Care of the Elderly Teams at a Multidisciplinary Team Event. There was clear learning from national standards including optimising anaesthetic risk. There has also been a multidisciplinary audit meeting in the orthopaedic and anaesthetic directorates where there was learning from a local audit on blood cross matching.

Following the Never Events that have occurred in theatres, there has been a retrospective audit, looking back 3 years, of theatre practice, identifying errors. This is linked into a comprehensive learning education programme.

National Audit of Care at the End of Life (NACEL).

The National Audit of Care at the End of Life (NACEL) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government in October 2017. NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland.
Every year, over half a million people die in England and Wales, almost half of these in a hospital setting. Following the Neuberger review, More Care, Less Pathway, 2013, and the phasing out of the Liverpool Care Pathway (LCP), the Leadership Alliance published One Chance To Get It Right, 2014, setting out the five priorities for care of the dying person. NACEL measures the performance of hospitals against criteria relating to the five priorities, and relevant NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

First round of NACEL

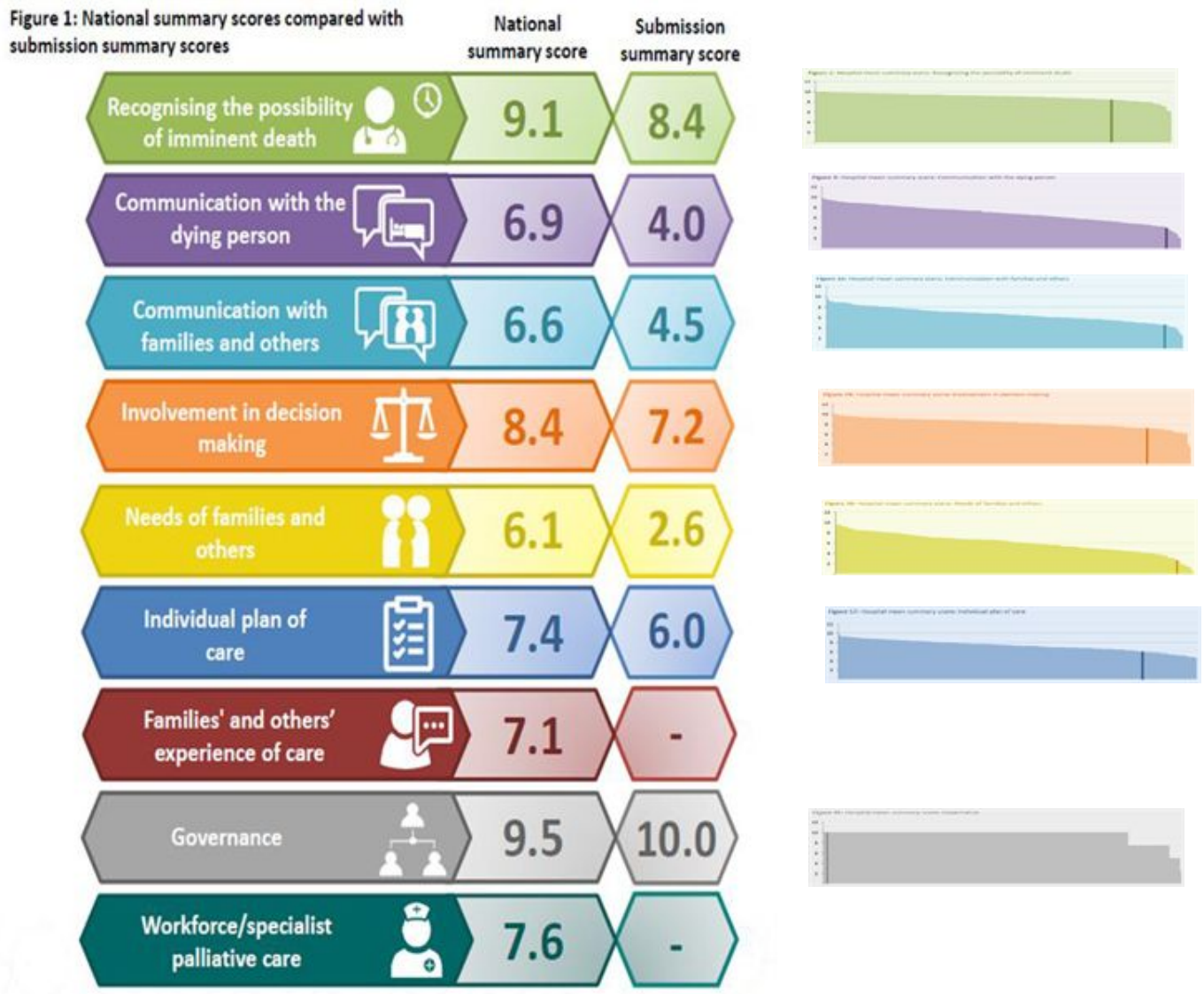
The audit, undertaken during 2018/19, comprised:

- an **Organisational Level Audit** covering trust/University Health Board (UHB) and hospital/submission level questions

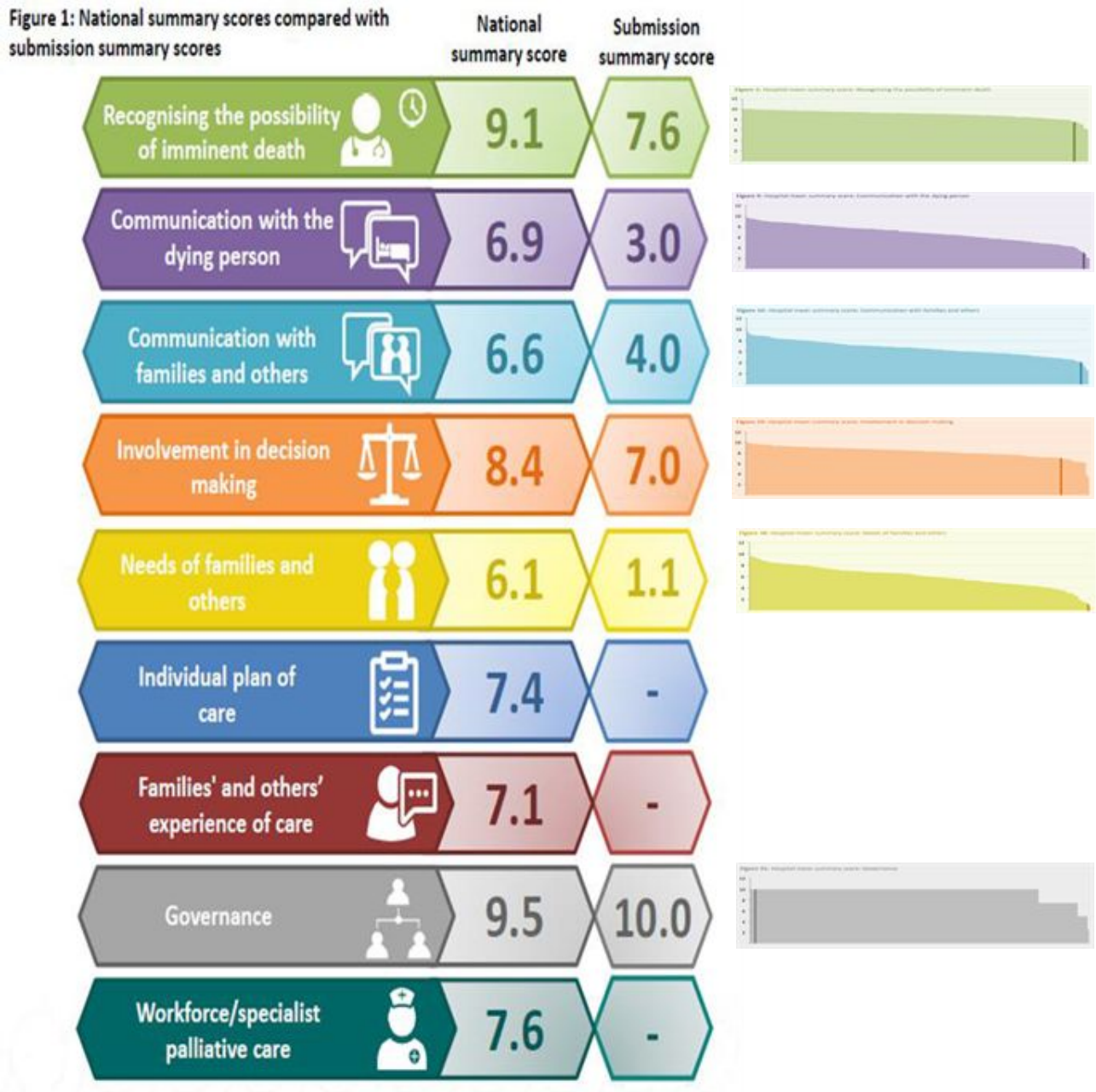
- a **Case Note Review** completed by acute and community providers only, which reviewed all deaths in April 2018 (acute providers) or deaths in April – June 2018 (community providers)
- a **Quality Survey** completed online, or by telephone, by the bereaved person

Data for all elements of the audit was collected between June and October 2018. In total, 206 trusts in England and 8 Welsh organisations took part in at least one element of the audit (97% of eligible organisations). No personal or patient identifiable data was collected. This report was published on 11th July 2019.

Acute Peer Group



Community Peer Group



The National Audit of Care at the End of Life has been discussed at the End of Life Care Board. It was agreed that a core action plan should focus on 3 main actions in order to improve care at the end of life. These are:

- Relaunching the Care Decisions tool for care at the end of life
- Improving the Bereavement Service in our hospitals
- Improving the use of the DNACPR form

The core action plan will be devolved to the Divisions for implementation, and enable them to add more actions to the plan, so that the core actions are implemented across ABUHB, but Divisions are able to make local improvements specific to their services that will help them to improve Care at the End of Life.

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 the wards in YYF. 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.

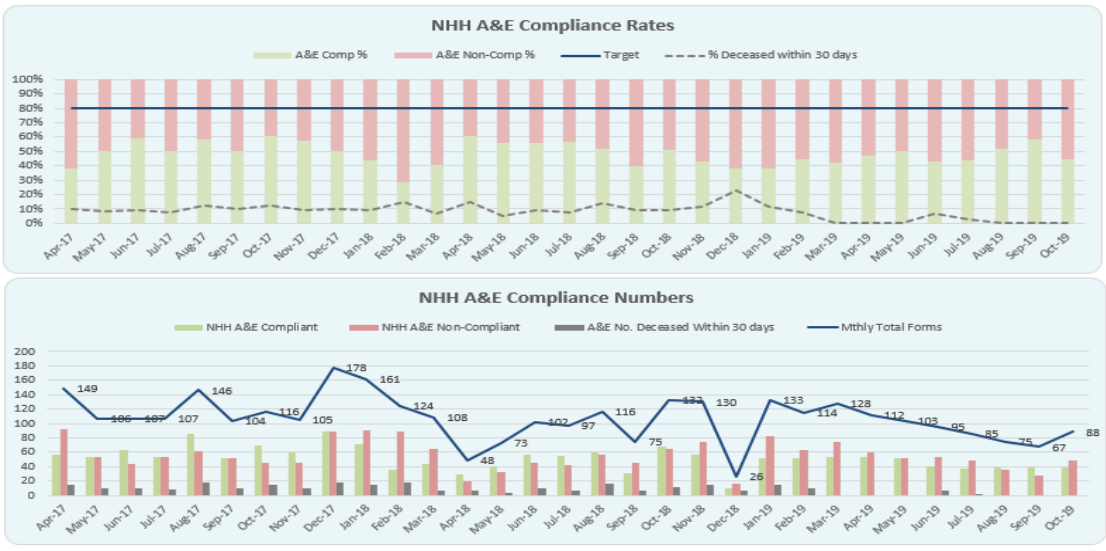
As the ABC Sepsis process is unreliable on the wards at NHH and RGH, the data for the wards is taken from the Outreach databases for NHH and RGH and from ABC Sepsis database for YYF wards.

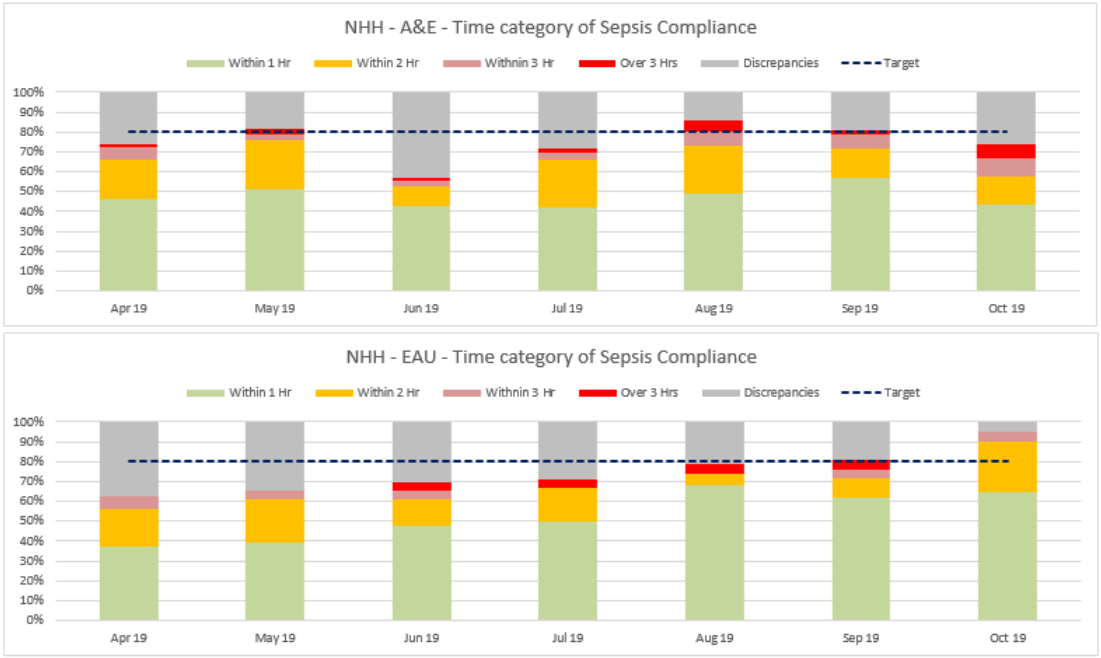
The data for the Emergency Departments is all from the ABC Sepsis database. It should be noted that ABC Sepsis applies the criteria for compliance with the sepsis 6 bundle within 1 hour robustly. This data is reported to the WG on a monthly basis.

Emergency Departments:

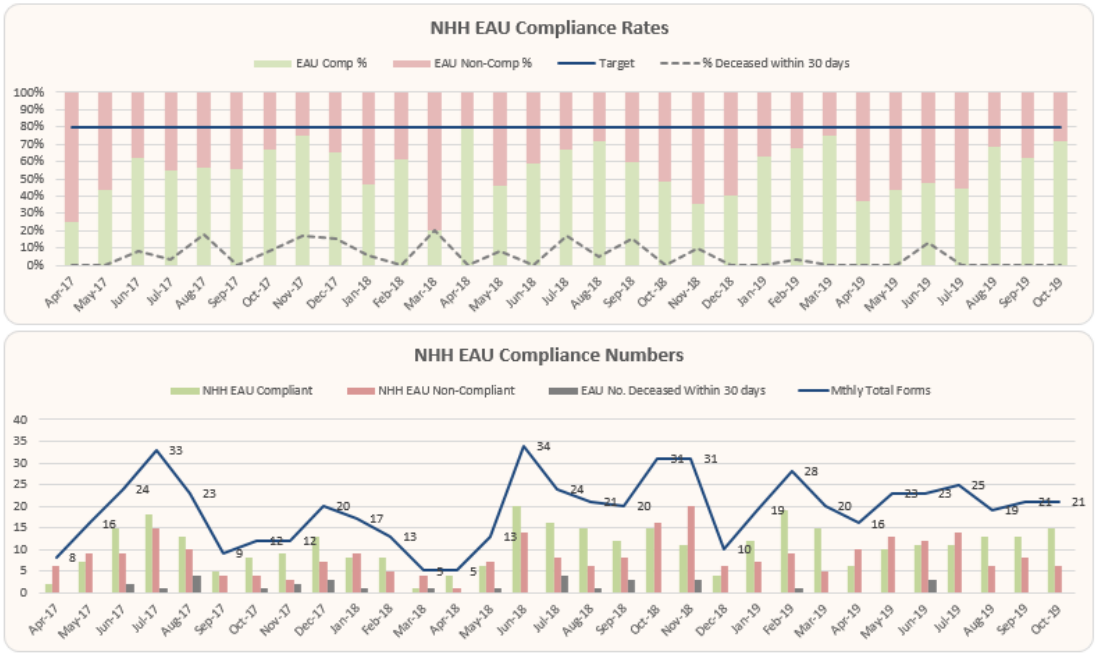
***Nevill Hall Hospital A and E*:** The number of forms at NHH has decreased over 2019. Compliance with the bundle in 1 hour has been variable. Compliance within 2-3 hours is at or much closer to 80% and this is still good care. The compliance is normally addressed within the department through discussion with the nurses about completing the form with all the necessary information, and with the doctors about the delays in the prescribing of antibiotics. However, it has been challenging to hold the DRIPS meetings every week in the A and E department during and since the winter period, due to the number of vacancies and therefore agency staff and the pressures within the department

Compliance within 1 hour of recognition of sepsis



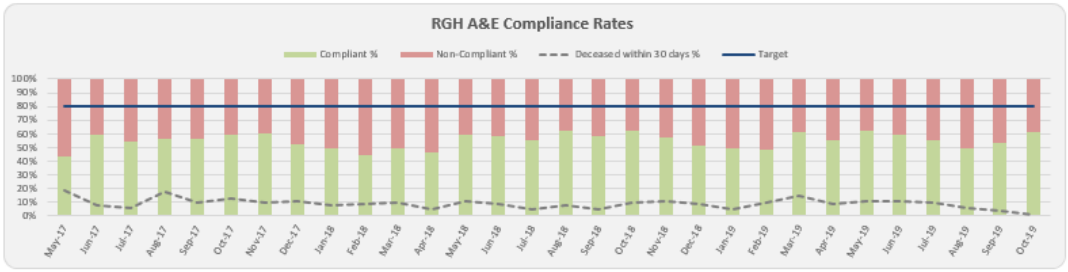


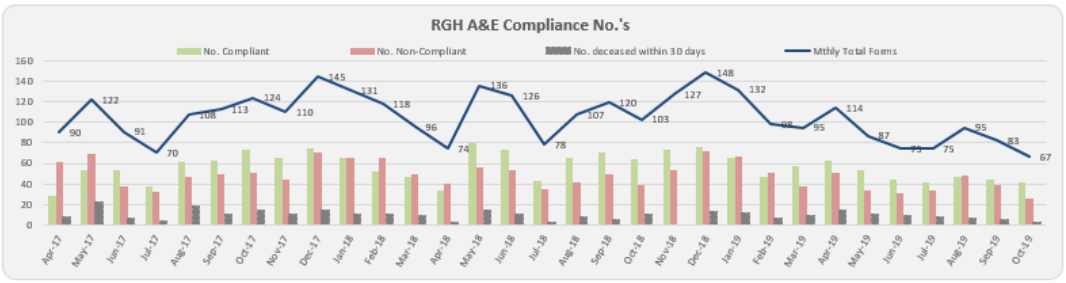
EAU at NHH is engaged with ABC sepsis. Both the recognition and response to sepsis have improved overall in the department, although they vary week to week. The DRIPS meetings have been well attended.

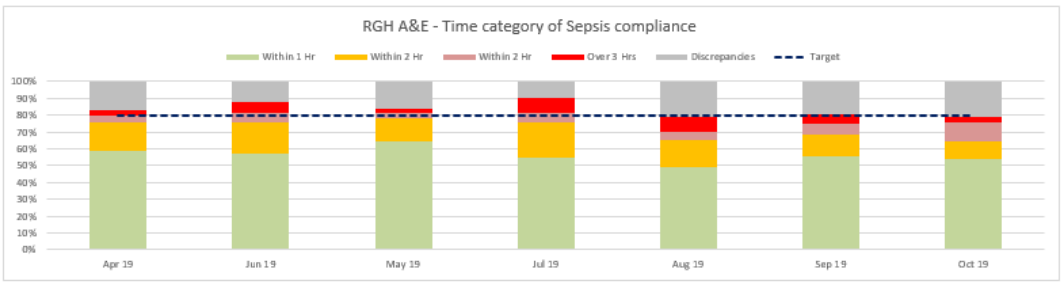


***Royal Gwent Hospital A and E*:** The number of forms from RGH A and E was high over the winter, but has since dropped off throughout 2019.

Compliance with the bundle within 1 hour has been variable, and is at ot close to 80% within 2-3 hours. There have been regular meetings with one member of senior staff, but it has not always been possible for many front line nurses to attend the meetings because of the level of vacancies and the pressures in the department. This means learning about the purpose and correct completion of the forms is not being passed on to new staff.

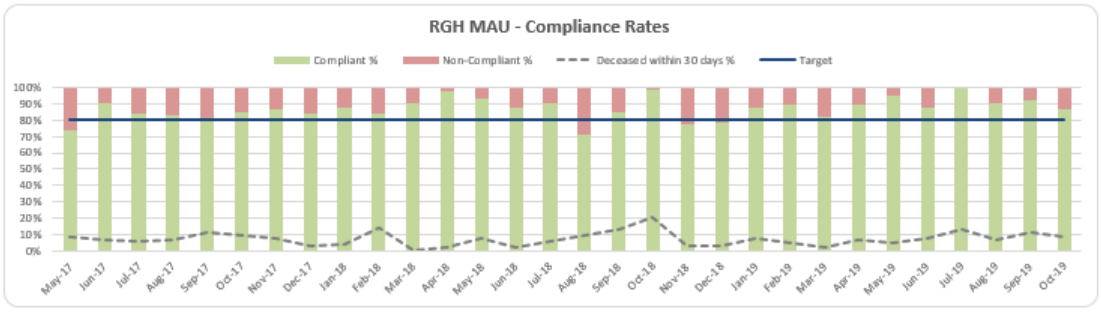


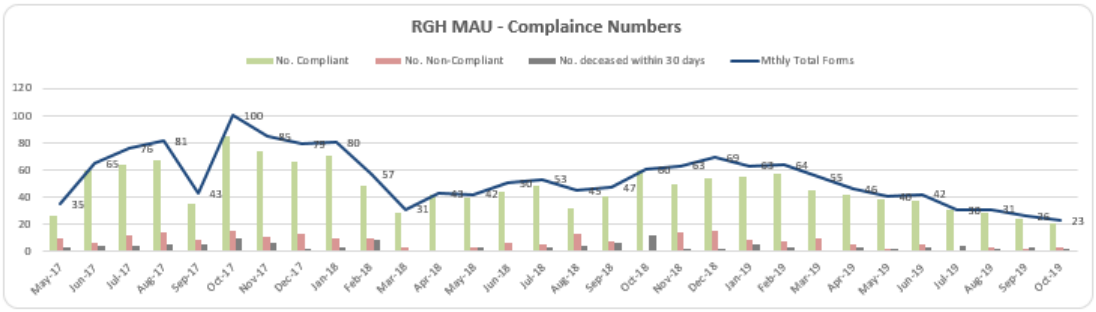


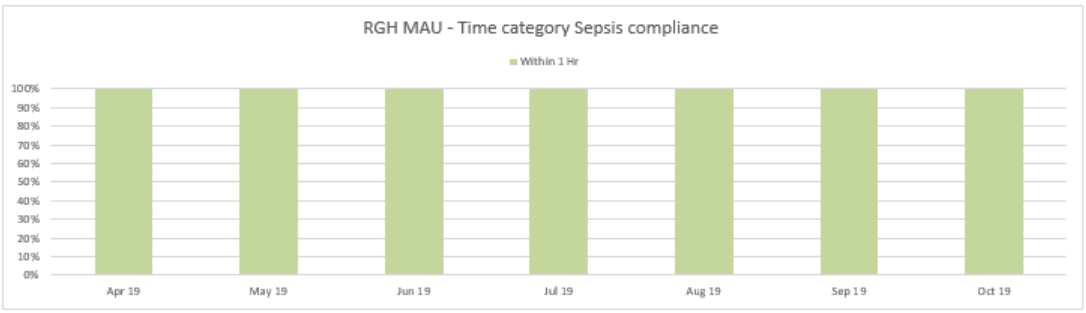


The bar charts above show the number of forms completed in 2 hours and 3 hours, as well as those completed in an hour. This shows that most patients are getting good care.

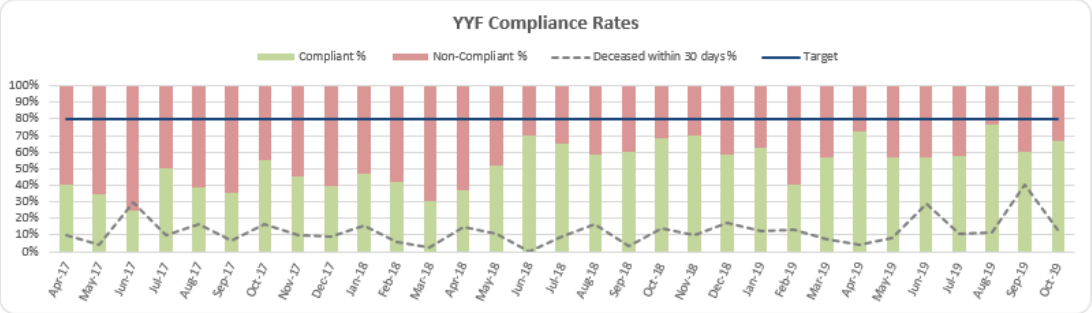
MAU at RGH is fully engaged with ABC Sepsis. The number of forms completed has decreased over the summer period but the compliance has remained high. ABC Sepsis will capture learning from MAU about how they achieve the high compliance and discuss with the other front door departments how the MAU approach could be used there.

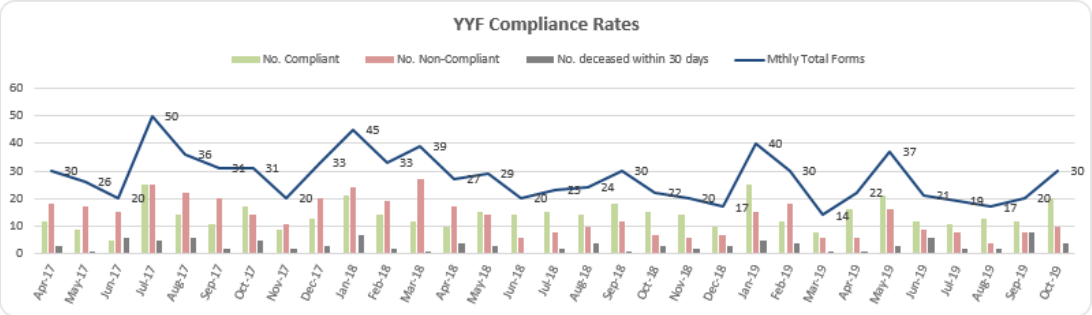


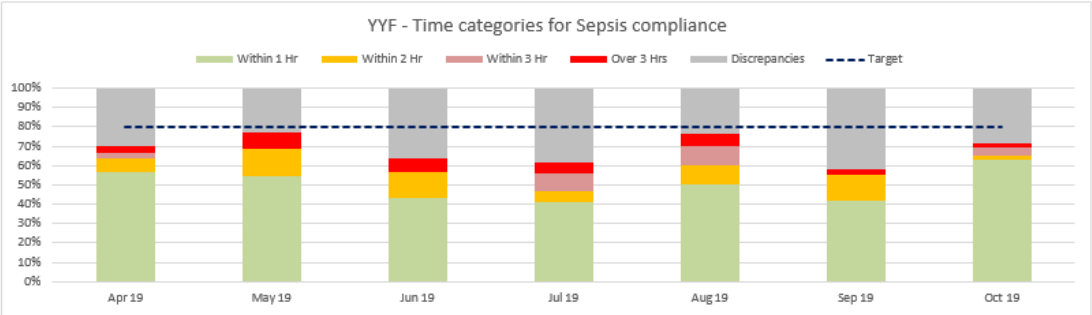




***Ysbyty Ystrad Fawr*:** ABC Sepsis covers the whole of YYF, wards and Emergency Department. The Vital Pac Pilot started at YYF in September 2017, and the ABC Sepsis Team have worked closely with the IT Staff so that the system supports the recognition of deteriorating patients on the wards. The number of forms completed has been very variable, in the Emergency Department and low on the wards. This has been addressed through meetings with senior clinicians.







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. This has included providing equipment to enable healthcare District Nurses to take observations, and doing additional training.

The 1000 Lives Team are now running a Collaborative on using physiological observations and NEWS to recognise a deteriorating patient in the community. ABUHB has participated strongly in this initiative. It has been recognised as a leader across Wales in ensuring that staff in the District Nursing Team all have the right equipment to take physiological observations, and in providing training on NEWS. This means all the District Nursing Teams are green for being NEWS Ready.

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 ABC Sepsis Lead Nurse regularly compare the sepsis trigger tools received with both data in the Outreach Team data base on the patients seen with sepsis and with patients with a high NEWs score recorded in data pack. The discrepancies are discussed with the ward manager. The data from Care Flow – the electronic capture of patient observations at YYF and NHH is also increasingly being used to identify sick patient, but this relies on the NEWs score, which is not a robust trigger on its own.

3.1.2. ABC Sepsis Steering Group

The ABC Sepsis Steering Group is taking forward the parts of the Peer Review Action Plan, that relate to sepsis. The whole plan is being monitored by the Acute Deterioration Steering Group, and the work in the Community has been incorporated in to the Plan. The Peer Review Team action plan covers 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 ABC Sepsis Steering Group has discussed the decrease in the number of sepsis trigger forms completed during 2019. The decrease could be because there are fewer cases of sepsis, or be because the front door departments are under pressure and they are not picking up sepsis as well as they have done. To understand this better, the Steering Group is going to review the data in the database on the source of the infection over the seasons, as it could be that there are fewer chest infections in the summer and this accounts for the decrease. It will also look at whether the decrease has been greater during working hours, or out of hours to see whether there is a difference.

3.2 Reducing C Diff and Healthcare Associated Bacteraemia

Aim: Welsh Government 2019/20 HB reduction target for C *difficile*, Staph *aureus (MRSA and MSSA)* and E*Coli* bacteraemia are:

- **C difficile - 25 per 100,000 population**

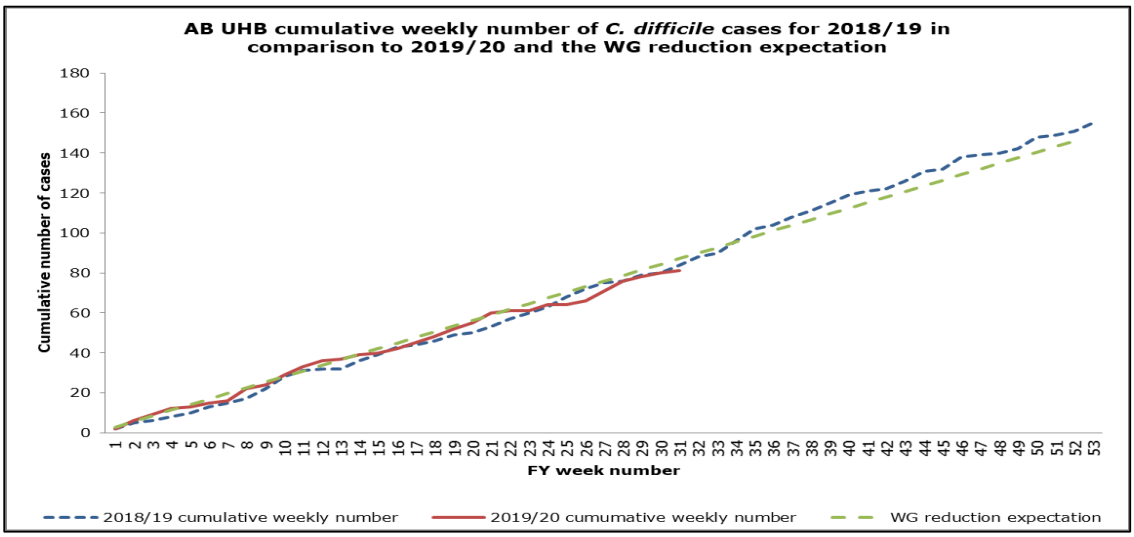
- **Staph aureus – 20 per 100,000 population**
- **E Coli – 67 per 100,000 population**

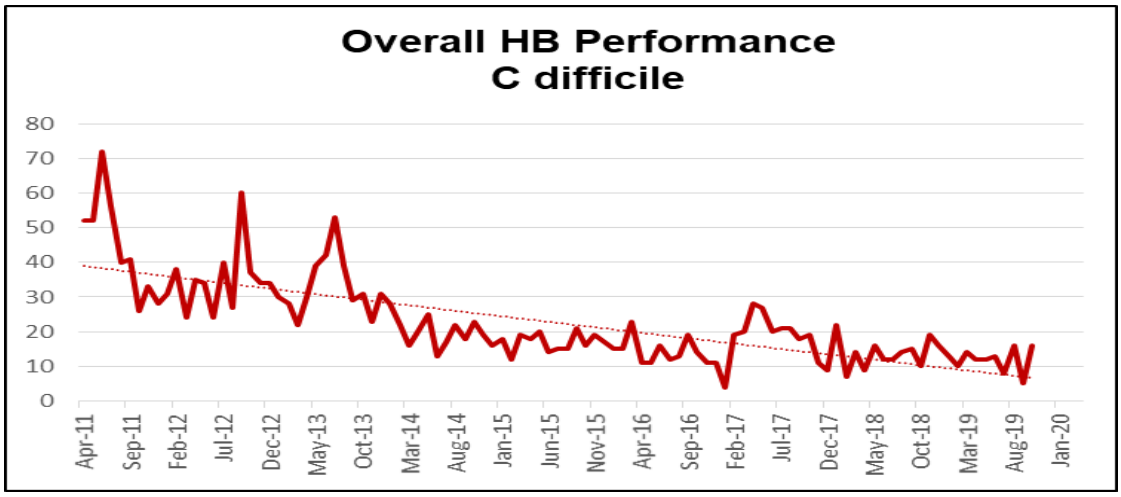
Two new targets were added in 2018/19 by Welsh Government:

- **Klebsiella – A 10% reduction against 2017/18 figures**
- **Pseudomonas *aeruginosa* - A 10% reduction against 2017/18 figures**

Overall, good reductions have been made across three target areas with further work needed to reduce numbers of Klebsiella and Pseudomonas

3.2.1. Total C diff. Cases





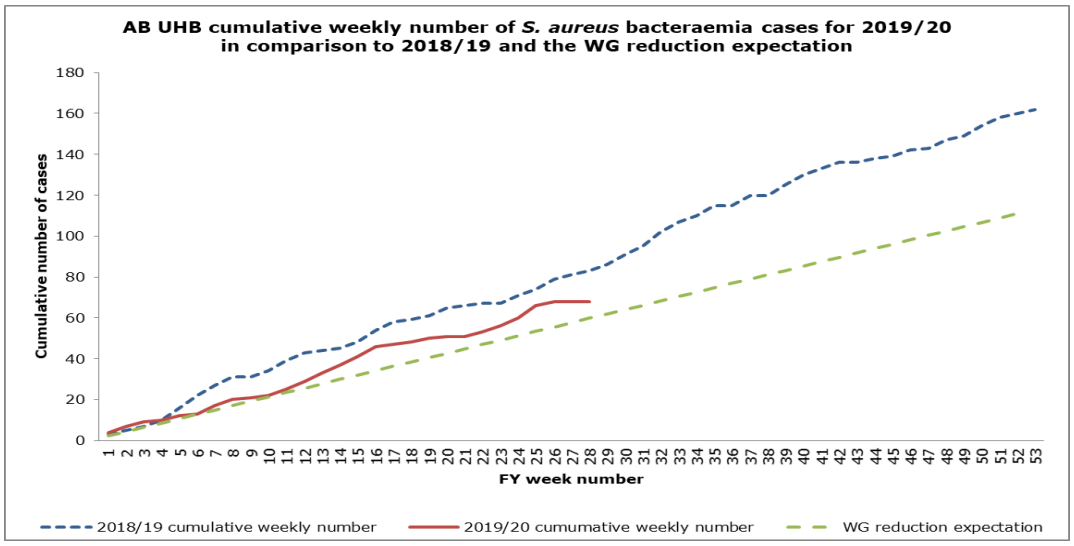
C.*difficile* – The Welsh Government 2018/19 C *difficile* target of 26 cases per 100,000 was narrowly missed. The HB achieved a rate of 26.37 per 100,000 population which equates to a 28% reduction compared to the previous year. This, in all probability was achieved through the delivery of a comprehensive deep clean programme in the previous year. Progress against this financial years target is good – currently running at 23.43 per 100,000 population as at 31st October 2019

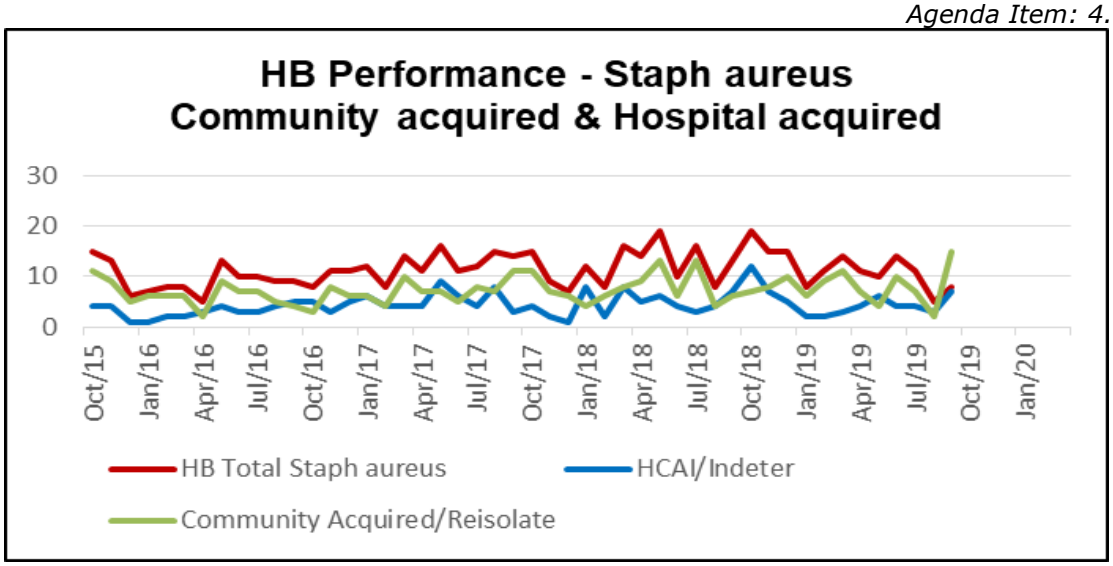
The HB has profiled the improvement required to meet the March 2020 target (see above) and this has been built up from Division specific profiles which identifies target numbers of cases weekly, monthly and cumulatively. There is monthly monitoring of performance and feedback to Divisions with the current performance indicating that we are on target to achieve the required WG goal.

The HB is looking for a further step reduction through the monitoring of antibiotic prescribing in Primary and Secondary Care. Antibiotic prescribing must reflect policies which in turn will have a positive effect on the number of C *difficile* cases.

The Executive Team is updated daily with the number of C *difficile* cases along with all pathogens associated with the WG HCAI Improvement Goals 2019/20.

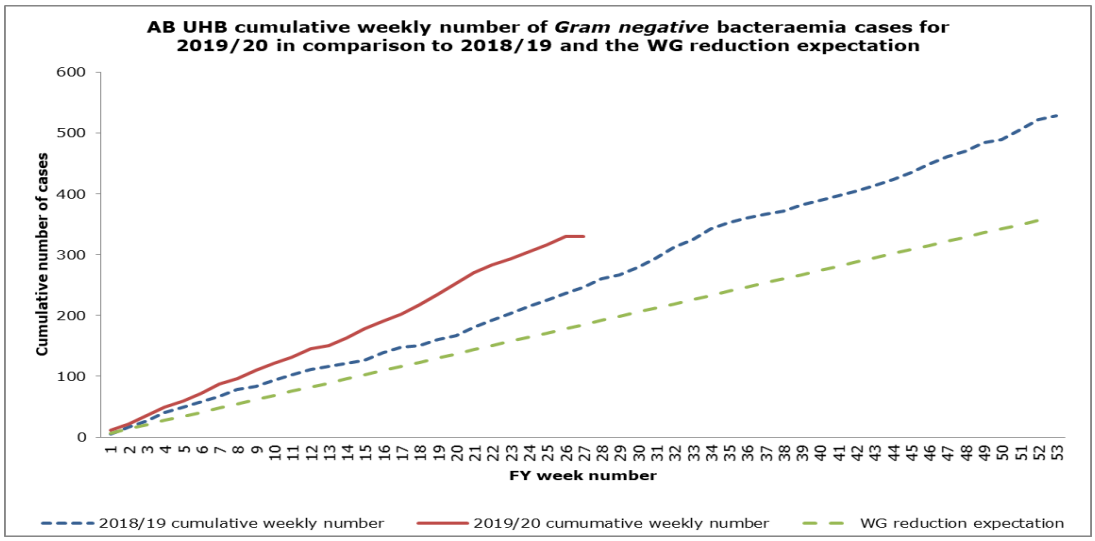
3.2.2. Total MRSA and MSSA Cases

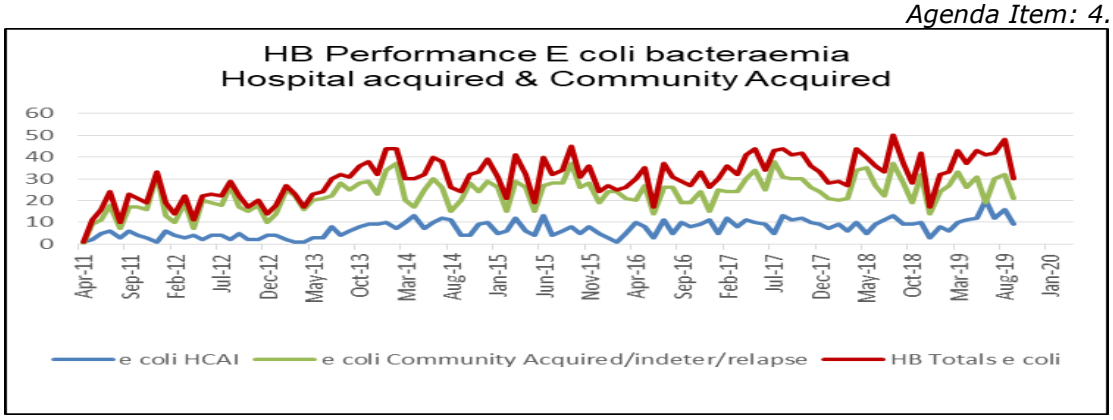




Staph *aureus* bacteraemia – The Health Board is currently running above the trajectory due to a rise in Methicillin sensitive S. aureus as opposed to MRSA. Our staff continue to work hard to reach the target set by Welsh Government. The key strategy is a sustained campaign of pre-emptive testing and treating patients to reduce risk, embedding the PVC and Central Line bundle and detailed root cause analysis to establish learning when cases arise. A number of cases are associated with the contamination of the blood bottles and whilst it is assuring that the patient is not in fact septic – the positive result nonetheless is recorded against the Tier 1 target. As a result – Education has been targeted to prevent these false positive results.

3.2.3. E Coli and other Gram Negative Organisms





E *Coli & other Gram negative organisms* Disappointingly, despite much work around urinary catheter management EColi rates are running at 84.56 per 100K population against a target of 67 per 100K population. Other Gram negatives such as Klebsiella are also above target. Work is progressing to improve the management of UTI's in Primary Care which will have a positive impact on EColi and Gran negative rates.

Gram negative bloodstream infections associated with UTI and urinary catheters will continue to be reviewed. All reviews will conclude the source of the infection and whether it was avoidable or unavoidable. The themes identified in relation to avoidable infections will be captured and fed back to the Infection Prevention and Control Committee so that action can be taken to address them. As Gram negative bloodstream infections are associated with UTI management & fluid intake a hydration campaign was instigated over the summer of 2019 and will be repeated in 2020.

Antibiotic Prescribing Performance – Primary Care

Objective	Measure		Latest data	Latest period	5% Reduction	Last Year Position	Trend - last 24 months
Medicines management							
Reduce risk of infection through prescription of appropriate antibiotics	Reduction in the number of 4C antimicrobial items per 1000 patients	Grand Total	2.9	Aug 2019	3.4	3.5	
		Blaenau Gwent East	3.7		4.3	4.6	
		Blaenau Gwent West	3.4		3.4	3.5	
		Caerphilly East	3.1		3.3	3.5	
		Caerphilly North	3.0		2.9	3.0	
		Caerphilly South	2.8		2.8	2.8	
		Monmouthshire North	4.1		5.0	5.3	
		Monmouthshire South	2.8		4.4	4.6	
		Newport East	2.0		2.5	2.6	
		Newport North	2.4		2.6	2.7	
		Newport West	2.1		2.5	2.6	
		Torfaen North	2.8		3.9	4.1	
		Torfaen South	3.0		3.6	3.7	

Prescribing: The latest reported position as at Aug 2019 was reported as 2.9 which is a variance of -18.01% compared to the same period the previous year which equates to aDecrease of -18.%.
For NCN benchmarking please see table at foot of this report.
In the prescribing section above the trends show an improved postion across all NCN's and this measure is also reported to all GP Practices by the prescribing team.

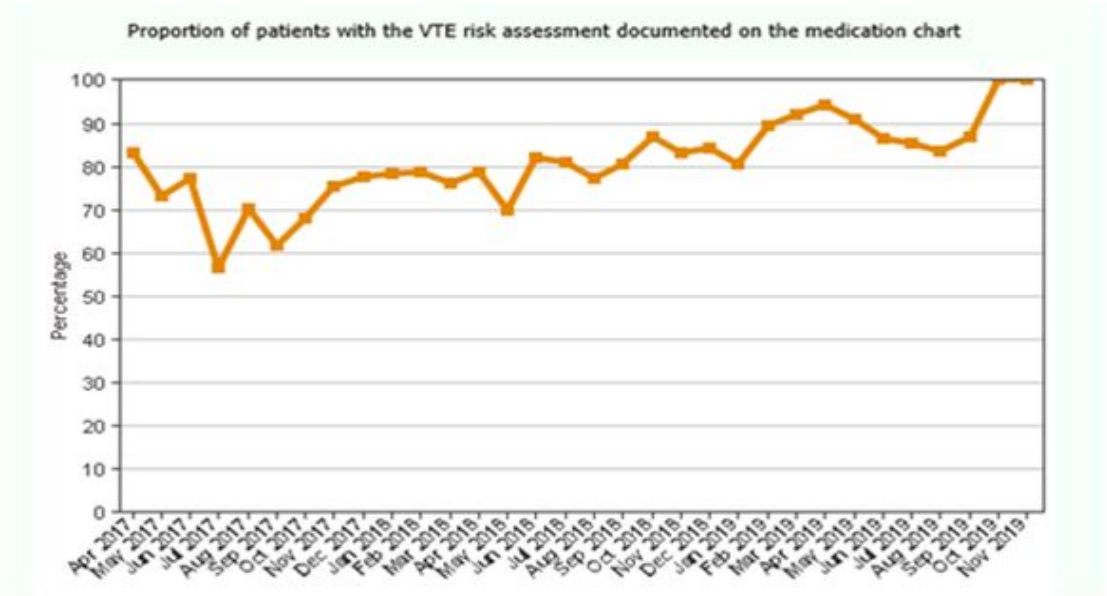
3.3 Hospital Acquired Thrombosis

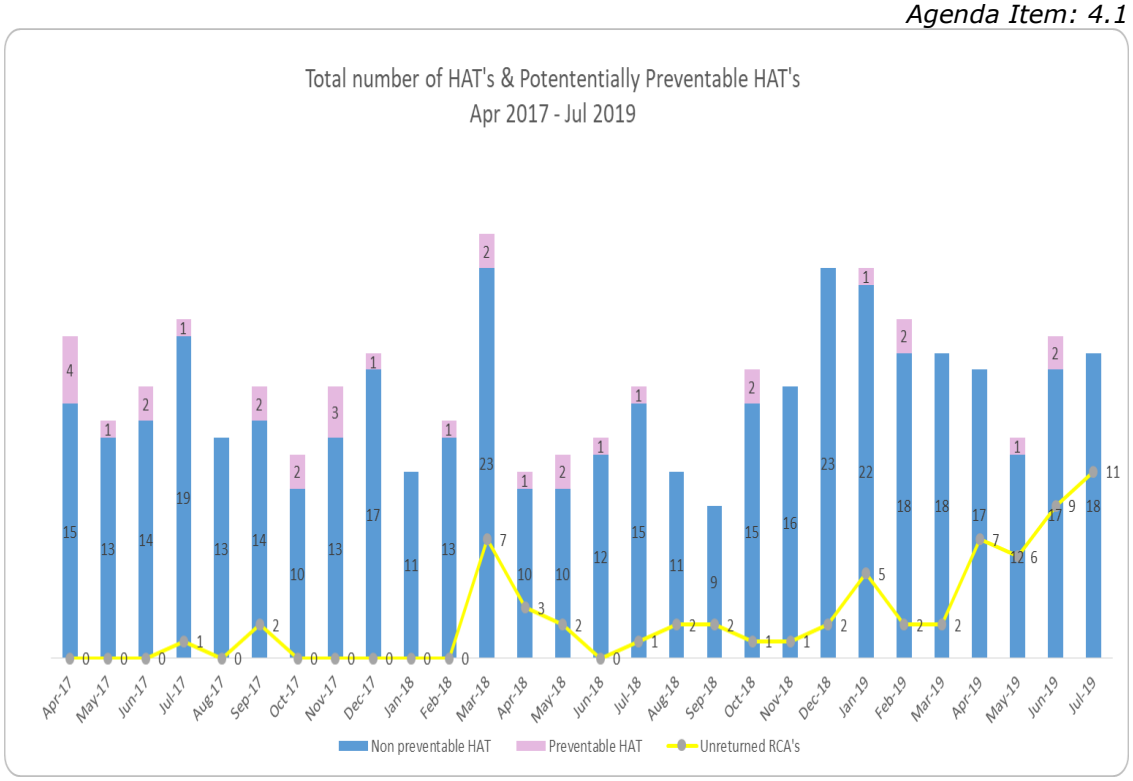
A Hospital Acquired Thrombosis (HAT) is defined as:

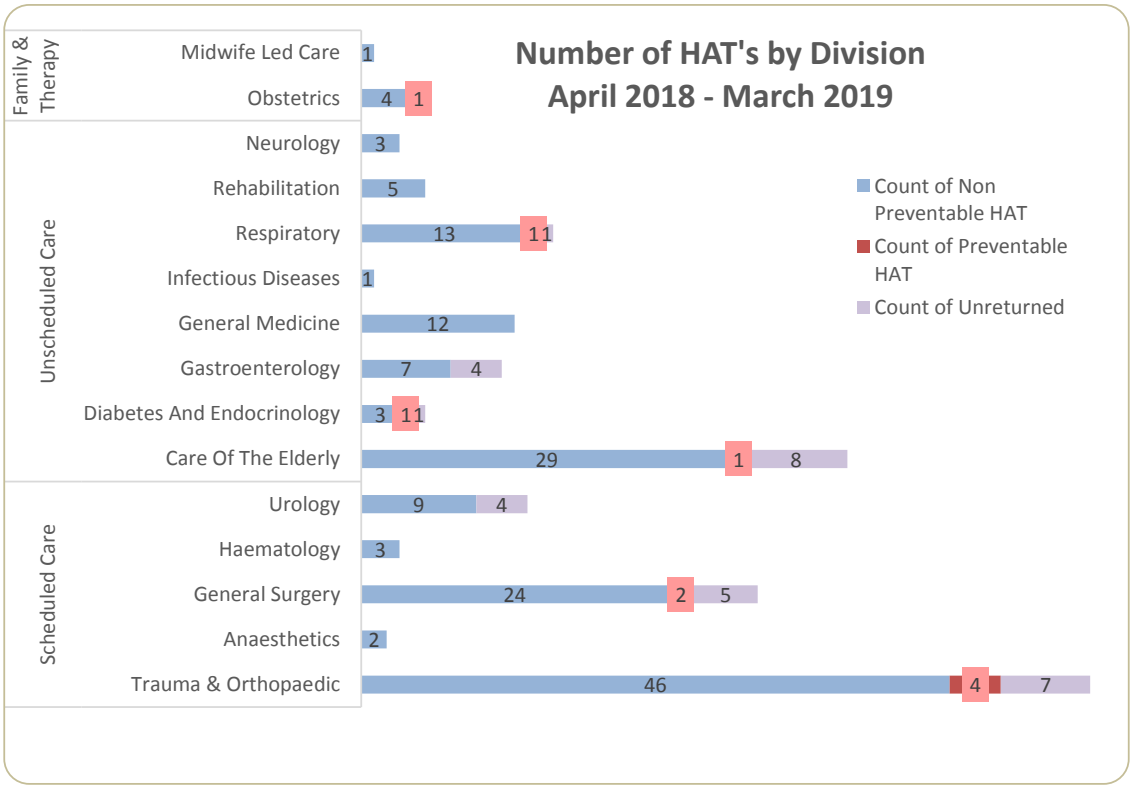
> ***"Any venous thromboembolism (VTE) arising during a hospital admission and up to 90 days post discharge".***

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 data for the Trauma and Orthopaedic HATS has been analysed by Consultant and by procedure. This data has been anonymised and sent

out to all T and O Consultants. Each Consultant was told which line represents their individual data, so that they can see how they compare to other Consultants. This exercise has now been undertaken for Care of the Elderly and then General Surgery.

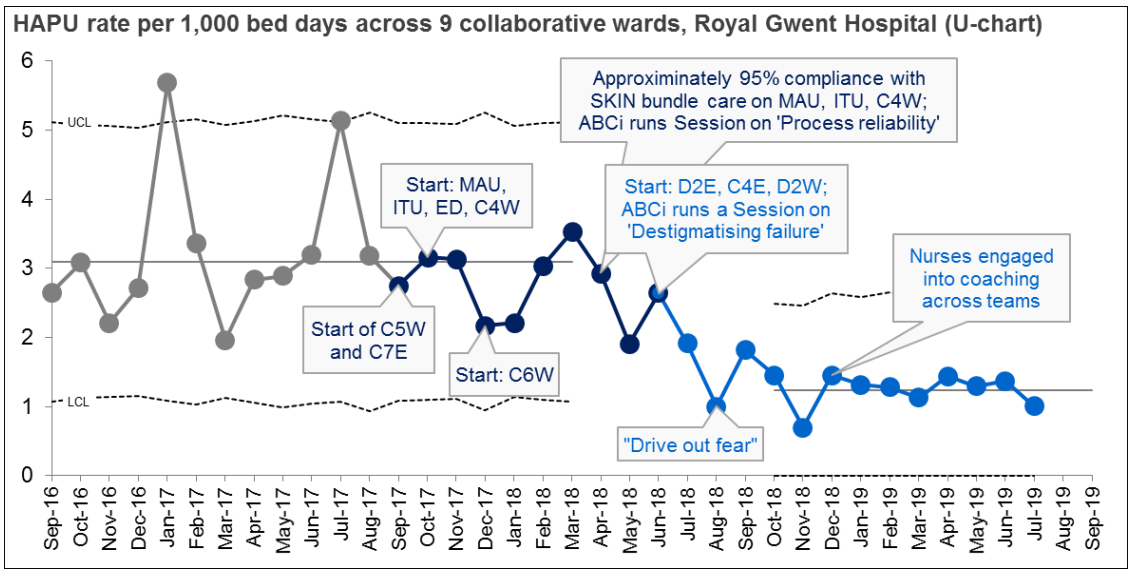
The data below shows the number of cases of HAT in ABUHB in 2018/19 and 2019/20 to date. The data is derived from combining RADIS data with discharge data.

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	12	14	16	12	9	19	17	25	26	22	20	**205**
Quarter 1 Total		**39**	**Quarter 2 Total**		**37**	**Quarter 3 Total**		**61**	**Quarter 4 Total**		**68**	
April 2019	**May 2019**	**June 2019**	**July 2019**	**Aug 2019**	**Sept 2019**	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb 2020**	**Mar 2020**	**Total**
16	13	19	18	12	10	19						
Quarter 1 Total		**48**	**Quarter 2 Total**		**40**	**Quarter 3 Total**			**Quarter 4 Total**			

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 all acute wards between April 2019 and September 2020

Royal Gwent PU Collaborative



Sustaining the reductions across the Royal Gwent site is to be be achieved through a nurse led patient safety group for Unscheduled and Scheduled Care.

In 2019/20 the Health Board is focussing on a reduction in pressure ulcers across the Community Division. This will be a challenging project and will be based on learning from the ABCi collaboriative above.

Pressure Ulcer Surveillance
Pressure Ulcer surveillance data is fed back to Divisional and Corporate nurses on a monthly basis. The method of collating this data is person dependent and complex. In light of this - work has commenced to align Datix reports with Qliksense which will provide accurate data electronically.

3.5 Stroke Care -

Quality Improvement Measures Summary — August 2019

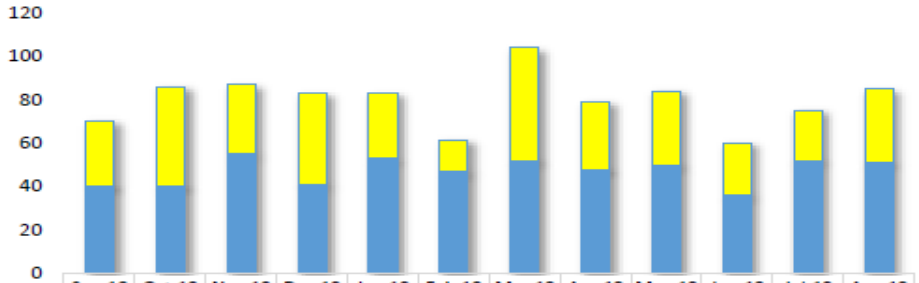
Discharge Standards Quality Improvement Measures		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		Royal Gwent	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Withybush	Glangwili	Prince Philip	Morriston	
Inpatient Rehab	*Compliance with patients receiving the required minutes for OT (3-month rolling)*	72.9%	55.3%	68.4%	92.8%	78.3%	85.4%	126.3%	70.6%	84.5%	36.2%	33.9%	92.0%	73.5%
	Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	76.0%	54.2%	63.7%	94.5%	95.9%	66.1%	25.3%	78.8%	71.9%	37.0%	41.7%	77.8%	69.6%
	Compliance with patients receiving the required minutes for SALT (3-month rolling)	50.8%	90.6%	63.9%	40.8%	54.0%	33.0%	30.0%	58.0%	39.8%	39.6%	35.8%	48.2%	48.7%
Discharge Standards	Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. palliative care pts)	100.0%	85.2%	100.0%	91.7%	89.7%	95.8%	62.5%	100.0%	100.0%	100.0%	100.0%	77.8%	91.6%
	Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	19.2%	2.3%	0.0%	0.0%	54.1%	40.7%	3.6%	15.0%	0.0%	0.0%	24.0%	0.0%	16.9%
	Percentage of patients treated by a stroke skilled Early Supported Discharge team	19.2%	2.3%	0.0%	0.0%	51.4%	32.4%	3.6%	5.0%	0.0%	0.0%	0.0%	0.0%	14.3%
	Percentage of patients discharged with a multidisciplinary community rehabilitation team	0.0%	0.0%	0.0%	0.0%	13.5%	12.0%	1.8%	10.0%	0.0%	0.0%	24.0%	0.0%	4.4%

Quality Improvement Measures Summary — August 2019

72 Hour Pathway Quality Improvement Measures		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		Royal Gwent	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Withybush	Glangwili	Prince Philip	Morriston	
Urgent Intervention	Percentage of stroke patients given thrombolysis (all stroke types)	11.8%	9.4%	25.0%	20.0%	17.0%	11.8%	6.3%	53.8%	28.0%	38.1%	9.1%	19.6%	17.8%
	Thrombolysed patients DTN <= 45 mins	10.0%	0.0%	22.2%	37.5%	11.1%	16.7%	100.0%	42.9%	14.3%	25.0%	100.0%	27.3%	24.7%
	Percentage of patients scanned within 1 hour of clock start	60.0%	62.5%	58.3%	60.0%	56.6%	66.7%	46.9%	100.0%	60.0%	81.0%	72.7%	48.2%	60.4%
	Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	40.0%	62.5%	58.3%	57.5%	56.3%	38.3%	21.9%	91.7%	12.5%	76.5%	88.9%	41.8%	48.3%
	Percentage of applicable patients who were given a swallow screen within 4 hours of clock start	65.9%	96.3%	75.0%	81.1%	69.4%	81.3%	93.3%	100.0%	75.0%	95.2%	100.0%	80.0%	79.3%
Urgent Assessment	Percentage of patients assessed by stroke specialist consultant physician within 24 hours of clock start	100.0%	78.1%	77.8%	72.5%	81.1%	72.5%	62.5%	84.6%	100.0%	90.5%	90.9%	94.6%	84.6%
	Assessed by one of OT, PT, SALT within 24 hours	76.5%	93.8%	97.2%	97.5%	96.2%	82.4%	90.6%	100.0%	92.0%	66.7%	72.7%	94.6%	88.4%
	Percentage of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start	100.0%	100.0%	100.0%	92.9%	85.7%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%

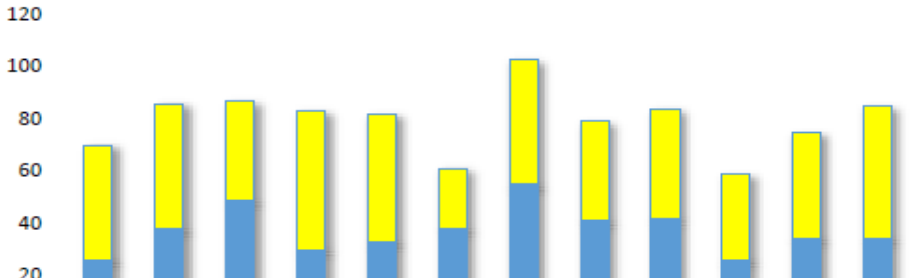
RGH Performance

CT Scan within 1 Hour Patient Volumes
Sep 18 to Aug 19



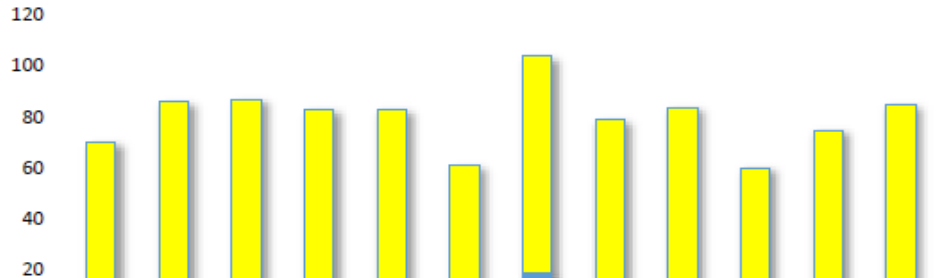
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Non Compliant	30	46	32	42	30	14	52	31	34	24	23	34
Compliant	40	40	55	41	53	47	52	48	50	36	52	51

Direct Admission to Stroke Unit Within 4 hrs Patient Volumes
Sep 18 to Aug 19



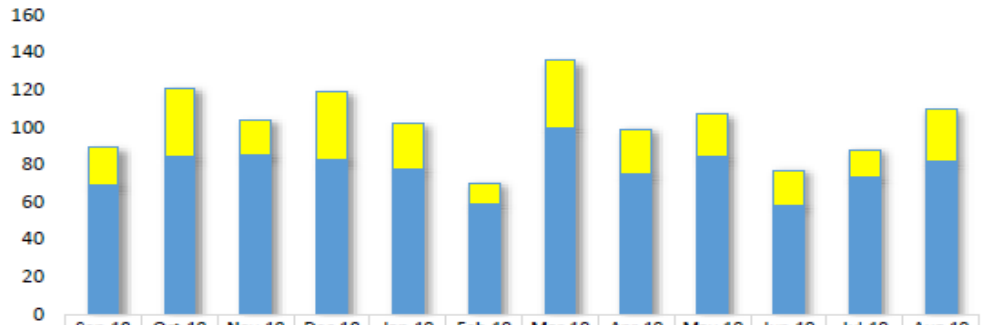
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Non Compliant	44	48	38	53	49	23	48	38	42	33	41	51
Compliant	26	38	49	30	33	38	55	41	42	26	34	34

Thrombolysed Patient Volumes
Sep 18 to Aug 19



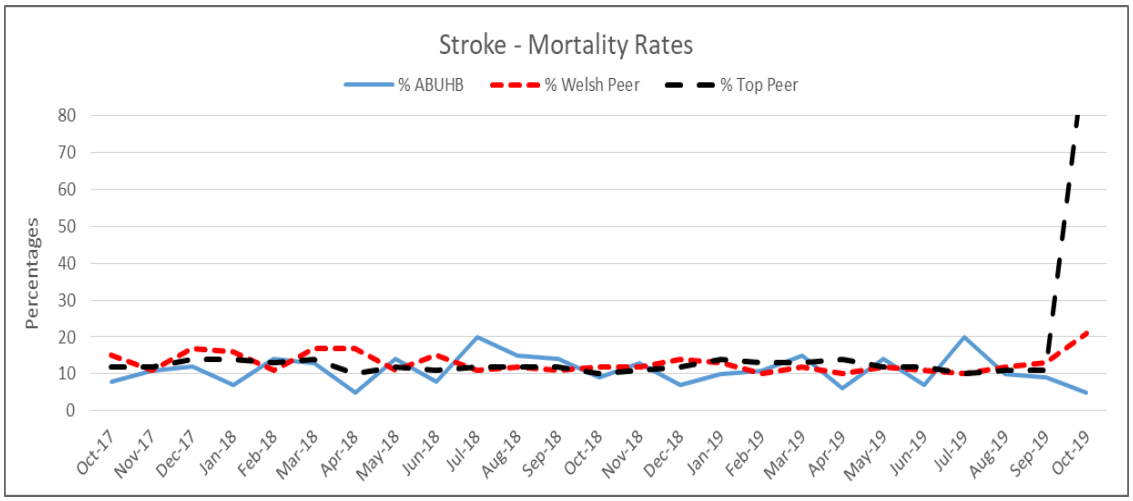
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Not Thrombolysed	65	80	77	76	74	50	85	68	75	55	66	75
Thrombolysed	5	6	10	7	9	11	19	11	9	5	9	10

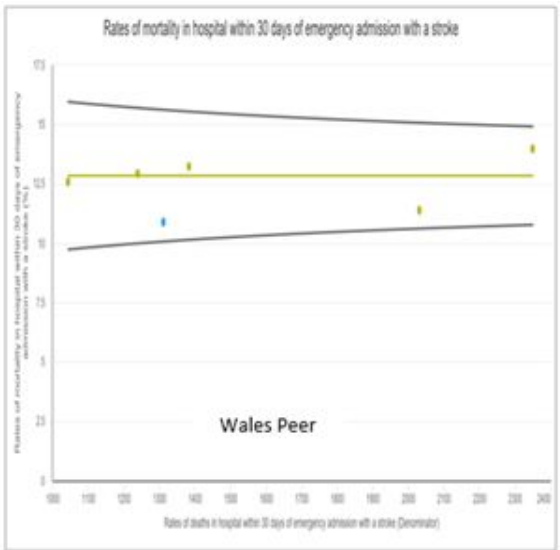
Swallow Screen within 4 hrs Patient Volumes
Sep 18 to Aug 19

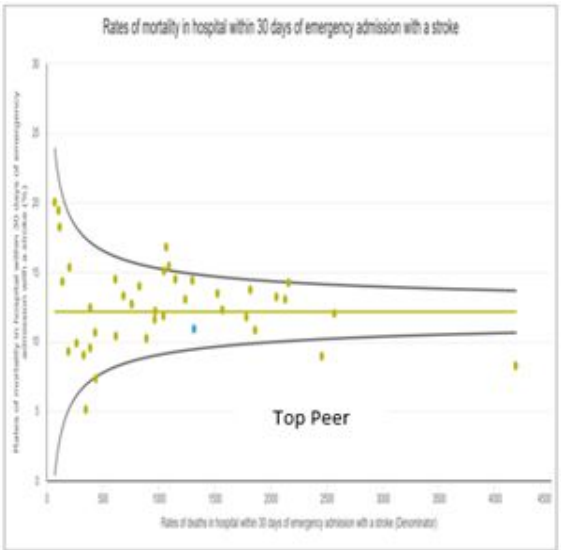


	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Non Compliant	20	37	19	36	24	11	36	24	23	19	15	28
Compliant	69	84	85	83	78	59	100	75	84	58	73	82

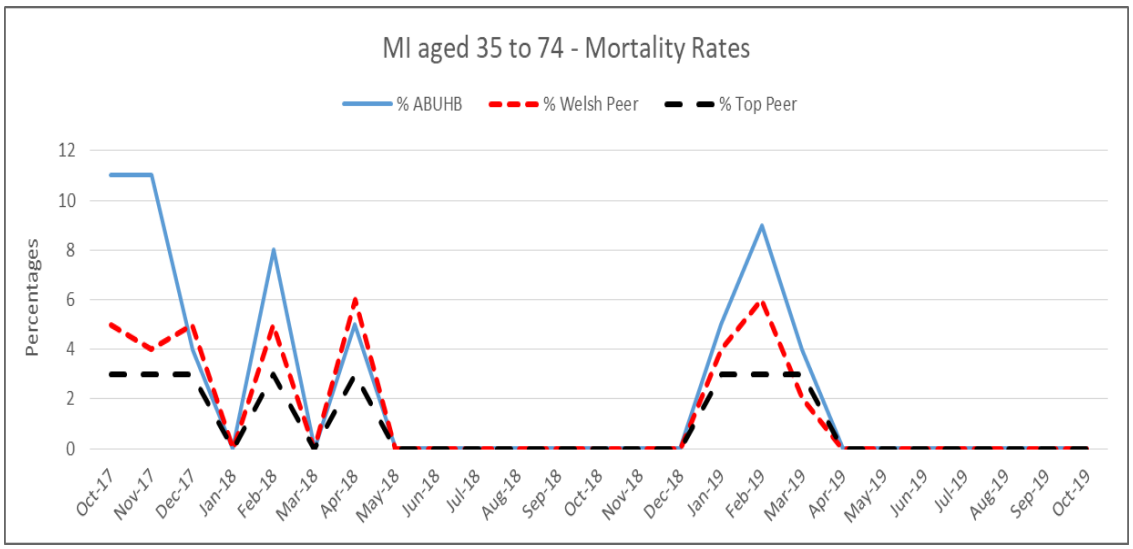
Stroke 30 day mortality against Top Peer

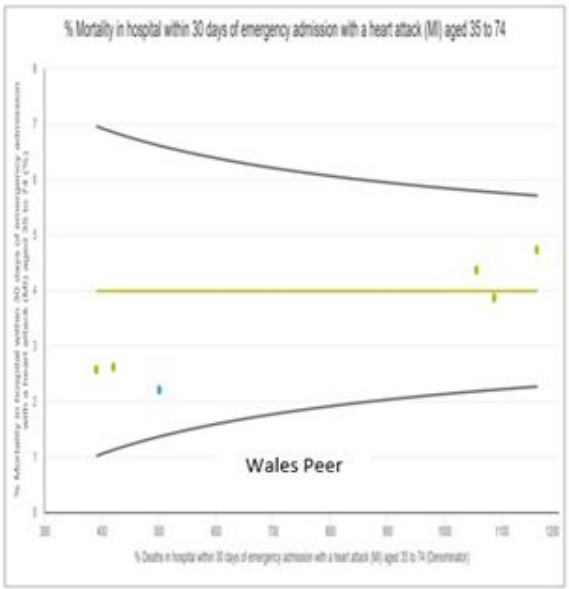


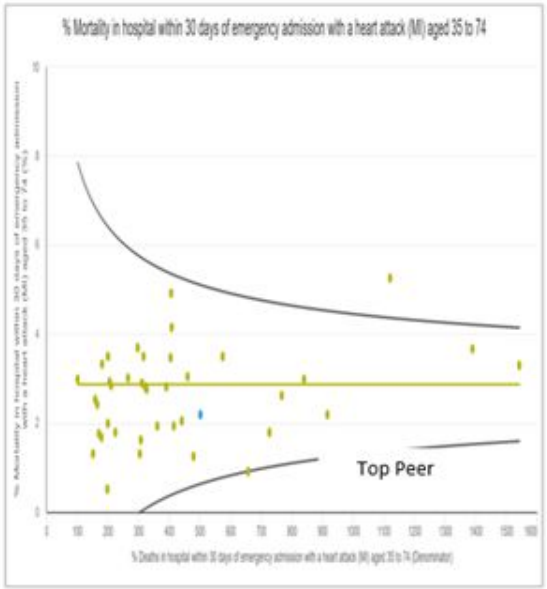




3.6 Myocardial Infarction 30 Day Mortality Ages 35-74 against Top Peer

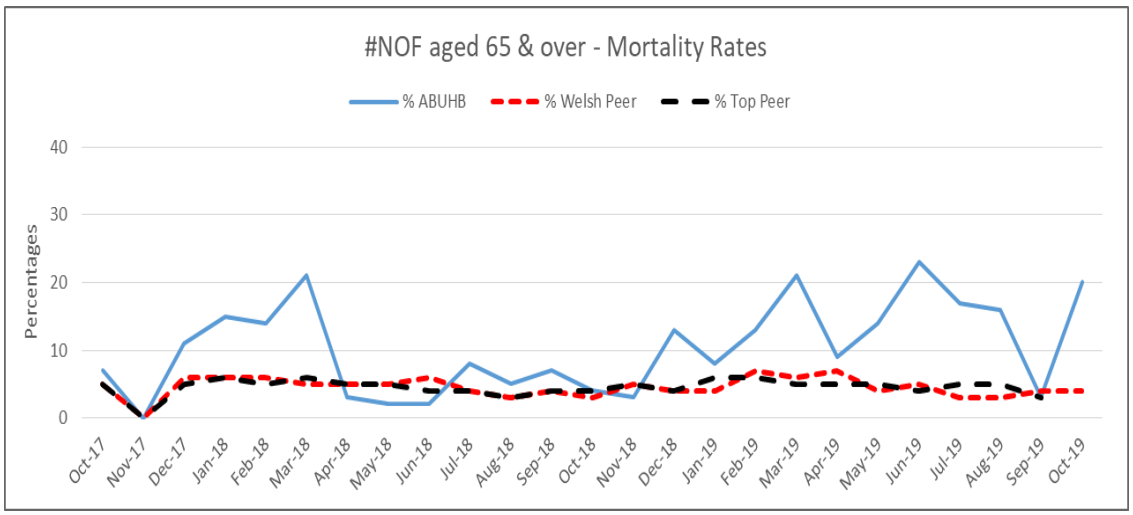


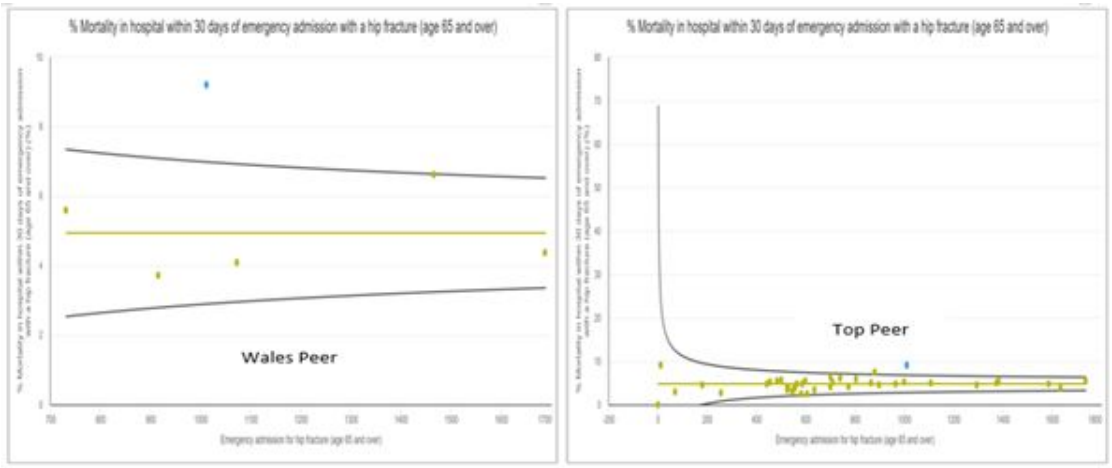




The CHKS data for this measure has been checked and is accurate.

3.7 Fractured Neck of Femur 30 Day Mortality against Top Peer





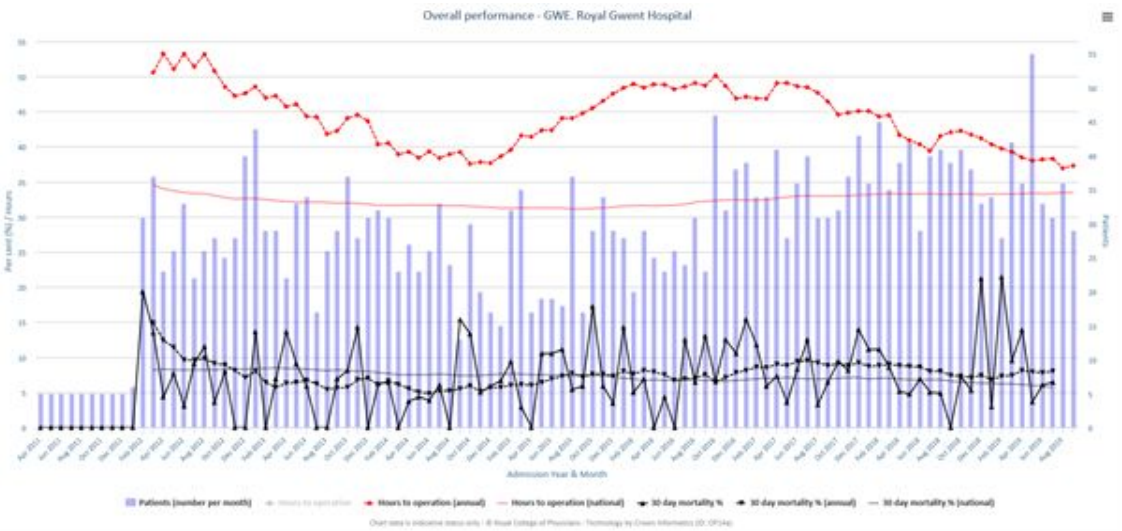
The above data is taken from CHKS, and uses the coded data. As deaths are coded as a priority, all the patients with a fractured neck of femur who sadly die will be in the numerator. But as our overall coding completeness has been 80-90%, it is probable that 20-10% of patients with a fractured neck of femur who are discharged, are not being coded, and therefore are missing from the denominator. The mortality rate for fractured neck of femur in CHKS is therefore likely to be higher than it should be.

However, the mortality rate for patients with a fractured neck of femur is also high compared to other organisations in the National Hip Fracture Data Base. This database records information on all patients with a fractured neck of femur treated in the Health Board. The cases are picked up directly by the treating clinicians and therefore does not rely on any coded data.

The Medical Director has liaised with the clinical lead for the Royal College of Physicians in London. He has scrutinised the data for both sites and feels confident that with KPIs in their current position, there will be a lag in improvement but that the mortality rate will improve. He is confident that by next year, ABUHB will be well within the pack for outcomes for patients with a fractured neck of femur. There are early signs of improvement.

To support further improvement in the fractured neck of femur outcomes, a fractured neck of femur pathway has been introduced at both RGH and NHH. Ring fenced beds are being introduced at RGH for patients who come in to A and E with a fractured neck of femur so they can get to the right ward quickly. There are pathway audits taking place and these will be presented to the Fractured Neck of Femur Clinical Governance Group. In addition to this, the Team at RGH are reviewing all deaths of patients with a fractured neck of femur each month, to see if there was anything that we should change in the care pathway. The results will be discussed at Fractured Neck of Femur Clinical Governance meeting. The clinicians are also working with Swansea University, looking at paramedics completing the nerve blocks for pain relief for these patients.

RGH National Hip Fracture Database Results



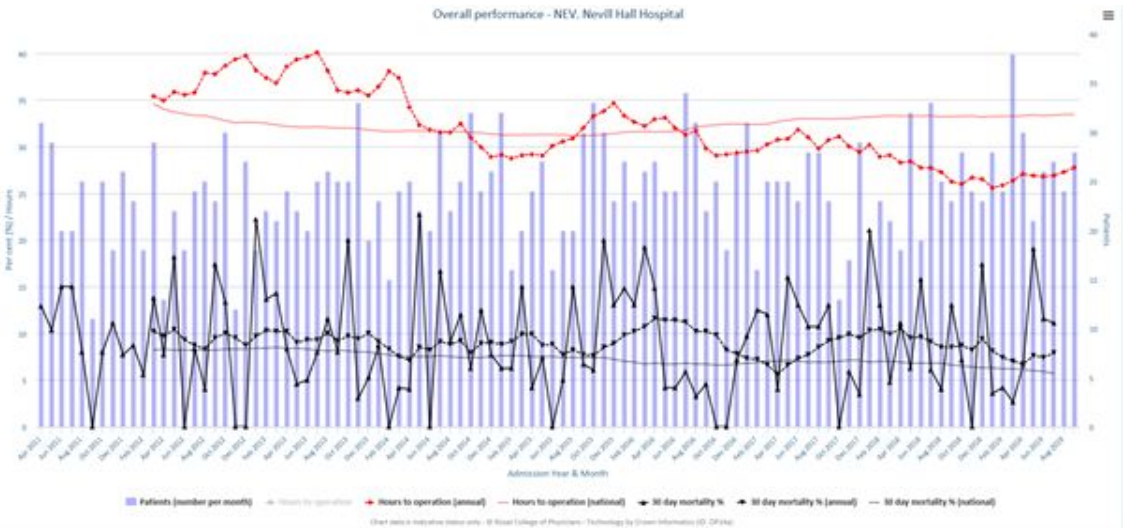
KPI overview: GWE. Royal Gwent Hospital

Annualised values based on 424 cases averaged over 12 months to the end of September 2019.

1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
96%	56%	78%
NHFD overall: 91%	NHFD overall: 69%	NHFD overall: 75%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
77%	75%	74%
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 315 cases averaged over 12 months to the end of September 2019.

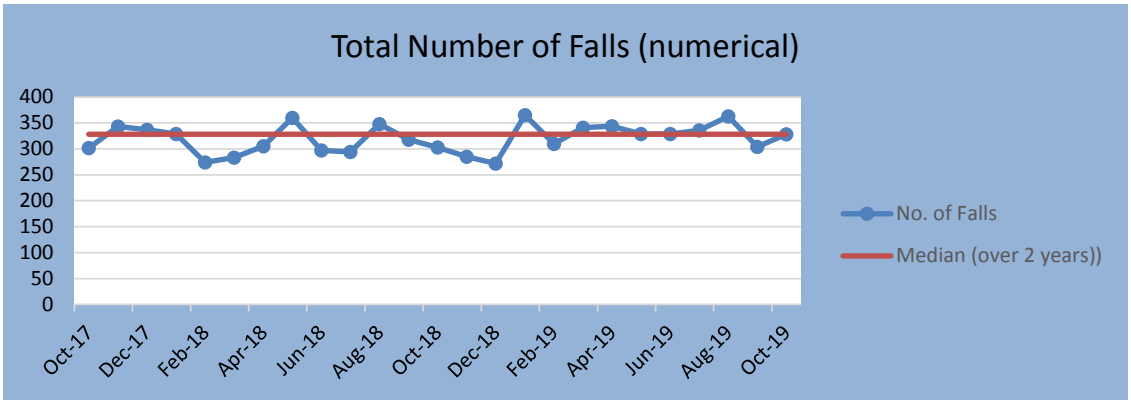
1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
96%	78%	77%
NHFD overall: 91%	NHFD overall: 69%	NHFD overall: 75%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
81%	76%	75%
NHFD overall: 81%	NHFD overall: 70%	NHFD overall: 71%

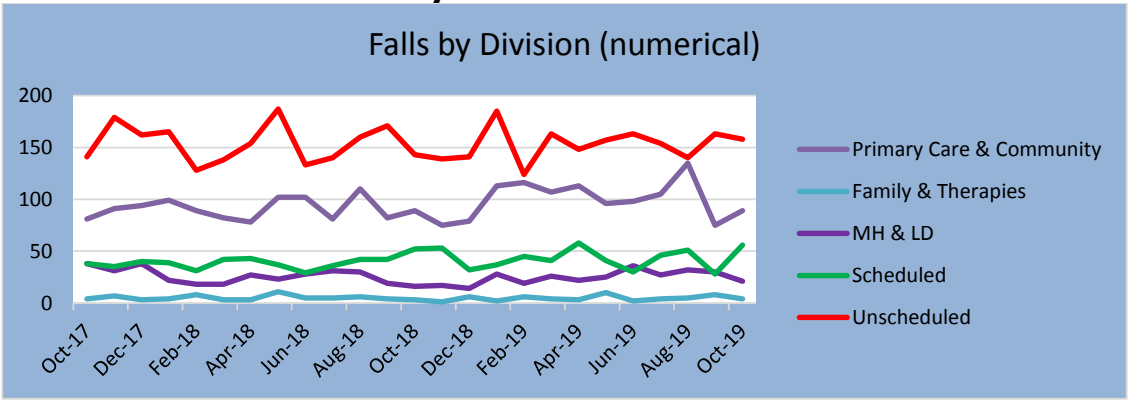
3.8. Preventing Falls

3.8.1. In-patient Falls Data

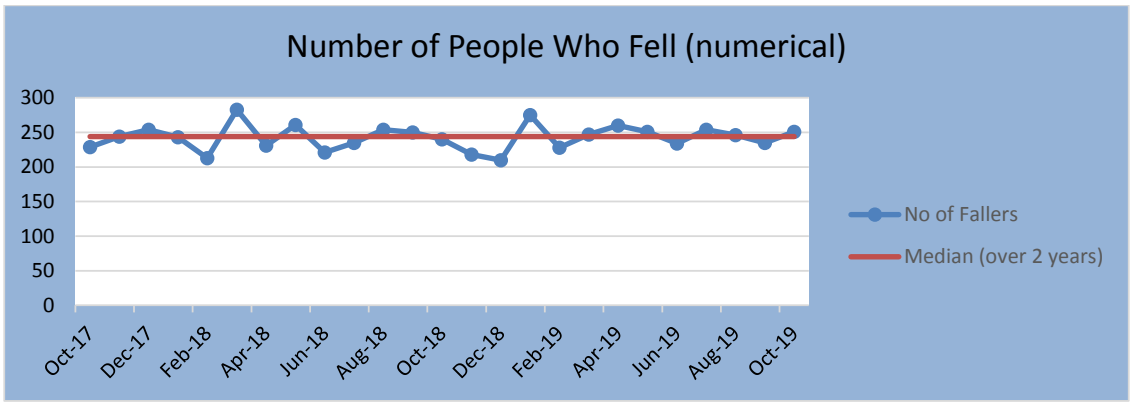
ABUHB Total Number of Falls



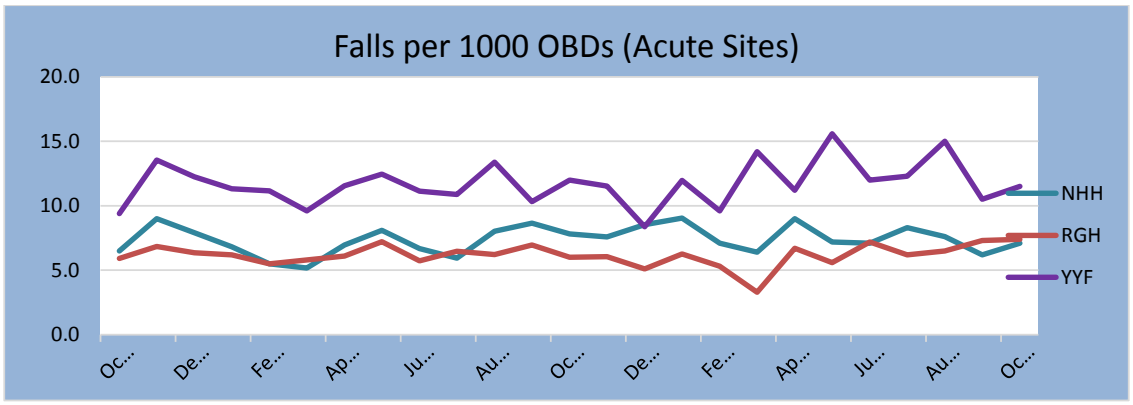
Number of Patient Falls by Division



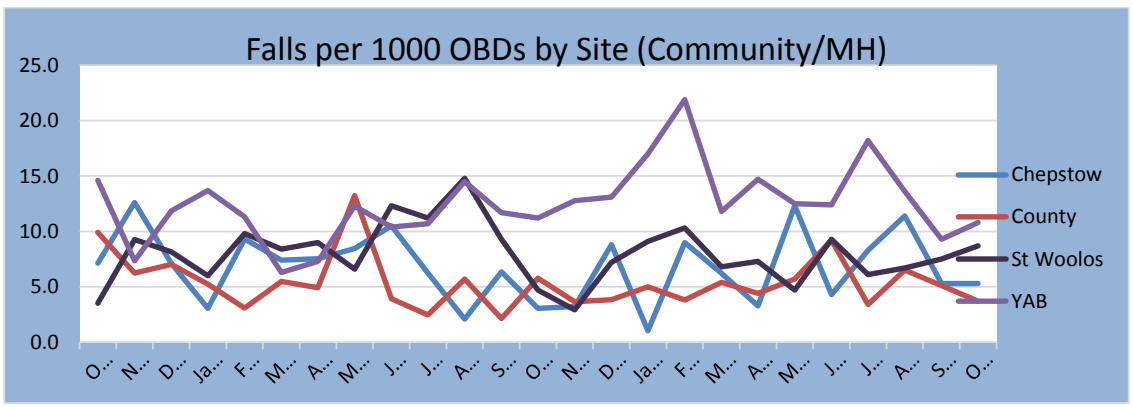
Number of people who fell



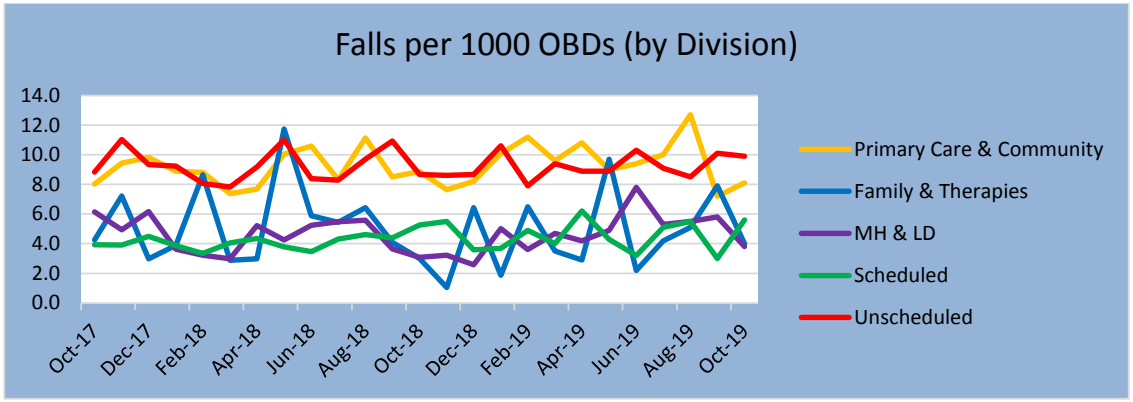
Number of Falls per 1000 Occupied Bed Days by Acute Site



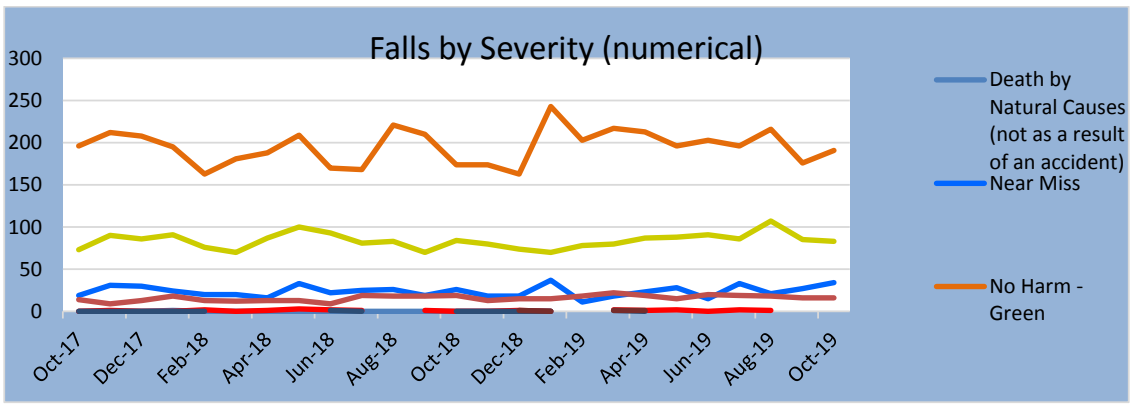
Number of Falls per 1000 Occupied Bed Days by Community/Mental Health Site



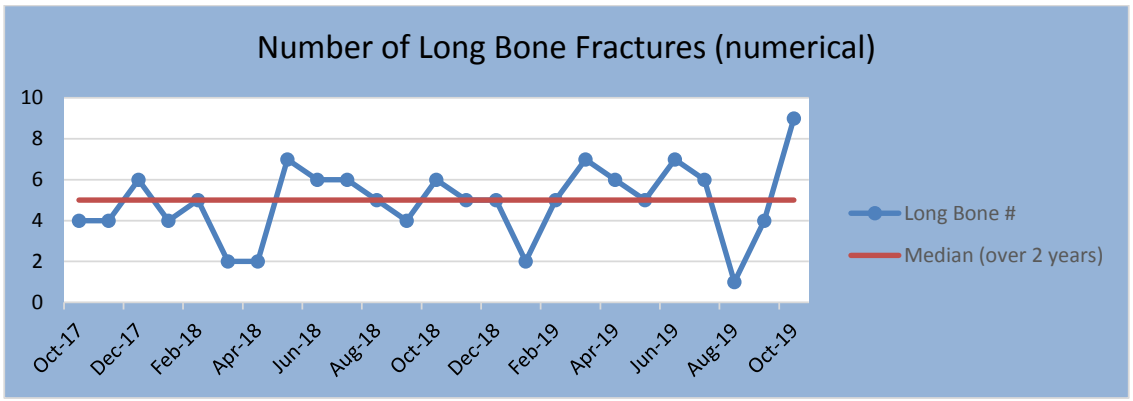
Number of Falls per 1000 Occupied Bed Days by Division

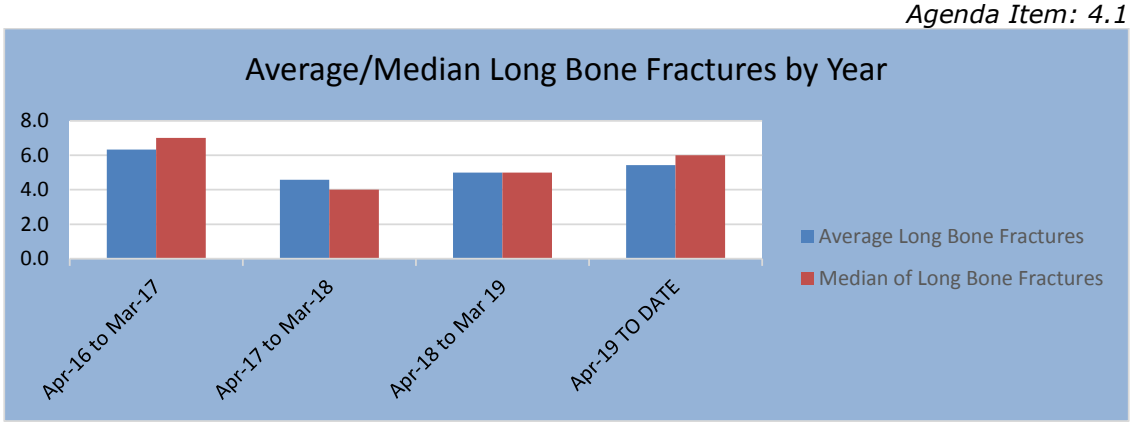


Number of Falls by Severity



Number of Long Bone Fractures





The overall number of falls reported on datix reduced over the last year. However, the number of falls increased sharply in January 2019, and has remained high when compared to last year. The number of long bone fractures is now increasing.

The Falls Scrutiny Panel is reviewing its Terms of Reference, following a recommendation in an Ombudsman report. This will ensure that the Investigation Form, which guides the investigation into a fall and fracture guides the investigation to ensure scrutiny of the assessment of falls risks and actions to mitigate the risk, and whether the risk assessment was reviewed when the patient's condition changes. The role of the Scrutiny Panel is the review the investigation to ensure that there has been appropriate learning and that themes are picked up and reported to the Falls and Bone Health Steering Group.

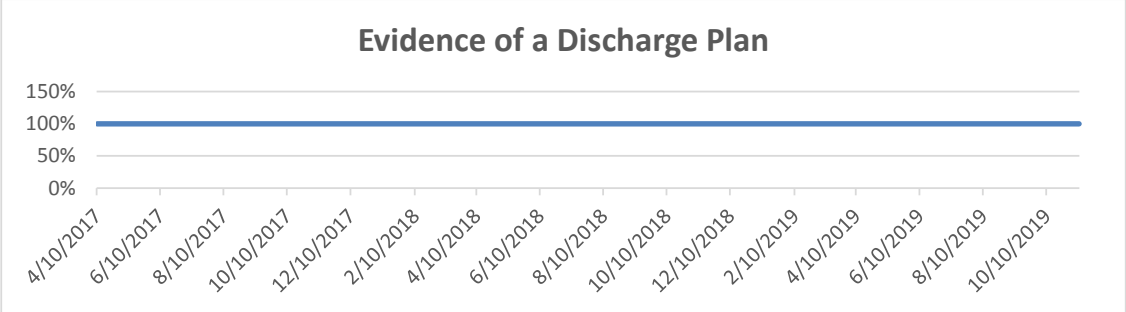
The Falls and Bone Health Steering Group is reviewing the Policy for Prevention and Management of Inpatient Falls to ensure it has captured all the changes that have been made to processes recently. In addition, the Group's action plan is being reshaped to ensure it covers both the hospital and the community, and captures the full extent of the work being undertaken. In the light of the learning over the past 18 months, the business case for a number of Falls Specialists is also being revisited.

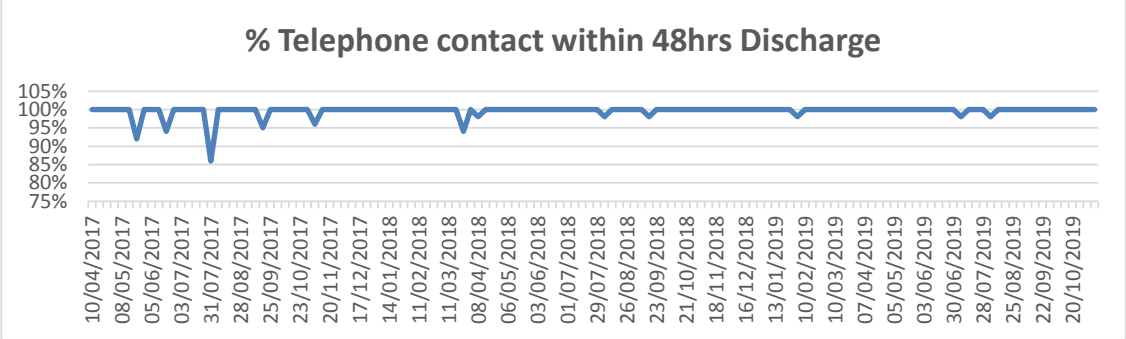
3.9. Mental Health – Compliance with Discharge Plans

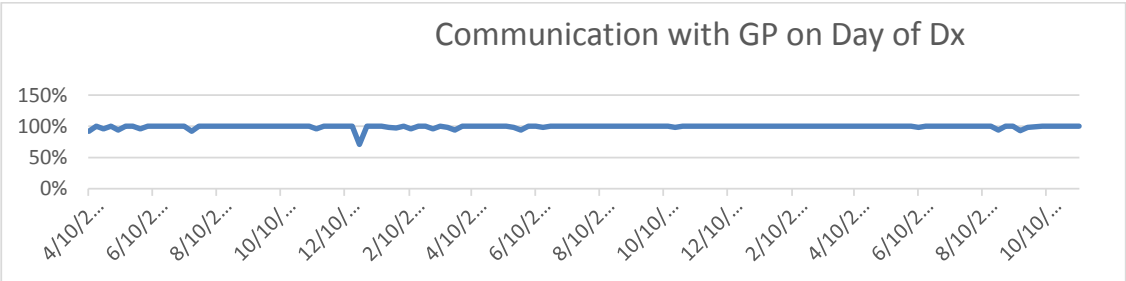
In December 2016 the Coroner issued a Regulation 28 report to the Health Board following the inquest for the death by suicide of a patient on discharge from one of the Health Board's acute mental health wards. These reports are issued when a Coroner believes that action should be taken to prevent future 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, in order to learn and make changes to processes if required. In the case of the communication with the GP on day of discharge, there have been 2 patients

missed due to the number of bank and agency staff and processes have been tightened and the absence of the ward clerk also meant some patients were delayed and there are processes in place now for this absence.

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 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	1434	Oct 2019	1,417	1,490	
		Blaenau Gwent East	135		135	142	
		Blaenau Gwent West	138		137	144	
		Caerphilly East	157		166	175	
		Caerphilly North	78		93	98	
		Caerphilly South	104		121	127	
		Monmouthshire North	155		130	137	
		Monmouthshire South	82		76	80	
		Newport East	102		108	114	
		Newport North	132		107	113	
		Newport West	133		114	120	
		Torfaen North	116		141	148	
		Torfaen South	102		87	92	
A&E Attendances: The latest reported position as at Oct 2019 was reported as 1434 which is a variance of -56 compared to the same period the previous year which equates to aDecrease of -3.8%. For NCN benchmarking please see table at foot of this report.							
ABUHB Assessment Unit Activity	GP Referrals to Assessment Units	Grand Total	3613	Oct 2019	3,379	3,557	
		Blaenau Gwent East	185		211	222	
		Blaenau Gwent West	253		232	244	
		Caerphilly East	453		386	406	
		Caerphilly North	280		285	300	
		Caerphilly South	274		246	259	
		Monmouthshire North	254		250	263	
		Monmouthshire South	246		232	244	
		Newport East	307		276	291	
		Newport North	362		290	305	
		Newport West	350		373	393	
		Torfaen North	333		308	324	
		Torfaen South	316		291	306	

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
ABUHB Emergency Admissions	Emergency Admissions to ABUHB - Patients Aged > 65 years	Grand Total	1842	Oct 2019	1,806	1,901	
		Blaenau Gwent East	144		139	146	
		Blaenau Gwent West	146		125	132	
		Caerphilly East	210		185	195	
		Caerphilly North	70		84	88	
		Caerphilly South	131		147	155	
		Monmouthshire North	166		171	180	
		Monmouthshire South	116		130	137	
		Newport East	156		157	165	
		Newport North	183		170	179	
		Newport West	174		171	180	
		Torfaen North	175		181	190	
		Torfaen South	171		146	154	

Assessment Units: The latest reported position as at Oct 2019 was reported as 3613 which is a variance of 36 compared to the same period the previous year which equates to an increase of 1.6%.

Admissions: The latest reported position as at Oct 2019 was reported as 1842 which is a variance of -59 compared to the same period the previous year which equates to aDecrease of -3.1%.
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
Grand Total	-4%	2%	-3%	-18.0%
Blaenau Gwent East	-5%	-17%	-1%	-19.8%
Blaenau Gwent West	-4%	4%	11%	-3.7%
Caerphilly East	-10%	12%	8%	-12.7%
Caerphilly North	-20%	-7%	-20%	-2.6%
Caerphilly South	-18%	6%	-15%	2.6%
Monmouthshire North	13%	-3%	-8%	-23.0%
Monmouthshire South	3%	1%	-15%	-38.7%
Newport East	-11%	5%	-5%	-23.5%
Newport North	17%	19%	2%	-12.7%
Newport West	11%	-11%	-3%	-19.0%
Torfaen North	-22%	3%	-8%	-32.3%
Torfaen South	11%	3%	11%	-19.7%

4. GLOSSARY OF TERMS

ABCi	**Aneurin Bevan Continuous Improvement**
ABUHB	**Aneurin Bevan University Health board**
A and E	**Accident and Emergency**
AKI	**Acute Kidney Injury**
C.Diff	**Clostridium difficile**
CRT	**Community Resource Team**
DATIX	**Incident Reporting Tool**
DVT	**Deep Vein Thrombosis**
EAU	**Emergency Admissions Unit**
E Coli	***Escherichia coli***
ED	**Emergency Department**
GP	**General Practitioner**
HAT	**Hospital Acquired Thrombosis**
HAPU	**Health Acquired Pressure Ulcer**
HCAI	**Healthcare Associated Infections**
HCSW	**Health Care Support Worker**
KPI	**Key Performance Indicator**
MAU	**Medical Admissions Unit**
MRSA	**Methicillin Resistant S. aureus**
MSSA	**Methicillin sensitive S. aureus**
NCN	**Neighbourhood Care Network**
NEWS	**NHS Early Warning Score**
OOHs	**Out of Hours**
PROMs	**Patient Reported Outcome Measure**
PREMs	**Patient Reported Experience Measure**
T and O	**Trauma and Orthopaedics**
UTI	**Urinary Tract Infection**
WAST	**Welsh Ambulance Service Trust**
WG	**Welsh Government**

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 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	See section 4.
Public Interest	Report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Thursday 5th December 2019 Agenda Item: 4.2

4.2

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT FOR QUALITY AND SAFETY

Executive Summary			
This paper provides an overview of the profile of the current risks at the end of October 2019, for which the Quality and Patient Safety Committee is responsible for monitoring. The risk profile of the Health Board is continuing to be assessed and monitored by the Executive Team. 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, Rhiannon Jones, Director of Nursing			
Report Author: Rachel Williams, Corporate Services Manager			
Report Received consideration and supported by :			
Executive Team	N/A	**Quality and Patient Safety Committee**	✓
Date of the Report: 26th November 2019			
Supplementary Papers Attached: Risk Dashboard			

Purpose of the Report
This report is provided for assurance purposes to highlight to the Quality and Patient Safety Committee the risks relating to quality and safety matters 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 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.

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

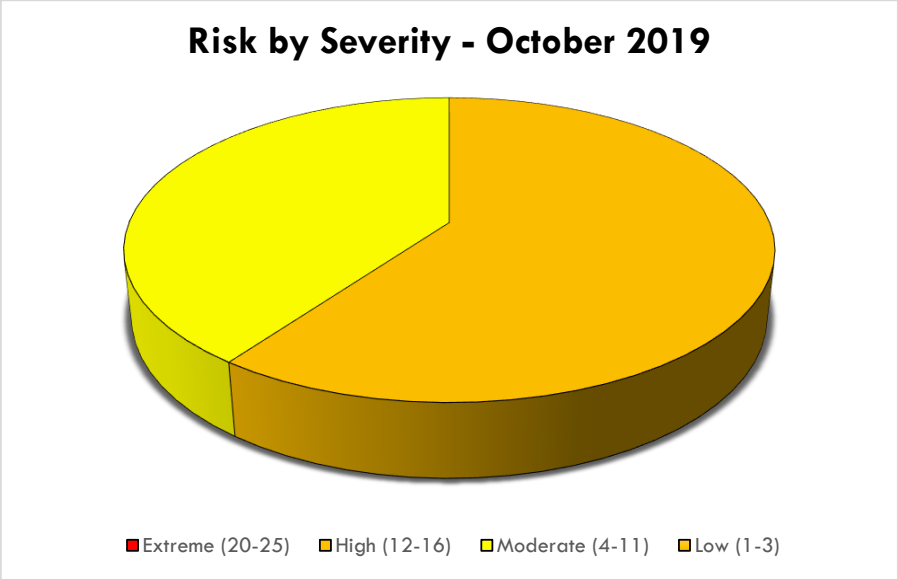
2. Corporate Risk Register and Dashboard Report

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.

There are currently 5 risks on the Quality and Patient Safety Risk Register. These are broken down by the following levels of risk severity:



Changes since the last report (September 2019)
In relation to the assessed risks since the last report, the initial risk rating indicates the risk score at the time of first assessment and the current risk rating shows the score at its last assessment in October 2019. The coloured arrows on each page indicate any movement since it was last reported to the Board in September 2019. The following changes have been made:

Risks with a Reduced Score:
None.

Risk with an Increased Score:
None.

New Risks
None.

Assessment and Conclusion
This paper provides an overview of risks as at the end of October 2019.

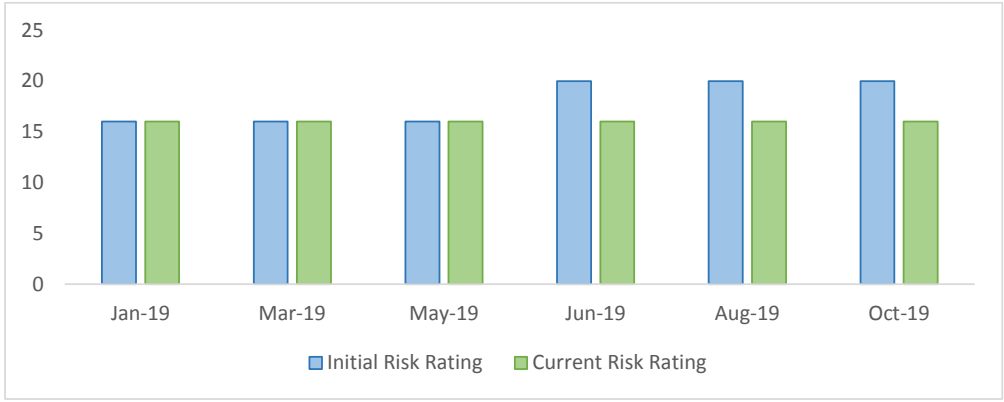
Recommendation
The Quality and Patient Safety Committee is asked to consider this report and note the identified risks as the current quality and patient safety risks for the Health Board as at October 2019.

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

Corporate Risk to a Page Report - as at end of October 2019

CRR015	**Director Lead:** Director of Nursing and Medical Director	**Date Opened:** July 2018
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** October 2019
	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.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Deteriorating patient experience/outcomes and quality of care.	



	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16

Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**	**Incremental Target**
	4	12 – April 2020

Movement since last presented to Board in September 2019

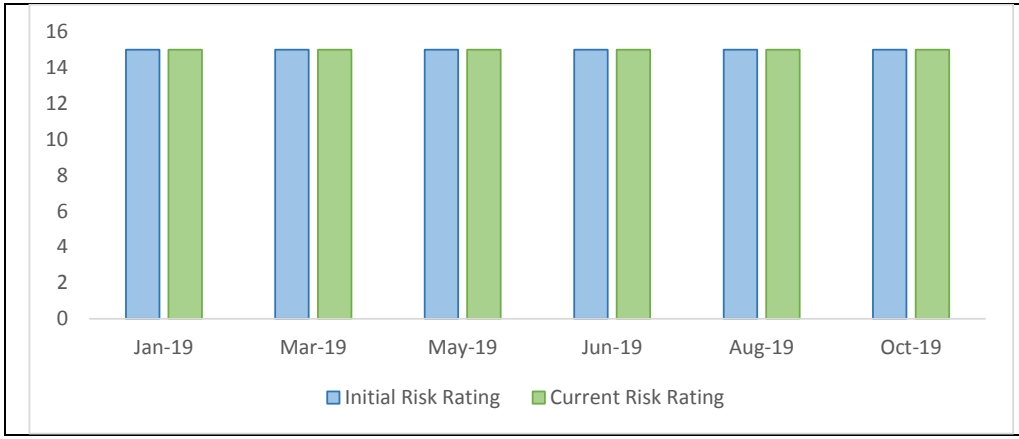
Risk remained unchanged

Controls in place	**Action taken to mitigate the risk**
• Monitoring of quality measures via Quality and Patient Safety Committee; • Patient experience is being captured and specific spot checks are being undertaken • Pressure Ulcer Collaborative and ED turnaround programme • Continued monitoring of HIW/CHC/Complaints/incidents to identify any areas of concern and lessons learnt reported to Executive Team • Workforce planning, planned use of temporary staffing and recruitment strategies in place with regular review • Weekly Clinical Executive Huddles take place and are reported to the Executive Team A Winter Review and learning has been undertaken and reported to the Board in May 2019 and Quality and Patient Safety Committee June 2019.	• Executive work to impact on flow and demand • Effort to exploration of new models of care • Daily reviews of staffing and escalation in the event of gaps • Weekly Executive Huddle to discuss Quality and Safety • Cliksense module to record Quality and Safety metrics which are reviewed and presented to Quality and Patient Safety Operational Group. • Improved reporting of patient experience.

Sources of Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the of Lessons Learnt to Quality and Patient Safety Operational Committee • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** Links to Priority – 3, 4, 5, 6, 7 and 8

Corporate Risk to a Page Report - as at end of October 2019

CRR023	**Director Lead:** Director of Therapies and Health Science	**Date Opened:** December 2017
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** October 2019
	Risk: Inadequate falls prevention on in-patient wards	**Target Risk Review Date:** Monthly review undertaken
	Impact: Failing to protect patients and risk of increased fractures and harm.	



	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	15

Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**	**Incremental Target**
	5	10 – December 2020

Movement since last presented to Board in September 2019

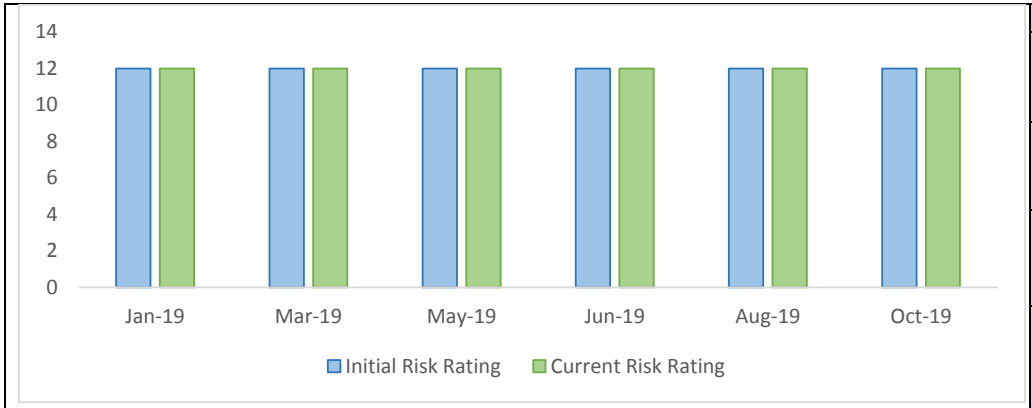
Risk remained unchanged ⇔

Controls in place	**Action taken to mitigate the risk**
• '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. Monthly Falls Scrutiny Panel review and learning from all inpatient falls resulting in a fracture. Numbers of inpatient falls is reducing.	• The Falls Steering Group is exploring resources for consistent delivery of falls prevention training for all inpatient areas. • Review inter-ward transfers at night ensuring patients with a high risk of falling or hold on falls are not moved.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Team Meetings • Executive led Falls & Bone Health Steering Group oversees improvement action and reports to QPSOG.	**Strategic Priorities in the IMTP** Links to Priority number 8.

Corporate Risk to a Page Report - as at end of October 2019

CRR007		
	Director Lead: Director of Therapies and Health Science	**Date Opened:** March 2017
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** October 2019
	Risk: Compliance rates of statutory and mandatory training of staff	**Target Risk Review Date:** Monthly review undertaken
	Impact: Risk of undermining the quality and safety of services.	



	Consequence	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	3	12

Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	Ultimate Target	Incremental Target
	4	8 – December 2020

Movement since last presented to Board in September 2019

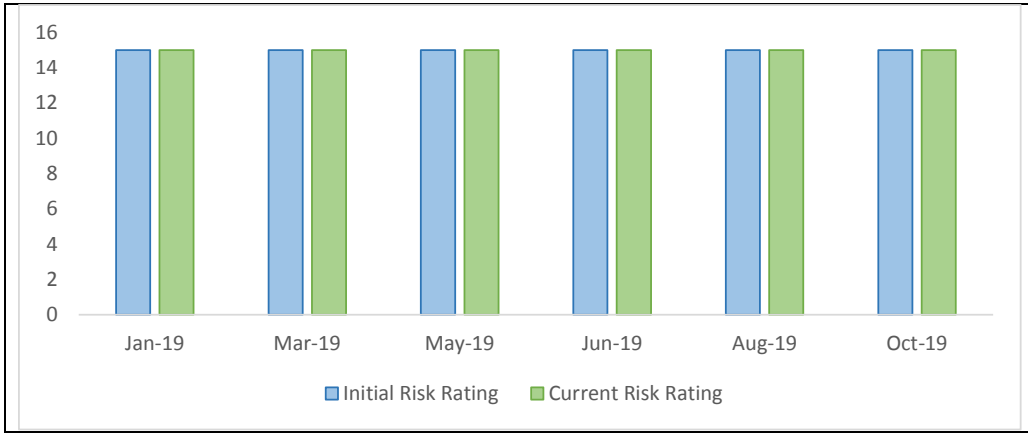
Risk remained unchanged ⟷

Controls in place	Action taken to mitigate the risk
• 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.	• Continued staff awareness raising and communication with regard to requirement for compliance and ensuring requirements are a key feature of Division and Corporate Department compliance and assurance reviews. • Executive Lead has established a compliance improvement task & finish group that will provide recommendations for improvement action to the Executive Team by end of 2019.

Assurances	Links to
• Performance Indicator Dashboard • WAO and Internal Audit Reports • Reports from Health and Safety Committee • PADR reports, • Inclusion in Induction Processes.	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of October 2019

CRR022	**Director Lead:** Director of Nursing	**Date Opened:** July 2018
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** October 2019
	Risk: Failure to reduce Healthcare Associated Infections	**Target Risk Review Date:** Monthly review undertaken
	Impact: Increase in Healthcare Associated Infections, in hospital and community, placing patients at risk, risk of losing bed capacity because of outbreaks, increasing costs, reducing quality of care, increased risk of mortality associated with HCAI and reputational risk.	



	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	10

	Ultimate Target	Incremental Target
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	5	5 – April 2020

Movement since last presented to Board in September 2019

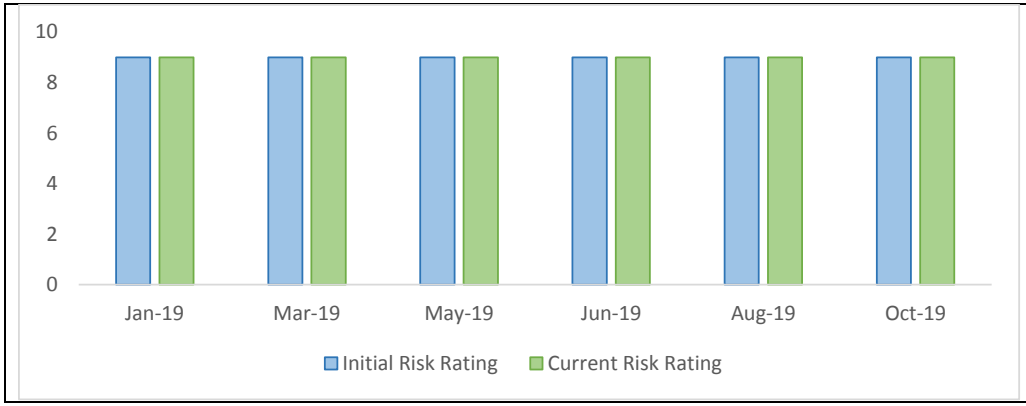
Risk remained unchanged ⇔

Controls in place	Action taken to mitigate the risk
• There is an annual programme of HPV cleaning for clinical areas at risk. • An active ward refurbishment programme is in place. • Root cause analysis undertaken for all HCAIs associated with Tier 1 target. • Deep Dives carried out for primary and community acquired infection have been undertaken and an action plan is in place. • Further investment in antimicrobial pharmacy agreed and have recently appointed. Investment in new HPV equipment agreed and procured.	• Bi-monthly Infection Prevention and Antimicrobial Resistance Committee (IPARC) Committee, illustrating good compliance to IPAC standards. • Metrics are target • Klebsiella risk – Catheter-associated Urinary Tract Infection (CAUTI) initiatives in-train

Assurances	Links to
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of Health and Care Standards • Performance against Tier targets and targets and monthly metrics	**Strategic Priorities in the IMTP** This risks links to a range of priorities, but particularly priority 8.

Corporate Risk to a Page Report - as at end of October 2019

CRR055	**Director Lead:** Director of Finance & Performance	**Date Opened:** January 2019
	Assuring Committee: Board, Finance & Performance Committee and Quality & Patient Safety Committee	**Date Last Reviewed:** October 2019
	Risk: Resources may not be used in the most effective way to optimise achievement of the Health Board's priorities.	**Target Risk Review Date:** Monthly review undertaken
	Impact: The Health Board would not achieve its identified priorities in the most effective way.	



	Consequence	Likelihood	Score
Initial Risk Rating	3	3	9
Current Risk Rating	3	3	9
Target Risk Score (Risk Appetite - Level Low Business Driver - Level Low)	**Ultimate Target**		**Incremental Target**
	3		9
Movement since last presented to Board in September 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• 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. • Budgets are delegated through the organisation based on the priorities set out in the IMTP. • 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.	• Continuing focus on IMTP delivery risks • Maximising the opportunities presented by value based healthcare approach.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Internal savings plans • IMTP Delivery Framework and Divisional Assurance Meetings • Performance and Finance Reports • Direct engagement through Business Partner model. • Value based healthcare reports	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Date: 5th December 2019 Agenda Item: 5.2

Aneurin Bevan University Health Board

ANNUAL REPORT FOR NATIONAL CLINICAL AUDIT 2019

5.2

Executive Summary

National Clinical Audits (NCAs) are clinical audits that assess the performance of clinical services for a particular clinical condition in Health Boards and Trusts against evidence based standards across the nations of the UK. The agreed NHS Wales programme of audits is the National Clinical Audit and Outcome Review Programme (NCAORP), which consists of about 40 NCAs.

In ABUHB, NCAs all have a Clinical Lead from the appropriate specialty, who is responsible for the systems and processes to fully participate in the audit, review the results and agree and implement the actions to improve the results. The Clinical Lead is supported by a member of the Medical Director's Support Team, who helps and monitors participation in the audit and helps to summarise and disseminate the results of the NCA. In addition, they work with the Clinical Lead to provide the required information to Welsh Government.

The Internal Audit of clinical audit, of which NCA is a major part, provided limited assurance. The action plan to address the recommendations of the Internal Audit is included as an appendix to report. However, good progress has been made in implementing the actions.

Key actions that have been taken in 2019 to progress NCA include:

- Setting up a clinical effectiveness group, with senior clinical representation from all the Divisions to monitor participation in the NCAs, review the results of all NCAs so there is an overview of the position across the health Board, and to provide the link back into the Divisions to ensure that participation in the NCAs and the results are discussed, and plans to address the issues raised are developed and implementation monitored
- Improving participation in some key audits, in particular, COPD, adult asthma and TARN.
- Recognising NCA as a Quality Improvement and an Assurance mechanism for clinical Services

The Quality and Patient Safety Committee is asked to receive the report for Assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	

Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor: Dr Paul Buss, Medical Director

Report Author: Kate Hooton, Assistant Director, Quality and Patient Safety and Jo Stimpson, National Clinical Audit Co-ordinator

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	**Quality and Patient Safety Operational Group Clinical Effectiveness Group**

Date of the Report: September 2019

Supplementary Papers Attached:
ABUHB National Clinical Audit (NCA) Annual Report 2019

5.2

Purpose of the Report

The purpose of the Annual Report for National Clinical Audit is to provide an overview of National Clinical Audit (NCA) in ABUHB, in terms of systems and processes for the NCAs on the National Clinical Audit and Outcome Review Programme (NCAORP), participation in these audits, the results of the audits and the changes being made so that the ABUHB results improve year on year.

Background and Context

National Clinical Audits (NCAs) are clinical audits that assess the performance of clinical services for a particular clinical condition in Health Boards and Trusts against evidence based standards across the nations of the UK. They therefore enable a clinical service to understand how it is preforming against recognised standards of care but also benchmark it against services for the same condition in other Health Boards or Trusts. Re-audit after a period of time that allows changes to be made to the service demonstrates whether the changes have been effective in improving the service. National Clinical Audits have traditionally been "snap shot" audits, which assess the care at a particular point in time. Increasingly, National Clinical Audits are moving away from snap shot audits to continuous data entry of all cases that meet certain criteria related to the clinical condition. This provides Health Boards with data over time and data that is closer to real time, but often requires more resource to facilitate the data entry.

The agreed NHS Wales programme of audits is the National Clinical Audit and Outcome Review Programme (NCAORP), which consists of about 40 NCAs and a number of Outcome Review Programmes, which will be the subject of a separate report. The NCAORP for Wales includes the majority of audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) which is managed by the Healthcare Quality Improvement Partnership (HQIP), but can also include a number of other national or multi-organisational audits recognised by the Welsh Advisory Committee for NCA as being essential.

In ABUHB, NCAs all have a Clinical Lead from the appropriate specialty, who is responsible for the systems and processes to fully participate in the audit, review the results and agree and implement the actions to improve the results. The Clinical Lead is supported by a member of the Medical Director's Support Team, who helps and monitors participation in the audit and helps to summarise and disseminate the results of the NCA.

In addition, they work with the Clinical Lead to provide the required information to Welsh Government.

The Internal Audit of clinical audit, of which NCA is a major part, provided limited assurance. The action plan to address the recommendations of the Internal Audit is included as an appendix to the Annual Report on NCA. Good progress has been made in implementing the actions. Key to this has been the setting up of a Clinical Effectiveness Group (CEG), with senior clinical representation from all the Divisions.

The CEG will ensure there is Health Board oversight of the results of all the NCAs, as the results are all reported to the Group, and the Group will determine which are escalated to the QPSC via the QPSOG. The CEG will also monitor participation in all the NCAs on the NCAORP, which is a priority for the Health Board, as high levels of case ascertainment for each audit are fundamental to the NCA process, or the results of the NCA will not be reliable.

The Medical Director's Support Team works closely with the Clinical Lead for each NCA to monitor and support participation in the NCAs. The Divisional representative on CEG will also ensure that participation in and the results of the NCA are discussed in the Division, and plans to address the issues raised are developed and implementation monitored The participation in NCAs is now reported to every QPSC. Good progress has been made in participation in the COPD NCA and the Adult Asthma NCA. In addition, staff have been recruited to the MDST to support data entry in to TARN, and data entry has now commenced. However, the pressures on clinical staff have meant that participation in some NCAs is fragile

As the CEG becomes established, and NCA results have a higher profile in the Divisions and Corporately, the Health Board will be able to move to a focus on outcomes and in particular, consider how the WG criteria can be used to judge the success of NCA in ABUHB.

Recommendation

The main priority for 2019-20 is to complete the actions related to the recommendations in the Internal Audit of Clinical Audit, which includes NCA. However, in addition to this, in relation to NCA, we will:

- Appoint to the posts and train the band 5 and band 6 administrative staff in the MDST to support data entry into TARN, and also the continuous data entry for a limited number of NCAs.
- Continue to support the full participation by ABUHB in the NCAs, with appropriate levels of case ascertainment, visibility and the results and agreed to changes to make improvements to the results.
- Improve the awareness of and engagement in of Divisions NCA through the representation on the CEG, in order to support the service change and improvement needed, if indicated by the results of a NCA.
- Further improve the timeliness of reporting of the assurance proforma to the WG.
- As the CEG becomes established, and NCA results have a higher profile, move to a focus on outcomes and in particular, consider how the WG criteria can be used to judge the success of NCA in ABUHB.

The Quality and Patient Safety Committee is asked to receive the report for Assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The Health Board is not participation or not participating fully in some NCAs, which put it at risk as participation in the Wales NCAORP is mandatory. The HB has been flagged as an outlier in the adjusted mortality at RGH for fractured neck of femur. This has been closely monitored, and the HB is now performing well on the KPIs for the National Hip fracture Database.
Financial Assessment, including Value for Money	The results of NCAs do demonstrate services where the HB is performing less well than other organisations, and therefore will highlight the need for additional resources. It is not possible to quantify this. However, looking across the results of all the NCAs should help the HB to prioritise where resources should be invested to gain the maximum improvement in health outcomes.
Quality, Safety and Patient Experience Assessment	NCAs promote quality planning, quality improvement and quality assurance.
Equality and Diversity Impact Assessment (including child impact assessment)	The NCAORP is set by WG.
Health and Care Standards	Participation in NCA is supported by the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	Participation in NCA is one of the quality issues included within the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	NCAs can ensure services are improved to benefit future generations. Most are focussed on health care services provided by ABUHB, not the wider service supported by our partner organisations.
Glossary of New Terms	National Clinical Audit and Outcome Review Programme – the Welsh programme of NCAs that Health Boards are mandated to participate in.
Public Interest	This report may be published.

ABUHB National Clinical Audit (NCA) Annual Report 2019

1. Background and Context

National Clinical Audits (NCAs) are clinical audits that assess the performance of clinical services for a particular clinical condition in Health Boards and Trusts against evidence based standards across the nations of the UK. They therefore enable a clinical service to understand how it is preforming against recognised standards of care but also benchmark it against services for the same condition in other Health Boards or Trusts. Re-audit after a period of time that allows changes to be made to the service demonstrates whether the changes have been effective in improving the service. National Clinical Audits have traditionally been "snap shot" audits, which assess the care at a particular point in time. Increasingly, National Clinical Audits are moving away from snap shot audits to continuous data entry of all cases that meet certain criteria related to the clinical condition. This provides Health Boards with data over time and data that is closer to real time, but often requires more resource to facilitate the data entry.

In the UK, the Health Quality Improvement Partnership (HQIP) is the organisation that determines the clinical services for which a national clinical audit is required and commissions the audits. HQIP aims to improve health outcomes by enabling those who commission, deliver and receive healthcare to measure and improve our healthcare services. HQIP commissions, manages, supports and promotes national programmes of quality improvement. This includes the National Clinical Audit Programmes, the Clinical Outcome Review Programmes and the National Joint Registry on behalf of NHS England and other healthcare departments and organisations. HQIP uses best management and procurement practice to ensure robust results and actionable recommendations. NHS Wales pays to be a part of the HQIP audits. In return, the NCAs commissioned by HQIP take account of the differences between the English and Welsh NHS and report data on Welsh Health Boards separately.

NHS Wales aims to be a learning organisation which regularly seeks to measure the quality of its services against consistently improving standards and, to compare itself with other healthcare systems across the UK, Europe and the World. This measurement should be used to set improvement priorities within NHS Wales. Participation in NCA is in line with the principles of prudent healthcare. It clearly demonstrates the

commitment to make the most effective use of all skills and resources and to reduce inappropriate variation, using evidence based practices consistently and transparently.

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh Health and Care Standards. The requirement to participate in and learn from audits is also a central component of the suite of Delivery Plans developed for NHS Wales.

To encourage greater focus on Welsh priorities, a National Clinical Audit and Outcome Review Advisory Committee (the Advisory Committee) exists to:

- Provide national leadership and professional endorsement for NHS Wales participation in a rolling annual programme of clinical audit and review.
- Ensure that audits, reviews and national registries are relevant to Wales and provide clearly identifiable Welsh data, where appropriate.
- Maximise the benefit by encouraging widespread learning.
- Promote action to improve the quality and safety of patient care through application of the 1000 Lives Plus standardised improvement methodology in areas prioritised by the audit.
- Recommend a programme of national clinical audits and clinical outcome reviews (the NCAORP) which all health boards and trusts who provide the relevant services must participate in as a minimum. This programme will be reviewed annually, and may be subject to additions during the course of the year if the Committee supports Welsh participation in any new National Audits being developed. The programme is published annually as a Welsh Health Circular (see WHC 2019/006).
- Liaise with HQIP in respect of NHS Wales' requirements.

The agreed NHS Wales programme of audits is the National Clinical Audit and Outcome Review Programme (NCAORP), which consists of about 40 NCAs and a number of Outcome Review Programmes, which will be the subject of a separate report. The NCAORP for Wales includes the majority of audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) which is managed by the Healthcare Quality Improvement Partnership (HQIP), but can also include a number of other national or multi-organisational audits recognised by the Advisory Committee as being essential.

From 2016-17, all Health Boards in Wales have had to complete and return an Assurance proforma to the Welsh Government on each NCA, when the NCA's Annual Report is published. This provides firstly an

overview of the health board's results for that audit and then an assurance that changes are planned as a result of the results of the audit.

The Health Board responsibilities for NCA in the NCAORP are:

- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Appoint a clinical lead to act as a champion and point of contact for every National Clinical Audit and Outcome Review which the health board is participating in. Health boards and trusts should also encourage and support clinical leads to take on the role of all-Wales representative on audit steering groups where required.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified
- Complete the assurance pro-forma developed and agreed by the National Clinical Audit & Outcome Review Advisory Committee which should be used for providing internal and external assurance of the actions being taken to address audit report findings. The assurance pro-forma should be completed within four weeks of audit report publications and should be regularly updated.
- Have clear lines of communication which ensures full board engagement in the consideration of audit and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.
- Facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

The following key criteria will be used in NHS Wales for judging success of the NCAORP:

- Year on year consideration of audit reports in comparison with other UK, European and international healthcare systems to determine how compliance with best practice and achievement of healthcare outcomes compares to national and international benchmarks.
- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.

- Less variation between local services and measurable year on year improvements in performance to achieve the highest standards. Organisations recognised as being above the audit "average" or within the top quartile for each audit and maintaining that level.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

2. National Clinical Audit in ABUHB

In ABUHB, National Clinical Audit (NCA) is one of the three main areas of clinical audit activity that is undertaken:

- National Clinical Audit,
- A Health Board wide programme of Clinical Audit,
- Divisional/Directorate audits

ABUHB aims to participate fully in all NCAs on the NCAORP for Wales. In addition it can decide to participate in National Clinical Audits that are not on the programme but are important for ABUHB. A clinical lead is appointed for each National Clinical Audit on the NCAORP, who leads the participation in the audit, the review of the results from the audit and the agreement of changes that need to be made in response to the results. A member of the Medical Director's Support Team is appointed to support the clinical lead in facilitating participation, summarising the local results of the NCA Annual Report, reporting the results within ABUHB and returning the Assurance Proforma to the Welsh Government.

3. Internal Audit of Clinical Audit, including NCA

In the last ABUHB NCA Annual Report (2017), the action plan included the recommendations that were contained in the Internal Audit of Clinical Audit undertaken in 2017, which had concluded that the level of assurance related to clinical audit was limited. Most of these recommendations have been completed (see action plan from the 2017 Annual Report on National Clinical Audit in Appendix 1). Although it acknowledged that clinical audit in ABUHB had moved forward, the Internal Audit re-audit of clinical audit in 2018 again concluded that there was limited assurance related to clinical audit systems and processes.

Good progress has been made with the implementation of the changes relating to the recommendations from the Internal Audit of Clinical Audit, with a number of them being achieved ahead of time plan.

The updated action plan for the Internal Audit of Clinical Audit is attached as Appendix 2. It includes actions related to all levels of clinical audit within ABUHB, not just NCA.

4. Progress in National Clinical Audit in ABUHB since 2017

The main areas where progress has been made in NCA in ABUHB since 2017 are:

- Participation in NCA
- Oversight and reporting of the results of NCA (within ABUHB and to Welsh Government)
- Recognition of NCA as an assurance and quality improvement mechanism and for clinical services

4.1 Participation in NCA

In ABUHB, the approach to NCA has been that the clinical staff for the relevant specialty enter the data for the NCA. In the last year, clinical staff in some specialties have increasingly found it difficult to sustain the data entry, as the number of clinical vacancies or sickness has meant that they have to focus on delivery of the clinical service, like Heart Failure. As more NCAs have moved to continuous data entry and the resource required to input data to each NCA has increased, and there has then been a decrease in the case ascertainment for some audits, like COPD.

Since 2017, the MDST has developed the links with the Lead Clinicians for the NCAs. This has enabled the Team to come alongside the clinical teams to support the participation in the NCAs. For the Heart Failure NCA, the Consultant Nurse strongly supported full participation, and when reviewing the Team, ensured that sessions were allowed for data entry across the whole service. The MDST have supported the clinicians with their access to the data base for the audit, and in identifying and making available the appropriate clinical notes. This is a continuous data entry audit, and the member of the MDST also accesses the data and provides information for the team to review at its clinical team meetings.

For COPD, this moved from a snap shot audit to a continuous data entry audit. The MDST and clinical team put in place a process for identifying the appropriate cases and entering the data. However, after a few months, the clinical team found they were unable to sustain the data entry using the original process. The MDST have therefore worked with the clinicians over the last year to put in place a more sustainable process, which has involved the MDST taking on some of the data entry.

In 2017, 3 NCAs were recorded as having no participation: TARN, Ophthalmology and Inflammatory Bowell Disease. Inflammatory Bowell Disease is no longer part of the NCAORP. The National Ophthalmology

Audit is dependent on the agreement of the electronic patient record for Ophthalmology across Wales, and this has still not been finalised.

The TARN has been a priority for the Health Board. The MDST has worked with the Emergency department to support clinicians in data entry using different approaches, but the pressures within the department have meant that data entry has been extremely limited. The need to participate in this audit has meant that the MDST have had to change approach, and move to data entry by an administrator, supported by a clinician. The Medical Director has therefore supported the MDST taking on additional staff in order to improve data entry to a limited number of NCAs, with the main priority being TARN. One additional Team member has been appointed and will take up post in October 2019. A second post is now being advertised.

ABUHB aims to participate in all the NCA on the NCAORP. The National Clinical Audits on the NCAORP that ABUHB participates in with appropriate levels of case ascertainment are:

National Joint Registry
National Emergency Laparotomy Programme
Case Mix Programme – Intensive Care
National Diabetes Inpatient Audit
National Pregnancy in Diabetes Audit
National Core Diabetes Audit
National Diabetes Transitions Audit
National Diabetes Paediatric Audit
Pulmonary Rehabilitation
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

In addition, ABUHB decided to participate in the National Cardiac Arrest Audit.

ABUHB has had no or limited data entry for the following NCAs, although for some the situation has now been addressed:

NCA	**Case Ascertainment**	**Narrative**	**Update**
Trauma Audit Research Network	Participation started	Registered for the audit and clinical staff trained for the audit but clinical staff unable to complete data entry within their working day.	Lead administrator for NCA now trained on TARN and entering some data. A member of staff is being appointed to enter data for this audit in September, and a further member by the end of the year.
National Ophthalmology Audit (Adult Cataract Surgery)	No Participation	Electronic Records systems for Ophthalmology required as this uploads the audit data automatically.	The procurement of an electronic medical record system for Wales is to be expedited, based on the Cardiff model. It is predicted to be ready in March 2020.
NACAP – National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: • COPD audit • Adult Asthma Audit • Children and Young People Asthma Audit	Full participation at NHH in COPD and Adult asthma. Participation at RGH and YYF in COPD initiated, with MDST support for data entry. No participation in Children and Young People Asthma Audit	The COPD NCA has recently moved to continuous data entry and the Asthma NCAs are new. The Respiratory Service has struggled to complete the data entry due to the high volume.	A process has been developed at NHH between the clinical staff and the MDST for COPD data entry. RGH Consultant is identifying primary COPD patients and MDST administrative staff are entering the RGH data. YYF clinical staff are now entering data for COPD and Asthma. Paediatricians are unable to enter data for the Asthma audit.

Heart Failure	Full Participation at NHH. Improving participation at RGH and YYF.	Process for data entry working well to date for 2019-20.	It is expected therefore that case ascertainment for ABUHB will achieve 70% in 2019-20.
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 started in 2019 and is being monitored. It is progressing well, but a review is needed to ensure that we are identifying all the required cases.
National Diabetes Foot care Audit	Limited participation	Process agreed with podiatry but case ascertainment is low	The MDST is linking with the NCA provider to understand the denominator for case ascertainment within the NCA report. The MDST is also linking with the clinical team to improve their data capture for the audit.

Details of these audits can be found in section 6.

4.2 Oversight and reporting of the results of NCA

Since 2017, the reporting of NCAs to the Welsh Government has improved, with most Part A returns submitted on time, and Part Bs returned, although some are outside the usual 3 month timescale.

Within ABUHB, the reporting of NCA results has improved as the results of the NCAs have been taken to the Quality and Patient Safety Operational Group, which has representation from all the Divisions. In addition, the results of one NCA are included in the Quality Performance Report to the Quality and Patient Safety Committee.

However, the oversight and reporting of NCA results will now improve further as the Clinical Effectiveness Group has been re-established. The Clinical Effectiveness and Standards Group is chaired by the Assistant Medical Director for Clinical Effectiveness and has Assistant Divisional Director representation from all Divisions. It will monitor the delivery of the ABUHB Clinical Audit for Improvement Programme, which consists of

the NCAORP audits and the Health Board wide clinical audit plan, and monitor the implementation of recommendations. It will therefore receive the results of the NCAs and determine which require escalation and reporting to QPSC.

At its first meeting in July 2019, the Group held a workshop on NCA in order to increase the members' knowledge about the NCAs and the role of the Group in relation to NCA, and to determine how it would undertake this. The members of the Group described the Divisional processes in relation to NCA and agreed that they would receive the headline data slides for all NCAs when the Annual Reports are published, as they are a helpful way of getting an overview of the results of a NCA. They will ask the Clinical Lead for a NCA to present the results if there are particular concerns. This will enable the Group to develop an overview of the results across all the NCAs, and an idea of where the focus for change and improvement should be. It can escalate this to the QPS Operational Group and decide which NCAs should be reported to QPSC. It will also highlight issues about participation in NCAs.

The information received from both the Welsh Government and HQIP on the publication timetable for NCAs on the NCAORP is now being circulated to Divisional Directors. This will enable them to programme the discussion of relevant NCAs in to their Quality and Patient Safety meetings. The NCAORP has also been discussed with the Clinical Directors at the Clinical Directors' Forum in order to increase awareness of the NCAs on the NCAORP.

There are 2 NCAs in primary care – COPD and diabetes. The data is collected electronically from the GP Practice Electronic record systems. GPs therefore only have to give their consent to the audit. Results are reported to the GP Practice at the Practice level, and to the Health Board at a Health Board and NCN level. The Health Board level report is discussed at the Primary and Community Division Quality and Patient Safety Meeting. NCN results are considered by the NCNs and changes to improve the results agreed.

4.3 Recognition of NCA as an Assurance and Quality Improvement Mechanism for Clinical Services

Clinical Audit was introduced as a quality improvement process, but is also used as a quality assurance mechanism. The Clinical Audit Strategy and Policy that have been developed and approved since 2017 emphasise the quality improvement aspect. This is important as since the Health Board took part in the Safer Patients Initiative 2 and the 100 Lives Programme, there has been a strong emphasis on the Model for Improvement as the improvement mechanism for the Health Board. The Health Board has also taken forward a strong work stream on value based healthcare.

The Quality Improvement Leaders Group, with representation from Value Based Healthcare, ABCi, Clinical Audit and Research and Innovation, is now working on a Quality Improvement Strategy, which will show how these 3 work streams work together using clinical information to improve healthcare services.

The Quality and Patient Safety Operational Group has also been considering the Quality Assurance Framework. Clinical Audit, including the National Clinical Audits, will be a part of this framework.

5. Next Steps for National Clinical Audit

The main priority for 2019-20 is to complete the actions related to the recommendations in the Internal Audit of Clinical Audit, which includes NCA. However, in addition to this, we will:

- Appoint to the posts and train the band 5 and band 6 administrative staff in the MDST to support data entry into TARN, and also the continuous data entry for a limited number of NCAs.
- Continue to support the full participation by ABUHB in the NCAs, with appropriate levels of case ascertainment, visibility and the results and agreed to changes to make improvements to the results.
- Improve the awareness of and engagement in of Divisions NCA through the representation on the CEG, in order to support the service change and improvement needed, if indicated by the results of a NCA.
- Further improve the timeliness of reporting of the assurance proforma to the WG.
- As the CEG becomes established, and NCA results have a higher profile, move to a focus on outcomes and in particular, consider how the WG criteria can be used to judge the success of NCA in ABUHB.

6. Position within ABUHB–Overview of Individual NCA

Audit Name	Frequency	Data (National/ Local /Both)	Additional Information	Page No.
National Joint Registry	Ongoing	Both	http://www.njrcentre.org.uk/njrcentre/	13
National Emergency Laparotomy Audit	Ongoing	Both	https://www.nela.org.uk/NELA_home	16
ICNARC	Ongoing	Both	https://onlinereports.icnarc.org/Reports/2017/12/annual-quality-report-201617-for-adult-critical-care	20
TARN	Ongoing	Both	https://www.tarn.ac.uk/	22
National Diabetes Audits: • Foot Care Audit • Inpatient Audit • Pregnancy in Diabetes • Core Diabetes Audit • Diabetes Transition Audit	Ongoing Ongoing	Both Both	https://digital.nhs.uk Footcare: https://digital.nhs.uk/data- and-information/clinical-audits-and-registries/national-diabetes- foot-care-audit NaDia: https://digital.nhs.uk/data- and-information/clinical-audits-and- Pregnancy: https://digital.nhs.uk/data- and-information/clinical-	23 27 30 38 44

			audits-and-registries/national-pregnancy-in-diabetes-audit Core: https://digital.nhs.uk/data- and-information/clinical-audits-and-registries/national-diabetes- audit Transition: https://digital.nhs.uk/data- and-information/clinical-audits-and-registries/national-diabetes- transition-audit	
COPD – Working Together	Ongoing	Both	https://www.rcplondon.ac.uk /projects/national-copd- audit-programme	47
COPD – Time to Integrate	Ongoing	Both	https://www.rcplondon.ac.uk /projects/national-asthma- and-copd-audit-programme- nacap-secondary-care- workstream-copd	53
Adult Asthma			https://www.rcplondon.ac.uk /projects/national-asthma- and-copd-audit-programme- nacap-secondary-care- workstream-adult-asthma	56

Children & Young People Asthma			https://www.rcplondon.ac.uk /projects/national-asthma- and-copd-audit-programme- nacap-secondary-care-workstream-children-and-young	56
Pulmonary Rehabilitation			https://www.rcplondon.ac.uk /projects/national-asthma- and-copd-audit-programme- nacap-pulmonary- rehabilitation-workstream	57
Rheumatoid and Early Inflammatory Arthritis			https://www.rheumatology.o rg.uk/Practice- Quality/Audits/NEIA-Audit	59
SSNAP	Ongoing	Both	www.strokeaudit.org	62
National Hip Fracture Database	Ongoing		https://www.rcplondon.ac.uk /projects/falls-and-fragility- fracture-audit-programme- fffap-2014	65
National Audit of Inpatient Falls	Ongoing		https://www.rcplondon.ac.uk /projects/falls-and-fragility- fracture-audit-programme- fffap-2014	68
Fracture Liaison Service Database			https://www.rcplondon.ac.uk /projects/falls-and-fragility- fracture-audit-programme- fffap-2014	72
National Dementia Audit	2018/2019		www.nationalauditofdementia.org.uk	73
National Breast Cancer in Older People	2018/2019		https://www.nabcop.org.uk/	77

National Audit for Care at the End of Life	2018/2019		https://www.nhsbenchmarking.nhs.uk/news/national audit itforcareattheendoflife	81
National Heart Failure Audit			https://www.nicor.org.uk/national ional-cardiac-audit- programme/nicor-and-data- gov-uk/national-heart-failure-audit/	85
Cardiac Rhythm Management	2016/2017		https://www.nicor.org.uk/national ional-cardiac-audit-programme/cardiac-rhythm- management-arrhythmia- audit/	89
Myocardial Ischemia National Audit Project (MINAP)	2015/2016		https://www.nicor.org.uk/ad ult-percutaneous-coronary- interventions-angioplasty- audit/	96
National Cardiac Arrest	Ongoing		https://www.nicor.org.uk/national ional-cardiac-audit- programme/adult-cardiac- surgery-surgery-audit/	100
National Vascular registry	2015-2017		www.vsqip.org.uk	101
National Bowel Cancer Audit	201/2018		https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-bowel-cancer-audit	106
National Lung Cancer Audit	2017		https://www.rcplondon.ac.uk /projects/national-lung-cancer-audit	110

National Prostate Cancer audit	2016/2017		www.npca.org.uk	116
National Neonatal Audit Programme	2017		www.rcpch.ac.uk/nnap	119
National Clinical Audit of Psychosis			https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis	125
Epilepsy 12			https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/epilepsy12-audit	127

6.1 National Audits Acute

National Audit/Registry Title:	National Joint Registry (NJR)
Clinical Lead:	Robin Rice (NHH)
Date of last data capture (or ongoing):	Ongoing
Publication date of last National Audit Report:	Annual Report NHH – June 2019 RGH - SWH -

Case Ascertainment: NJR StatsOnline provide data in calendar year by individual operations, Hip, Knee, Ankle, Elbow and Shoulder, along with NJR Consent rate. The Compliance and Data Validation report is relating to data from April 2017 to March 2018.

Please give a brief overview of the National Audit scope and aims:

The purpose of the National Joint Registry for England, Wales, Northern Ireland and the Isle of Man is to collect high quality and relevant data about joint replacement surgery in order to provide an early warning of issues relating to patient safety. In a continuous drive to improve the quality of outcomes and ensure the quality and cost effectiveness of joint replacement surgery, the NJR will monitor and report on outcomes, and support and enable related research.

NJR Goals:

- Monitor in real time the outcomes achieved by brand of prosthesis, hospital and surgeon, and highlight where these fall below an expected performance in order to allow prompt investigation and to support follow-up action.
- Inform patients, clinicians, providers and commissioners of healthcare, regulators and implant suppliers of the outcomes achieved in joint replacement surgery.
- Evidence variations in outcome achieved across surgical practice in order to inform best practice.
- Enhance patient awareness of joint replacement outcomes to better inform patient choice and patients' quality of experience through engagement with
- Support evidence-based purchasing of joint replacement implants for healthcare providers to support quality and cost effectiveness.

- Support suppliers in the routine post-market surveillance of implants and provide information to clinicians, patients, hospital management and the regulatory authorities.

Please give a brief overview of main <u>Local</u> findings from the published National Audit Report.

NHH – 2017/2018 Compliance and data validation report

- **98% of eligible records were submitted - there appears to be excellent systems in place for the capture & submission of eligible NJR procedures. Credit should be given to all staff involved in the NJR process**
- **656** Matched records
- **21** Unmatched records (records in the provider extract with no corresponding NJR record)
    - **61.9% of the unmatched records had failed to be submitted to the NJR (13 records)**
    - **19.0%** were not NJR procedures
    - **4.8%** had been performed at another unit
    - **9.5%** had the operation date incorrectly recorded
    - **4.8%** were procedures not included in the audit
- Of those records which were not submitted to the NJR
    - **7.7%** were primary knee procedures
    - **38.5%** were primary hip procedures
    - **30.8%** were knee revision procedures
    - **15.4%** were hip revision procedures
    - **7.7%** were primary procedures with no joint specified
- **45** records on the NJR with no corresponding record in the provider extract
    - **9%** incorrect operation date
    - **91%** correct submission (41 records)
- **All missing NJR records have subsequently been submitted**

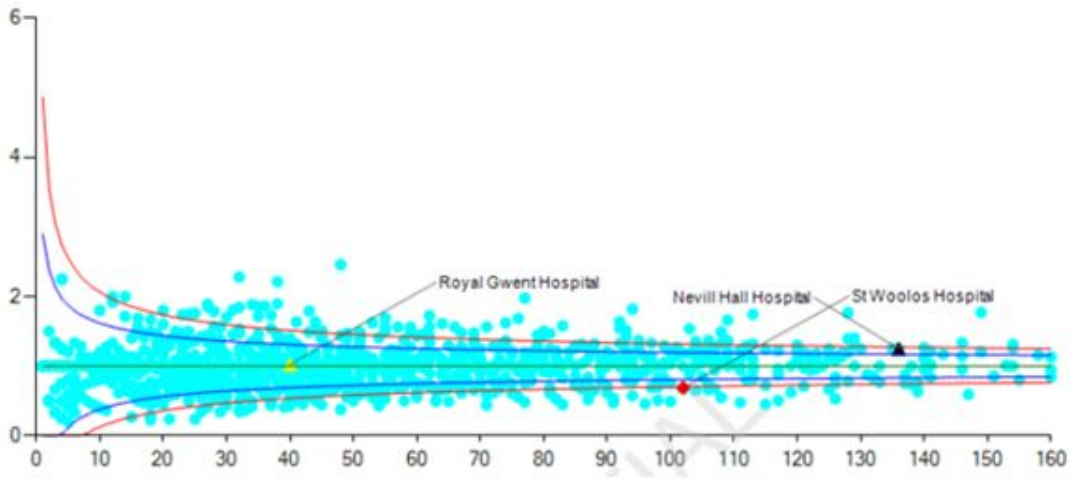
Was a national audit report provided which included ABUHB level data and conclusions?

Yes – Individual reports are published for NHH and RGH relating to Compliance and Data Validation. In addition, an annual clinical report is sent to the Medical Director every year. Individual Consultants who report to the NJR can access the report, as well as the detailed data on their own performance.

RGH		
Totals for this hospital	2018	Year to date: 2019
Total completed ops	512	126
Hip procedures	230	78
Knee procedures	261	41
Ankle procedures	0	0
Elbow procedures	1	3
Shoulder procedures	20	4
NJR consent rate	100%	100%

NHH		
Totals for this hospital	2018	Year to date: 2019
Total completed ops	898	147
Hip procedures	364	61
Knee procedures	513	84
Ankle procedures	1	0
Elbow procedures	0	0
Shoulder procedures	20	2
NJR consent rate	96%	96%

YYF		
Totals for this hospital	2018	Year to date: 2019
Total completed ops	3	3
Hip procedures	0	0
Knee procedures	0	0
Ankle procedures	3	3
Elbow procedures	0	0
Shoulder procedures	0	0
NJR consent rate	67%	100%



For the whole NJR ie all the data entered to date, the 2018 Annual report shows that NHH is a high volume hospital, but is between the 95-99.8 limits (worse than average), whilst RGH is average and SWH better than average.

The NHH position has been fully investigated. It is in part due to the hip revisions being high due to the surgeons who had used metal on metal hip joints. This practice ceased 7 years ago but for the whole NJR, still influences the figures.

The knee revision rate is high for the whole NJR at NHH. The investigation has led to a change in practice in terms of the type of knee joint used.

What are the key actions?	
Key Actions	**Progress against action**
1. Include NJR audit in the hospital annual audit plan.	The NJR and the results and the audit are regularly presented to the NH T & O audit meetings

National Audit/Registry Title:	National Emergency Laparotomy Audit
Clinical Lead: NHH –	T J Morgan-Jones (anaes)/RGH – Babu Muthuswamy (anaes)/Charlotte Tomas – Surgical
Date of last data capture:	Ongoing – 4th Patient Report of NELA Dec 2016 – Nov 2017
Publication date of last National Audit Report:	October 2018

Case Ascertainment:
RGH – 144.9%
NHH – 64.3%

Please give a brief overview of the National Audit scope and aims:
In this 4th report there are six key themes which cover the standards against which NELA measures delivery of care for patients undergoing emergency laparotomy. For each theme there are associated actions allocated to specific owners; all are underpinned by the principles of quality improvement being specific, using measurable data from NELA, and are intended to be achievable tasks that are relevant and realistic to teams and patients within the defined time frame. The six key NELA themes are:
1) improving outcomes and reducing complications
2) ensuring all patients receive an assessment of their risk of death
3) delivering care within agreed timeframes for all patients
4) enabling consultant input in the perioperative period for all high risk patients
5) effective multidisciplinary working
6) supporting quality improvement

Please give a brief overview of main National findings from the published National Audit Report.
Patient outcomes

- 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.
- 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.

Patient care

NELA allows hospitals to quality-assure their service by comparing care against published standards that cover the timeliness of care, delivery of care according to assessment of risk, and seniority of the clinician involved.
Improvement has been seen in the following areas:

- 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. We are calling for urgent action to address these areas:

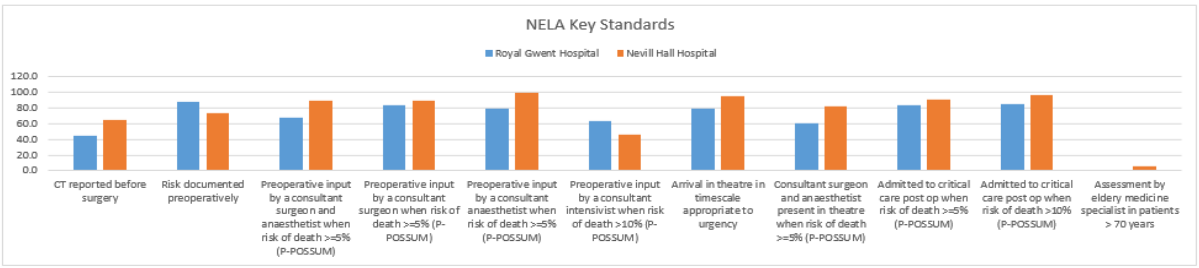
- only a quarter of patients suspected of sepsis on admission received antibiotics within the recommended 60 minutes
- the proportion of patients arriving in the operating theatre within appropriate timeframes has remained static at 82% (almost unchanged since Year 1). Of greater concern is that the 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.

Was a national audit report provided which included ABUHB level data and conclusions?

5.2

Yes – ABUHB data can be exported directly from the database and reports for each site are available on the NELA database. All patients are identified by the clinical team and entered onto the NELA database for both sites. Admins support ensures that all cases are 100% completed and locked. The HB is also working with 1000Lives as part of the Emergency Laparotomy Collaborative Wales (ELCW) to ensure improvements are made. There is a breakdown of data relating to the nine key standards currently subject to RAG-Rating. This data had been provided to the clinical team involved in ELWC.



Emergency Laparotomy Cymru (ELC) is using a **6 step Care Bundle** to improve standards of care for patients undergoing emergency laparotomy surgery

The care bundle consists of:

Use of National Early Warning Score (NEWS) or lactate to identify patients most at risk of deterioration and the delivery of prompt resuscitation for these patients.

Use of a sepsis screening tool to identify septic patients and treatment with Sepsis Six.

Definitive surgery within 6 hours of decision to operate for patients categorised as Level 1 and 2a in urgency.

Appropriate dynamic fluid resuscitation and optimisation using goal-directed fluid therapy.

Postoperative critical care (Level 2 or 3) for all patients.

Consultant delivered care throughout the perioperative journey.

What are the key actions?	
Action:	**Timescale**
1. Participation by NHH and RGH in the Emergency Laparotomy Collaborative for Wales to identify key areas for improvement	Ongoing
2. To work using improvement processes to improve against chosen key indicators (Sepsis and discussion of high risk cases by Consultant Surgeon, Anaesthetist and intensively pre – operatively)	

National Audit/Registry Title:	ICNARC (Intensive Care National Audit and Research Centre)
Clinical Lead:	Mike Martin (NHH) and Jack Parry Jones (RGH)
Date of last data capture:	Continuous
Publication date of last National Audit Report:	**June 2019 for 2018-19 data**

Case Ascertainment:
RGH – 1077 admissions
NHH – 508 admissions

Please give a brief overview of the National Audit scope and aims:
Since 2011, ICNARC has published the Annual Quality Report for the Case Mix Programme (CMP). The Annual Quality Report makes results from the CMP public to provide a valuable insight into the quality of NHS adult critical care both overall, and at the following levels:

- Critical Care Network*
- Trust or Health Board*
- Hospital
- Individual critical care unit

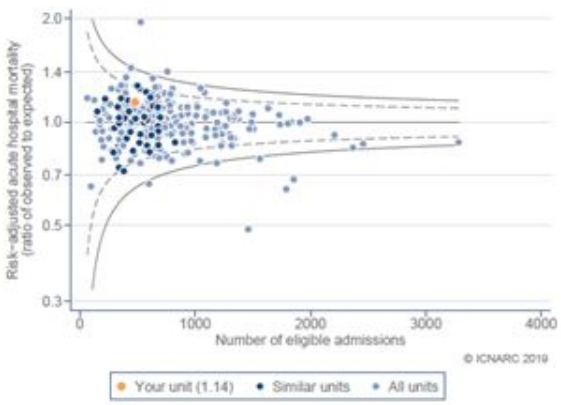
100% of all adult general critical care units in England, Wales and Northern Ireland now participate in the CMP. Following rigorous data validation, all participating units receive regular, quarterly comparative reports for local performance management and quality improvement.

Please give a brief overview of main <u>Local</u> findings from the published National Audit Report.
The Annual Quality Report 2018/2019 for Adult Critical Care Quality Indicator Dashboard demonstrates both RGH & NHH CCU's are mainly performing within 2 standard deviations of the comparator. Bed Days of Care post 8 hr delay and 24 hr delay are higher than some comparators.
Mortality: the (SMRs) for both units are within the normal range.
Spikes in mortality have been discussed with the statistician for ICNARC and are accepted to be part of normal variation, but have been fully reviewed. In addition discussion of the results has identified some significant issues with the data input which are now being addressed.

Was a national audit report provided which included ABUHB level data and conclusions?

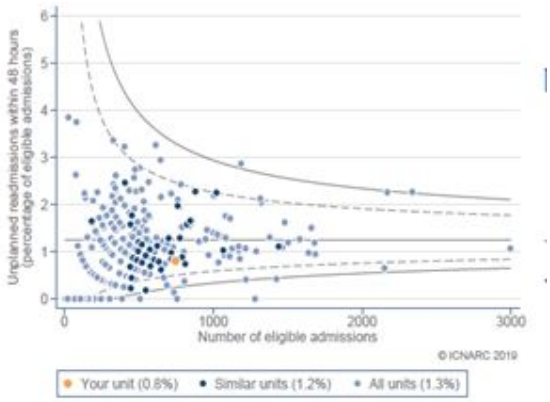
NHH:

Risk-adjusted acute hospital mortality



RGH:

Risk-adjusted acute hospital mortality



What are the key actions?	
Key Actions	**Timescale**
We are constantly reviewing the mortality / morbidity data in our bimonthly M&M meetings (led by a dedicated lead) to ensure there is clinical governance arrangements for the 'predicted high-risk deaths' and the 'unpredicted low-risk deaths	Ongoing

National Audit /Registry Title: Trauma Audit and Research Network

The Trauma Audit and Research Network is the research network that independently monitors trauma care in England and Wales and is committed to making a real difference to the delivery of care of those who are injured. One of the ways this is done is through promoting improvements in care through national comparative clinical audit.

Every year across England and Wales, 16,000 people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life. Our foundation in research and our highly skilled team ensures that we provide accurate and relevant information to help Doctors, Nurses and Managers improve their services.

Suggested changes in trauma management included:

- Enhancing pre-hospital care, ensuring appropriate medical intervention
- Rapid transfer to the best local facility
- Assessing the use of helicopters
- Adopting ATLS principles
- Integrating trauma services within and between hospitals
- Investing in rehabilitation services
- Auditing and Researching injury and systems of care

Commencing data entry into TARN is a priority for ABUHB. Previously the focus has been to support divisional clinical staff to enter data in TARN and clinical staff have TARN training. However, pressures on ED clinical staff have meant that they have not able to free up time for data entry. We are now setting up the process for administrative staff to enter data under supervision of clinical staff. The NCA lead for ABUHB has completed the TARN training and is setting up the system and processes for data entry. A TARN data entry administrator has been appointed and a TARN Co-Ordinator will be appointed by the end of 2019.

National Audit /Registry Title: Ophthalmology Audit (Adult Cataract Surgery)

Data is collected manually and processes for auditing are carried out by relevant consultants. Funding issues have resulted in the data entry clerk role not being carried out. There is an 'All Wales' procurement process for and Electronic Patient Record for Ophthalmology and once secured and in place the data should be greatly improved, resulting in improved efficiency for Glaucoma and Cataract patients.

6.2 National Audits – Long Term Conditions

National Audit/Registry Title: National Diabetes Audit 2017-2018 (Care Processes and Treatment Targets)

Clinical Lead:

Date of last data capture: Ongoing

Publication date of last National Audit Report: 13th June 2019

Case Ascertainment:
ABUHB has 78 GP practices with 77 participating, the one practice not participating was due to timing issues with completing data.

Please give a brief overview of the National Audit scope and aims:
The Core National Diabetes Audit (NDA) answers five key questions:-

1. Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
2. What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?
3. What percentage of people registered with diabetes achieved the NICE defined treatment targets for glucose control, blood pressure and cardiovascular disease risk reduction?
4. What percentage of people registered with diabetes are offered and attend a structured education course?
5. For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)?

The NDA supports improvement in the quality of diabetes care by enabling participating NHS services and organisations to:-

- Assess local practice against NICE Guidelines
- Compare their care and care outcomes with similar services and organisations
- Identify gaps or shortfalls that are priorities for improvement
- Identify and share best practice
- Provide comprehensive national pictures of diabetes care and outcomes in England and Wales

Please give a brief overview of main national findings from the published National Audit Report.

Variation:

All measurements showed marked geographical and inter-service variation.

Annual Care Processes:

The urine albumin care process check is completed less frequently than other checks across all types of diabetes.

BMI recording and foot examination appeared to improve in 2017-18. For BMI, this is possibly due in part to the new collection of height and weight from which BMI could be calculated if it had not been recorded. For foot examination, the improvement was probably partly due to the resolution of a TPP technical issue*.

Most other care processes remain well completed, though less frequently in all people with Type 1 diabetes and in younger people with any type of diabetes.

Achievement of the Treatment Targets (HbA1c, Blood Pressure, Cholesterol)

Between 2013-14 and 2017-18, there were similar levels of three target achievement for both people with Type 1 diabetes and people with Type 2 and other diabetes.

People of working age and younger are almost half as likely to achieve treatment targets as their older counterparts.

Structured Education

Recording within primary care systems showing that structured education has been offered continues to increase but there has not yet been an increase in the recording of attendance or completion.

Cardiovascular Disease (CVD) Risk reduction

Medication records show that many eligible people are not prescribed statins especially those aged 40-60. There are also appreciable numbers with above target blood pressure who are not prescribed any antihypertensive drugs.

Was a national audit report provided which included ABUHB level data and conclusions?

Yes – See local results for ABUHB below:

For the NICE key processes for diabetes, ABUHB performs slightly better than Wales for all except Urine Albumin, Foot surveillance and Smoking. England performs better than Wales for all NICE key processes for Type 1 Diabetes. For the 3 treatment targets, ABUHB performs worse than Wales. England performs better than Wales for all treatment targets for Type 1 Diabetes.

For Type 2 Diabetes, for the NICE key, processes for Diabetes, ABUHB performs slightly better than Wales for all processes. England performs better than Wales for all NICE key processes for Type 2 Diabetes.

For the 3 treatment targets, ABUHB performs worse than Wales for HBAIC and Blood Pressure. It equals the Wales average for cholesterol. England performs better than Wales for all treatment targets for Type 2 Diabetes.

TYPE 1 Diabetes – Care Processes

The table below shows the percentage compliance against the NICE key processes of Diabetes Care (the 9th KP is Digital Retinal Screening, not detailed in the full report)

	ABUHB		Wales		England	
	2017_18	2016_17	2017_18	2016_17	2017_18	2016_17
HbA1c	76.7	77.5	74.7	74.7	85.4	84.9
Blood Pressure	83.6	85.0	83.5	84.8	91.1	90.6
Cholesterol	67.5	68.4	65.2	66.4	81.1	80.8
Creatinine	75.9	75.2	73.8	74.0	83.5	83.3
Urine Albumin	34.8	34.6	35.1	36.2	52.3	51.0
Foot surveillance	55.8	61.0	56.9	60.6	75.1	70.1
BMI	69.4	70.4	66.7	67.2	82.7	75.8
Smoking	82.0	73.6	82.8	70.0	90.4	79.8
All Eight Care Processes	26.8	26.5	24.7	23.8	42.9	34.4

TYPE 1 Diabetes – Treatment Target Achievement

The table below shows the percentage compliance for the NICE Defined Treatment Targets that form part of the scope of the NDA.

	ABUHB		Wales		England	
	2017_18	2016_17	2017_18	2016_17	2017_18	2016_17
Target HbA1c < 48 mmol/mol	6.99	7.1	7.0	7.2	8.1	8.5
Target HbA1c <= 58 mmol/mol	24.71	24.3	26.0	26.8	29.9	30.4
Target HbA1c <= 86 mmol/mol	81.35	78.9	82.5	82.6	84.2	84.8
Target BP <= 140/80	70.05	72.2	71.6	73.3	74.8	76.0
Target cholesterol < 4 mmol/l	24.58	23.2	30.4	27.5	29.9	28.7
Target cholesterol < 5 mmol/l	65.36	62.8	69.2	68.0	70.3	69.4
All Three Treatment Targets	14.96	13.8	15.3	15.9	18.6	19.0

TYPE 2 Diabetes – Care Processes

NICE key processes for Type 2 Diabetes percentage compliance:

	ABUHB		Wales		England	
	2017_18	2016_17	2017_18	2016_17	2017_18	2016_17
HbA1c	93.1	93.4	92.4	92.8	95.3	95.3
Blood Pressure	94.0	95.2	93.3	94.4	96.3	96.4
Cholesterol	87.2	88.6	85.1	86.9	92.9	93.1
Creatinine	93.6	94.0	92.9	93.1	95.1	95.1
Urine Albumin	56.9	59.3	56.9	59.8	66.2	65.6
Foot surveillance	76.5	79.7	74.8	78.6	86.8	79.4
BMI	82.2	82.1	79.0	79.7	88.0	83.3
Smoking	93.0	85.1	91.7	82.2	95.5	85.7
All Eight Care Processes	47.7	48.8	45.9	47.0	58.8	47.7

TYPE 2 Diabetes – Treatment Target Achievement

Nice defined Treatment Targets for Type 2 Diabetes:

	ABUHB		Wales		England	
	2017_18	2016_17	2017_18	2016_17	2017_18	2016_17
Target HbA1c < 48 mmol/mol	27.34	29.6	27.7	29.6	29.0	30.6
Target HbA1c <= 58 mmol/mol	61.68	63.8	63.0	64.7	65.8	67.0
Target HbA1c <= 86 mmol/mol	91.61	92.1	92.4	92.6	93.1	93.3
Target BP <= 140/80	66.38	68.8	68.4	71.1	73.8	74.4
Target cholesterol < 4 mmol/l	36.24	36.8	36.2	36.8	42.3	41.3
Target cholesterol < 5 mmol/l	72.10	72.8	72.1	72.8	76.6	76.2
All three treatment targets	32.24	34.8	32.2	34.8	40.1	41.1

Percentage of Type 1 and Type 2 Diabetes patients offered Structured Education within 12 months of diagnosis

Structured Education			
TYPE 1	ABUHB	Wales	England
2016	35.3	30.2	38.6
2015	36.8	33.3	34.4
TYPE 2	ABUHB	Wales	England
2016	67.5	69.5	75.1
2015	60.0	63.3	69.6

What are the key actions from last report?
Action:
Actions are still being identified and will be shared with Welsh Government Policy Leads

National Audit/Registry Title:	National Diabetes Foot Care Audit 2015-2018
Clinical Lead:	Heather Barne/Mellisa Blow
Date of last data capture:	Ongoing
Publication date of last National Audit Report:	9th May 2019

Case Ascertainment:

Table 2: Case ascertainment in the audit, 2015-18

	Aneurin Bevan University LHB			England and Wales		
Audit year	Provider estimated	Submitted patients	Ascertain-ment	Provider estimated	Submitted patients	Ascertain-ment
2015-16	650	35	5.4%	52,600	5,255	10.0%
2016-17	650	35	5.4%	52,600	6,575	12.5%
2017-18	650	70	10.8%	52,600	10,325	19.6%

* Case ascertainment figures are only available for providers that completed the care structures survey, where they were asked to estimate the number of patients with foot ulcers seen at their service(s) during a year. These banded estimates were then compared with the number of patients the provider had recorded in the audit. Where a trust only estimated the number of patients seen at SOME of its services, the estimated and submitted figures above refer to patients seen at those services only, and not to all patients seen at all services within the provider.

Please give a brief overview of the National Audit scope and aims:

The National Diabetes Foot Care Audit (NDFA) is a continuous audit of diabetic foot disease in England and Wales. The audit enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease. All organisations which provide a diabetic foot ulcer treatment service are eligible for inclusion in the audit.

The audit reports on the following:

- Structures: are the nationally recommended care structures in place for the management of diabetic foot disease?
- Processes: does the treatment of active diabetic foot disease comply with nationally recommended guidance?
- Outcomes: are the outcomes of diabetic foot disease optimised?

The NDFA is part of the National Diabetes Audit (NDA) portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP)

Please give a brief overview of main National findings from the published National Audit Report.

Healthcare Professionals:-

- Use the audit findings to encourage commissioners and service managers to ensure a NICE-recommended diabetes foot care service is in place.
- Create simple and rapid referral pathways.
- Participate in the NDFA to collaborate in this nationwide drive to improve the outcomes for diabetic foot disease.

For Commissioners:-

- Work with providers to ensure that in every locality the NICE – recommended diabetic foot care structures are implemented and that the delivery of care is effectively integrated between all those involved.
- Ensure that your local diabetes specialist foot care services participate in the NDFA so that measurement of care processes and outcomes can support continuous quality improvement in all services.

Was a national audit report provided which included ABUHB level data and conclusions?

Care Structures

Table 7: Responses to the care structures provider survey, 2018

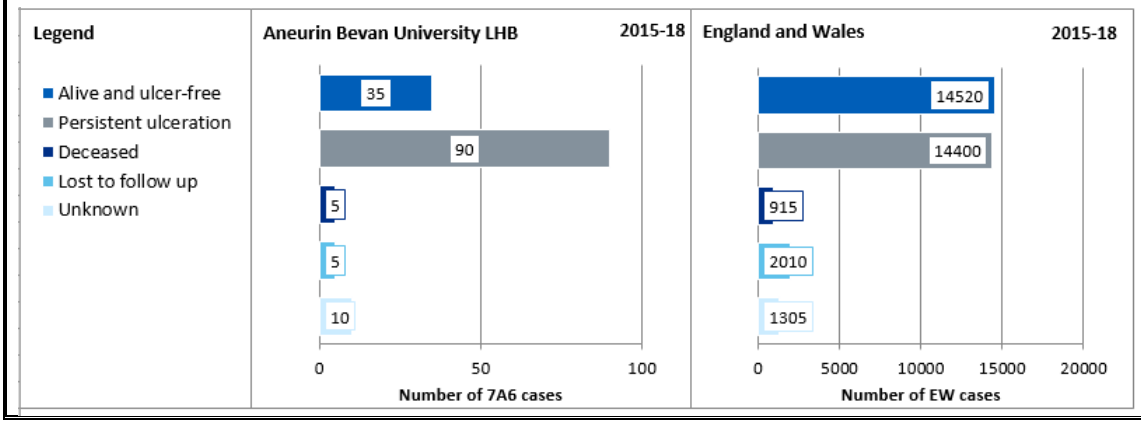
	Aneurin Bevan University LHB	England and Wales
Foot care structure	**Provider response**	**Provider response**
Training for routine diabetic foot examinations	Yes	-
An established Foot Protection Service pathway	Yes	-
An established pathway for new referrals – if needed – for an assessment within 24 hours	No	-
Step-down or shared care between the Multi-Disciplinary Foot Team and the FPS	Yes	-
Urgent vascular assessment within 24 hours	Yes	-
Time dedicated to discuss patients with vascular services	Yes	-

The local results are unavailable as Case Ascertainment is so low.

NDFA 12 Week Outcomes

Aneurin Bevan University LHB was the responsible provider for 145 ulcers within the audit (2015-18). The chart below shows the distribution of these cases split by the reported outcome 12 weeks after the first expert assessment by the specialist foot care service, alongside equivalent figures for the 33155 ulcers from England and Wales (2015-18). Key findings include:

- 130 (89.7 per cent) of the ulcer episodes seen at Aneurin Bevan University LHB (2015-18) had a 12 week outcome recorded, compared to 90.0 per cent nationally (England and Wales combined).
- In 35 (24.1 per cent) of the ulcer episodes the patient was reported to be alive and ulcer-free at 12 weeks, compared to 43.8 per cent nationally.
- In 90 (62.1 per cent) of the ulcer episodes the patient was reported to have persistent ulceration at 12 weeks, compared to 43.4 per cent nationally.



What are the key actions?	
Action:	**Timescale**
Continued improvement of ascertainment rates	Ongoing
Membership of All Wales National Diabetes Foot Executive and national network, RAG dashboard against National Diabetes Implementation Plan	Ongoing
Improvement of referral times to specialist service: primary care training days planned 2019-20 to inform on wound referral standards	3rd Qtr 2019/2020
ABUHB Cross specialism review of current referral pathway to support development of central point of referral and triage for lower limb wounds inclusive of diabetic foot wounds and 'foot attack'	Ongoing, in place 3rd Qtr

National Diabetes Audit/Registry Title:	**National Diabetes Inpatient Audit 2017 – Snap Shot Clinical Audit**
Clinical Lead:	**Dr Leo Pinto**
Date of last data capture:	**2017**
Publication date of last National Audit Report:	**14th May 2018**

Case Ascertainment:
104 patients RGH (19.6% of beds)
65 patients NHH (21.2% of beds)

Please give a brief overview of the National Audit scope and aims:
The audit sets out to measure the quality of diabetes care provided to people whilst they are admitted to hospital by answering the following questions:

Did diabetes management minimise the risk of avoidable complications?
Did harm result from the inpatients stay?
Was the patient experience of the inpatient stay favourable?
Has the quality of care changed since the NaDIA started in 2010?

Please give a brief overview of main National findings from the published National Audit Report.

National Findings:

Key Findings (England and Wales):-

Improvement in care:-

Teams have reduced patient harms for people with diabetes and delivered more care.

- Fewer inpatient had a medication error (from 40 to 31%, 2011 – 17)
- Fewer inpatients had any episodes of hypoglycaemia (from 26 – 18%, 2011 – 17)
- Fewer inpatient needed injectable rescue treatment (from 2.1 to 1.3%, 2011 – 17)
- Fewer inpatients developed foot ulcers during their hospital stay (from 1.6 to 1% 2011 – 17)
- More inpatients were seen by the diabetes team where appropriate (from 58 – 72%, 2011 – 17)

Scope for further improvement in care:-

- 28% of hospital sites report no diabetes inpatient specialist nurses (DISNs)
- Just 9% of hospital sites provide 7 day DISN provision
- Medication errors occurred more frequently in surgical wards (33%). Where Electronic Prescribing is used medication errors are less likely (33 vs. 29%)
- One fifth of hospital sites do not have an MDFT (20%). 36% of inpatients with active foot disease do not have a foot risk exam within 24 hours.
- 6% of infusions were inappropriate and 7% lasted for 7+ days. For 1 in 6 patients the transfer from infusion was not appropriate (16%)
- 1 in 25 of patients with Type 1 diabetes developed DKA in hospital as a result of under-treatment with insulin (4%) and 1 in 800 of patients with Type 2 diabetes developed HHS (0.1%)

Patient experience:-

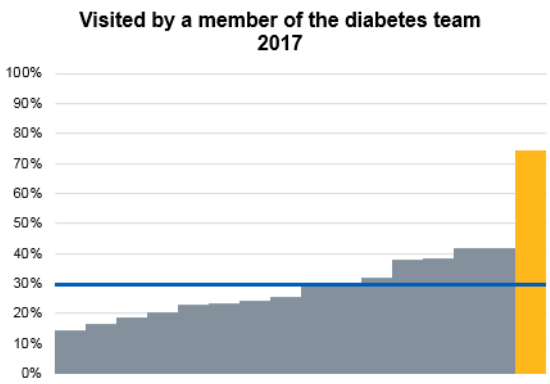
Inpatient perception of the suitability of meal choice (54% and timing (62%) have worsened from 63% (meal choice) and 70% (meal timing) in 2013

Was a national audit report provided which included ABUHB level data and conclusions?

Local Finding:

As in the previous National Clinical Audit of Inpatient Diabetes, the results appear to show that there is a difference in the care of the patients between NHH and RGH. In the last audit, the data indicated that there was a very low level of medical staffing at RGH. This audit shows that the medical staffing level at the 2 hospitals is the same. No appointments have been made. The change is accounted for by a difference in the way staffing levels are being collected

NHH Results

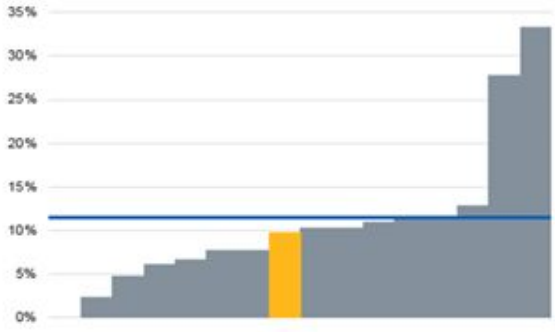


Visited by a member of the diabetes team 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	33.9%	Quartile 2	32.6%
2012	72.4%	Quartile 4	35.6%
2013	56.7%	Quartile 4	37.1%
2015[b]	58.2%	Quartile 4	31.1%
2016	69.4%	Quartile 4	39.8%
2017	74.1%	Quartile 4	29.4%

b = break in time series.

Admitted with active foot disease 2017

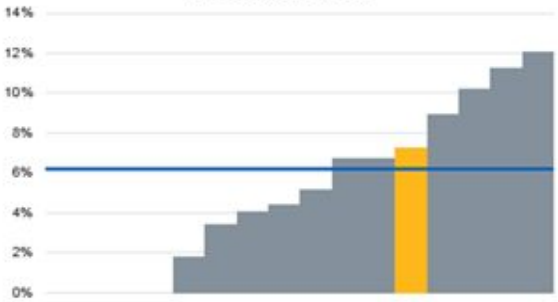


Admitted with active foot disease 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	4.0%	Quartile 1	8.5%
2012	7.0%	Quartile 2	10.1%
2013	8.6%	Quartile 3	9.9%
2015[b]	9.4%	Quartile 3	9.1%
2016	6.7%	Quartile 1	11.9%
2017	9.7%	Quartile 2	11.5%

b = break in time series.

Severe hypoglycaemic episodes (<3.0mmol/L) 2017



Severe hypoglycaemic episodes (<3.0mmol/L) 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	12.2%	Quartile 3	10.7%
2012	30.6%	Quartile 4	10.5%
2013	8.7%	Quartile 2	10.7%
2015[b]	6.0%	Quartile 2	9.2%
2016	6.5%	Quartile 2	9.0%
2017	7.3%	Quartile 3	6.2%

b = break in time series.

Patients reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital 2017

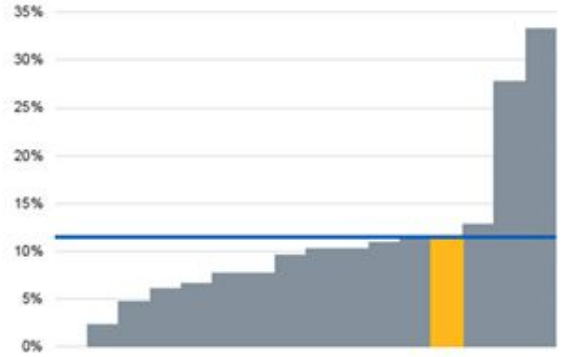
Patients reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	85.8%	Quartile 3	84.1%
2012	88.1%	Quartile 3	84.8%
2013	86.3%	Quartile 2	83.8%
2015[b]	92.1%	Quartile 4	81.2%
2016	88.3%	Quartile 4	82.1%
2017	98.6%	Quartile 4	86.0%

b = break in time series.

RGH Results

Admitted with active foot disease 2017

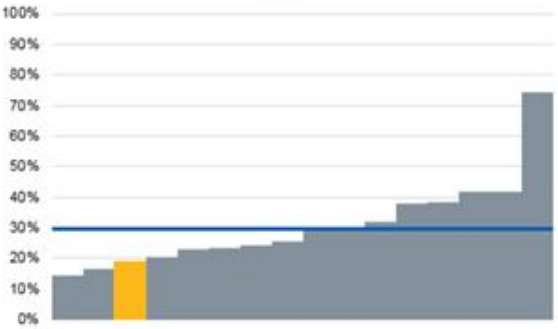


Admitted with active foot disease 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	12.6%	Quartile 4	8.5%
2012	13.0%	Quartile 4	10.1%
2013	7.5%	Quartile 2	9.9%
2015[b]	10.2%	Quartile 3	9.1%
2016	9.3%	Quartile 2	11.9%
2017	11.5%	Quartile 4	11.5%

b = break in time series.

Visited by a member of the diabetes team 2017

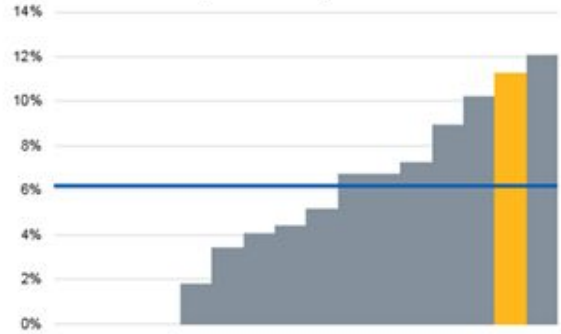


Visited by a member of the diabetes team 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	35.0%	Quartile 3	32.6%
2012	27.2%	Quartile 2	35.6%
2013	29.5%	Quartile 2	37.1%
2015[b]	21.4%	Quartile 1	31.1%
2016	35.4%	Quartile 2	39.8%
2017	18.7%	Quartile 1	29.4%

b = break in time series.

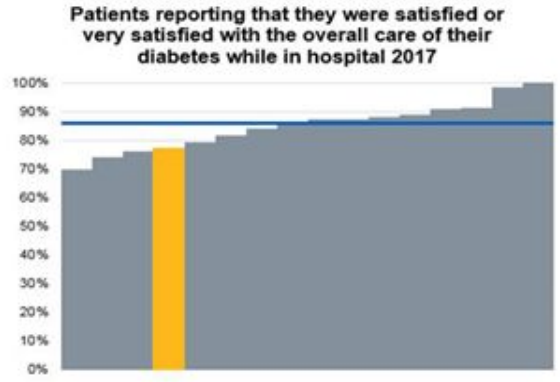
Severe hypoglycaemic episodes (<3.0mmol/L) 2017



Severe hypoglycaemic episodes (<3.0mmol/L) 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	15.1%	Quartile 4	10.7%
2012	9.1%	Quartile 3	10.5%
2013	9.6%	Quartile 3	10.7%
2015[b]	11.9%	Quartile 4	9.2%
2016	3.9%	Quartile 1	9.0%
2017	11.3%	Quartile 4	6.2%

b = break in time series.



Patients reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital 2010 - 2017

Audit year	Chosen site	Quartile	Wales
2010	N/A	N/A	N/A
2011	80.0%	Quartile 2	84.1%
2012	76.6%	Quartile 1	84.8%
2013	90.0%	Quartile 3	83.8%
2015[b]	80.6%	Quartile 2	81.2%
2016	75.4%	Quartile 1	82.1%
2017	77.2%	Quartile 1	86.0%

b = break in time series.

5.2

What are the key actions?
Action: A Business Case for the Diabetes pathway has been developed and presented to PIP. The business case addresses the gap in the provision of diabetes inpatient care at RGH, by investing in Diabetes inpatient specialist nurses (DISNs), along with Consultant sessions to support inpatient diabetes care, and dietetic sessions to provide advice for in-patients with diabetes. Such an investment is likely to transform the care of in-patients with diabetes at RGH. The business case also addresses the gap in antenatal diabetes service, with the provision of psychological services for people with diabetes. It also invests in the provision of comprehensive annual diabetes review for patients attending secondary care clinics.

National Diabetes Audit/Registry Title: National Diabetes Inpatient Audit 2017 – Hospital Characteristics

Clinical Lead: Dr Leo Pinto

Date of last data capture: Ongoing

Publication date of last National Audit Report: 9th May 2019

Case Ascertainment:
RGH reported 550 beds with 104 Diabetes patients.
YYF reported 165 beds with 33 Diabetes patients.

A *National Diabetes Inpatient Hospital Characteristics Report Audit 2019* was published on 9 May 2019. The Nadia Snap Chat audit will be repeated in 2019.
https://www.hqip.org.uk/resource/national-diabetes-inpatient-audit-2018/
The harms report contains no welsh data as the proper data governance permissions were not in place in time for this round of audit. Due to the lack of Welsh data for this report, there are no recommendations/actions.

Please give a brief overview of the National Audit scope and aims:

The NaDIA Hospital Characteristics report covers the structures of care that are fundamental to achieving the standards of safe effective inpatient diabetes care. Achievement of these standards is measured by the bedside NaDIA snapshot audit and the new NaDIA-Harms audit a continuous measurement that commenced in July 2018.

2018 was a designated NaDIA Quality Improvement Collaborative (QIC) year. To reduce the burden on QIC participants, the NaDIA 2018 collection has focused on the Hospital Characteristics survey only. The Bedside Audit and Patient Experience surveys will be repeated for NaDIA 2019.
The report uses the Hospital Characteristics survey to answer the following questions:
•Have staffing levels for inpatient diabetes teams increased since 2015?
•Has take-up of care improvement initiatives and healthcare technologies for diabetes care increased since 2013?
•What additional transformation funding has been provided for inpatient diabetes teams in 2018?

Please give a brief overview of main National findings from the published National Audit Report.

Staffing Levels:

- Staffing levels for inpatient diabetes care have increased for all professions between 2017 and 2018, apart from pharmacists.
- Access to podiatry services has improved: the proportion of hospital sites with no podiatry services has halved since 2017, from 32 to 16 per cent.

- There has been an increase in the proportion of sites with 7 day DISN provision since 2017 (from 9 to 12 per cent), which tallies with the increase in DISN staffing levels found elsewhere.
- Nonetheless, more than a fifth of hospital sites have no diabetes inpatient specialist nurses (22 per cent).
- The proportion of sites with 7 day Diabetes Physician access has decreased by almost 4 percentage points.
- One sixth of hospital sites do not have a Multi-disciplinary Foot Care Team, though this proportion has halved since 2011.

Care improvement initiatives:

- Increasing proportion of hospital sites are now fully-utilising electronic prescribing (EP) and remote blood glucose monitoring (BGM). The proportion having regular ward staff training has also increased.
- Nonetheless, take-up of these technologies is still slow. For example, only 4 in 10 sites fully-utilise an Electronic Patient Record (EPR), with one third fully-utilising EP.

Transformation Funding:

- Two fifths of NaDIA sites received transformation funding to improve access to an MDFT.
- One quarter of NaDIA sites received transformation funding to improve access to DISNs.
- The large majority (more than 90 per cent) of organisations that have received transformation funding have used (or plan to use) the funding to recruit new staff.

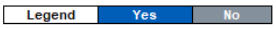
5.2

Was a national audit report provided which included ABUHB level data and conclusions?

Team information: 7A6AR	Total team hours per inpatient with diabetes is spent on: Inpatient diabetes care	
Specialty	**Hospital: 7A6AR**	**Wales**
Diabetes Inpatient Specialist Nurses (DISNs)	0.14	0.40
Diabetes Specialist Nurse (DSNs)	1.08	0.82
Specialist Diabetes Dietitians	0.07	0.06
Non-specialist Dietitians	0.00	0.13
Podiatrists	0.02	0.14
Diabetes Specialist Pharmacist	0.27	0.09
Consultants (general medicine, diabetes, endocrinology, etc)	0.14	0.30

Diabetes management and 7 day / week care

Hospital: 7A6AR		Wales
Does 7A6AR provide Diabetes Inpatient Specialist Nursing (DISN) care 7 days a week (this could include partial cover at the weekends)?	No	100.0%
Does 7A6AR provide access to a Diabetes Physician 7 days a week (this could include partial cover at the weekends)?	No	6.3% / 93.8%

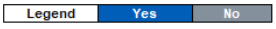


Care initiatives and staff education

Hospital: 7A6AR		Wales
Regular ward nurse diabetes training	Yes	87.5% / 12.5%

Diabetes management

Hospital: 7A6AR		Wales
Does 7A6AR have regular mortality and morbidity meetings where diabetes is discussed?	No	62.5% / 37.5%



Diabetes footcare

Hospital: 7A6AR		Wales
In 7A6AR, have any tools or systems been put into place to increase the number of inpatients with diabetes who have a foot risk examination?	Yes	50.0% / 43.8% / 6.3%

Multi-disciplinary Diabetes Foot Team (MDFT) definition:

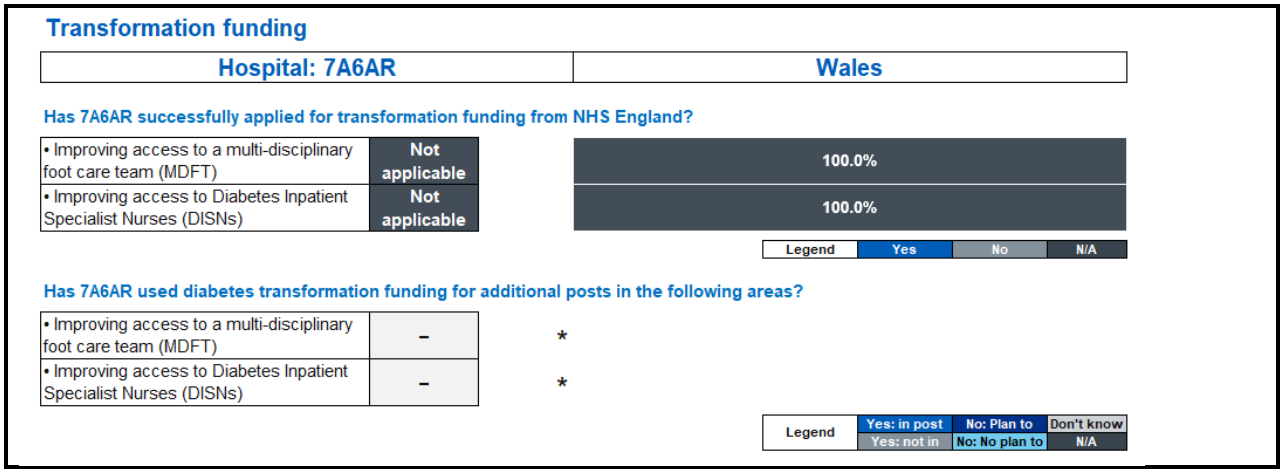
A multi-disciplinary foot team (MDFT) is defined as a team consisting of at least a diabetologist, a podiatrist with skills in managing the diabetic foot and a surgeon (general, orthopaedic or vascular surgeon). These members must be in weekly contact to discuss patient care.

Is there an established multi-disciplinary diabetic foot team (MDFT) in 7A6AR as defined above?	Yes	62.5% / 37.5%

Electronic recording and reporting

Hospital: 7A6AR		Wales
Does 7A6AR use any of the following?		
• Electronic patient record	No	25.0% / 12.5% / 62.5%
• Electronic prescribing	No	12.5% / 87.5%
• Remote blood glucose monitoring	Yes	50.0% / 43.8% / 6.3%

(YYF results stated 'Partially' fro Remote Blood Glucose Monitoring, otherwise all other measure are the same for RGH and YYF)



5.2

What are the key actions?	
Action:	**Timescale**
A business case is being developed to address the staffing shortage (Consultant, DISNs, Dietitian and Clinical Psychologist). This additional resource will help improve the diabetes care for inpatients, and provide training and support to the staff delivering care on the wards	Presentation to PIP on 27/06/2018, before submission to the Exec Board for approval

National Audit/Registry Title: National Pregnancy in Diabetes Audit

Clinical Lead: Mrs A Pinto

Date of last data capture: 01st Jan – 31st Dec 2016
Continuous Data collection

Publication date of last National Audit Report: 12th October 2017 *(no further report has been published)*
Next report due 10th October 2019

Case Ascertainment:
NHH recorded 23 pregnancies and RGH recorded 69 pregnancies.

Please give a brief overview of the National Audit scope and aims:

The audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address the three key questions:

1. Were women adequately prepared for pregnancy?
2. Were adverse maternal outcomes during pregnancy minimised ?
3. Were adverse fetal/infant outcomes minimised?

Please give a brief overview of main National findings from the published National Audit Report.

In 2016, 3,304 pregnancies in 3,297 women with diabetes were recorded in 172 antenatal diabetes services.

- 1,608 women had Type 2 diabetes. Nearly half of women with Type 2 diabetes were Black, Asian or of mixed ethnicity.
- Initiatives around supporting women to use safe and effective contraception and to prepare successfully for pregnancy will need to take account of ethnicity, age and deprivation, and how these may influence the way women access support from health services.
- Women with Type 2 diabetes tended to be older, have shorter diabetes duration, be more overweight and be more likely to live in areas of social deprivation

Few women were well prepared for pregnancy

- Only one in twelve women (8 per cent) had achieved HbA1c < 48mmol/mol, use of 5mg folic acid and avoidance of potentially harmful medications before conception.
- Despite the fact that women with Type 2 diabetes have better glucose control, other measures, including use of folic acid, suggest that they were not getting the pre-pregnancy care they needed.

Presentation before 10+0 weeks of pregnancy:

- 24.0 per cent of women with Type 1 diabetes and 41.9 per cent of women with Type 2 diabetes did not present to the joint diabetes antenatal team before 10+0 weeks gestation.
- This suggests reduced awareness of pregnancy risks and/or failure of diabetes antenatal care and referral pathways.

Maternal hypoglycaemia and ketoacidosis:

- Almost one in 10 women with Type 1 diabetes had at least one hospital admission for severe hypoglycaemia.

- Ketoacidosis, a high risk for mother and fetus, occurred in 2.7 per cent of women with Type 1 diabetes.

Almost one in two babies had complications related to maternal diabetes:

- 47.6 per cent of babies born to women with Type 1 diabetes were large for gestational age (LGA), as were 22.9 per cent of babies born to women with Type 2.
- Preterm delivery was common especially in women with Type 1 diabetes (43.3 per cent of singleton live births).
- Delivery by caesarean section was common (64.7 per cent of Type 1 and 56.9 per cent of Type 2).
- HbA1c levels at or above 48 mmol/mol after 24 weeks were associated with preterm delivery, LGA babies, and neonatal unit admission.
- Even after 37+0 weeks, rates of infant admission to neonatal care units was higher in women with diabetes than in the general population.

Adverse neonatal outcomes are more common than in the general population:

- 99.0 per cent of registered births were live births.
- Stillbirth rates were more than twice, and neonatal death rates nearly four times the general population rate.
- Congenital anomaly rates were high (47.6 per 1,000 for Type 1 diabetes and 44.8 per 1,000 for Type 2 diabetes).
- Higher first trimester HbA1c was related to congenital anomaly rates and in women with Type 1 diabetes to stillbirth and neonatal death.

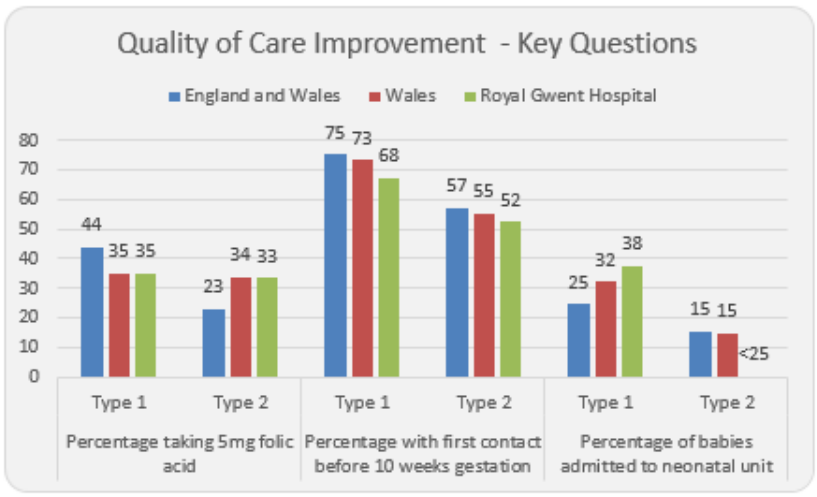
Progress since 2014 and future opportunities :

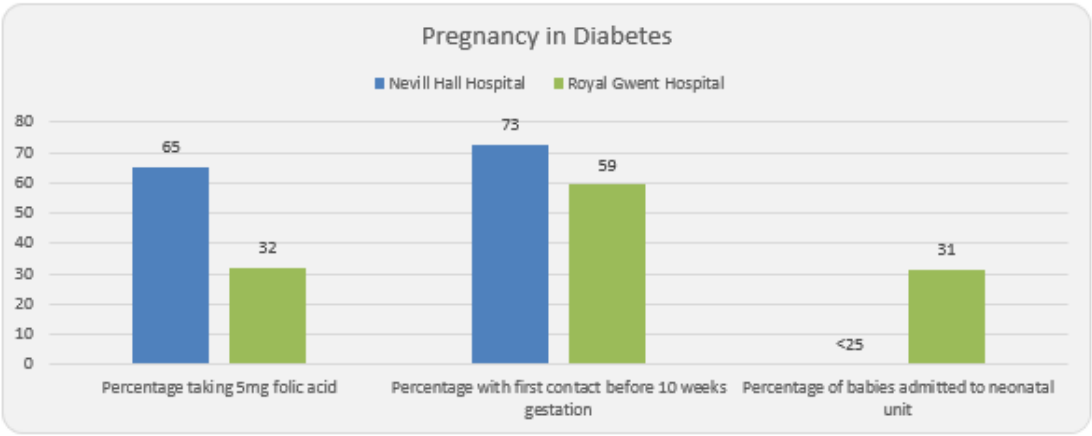
There has been little overall change since 2014. However there is very considerable inter-service variation in measures relating to:

- First trimester glucose control and 5mg folic acid supplementation.
- First contact with the antenatal diabetes team.
- Admission rates of term infants to a neonatal unit.

Was a national audit report provided which included ABUHB level data and conclusions?

Data for Type 1 and Type 2 is not available for NHH on the Service Level Report for 2016, however NHH data is available as a combined Type 1 and Type 2 figure.





What are the key actions?	
Action:	**Timescale**
Being seen early in the joint clinics and having 5mg Folic acid- we seem to be doing very well- well above the Wales and English average.	Ongoing
Work will continue on improving access to clinics in a timely manner (by opening 0.5 clinic per week in response to the work load), pre conception folic acid and treatment amendment by GP education and improve fetal outcome by frequent review by the multidisciplinary team.	Ongoing

National Audit/Registry Title:	National Paediatric Diabetes Audit 2017/2018
Clinical Lead:	Dr Davida Hawkes (RGH) and Dr Ramya Venkataramakrishnan (NHH)
Date of last data capture:	Audit Period 2017/2018
Publication date of last National Audit Report:	9th May 2019

5.2

Case Ascertainment:
Type 1 Diabetes in children and young people in England and Wales = 28,300, compared to 745 with Type 2 diabetes.

Please give a brief overview of the National Audit scope and aims:

The 2017/18 NPDA included all 173 PDUs in England and Wales, and captured information on 29,748 children and young people up to the age of 24 years under the care of a consultant paediatrician.

The audit collects data submitted by PDUs detailing patient demographics, completion of health checks recommended for children and young people with diabetes, and their outcomes. The NPDA has considered seven of these to be essential annual checks:
1. Glycated Haemoglobin A1c (HbA1c) (blood test for diabetes control)
2. Body Mass Index (BMI) (measure of cardiovascular risk)
3. Blood pressure (measure of cardiovascular risk)
4. Urinary albumin (urine test for kidney function)
5. Thyroid screen (blood test for hyper/hypothyroidism)
6. Eye screening (photographic test for eye risk)
7. Foot examination (foot examination for ulcer risk)

The health checks audited were those recommended by NICE in their guidance for the diagnosis and management of children and young people with Type 1 and Type 2 diabetes (NG18, NICE, 2015).
Prevalence and incidence of diabetes, associated complications, and completion of health checks (care processes) are broken down by age group, gender, type of diabetes, deprivation (using Indices 6 of Multiple Deprivation based on patient postcode), region and country. The audit's online reporting tool also provides breakdown by CCG (England) and Health Board (Wales). Since gender, ethnicity, age and deprivation are known to impact upon the level of diabetes control typically achieved by patients as reflected in mean HbA1c levels, case-mix adjusted mean HbA1c levels are presented so that PDU performance can be fairly represented and benchmarked taking these factors into account.

Please give a brief overview of main <u>National</u> findings from the published National Audit Report.

There are only around 25 children in Wales with type 2 diabetes; therefore the findings reiterated here relate to type 1 diabetes only (1,447 patients). The main finding is that this is the first year in six years without an improvement in population level, mean blood glucose control but there has been further improvement in completion of all key care processes (55% Wales, 50% England), although there is significant variation between units. The report also highlights the rates of complication risk such as kidney damage (6.2%), eye disease (8.9%), high blood pressure (25.5%) and high cholesterol (23%). Around 24.5% of patients are thought to be in diabetic ketoacidosis at diagnosis in Wales compared to 17.9% in England but the report highlights the inaccuracy of the data in this metric. The use of pump therapy and continuous glucose monitoring is increasing, with around 35% of patients in Wales only on an insulin pump (similar to England) and around 12% receiving continuous glucose monitoring (England 9.2%). The report recommendations focus on implementing quality improvement approaches in order to improve care process completion and target achievement rates in order to improve outcomes.

Type 1

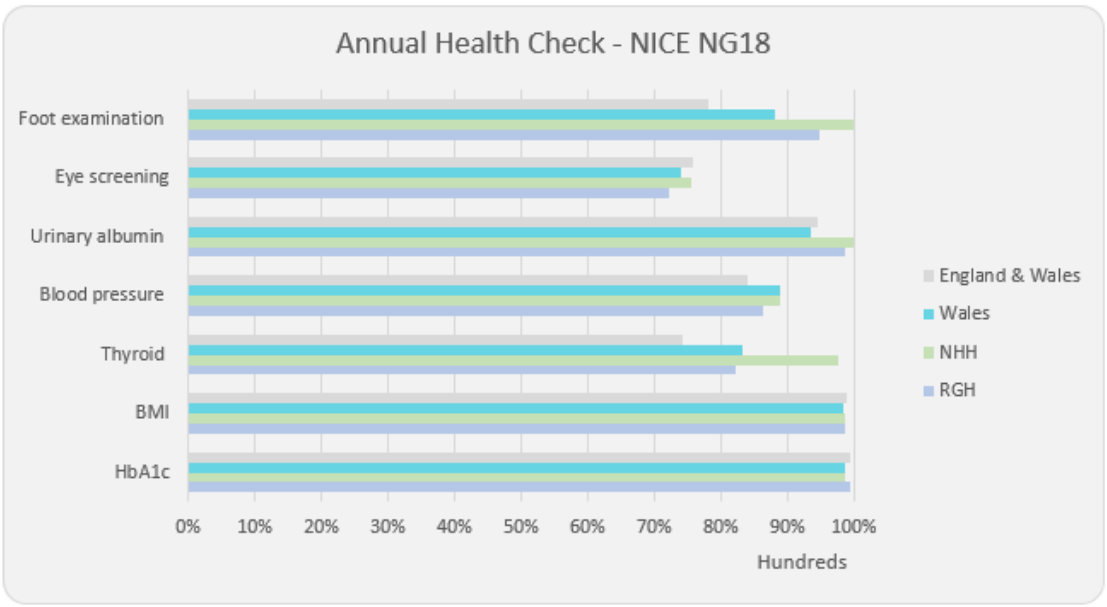
	0-4 years	5-9 years	10-14 years	15-19 years+	20-24 years+	Total (% of cohort)
England and Wales	1,588	6,303	11,432	8,962	15	28,300 (100)
England	1,525	5,969	10,807	8,537	15	26,853 (94.9)
Wales	63	334	625	425	0	1,447 (5.1)

Type 2

	No. of children and young people with T2 diabetes	% of total
England and Wales	745	100
England	720	96.6
Wales	25	3.4

Was a national audit report provided which included ABUHB level data and conclusions?

NHH are 100% compliance on 2 of the 7 health checks. BMI scores are comparative across the board, however both RGH & NHH need to improve with regards to Eye Screening.



What are the key actions?	
Action:	**Timescale**
No Actions returned	

National Audit/Registry Title: National Diabetes Transition Audit 2003-2014

Clinical Lead:

Date of last data capture: Audit Period 01 Jan 2003 to 31 Mar 2015

Publication date of last National Audit Report: 23rd June 2017

Case Ascertainment:

Please give a brief overview of the National Audit scope and aims:
The National Diabetes Transition Audit (NDTA) links datasets from the adult and paediatric national diabetes audits. The NDTA has been designed to audit care provision during the period when young people with diabetes move from paediatric to adult based clinical care.

- A working group comprises the clinical leads and audit managers for both the National Diabetes Audit (NDA) and the National Paediatric Diabetes Audit (NPDA), analysts from NHS Digital, and representation from Diabetes UK. The working group has designed, developed and delivered the NDTA according to the requirements and methodology set out overleaf.
- The NDTA measures changes in glycaemic control and care provision across the period of transition. It signals priorities for improvement and provides a framework for monitoring the impact of improvement action plans.

Diabetes is a very difficult condition to manage. From the point of diagnosis onwards, diabetes has a major impact on the life of a young person, placing an enormous 24/7 burden on them and their family or carers. Supporting lifelong management of the condition is essential in achieving the most positive outcomes for the individual.

- Patients making the transition from childhood to adulthood are particularly at risk of disruption in care, with both short and long-term health effects. It is therefore very important that the handover of care from paediatric to adult services defends against this and does not intensify the risk.
- Transitional care needs collaborative support from medical, educational and psychological services. Engagement between paediatric and young adult services to provide continuity of care, and give young adults confidence to continue to manage their diabetes is pivotal. Falling short of this can lead to serious and lasting consequences, resulting in increased morbidity and mortality.

The report aims to answer the following audit questions:
1. Is the transition from paediatric to adult care associated with changes in care process completion rates?
2. Is the transition from paediatric to adult care associated with a change in treatment target achievements?
3. Is the transition from paediatric to adult care associated with changes in rates of diabetic ketoacidosis (DKA)?

Please give a brief overview of main National findings from the published National Audit Report.

Annual Care Processes

•KF1: Annual measurement of HbA1c decreases after transition.
•KF2: Annual measurements of blood pressure and cholesterol remain similar, whereas kidney, foot, retinopathy and smoking check completion rates increase after transition.
•KF3: The differences in care process completion pre and post transition do not appear to be influenced by gender, ethnicity, or living in a deprived area.
•KF4: Pre-transition annual care process completion rates fall as age at transition increases, while post-transition completion rates increase as age at transition increases. A similar pattern is seen for duration of diabetes.
•KF5: The least variation in care process completion rates was found where transition occurred between the age of 16 and 19 years. This may be because planned transition usually occurs during this time window. Planned movement from paediatric to adult care is less likely at younger and older ages.

Treatment Targets (HbA1c)

•KF6: The HbA1c target is more likely to be reached pre-transition compared to post-transition; the difference is greatest at younger ages.
•KF7: The decrease in meeting the HbA1c target is not influenced by gender, ethnicity, or living in a deprived area.

Risk Factors

•KF8: For both cholesterol and blood pressure, the percentage of children achieving the targets are higher pre-transition compared to post-transition.

Diabetic Ketoacidosis (DKA)

•KF9: There are a higher number of DKA admissions post-transition. However, this may be due to the fact that DKA rates increase with increasing duration of diabetes.

Was a national audit report provided which included ABUHB level data and conclusions?

No – Data is relevant to England and Wales.

What are the key actions?	
Action:	**Timescale**

1. Need to develop transition services in ABUHB to ensure they meet the standards recommended and are equitable across ABUHB. Wrexham model of 5 joint clinics over 2 years is accepted as best practice	All wales transition standard is in final stages of development/ approval by WAG Yet to be accepted/ put into place locally
2. Consider employing youth worker as has been successful in other areas in England and Wales to keep this vulnerable group engaged	Discussed at DPDG

National Audit/Registry Title: UK Inflammatory Bowel Disease Audit

Clinical Lead: Dr Karen Yearsley

Date of last data capture (or ongoing): Currently not participating

Publication date of last National Audit Report: N/A

Update:

ABUHB are currently not participating in this audit due to resource issues within the division to support the data entry. There have been discussions regarding using bank staff for this process however, nothing has been confirmed to date.

National Audit/Registry Title: National Chronic Obstructive Pulmonary Disease – Working Together

Clinical Lead: **RGH -** Dr Patrick Flood-Page
NHH - Dr Mike Pynn
YYF – Martha Scott (currently unavailable)

Date of last data capture: Ongoing

Publication date of last National Audit Report: 12th April 2018

Case Ascertainment:

- Royal Gwent Hospital 49 of 412
- Nevill Hall Hospital 22 of 234
- Ysbyty Ystrad Fawr 15 of 192

Case Ascertainment was very low and therefore local results are unreliable.

Please give a brief overview of the National Audit scope and aims:

The National COPD Audit Programme is a programme of work that aims to drive improvements in the quality of care and services provided for patients with COPD in England and Wales. The objective is to capture the process and clinical outcomes of treatment in patients admitted to hospital in England and Wales with COPD exacerbations via data entry to the audit programme's bespoke web-tool by clinicians. The emergence of key themes and the resistance of some processes to change over repeated audit cycles have been drivers for the development in the secondary care clinical audit to move to continuous collection of clinical data.

Clinical and audit teams are however to be commended for delivering not only improvements in care under sometimes challenging circumstances, but also for collecting what is believed to be the largest COPD audit dataset worldwide at the time of analysis.

Please give a brief overview of main <u>Local</u> findings from the published National Audit Report.

- **Royal Gwent Hospital (RGH)**

General information: The average age of patients admitted to RGH was 66 compared to the national average of 72 which shows a lower age of those who have COPD within this area, there was a higher cohort of men to women being admitted with COPD which was the opposite to the national figure.

1.3.2 Index of Multiple Deprivation measures by national quintile in Wales

	% of audit sample living in a Welsh Lower-layer Super Output Area (LSOA)				
Index of Multiple Deprivation	Q1 (Most deprived)	Q2	Q3	Q4	Q5 (Least deprived)
Wales 2017 (N=1,664)	38.4% (639)	26.0% (433)	16.2% (269)	10.5% (175)	8.9% (148)
Your hospital (N=46)	34.8% (16)	17.4% (8)	23.9% (11)	10.9% (5)	13.0% (6)

RGH shows a lower % in the most deprived area, and a higher % in the least deprived area.

The case ascertainment for RGH was reported as 49 and they were admitted within 0.8 hours of arrival to admission, which is lower than the national average.

Provision of timely care: Review by an acute physician (Grade ST3 or above) showed a higher than average compliance of 91.8%, with only 6.1% not be reviewed and 2% not recorded; Review by the respiratory team was poor and only 36.7% were seen during their admission, however, 8.2% of those were seen within 24 hours.
Recording key clinical information: Oxygen prescription was low, being below average within the target range 88-92% but high within all other ranges. The availability of spirometry results were well above average with the overall average which included the patients' most recent FEV1 was on par with the national average. There was a higher than average of patients who had never smoked and were a current smoker and lower than average of patients who were ex-smokers. Of those that were still smoking 58.8% were not prescribed smoking cessation pharmacotherapy during the admission but 5.9% were offered and declined. 100% of DECAF score was recorded for these patients.
NIV: 16.3 % of patients received acute treatment with NIV which was higher than the national average, however, there was a significant lack of recording with these patient that had received NIV within 3 hours of arrival, which seems to have skewed the results somewhat.
Discharge processes: There is a trend that shows patients are discharged mainly on a Tuesday, Wednesday and Friday, the patients are less likely to be discharged on the weekend. The average length of stay is lower in RGH compared to nationally as is inpatients mortality, however, the discharge bundles do not seem to be completed on admission or it is not clear if they have been completed. There is a high average recorded for patients who do not appear to have arrangements made upon discharge, but the amount of patients discharged for end of life care is almost four times the national average.

- **Nevill Hall Hospital (NHH)**

General information: The average age of patients admitted to NHH was 68 compared to the national average of 72 which shows a lower age of those who have COPD within this area, there was a higher cohort of women to men being admitted with COPD which was the same as the national figure.

1.3.2 Index of Multiple Deprivation measures by national quintile in Wales

	% of audit sample living in a Welsh Lower-layer Super Output Area (LSOA)				
Index of Multiple Deprivation	Q1 (Most deprived)	Q2	Q3	Q4	Q5 (Least deprived)
Wales 2017 (N=1,664)	38.4% (639)	26.0% (433)	16.2% (269)	10.5% (175)	8.9% (148)
Your hospital (N=22)	50.0% (11)	18.2% (4)	9.1% (2)	22.7% (5)	0.0% (0)

NHH shows a higher % in the most deprived area than the rest of Wales and zero % in the least deprived area, compared to the rest of Wales.

The case ascertainment for NHH was reported as 22 and

they were admitted within 2.5 hours of arrival to admission, which is lower than the national average.
Provision of timely care: Review by an acute physician (Grade ST3 or above) showed a higher than average compliance of 100%; Review by the respiratory team was lower than the national average with 63.6% being seen during their admission, and, 50% of those were seen within 24 hours, which was lower than the average.
Recording key clinical information: Oxygen prescription was low, yet above the target range for 88-92% and 94-98%. The availability of spirometry results were well above average as was the target which included the patients' most recent FEV1 and was on par with the national average. There was a higher percentage of patients who were ex smokers and current smokers were below the national average. Of those that were still smoking 50% were not prescribed smoking cessation pharmacotherapy during the admission but 16.7% were offered and declined. 72.7% of DECAF score was NOT recorded for these patients.
NIV: 13.6 % of patients received acute treatment with NIV which was higher than the national average, however, there was nothing recorded to show if the patient had received NIV within 3 hours of arrival.
Discharge processes: There is a trend that shows patients are discharged mainly on a Sunday, Monday, Thursday and Friday. The average length of stay is lower in NHH compared to nationally, however, inpatient mortality is higher by 10%. The discharge bundles do not seem to be completed on admission in the main. There is a high average recorded for patients who do not appear to have arrangements made upon discharge, but the amount of patients who are discharged with a follow up appointment having been made with either GP, community respiratory clinic or hospital respiratory clinic is above average.

- **Ysbyty Ystrad Fawr (YYF)**

General information: The average age of patients admitted to YYF was 74 compared to the national average of 72 which shows a higher age of those who have COPD within this area, there was a higher cohort of women to men being admitted with COPD which was on par with the national findings.

1.3.2 Index of Multiple Deprivation measures by national quintile in Wales

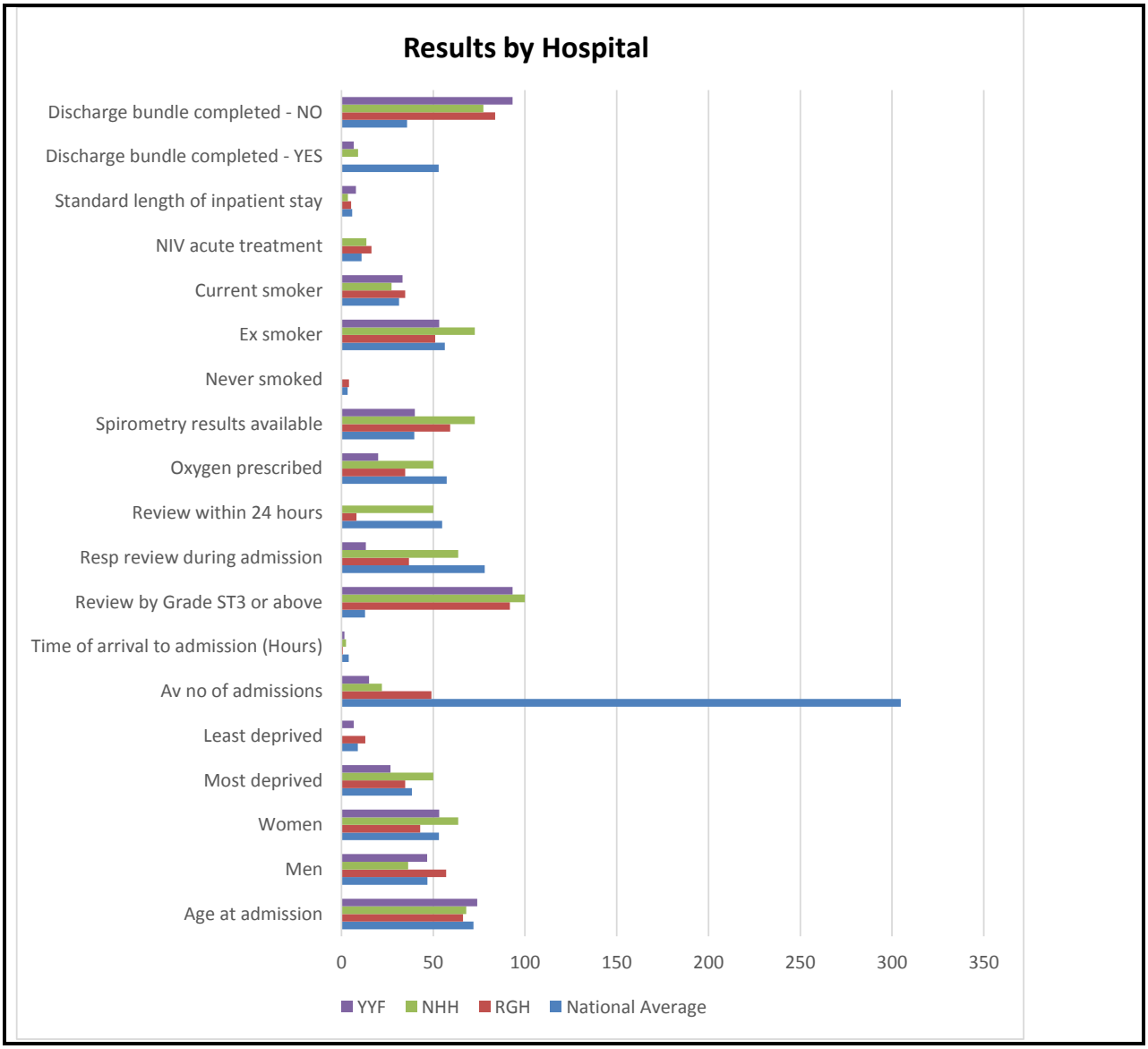
	% of audit sample living in a Welsh Lower-layer Super Output Area (LSOA)				
Index of Multiple Deprivation	Q1 (Most deprived)	Q2	Q3	Q4	Q5 (Least deprived)
Wales 2017 (N=1,664)	38.4% (639)	26.0% (433)	16.2% (269)	10.5% (175)	8.9% (148)
Your hospital (N=15)	26.7% (4)	40.0% (6)	26.7% (4)	0.0% (0)	6.7% (1)

YYF shows a lower % than the Wales figure for the most deprived area and also a lower % than Wales for the least deprived

The case ascertainment for YYF was reported as 15 and they were admitted within 1.6 hours of arrival to admission, which is lower than the national average.

Provision of timely care: Review by an acute physician (Grade ST3 or above) showed a higher than average compliance of 93.3%; Review by the respiratory team was lower than the national average with 13.3% being seen during their admission, and, NONE of those were seen within 24 hours, giving a respiratory team review in hours as 181.1. This reflects the fact that there are no respiratory physicians based at YYF.
Recording key clinical information: Oxygen prescription was on par with the national average, and 100% compliant with the target range for 88-92%. The availability of spirometry results were above average and the target which included the patients' most recent FEV1 and was on par with the national average. There was a higher percentage of patients who were ex smokers and current smokers were slightly above the national average. Of those that were still smoking 100% were not prescribed smoking cessation pharmacotherapy during their admission. No DECAF score was recorded for these patients.
NIV: This is not available at YYF.
Discharge processes: There is a trend that shows patients are discharged mainly on a Monday, Tuesday and Friday, however, Sunday discharges match the national findings. The average length of stay is higher in YYF compared to nationally, at 7.9 in patient days. The discharge bundles do not seem to be completed on admission in the main. There is a high average recorded for patients who do not appear to have arrangements made upon discharge, but the amount of patients who are discharged with a follow up appointment having been made with the hospital respiratory clinic or the patient has been discharged under the care of an early/assisted discharge team/integrated service and is above average.

Was a national audit report provided which included ABUHB level data and conclusions?



What are the key actions?	
Action:	**Timescale**
Introduce a system to facilitate the improvement of data inputting	Aug 2019

National Audit/Registry Title:	National Chronic Obstructive Pulmonary Disease – Time to Integrate Care
Clinical Lead:	**RGH -** Dr Patrick Flood-Page **NHH -** Dr Mike Pynn **YYF -** Dr Adlam (in the absence of Martha Scott) Martha Scott (currently unavailable)
Date of last data capture:	Ongoing
Publication date of last National Audit Report:	12th April 2018

Case Ascertainment:

Please give a brief overview of the National Audit scope and aims:

The programme looks at COPD care across the patient pathway, both in and out of hospital, bringing together key elements from the primary, secondary and community care sectors. This is the second of the COPD secondary care organisation audit reports, published as part of the National Programme detailed above. This report details national data relating to the organisation and resourcing of COPD care in acute hospitals in England and Wales. The structure of the dataset was largely similar to that used in 2014; however, an additional quality improvement (QI) section was included to capture any change projects or improvement action plans that had been instigated since the publication of the 2014 findings and recommendations. Out of 197 secondary care hospitals who admit patients with acute exacerbations of COPD were approached to participate in the audit and 190 hospitals took part.

- **Core Aims:**

The National COPD Audit Programme is a programme of work that aims to drive improvements in the quality of care and services provided for patients with COPD in England and Wales.

- **Objectives:**
- Following the 2014 audit improvement measures were recommended to increase the proportion of patients who receive early respiratory specialist review and to achieve better co-ordination of patient care at discharge and beyond.

Hospitals and clinical commissioning groups (CCG's) were urged to develop more effective pathways for managing COPD patients.

Please give a brief overview of main <u>National</u> findings from the published National Audit Report.

- Develop achievable Quality Improvement projects that aim to improve patient access to service, thereby possibly reducing the risk of avoidable admission;
- Review respiratory bed allocation, in light of the audit showing that most COPD patients are not being cared for by respiratory teams;
- Work to develop a 7-day, cross sector COPD service. Look at the existing resource and consider developing a business case to increase the team;
- Ensure there is an agreed COPD pathway that links discharge processes to admission avoidance strategies, as well as to evolving community-based frailty and social care services;
- Ensure that pulmonary rehabilitation is available to all appropriate patients, including early post-discharge.

The results for the 190 hospitals taking part in this audit are shown below:

	2017 (N=190)		
	Achieved	Not Achieved	Field left blank
6.1 All patients with COPD exacerbation who remain in hospital should be managed on a respiratory ward.	8% (16)	90% (171)	2% (3)
6.2 All patients with COPD exacerbation who remain in hospital should receive a specialist respiratory opinion within 24 hours.	32% (61)	66% (125)	2% (4)
6.3 Respiratory wards should be staffed to run at least one level 2 bed where NIV can be administered, commensurate on demand and the size of hospital.	57% (108)	41% (78)	2% (4)
6.4 ICU outreach services should be available 24 hours, 7 days a week.	64% (121)	35% (66)	2% (3)
6.5 All hospitals should have a fully funded and resourced smoking cessation programme delivered by dedicated smoking cessation practitioners. At least one WTE per week of smoking cessation support, commensurate with the size of the hospital, should be delivered to patients through individual and group sessions.	32% (61)	66% (126)	2% (3)
6.6 All hospitals should make spirometry results, normally available on lung function laboratory software, accessible from every computer desktop via their IT department's browser system/intranet.	47% (90)	51% (97)	2% (3)
6.7 There should be a data sharing agreement between the hospital and primary care IT services that ensures general practice spirometry data are made universally available.	21% (39)	78% (148)	2% (3)
6.8 Each acute hospital or trust should nominate a respiratory clinical lead for discharge care and integrating services, this individual having designated time within their job plan and responsibility for establishing discharge bundles within their organisation, improving the transfer and quality of discharge information to primary care teams, liaising with the existing CCG respiratory programme group or, where such a group is absent, forming one.	42% (79)	56% (107)	2% (4)
6.9 Hospitals should develop an improvement plan, agreed by the MDT and supported formally at trust board and CCG level, based upon the recommendations within the national and their site-specific report.	32% (60)	67% (127)	2% (3)

Was a national audit report provided which included ABUHB level data and conclusions? **No.**

What are the key actions?	
Action:	**Timescale**
To update the Quality Improvement Plans for each site involved in COPD care where staffing and budgets allow: There has been progress in the data entry for the COPD audit at NHH & YYF. The process is now improving at RGH and a partnership between the clinicians and Medical Directors Support Team, with admin staff undertaking the data entry.	No timescale
Develop achievable Quality Improvement projects that aim to improve patient access to service, thereby possibly reducing the risk of avoidable admission; Ensure that Pulmonary Rehabilitation (PR) is available to all appropriate patients, including early post-discharge. Progress has been made towards the delivery of universal access to PR across Gwent within acceptable timescales.	2019
Work to develop a 7-day, cross sector COPD service. Look at the existing resource and consider developing a business case to increase the team; There is already a 7 day access to COPD community care through the long standing COPD homecare service.	Complete
Ensure there is an agreed COPD pathway that links discharge processes to admission avoidance strategies, as well as to evolving community-based frailty and social care services; Further progress towards the development of a universal agreed COPD pathway and further development of community based services is hampered by the lack of a Gwent wide COPD/Chronic respiratory disease service. The personnel are in place and no additional resource is required but are managed by disparate agencies with differing agendas.	No timescale

National Audit/Registry Title: (National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme NACAP)	Adult Asthma
Clinical Lead:	**RGH -** Dr Patrick Flood-Page **NHH -** Dr Mike Pynn **YYF –** Dr Adlam (in the absence of Martha Scott)
Date of last data capture:	New audit
Publication date of last National Audit Report:	No publications as yet

The secondary care (adult asthma) work stream comprises two parts: a continuous clinical audit of people admitted to hospital adult services in England, Scotland and Wales with asthma attacks, and a snapshot audit of the organisation and resourcing of care. Participation in the secondary care work streams of the National Asthma and COPD Audit Programme (NACAP) is a requisite of trust quality accounts.

This audit aims to collect information on all people admitted to hospital adult services with asthma attacks. Admission data, obtained from patient case notes, is collected and entered into a secure and bespoke audit web tool. This audit launched on 1 November 2018. Within ABUHB, NHH started to enter to the data to the web tool in November 2018, along with YYF. However there are not the resources available in RGH for the same level of input and no records to date have been entered.

National Audit/Registry Title:	Children & Young People Asthma
Clinical Lead:	Dr Pierrepoint – NHH Dr Jyotsna Vaswami - RGH
Date of last data capture:	New audit
Publication date of last National Audit Report:	

The secondary care (children and young people asthma) work stream, which commenced in June 2019, which comprises of two parts: a continuous clinical audit of people admitted to hospital paediatric services in England, Scotland and Wales with

asthma attacks, and a snapshot audit of the organisation and resourcing of care. The clinical audit launched on Monday 3 June 2019.

This audit aims to collect information on children and young people aged 1-18 years, admitted to hospital paediatric services with an asthma attack. Admission data, obtained from patient case notes, will be collected, and entered into a secure and bespoke audit web tool.

The biennial snapshot organisational audit will collect data on the organisation and resource of services, with data collection via the bespoke audit web tool.

ABUHB Paediatric Services cannot commit to the participation of this audit on any of the hospital sites due to the pressure on Paediatricians in providing the operational service because of vacancies.

National Audit/Registry Title:	Pulmonary Rehabilitation
Clinical Lead:	Dr Mat Jones
Date of last data capture:	03/01/2017 – 28/04/2017
Publication date of last National Audit Report:	12th April 2018

Case Ascertainment:
ABUHB –
85% audit cases
22% Start date offered Pulmonary Rehab within 90 days

Please give a brief overview of the National Audit scope and aims:
Pulmonary rehabilitation (PR) is one of the most effective and high value interventions for people suffering with COPD. This report presents the second round of both clinical and organisational PR audits, which follow the first rounds conducted in 2015.
The 2015 audits demonstrated the substantial and clinically important health benefits associated with completion of PR, including a reduced risk of subsequent admission to hospital. However, they also emphasised the key problem of under-referral and non-completion of PR. The core aim is to disseminate the results of the national clinical and organisational audits of pulmonary rehabilitation services in England and Wales 2017.

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

- All patients referred for PR should be enrolled to the programme within 90 days of receipt of the referral. PR services that solely run cohort programmes could consider switching to rolling programmes (or using a combination of both) to reduce waiting times.

- Care processes should be reviewed to ensure that they meet BTS guidelines and quality standards. Particular attention should be paid to ensure that: exercise testing at assessment is performed to accepted standards; exercise training is accurately prescribed from an exercise test performed at assessment: patients are provided with a written, individualised exercise plan at discharge from PR.
- Patients at high risk of exacerbation and hospital admission should be identified at assessment for PR and evidence-based exacerbation prevention strategies implemented by developing integration and referral pathways. Key interventions may include: ensuring correct diagnosis; promoting smoking cessation and vaccination optimising drug therapy o managing comorbidities.
- Practices should review COPD registers to ensure all eligible patients are offered PR and that this offer is considered at each annual review.
- Hospital discharge teams should ensure that local discharge care bundles include the offer of early post-discharge PR, accompanied by information about the benefits of PR.
- Hospital and community specialist COPD healthcare teams should work with PR programmes to arrange review of individual patient exacerbation prevention measures.

5.2

Was a national audit report provided which included ABUHB level data and conclusions?

Yes - ABUHB reports above average cases at 85% where the median is 81% and yet only offers 22% a start date within 90 days.

What are the key actions?	
Action:	**Timescale**

National Audit/Registry Title:	Rheumatoid and Early Inflammatory Arthritis
Clinical Lead:	Dr Eleri Thomas
Date of last data capture (or ongoing):	Ongoing
Publication date of last National Audit Report:	July 2016

Case Ascertainment:
The first annual report based on continuous data entry will be published in October 2019.

Please give a brief overview of the National Audit scope and aims:

This audit aimed to assess the early management of patients referred to English and Welsh rheumatology services with suspected inflammatory arthritis and to enable patients to provide feedback on the services provided to them and on the impact of their arthritis on their lives. The audit enabled rheumatology services to measure their performance against NICE Quality Standards, benchmarked to regional and national comparators for the first time.
The 1st clinician and patient report, published in January 2016, highlighted wide variation in compliance against the NICE Quality Standards. This led the report to publish a series of recommendations for those responsible for medical education, rheumatology services and providers, CCGs, service users, NHS England and the wider research community within the specialty. We are aware of a large number of examples where the data have been used to address these recommendations and drive local service improvements.

The 2nd report provides an analysis of data collected between 1 February 2015 and 29 January 2016. The data collection, analysis processes and the IT platform remained unchanged during this time. This shortened data collection period was implemented in order to enable the analysis to be completed before the close of the contract. It did however mean that providers did not have an opportunity to act on the findings of the 1st report, aside from a few weeks for those which had been identified as outliers. The shortened time period meant that whilst the absolute number of participants in year was numerically lower (5,002 patients against 6,354 in year 1), the recruitment rate actually increased. There was also a considerable increase in the follow up data collection, which was completed at the end of January 2016.

Please give a brief overview of main national findings from the published National Audit Report.

The quality and range of data have increased significantly, with 124 (88%) providers providing sufficient data to allow robust benchmarking, up from 100 (70%) in year 1. In addition, the number of patients returning follow-up data increased by 50%.

• 95% of patients agreed that they had a good experience of care, up from 78% in year 1.

1% of patients disagreed, which remains unchanged from year 1 even with the increase in sample size.

• 68% of patients received Disease-Modifying Antirheumatic Drugs (DMARDs) within 6 weeks of referral (NICE Quality Standard 3), up from 53% in year 1.

• There was a strong correlation between nurse staffing levels and compliance with treatment initiation within 6 weeks (NICE Quality Standard 3) and delivery of treatment targets (NICE Quality Standard 5).

• The percentage of patients who recalled being asked about work in the course of their consultation increased to 66%, up from 42% in year 1.

• As in year one, the national findings disguised considerable variation at a local level. Compliance with NICE Quality Standard 2 for example ranged from 47% in London to 22% in Wales.

Was a national audit report provided which included ABUHB level data and conclusions?

Yes - Dashboards are available on the National Early Inflammatory Arthritis Audit (NEIAA) site with some of the Quality Standards detailed.


Health Board/Trust : NEVILL HALL HOSPITAL
Date from: May 2018
Date to: August 2019
View Dashboard
8
Records Complete
50
Records Incomplete
0
Records Errors
0
Records unstarted
Compliance: QS2
Days
National 25th centile baseline
QS2 NICE Standard (Assessment within 3 weeks of referral)
07/2019
National: 34
National
Local
Compliance: QS3
QS3 NICE Standard (DMARDS within 6 weeks of referral)
National 25th centile baseline
National
Local
Health Board/Trust : ROYAL GWENT HOSPITAL
Date from: May 2018
Date to: August 2019
View Dashboard
21
Records Complete
43
Records Incomplete
0
Records Errors
0
Records unstarted
Compliance: QS2
National 25th centile baseline
QS2 NICE Standard (Assessment within 3 weeks of referral)
National
Local
Compliance: QS3
QS3 NICE Standard (DMARDS within 6 weeks of referral)
National 25th centile baseline
National
Local

What are the key actions?	
Action:	**Timescale**

6.3 National Audits – Older People

National Audit/Registry Title: SSNAP

Clinical Lead: Dr Bhat

Date of last data capture (or ongoing): April 2013 – March 2018

Publication date of last National Audit Report: 14th February 2019

Case Ascertainment:
90%+

Please give a brief overview of the National Audit scope and aims:
Sentinel Stroke National Audit Programme (SSNAP) uses data collected from April 2013 to March 2018. It includes national level results for each domain of care and highlights changes in key aspects of stroke care over time. Each of the 'Key areas in depth' sections provide a more detailed commentary of national performance in specific areas of stroke care management and covers both acute and post-acute care processes.
In recent years we have observed consistent and sustained quarter by quarter improvements in stroke service performance. In the latest reporting period included in this publication (December 2017- March 2018), 36 teams achieved an overall 'A' score in SSNAP, which indicates fantastic quality of care. Services are continually improving the stroke care provided to patients. This is evident from the fact that in the first reporting period which included SSNAP scoring, July-September 2013, zero teams achieved an A grade and only 8 achieved a B grade.

Jul-Sep13	Apr-Jun14	Jul-Sep15	Apr-Jul16	Dec17-Mar18
A 0 (0%)	A 6 (3%)	A 36 (17%)	A 42 (18%)	A 36 (17%)
B 8 (4%)	B 17 (8%)	B 43 (21%)	B 59 (26%)	B 81 (37%)
C 19 (11%)	C 38 (19%)	C 38 (18%)	C 53 (23%)	C 54 (25%)
D 74 (42%)	D 97 (48%)	D 73 (35%)	D 62 (27%)	D 40 (18%)
E 77 (43%)	E 46 (23%)	E 16 (8%)	E 12 (5%)	E 7 (3%)

A: First class service B: Good or excellent in many aspects C: Reasonable overall – some areas require improvement D: Several areas require improvement E: Substantial improvement required

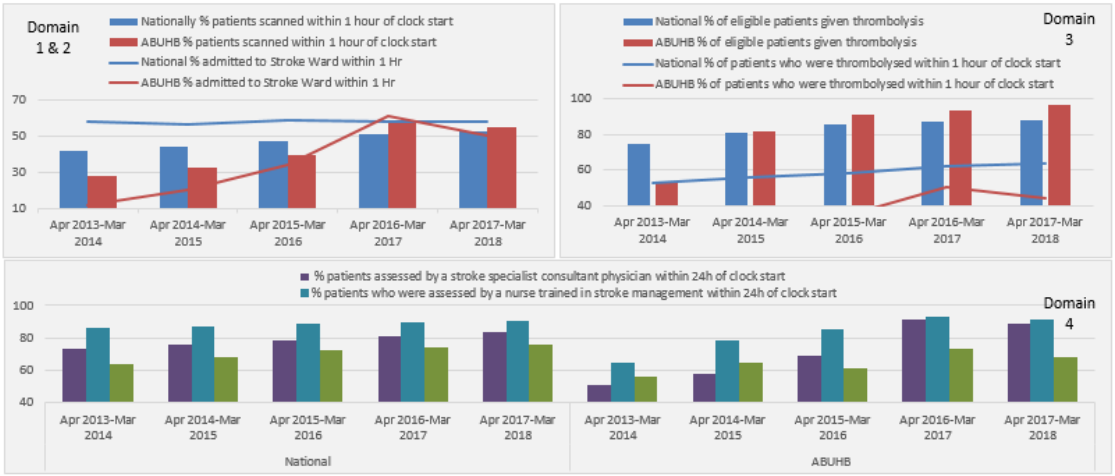
Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

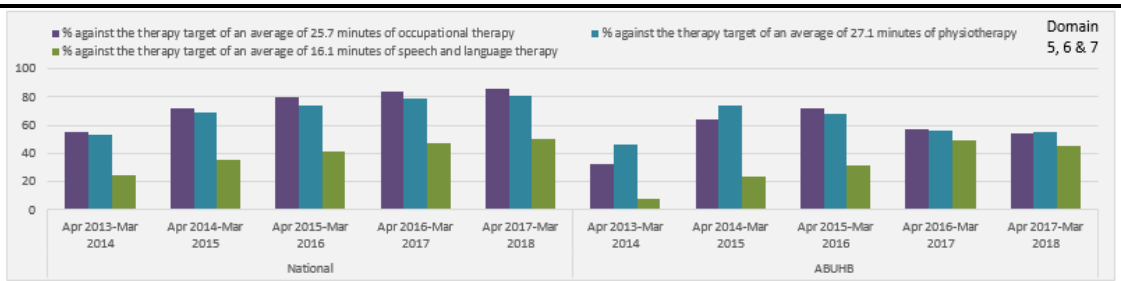
- Identification of AF patients and provide appropriate medication to reduce the risk of stroke.
- Tighter working with WAST to ensure the reduction of pre-hospital delays while continuing to improve the accuracy of initial pre-hospital strokes diagnosis and pre-alerts
- Ensuring rapid imaging after stroke continues and remains equitable whatever time or day of week
- Ensure stroke patients are admitted to the most appropriate ward for their care, whether Stroke Unit, ICU or HDU in a timely manner i.e. within 4 hours of clock start
- Keep improving on the quality of services delivering Thrombolysis regardless of time or when in the week they have their stroke, and raising public awareness of the symptoms of stroke.
- Ensuring appropriately trained staff are available 24/7 to provide a Thrombolectomy service.
- Research findings on improving patient outcomes after ICH stroke is very encouraging and the challenge is to now put these into practice across the

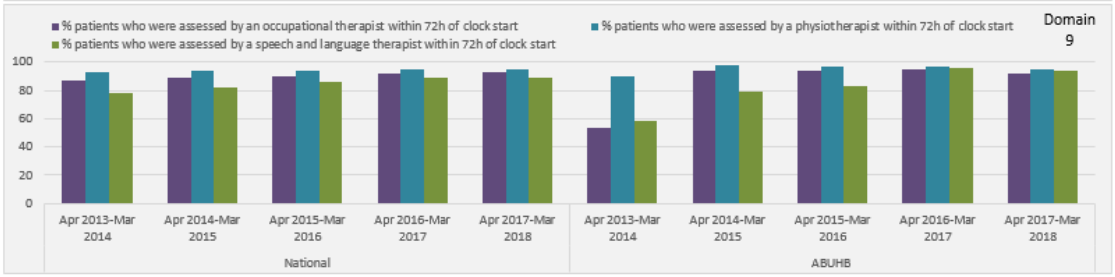
country. A case study by Dr Adrian Parry Jones is encouraged to be read by clinicians working in stroke and to adopt similar practices

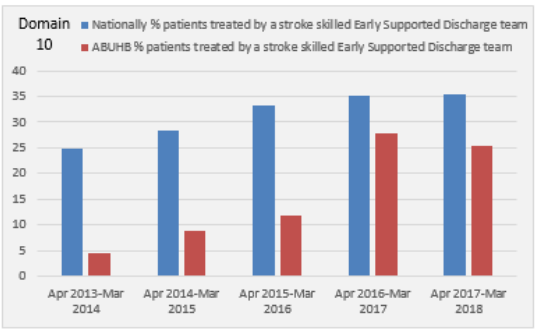
- Maintain staffing levels across the stroke pathway, from stroke specialists, specialist nurses and stroke trained OT< PT & SALT who see the patients within the timescales associated with key indicators
- Offer greater intensity of rehabilitation after stroke in hospital and when care is transferred home
- Ensuring patients remain on the stroke unit for the whole of the hospital stay and ensuring better transition from hospital to home for patient and carer
- Ensuring Patient Reported Outcomes Measures (PROMS) are used and documented
- Ensure longer term rehabilitation needs are met when required

Was a national audit report provided which included ABUHB level data and conclusions?









What are the key action?	
Action:	**Timescale**

National Audit/Registry Title: National Hip Fracture Database

Clinical Lead: Aled Evans (RGH) & Ian Mackie (NHH)

Date of last data capture (or ongoing): Jan – Dec 2017

Publication date of last National Audit Report: 15th Nov 2018

Case Ascertainment:
RGH - 123.5%
NHH - 91.6%

Case Ascertainment is calculated using the 2017 number of patients entered (numerator) and the 2016 number of patients treated (denominator) treated with a Hip Fracture from Patient Episode Database Wales (PEDW). It is therefore possible to have a >100% case ascertainment.

Please give a brief overview of the National Audit scope and aims:

The National Hip Fracture Database (NHFD) – established to measure quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.

The aim of the report is to compare individual care for patients with hip fracture to the evidence based standards, in order to challenge variations in practice around the country, supporting the development of a consensus about the best way to care for the frail elderly people who typically suffer this injury.

Please give a brief overview of main <u>Local</u> findings from the published National Audit Report.

The National Hip Fracture Database (NHFD) –

<u>RGH</u>

- Improved in 11 out of 20 standards, compared to 6 out of 20 last year
- Was in the top quartile for the overall audit in 4 standards, which matched last year. 2 of these standards were the same category as last year and 2 were different.
- Was in the bottom quartile for the overall audit in 9 standards, compared to 10 last year. 8 of these were the same category as last year, although performance was shown as improving in 5 out of these 8 standards.
- Delirium assessment was a new standard in the 2017 report. Although RGH is only in the second quartile for this standard in 2018, the rate has increased from 3% last year to 89.5% this year.
- The rate of those receiving a falls assessment rose from 78.6% last year to 96.7% this year
- There was a highlighted crude mortality data of 9.2% and an adjusted mortality of 10.8%. This is a slight improvement on last year's adjusted rate of 12% but RGH remains as an outlier above the 99.8% limit

<u>NHH</u>

- There was an improvement in 5 out of 20 standards, which matched last year. 2 of these standards were the same category as last year; 3 were different.

- Was in the top quartile for the overall audit in 3 standards, which matched last year. 1 of these standards was the same; 2 were different
- Was in the bottom quartile for the overall audit in 8 standards, which matched last year. 6 of these were the same as last year and, of these 6, performance had declined since last year in 4 standards
- The rate of those receiving a falls assessment had a slight rise from 97.1% last year to 98.2% this year
- There was a highlighted crude mortality rate of 9.5% and an adjusted rate of 11%. This was a decline on last year's adjusted figure of 7.8%. It was highlighted that missing or poor quality data was an concern in respect of NHH data

Was a national audit report provided which included ABUHB level data and conclusions?

Yes – There is access to individual hospital data via the benchmarking tables and dashboards.

Comparison of RGH & NHH against **All Wales** Average Data

Comparison of RGH & NHH against **Wales** National Data									
	2015			2016			2017		
	Wale	RGH	NHH	Wale	RGH	NHH	Wale	RGH	NHH
Admitted to orthopaedic ward within 4 hours	31.8	13.3	23.9	29.9	18.3	26.8	28.4	15.5	33.6
Mental test score recorded on admission	68.8	64.5	69.8	77.4	68.7	82.5	71.3	70.4	72.1
Perioperative medical assessment	43.7	14.3	81.1	49.9	12.8	89.3	51.6	40.8	87.3
Physiotherapy assessment by the day after surgery	No data	No data	No data	84	91.9	93.5	83.2	97.4	96
Mobilised out of bed by the day after surgery	62.8	61.2	65.6	66.1	76.2	64.7	65.2	75.7	72.5
Nutritional risk assessment	No data	No data	No data	62.2	90.1	34	68.7	98.4	42.4
Delirium assessment	No data	No data	No data	18.4	3	89	30.7	89.5	92.3
Not delirious when tested post-op.	No data	No data	No data	14.4	2.4	76.4	23.4	73.3	72.2
Received falls assessment*	71.1	81.7	97.9	71.5	78.6	97.1	68.8	96.7	98.2
Received bone health assessment*	84.1	84.7	98.6	84.8	79.7	98.1	83.4	87.8	99.3
Met best practice criteria	2.6	1	2.5	6.1	1.5	47.9	6.6	12.9	32.6
Surgery on day of, or day after, admission	62.9	45.2	73.5	63.6	42.2	77.1	59.4	47.7	78.4
Surgery supervised by consultant surgeon and anaesthetist	No data	No data	No data	39.1	50.9	31.8	44.9	49.2	41.4
General anaesthetic	59.6	30.4	52.3	57.3	38.3	45.2	59.3	38.4	52.4
General anaesthetic and nerve block (of all GA)	56.5	47.3	59.2	59.9	58.3	67.4	64.9	87	74.8
Spinal anaesthetic	37.4	68.2	47	39.4	61.1	52.4	37.7	58.9	44
Spinal anaesthetic and nerve block (of all SA)	41.6	56.4	51.1	45	65	51.6	58.7	74.9	72.5
Proportion of arthroplasties which are cemented	82.5	95.9	68.8	79.9	86.6	64	84.6	98.5	54.8
Eligible displaced intracapsular fractures treated with THR	28.2	16.4	40	25.4	8.9	21.6	29.2	11.3	42.5
Intertrochanteric fractures (excl. reverse oblique) treated with SHS	86.3	82.6	92.7	86.3	76.1	96.5	83.4	81.7	90.6
Subtrochanteric fractures treated with an IM nail	82.1	91.7	83.3	83.7	95.2	76.9	84.5	89.5	65
Case ascertainment: total cases compared to last year (%)	90.3	77.4	94.7	96.9	105.8	98.4	98.7	123.5	91.6
Acute length of stay (days)	19.7	22.5	19	20.1	21.3	16.7	19.6	17.1	16.6
Overall hospital length of stay (days)	33.5	39.7	35	34.2	35.6	33	33.6	30.7	30.7
Documented final discharge destination	91.9	100	97.3	92.8	97.4	96.4	92	98.1	93.3
Discharge to original residence within 120 days	67.1	73.8	67.4	69.5	69.6	71.2	69.7	72.8	68.9
Hip fractures which were sustained as an inpatient	5.9	4	9.3	5.4	5.5	6.8	5.5	8.2	7.1
Documented not to have developed a pressure ulcer	93	97.3	97.6	93.3	95.4	97.4	90.4	89.9	94
Documented not to have had a reoperation within 120 days	59.5	88.4	93.8	41	65.2	80.3	31.1	49.1	66.8
120 day follow up	28.3	88.1	98.8	35.2	71.1	98.9	36	60.4	85.2
Crude 30 day mortality rate	6.5	7.3	8.9	7	7.8	7.8	7.8	9.2	9.5
Adjusted 30 day mortality rate	7	10	8.8	7.8	12	7.8	8.6	10.8	11

Key
Better result than Wales overall
Worse result than Wales overall

Comparison of RGH & NHH against UK Average Data

Comparison of RGH & NHH against UK Average Data									
	2015			2016			2017		
	UK	RGH	NHH	UK	RGH	NHH	UK	RGH	NHH
Admitted to orthopaedic ward within 4 hours	47.4	13.3	23.9	39.9	18.3	26.8	39.7	15.5	33.6
Mental test score recorded on admission	95	64.5	69.8	95.6	68.7	82.5	94.8	70.4	72.1
Perioperative medical assessment	88	14.3	81.1	88.7	12.8	89.3	88.7	40.8	87.3
Physiotherapy assessment by the day after surgery	No data	No data	No data	90.2	91.9	93.5	94.5	97.4	96
Mobilised out of bed by the day after surgery	78	61.2	65.6	77.3	76.2	64.7	79	75.7	72.5
Nutritional risk assessment	No data	No data	No data	84.6	90.1	34	93.8	98.4	42.4
Delirium assessment	No data	No data	No data	55.8	3	89	85.7	89.5	92.3
Not delirious when tested post-op.	No data	No data	No data	42.6	2.4	76.4	63.8	73.3	72.2
Received falls assessment*	96.5	81.7	97.9	96.2	78.6	97.1	95.7	96.7	98.2
Received bone health assessment*	97	84.7	98.6	96.7	79.7	98.1	96.2	87.8	99.3
Met best practice criteria	61.7	1	2.5	59.2	1.5	47.9	57.1	12.9	32.6
Surgery on day of, or day after, admission	73.2	45.2	73.5	70.6	42.2	77.1	69.4	47.7	78.4
Surgery supervised by consultant surgeon and anaesthetist	No data	No data	No data	56.6	50.9	31.8	60.7	49.2	41.4
General anaesthetic	51.4	30.4	52.3	51	38.3	45.2	50.6	38.4	52.4
General anaesthetic and nerve block (of all GA)	58.6	47.3	59.2	64.2	58.3	67.4	70.8	87	74.8
Spinal anaesthetic	42.7	68.2	47	43.3	61.1	52.4	44.2	58.9	44
Spinal anaesthetic and nerve block (of all SA)	33	56.4	51.1	40.2	65	51.6	50.1	74.9	72.5
Proportion of arthroplasties which are cemented	85.1	95.9	68.8	86.1	86.6	64	88.9	98.5	54.8
Eligible displaced intracapsular fractures treated with THR	27	16.4	40	30.4	8.9	21.6	31.4	11.3	42.5
Intertrochanteric fractures (excl. reverse oblique) treated with SHS	80	82.6	92.7	80.8	76.1	96.5	78.8	81.7	90.6
Subtrochanteric fractures treated with an IM nail	79.8	91.7	83.3	84.2	95.2	76.9	86.4	89.5	65
Case ascertainment: total cases compared to last year (%)	91.2	77.4	94.7	95	105.8	98.4	100.7	123.5	91.6
Acute length of stay (days)	16	22.5	19	16.6	21.3	16.7	15.8	17.1	16.6
Overall hospital length of stay (days)	20.5	39.7	35	21.6	35.6	33	20.6	30.7	30.7
Documented final discharge destination	84.1	100	97.3	86.9	97.4	96.4	87.8	98.1	93.3
Discharge to original residence within 120 days	64	73.8	67.4	67.5	69.6	71.2	69.4	72.8	68.9
Hip fractures which were sustained as an inpatient	3.9	4	9.3	4.1	5.5	6.8	4	8.2	7.1
Documented not to have developed a pressure ulcer	95.3	97.3	97.6	95.7	95.4	97.4	96	89.9	94
Documented not to have had a reoperation within 120 days	50.1	88.4	93.8	36.7	65.2	80.3	33.9	49.1	66.8
120 day follow up	32.3	88.1	98.8	37.4	71.1	98.9	38.9	60.4	85.2
Crude 30 day mortality rate	7.1	7.3	8.9	6.7	7.8	7.8	6.9	9.2	9.5
Adjusted 30 day mortality rate	7.1	10	8.8	6.7	12	7.8	6.9	10.8	11

Key
Better result than UK overall
Worse result than UK overall

Key Actions - NHFD	Progress against action
• Action 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*	Complete

National Audit/Registry Title: National Audit of Inpatient Falls

Clinical Lead: Dr Vasishta

Date of last data capture (or ongoing):

Publication date of last National Audit Report: 22nd Nov 2017

Case Ascertainment:
Not available.

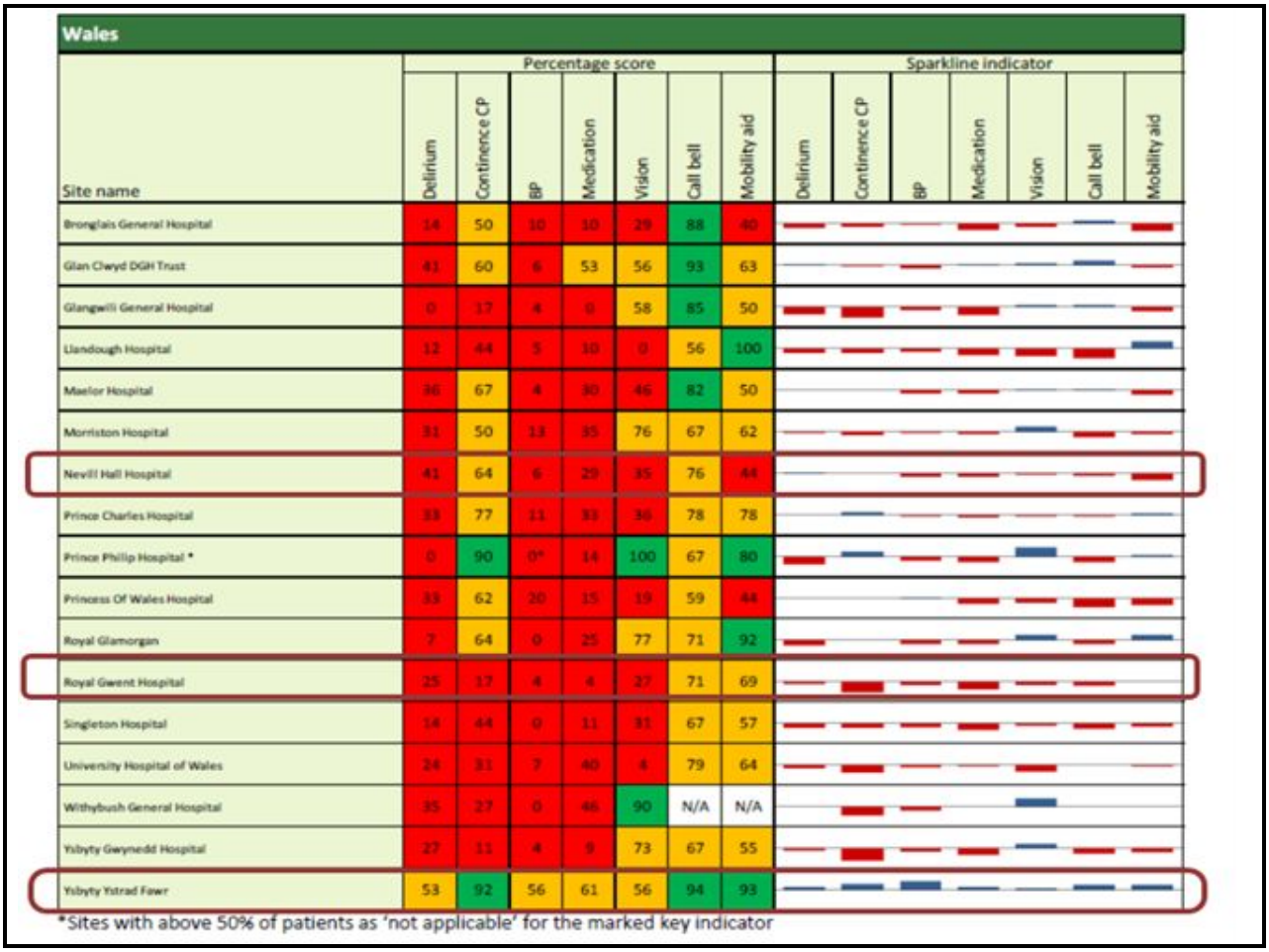
Please give a brief overview of the National Audit scope and aims:

The aim was to provide reliable, relevant and timely data suitable to facilitate local improvements in clinical practice and patient safety work in acute hospitals in order to reduce inpatient falls. Generally Welsh Hospitals compare poorly against the audit average for the 7 key indicators

- RGH was above the audit average for 0 indicators, below the audit average for 6 indicators and average for 1 indicator.
- NHH was marginally above the audit average for 1 indicator, below the audit average for 5 indicators and average for 1 indicator.
- YYF was above the audit average for all 7 indicators (although the return here was on 21 patients, rather than the 30 required)
- ABUHB has an Executive Led Falls Steering Group across Community and Hospital falls, with Operational Groups for both Hospital and Community falls.
- The Steering Group re-launched the reviewed In-patient Falls Policy in March 2017, which included the updated Multifactorial Risk Assessment. Following feedback, the MFRA is being reviewed again with further input from clinicians. It is planned to release to updated tool in January 2018
- Data regarding inpatient falls and fractures sustained from inpatient falls is now collected and shared with the Steering Group regularly

Was a national audit report provided which included ABUHB level data and conclusions?

The report is mostly based on national data however, there is data relating to RGH & NHH relating to key indicators.



Wales

Site name	Percentage score							Sparkline indicator						
	Delirium	Continence CP	BP	Medication	Vision	Call bell	Mobility aid	Delirium	Continence CP	BP	Medication	Vision	Call bell	Mobility aid
Bronglais General Hospital	14	50	10	10	29	88	40							
Glan Clwyd DGH Trust	41	60	6	53	56	93	63							
Glangwili General Hospital	0	17	4	0	58	85	50							
Llandough Hospital	12	44	5	10	0	56	100							
Maelor Hospital	36	67	4	30	46	82	50							
Morriston Hospital	31	50	13	35	76	67	62							
Nevill Hall Hospital	41	64	6	29	35	76	44							
Prince Charles Hospital	33	77	11	33	36	78	78							
Prince Philip Hospital *	0	90	0*	14	100	67	80							
Princess Of Wales Hospital	33	62	20	15	19	59	44							
Royal Glamorgan	7	64	0	25	77	71	92							
Royal Gwent Hospital	25	17	4	4	27	71	69							
Singleton Hospital	14	44	0	11	31	67	57							
University Hospital of Wales	24	31	7	40	4	79	64							
Withybush General Hospital	35	27	0	46	90	N/A	N/A							
Ysbyty Gwynedd Hospital	27	11	4	9	73	67	55							
Ysbyty Ystrad Fawr	53	92	56	61	56	94	93							

*Sites with above 50% of patients as 'not applicable' for the marked key indicator

What are the key actions?	
Key Actions - NAIF	**Progress against action**
Reported Level of Harm – Ensure that all falls in hospital resulting in hip fractures are reported as severe, as recommended by the National Reporting and Learning System. Do not adjust the level of harm according to the circumstances of the fall	This has been agreed for falls reported on DATIX.
Do not use falls risk prediction tool – Where these are still in use, we suggest that the group reviews the strong evidence and logic underpinning the NICE guidance, reviews the place of falls risk assessment and prevention in the acute care processes and works with colleagues to remove these where necessary	Removed from ABUHB Inpatient Falls and Prevention Policy.

Audit against NICE QSD86 quality statements 4-6 – These statements identify how you manage a patient following a fall and how to audit against these statements. This will identify areas of weakness and improve the care of these vulnerable patients	Post Falls assessment proforma based on NICE guidance developed and trialled on the wards. It has been incorporated into the ABUHB Falls policy
Dementia and delirium – We recommend that trusts and LHBs review their dementia and delirium policies to embed the use of standardised tools and link assessments to related clinical issues such as falls	A Delirium Assessment Tool has been piloted. Delirium Assessment is part of the Falls Multi-Functional Risk Assessment Tool (MFRA).
Continence care plan – We recommend that, for patients with lower urinary tract symptoms such as frequency, urgency, nocturia or incontinence, the implications for falls risk is considered and reflected in the care plan**.**	To be discussed with the Continence Team.
Lying and standing blood pressure – if rates are low in the local audit result, consider using the RCP clinical practice tool to standardise practice	This is part of the MFRA tool and is emphasised by the falls scrutiny panel.
Medication review – where rates of documented medication reviews and adjustments are low, we recommend working with colleagues locally, including pharmacy to review the approach to relevant documentation, ensuring that the reasons for changes are clearly recorded and communicated to the GP on hospital discharge.	This is part of the MFRA tool. A tool to support medication reviews so they take account of the increased falls risk of some medications, has been devised.
Visual impairment – If rates are low in the local audit result, consider using the RCP clinical practice tool to standardise practice.	Ensuring glasses are available and clean for patients with visual impairment is part of the MFRA.
Call bell at hand	This is standard practice.

Walking aids – We recommend that Trusts and LHBs develop a workable policy to ensure that all patients who need walking aids have access to the most appropriate type from the time of admission, 24/7. Regular audits should be undertaken to assess whether the policy is working and whether mobility aids are within the patient's reach, if they are needed.	Work is underway on the impact of colour Zimmer frames to ensure patients recognise their own Zimmer frame.

National Audit/Registry Title: Fracture Liaison Service Database

Clinical Lead: Jo Whiles

Date of last data capture (or ongoing): Jan – Dec 2017

Publication date of last National Audit Report: 3rd December 2018

Case Ascertainment:
Data entry commenced in January 2019.

Please give a brief overview of the National Audit scope and aims:

The Falls and Fragility Fracture Audit has been managed as a programme (FFFAP) designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives. It consists of the following three audits:

- **Fracture Liaison Services (FLS)** are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database (FLS-DB) to benchmark services and drive quality improvement.

Please give a brief overview of main <u>National</u> findings from the published National Audit Report.

Although a FLS has been in place within ABUHB for many years, data has not been added to the national database. The service manager commenced data entry at the end of 2018 with the intention of complete data being captured for 2019.

Was a national audit report provided which included ABUHB level data and conclusions?

No – the report provides national findings and recommendation.

What are the key actions?

Key Actions - FLS	Progress against action
Commence data entry	January 2019

National Audit/Registry Title: Dementia

Clinical Lead: Inder Singh

Date of last data capture (or ongoing): 2018/2019

Publication date of last National Audit Report: 11th July 2019

Case Ascertainment:
NHH - 38 case note reviews
YYF -14 case note reviews
RGH - 40 case note reviews

Please give a brief overview of the National Audit scope and aims:
Audit standards are derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter, and reports from Alzheimer's Society, Age UK and Royal Colleges. A full list of these standards can be found in the 'Round 4 resources' section on the NAD website.
The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against standards relating to care delivery which are known to impact upon people with dementia while in hospital. These standards have been derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter, and reports from Alzheimer's Society, Age UK and Royal Colleges. A full list of these standards and associated references can be found in the 'Round 4 resources' section on the NAD website.
This is the fourth national report produced by the National Audit of Dementia. Round 3 results showed that there had been a continued effort at an organisational level to improve care experience. However, further improvements were needed in relation to:

- Assessing and recording delirium

- Collection of personal information about the person with dementia's care needs
- Access to finger food and snacks
- Availability of dementia champions to support staff
- Ensuring people with dementia are properly consulted

The Welsh Government's Dementia Action Plan 2018–222 emphasises the importance of providing high quality dignified care for people with dementia.

Please give a brief overview of main <u>National</u> findings from the published National Audit Report.

Assessment

Round 3 Recommendations	Update
Medical and Nursing Directors should: Ensure that hospitals have robust mechanisms in place for assessing delirium in people with dementia including: • At admission, a full clinical delirium assessment, whenever indicators of delirium are identified • Cognitive tests administered on admission and again before discharge • Delirium screening and assessment fully documented in the patients notes (regardless of the outcome) • Care offered in concordance with the delirium evidence-base recommendations when the assessment indicates symptoms of delirium • Results recorded on the electronic discharge summary	Evidence of initial assessment of delirium carried out: 58%* Evidence of full assessment following signs of delirium: 66%* **Not comparable to Round 3 – changes to question*
	Cognitive testing before discharge: 22% (↓ 11%)
	Recording mental health needs in discharge correspondence: BPSD 44% (–) Delirium symptoms 47% (↓ 1%)
Medical and Nursing Directors should ensure that structured pain assessments are in use and properly recorded for people with a diagnosis or current history of dementia.	Pain assessment 85% (↑ 2%)

Information and Communication

Round 3 Recommendations	Update
Ward Managers should audit implementation/use of personal information collected to improve care for patients (e.g. This is Me[16] or other locally developed document). The result of the audit should be fed back to the dementia champions/dementia lead and ward staff.	Staff reporting that the personal information about patients with dementia was available for them always/most of the time: 63% (↑ 3%)
The Senior Clinical Lead for Dementia should ensure that copies of the personal information document (such as This is Me[16] or other locally developed document) are available on the ward and that the information is kept accessible to staff and visiting carers.	Spot check audit showing information present at bedsides: 59% (↑ 10%)
	Staff reporting they had the opportunity to use the information when it was available: 68% (–)

Nutrition

Round 3 Recommendations	Update
Clinical Commissioning Groups/Health Boards should ensure that tenders let by Trusts for new catering contracts always specify provision of finger foods for main meals and access to a range of snacks 24 hours a day.	Complete meal options that can be eaten without cutlery everyday: 75% (↑10%) Meal alternatives are available 24-hours a day: 60% (↑9%)
The Medical Director and Nursing Directors should promote the attendance of key carers to support care, but ensure that this is complementary to, and not instead of, care delivered by staff. The level of input by carers, and how carers feel about the level of input they have been asked to deliver should be monitored through carer feedback, complaints and PAL enquiries. Carer satisfaction should be seen as a marker of good care. Ward managers should be supported to ensure carers supporting patients should not be asked to leave at mealtimes and/or stopped from helping with meals. (This excludes emergency and urgent care and treatment).	Staff reporting that carers could visit out of hours always or most of the time: 86% (↑7%)
Ward Managers and Multidisciplinary teams should encourage carers to attend mealtimes whenever they want and ensure their input is valued.	

Staffing and Training

Round 3 Recommendations	Update
The Medical Director and Nursing Directors should (with the Education Lead for the Trust or Health Board) ensure that training in dementia awareness is a priority for all staffing groups. eLearning should not be relied on as the sole medium for delivering training in dementia awareness.	Staff reporting that they had received some form of dementia training from the hospital they currently work at: 89% (↑6%) Staff only receiving training in eLearning format: 23% (↓11%)
The Medical Director and Nursing Directors should (with the Head of Therapy Directorate) keep central training records on all staff receiving training in dementia, enabling them to be aware of the levels of awareness and expertise in the hospital.	Hospitals able to provide hospital level information on the number of staff with dementia training: 53%* Hospitals able to provide Trust level information on the number of staff with dementia training: 77%* **Not comparable to Round 3 – changes to question*

Discharge

Round 3 Recommendations	Update
The Safeguarding Lead should ensure that staff are trained in the Mental Capacity Act, including consent, appropriate use of best interests decision making, the use of Lasting Power of Attorney and Advance Decision Making. Training should cover supportive communication with family members/carers on these topics.	Record of patient's consent/best interests decision making when change of residence proposed: 66% (–)
The Safeguarding Lead should ensure staff are properly trained and informed on the need for the appropriate presence and participation of the patient in discussions about the patient's care, treatment and discharge. Discharge discussions should include a comprehensive note of who was present and the views expressed. The appropriate presence and involvement of the carer(s), as determined by patient consent or best interest decision, should also be recorded.	Evidence of discussion with the person with dementia at discharge: 57% (↑3%). Evidence of discussion with the carer or relative: 83% (↑2%)

Governance

Round 3 Recommendations	Update
The Chief Executive Officer should ensure that there is a dementia champion available to support staff 24 hours per day, seven days per week. This could be achieved through ensuring that people in roles such as Site Nurse Practitioners and Bed Managers have expertise in dementia care.	Dementia champions in place at Directorate level: 77% (↓5%) Ward level: 89% (↓5%)
Trust Boards/Council of Governors/Health Boards should request that the information they receive on delayed discharges and patient safety indicators including falls, pressure ulcers and readmissions can identify the proportion of the patient population with dementia	The number of hospital Trusts/ Health Boards that can identify patients with dementia when reviewing: In-hospital falls: 64% (↑4%) Delayed discharges: 40% (↑8%) Readmissions: 37% (↑5%)
The Chief Executive Officer should ensure that there is an activity program which provides opportunities for social interaction for people with dementia The Director of Nursing and Head of Therapy Directorate should work with dementia and therapy leads to create or enhance activity programs to provide opportunities for social interaction for people with dementia – especially for patients experiencing longer lengths of stay.	Hospitals provide opportunities for social interaction away from the bedside: On all adult wards: 17% (↑2%) On care of the elderly wards: 36% (↓3%) On some wards: 41% (↑11%)
The Senior Clinical Lead for Dementia should: • Build clear links to the delirium pathway into the dementia pathway, care bundle or protocol. • Work with clinical teams to target local Trust quality improvement initiatives aimed at improving care by developing and implementing integrated evidence-based care pathways for people with dementia and delirium. These should include: – Falls and fractured hips; UTIs; Chest infections; Stroke The overlap and learning from other audits such as the National Audit of Inpatient Falls should be acknowledged and incorporated in this work and highlighted within staff training.	Hospitals care pathways that are integrated with the dementia pathway: Delirium: 95% Stroke: 47% Fractured neck of femur: 58%* **Not comparable to Round 3 – changes to question*

Reports are avaialable for RGH, NHH and YYF with the same recommendations that fall in line with the national findings.

Was a national audit report provided which included ABUHB level data and conclusions?

Yes - Local reports are provided for RGH, NHH & YYF

	Governance % (Rank/195)	Nutrition % (Rank/195)	Discharge % (Rank/191)	Assessment % (Rank/191)	Staff Comm % (Rank/182)	Carer Comm % (Rank/141)	Overall Carer % (Rank/141)
Royal Gwent Hospital	32.3 (182) ↓	100 (1) ↑	61.2 (162) ↓	89.3 (85) ↑	59.5 (153) ↓	-	-
Nevill Hall Hospital	38.7 (173) ↓	100 (1) –	84.4 (57) ↑	89.3 (85) ↑	60.8 (147) ↑	-	-
Ysbyty Ystrad Fawr	45.2 (160) ↑	100 (1) –	93.2 (29) ↑	87.5 (106) ↑	68.1 (71) ↑	80 (11) ↑	82.5 (18) ↑

5.2

What are the key actions?

Key Actions	Progress against action
Action plans due October 2019	

National Audit/Registry Title: National Breast Cancer in Older People

Clinical Lead: Chris Gateley

Date of last data capture (or ongoing): 2018/2019

Publication date of last National Audit Report: 9th May 2019

Case ascertainment:
ABUHB submitted 354 records for patients over 50 years diagnosed in 2017.

Please give a brief overview of the National Audit scope and aims:
The National Audit of Breast Cancer in Older Patients (NABCOP) was established to evaluate the care received by older women (aged 70+ years) diagnosed with breast cancer in NHS hospitals within England and Wales. The audit was commissioned because of the greater variation in the management of breast cancer among older women compared with women aged under 70 years.
The NABCOP is a collaboration between the Clinical Effectiveness Unit at the Royal College of Surgeons of England (RCS) and the Association of Breast Surgery. The audit works in partnership with the National Cancer Registration and Analysis Service, Public Health England and the Wales Cancer Network, and uses the routinely collected data

collected by these national bodies. The audit was commissioned by the Healthcare Quality Improvement Partnership.
The audit aims to evaluate the care provided to, and subsequent outcomes for, women diagnosed with breast cancer aged 70 years or over, comparing this with a younger cohort of women diagnosed between 50 and 69 years to study any age-related treatment variations.
There is now a clear theme emerging from the data that women aged 70+ years are not receiving the same treatment as those in the younger cohort, and that this appears to be related to their older age rather than their fitness to receive treatments. It is now important to spread the key message that chronological age alone should not be the main factor in determining treatment if we are to improve breast cancer outcomes in older people.

Please give a brief overview of main <u>National</u> findings from the published National Audit Report.

An emerging theme in this report is that the older patients have similar clinical and pathological characteristics to younger patients, and there is no evidence that invasive breast cancer is a more benign disease in older patients. Variations in practice are therefore of greater concern.

Participation and data quality

Among women aged 50 years and over diagnosed with breast cancer in 2017:
• data completeness exceeds 90% among many key items and has improved overall
• data on pre-treatment performance status and molecular markers were poorly completed in some NHS organisations, particularly for older women.

Care at the time of diagnosis

The routes to diagnosis followed the expected pathways:
• 59% of women aged between 50–69 years were diagnosed after screening.
• 67% of women aged 70+ years were diagnosed after general practitioner (GP) referral.
• Overall, 1% of women were diagnosed after an emergency admission.

Among women diagnosed with early invasive breast cancer not detected at screening:
• 67% received the standard triple diagnostic assessment in a single visit, with no difference by age.

This low estimate of women having triple diagnostic assessment arose from uncertainty and incompleteness of the imaging and biopsy dates.

Where data were available, 95% of women were reported to have seen a breast clinical nurse specialist.

Treatment for women diagnosed with DCIS
Surgical resection is the most important treatment for DCIS, but there is lack of strong trial-based evidence to support treatment decisions in older women.

• 93% of women aged 50–69 years had surgery, compared with 81% of women aged 70+ years.
• Rates varied across NHS organisations, particularly for women aged 70+ years.
• 63% of women aged 50–69 years received adjuvant radiotherapy after breast conserving surgery, compared with 47% of women aged 70+ years.

Was a national audit report provided which included ABUHB level data and conclusions?

Charts highlighting the ABUHB position against other hospitals are available.

What are the key actions?

Key Actions	Progress against action
Completeness of data items NHS organisations must ensure that the following information is uploaded to the national cancer registration services: • tumour size consistent with the entered T (tumour) stage • N (nodal) stage, M (metastasis) stage • ER and HER2 status for invasive breast cancer • World Health Organization performance status. NHS organisations should identify a clinician responsible for reviewing and checking their units' data returns.	Not included in national cancer services database, recorded in patients assessed for or undergoing surgery
Triple diagnostic assessment NHS organisations must ensure that: • women are able to receive triple assessment at their initial clinic visit after referral for suspected breast cancer, in line with National Institute for	Where GP referral letter indicates that a mammogram is likely to be required this is performed at a separate pre-clinic visit, this allows

Health and Care Excellence (NICE) recommendations • dates of assessment for all investigations performed at a triple assessment clinic are submitted to the national cancer registration services.	us to see greater numbers of patients in the clinic to keep up with targets. All other investigations required, other than stereotactic biopsy are performed at the clinic visit
Involvement of a breast clinical nurse specialist NHS organisations must ensure that: • women are assigned a named breast clinical nurse specialist to provide information and support • data on the assignment of a named breast clinical nurse specialist are submitted to the national cancer registration services.	All breast cancer patients have a named Breast Cancer Nurse/Key worker, who is recorded in the patient's notes and GP communications
Treatment for DCIS NHS organisations must ensure that: • women are counselled appropriately about the gap in knowledge and guidelines • emphasis is placed on treating women with DCIS using a risk-based, rather than age-stratified, approach (clinical research in this area should be prioritised) • older women who undergo breast conserving surgery for high-risk DCIS, and who have few comorbidities and frailty, should be considered for radiotherapy.	Discussions are had with patients with low grade DCIS that this could be considered to be a risk factor rather than an early cancer. All patients are offered surgery for DCIS, numerically however less is identified in the over 70's as they are not invited for breast screening. All patients with high grade DCIS are offered radiotherapy, independent on age.
Treatment for early invasive breast cancer NHS organisations must ensure that: • there is consistent assessment and recording of comorbidity and frailty in breast clinics • medical optimisation of women with ER-positive early invasive breast cancer is instituted to maximise potential for their suitability for surgery • women with high-risk early invasive breast cancer are counselled on the benefit and risk of adjuvant radiotherapy based on tumour characteristics and objective assessment of	Fitness for anaesthesia is assessed in the breast clinic in all patient diagnosed with breast cancer. Where there is uncertainty they are referred to an anaesthetic assessment clinic and their medical status optimised. We also have the option of performing awake breast surgery, under a regional block.

patient fitness, rather than chronological age alone • all women, irrespective of age, with (1) ER-negative, HER2-negative early invasive breast cancer with malignant lymph nodes or (2) HER2-positive early invasive breast cancer have an objective assessment of likelihood of benefit and risk of chemotherapy based on tumour factors and patient fitness • they evaluate their services for medical optimisation for older women, who would benefit from receiving chemotherapy.	High risk patients are offered radiotherapy unless they are unable to be compliant. All patients who are ER negative or HER2 positive are considered for chemotherapy and Herceptin.
Treatment for metastatic breast cancer NHS organisations must ensure that: • ER status is assessed and recorded for women with metastatic breast cancer; all women who are ER-positive should be offered endocrine therapy • consideration of chemotherapy is based on an objective assessment of the likelihood of benefit, health and predicted life expectancy rather than chronological age alone.	ER status is recorded in all breast cancer patients, reviewed and/or repeated when metastatic disease develops. The palliative treatment is tailored individually depending on the patient and site of recurrence.
Patient experience of breast cancer NHS organisations must ensure that women are given enough information about their radiotherapy or chemotherapy treatments. Clinical teams should ask for feedback from their patients, at regular intervals, to ensure that they have sufficient information and are engaged in a shared decision-making process.	Every breast cancer patient has a Breast Care Nurse/Key Worker who supports them throughout and at the end of treatment.

National Audit/Registry Title:	National Audit for Care at the End of Life
Clinical Lead:	
Date of last data capture (or ongoing):	2018/2019
Publication date of last National Audit Report:	11th July 2019

Case Ascertainment:
80 cases were audited for acute hospitals and 20 cases for deaths within the community hospitals.

Please give a brief overview of the National Audit scope and aims:

The National Audit of Care at the End of Life (NACEL) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government in October 2017. NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland.

Every year, over half a million people die in England and Wales, almost half of these in a hospital setting. Following the Neuberger review, More Care, Less Pathway, 2013, and the phasing out of the Liverpool Care Pathway (LCP), the Leadership Alliance published One Chance To Get It Right, 2014, setting out the five priorities for care of the dying person. NACEL measures the performance of hospitals against criteria relating to the five priorities, and relevant NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

The objectives of the first round of NACEL are:

- To establish whether appropriate structures, policies and training are in place to support high quality care at the end of life.
- To assess compliance with national guidance on care at the end of life – *One Chance To Get It Right, NICE Guideline* and the *NICE Quality Standards* for end of life care.
- To determine what is important to dying people and those important to them.
- To provide audit outputs which enable stakeholders to identify areas for service improvement.
- To provide a strategic overview of progress with the provision of high quality care at the end of life in England, Wales and Northern Ireland.

Please give a brief overview of main <u>Local</u> findings from the published National Audit Report.

Recognising the possibility that death may be imminent

Compliance with documenting that a person may die within the next few hours or days is high. However, for around half of patients, they are recognised to be dying less than one and a half days before they die, leaving a limited amount of time to discuss and implement an individual plan of care.

Communication with the dying person

Recording of discussions with the dying person could be improved. In around one third of cases, a discussion with the patient about the plan of care, and discussions about medication, hydration and nutrition had not been recorded.

Around three quarters of respondents to the Quality Survey reported a positive experience of communication, but concerns were raised about communication with the dying person not being sensitive or being 'mixed' in 22% of cases.

Communication with families and others

As would be expected given the timing of recognition of death, discussions about the plan of care were more likely to be held, and documented, with families and others than with the dying patient. Discussions about medication, hydration and nutrition could be better recorded.

In around a quarter of cases, the Quality Survey results suggest there was scope for improvement in communication with families and others.

Involvement in decision making

In the majority of cases, discussions with the patient and with the family/others about life-sustaining treatments and cardiopulmonary resuscitation (CPR) were held and documented or reasons recorded as to why the discussion did not take place.

Although the use of advance care planning has increased (in place in 7% of cases) compared to the *2016 Audit* result (4%, England, acute trusts only), there remains scope for improvement.

Responses to the Quality Survey suggest most people felt that they, and the dying person, were as involved in decision making as they wanted to be, however, 22% of those responding would like to have been more involved.

Executive summary

The Quality Survey results indicate that around one third of dying patients were admitted to hospital three or more times within the last 12 months of life, suggesting there may be more opportunities to plan for end of life care from a much earlier stage.

Needs of families and others

There is documented evidence that the needs of the family were asked about in just over half of cases, a result which is in line with low compliance highlighted in this area in the previous audit (*End of Life Care Audit – Dying in Hospital, 2016*).

Although a high proportion of respondents to the Quality Survey felt they were supported after the patient's death, when asked more specifically about emotional and practical support during the last two or three days, almost one third of those responding felt they did not have enough support.

Individual plan of care

The evidence overall from the audit suggests there remains a gap in the development and documentation of an individual plan of care for every dying person. There was documented evidence of the existence of an end of life care plan in 62% of cases.

Review of routine monitoring of vital signs, blood sugar monitoring, administration of oxygen and antibiotics was not recorded, and no reason given for this, in between a third and a quarter of cases.

Three quarters of respondents felt that hospital was the right place for the person to die. From the Case Note Review, attempts were made to transfer 11% of patients out of hospital which were, for some reason, unsuccessful. Respondents to the Quality Survey reported that 16% felt no effort had been made to transfer the person from hospital if that was their wish. The audit will not have captured instances where a successful transfer out of hospital was made.

Many of the comments received in the Quality Survey related to a lack of privacy and appropriately quiet environment where the person was on a ward rather than in a side room. The results showed that around one third of people died in a shared bay.

Families' and others' experience of care

The results suggest the majority of people responding to the Quality Survey felt the patient had received good care and had been treated with compassion. However, around one in five Quality Survey respondents felt there was scope to improve the quality of care and sensitive communication with both the patient and the family and others.

Governance

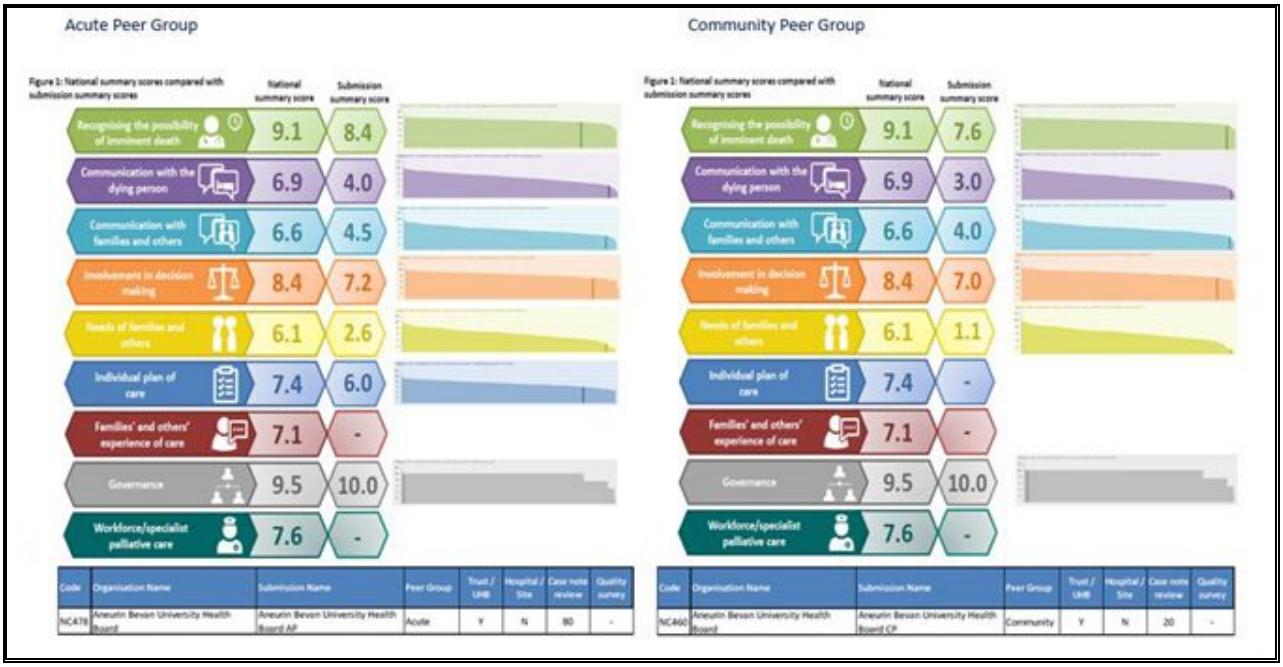
Compliance with appropriate policies is generally high and the majority of organisations have action plans to promote improvements in end of life care. However, the results from other themes of the audit suggest further work needs to be done on the implementation of policies and action plans.

Workforce/specialist palliative care

Just over half of hospitals have specialist palliative care nurses available 7 days a week for face-to-face contacts (as recommended in *One Chance To Get It Right*).

Was a national audit report provided which included ABUHB level data and conclusions?

Yes – HB local audit results as shown in the NACEL online toolkit and bespoke dashboards, in the context of the national guidance.



What are the key actions?	
Key Actions	**Progress against action**
Actions due October 2019	

6.4 National Audits – Heart

National Audit/Registry Title: National Heart Failure Audit

Clinical Lead: Nigel Brown

Date of last data capture (or ongoing): Ongoing (report based on data from April 2015-March 2016)

Publication date of last National Audit Report: 10th Aug 2017

Case ascertainment:
ABUHB Case Ascertainment: 52%
England & Wales average 82%
Wales average 77%

Please give a brief overview of the National Audit scope and aims:

Aim: Helping all Clinicians to improve the quality of the Heart Failure Service to achieve better outcomes for Patients

- **RGH** In hospital care was below national average in 5 out of 5 standards, Heart Failure medicines was above national average in all 4 out of 4 standards while Follow up referrals was below national average in all 4 out of 4 standards
- **NHH** In hospital care was below national average in 4 out of 5 standards, Heart failure medicines was above national average in all 4 out of 4 standards while Follow up referrals was below national average in 3 out of 4 standards
- **NHH** still has a high percentage referred to cardiac rehabilitation compared to the National Average, 30.1% compared to 12.1%, whilst RGH only achieved 1.9%

There is an HF Specialist Nurse for each Borough: 1 works at NHH (covering the Hospital, Monmouthshire and Blaenau Gwent Communities), 1 at RGH (covering the Newport Community), 1 at YYF (Covering the Caerphilly Community) and 1 community based (covering Torfaen).

The HF specialist nurse at RGH has had long term sickness and there was no cover – hence the reduced case ascertainment at RGH. There are plans by the newly appointed HF clinical lead to change work patterns, in order to facilitate data-entry to the audit. There are also plans to include YYF data for future HF audits.

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

1. This year's Heart Failure (HF) audit is based on 66,695 admissions to hospitals in England and Wales between April 2015 and March 2016. This represents 82% of HF admissions as the patient's primary diagnosis in England and 77% in Wales.

2. During hospital admission, more than 90% of patients are recorded as having had an up to date echocardiogram, a key diagnostic test. However, rates are higher for those admitted to Cardiology (96%) rather than General Medical (85%) wards. Specialist input, irrespective of the place of admission is associated with higher rates (95%) of echocardiography.

3. The prescription of key disease-modifying medicines for patients with heart failure and a reduced left ventricular ejection fraction (HF-REF) has increased, including beta-blockers (87%) and mineralocorticoid antagonists (53%); treatments that are both life-saving and inexpensive.

4. Prescription rates for all three key disease modifying medications [angiotensin converting enzyme inhibitors (ACEI), beta-blockers (BB) and mineralocorticoid

(aldosterone) receptor antagonist (MRA)] for patients with HF-REF has increased from 35% to 53% for those admitted to cardiology wards over the last six years.

5. Irrespective of the place of admission, 47% of patients with HF-REF seen by a member of the specialist HF team as an inpatient, were prescribed all three disease modifying drugs, key priorities for implementation (KPI)1.This has increased from 45% last year, albeit with considerable room for further improvement.

6. The number of patients seen by HF specialists remains high at 80% this year. In particular HF nurses saw more HF patients admitted onto general medical wards (33%) than last year (24%). This is important as specialist care improves mortality.

7. The mortality of patients hospitalised with heart failure is significantly lower this year at 8.9% compared to 9.6% last year. However, mortality remains too high and there are large variations in mortality amongst hospitals.

8. Mortality rates in hospital are better for those admitted to cardiology wards.

9. Post mortality rates at one year to 6 year are independently associated with admission to a cardiology ward, cardiology follow up and the use of key disease-modifying medicines for HF-REF.

10. Had the patients identified within this audit cycle as having HF-REF, who left hospital on none of the three disease modifying drugs, been prescribed all three, then at least an additional 212 patients would likely have been alive at the time of census. With more comprehensive prescription and dose optimisation across the audit there is the ability to prevent numerous additional deaths.

11. This year's report shows modest but important improvements which are to be celebrated. But an 8.9% inpatient mortality cannot be accepted and requires urgent attention within every acute Trust admitting patients with Heart Failure.

Was a national audit report provided which included ABUHB level data and conclusions?

- Work closely to ensure accurate and complete audit/data collection for all patients
- Ensure sustainable resources allocated to clinical audit
- Ensure RGH meets the minimum data entry requirement to the audit which is currently set at 70% of all HF admissions
- Improvements need to be made in RGH and NHH with regards to "In hospital care" which are below national average in all 4 standards.
- Only 54.3% RGH & 48.8 NHH patients were seen by a Cardiologist compared to a national average of 56.9%
- Only 61.9% RGH & 53.1% NHH patients were seen by a HF specialist compared to the national average of 79%

- Only 79.7% RGH & 67.3% NHH patients received an Echo compared to the national average of 90.1%
- Improvement needs to be made in RGH in the % receiving Discharge planning-50.7% compared to the national average 87.3%

Improvement need to be made in "Follow up referrals": RGH was below National average in 4 out 4 standards whilst, NHH was below in 3 out of 4 standards. NHH has a high percentage referred to cardiac rehabilitation 30.1% compared to the national average 12.1%, whilst RGH has only 1.9%

What are the key actions?	
Action:	**Timescale**
• Audit at NHH being under taken weekly by HF nurse to maintain at least 70% data input. • NICOR audit being commenced January 2018 for discharges from RG and YYF. This is to be undertaken by Heart failure nurses which will impact on clinical capacity. • Currently waiting for sign off by Caldicott guardian to enable registration onto NICOR site	Timescales to be confirmed.
• Due to <50% data collection at RGH it is difficult to draw any definitive conclusions from this data and our key priority is to ensure we capture accurate data as we move forward as outlined above in point 1. • Limited data collection makes this difficult to accurately interpret but it is considered that review by cardiologist would not differ statistically from the national average at RGH. • Previous internal ICHOM work at NHH identified inaccuracies in those that were coded as heart failure and not under the care of a cardiologist and therefore it is felt that the % reviewed by cardiology may be inaccurate. • Internal audit is proposed for 2018 to identify any discrepancies in coding and numbers not seen by cardiologists	Timescales to be confirmed.
• A recent appointment of a cardiologist to NHH should enable more patients to be reviewed by a cardiologist. • Currently there is limited provision for HF nurses (RG) to review patients as inpatients and therefore those patients not on a cardiology ward may have limited input, however	Timescales to be confirmed.

without accurate data this is difficult to be sure of. Without additional resource it is not possible to progress this area of work. • Since September 2017 there has been scope for some inpatient work at NHH • The need for inpatient HF nurse specialist input is proposed as part of the IMTP. • Details of patients have been requested to enable an audit of those not receiving an ECHO to be undertaken by junior Doctors so that this data may be understood in more detail.	
• Discharge plan to be discussed at cardiology Directorate (February 2018) and format of discharge plan agreed.	Timescales to be confirmed.
• There is insufficient capacity within the HF nurse service to review patients within 2 weeks of discharge and because of this a lower percentage of patients are referred, and usually the referrals are for the more complex patients. • A revised model is being developed to support the review of patients in both secondary and primary care. • There is insufficient capacity to enrol all heart failure patients onto cardiac rehabilitation programs and therefore few are referred. Data is being collected on the number of current referrals, waiting times and % of total so that this may be shared with the Health Board and considered as part of the IMTP	Timescales to be confirmed.

National Audit/Registry Title:	Cardiac Rhythm Management
Clinical Lead:	Phillip Campbell
Date of last data capture (or ongoing):	2016-2017
Publication date of last National Audit Report:	11th July 2019

Case ascertainment:

Please give a brief overview of the National Audit scope and aims:
The national CRM annual report details clinical activity in the fields of:

- Permanent pacemakers (PPMs - for the treatment of blackouts and other symptoms);
- Implantable cardioverter defibrillators (ICDs - for the prevention of sudden cardiac death);
- Cardiac resynchronisation therapy (CRT - for the treatment of heart failure, cardiac resynchronisation therapy with defibrillation (CRT-D) or pacing (CRT-P));
- Catheter ablation (for the treatment of simple, complex atrial, and ventricular arrhythmias).

Please give a brief overview of main National findings from the published National Audit Report.

NATIONAL TRENDS

1. The overall pacemaker implant rate in the UK has gradually increased over the last decade, in line with an ageing population, though this trend was not seen in the last year.
2. The overall implant rate for defibrillators (ICD and CRT-D) rose substantially following NICE guidance in 2014, but has levelled off in the last year. An increasing proportion of implants are of CRT-D rather than ICD devices. The rate of implantation of CRT-P devices is also increasing.
3. Nationally, rates vary considerably between the UK nations. Scotland reports considerably fewer ICDs and CRT devices per head of population compared to England, Wales and Northern Ireland.

- Regionally, the maps detail the rate of treatment with CRM devices and three classes of catheter ablation, according to where patients reside (within CCG and Health Board boundaries) across England and Wales for financial years 2014/15, 2015/16 and 2016/17. These show considerable variation in implant rates, which has not improved in the last two years.
- Variation is particularly marked for ICD and CRT devices and catheter ablation. This geographical variance is greater than one might expect regarding the need for treatment and could suggest other factors responsible for the extent to which current evidence is applied. A better understanding of the causes of variation is needed.

4. Annual growth in catheter ablation procedures has slowed from 20% (2007/08-2011/12) to 4% (2012/13-2016/17). Recent growth has been entirely in Atrial Fibrillation (AF) ablation and related procedures.

SAFETY – PROCEDURE VOLUMES

5. Following a fall in the previous year, the number of adult NHS hospitals implanting small numbers of pacemakers (below the recommended minimum) has increased slightly (from 24 to 30). The number of adult NHS hospitals implanting small numbers of complex devices (below the recommended minimum) has fallen from 47 to 39, but this still represents 36% of such hospitals.
6. A third of centres undertaking catheter ablation procedures do not reach the minimum recommended overall procedure volume, though half of these are private/ children's hospitals.
7. The number of NHS adult hospitals failing to reach the minimum recommended volume for AF ablation has fallen from 13 to 4 over two years.
8. A small minority of patients are treated in low volume centres (including private and children's hospitals) – this ranges from 3.2% for AF ablation to 7.4% for complex devices.

EFFECTIVENESS

9. Data completeness is variable between centres, especially for operator General Medical Council (GMC) Number and some clinical variables. Low completeness is more common in small volume centres. Considerable improvement in data submission will be essential to pursue plans to report clinical outcomes and quality indicators in the future.
10. Approximately 90% of centres achieve the target of ≥80% compliance with NICE guidance for pacemaker type, and over 90% of patients receive the recommended type of pacemaker.
11. However, only around 50% of centres document ≥80% compliance with NICE guidance for ICD implantation. Approximately 80% of ICD implants are documented to meet NICE guidance.

OUTCOMES

1-year re-intervention rates are reported for the first time. These are dependent on submission of NHS Number, so some centres were excluded from analysis. Should event rates be higher in those excluded, these figures would represent a low estimate.

12. First pacemaker implants: the average re-intervention rate was 4.2%, with 5% of centres having a high rate.
13. First complex device implants: the average re-intervention rate was 6.3%, with 4% of centres having a high rate.
14. Simple ablations: the average re-intervention rate was 3.0% with no centres having a high rate.
15. AF ablations: the average re-intervention rate was 10.3%, with four centres having a high rate.

16. Ventricular ablations: the average re-intervention rate was 10.2%, with one centre having a high rate.

Was a national audit report provided which included ABUHB level data and conclusions?

Safety: RGH and NHH have not met the BHRS standard for procedure volume for PPM, ICD & CRT and ablations.

- RGH : 72 PPM (min 80) – down by 60% from 2015/16
- NHH : 45 PPM (min 80) – up by 336% from 2015/16 but below minimum required

No ICD/CRT or ablations recorded.

Effectiveness: Data completeness has been issue in RGH & NHH.

- RGH has had zero completeness for General Medical Council (GMC) Number due to problems with the new electronic system recognising the GMC number, this issue has now been resolved and should improve going forward.

Outcomes: re-interventions is considered by the audit to provide a useful indication of procedure safety, however, the results should be interpreted with caution as it is understood that re-intervention does not always reflect a complication from original procedure but may be due to a manufacturers recall or a change in clinical indication which is not currently identified in the audit.

- RGH : 3 re-interventions (from 156 simple devices in 2015-16) = 2%
- NHH : 0 re-interventions (from 4 simple devices in 2015-16) = 0%
  (4.2% audit average)

What are the key actions?	
Action:	**Timescale**
Increase case ascertainment in RGH and NHH	
Review all entries for 2016/17 data, consider resubmission of NHS and GMC numbers in particular, although it will not change current report it will be important for future retrospective analyses	
Submit data on a regular basis, as up to date data is associated with higher completeness and accuracy	

National Audit/Registry Title:	National Audit of Percutaneous Coronary Interventions
Clinical Lead:	Dr Shawmendra Bundhoo
Date of last data capture:	1st Jan 2015 – 31st Dec 2015
Publication date of last National Audit Report:	Sept 2017

Case Ascertainment:

5.2

Please give a brief overview of the National Audit scope and aims:

The British Cardiovascular Interventional Society (BCIS) has continuously audited PCI activity since 1988 and in collaboration with NICOR since 2006. The audit has collected patient level data nationwide since about 2005. The audit provides information on the:

- Structure of the provision of PCI services across the UK (for example the number of PCI centres and their coverage, number of PCI procedures per centre and population, number of operators in each centre etc).
- Appropriateness of clinical care and treatment provided by each hospital, measured against national aggregated data and agreed national standards (for example. indication for treatment, use of stents, arterial access routes).
- Process of care (for example delays in receiving treatments such as primary PCI).
- Outcome for patients such as complications, adverse cardiac events and death/survival.

The National Institute for Health and Clinical Excellence (NICE) recommends that PCI is used to manage stable angina and acute coronary syndromes in three ways:

- Alleviate the symptoms of angina.
- Restore coronary blood flow during a heart attack (primary PCI).
- Prevent future myocardial infarction.

To achieve this NICE have published the following statements (QS68) & guidance:

- Coronary angiography and PCI is performed within 72 hours for patients with NSTEMI or unstable angina.
- Coronary angiography and PCI for adults with NSTEMI or unstable angina who are clinically unstable as soon as possible or within 24 hours from becoming clinically unstable.
- Adults who are unconscious after cardiac arrest caused by suspected acute ST segment elevation myocardial infarction (STEMI) are not excluded from having

coronary angiography (with follow–on primary percutaneous coronary intervention [PCI] if indicated).
- Drug-eluting stents for the treatment of coronary artery disease where indicated for patients with small arteries and long lesions.

5.2

Please give a brief overview of main Local findings from the published National Audit Report.

The optimal rate of PCI per million population (pmp) is difficult to judge and is dependent on many factors, including the varying characteristics of populations in different countries. While the rate of PCI pmp in the UK has, historically, been considerably lower than most other European countries, there have been steady increases in activity. A total of 97,376 PCIs were performed from January to December 2015 compared with 96,143 in 2014.This represents rate of 1,496 PCI pmp in 2015 compared to 1,488 pmp in 2014 (see Figure 1 for temporal trends). There is variation in the rate of CI across the different regions of the United Kingdom.

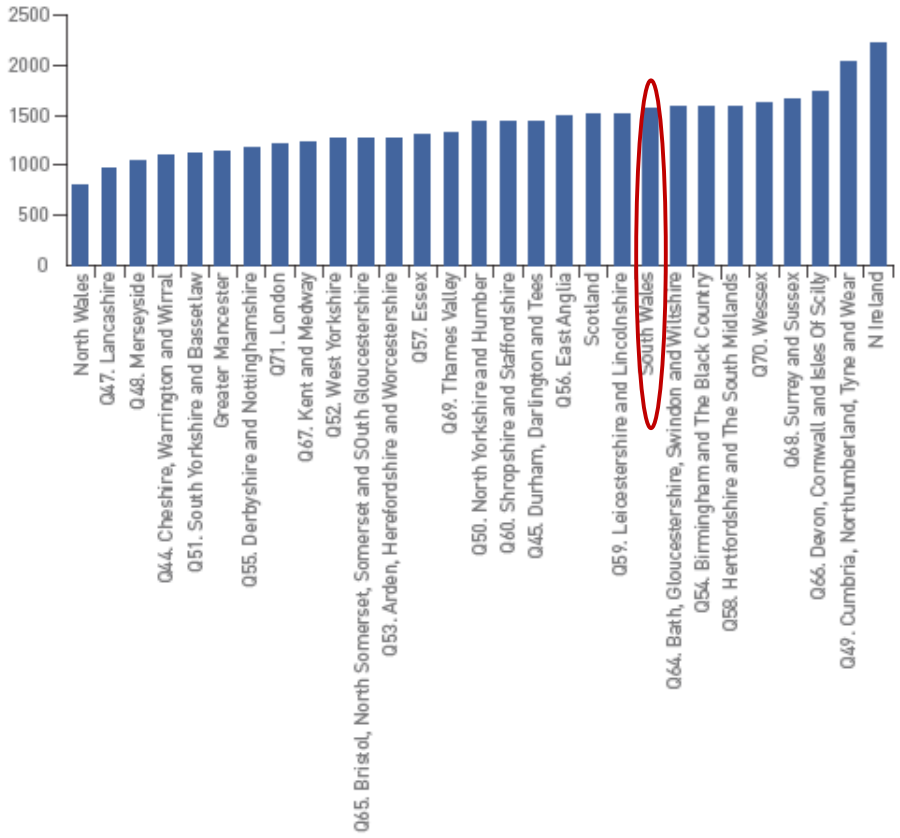
Primary PCI is established across most of the UK as the default treatment for ST elevation MI and represents about 27% of all PCI activity, and for most regions in the UK represents a rate of between 300 and 500 pmp which is comparable to the rates in other European countries. There are 69 PCI centres in the UK to whom ambulances bring patients with STEMI to be treated by primary PCI.

- All PCI hospitals are expected to collect comprehensive and accurate data that relate to the interventional treatment they provide for their patients.

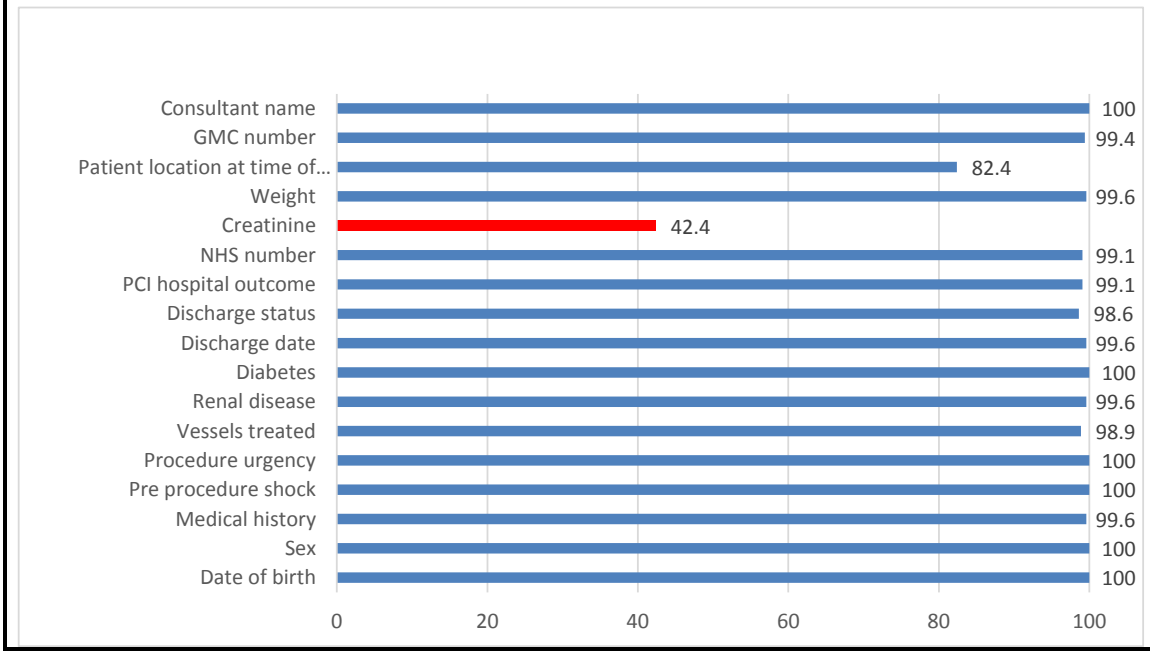
- Data completeness: overall RGH has good conformance with data completeness except in the field of Creatinine levels which was below 50% at 42.4%

Was a national audit report provided which included ABUHB level data and conclusions?

Figure 2a: Rate of PCI pmp by local area team (LAT) and UK country



- Data completeness: Data completeness: overall RGH has good conformance with data completeness except in the field of Creatinine levels which was below 50% at 42.4%



- Radial access: in RGH radial access was used in 90.31% of all PCI procedures, which compares favourably when compared to the UK average of 80.5% (see slide 3)
- Minimum case volume for a PCI hospitals is 400 procedures per year, RGH is exceeding the minimum requirement with 424 eligible cases.

What are the key actions?	
Action:	**Timescale**
Highlighting of missing data in Directorate meetings	6 months
Resolving the issue of transfer of Centricity Data and Haemolink to Mc Kesson	12 months
Regular submission of PCI data to NICOR – 3 monthly basis	3 months

National Audit/Registry Title: Myocardial Ischaemia National Audit Project

Clinical Lead: Dr Nigel Brown/Pamela Jones

Date of last data capture (or ongoing): April 2015 – March 2016

Publication date of last National Audit Report: 27th June 2017

Case Ascertainment:
The reports shows RGH as <20 and no data for NHH.

Please give a brief overview of the National Audit scope and aims:

The aim of MINAP is to measure the processes and outcomes of care of every patient diagnosed with heart attack, from their call to the emergency services, or self-presentation to an Emergency Department, to the prescription of preventative medications on discharge from hospital. Largely this reflects hospital care, but often includes diagnosis and treatments before arrival at hospital. The audit describes aspects (process measures) of the quality of care of hospitals and of ambulance trusts, and is based on analyses of data that has been directly submitted by the participating organisations.

NICOR is participating in the development and implementation of NHS England's Clinical Services Quality Measures (CSQMs). CSQMs combine various aspects of care to produce composite measures that are designed to provide an at-a-glance indication of how well services are performing. Cardiac CSQM will initially focus on the treatment of patients with heart attack, and MINAP will be an important source of relevant data. The information will be useful by allowing:

- Patients to have easier access to information to see how their local hospitals are performing and what facilities are available in these hospitals
- Commissioners to have more insight into the quality of service provided by centres where they commission care on behalf of the populations they serve – including in some cases patient outcomes
- NHS staff to see how their centre performs against similar centres across the country

The NHS will benefit as centres use this information to implement improvements.

Please give a brief overview of main <u>Local</u> findings from the published National Audit Report.

In the analyses, heart attack is categorised as either STEMI or nSTEMI, to address the appropriate patient pathway that has been activated.

ST-elevation myocardial infarction (STEMI) often requires immediate specialised treatment. A primary percutaneous coronary intervention (PCI) is the preferred reperfusion procedure. Compared with 2011, the proportion of patients with STEMI receiving PCI as their reperfusion therapy has increased in all nations.

Figure 1: The proportion of STEMI cases that received primary PCI as reperfusion therapy.

Country	2011	2016
England	82.0%	99.3%
Wales	30.0%	86.0%
Northern Ireland	99.0%	99.9%

Hospitals provide primary PCI to most patients presenting with STEMI within the recommended1 timeframe of 150 minutes from call for help (call to balloon, CtB), and 120 minutes from arrival at hospital (door to balloon, DtB). Overall, 75% of patients are treated within 150 minutes of calling for help. The median time for CtB is 117 minutes in England, 127 minutes in Wales, and 107 minutes in Northern Ireland.

Four in every five patients with STEMI are taken by ambulance directly to a hospital capable of providing primary PCI. 89% of patients are treated with PCI within 90

minutes of arrival at hospital – the equivalent figure being 52% in 2005. Median DtB time for England is 40 minutes, with Wales and Northern Ireland achieving 41 minutes and 33 minutes respectively.

There has, however, been a slight lengthening of the median CtB time between 2010/11 and 2015/16. Given that median DtB has improved over that period, it follows that changes in the time spent outside hospital following the call for help has resulted in increasing CtB. The median call to door time (a measure of ambulance service response, treatment and transportation) has increased, year-on-year, by 10 minutes between 2010/11 and 2015/16.

Ideally patients with non-ST elevation myocardial infarction should be managed in a cardiac ward and be assessed by a cardiologist. In 2016, 57.5% of patients with nSTEMI were admitted to a cardiac ward compared with 49% in 2011; 96% were seen by a cardiologist in 2016 compared with 90% in 2011 and, of those eligible, 86% received an angiogram in 2016 compared with 68% in 2011.

In accordance with clinical guidelines, patients with nSTEMI at moderate to high risk should undergo angiography, with a view to PCI, within 72 hours of admission to hospital. The delay from admission to angiography for nSTEMI has not improved. For those admitted directly to hospitals that are capable of providing on-site angiography, 17.5% received an angiogram within 24 hours; 53% within 72 hours; 66.3% within 96 hours. In 2010/11 the equivalent figures were 21% within 24 hours, 55% within 72 hours and 67% within 96 hours. Centres have an opportunity to provide more timely treatment, which may lead to shorter lengths of stay, reducing the burden on the health system.

Recognising the need to improve this aspect of care, NHS England has introduced a Best Practice Tariff for angiography for those with nSTEMI in the 2016/17 financial year. Participating hospitals will receive a higher reimbursement for services where at least 60% of all nSTEMI patients receive angiography within 72 hours.

Was a national audit report provided which included ABUHB level data and conclusions?

- Excellent performance re review by cardiologist of 96.6% at Royal Gwent and 93.9% at NHH – higher than All Wales average. Only 62% and 78.5% patients at RGH and NHH admitted to a cardiac ward requires improvement and is currently the focus of a new initiative with bed management
- Excellent angiography rates at 85% and 78% (RGH and NHH respectively) but delays particularly for NHH (referral to tertiary centre) mean longer than ideal LOS. New catheter lab commissioned at RGH to support more timely access to angio/PCI from June 2017

- Work ongoing supported by Cardiac Network to reduce inter-hospital transfer delays for PPCI patients (self presenters/non-diagnostic ambulance ECG's) attending hospitals without 24/7 PPCI. Clinical leads to drive improvement identified in both NHH and RGH Emergency Departments

What are the key actions?	
Action:	**Timescale**
• A new initiative has been recently introduced via bed management with a full time cardiology specific flow co-ordinator appointed from May 2017. The role includes facilitating timely transfer of patients from non-interventional hospitals in our Health Board and to fast track patients from the ED and MAU to the appropriate wards/unit. Agreed minimum 3 ring fenced beds across cardiology floor for emergency admission.	In place - improvement already evident but subject to overarching bed pressures and resulting "breaching" compromise of dedicated beds.
• A new, 2nd cardiac catheter lab was commissioned at the Royal Gwent Hospital in June 2017 with a planned incremental uplift in activity to reduce in-patient waiting times and help reduce LOS.	Ongoing
• Work in progress with the Clinical leads supported by the Cardiac Network to guide and drive improvement in RGH and NHH Emergency Department delays in transfer of STEMI patients to the regional centre	Ongoing

National Audit/Registry Title:	National Cardiac Arrest Audit
Clinical Lead:	Sam Bright
Date of last data capture (or ongoing):	Continuous (Report April 2018 – March 2019)
Publication date of last National Audit Report:	June 2019

Case Ascertainment:
RGH = 130
NHH = 63

Please give a brief overview of the National Audit scope and aims:

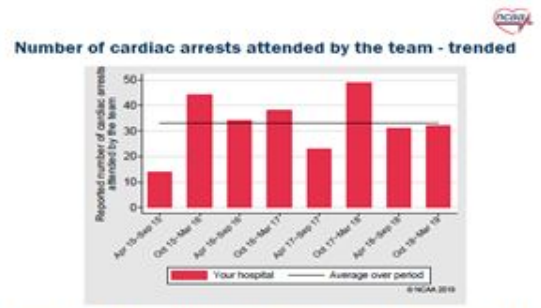
NCAA is the national comparative audit for in-hospital cardiac arrest.
The NCAA Report provides an overview of the completeness of data; analyses of activity and outcome; stratified analyses (drawing comparisons between our hospital and NCAA data); basic anonymised comparative analyses (non-risk adjusted); and risk-adjusted comparative analyses, and the report identifies unexpected non-survivors.
NCAA data is collected for any resuscitation event commencing in-hospital where an individual (excluding neonates) receives chest compression(s) and/or defibrillation and is attended by the hospital based resuscitation team in response to a 2222 call.

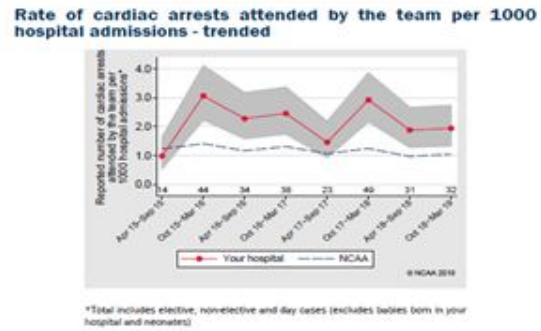
Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

For this audit, there is no national report. NCAA Reports are provided confidentially to each individual hospital. Quarterly reports have been provided for 2018/2019.

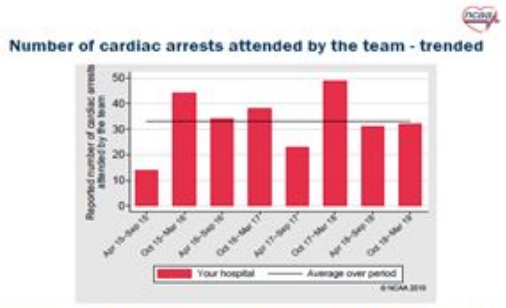
Was a national audit report provided which included ABUHB level data and conclusions?

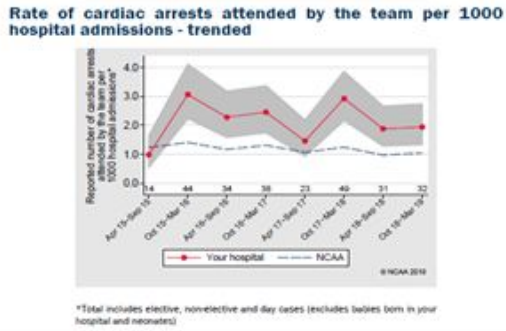
See data below:





RGH





NHH

Action:

No assurance proformas are submitted to WG as this audit does not form part of the NCAOR mandatory audits.

National Audit/Registry Title:	National Vascular Registry
Clinical Lead:	David McLain
Date of last data capture (or ongoing):	2015-2017
Publication date of last National Audit Report:	November 2018

Case Ascertainment:

Please give a brief overview of the National Audit scope and aims:

The National Vascular Registry (NVR) was established to provide information on the performance of NHS vascular units and support local quality improvement. It also aims to inform patients about major vascular interventions delivered in the NHS. The Registry is commissioned by the Healthcare Quality Improvement Partnership, and all NHS hospitals in England, Wales, Scotland and Northern Ireland are encouraged to participate in it.

This 2018 Annual report is the sixth since the NVR was launched in 2013. It contains comparative information on five major interventions for vascular disease:

- Carotid endarterectomy
- Repair of aortic aneurysms, including elective infra-renal, ruptured infra-renal, and more complex aneurysms
- Lower limb bypass
- Lower limb angioplasty/stenting
- Major lower limb amputation

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

1. Local services should review their pathways of care for patients with critical limb ischaemia, using the VSGBI Quality Improvement Framework for Amputation.
2. Networks should ensure they have enough consultant vascular surgeons and interventional radiologists to be able to provide a 24/7 on call service.
3. Local services should ensure that diagnostic imaging services are available out-of-hours.
4. NICE guideline CG68 recommends that carotid endarterectomy is undertaken within 14 days of a patient experiencing symptoms. NHS trusts that are not meeting this target should optimise referral pathways within their networks and implement improvements to drive down the waiting times. More generally, units should examine how their performance compares against the NICE guideline.
5. Vascular units should assess whether all AAA patients are discussed at the vascular MDT meeting and that this is document clearly in the medical notes. Units should ensure this information is uploaded to the NVR, including the date of discussion.
6. The National AAA Screening Programme has a target of 8 weeks for the time patients taken from referral for vascular assessment to elective AAA repair. For non-complex aneurysms, vascular units should adopt this as a target for both screen and non-screen detected AAA patients, and alter the care pathway to avoid excessive waits.
7. Complex aortic surgery remains a relatively low-volume, high-cost service. Vascular units should only be commissioned to perform complex AAA repair if they submit complete and accurate data on case activity and outcomes to the NVR to ensure the provision of safe and effective services for patients with complex aortic disease.
8. Vascular units should look at the numbers of complex interventions being performed and if volumes are low, consider how provision can be organised best within their regions.
9. For patients requiring complex AAA repair, vascular units should also examine how the time from vascular assessment to surgery can be reduced, particularly, the process of requesting non-conventional devices for endovascular procedures.

10. Vascular units should evaluate how access to endovascular repair can be improved for emergency repair of ruptured aneurysms. This may require review of anaesthetic as well as surgical aspects of the care pathway.
11. Vascular units should review local care pathways and patient outcomes for lower limb amputation, and adopt the care pathway and standards outlined in the Vascular Society's Quality Improvement Framework.
12. Vascular units should examine how to improve their performance against the NCEPOD recommendations for amputation, specifically in relation to the use of prophylactic medication.
13. Units should ensure that all data on lower limb revascularisation and major amputation procedures are being uploaded accurately to the NVR.

Was a national audit report provided which included ABUHB level data and conclusions?

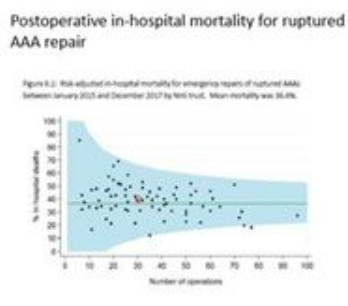
AA Repair

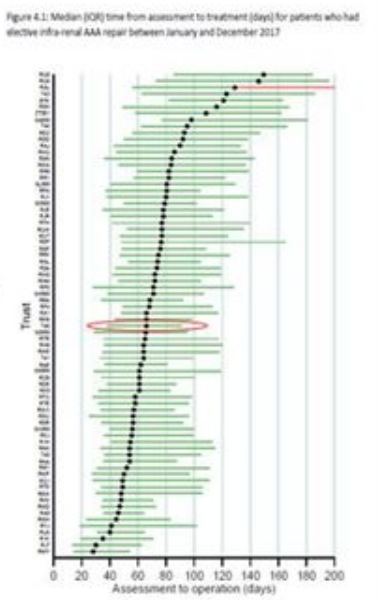
The estimated 2017 case-ascertainment figures for the four nations were approximately 90% for England, 100% for Wales, 100% for Northern Ireland and 74% for Scotland. The overall case-ascertainment has remained fairly stable over the last three years (Table 4.1).

The estimated case-ascertainment figures for individual NHS trusts may differ slightly from those published on www.VSQIP.org.uk website due to the different time periods covered.

Table 4.1: Estimated case-ascertainment of elective infra-renal AAA repairs**

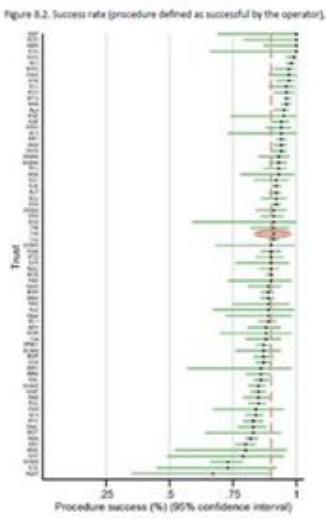
	2015	2016	2017	Total
Audit procedures	4,389	4,264	4,208	12,861
Expected procedures	4,813	4,812	4,668	14,293
Estimated case-ascertainment	91%	89%	90%	90%

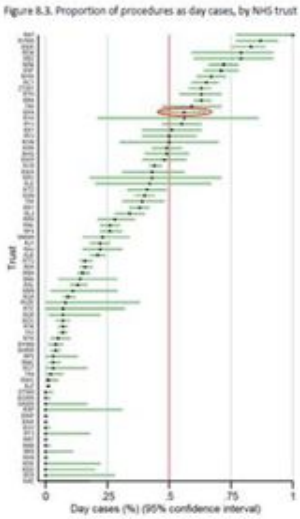


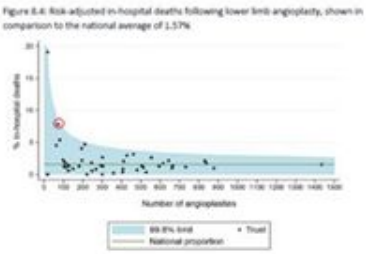


Lower Limb Angioplasty

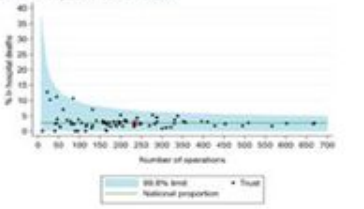
Lower limb angioplasty





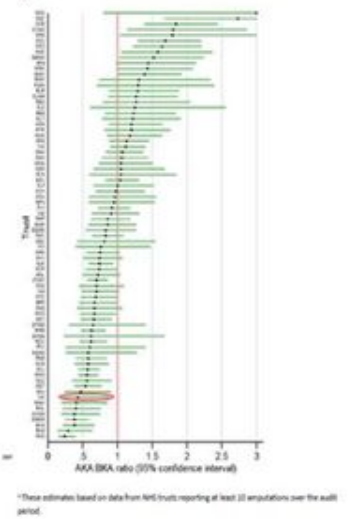


Rates of in-hospital death after lower limb bypass



Major Lower Limb Amputation

Major lower limb amputation



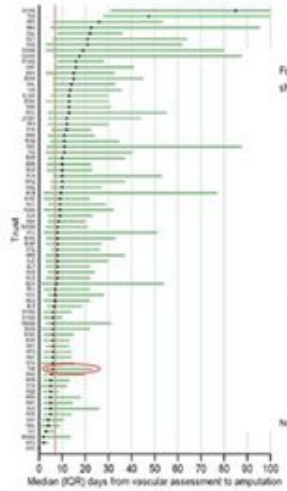
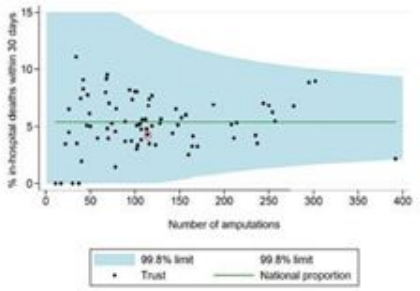
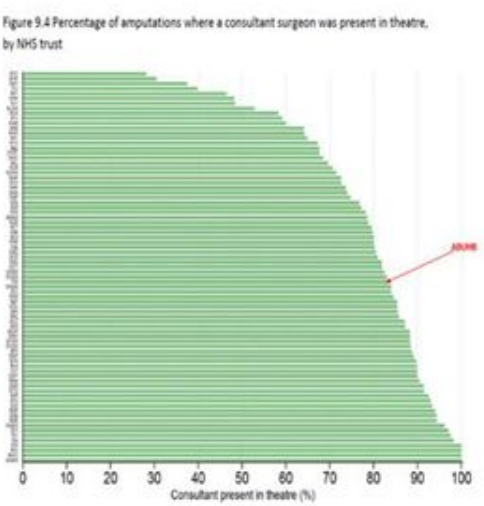


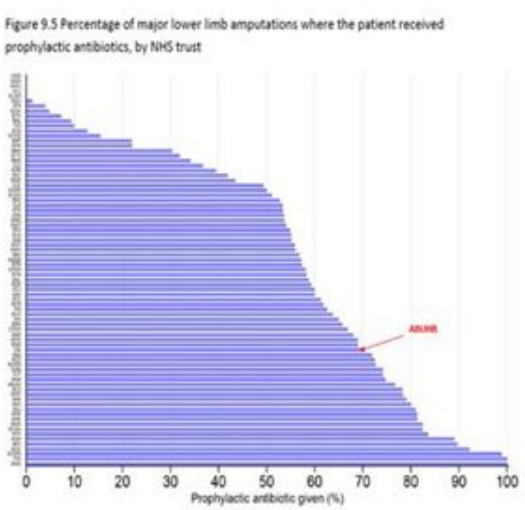
Figure 9.6: Risk-adjusted 30 day in-hospital mortality rate following major amputation, shown in comparison to the overall average of 5.4%



Note to Figure 9.6: this figure is based on data from Trusts with ≥ 10 amputations.

Perioperative Care





5.2

What are the key actions?	
Action:	**Timescale**
AAA: All cases are discussed in MDT. Regular review of MDT cases vs NVR cases ensures full compliance. The MDT discussion becomes a letter added to the e-records in all 3 UHB's in the SE Wales region. Time to surgery is under constant review and is improving, although there is room for further improvement. It is noted that only 12 units in the UK treat 50% of their cases within the 8 week target and no-one achieves this for 75% of their cases. We do not differentiate between screened and non-screened patients but offer an equal service to all.	Ongoing
Ruptured AAA: An IR on call service across SE Wales has now commenced to deliver EVAR as an emergency.	Achieved
Carotid Endarterectomy: Good results already achieved.	Achieved
Amputation: National standards and pathway already incorporated in unit protocols and practice. The provision of a fourth all day dedicated vascular operating list has largely overcome the delays and cancelations previously affecting these patients.	Achieved
Sustainability: Creation of one further consultant post, converting a research post to a substantive clinical post. This would bring us closer to the national standards from the Vascular Society.	1 Year

6.5 National Audits – Cancer

National Audit/Registry Title: National Bowel Cancer Audit

Clinical Lead Mr K Swarnkar RGH / Mr Ray Delicata NHH

Date of last data capture (or ongoing): 2017/2018

Publication date of last National Audit Report: 13th Dec 2018

Case Ascertainment:

Cancer Alliance/Trust Name	No. cases reported to the Audit	No. cases identified in HES/PEDW	Case ascertainment %
Nevill Hall Hospital MDT	110	79	139
Royal Gwent Hospital MDT	230	139	165

Please give a brief overview of the National Audit scope and aims:

The aim of the audit is to measure the quality of care and outcomes of patients with bowel cancer in England and Wales.
Audit values
The NBOCA values define what is important in the way we deliver the National Bowel Cancer Audit. In carrying out our work we aim to:

- Produce accurate and reliable information for clinicians, patients, hospital staff and the public by ensuring that the data we collect is as complete and accurate as possible and by ensuring the information is produced using appropriate statistical methods
- Deliver NBOCA in a way that supports bowel cancer services to improve quality of care delivered to patients
- Ensure the confidentiality of patient information supplied by hospitals is protected

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

<u>Care pathways</u>

20% of patients present as an emergency with bowel cancer 52% of patients presenting as an emergency are treated with curative intent, compared to 69% and 86% referred from GP and screening services respectively.

23% of patients within the eligible age range for bowel cancer screening (aged 60-74 years) are diagnosed via screening services There is geographical variation in the proportion of patients aged 60-74 years being diagnosed via screening (17%-29%).

76% of patients who could be allocated to a care pathway were treated with curative intent 93% of this group had a major resection and 7% had 'too little' cancer to be treated curatively..

24% of patients who could be allocated to a care pathway were treated with non-curative intent Of those categorised as non-curative, 18% had major resection, 58% had 'too much' cancer and 24% were 'too frail'. We are still unable to assign 5,011 patients to a care pathway, largely due to missing data.

54% of patients with stage III colorectal cancer received adjuvant chemotherapy Patients who are younger and fitter are more likely to receive chemotherapy. Administration of adjuvant chemotherapy varies geographically from 39%-63%

<u>Surgical care</u>

Over the last 5 years, 90-day mortality after emergency major resection has decreased from 16.3% to 11.5% 90-day mortality after elective major resections has also decreased from 2.9% to 2.0%, plateauing since 2014/15.

Median length of stay is 7 days for elective major resection compared to 10 days for emergency surgery. These figures have remained stable. There is considerable geographical variation in length of stay, particularly for emergency admissions. For example, the proportion of patients with a length of stay of 5 days or less after emergency major resection varies from 7% to 38%. Emergency 30-day re-admission rates remain stable at 10.5%.

Use of laparoscopic surgery continues to expand with 58% of major resections performed using this approach in patients diagnosed between 01 April 2016 and 31 March 2017 There is significant variation in the use of laparoscopic surgery across different cancer alliances (37%-74%). Approximately, one quarter of emergency procedures are completed laparoscopically with a 4% conversion rate.

There is significant regional variation in the proportion of colonic resections with >12 lymph nodes reported The national average for >12 lymph nodes reported after colonic resection is 82%. However, this varies from 0%- 100% in different geographical areas

Rectal cancer

53% of patients underwent major resection for rectal cancer 7% had local excision, 7% non-resectional surgery (e.g. stent) and 33% had no surgical intervention. The proportion of patients not having intervention has increased over time (29% to 33%). This may be explained in part by more chemoradiotherapy complete responders being managed by a watch and wait policy.

There is significant geographical variation in the use of neo-adjuvant radiotherapy (from 24% to 61% between cancer alliances) Variation is also present in the proportions of patients receiving long- and short-course radiotherapy.

35% of patients undergoing major resection for rectal cancer still have a stoma at 18 months (excluding intended abdomino-perineal excision of the rectum) The overall 18-month stoma rate is 52% with significant regional variation (42%-63%). 59% of patients having emergency procedures have a stoma at 18 months compared to 35% having elective procedures

End of life care

There has been a reducing trend in hospital deaths from 2011 to 2016 for patients diagnosed with colorectal cancer (46% to 35%) Home deaths have increased from 2011 to 2016 (25% to 32%) but this remains far below reported patient preference in the literature (up to two thirds would prefer to die at home).

Place of death appears to be related to socioeconomic status with almost a 10% difference in hospital deaths in the least affluent (43%) compared to the most affluent (35%) Age, time from diagnosis and (to a lesser degree) sex appear to influence place of death.

Geographical variation in place of death occurs This is most marked for deaths in hospitals (29%-48%) and hospices (8%-27%)

Was a national audit report provided which included ABUHB level data and conclusions?

Management of all patients reported to the audit according to trust/hospital site

Diagnosing Cancer Alliance/Trust Name	Number of patients reported to the audit	Seen by clinical nurse specialist (%)	Curative Major Resection Treatment Pathway (%)	Too Little Treatment Pathway (%)	Non-Curative Major Resection Treatment Pathway (%)	Too Much/ Too Frail Treatment Pathways (%)	Not Known/ Other Treatment Pathway (%)
Wales	**1,911**	**89**	**57**	**4**	**7**	**15**	**18**
Bronglais MDT	57	86	53	0	7	21	19
Cardiff MDT	218	95	51	4	5	11	29
Nevill Hall Hospital MDT	110	100	54	3	11	15	17
Prince Charles Hospital MDT	100	94	66	3	2	19	10
Princess of Wales MDT	137	89	61	4	5	18	12
Royal Glamorgan Hospital MDT	131	63	54	8	4	23	11
Royal Gwent Hospital MDT	230	85	59	3	4	11	22
Swansea MDT	199	84	61	1	11	4	23
West Wales General and Prince Phillip MDT	164	85	55	4	4	19	18
Withybush General MDT	91	96	65	0	3	19	13
Ysbwyty Glan Clwydd MDT	152	97	53	6	14	13	13
Ysbwyty Gwynedd MDT	153	90	61	4	8	17	10
Ysbwyty Maelor MDT	168	98	57	7	5	14	17

Diagnosing Cancer Alliance / Trust Name	No. patients having major surgery	Patients with distant metastases at time of surgery (%)	Major surgery carried out as urgent or emergency (%)	Median number of lymph nodes excised	Proportion of patients with recorded number of lymph nodes (%)	Proportion cases ≥12 nodes (%)	Laparoscopic surgery attempted (%)	No. patients included in risk-adjusted length of stay	Risk-adjusted length of stay >5 days (%)
Wales	**1,218**	**14**	**20**	**16**	**100**	**78**	**46**	**979**	**71**
Bronglais MDT	11	25	80	16	100	82	27	7	82
Cardiff MDT	120	15	20	16	100	79	72	90	61
Nevill Hall Hospital MDT	68	13	19	16	100	79	32	58	75
Prince Charles Hospital MDT	68	9	15	14.5	100	76	84	58	55
Princess of Wales MDT	77	8	9	17	100	82	32	68	67
Royal Glamorgan Hospital MDT	78	13	17	15	100	73	51	64	79
Royal Gwent Hospital MDT	147	14	23	17	100	82	46	117	80
Swansea MDT	158	18	23	17	100	84	31	130	72
West Wales General and Prince Phillip MDT	103	17	24	15	100	72	51	86	79
Withybush General MDT	70	6	14	15	100	73	59	65	77
Ysbwyty Glan Clwydd MDT	103	22	30	19	100	83	34	83	59
Ysbwyty Gwynedd MDT	110	14	14	16	100	75	31	63	86
Ysbwyty Maelor MDT	105	8	18	17	100	73	53	90	58

Cancer Alliance/Trust Name	Number of patients with rectal cancer undergoing major surgery	Positive margins reported (%)	Records missing status of margins (%)	APER rate (%)	Number of patients diagnosed with rectal cancer Jan-Dec 2015 undergoing major surgery	Short or long-course Pre-operative radiotherapy (%)	Number of patients in HES 18-month stoma estimate	Observed 18-month stoma rate using HES/PEDW (%)	Adjusted 18-month stoma rate using HES/PEDW (%)
Wales	**273**	**4**	**5**	**36**	**296**	**38**	**956**	**62**	**61**
Bronglais MDT	▲	▲	▲	▲	▲	▲	17	47	43
Cardiff MDT	31	0	0	29	26	35	102	51	53
Nevill Hall Hospital MDT	12	8	0	42	15	40	58	78	73
Prince Charles Hospital MDT	18	6	6	28	21	24	76	53	53
Princess of Wales MDT	24	0	0	21	31	35	103	67	65
Royal Glamorgan Hospital MDT	16	6	0	38	15	27	42	67	65
Royal Gwent Hospital MDT	31	3	3	13	40	30	138	60	56
Swansea MDT	39	3	0	54	44	30	115	57	56
West Wales General and Prince Phillip MDT	19	5	42	47	19	53	58	86	85
Withybush General MDT	15	7	27	20	17	53	42	71	70
Ysbwyty Glan Clwydd MDT	24	8	0	63	21	57	70	69	65
Ysbwyty Gwynedd MDT	19	5	0	37	18	61	62	58	59
Ysbwyty Maelor MDT	23	4	0	35	27	30	73	51	52

What are the key actions?	
Action:	**Timescale**

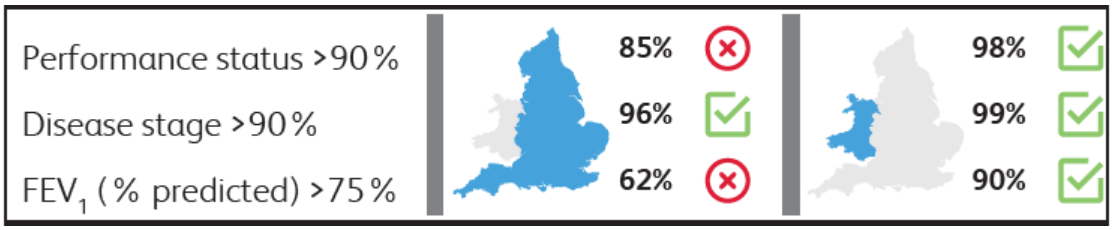
National Audit/Registry Title	National Lung Cancer Audit
Clinical Lead:	Dr Ian Williamson
Date of last data capture (or ongoing):	2017
Publication date of last National Audit Report:	9th May 2019

Case Ascertainment:

5.2

Please give a brief overview of the National Audit scope and aims:
This NLCA annual report represents the culmination of nearly 2 years of patient care and follow up, data collection, data analysis and interpretation. Its purpose is to understand the current quality of care and outcomes for patients with lung cancer, to celebrate good practice and to highlight variability, to ensure that all patients have access to the very best care. In our last report, we made a number of recommendations to improve the already excellent quality of the data submitted to the audit. We noted a small rise in the proportion of patients receiving surgery, but a small drop in the proportion receiving non-surgical treatments such as chemotherapy, and made further recommendations to increase treatment rates across all these modalities. We highlighted a small number of organisations in which results were statistically significantly worse than their peers, and we have worked with those organisations to develop action plans to recover performance.

Data completeness in Wales is of a very high standard, exceeding all the recommended benchmarks.



Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

Data completeness
Commentary

We set very high standards for data collection, and overall the lung cancer care community should be proud of its achievements. Data completeness in Wales is of a very high standard, exceeding all the recommended benchmarks. In England, data completeness has again improved as it did last year. It is slightly disappointing that the 90% target for PS has not been met, but a year-on-year improvement from 75% 2 years ago shows that progress is being made. Staging data completeness is excellent and is the highest ever achieved in the NLCA. This reflects good practice from MDTs, but also work done by NCRAS to obtain missing staging data from primary sources. For future years, we have raised the recommended standard for PS and stage to 95%.

Recommendations

1. Both performance status (PS) and stage should be recorded in at least 95% of cases; for patients with stage I–II and PS 0–1, data completeness for FEV1 and FEV1% should exceed 75%.
2. All lung cancer MDTs should appoint a 'clinical data lead' with protected time to allow promotion of data quality, governance and quality improvement. Data submitted should undergo clinical validation and assessment for data completeness. Data completeness can also be assessed by logging onto the NLCA CancerStats portal (www.ncin.org.uk/cancer_information_tools). Particular attention should be focused on completing the 'trust first seen' and PS fields.

Pathological confirmation in stage I–II and PS 0–1 patients

Commentary

Overall, 89% of patients with stage I–II and PS 0–1 received a pathological diagnosis (England 89%, Wales 88%), which means that the audit standard has only just been missed. Across individual organisations (excluding tertiary trusts) the results, adjusted for casemix, varied from 56% to 100%, with five organisations identified as negative outliers.

Recommendations

3. MDTs with lower than expected pathological confirmation rates in this patient group (<90%) should perform a detailed audit of the clinically diagnosed cases, and should ensure that they have access to all the appropriate diagnostic procedures and pathological processing techniques. Based on the results from the first year of this metric, we believe that in future trusts should be expecting at least 93% of patients in this group to have pathological confirmation.

Surgery rates in all non–small–cell lung cancer (NSCLC)

Commentary

This is an excellent result, with a further incremental increase in the proportion of patients receiving potentially curative surgical treatment. The audit standard has been met in both England and Wales. 15 organisations were identified as having a significantly

better rate of surgery than the national average, suggesting good practice. Variation is noted but is considerably less than in the previous year, with adjusted surgical resection rates varying from 10% to 37%. 52 organisations failed to meet the audit standard of 17% (compared with 60 last year). Eight organisations have been notified of their negative outlier status. These results should be interpreted alongside the proportion of patients who receive overall radical treatment rate (consisting of surgery and/or curative-intent radiotherapy) in patients with stage I and II disease with PS 0–2, which is covered later in this report.

With the introduction of the 8th version of the Tumour Node Metastasis (TNM) staging system, MDTs should be aware that the staging manual states that if there is uncertainty over stage, then the lower stage should be adopted for clinical decision-making.

Recommendations

4. MDTs with lower than expected resection rates for NSCLC should perform detailed case-note review to determine why resectable patients with good performance status did not receive an operation. Low surgical rates in some organisations may be due to their surgical cases being allocated to a tertiary surgical trust. A priority for these trusts will be to ensure that their data reflect their workload.

Systemic anti-cancer treatment rates in NSCLC (stage IIIB–IV and PS 0–1)

Commentary

Overall, 65% of patients with good PS and advanced NSCLC received SACT (England 66%, Wales 56%). This represents a substantial increase from last year where the overall result was only 62%, and this is the first time the audit standard has been met in the overall population. This positive news may reflect the increasing range of options for this patient group, although the lower result for Wales suggests that more detailed evaluation may be required in the local hospitals. Across individual organisations (excluding tertiary trusts), the casemix-adjusted results varied from 36% to 96%, with 65 organisations failing to achieve the standard (reduced from 85 last year), and encouragingly this variation is considerably less than in the previous year. 12 organisations have been identified as negative outliers.

Recommendations

5. MDTs with lower than expected systemic anti-cancer treatment rates for good PS (0–1) stage IIIB–IV NSCLC (<65% after casemix adjustment) should perform detailed case-note review to determine why each advanced NSCLC patient with good PS did not receive systemic therapy. MDTs should review their approach to offering SACT to groups such as older patients and patients with comorbidities, and how they explain the risks and benefits of treatment to patients and their relatives.

Chemotherapy rates in small-cell lung cancer (SCLC)

Commentary

Overall, 71% of SCLC patients received chemotherapy (England 70%, Wales 77%), which represents a welcome 3% increase on the result from last year, and means that the audit standard has been achieved for the first time. Across individual organisations (excluding tertiary trusts) the results, adjusted for case mix, varied from 29% to 100%, with four organisations identified as negative outliers.

SCLC can be rapidly progressive and it is particularly important that patients are diagnosed quickly and receive their chemotherapy as soon as possible after the diagnosis is made. Last year we set a standard that at least 80% of patients should receive their chemotherapy within 14 days of their pathological diagnosis. For patients diagnosed in 2017, that standard was achieved for only 34% of patients, with the performance varying from 0% to 84% across individual organisations, and only three of these organisations achieved the audit standard. There is clearly an urgent need to improve pathways for these patients.

Recommendations

6. MDTs with lower than expected chemotherapy rates for SCLC (<70% or low odds ratio after case mix adjustment) should perform detailed case-note review to determine why each SCLC patient did not receive chemotherapy.

7. All MDTs should review their patient pathways, to ensure that systems are in place to deliver SCLC chemotherapy within 14 days of pathological confirmation in at least 80% of cases.

Curative treatment rates

Commentary

Overall, 81% of patients in England received curative-intent treatment in 2017, which was very similar to the result from last year (80%), and means that the audit standard has again been achieved. Across individual organisations (excluding tertiary trusts), the rate of this curative treatment varied from 50% to 100%, and 65 organisations failed to achieve the standard. Although it is welcome that the audit standard is achieved, it does mean that one in five patients with potentially curable disease do not receive optimal treatment. Our previous spotlight audit looking at these patients suggests that patient choice is an important factor. In our next annual report, we will include this measure in our outlier policy and process, and will work with the Wales Cancer Network to try to ensure they collect the radiotherapy data that will allow this to also apply to Wales.

Recommendations

8. MDTs with lower than expected curative-intent treatment rates for stage I–II PS 0–2 NSCLC (80% or lower) should perform detailed case-note reviews to determine why each patient did not receive either surgery or radical radiotherapy, including whether a second opinion was offered to borderline-fit patients. MDTs should review their approach to shared decision-making in offering radical treatment to groups such as older

patients and patients with comorbidities, and how they explain the risks and benefits of treatment to patients and their relatives.

Was a national audit report provided which included ABUHB level data and conclusions?

Summary of Unadjusted Results

Trust	Cases	PCR[1]	LCNS[1]	Anti-Cancer[1]	Curative[1]	Surgery[1]	NSCLC SACT[1]	SCLC Chemo[1]	Survival[1]
Bronglais General Hospital	56	73.2%	30.4%	51.8%	N/A	15.4%	61.1%	100.0%	33.3%
Prince Philip Hospital	188	83.0%	87.8%	62.2%	N/A	18.4%	51.0%	73.3%	39.3%
Withybush General Hospital	97	74.2%	99.0%	55.7%	N/A	15.1%	37.5%	77.8%	38.6%
Princess of Wales Hospital	106	66.0%	81.1%	63.2%	N/A	27.0%	79.0%	100.0%	52.1%
Morriston Hospital	294	69.4%	83.0%	58.5%	N/A	22.9%	48.4%	78.1%	41.5%
University Hospital Llandough	290	67.9%	97.2%	57.6%	N/A	17.1%	57.1%	92.0%	37.3%
The Royal Glamorgan Hospital	152	69.7%	84.9%	60.5%	N/A	23.1%	43.5%	76.5%	47.1%
Prince Charles Hospital Site	133	67.7%	46.6%	60.9%	N/A	18.3%	65.0%	66.7%	36.7%
Nevill Hall Hospital	106	78.3%	94.3%	66.0%	N/A	13.1%	76.5%	81.0%	40.0%
Royal Gwent Hospital	268	73.1%	91.4%	58.2%	N/A	16.8%	67.4%	61.3%	42.1%
South Wales	1690	71.9%	84.4%	59.5%	N/A	19.4%	56.2%	76.9%	40.9%
Wales	2,179	71.5%	76.1%	59.2%	N/A	18.3%	56.1%	76.6%	40.0%

[1] Proportion of all patients with pathological confirmation of cancer :: [2] Proportion of all patients assessed by a specialist nurse :: [3] Proportion of all patients who have anti-cancer treatment (surgery, radiotherapy systemic treatment) :: [4] Proportion of patients with stage I/II and PS 0-2 receiving treatment with curative intent (surgery or radical radiotherapy) - this measure is only available for England :: [5] Proportion of patients with NSCLC who undergo surgery :: [6] Proportion of patients with Stage IIIB/IV and PS 0-1 who have systemic anti-cancer treatment :: [7] Proportion of patients with SCLC who undergo chemotherapy :: [8] Proportion of patients alive at 1 year after diagnosis

Disease Stage

Trust	Stage Recorded	Stage I/II *
Bronglais General Hospital	100.0%	23.2%
Prince Philip Hospital	100.0%	22.9%
Withybush General Hospital	100.0%	26.8%
Princess of Wales Hospital	89.6%	33.7%
Morriston Hospital	96.3%	27.2%
University Hospital Llandough	99.7%	35.0%
The Royal Glamorgan Hospital	100.0%	40.1%
Prince Charles Hospital Site	100.0%	32.3%
Nevill Hall Hospital	99.1%	26.7%
Royal Gwent Hospital	99.3%	29.0%
South Wales	**98.5%**	**30.1%**
Wales	***98.5%***	***28.9%***

*Proportion of patients with stage I/II at diagnosis (excludes missing data)
Further breakdown available here...

Performance Status

Trust	PS Recorded	PS 0-1 *
Bronglais General Hospital	100.0%	62.5%
Prince Philip Hospital	100.0%	60.1%
Withybush General Hospital	100.0%	59.8%
Princess of Wales Hospital	92.5%	50.0%
Morriston Hospital	91.2%	57.1%
University Hospital Llandough	100.0%	40.0%
The Royal Glamorgan Hospital	100.0%	52.6%
Prince Charles Hospital Site	99.3%	37.1%
Nevill Hall Hospital	100.0%	41.5%
Royal Gwent Hospital	100.0%	46.3%
South Wales	**97.9%**	**49.6%**
Wales	***97.0%***	***43.9%***

*Proportion of patients with performance status 0-1 at diagnosis (excludes missing data)
Further breakdown available here...

What are the key actions?	
Action:	**Timescale**
The percentage of patients with Small Cell Lung Cancer receiving chemotherapy was 81% in the Nevill Hall Hospital cohort and 61.3% in the Royal Gwent Hospital cohort. There remains issues in the organisation of care around the delivery of chemotherapy within 14 days of pathological confirmation of small cell cancer at both sites, particularly the Royal Gwent Hospital. There is ongoing work on the mechanisms underpinning the delivery of this treatment to patients at both sites	Ongoing – under regular review
The adjusted surgical resection rate for Nevill Hall Hospital was 15% which is below the national mean of 18.4%. Furthermore, surgery in Stage I/II PS 0-2 NSCLC was 30% compared to the National Mean of 60.7%. Subsequent to this, we have performed a case-based analysis of the data (20 patients) in order to review whether decisions made via the MDT were appropriate for the patient population and to inform future decision making within the MDT. Themes emerging were that a high proportion of patients managed non-surgically were PS 2 (9/14) and other factors preventing surgery included poor fitness and high cardiovascular risk. A number of the patients not receiving surgery underwent treatment with radical radiotherapy. It was felt that the decisions made were appropriate to the patient population.	Presented at Lung Cancer Operation Meeting 21/5/2019
Next year will see the introduction of two key initiatives that may help reduce variation. Firstly, the National Optimal Lung Cancer Pathway (NOLCP) will be adopted in Wales. The second is the introduction of the Single Cancer Pathway (SCP), which aims to record the time from point of suspicion of cancer to treatment as a single Cancer Waiting Time (CWT) target. It will replace the current two CWT targets for urgent suspected cancer (USC) and not urgent suspected cancer (nUSC). The combination of these two initiatives will ensure a patient is afforded the same priority in the healthcare system regardless of how they present: whether through their local A&E department with haemoptysis, or through referral via the USC route. Since 60% of patients with lung cancer present via the nUSC route, the SCP should more accurately reflect patient experience and pressure points in the diagnostic system for all patients regardless of the route of presentation.	

National Audit/Registry Title:	National Prostate Cancer Audit
Clinical Lead:	
Date of last data capture (or ongoing):	1st Apr 2016 – 31st Mar 2017
Publication date of last National Audit Report:	14th February 2019

Case Ascertainment:
In Wales we received a total of 2,027 NPCA records of newly diagnosed men who could be assigned to a valid NHS provider. The number of prostate cancer diagnoses appearing in WCISU for 2015 was 2,434 resulting in approximate case ascertainment of 83%.

Please give a brief overview of the National Audit scope and aims:
The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales.
The key objectives of the Audit are to investigate:

- Service delivery and organisation of care in England and Wales.
- The characteristics of patients newly diagnosed with prostate cancer.
- The diagnostic and staging process and planning of initial treatment.
- The initial treatments that men received.
- The experiences of men receiving care and their health outcomes 18 months after diagnosis
- Overall and disease-free survival

The NPCA determines whether the care received by men diagnosed with prostate cancer in England and Wales is consistent with current recommended practice, such as those outlined in the National Institute for Health and Care Excellence (NICE) Guidelines and Quality Standards as well as to provide information to support healthcare providers, commissioners and regulators in helping improve care for patients.

NICE Quality Standards, 2015

1. QS1: men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.
2. QS2: men with low-risk prostate cancer for whom radical treatment is suitable are also offered the option of active surveillance.
3. QS3: men with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.
4. QS4: men with adverse effects of prostate cancer treatment are referred to specialist services.
5. QS5: men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer MDT.

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

Patient characteristics

Over one-third of men are aged between 70 and 80 (37% and 41% for England and Wales, respectively). One-third are also aged between 60 and 70. Prostate cancer is very much a disease of the elderly shown with a high number being diagnosed when they are over 80 years old (17% and 14% in England and Wales, respectively). This remains consistent with last year's report. In England two thirds of the men had a performance status of 0 versus only 56% for Wales, again consistent with last year's report. However to note, this measure is reported only for patients for whom data has been submitted. Whilst performance status was completed for all patients in Wales; completeness in England is low at 51%

Diagnostic investigations

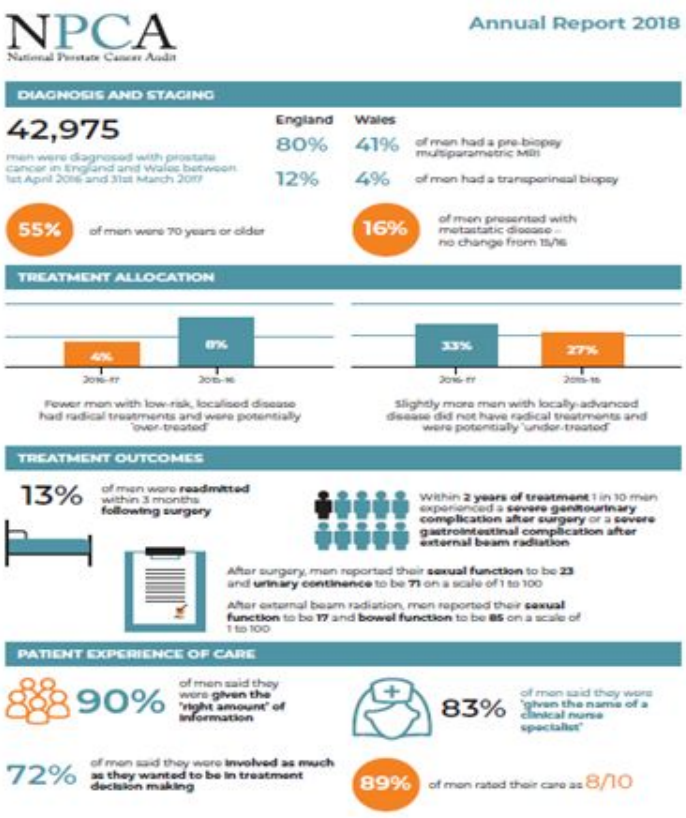
Transrectal ultrasound guided prostate biopsy remains the most common biopsy technique at 88%, with the remainder undergoing a transperineal biopsy (12%). Significantly more men are undergoing a transrectal ultrasound guided biopsy in

Wales at 96%, versus the transperineal route (4%). This is consistent with last year's results. It is important to note that this measure is reported only for patients for whom data has been submitted. Whilst the data on route of biopsy was completed for all patients in Wales the completeness in England was low at 54%. By contrast, the use of multiparametric MRI has increased from 51% to 58% in England, and from 54% to 59% in Wales. The use of pre-biopsy multiparametric MRI is also increasing and is up to 80% (from 74%) in England, and 41% (from 27%) in Wales, but this does indicate that the use of post-biopsy multiparametric MRI is still high. Again, these results need to be interpreted alongside the high level of incompleteness of this variable in England (51%).

PSA, tumour grade, tumour stage and disease status at presentation

The distribution of PSA, Gleason score and TNM staging is shown in Table 2 and has remained consistent with last year's results. The proportion of men presenting with metastatic prostate cancer at diagnosis is stable in England (16%).

However, it appears that more men are now being diagnosed with locally advanced disease, which has risen from 35% to 39%. The proportions of low and intermediate risk disease have both dropped to 7% (2,837) and 35% (13,424), respectively. The presentation of Welsh men at diagnosis appear to be generally consistent with last year's results but with only 2,027 men the sample size is too small to effectively comment on disease trends.



Was a national audit report provided which included ABUHB level data and conclusions? **No – a comparison is shown between English providers and Welsh providers.**

What are the key actions?	
Action:	**Timescale**

National Audit/Registry Title: National Paediatric Intensive Care (PICaNet) The report relates to data held for PICU at Noah Ark Children's Hospital for Wales, Cardiff.

6.6 National Audits - Women's and Children's Health

National Audit/Registry Title:	National Neonatal Audit Programme 2018
Clinical Lead:	Dr Siddhartha Sen
Date of last data capture:	01/01/2017-31/12/2017
Publication date of last National Audit Report:	September 2018

Case Ascertainment: 100%

Please give a brief overview of the National Audit scope and aims: The aims of the audit are:

• To assess whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards.
• To identify areas for quality improvement in neonatal units in relation to the delivery and outcomes of care.

In 2017, the NNAP focussed on the following areas of neonatal care:
• Administering antenatal steroids
• Administering antenatal magnesium sulphate
• Birth in a centre with a neonatal intensive care unit (NICU)
• Promoting normal temperature on admission for very preterm babies
• Speaking with parents within 24 hours of admission
• Involving parents in decision making through presence at consultant ward rounds
• Screening on time for retinopathy of prematurity (ROP)
• Measuring rates of infection
• Measuring rates of bronchopulmonary dysplasia
• Measuring rates of necrotising enterocolitis
• Minimising inappropriate separation of mother and baby (term and late to moderate preterm)
• Feeding breastmilk at discharge home
• Carrying out follow-up assessment at two years of age
• Measuring mortality rates

Please give a brief overview of main national findings from the published National Audit Report.

Antenatal magnesium sulphate

Giving magnesium sulphate to women who are at risk of delivering a preterm baby reduces the chance that their baby will develop cerebral palsy. The NNAP looks at whether mothers who delivered their baby at less than 30 weeks were given antenatal magnesium sulphate. Magnesium sulphate administration was much higher in 2017 than in 2016 (2017
– 64.1% of eligible mothers; 2016 – 53.3% of eligible mothers), reflecting rapid assimilation into practice of this aspect of NICE guidance, which is aimed at reducing cerebral palsy.

Selected recommendation:

To seek missed opportunities, and themes as to why magnesium was not given in line with NICE guidance, **neonatal and maternity care staff in units** with below average rates of administration should formally review records of babies born at less than 30 weeks where magnesium sulphate was not given to the mother.

Birth in a centre with a neonatal intensive care unit (NICU)
The NNAP looks at the proportion of babies born at less than 27 weeks gestational age who were born at a hospital with an on-site NICU. Babies who are born at less than 27 weeks gestational age are at high risk of death and serious illness. There is evidence that outcomes are improved if such immature babies are cared for in a NICU from birth. Three in four babies born less than 27 weeks gestational age were born at a hospital with an onsite NICU. Only two of 15 neonatal networks have more than 85% of these babies born within a hospital with an on-site NICU. Geographical size of network does not readily explain why more of some networks' babies are delivered in centres with a NICU.
Selected recommendation:
Neonatal networks, maternity networks and local maternity systems in England, and their equivalent bodies in Wales and Scotland, which do not achieve delivery of 85% of babies less than 27 weeks in a hospital with an onsite NICU should review whether they have realistic plans to achieve improvements in this area, and develop plans if required.

Promoting normal temperature on admission for very preterm babies
More very preterm babies in England, Scotland and Wales are admitted with a normal temperature than has been recorded for other nations in the international literature.1,2,3
Sixty four percent of babies had a normal first temperature (36.5 to 37.5°C) measured within an hour of birth. This is an improvement in performance from recent years (2016 – 60.8%; 2015 – 58.1%) without an increase in hyperthermia – temperature above 37.5°C (2017 – 12.2%; 2016 – 12%). However there remains room for significant further improvement in the promotion of normothermia on admission to neonatal units for very preterm babies.
Selected recommendation:
Neonatal units should ensure that they have a care bundle in place, developed with multidisciplinary input, which mandates the use of evidence-based strategies to encourage admission normothermia of very preterm babies.

Necrotising enterocolitis
Necrotising enterocolitis (NEC) is a devastating illness which can follow preterm birth. One in twenty (5.6%; 428 of 8,228) babies born at less than 32 weeks gestational age developed necrotising enterocolitis (NEC). The NNAP uses a surveillance definition of NEC based on diagnosis at surgery, post-mortem or on the presence of clinical or radiographic signs.
Selected recommendation:

Neonatal units who validated their NEC data for 2017 should use NNAP Online to compare rates of NEC with other units, and use these comparisons to seek quality improvement opportunities.

Minimising separation of mothers and term and late preterm babies

The NNAP looks at the number of days that term and late preterm babies requiring low dependency care are separated from their mother. Variation exists in the average number of separation days between neonatal units and networks, for both term and late preterm babies. Findings for these two measures suggest that opportunities exist to reduce separation of mothers and term and late preterm babies by providing some neonatal care as transitional care.

Selected recommendation:

Neonatal units and trusts/health boards where transitional care cannot be delivered should work with their commissioners to develop the ability to deliver such care to minimise mother and baby separation, following the BAPM guidance A Framework for **Neonatal Transitional Care**

Was a national audit report provided which included ABUHB level data and conclusions?

Yes -

- Royal Gwent Hospital performed statistically above par (positive outlier) in the following areas:
  - MgSO4 to eligible mothers 83% against a National average of 64%
  - Timely consultation with parents at 99% against a National average of 95%
  - Clinical Follow up at 2 years: 88% against a National average of 63%
- Royal Gwent Hospital performed statistically below par (negative outlier) in the following areas:
  - Mothers Milk at time of discharge was nationally recorded at 60% and the Royal Gwent was 37% which is a statistically significant finding.
- In all other aspects Royal Gwent Hospital was statistically at par with National figures
- Nevill Hall Hospital performed very poorly in 1 audit measure (negative outlier)
  - Timely consultation with parents. Nevill Hall's performance in this parameter was > 3SD below the National average in the category of "alarm".
- Nevill Hall performed very well in 1 audit measure (positive outlier)
  - Timely screening for ROP. In this audit measure, Nevill Hall was a positive outlier – it recorded a score of 100% against a National average of 94%.

- In all other measures Nevill Hall had performances below the National average, though none of them were statistically significant.

All areas of the audit will need to be addressed at Nevill Hall Hospital.

Your baby's care

Measuring standards and improving neonatal care

NEVILL HALL HOSPITAL takes part in the **National Neonatal Audit Programme (NNAP)** which monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. This poster shows how the 2017 results for NEVILL HALL HOSPITAL compare with national rates, as indicated in the NNAP 2018 Annual Report on 2017 data.

Antenatal steroids
Mothers who delivered babies between 24 and 34 weeks gestation who were given antenatal steroids. This is recommended to help prevent breathing problems in baby.

86% National rate 89%

Antenatal magnesium sulphate
Mothers who delivered babies below 30 weeks gestation who were given magnesium sulphate in the 24 hours before delivery. This is recommended to help prevent cerebral palsy in baby.

33% National rate 64%

Temperature on admission
Babies born at less than 32 weeks gestation who had an appropriate temperature (between 36.5°C and 37.5°C) on admission to the neonatal unit.

58% National rate 64%

Consultation with parents
Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of a baby's admission.

70% National rate 95%

Parents on ward rounds
The proportion of admissions where parents were present on at least one consultant ward round during a baby's stay.

49% National rate 74%

Screening for retinopathy of prematurity
Babies who are born weighing less than 1501g, or are born at less than 32 weeks gestation who receive on-time screening for retinopathy of prematurity

100% National rate 94%

Mother's milk at time of discharge
Babies born at less than 33 weeks who were receiving some of their mother's milk, either exclusively or with another form of feeding, when they were discharged from neonatal care.

44% National rate 60%

Follow-up at two years of age
Babies born at less than 30 weeks who had received documented medical follow-up at two years of age.

50% National rate 63%

Please see **Poster 2** for this unit's response to the results.
To find out more about how we use your baby's information, please visit:
www.rcpch.ac.uk/nnap

RCPCH
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Your baby's care

Measuring standards and improving neonatal care

ROYAL GWENT HOSPITAL takes part in the **National Neonatal Audit Programme (NNAP)** which monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. This poster shows how the 2017 results for ROYAL GWENT HOSPITAL compare with national rates, as indicated in the NNAP 2018 Annual Report on 2017 data.

Antenatal steroids

Mothers who delivered babies between 24 and 34 weeks gestation who were given antenatal steroids. This is recommended to help prevent breathing problems in baby.

91% — National rate 89%

Antenatal magnesium sulphate

Mothers who delivered babies below 30 weeks gestation who were given magnesium sulphate in the 24 hours before delivery. This is recommended to help prevent cerebral palsy in baby.

83% — National rate 64%

Temperature on admission

Babies born at less than 32 weeks gestation who had an appropriate temperature (between 36.5°C and 37.5°C) on admission to the neonatal unit.

66% — National rate 64%

Consultation with parents

Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of a baby's admission.

99% — National rate 95%

Parents on ward rounds

The proportion of admissions where parents were present on at least one consultant ward round during a baby's stay.

67% — National rate 74%

Screening for retinopathy of prematurity

Babies who are born weighing less than 1501g, or are born at less than 32 weeks gestation who receive on-time screening for retinopathy of prematurity

97% — National rate 94%

Mother's milk at time of discharge

Babies born at less than 33 weeks who were receiving some of their mother's milk, either exclusively or with another form of feeding, when they were discharged from neonatal care.

37% — National rate 60%

Follow-up at two years of age

Babies born at less than 30 weeks who had received documented medical follow-up at two years of age.

88% — National rate 63%

Please see **Poster 2** for this unit's response to the results.
To find out more about how we use your baby's information, please visit:
www.rcpch.ac.uk/nnap

RCPCH
Royal College of Paediatrics and Child Health

What are the key actions?	
Action:	**Timescale**
Breast milk at discharge (Royal Gwent Hospital). A consultant has taken the lead in this area and has formed a team to improve breast feeding rates.	12 months
Parent present at word round (Royal Gwent Hospital): This has been identified as a problem with documentation. Nurses have been shown where the entry is to be made and have been encouraged to so.	12 months
Parental consultation (Nevill Hall Hospital). A consultant has taken the lead in this. It has been identified essentially as a problem with both action and documentation.	12 months

6.7 National Audits - Other

National Audit/Registry Title: National Clinical Audit of Psychosis

Clinical Lead: Ana Llewellyn

Date of last data capture (or ongoing):

Publication date of last National Audit Report: 10th January 2019

Case Ascertainment:
ABUHB:

Trust ID	Expected sample	Final sample after data cleaning
ORG 03	100	34

Please give a brief overview of the National Audit scope and aims:

Audit standards
The audit has focused on four issues relating to the quality of care provided for people with psychotic disorders: management of physical health, prescribing practice, access to psychological therapies and outcomes. Twelve audit standards and two outcome measures were developed to address these issues.

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

The main results focus on those patients who were living in the community on the 'census date' for the audit and who had a diagnosis of either schizophrenia or schizo-affective disorder (the NCAP community sub-sample; n=7,773). The findings for this sub-sample are directly comparable to the findings from the two previous audits. In comparison with the findings from NAS1 and NAS2, the NCAP results show some improvements in monitoring of physical health and substantial improvements in the provision of interventions for identified physical health risk factors. However, overall assessment of risk for cardiovascular disease, with a tool such as Q-Risk, requires more attention. There were also improvements in prescribing practice for antipsychotic medications, with a small reduction in polypharmacy and an important reduction in the proportion of patients being prescribed antipsychotics at doses above those recommended in the British National Formulary (BNF). However, provision of written information, or other appropriate forms of information, to patients about their medication remains poor.

Provision of evidence based psychological therapies remains below the expectation of the NICE guideline (NICE CG178) that all patients should be offered these. Only 36% had been offered some form of CBT and only 26% had been offered CBTp. Only 12% of patients in contact with their families had been offered family intervention. Only one in ten patients in the audit were involved in work or education and less than half of those seeking work had been offered appropriate support to help them find a job.

The findings in relation to those patients who were inpatients (n=689) and those who had diagnoses other than schizophrenia or schizo-affective disorder (n=1,034) are summarised in Tables in the main body of the report (pages 61–66) and compared with performance against standards for the NCAP community sub-sample.

Was a national audit report provided which included ABUHB level data and conclusions?

No – data is provided based on the last 3 data capture exercise at a national level only.

What are the key actions?	
Action:	**Timescale**

National Audit/Registry Title:	Epilepsy 12 (NCA of Seizures and Epilepsies for children & young people)
Clinical Lead:	Ana Llewellyn
Date of last data capture (or ongoing):	Sally Jones/Charlotte Lawthom
Publication date of last National Audit Report:	January 2019

Case Ascertainment:
There is no ABUHB data, although he HB participates as part of South Wales Epilepsy Forum (SWEP).

Please give a brief overview of the National Audit scope and aims:
Epilepsy12 was established in 2009 and has the continued aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. The audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and is delivered by the Royal College of Paediatrics and Child Health (RCPCH).
The RCPCH delivered Rounds 1 and 2 of Epilepsy12 between 2009 and 2015, publishing related national reports for each Round in 2012 and 2014 respectively. The audit was inactive for two years at the end of Round 2, however, paediatric epilepsy was once again prioritised as a topic for the NCAPOP and the RCPCH was recommissioned by HQIP to deliver Round 3 of Epilepsy12 from 1 April 2017 to 31 March 2021.
Rounds 1 and 2 of the audit included Health Boards and Trusts across England, Northern Ireland, Scotland and Wales. This report covers the analysis of data collected by the audit on the organisation of paediatric epilepsy services within Health Boards and Trusts in England and Wales. It is hoped that in future, Health and Social Care Trusts in Northern Ireland and Health Boards in Scotland will also join Round 3 of the audit, subject to contractual and governance arrangements being put in place.
As per Rounds 1 and 2, the work of Round 3 of the audit is overseen by a Project Board which includes representatives of patient and professional organisations and a dedicated project team within the RCPCH.

Please give a brief overview of main <u>national</u> findings from the published National Audit Report.

Key findings

• 94.6% (140/148) of Health Boards and Trusts employed a consultant paediatrician with expertise in epilepsy. There has been an increase in the total number of whole time equivalent
(WTE) consultant paediatricians with expertise in epilepsy employed across England and Wales, compared to Rounds 1 and 2

• 85.1% (126/148) of Health Boards and Trusts Health Boards and Trusts had a defined paediatric epilepsy clinical lead

• 77.7% (115/148) of Health Boards and Trusts had some epilepsy specialist nurse (ESN) provision within their paediatric service. 22.3% of Health Boards and Trusts still have no epilepsy specialist nurse provision. There has been an increase in the total number of WTE epilepsy specialist nurses employed across England and Wales, compared to Rounds 1 and 2

• 75% (111/148), of Health Boards and Trusts indicated that they could offer ESN support for rescue medication training for parents

Was a national audit report provided which included ABUHB level data and conclusions?

No – data is relevant to the South Wales Epilepsy Forum.

What are the key actions?	
Action:	**Timescale**

Appendix 1 – ABUHB Action Plan

Action Plan for the NCA Annual Report 2017 including the Recommendations in the Internal Audit of Clinical Audit and Assurance 2017

Action	Responsible Officer	Timescale	Update
Development and agreement of Strategic Documents for ABUHB Clinical Audit to cover: • The governance structure, including links to the risk register, and responsibility for audit programmes at different levels in the organisation • A programme methodology for identifying clinical audits for the Health Board audit programme • Reporting/monitoring of clinical audit results and actions for improvement in the corporate programme • Clear dissemination and escalation processes	Assistant Director – Quality and Patient Safety and Lead for NCA	November 17	A Clinical Audit Strategy and Policy are nearing completion. These key documents cover the issues in the bullet points. Now complete.

Initiate Programme of Local Clinical Audit	Assistant Director – Quality and Patient Safety	May 17	Local programme initiated, with audit of Deteriorating Patient underway and Consent Form audit planned
Process for agreeing a clinical audit annual programme, to include the NCAOR plan and local clinical audits	Assistant Director – Quality and Patient Safety	November 17	Will be part of the Clinical Audit Strategy and Policy documents
Take forward a review of assurance mechanisms to clarify where and how assurance is provided on clinical risks in the Health Board. This will include consideration of how the Health Board moves towards an assurance plan marrying together traditional assurance with real time data from the outcomes and values work	Assistant Director – Quality and Patient Safety	September 18	To be initiated December 17 Not taken forward**.** Now superseded by updated recommendations.
Development of a spread sheet to monitor: • Participation in audits • Review and dissemination of findings	Lead for National Clinical Audit	July 17	Complete

• Identification of actions based on the findings			
Production of an Annual Report on National Clinical Audit in ABUHB	Assistant Director – Quality and Patient Safety Lead for National Clinical Audit	November 17	Complete
Address backlog of reporting to WG on NCAs published since September 16	Lead for National Clinical Audit	November 17	In Progress
Initial Training on audit methodology for members of MDST	Assistant Director – Quality and Patient Safety	June 17	Complete
Regular 1-1s between Assistant Director – Quality and Patient Safety and MDST members at which training needs can be identified as staff develop in their roles	Assistant Director – Quality and Patient Safety	August 17	Complete

Work with Urgent Care Directorate to facilitate participation in TARN Audit	Assistant Director – Quality and Patient Safety	March 18	Meeting being arranged with Urgent Care manager. Different approaches tried, but unsuccessful.
Work with Ophthalmology Directorate to facilitate participation in Audit	Lead for NCA	March 18	In discussion with Clinical Director and WG.
Work with Inflammatory Bowel Service to facilitate participation in NCA	Lead for NCA	December 17	Funding for audit agreed
Embed process for Dissemination of NCA report findings and escalation of NCA findings where ABUHB is highlighted as an outlier or the report highlights clinical risks	Assistant Director – Quality and Patient Safety and Lead for NCA	March 18	Audit Headline data slides to be reported to QPS Operational Group. Report format being developed. Template e-mail for dissemination of Headline data slides to be finalised.
Develop a NCA page on the intranet so that all the information relating to NCA in ABUHB is easily accessible	Lead for NCA	January 2018	Page in place, and more information will be added over time
Consider how the results of NCAs should be made available to the	Assistant Director – Quality and Patient	November 18	Results of audits available on audit websites.

public, so that there is openness and transparency	Safety and Lead for NCA		
Make links with the Value and Outcomes work stream, so that there is no duplication and the work streams dovetail	Assistant Director – Quality and Patient Safety	Ongoing	Meetings arranged

Appendix 2

INTERNAL AUDIT OF CLINICAL AUDIT 2018-19 ACTION PLAN

ACTION	TIMESCALE	RESPONSIBLE OFFICER	UPDATE
A Quality Improvement Leaders Group will be set up, with the leaders of ABCi, Value based healthcare, clinical audit and R and D and innovation, to seek to develop a new way of using clinical information for improvement and from this, a Quality and Patient Safety Improvement Strategy and Assurance Framework. It will incorporate a review of known clinical risks and those on the patient safety risk registers, focussing on major clinical risks.	Group set up – April 2019 Initial Output from the Group – September 2019 Strategy and Assurance Framework – Dec 19	Medical Director	The Group was set up in March 2019 and has meeting planned through out the year. A presentation on the development of the Strategy and Assurance is on the agenda for the QPS Op Group in Sept 19.
The MDST will develop over a number of meetings, a report on NCAs within the Quality Performance Report for QPSC	Initial Report to QPSC – June 19	Assistant Director - QPSC	A report on NCAs was included in both QPSC in April and June 2019 and will continue to be developed COMPLETE
One to one support on clinical audit is always available to staff through the MDST. The training resources available	Section on CA training on the intranet June 19	Assistant Director - QPSC	A powerpoint training presentation is available on the intranet, and it is clear that 1-1

will be clarified on the Clinical Audit Intranet page			support/bespoke training is available from the MDST. COMPLETE
Set up a Clinical Effectiveness and Standards Group, chaired by the AMD for Clinical Effectiveness and with ADD representation from all Divisions, which will monitor the delivery of the Clinical Audit for Improvement Programme and monitor the implementation of recommendations. It will receive the results of the NCAs and Health Board Audits and determine which require escalation and reporting to QPSC.	First meeting - June 19	Medical Director	The first meeting of the Clinical Effectiveness and Standards Group has been set up for July 2019. The development of the Group into its full role is ongoing.
The clinical audit registration form and checklist will be updated and be available on the Clinical Audit intranet site.	June 2019	Assistant Director – Quality and Patient Safety	The clinical audit registration form and checklist have been updated and are available on the Clinical Audit intranet site. COMPLETE
The Medical Education Team will be charged with randomly selecting 100 non-identifiable Consultant re-validation quality improvement domains, to identify the volume and subject of the audit activity in a year. This will be mapped against the broad areas where	Review of Consultant revalidation QI domains - Sept 2019 Mapping against risk – Nov 2019	Medical Director	The review of Consultant revalidation QI domains has been completed. COMPLETE

clinical risk has been identified, not withstanding large scale work undertaken via other QPS improvement mechanism			
The MDST will bring together the NCA and health board wide audit into a clinical audit for improvement programme, through discussion at QPS Operational Group. It will be approved at QPSC.	Clinical audit plan agreed at QPSC – Sept 2019	Assistant Director – QPS	The Health Board wide clinical audit programme has been discussed with the Quality and Patient Safety Operational Group, and has been taken to the new Clinical Effectiveness Group for agreement. COMPLETE
Whilst the Divisions will produce and present annual workplans of assurance against their major clinical risks, and significant issues arising from the work plan, alignment of these risks to clinical audit for improvement will be highlighted within the workplans. These will be presented to the CESG, and this will be summarised in an annual over view of Clinical audit to QPSC every September from 2020.	Presentation to CESG from Nov 19 Summary to QPSC from Sept 2020	Medical Director	In development
From this Quality and Patient Safety Improvement Strategy and Assurance Framework, the Executive Team will assess the level of clinical audit required by the organisation and the	Review of level of clinical audit – March 2020.	Medical Director	

resource needed to support this, in order to undertake the Health Board wide audit above and beyond the NCAORP, ensuring that the clinical audit activity is effective in bringing about improvement.			
The Clinical Audit Strategy and Policy will be updated to include the outputs from the recommendations from this review once the process has been completed. This will be approved at Exec Board and QPSC and communicated across the organisation, through dissemination to the Clinical Directors.	Update Clinical Audit Strategy and Policy, approve and communicate – June 2020	Assistant Director – QPS	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Date: 5th December 2019 Agenda Item: 5.2

Aneurin Bevan University Health Board

ABUHB CLINICAL AUDIT PLAN 2019-20

5.2

Executive Summary

The Clinical Audit Plan for ABUHB for 2019-20 is a combination of the NHS Wales National Clinical Audit and Outcome Review Programme (NCAORP) for 2019-20 and the Health Board's programme of Health Board wide Clinical Audits. The NCAs on the NCAORP address risks specific to a clinical service and the Health Board wide programme of clinical audits addresses corporate risks that do not lie within any one particular clinical service.

The Committee will be able to monitor the implementation of the plan through the Annual Report for National Clinical Audit 2020 and a report summarising the results and action plans for the audits on the HB wide programme of clinical audits, which will be brought to the Committee in 2020-21.

The Quality and Patient Safety Committee is asked to approve the ABUHB Clinical Audit Plan 2019-20.

The Committee 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, QPS

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	**Quality and Patient Safety Operational Group Clinical Effectiveness Group**

Date of the Report: November 2019

Supplementary Papers Attached:
NHS Wales National Clinical Audit and Outcome Review Plan for 2019-20
Health Board programme of Health Board wide Clinical Audits

Purpose of the Report

The Clinical Audit Plan for ABUHB for 2019-20 is a combination of the NHS Wales National Clinical Audit and Outcome Review Programme for 2019-20 and the Health Boards programme of Health Board wide Clinical Audits. The Plan is brought to the Quality and Patient Safety Committee for approval.

Background and Context

The NHS Wales National Clinical Audit and Outcome Review Programme was issued as WHC 2019/006 in May 2019. This determines the National Clinical Audits that the Health Board participates in as they are mandated by Welsh Government. The audits are commissioned by the Health Care Quality Improvement Partnership (HQIP) and the audit design has to meet certain standards, including recognising differences in the way the NHS operates in Wales compared to the rest of the UK. The audits included on the programme are chosen as they cover services where it is believed there is more that can be done to improve services nationally. National Clinical Audits assess the performance of a clinical service for a particular clinical condition in Health Board against evidence based standards, and in other organisations across the nations of the UK. They therefore enable the Health Board to understand how a clinical service is preforming against recognised standards of care and also benchmark it against services for the same condition in other Health Boards or Trusts. Re-audit after a period of time allows changes to be made to the service and measures whether the changes have been effective in improving the service.

The Health Board wide Programme of Clinical Audits is a small programme of clinical audits to address clinical risks that impact across a large part of the Health Board and are identified through a variety of surveillance mechanisms. In order to develop this programme for 2019-20, the Quality and Patient Safety Operational Group was asked in March 2019, because of its overview of corporate and divisional risks, to consider which audits should be included on the programme. The programme has also been agreed by the Clinical Effectiveness Group, at its first meeting in July 2019. The audits are carried out by the Medical Director's Support Team, with guidance from experts on the issue. The audit reports are taken to a Group in the Quality and Patient Safety Assurance Structure in order to develop, agree and monitor an action plan against the results.

These two programmes of audits together make up the ABUHB Clinical Audit Plan for 2019-20. The NCAs on the NCAORP address risks specific to a clinical service and the health board wide programme of clinical audits addresses corporate risks that do not lie within any one particular service.

Other clinical audits are carried out within the Directorates to address issues specific to the individual specialties. However, these are not co-ordinated and monitored corporately.

The Committee will be able to monitor the implementation of the ABUHB Clinical Audit Plan through the Annual Report for National Clinical Audit 2020 and a report summarising the results and action plans for the audits on the HB wide programme of clinical audits, which will be brought to the Committee in 2020-21.

Recommendation

The Quality and Patient Safety Committee is asked to approve the ABUHB Clinical Audit Plan 2019-20.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The audits on the plan are there to address risks in clinical services, and risks from clinical issues that go across large areas of the health board
Financial Assessment, including Value for Money	Participating in the audits requires resource. The National Clinical Audits are largely completed by clinical staff. The Health Board programme is completed by the Medical Director's Support Team. The audits can identify that improvements are needed, which may also require additional resource to meet the evidence based standard.
Quality, Safety and Patient Experience Assessment	Clinical Audits promote quality planning, quality improvement and quality assurance.
Equality and Diversity Impact Assessment (including child impact assessment)	The NCAORP is set by Welsh Government.
Health and Care Standards	Undertaking clinical audit is a requirement of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	Participating in the NCAs on the NCAORP is one of the quality issues in the quality appendix for the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Clinical Audits can ensure services are improved to benefit future generations. Most are focussed on health care services provided by ABUHB, not the wider service supported by our partner organisations.
Glossary of New Terms	National Clinical Audit and Outcome Review Programme – the Welsh programme of NCAs that Health Boards are mandated to participate in.
Public Interest	This report may be published.

HEALTH BOARD WIDE CLINICAL AUDIT PROGRAMME 2019-20

ISSUE and RISK ADDRESSED	CLINICAL AUDIT AIM	ABUHB LEAD GROUP	DEVELOPMENT OF AUDIT PROTOCOL	APPROVAL OF AUDIT PROTOCOL	CARRY OUT CLINICAL AUDIT	COMPLETE AUDIT REPORT, WITH DRAFT ACTION PLAN	APPROVAL OF AUDIT REPORT AND ACTION PLAN
Implementation of NatSSIPs (delayed from 2018-19 programme) *Risk: Poor implementation of PSN 034 with consequence that surgical Never Events are not reduced*	To assess whether the main departments where invasive procedures are undertaken comply with standards 4-13 of the NatSSIPs.	Clinical Effectiveness Group (bimonthly)	July 2019	July 2019	August 2019	September 19 UPDATE Nov 19: Audit Report in draft	November 19
Antimicrobial Stewardship New Audit suggested by QPS Op Group *Risk: Antimicrobial prescribing Policy is not adhered to with consequence of*	To assess adherence to the principles of start smart and focus antimicrobial prescribing, with the All Wales audit tool (with a link back to "start smart" for patients that triggered with sepsis in	Infection Prevention and Control and antimicrobial resistance group (Monthly)	August 2019	September 2019	October 2019 UPDATE Nov 19: Audit work completed on wards	November 2019 UPDATE Nov 19: Report being drafted	December 2019

increased HCAI and increased antibiotic resistance.	A+E/MAU, to assess how long it took for "focus"						
Informed Consent – Consent to Treatment Form and Process Re-audit *Risk: Patients are not giving Informed Consent to treatment, with consequence of inappropriate treatment and increased litigation*	To assess whether the completion of the Consent to Treatment Form and Consent process meets the standards in the Consent Policy. Specific issues audited by Directorates, such as: - what written information is given to the patient, when it is given and how this is recorded on the consent form -recording of discussion of the concerns of the patient -patient given a copy of the consent form	Clinical Effectiveness Group (bimonthly)	August 2019 UPDATE: Nov 19 Audit delayed to Jan 20	September 2019	November 2019	December 2019	January 2020

Readmissions New Audit suggested by QPS Op Group *Risk: Failed discharge if discharge policy is not adhered to leading to readmission (rather than delays in discharge)*	To assess whether the Discharge Policy was adhered to in DTOC patients that are readmitted in less than 7 days	Acute Deterioration Group (bimonthly)	December 2019 UPDATE: Nov 19 This audit will be delayed until 2020-21 as the Corporate Innovation Team undertook an audit of the discharge policy in early 2019-20, and changes are still being made to the processes.	January 2020	February 2020	March 2020	May 2020
DNACPR Re-audit *Risk: Attempted resuscitation when it is futile, with consequence of an undignified death and additional stress for the relatives*	To assess whether clinical practice in relation to the DNACPR process meets the standards set out in the All wales DNACPR Policy	EOLCB (quarterly)/ Acute Deterioration Group (bimonthly)	December 2019 UPDATE Nov 19: Audit protocol development will take place as planned	January 2020	March 2020	April 2020	May 2020

WHC/2019/006

WELSH HEALTH CIRCULAR

Llywodraeth Cymru
Welsh Government

Issue Date: 9 May 2019

STATUS: INFORMATION/ACTION

CATEGORY: HEALTH PROFESSIONAL LETTER

Title: NHS Wales National Clinical Audit and Outcome Review Plan
Annual Rolling Programme for 2019/20

Date of Review: April 2020

For Action by:
Health Boards and NHS Trusts
National Clinical Leads
National Clinical Audit and Outcome Review Advisory Committee.

For information:
Chief Executives
Medical Directors
Directors of Primary Care

Action required by: N/A

Sender: Dr Frank Atherton, Chief Medical Officer

DHSS Welsh Government Contact(s):
Population Health Division, Health and Social Services Group, Welsh Government, Cathays Park, Cardiff, CF10 3NQ. Email: PopulationHealthcare@gov.wales

Enclosure(s): NHS Wales National Clinical Audit and Outcome Review Plan: Annual Rolling Programme from 2019/20

Dr Frank Atherton
Prif Swyddog Meddygol/Cyfarwyddwr Meddygol, GIG Cymru
Chief Medical Officer/Medical Director NHS Wales

Llywodraeth Cymru
Welsh Government

Dear Colleagues**,**

Health boards and trusts in Wales are required to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2019/20, which shall also be available via the Welsh Government website: https://gov.wales/national-clinical-audit-and-outcome-review-plan-2019-2020

National clinical audits are a major source of information aimed at measuring and benchmarking the improvement of healthcare services in Wales. The audit data are used to assess the quality and effectiveness of the healthcare provided by health boards and trusts and can make a big difference to the way we provide services when coupled with suitable improvement actions. It is essential all parts of NHS Wales participate fully in the national programme.

The Plan details the role each of us has for taking this work forward and includes the list of National Clinical Audits and Outcome Reviews which all healthcare organisations **must fully** participate when they provide the service.

If you have any queries regarding the annual plan please contact: wgclinicalaudit@gov.wales.

Yours sincerely

DR FRANK ATHERTON

NHS Wales National Clinical Audit and Outcome Review Plan

Annual Rolling Programme from 2019/20

April 2019

This is the 8th annual National Clinical Audit and Outcomes Review Plan confirming the list of National Clinical Audits and Outcome Reviews which all health boards and trusts are expected to participate in 2019-20 (when they provide the service). The plan also confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

As with previous reports, to ensure consistency, changes to the list of audits and reviews have been kept to a minimum.

Section 1 of the National Health Service (Wales) Act 2006 places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.

1. What do we want to achieve?

NHS Wales needs to be a learning organisation which regularly seeks to measure the quality of its services against consistently improving standards and, in comparison with other healthcare systems across the UK, Europe and the World. This measurement should be used to set improvement priorities and, the standardised improvement methodology taken forward by 1000 Lives Plus is a recognised approach for how this work should be taken forward within NHS Wales.

The Welsh Government and NHS Wales is committed to the principles of prudent healthcare to help meet the challenges of rising costs and increasing demand, while continuing to improve the quality of care. Participation in the national clinical audit programme is entirely in line with the principles of prudent healthcare. It clearly demonstrates the commitment to make the most effective use of all skills and resources and, to reduce inappropriate variation using evidence based practices consistently and transparently.

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards. The requirement to participate and learn from audits is also a central component of the suite of Delivery Plans developed for NHS Wales e.g. Stroke Delivery Plan, Diabetes Delivery Plan, Heart Disease Delivery Plan, etc.

2. What is the role of the National Clinical Audit and Outcome Review Advisory Committee?

To encourage greater focus on Welsh priorities, a National Clinical Audit and Outcome Review Advisory Committee (from hereon referred to as the Advisory Committee) exists to:

- Provide national leadership and professional endorsement for NHS Wales participation in a rolling annual programme of clinical audit and review.
- Ensure that audits, reviews and national registries are relevant to Wales and provide clearly identifiable Welsh data, where appropriate.
- Maximise the benefit by encouraging widespread learning.
- Promote action to improve the quality and safety of patient care through application of the 1000 Lives Plus standardised improvement methodology in areas prioritised by the audit.
- Recommend a programme of national clinical audits and clinical outcome reviews which all health boards and trusts who provide the relevant services must participate in as a minimum. This programme will be reviewed annually, and may be subject to additions during the course of the year if the Committee supports Welsh participation in any new National Audits being developed.
- Liaise with HQIP in respect of NHS Wales' requirements.

New proposed audits are assessed by the Advisory Committee against the following criteria. Proposals must;

- Have national coverage of all relevant providers (achieved or intended)
- Focus on improving the quality of clinical practice
- Provide comparison of providers at an organisational, hospital or unit level
- Evaluate practice against clinical criteria/guidelines and/or collect outcomes data
- Publish regular open (public) reports of findings
- Apply to the complete audit cycle and/or monitors clinical/patient outcomes data in an ongoing way as part of a programme of driving change
- Be prospective - i.e. does not include retrospective reviews of adverse outcomes such as confidential enquiries
- Collect data on individual patients and includes patients in their governance – recruits data from patients during the current financial year.

The agreed NHS Wales programme of audits includes the majority of audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) managed by the Healthcare Quality Improvement Partnership (HQIP), but can also include a number of other national or multi-organisational audits recognised by the Advisory Committee as being essential.

The Clinical Outcome Review Programme (formerly Confidential Enquiries) is commissioned by HQIP on behalf of the Welsh Government, NHS England, NHSSPS Northern Ireland, ISD Scotland and the Channel Island and Isle of Man

governments. The programme is designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

The final agreed list of audits and reviews will be published annually. The programme for 2019-20 is attached at Annex A.

Full list of Advisory Committee membership:

1.	Dr Jacinta Abraham – Chair	Medical Director, Velindre NHS Trust
2.	Prof Chris Jones	Deputy Chief Medical Director, Welsh Government
3.	Jane Ingham	CEO, Healthcare Quality Improvement Partnership
4.	Jenny Thomas	Medical Director, Welsh Health Specialised Services Committee
5.	Rhidian Hurle	Medical Director, NHS Wales Informatics Service
6.	Arlene Shenkerov	Chair, Welsh Clinical Audit & Effectiveness Association
7.	Gill George	NHS Delivery Unit
8.	Heather Payne	Senior Medical Officer, Maternal & Child Health, Welsh Government
9.	Dr Aidan Byrne	Interim Deputy Medical Director, Abertawe Bro Morgannwg University Health Board
10.	Mark Townsend	Head of Clinical Audit & Quality Informatics, Cwm Taf University Health Board
11.	Kate Hooton	Ass. Dir. Patient Quality &Safety, Aneurin Bevan University Health Board
12.	Adrian Thomas	Executive Director of Therapies, Betsi Cadwaladr University Health Board
13.	Alexandra Scott	Patient Safety and Quality Assurance Manager Cardiff and Vale University Health Board
14.	Ceri Brown	Consultant Anaesthetist, Hywel Dda University Health Board
15.	Howard Cooper	Head of Clinical Governance, Powys Teaching Health Board
16.	Olivia Shorrocks	Head of Major Conditions, Welsh Government
17.	Chris Connell	NICE
18.	Gareth Hewitt	Head of Older People's Health & Chronic Conditions Management, Welsh Government
19.	David Thomas	Representative from Dental Deanery
20.	John Boulton	Representative of 1000 Lives Improvement Service
21.	Andrew Havers	Primary Care Representative, Welsh Government
22.	Caroline Whittaker	Quality Lead, Public Health Wales
23.	John Watkins	Public Health Consultant, Public Health Wales
24.	Joseph Wilton	Health Inspectorate Wales
25.	Rachel Powell	Welsh Ambulance Service Trust

3. How will participation, learning and action on findings be encouraged throughout Wales?

This will be achieved by:

Improved communication and encouragement of audit:

- With the regular publication of a National Clinical Audit and Outcome Review e-bulletin highlighting developments and findings from recent reports.
- Feeding back on the benchmarked performance of individual providers within clinical audits and reviews to organisations as appropriate for reflection and action.
- By raising the profile of clinical audit with boards, patient groups, clinicians and all staff working within the NHS. To include national events, organisational visits and liaison with professional bodies in Wales to encourage audit amongst their disciplines and specialism.
- Developing closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.
- Working in partnership with other healthcare organisations e.g. Public Health Wales, National Welsh Information Service to promote and encourage a culture of participation in audit and action on findings.

Identifying areas needing a national approach to improvement:

- Reviewing common issues for all Welsh healthcare providers arising from audit and reviews and sharing solutions.
- Through the development of closer links to 1000 Lives Plus improvement programme.
- By ensuring the findings and recommendations from audits are fully considered by the appropriate Delivery Plan implementation groups.
- Working in partnership, via HQIP and with audit project teams to ensure the provision of Welsh-specific findings and potential solutions, and develop and organise workshops and events to disseminate them.

Addressing clinical services where performance may give cause for concern:

- Clearly identifying the comparative performance of individual provider organisations and understanding the reasons for any disparity.
- Ensuring issues are considered in regular performance review meetings between health boards/trusts and the Welsh Government Performance & Delivery Unit.
- Developing and publishing a protocol confirming the arrangements for the identification and handling of organisations identified in audits and reviews as

being “Outliers” including such activity designed to improve and encourage quality improvement.

Greater transparency:

- By seeking to improve the way in which the findings, recommendations and improvement actions from audit and reviews are made available to patients, public and all staff working in the NHS.

4. What is the Role of Welsh Government?

In partnership with NHS England and HQIP, the Welsh Government supports and funds the cost of NHS Wales’ participation in the National Clinical Audit and Clinical Outcome Review Programme. Through improved communication, leadership, feedback and by building on the advice that it receives from the Advisory Committee, the Welsh Government also seeks to encourage greater participation and learning from clinical audits and reviews leading to improved services, better patient outcomes and safer patient care.

Given ongoing financial restraints the Welsh Government will continue to work closely with NHS England and HQIP to systematically review the current programme with a view to reducing costs where possible onwards.

5. What are the responsibilities of Welsh health boards and trusts?

Welsh health boards and trusts should provide the resources to enable their staff to participate in all audits, reviews and national registers included in the annual plan (where they provide the service). They should ensure the full audit cycle is completed and that findings and recommendations from audit link directly into the quality improvement programme and lead to improved patient care and outcomes.

To ensure the maximum benefit is derived from the clinical audit programme health boards and trusts should:

- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Appoint a clinical lead to act as a champion and point of contact for every National Clinical Audit and Outcome Review which the health board is participating in. Health boards and trusts should also encourage and support clinical leads to take on the role of all-Wales representative on audit steering groups where required.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

- Complete the assurance pro-forma developed and agreed by the National Clinical Audit & Outcome Review Advisory Committee which should be used for providing internal and external assurance of the actions being taken to address audit report findings. The assurance pro-forma should be completed within four weeks of audit report publications and should be regularly updated.
- Have clear lines of communication which ensures full board engagement in the consideration of audit and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.
- Facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

6. How Will We Measure Success?

By year on year consideration of audit reports and in comparison with other UK, European and International healthcare systems to determine how compliance with best practice and achievement of healthcare outcomes compares to national and international benchmarks.

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Less variation between local services and measurable year on year improvements in performance to achieve the highest standards. Organisations recognised as being above the audit “average” or within the top quartile for each audit and maintaining that level.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

7. How Will We Maintain Success?

It is one thing to attain success and another to maintain it sustainably. The audit and quality improvement approach has the advantage of engaging those placed to make change and those expected to deliver and maintain change on a daily basis. This approach has a demonstrated track record of delivering and maintaining service improvement for a range of issues in a range of settings. Where there are expectations of delivering and maintaining better quality care and outcomes, the audit and quality improvement should be the normally used first-line approach.

8. Conclusion

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

In line with our stated ambition to develop a healthcare service that is recognised as being one of the best in the world, and to drive forward improvement, the clinical audit process will also be used to assess Welsh healthcare services against similar services being provided in other countries across the UK, Europe and Internationally.

Annex A

Annual Programme for 2019 - 20 of National Clinical Audit and Outcome Reviews in which all Welsh health boards and trusts must participate (where services are provided)

Acute	Audit website homepage	Main Contact	Collecting data in 2019/20
National Joint Registry	www.njrcentre.org.uk	Elaine Young elaine.young@hqip.org.uk Welsh Clinical Lead robin.rice@wales.nhs.uk	Yes (W, E & NI)
National Emergency laparotomy Audit *	www.nela.org.uk	Jose Lourtie jlourtie@rcoa.ac.uk Welsh Clinical Lead hywel.jones3@wales.nhs.uk	Yes (W & E)
Case Mix Programme (CMP)	www.icnarc.org	Bernadette Light cmps@icnarc.org	Yes (W, E & NI)
Major Trauma Audit #	https://www.tarn.ac.uk/	Antoinette Edwards antoinette.edwards@manchester.ac.uk	Yes (W, E & NI)
National Ophthalmology Audit (Adult Cataract surgery) *	https://www.nodaudit.org.uk/ Project closes August 2019	Beth Barnes noa.project@rcophth.ac.uk	Yes (W & E)

Long Term Conditions	Audit website homepage	Main Contact	Collecting data in 2019/20
National Diabetes Audit * **Note this covers the following areas :** National Diabetes Foot Care Audit National Diabetes Inpatient Audit (NaDia)	General: https://digital.nhs.uk Footcare: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-foot-care-audit NaDia: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-	 Julie Michalowski ndfa@nhs.net Welsh Clinical lead Scott.Cawley@wales.nhs.uk Sharon Thandi nadia@nhs.net Welsh Clinical lead Neera.Agarwal@wales.nhs.uk	(W & E) Yes Yes

	inpatient-audit		
National Pregnancy in Diabetes Audit	Pregnancy: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-pregnancy-in-diabetes-audit	Cher Cartwright npid@nhs.net Welsh Clinical lead Margery.Morgan@wales.nhs.uk	Yes
National Core Diabetes Audit	Core: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit	Cher Cartwright diabetes@nhs.net Welsh Clinical Lead Julia.Platts2@wales.nhs.uk	Yes
National Diabetes Transition Audit	Transition: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-transition-audit	Gary Jevon diabetes@nhs.net Welsh Clinical Lead Sara.Crowley2@wales.nhs.uk	Yes
National Diabetes Paediatric Audit (NPDA) * #	www.rcpch.ac.uk/npda	Holly Robinson npda@rcpch.ac.uk holly.robinson@rcpch.ac.uk Welsh Clinical Lead justin.warner@wales.nhs.uk	Yes (W & E)
National Asthma and COPD Audit Programme (NACAP)* # **Note this covers the following areas :**	https://www.rcplondon.ac.uk/projects/national-copd-audit-programme	Viktoria McMillan Juliana Holzhauer-Barrie copd@rcplondon.ac.uk viktoria.mcmillan@rcplondon.ac.uk Welsh Clinical Lead Simon.Barry@wales.nhs.uk	Yes (W & E)
COPD	https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-copd		
Adult Asthma	https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult-asthma		
Children and Young People Asthma	https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-children-and-young		

Pulmonary Rehabilitation	https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-pulmonary-rehabilitation-workstream		
Renal Registry (Renal Replacement Therapy) #	https://www.renalreg.org/	renalregistry@renalregistry.nhs.uk Hilary Doxford Hilary.Doxford@renalregistry.nhs.uk	Yes (W, E & NI)
National Early Inflammatory Arthritis Audit * #	https://www.rheumatology.org.uk/Practice-Quality/Audits/NEIA-Audit	Jessica Ellis, Project Manager JEllis@rheumatology.org.uk	Yes (W & E)
All Wales Audiology Audit #		john.day@wales.nhs.uk	Yes (Wales only)

Older People	**Audit website homepage**	**Main contact**	**Collecting data in 2019/20**
Stroke Audit (SSNAP) *	www.strokeaudit.org	Alex Hoffman ssnap@rcplondon.ac.uk Welsh Clinical lead Phil.Jones@wales.nhs.uk	Yes (W, E & NI))
Falls and Fragility Fractures Audit Programme Including: Inpatient Falls National Hip Fracture Database Fracture Liaison Service Database *	https://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-fffap-2014	**General email:** FFFAP@rcplondon.ac.uk Inpatient Falls Catherine Gallagher falls@rcplondon.ac.uk Hip Fracture Database Elizabeth Fagan elizabeth.fagan@rcplondon.ac.uk Fracture Liaison Service Database Naomi Vasilakis FLSDB@rcplondon.ac.uk Welsh Clinical Lead Antony.Johansen@wales.nhs.uk	Yes (W, E, NI))
National Dementia Audit *	www.nationalauditofdementia.org.uk	Chloe Hood nad@rcpsych.ac.uk chloe.hood@rcpsych.ac.uk Welsh Lead Elizabeth.Davies025@gov.wales	Yes (W & E)

National Audit of Breast Cancer in Older People (NABCOP) *	https://www.nabcop.org.uk/	Ms Jibby Medina nabcop@rcseng.ac.uk jmedina@rcseng.ac.uk Welsh Clinical Lead Marianne.Dillon@wales.nhs.uk	Yes (W&E)

End of Life	**Audit website homepage**	**Main contact**	**Collecting data in 2019/20**
National Audit for Care at the End of Life (NACEL) *	https://www.nhsbenchmarking.nhs.uk/news/nationalauditforcareattheendoflife	Debbie Hibbert debbie.hibbert@nhs.net Welsh Clinical Lead Melanie.Jefferson@wales.nhs.uk	TBC (W & E)

5.2

Heart	**Audit website homepage**	**Main contact**	**Collecting data in 2019/20**
National Cardiac Audit Programme (NCAP)	https://www.nicor.org.uk/	Akosua Donkor Akosua.donkor@bartshealth.nhs.uk	(W & E)
National Heart Failure Audit *	https://www.nicor.org.uk/national-cardiac-audit-programme/nicor-and-data-gov-uk/national-heart-failure-audit/	nicor-auditenquiries@bartshealth.nhs.uk Welsh Clinical lead Jonathan.Goodfellow2@wales.nhs.uk	Yes
Cardiac Rhythm Management *	https://www.nicor.org.uk/national-cardiac-audit-programme/cardiac-rhythm-management-arrhythmia-audit/		Yes
National Adult Cardiac Surgery Audit*	https://www.nicor.org.uk/national-cardiac-audit-programme/adult-cardiac-surgery-surgery-audit/		Yes
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) *	https://www.nicor.org.uk/adult-percutaneous-coronary-interventions-angioplasty-audit/		Yes
National Congenital Heart	https://www.nicor.org.uk/national-cardiac-audit-programme/congenital-		Yes

Disease Audit * # Myocardial Ischaemia National Audit Project (MINAP)* National Vascular Registry Audit (includes Carotid Endarterectomy Audit) *	heart-disease-in-children-and-adults-congenital-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/myocardial-ischaemia-minap-heart-attack-audit/ www.vsqip.org.uk		Yes Yes
Cardiac Rehabilitation Audit	http://www.cardiacrehabilitation.org.uk/	corinna.petre@york.ac.uk	Yes (W, E & NI)

Cancer	**Audit website homepage**	**Main contact**	**Collecting data in 2019/20**
National Lung Cancer Audit *	https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit	Dominic Leadbetter nlca@rcplondon.ac.uk Welsh Clinical Lead Gareth.M.Collier@wales.nhs.uk	Yes UK & Rep. I.
National Prostate Cancer Audit *	www.npca.org.uk	Dr Julie Nossiter npca@rcseng.ac.uk Welsh Clinical Lead Howard.Kynaston@wales.nhs.uk	Yes (W & E)
National Gastrointestinal Cancer Audit Programme *	https://www.nogca.org.uk/	Alison Roe og.cancer@nhs.net Welsh Clinical Lead Tom.Crosby@wales.nhs.uk	Yes (W & E)

Women's and Children's Health	Audit website homepage	Main contact	Collecting data in 2019/20
Paediatric Intensive Care (PICaNet) * #	www.picanet.org.uk	Victoria Hiley- Operational Manager v.hiley@leeds.ac.uk Sophie Butler- Project Officer S.Butler1@leeds.ac.uk	Yes (UK)
National Neonatal Audit Programme Audit * #	www.rcpch.ac.uk/nnap	Rachel Winch Rachel.Winch@rcpch.ac.uk Welsh Clinical Lead Siddhartha.Sen@wales.nhs.uk	Yes (W & E)
National Maternity and Perinatal Audit *#	http://www.maternityaudit.org.uk/pages/home	Fran Carroll fcarroll@rcog.org.uk Welsh Lead Karen.Jewell@gov.wales	Yes (W, E & S)

Other	Audit website homepage	Main Contact	Collecting data in 2019/20
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *#	https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/epilepsy12-audit	Calvin Down Calvin.down@rcpch.ac.uk	TBC
National Clinical Audit of Psychosis *	https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis	Krysia Zalewska krysia.zalewska@rcpsych.ac.uk Welsh Lead Elizabeth.Davies025@gov.wales	Yes (W & EW)

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)

Annex B

Clinical Outcomes Review Programme

The Clinical **Outcome Review** Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

Without high quality data, improvement in clinical care is unlikely to occur. National clinical audits and outcome reviews are focused on areas of healthcare considered to be important, where there are often issues of concern and where national results are considered essential to improve practice and standards.

With the ability to measure against recognised standards and compare services on a local, regional or national basis, clinical audit and outcome reviews are very powerful tools for assessing the quality of services being provided. When used as part of the wider quality improvement cycle, they provide a strong mechanism for driving service change and improving patient outcomes, but full participation and a determination to learn from the findings is essential.

Service provider contracts for these programmes have been awarded to the following suppliers (links are provided to website homepages):

Clinical Outcomes Review Programme	**Programme website homepage**	**Main Contact**	**Collecting data in 2019/20**
Medical and Surgical programme *	http://www.ncepod.org.uk/ - Dysphagia in Parkinson's Disease *Patients with Parkinson's disease* - Cancer in Children, Teens & Young Adults *Review the quality of care provided to patients under 25 who died/ or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy* - Acute Heart Failure *Review the quality of care provided to patients 16 and above, for patients admitted to hospital with acute heart failure*	Dr Marisa Mason mmason@ncepod.org.uk Welsh Lead Heather.Payne@gov.wales	(W, E) TBC No No

	- Perioperative Diabetes *Review the process of care in the peri-operative management of surgical patients with diabetes across the whole patient pathway.* - Pulmonary Embolism *Review the process of care for patients diagnosed with pulmonary embolism.* - Bowel Obstruction *Review the process of care for patients diagnosed with bowel obstruction.* - In-hospital management of out-of hospital cardiac arrest		No No No Yes
Mental Health programme *	http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci - Suicide, Homicide & Sudden Explained Death - Safer Care for Patients with personality disorder - Assessment of Risk and Safety in Mental Health Services -	Dr Pauline Turnbull pauline.turnbull@manchester.ac.uk Welsh Lead Elizabeth.Davies025@gov.wales	(W, E) Yes No
Child Health Clinical Outcome Review Programme *#	http://www.ncepod.org.uk/ - Young People's Mental Health study *Review of Young People's Mental Health, focusing on self harm* - Long Term Ventilation *Review the process of care for patients under 25 diagnosed with long term ventilation.*	Kirsty MacLean Steel kmacleansteel@ncepod.org.uk Heather Freeth hfreeth@ncepod.org.uk Welsh Lead Heather.Payne@gov.wales	(W, E) No Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme *#	https://www.npeu.ox.ac.uk/mbrrace-uk - Perinatal Mortality Surveillance - Perinatal morbidity and mortality	Professor Jenny Kurinczuk jenny.kurinczuk@npeu.ox.ac.uk Welsh Lead Karen.Jewell@gov.wales	(UK) Yes

	confidential enquiries - Maternity mortality surveillance and mortality confidential - Maternity morbidity confidential enquiries		Yes Yes Yes

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Thursday 5th December 2019 Agenda Item: 5.3

Aneurin Bevan University Health Board

Current Performance against agreed PTR Improvement Trajectories

5.3

Executive Summary

This report provides an overview for the QPSC of performance against Serious Incidents and Concerns turnaround times, year to date.

In April 2019 the Quality and Patient Safety Committee received a report setting out the performance for both concerns and SIs which outlined the improvement required. An improvement plan was endorsed for implementation.

There has been improvement in the response times for both SI and Concerns, but clearly this is not embedded and there remains significant improvement required to comply with turnaround times.

A summary of progress against the previously agreed improvement plan is provided, with further actions identified for corporate PTR and Divisions.

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

Executive Sponsor: Rhiannon Jones - Executive Director of Nursing			
Report Author: Martine Price - Deputy Director of Nursing			
Report Received consideration and supported by :			
Executive Team	**TBA**	**Committee of the Board [Committee Name]**	**QPSC**
Date of the Report: November 2019			
Supplementary Papers Attached: Nil			

Purpose of the Report

This report provides an overview of performance against Serious Incidents and Concerns turnaround times, as per Divisional improvement trajectories.

A summary of progress against the ABUHB improvement plan is provided. An assessment is made of predicted performance to year end.

Background and Context

The underlying principle of 'Putting Things Right' is that whenever concerns are raised about treatment and care, whether through a complaint, claim or clinical incident, those involved can expect to be dealt with openly and honestly, receive a thorough and appropriate investigation, a prompt acknowledgment and a response about how the matter will be addressed. The need to ensure that these principles are implemented was highlighted in the *Evans Report: A Review of Concerns (Complaints) Handling in NHS Wales* (2014).

In April 2019 the Quality and Patient Safety Committee received a report setting out the performance for both concerns and SIs, which at the time was unacceptable. An improvement plan was endorsed for implementation. This report provides an update on current progress and the likely year-end position.

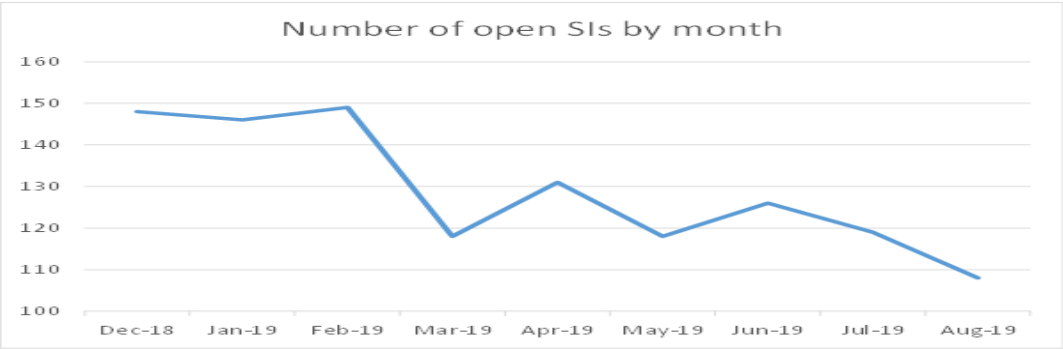
Year to date performance 2019/'20 (against trajectory):

Month	SI % met 60 day **Actual**	SI % met 60 day **Trajectory**	Concerns % closed 30 days **Actual**	Concerns % closed 30 days **Trajectory**
April	37	45	65	50
May	58	45	41	52
June	70	55	53	55
July	52	55	65	58
August	59	60	70	62
September	65	65	71	62
October	40	67	59	67

There has been a significant reduction in the total number of SI cases and concerns open. The graph below shows the reduction of SIs by month. The position at October is 102 open SI's (including 10 PRUDiC cases).

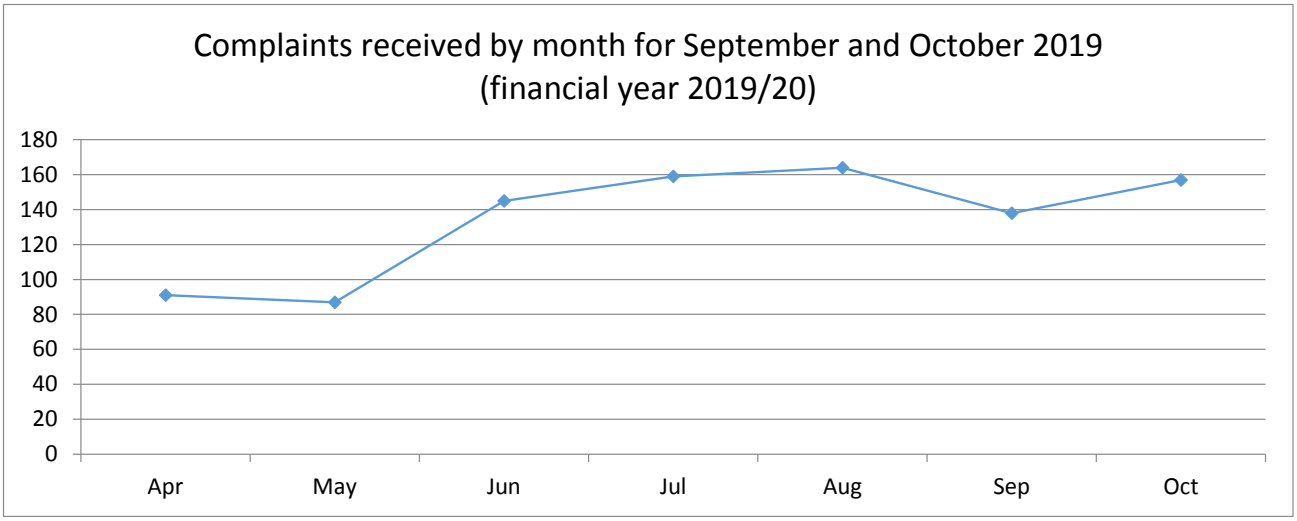
Numbers of open concerns cases has reduced as backlogs have been addressed. The number of cases that are open over six months currently stands at 23 concerns as of October.

Number of open Serious incidents by month



Whilst improvement has been demonstrated this is not embedded for either SIs or concerns, with trajectories deteriorating for October.

Trend in both Complaints and Serious Incidents for September and October 2019



A change in Welsh Government Legislation took place from 30 May 2019. Informal complaints have now been changed to Early Resolution and contain those that can be addressed 'on the spot' or within 24 hours.

Therefore the large increase in formal complaints noted from May 2019 is due to the change in Welsh Government Legislation. We

During September we received 135 complaints and in October 155 which is relatively consistent with 157 received in July and 154 in August.

Concerns Performance for October 2019, by Division:

Compliance Figures October 2019

Division	Formal complaints received	Total Formal complaints Closed	WG Target Formal Complaints Closed with 30 working days	30 Day Response in Month Actual Performance	Total open complaints	Total overdue complaints	overdue < 3 months	overdue > 3 months	overdue > 6 months	overdue > 12 months	October 19 Trajectories %
Scheduled Surgical & Critical Care	73	66	39	59%	126	34	17	10	5	2	70%
Unscheduled & Acute Care	31	49	30	61%	69	42	23	9	10	0	65%
Family & Therapy Services	29	23	16	70%	30	9	5	3	0	0	75%
Facilities	0	0	0	#DIV/0!	0	0	0	0	0	0	0%
Primary Care & Community	12	12	2	17%	45	25	16	4	5	0	65%
Mental Health & Learning Disabilities	10	6	4	67%	18	6	4	1	1	0	60%
CHC	0	1	1	n/a	1	0	0	0	0	0	0%
Health Board	**155**	**157**	**92**	**59%**	**289**	**116**	**65**	**27**	**21**	**2**	**67%**

For October 2019 no Division achieved their performance trajectory, with the lowest performing Division being Primary and Community Care, with 17% actual performance.

The number of Serious Incidents reported during both September and October was 23. This was a noticeable increase from August whereby there were 13.

Serious Incident Closure Performance for October 2019, by Division:

SI Compliance Figures October 2019				WG target for investigation - 60 working days						
Division	Number reported to WG in month	Description	Total open SIs	Number in date	overdue 0-3 months	overdue 3-6 months	overdue 6-12 months	overdue >12 months	% Compliance with 60 day target - (Number closed)	% Trajectory
Scheduled Care	6	4 never events 1# NOF - delay in diagnosis 20 1 unexpected death	20	11	3	1	4	1	0% (0/1)	65%
Unscheduled Care	4	1 video footage of pts 1 c diff cluster 1 pt fall, head injury & death 1 pt fall # humerus	20	12	3	3	1	1	25% (1/4)	65%
F&T	0		10*	2	3	3	2	0	0% (0/1)	100%
Mental Health & LD	9	7 unexpected deaths 1 absconsion whilst detained 1#NOF	21	15	2	3	1	0	75% (6/8)	60%
Community	3	1# NOF 1# Humerus 1 pt fall, head injury & death	14	4	3	5	0	2	50% (2/4)	70%
Primary Care	0		7	1	1	2	1	2	n/a	70%
CHC	0		0	0	0	0	0	0	n/a	n/a
Facilities	0		0	0	0	0	0	0	n/a	n/a
Corporate	0		0	0	0	0	0	0	n/a	n/a
Total	22		92*	45	15	17	9	6	40% (8/20)	67%
			*102 with PRUDICs							
* 10 PRUDICs										

The table shows mixed performance against trajectories set, with only Mental Health & LD Division meeting their trajectory.

Improvement Plan – key actions completed: -

Corporate PTR

- Strengthening of leadership in the PTR team to include recruitment of Assistant Director Organisational Learning (commenced August 1st 2019) and Senior Concerns Manager (commenced 7th October 2019).
- Independent review of corporate PTR undertaken. New structure confirmed, currently appointing substantively to posts but historical budget deficits making this a challenge.
- PTR team members are working more closely with complaints co-ordinators and Divisional Management Teams.
- A complaints tracker has been developed to log and track all complaints. This is monitored by the PTR Team.
- A thematic review of Ombudsman cases has been completed and additional resource identified in revised structure to support Ombudsman work and relationship management.
- Training requirements for SI and Concerns is being scoped.
- Serious Incident Learning events held on the 17th October, with another scheduled for the 6th December. Learning from Concerns Event focussed on End of Life Care was held on 20th November. Testing a revised approach to sharing learning.

Divisions

- Each Division agreed their trajectory for SI and Concerns improved performance
- Specific Divisional improvement actions identified
- Directors holding Assurance meetings with Divisions monthly
- Focussed efforts to address backlog of concerns

Assessment and Conclusion

There has been some improvement in the response to both SI and Concerns performance; but this is not embedded and there remains significant improvement work required to ensure compliance with turnaround times.

Progress has been challenging due to the increase in the SI and Concerns workload. From a Corporate perspective the vacancies in the PTR Team and significant staff turnover has presented a challenge.

Further action required:

PTR Team

- Confirm the revised structure and appoint substantively and build the team.
- Confirm revised Concern and SI Policies (streamline process and responsibilities).
- Secure training for SI Investigating Officers – This will ensure Investigating Officers have the necessary competencies to conduct in-depth investigations. A scoping of training has identified 'Investigating Well – Developing the right skills to lead in-depth investigation'. £2867.00 for 16 delegates with an additional cost of £50 per person up to 30. This is a well-recognised training programme.
- Review SI process, including chairs of SIs and training requirements.
- Progress Concerns training and offer to work with the Complaint Standards Authority – CSA who are developing training materials (PSOW).
- Evaluate learning events held and confirm learning forum approach going forward
- Further develop reporting and monitoring systems.

Divisions

Each Division has assessed their current position and developed a further specific improvement plan that have been submitted to the Executive Director of Primary, Community and Mental Health and the Director of Operations (Unscheduled Care, Scheduled Care and Family and Therapy Divisions).

Themes have been identified by Divisions, as follows:

- Need for training for Investigating Officers (IOs) for both concerns and SIs, more IOs and time for the investigator to undertake investigation in a timely manner.
- Over-reliance on the Senior Nurses as IOs and the pull of Senior Nurses into operational management.
- Improve Pathway of Concerns and SIs between Corporate Team and Divisions.
- Earlier identification of complex cases.

A Divisional assessment has been made of the forecast position to year end for both Concerns and SIs. Each divisional plan will be reviewed at the December Assurance meetings with respective Directors.

Divisions have indicated an inability to meet the previously agreed performance trajectories, citing workload as key factors. The revised trajectories have been agreed by the Divisions and respective Directors but have yet to be discussed at Executive Team.

Recommendation
The committee is asked to discuss the performance and note actions being taken to improve performance from April 2020.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Concerns raised under these regulations may pose a financial risk. Reputational and Governance risks to the Health Board due to performance and quality of investigation and response.
Financial Assessment, including Value for Money	Financial cost pressure within PTR structure
Quality, Safety and Patient Experience Assessment	Risk of not meeting required performance
Equality and Diversity Impact Assessment (including child impact assessment)	The Health Board is required to make all reasonable adjustment to allow a patient or relative to raise a concern. An individual assessment is required to ensure that in all cases, all reasonable adjustments have been taken to allow all patients to raise a concern in the most appropriate format.
Health and Care Standards	The regulations relate to the Health and Care Standards 2015, (theme Individual Care).
Link to Integrated Medium Term Plan/Corporate Objectives	Concerns are a key theme for Quality Assurance in the 2019-21 IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	***Long Term*** *– actions are being put into place to improve the long term quality and performance of the complaints system and ensure organisational learning from complaints and serious incidents* ***Integration*** *– The service for managing complaints and incidents encompasses the whole system of across the Health Board* ***Involvement*** *– The PTR team is working in partnership with the Community Health Council and is working with the Public Services Ombudsman for Wales to ensure the involvement of the service user perspective* ***Collaboration*** *– The Putting things Right Team is working across corporate, divisional and directorate teams to co-produce its service developments and with Health Board partners throughout Wales to improve its complaints and incident management* ***Prevention*** *– Service improvement in the complaints system will help to identify areas for quality improvement in clinical care*
Glossary of New Terms	*None*
Public Interest	Report to be published in the public domain