A meeting of the Aneurin Bevan University Health Board
Quality and Patient Safety Committee
will be held on Thursday 7 February 2019, commencing at 9:30am
in Conference Rooms 1 & 2, Headquarters,
St Cadoc's Hospital, Caerleon

AGENDA

Preliminary Matters		**Attachment**		**9:30**
1.1	**Welcome and Introductions**	Verbal	**Chair**	**15 mins**
1.2	**Apologies for Absence**	Verbal	**Chair**	
1.3	**Declarations of Interest**	Verbal	**Chair**	
1.4	**Draft Minutes of the Committee held on 21 November 2018**	Attachment	**Chair**	
1.5	**Action Sheet**	Attachment	**Chair**	
Presentations				**9:45**
2.1	**Maternity Services Board**	Presentation & Attachment	**Deb Jackson/ Jayne Beasley**	**40 mins**
2.2	**Winter Plans Progress Update**	Presentation	**Claire Birchall**	**15 mins**
For Consideration				**10:40**
3.1	**Quality, Safety and Performance Overview**	Attachment	**Dr Paul Buss/ Martine Price**	**15 mins**
3.2	**Risk Assessment Overview** • Risk Register ○ Issues arising for action	Attachment Verbal	**Chair** **Martine Price**	**15 mins**
Break (10 mins)				**11:10**
Items for Quality Assurance				**11:20**
3.3	• **QPSOG Assurance Report from Meeting held on 10 December 2018** • **Health Care Standards Audit**	Attachment Attachment	**Peter Carr** **Kate Hooton**	**5 mins** **15 mins**
3.4	**Putting Things Right Report/Ombudsman Response**	To Follow	**Martin Lane**	**15 mins**

Final Matters/For Information				**11:55**
4.1	**Items for Board Consideration** To agree agenda items for Board consideration and decision	Verbal	**Chair**	**5 mins**
Date of Next Meeting				
Thursday 4 April 2019, 9.30am, Conference Rooms 1 & 2, ABUHB Headquarters, St Cadoc's Hospital				**Chair**

Quality and Patient Safety Committee
Date 7 February 2019
Agenda Item: 1.4

Aneurin Bevan University Health Board

Minutes of the Quality and Patient Safety Committee held on Wednesday 21 November 2018

Present:

Prof Dianne Watkins	-	Chair, Independent Member (University)
Cllr Richard Clark	-	Independent Member of Local Government
Frances Taylor	-	Independent Member
Phil Robson	-	Special Adviser to the Board

In Attendance:

Bronagh Scott	-	Director of Nursing
Claire Birchall	-	Interim Director of Operations
Deb Jackson	-	Head of Midwifery and Associate Director of Nursing
Kate Wright	-	Associate Medical Director/Consultant in Emergency Medicine
Kate Hooton	-	Associate Director, Patient Quality and Safety
James Quance	-	Observer, Internal Audit
Jemma McHale	-	Community Health Council
Sian Millar	-	Divisional Director, Primary Care
Siddhartha Sen	-	Consultant Neonatalologist
Claire Barry	-	Committee Secretariat

Apologies:

Judith Paget	-	Chief Executive
Paul Buss	-	Medical Director
Peter Carr	-	Deputy Director of Therapies and Health Sciences
Liam Taylor	-	Deputy Medical Director

QPSC 2111/01 Welcome and Introductions

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

QPSC 2111/02 Declarations of Interest

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

QPSC 2111/03 Minutes of the Meeting held on 12 September 2018

The minutes of the meeting held on 12 September 2018 were agreed as a true and accurate record of the meeting

QPSC 2111/04 Action Sheet – 12 September 2018

The Committee considered the Action Sheet from the meeting held on the 12 September 2018 and noted that all actions had been completed or were progressing.

1209/06 – Learning Disabilities Audit – It was noted that work had been undertaken on an All Wales basis around learning disability and care of people with learning disabilities in acute settings.

Penny Gordon, Assistant Divisional Nurse, was the lead on this project but had recently been seconded into a new role. A new Lead had been appointed to take on this project. The Committee asked for the newly appointed lead to be invited to the next Committee meeting to give the Committee assurance and to provide an update on what actions had come out of the All Wales meeting.
ACTION: Bronagh Scott/Secretariat

1209/14 – Update on Tawel Fan – A Task and Finish Group had been established and a table had been produced, mapping required actions across the two reports, identifying key leads and outlining progress and further plans.

A report was nearing completion and it was agreed that Bronagh Scott would circulate the draft report to the Committee for their comments which will then be considered by the Executive Team in December 2018 prior to submission to the Board at its January meeting.
ACTION: Bronagh Scott

Frances Taylor commented that at the Mental Health and Learning Disabilities Committee meeting, the Committee wanted to understand which elements would be reported to the Board for assurance. The Committee agreed at the meeting that due to timings it may be worthwhile having a joint briefing between the two Committees in early January 2019 in order to enable enough time for both Committees to provide an accurate assurance report to the Board.
ACTION: Richard Bevan/Secretariat

QPSC 2111/05 Winter Plan 2018/19

Claire Birchall and Sian Millar gave a presentation on the Winter Plan 2018/19. It was noted that Welsh Government had taken a different approach this year about winter planning and encouraged further partnership working relationships. The Plan had been developed in close

partnership across all of our Divisions, and also with our partners in Local Authorities and the Third Sector.

It was reported that the impact of winter showed that winter months were getting busier each year. Total admitted patient activity had grown significantly, year on year, since 2006 and 5.64% in the last year. However ED demand had been relatively stable in terms of total patients over the last 5 years, but the pattern and mode of arrival had changed. There were more "walk ins" and an increase in majors.

The winter demand did not necessarily increase our number of patients but it did increase our bed day demand, this had increased the complexity of patients and the impact that winter had and ability to discharge patients appropriately. Demand analysis predicts another busy winter in 2018/19, especially at Christmas and New Year. Unfortunately we cannot predict the cold weather but know that we need to be prepared for it, learning from last year.

It was noted how the winter plan was seeking to manage and better direct demand. Lower lengths of stay in hospital are important, but the intention is to support and treat people closer to their home to avoid hospital attendance or admission. The following key points were noted:

- Targeted Support for Frequent A&E Attenders – across Unscheduled Care, Primary and the Community.
- Established A&E Physician response, unit potentially for weekends.
- Advanced Care Planning and My Winter Health plans keeping sagely at home.
- Directing GP referrals to the best place (HCP Call Handling)
- Out of Hours (OOH) nursing team supporting Welsh Ambulance control centre staff to direct away from hospital.
- Increased access to Primary Care and OOH resilience.
- Advanced Paramedic Practitioner deployment to support GP services.
- St. John Tier 1 falls service supporting Falls Assessment and Response Services.
- Graduated Care step up – Community Frailty Units.

It was highlighted to the Committee the risks and what plans have been put into place to mitigate them:

- Workforce and Recruitment – to incentivise nursing staff and recruit Locum Doctors.
- Funding – target to those areas that have most impact.
- GP Out of Hours – making sure we can fill out of hours sessions.
- Flu and Infection – making sure we increase staff and patient vaccinations and on call arrangements for our infection control team when flu and other infections present.
- Social Care Capacity – working closely with Social Care colleagues to secure additional care home beds to discharge patients quickly and use our new Home First Service to support increased support at home.
- Changes to our Assumptions – making sure we have responsive management during the main pressure periods and clear contingency plans.
- Delivery of Normal Business – additional sessions for Gynaecology and a daily review of surgical activity, maximizing day case and out theatres at Ysbyty Ystrad Fawr.

The Committee was advised that there was to be more of a focus on patient experience in 2018/19 and this was to be achieved by working with the Community Health Council (CHC) to improve how we learn from patients. The processes put in place are:

- Talking Mats – to consider further testing of this as part of the Winter Feedback project and using core cards to gain feedback.
- PROMS/PREMs – developing the concept of talking mats/easy read accessible ways of giving feedback jointly with the CHC.
- Winter Feedback – looking at period January to March CHC project to gain feedback from both patients and their families. An agreed focus on the front door activities at Royal Gwent/Nevill Hall Hospitals, A&E, Medical Assessment Unit, Emergency Assessment Unit, Wards and Primary Care. CHC to use their "Survey Me" which can be real time feedback. To explore potential for using DoctorDr platform for Primary Care.

- Doctor/Dr Feedback – to add in the overall rating of care question, in order that we can gain this feedback.

It was noted that urgent Primary Care demand and capacity 2018/19 rises every winter. The total level of demand appears to have varied over the last 3 years. There is more demand in December and January, this was due in large part to extended bank holidays. Shift fill rates were typically higher in December and January, which aligned well with demand. Recent recruitment activity in Urgent Primary Care Out of Hours is expected to achieve an average fill rate of 80% to 82% in 2018/19, which was anticipated to be significant improvement on 2017/18. A clinical reference group was now in place which contained around 7/8 GPs who routinely work in the service. This has proved to be beneficial in terms of understanding where service improvements are needed to be made and where efficiencies can be made to help manage the demand. Plans put in place are proving successful in recruiting additional GPs who have registered to work within the service.

The latest peer review of the OOH service noted the outstanding work nurses are undertaking in verification of death and the caring and dignified service they provided for families. The 111 Programme is up and running and a HUB which consists of a Lead Doctor, Nurses and a Pharmacist in place for the weekends and it hoped that this will be extended with a plan to add a Mental Health Practitioner and a Palliative Care Specialist for the winter period using the money received from the 111 Programme to fund these posts.

It was noted to the Committee that there is a need to increase Community beds over the winter period and every winter a bed plan is put into place. One of the challenges at present is there are currently 40 nursing vacancies; in addition a further ward is to be opened at St Woolos. A meeting has taken place with members of staff to provide assurance as the staff have concerns about staffing this ward. Interviews have been arranged and it is expected that there will be success in appointing staff into these vacancies.

It was noted for the Committee to have assurance that the additional money received from Welsh Government was focusing more on the collaborative work that has been undertaken with Local Authority and WAST. It was highlighted that a separate template was used and updated regularly around falls prevention particularly in advanced care planning care homes, and work led by Tanya Strange has been spread out nationally. Enhanced Care homes support and also review of the WAST stack by Out of Hours Service and Choose Pharmacy is enabling people to go straight to a Pharmacist rather than queuing up to see a GP and not being able to get an appointment which will spill over to A&E. It was reported for the Committee to be reassured that they are on track with this support in terms of the actions that was needed to done. These are the actions that Welsh Government are focusing on for Primary and Community Care in tandem with WAST and Local Authorities.

Frances Taylor commented that it was pleasing to know that there was extra capacity with call handlers during the winter period and expressed an interest for a future update to know whether extra capacity was sufficient; the effect on waiting times and whether it had helped to prevent people from attending A&E or pursuing other alternatives.

Jemma McHale commented that the CHC had completed their winter plan and have scoped out around 50 visits during the winter period in A&E and Out of Hours and engage in weekly live reporting. The CHC national A&E report is published around 3-4 months after the winter pressures and will be utilized to feed into future service improvement where applicable. In order to help the Health Board the Patient Engagement Officer will provide raw data updates weekly.

The Chair commented it was recognised that a huge amount of work had been put into formulating the winter plan and complimented the team on the fantastic ideas going forward.

QPSC 2111/06 RGH Neonatal Annual Report 2017

Dr Siddhartha Sen gave a detailed presentation on the challenges for the Neonatal Unit. There are 2 Neonatal Units in existence, one is based at the Royal Gwent Hospital (RGH) and the other is based at Nevill Hall Hospital (NHH),

and this presentation is based on the Annual Report 2017 for RGH.

It was reported that in 2017 there was a total of 472 admissions, of which 21 were readmissions making a total of 451 babies admitted to the Unit, it was noted that the 21 readmissions included babies that had been referred out for specialist care. The majority of the admissions were inborn babies, 82 babies were retrieved or transferred in after birth from another hospital or home. A total of 114 babies were transferred out of the unit which included 91 babies for follow up care, and 23 babies for specialist and surgical care.

It was noted that there are 3 levels of activity; Intensive Care, High Dependency and Special Care, and the report shows that there is variation from month to month and there is no season where it is heavier because babies are not born in any particular season so it is unpredictable that activity rises up and down from month to month and day to day. Activity has been recorded over the last 24 years beginning in 1994 with 500 days of intensive care and in 2017 we have around 1500 days of intensive care so over the years there has been an increase in activity.

The Chair asked what the reason was for the increase in activity. Dr Sen explained that this was related to the increase in the complexity of the babies.

It was noted that the data collected by the Unit was benchmarked against the Vermont Oxford Network data. This was a network of around 350 international units across the world that included, America, United Kingdom and across Europe. The Neonatal Unit has been a member of this network for 11 years and the analysis of information was presented to the Committee.

The National Neonatal Audit Programme 2017 demonstrates the following levels of performance:

1. **Above par performance in –**
    - MgSO4 to mothers – proportion of mothers who received magnesium sulphate in the 24 hours prior to delivery.
    - Consultation with parents
    - 2 year follow up

2. **Par performance in –**
    - Antenatal steroids
    - Temperature on admission
    - Retinopathy Of Prematurity (ROP) Screening
    - Broncho Pulmonary Dysplasia (BPD) or death

3. **Below par performance in –**
    - Breast feeding on discharge

The Chair asked if the Model of Care when moved into the Grange University Hospital is going to take some of this on board. Dr Sen assured the Committee that the service redesign would indeed include the outcomes of the audit as appropriate and strive to improve areas of below par performance.

The Chair also asked if they had been any signs of an increase of admissions to the Unit due to birth injury over due to delivery. Dr Sen assured the Chair and the Committee that there had been no increase in birthing injury due to delivery and that over the last 2 years birth injuries had reduced.

The Chair asked for clarification that RGH and NHH was a breast friendly unit. Dr Sen confirmed that both RGH and NHH were breast friendly Units and resources have been invested to improve this and it was noted that mothers would breast feed upon admission however, following discharge the rate of breast feeding was reducing. The challenge for the Unit was to encourage the continuation of breast feeding after discharge.

It was noted that the presentation referring to outcomes and performance from the RGH neonatal unit only, and did not include NHH. The Chair requested that further thought be given to comparisons in outcomes across the two sites wherever possible, recognising that that are differences in neonatal health status which would influence some outcomes.

QPSC 2111/07 Quality, Safety and Performance Overview

Kate Hooton presented the Quality, Safety and Performance Report. The Committee reviewed the report, noted the progress that was being made in many areas and highlighted the issues.

It was reported that the number of deaths and mortality rate had decreased since the winter period. The Crude mortality in Aneurin Bevan University Hospital (ABUHB), Nevill Hall (NHH), and Royal Gwent Hospital (RGH) has decreased steadily since the peak in January 2018, apart from a slight increase in July 2018, whereas Ysbyty Ystrad Fawr (YYF) has remained relatively consistent. The mortality rate for ABUHB is generally lower than the Welsh Hospitals, and the mortality rate for ABUHB has decreased steadily since January 2018, apart from a small increase in the months of June and July 2018.

The Committee noted the learning from mortality reviews and at the last meeting of the Mortality and Harm Review Group it was identified that there was no new issues from the notes. De-escalation of care when a patient is at the end of life was discussed again as it was felt that all the aspects of care that should be considered are not always reviewed. The reviewers would flag cases when de-escalation of care was not done and feedback to Consultants. It would mean that this important aspect of end of life care can be quantified as a theme. An overview of this area of care was being developed for circulation to all Consultants.

It was reported that the number of people screened for sepsis in the emergency departments at RGH and NHH have increased, but compliance with the sepsis 6 bundle is still variable. The numbers and compliance at YYF have increased since specific interventions have been introduced and the data in vital pac can now be used to improve patient care. The Peer Review of sepsis care at ABUHB took place in September and October.

It was reported that the number of cased of C.difficile per month have now reduced to the levels required to meet the target in 2018/19. Good progress has been made and the Health Board is on target to achieve the required reduction. The Health Board's strategy to reduce cases is heavily reliant on hospital cleans using Hydrogen Peroxide Vapour (HPV).

It was noted that a second important intervention related to antibiotic guidelines. A change of guidelines utilising co-trimoxazole as the broad spectrum antibiotic of choice was introduced in Cardiff and Vale and Cwm Taff University Health Boards approximately 2 years ago – with what

appears to be positive results. This change in antibiotic use was discussed at ABUHB Infection Control Committee at the time but the proposal was rejected. The situation had been reviewed by the ABUHB Antimicrobial Working Group and guidelines as introduced by Cardiff and Vale and Cwm Taff UHBs have been agreed and launched. If these guidelines are implemented with a tight programme of close monitoring, there is an expectation that it will have a positive effect on C.difficile rates.

Included in the report is Data on prescribing performance against Welsh Government indicators for Primary and Secondary Care. The Health Board had the lowest use of the "high risk" antibiotics in Primary Care and is making good progress in reducing the overall number of antibiotics prescribed.

The Committee discussed the concerns they have around issues in the Neonatal Unit Service at NHH, (page 28 of the report). The Committee requested a more detailed investigation into this at the next Committee meeting and transition arrangements will need to be put into place to ensure that Neonates work as a team across ABUHB.

Bronagh Scott, Director of Nursing, provided the Committee with the assurance that the issues with Paediatrics stainability which includes the Maternity and Neonatal Services had been discussed at the Executive Team meeting and from that discussion it was agreed that a paper would be presented to the Board to advise the Board and seek approval for next steps.

The Chair highlighted a further two issues with the report, one of which was the 30 day mortality around Stroke and the other issue was around Fractured Neck of Femur. It was noted that there was work in place on improving these two issues. It was reported that the issue with the 30 day mortality around Stroke was due to data, but it was anticipated that this should be reduced once the data had improved. The Committee has asked for an update at the next Committee meeting. **ACTION: Peter Carr**

It was highlighted that Fractured Neck of Femur mortality at RGH has improved, although NHH requires further work. Dr Muhammed Usman, Care of the Elderly, is fully aware of these issues and will implement the changes that have taken place at RGH into NHH to try to improve outcomes.

- **Infection Protection Annual Review**

Moira Bevan presented the Infection Protection and Decontamination Annual Review 2017/18. Tackling infections is a key priority for ABUHB and the goal is to stop any preventable infections from developing and causing harm to patients. Data on key healthcare associated infections (HCAI) are reported as part of the surveillance programme mandated by Welsh Government (WG). From April 2017 to March 2018 the key points were as follows:

- A total of 215 cases of Clostridium difficile (C.difficle) were reported across the Health Board during 2017/18. This equates to a 36% increase compared to 2016/17 which equates to a Health Board rate of 36.81 per 100,000 population. The increase in cases resulted in non-compliance with the WG target of 25 per 100,000 population.
- The WG target combined Methicillin resistant staphylococcus aureus (MRSA) and Methicillin sensitive staphylococcus aureus (MSSA) and as rates have been historically low, the Health Board was given a special target (a lower figure than other Health Boards in Wales) of 19 per 100,000 population. A total of 151 cases of Staph aureus bacteraemia were identified resulting in a rate of 25.83 per 100,000 population, a 20% increase on the previous year.
- A relatively new target area relates to EColi blood stream infections. The Health Board reported a total of 445 cases, this equates to a rate of 76.87 per 1010,000 population. The Health Board was given a special target of 63 per 100,000 population therefore the target was not achieved.
- Surgical Site Infection (SSI) rates for Caesarean Section throughout 2017 were 5.8% which is above the All Wales average of 3.4%.
- The SSI rates for elective orthopaedic surgery during 2017 was 1.1% which matches the All Wales rate (1%).

The Chair asked for clarification on the reason for the upward trend in staphylococcus aureus infections. The response was that it related to the increased acuity of patients.

It was reported that eliminating avoidable healthcare associated infection remained a top priority for the public, patients and staff. In response, a robust annual programme of work has been implemented over 2017/18 owned by the Divisions but supported by and experienced and highly motivated Infection Protection and Control Team.

Non-compliance with targets had been disappointing, but good progress has been made this year with C.difficile reductions in particular. The 2018/19 annual programme of work will rise to the challenge of resistant organisms which will be a focus in 2018. It was noted that Infection Prevention and Control was the responsibility of all Health Board staff and the Infection Prevention and Control Team do not work in isolation. The considerable success over the last year has been possible due to the commitment to infection prevention and control demonstrated at all levels of the organisation.

Influenza – it was reported that 1,211 flu swabs had been taken and each of these patients were followed up by the Infection Prevention Team of which 402 patients tested positive. The Infection Prevention Team would continue to support the Health Board and actively promoting the flu champion campaign with staff vaccination and at this stage had provided a 2 hour service and through the winter planning it has been agreed that an Infection Prevention Nurse will be available on Saturdays and Sundays from 08:30am to 4:30pm for a 3 month period to help support the Health Board.

The Committee received the Annual Report.

QPSC 2111/08 Risk Assessment Overview - Risk Register

The Committee received the risk register and noted that there were no changes. The Committee asked for clarity that Patient Experience had been reviewed. Bronagh Scott assured the Committee that it was on the risk register for Board and the risk rating has been increased to 20. The Committee would receive an update on Patient Experience at the next meeting. **ACTION: Martine Price**

QPSC 2111/09 Risk Assessment Overview – QPSOG Assurance Report

The Committee received the assurance report from the Quality and Patient Safety Operational Group (QPSOG) meeting which was held on 23rd October 2018. The

Committee received an update on the key matters considered at the meeting including:

- Patient Performance Report
- Infection Prevention and Decontamination Annual Report

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

The Committee was assured by the report.

QPSC 2111/10 Patient Experience Committee

The Committee received the report for information. Frances Taylor highlighted to the Committee the concerns that the Patient Experience Committee had at the meeting regarding the focus for patient experience in the current Clinical Futures programme, and therefore was escalating her concerns to the Quality and Patient Safety Committee.

The other item to be escalated to the Committee was identifying the required level of resources for patient experience activity with the Clinical Futures programme. Frances raised that significant resources have gone into planning Clinical futures and she sought assurance that patient experience would be placed at the centre of service re-design.

QPSC 2111/11 Maternity Services Board

Deb Jackson provided a report on the Maternity Services Board. This report outlines to the Committee the purpose of the Maternity Services Board.

The Maternity Services Board was established in 2007 following Maternity Services in former Gwent Health Trust being placed in Special Measures, which was lifted in 2009. The Maternity Services Board was established to focus on quality and safety thereby providing assurance to patients, staff and the Board.

The role of the Maternity Service Board was highlighted in the report which includes the membership that is Chaired by the Director of Nursing and a multitude of representatives which include Divisional Director, General Manager, Clinical Director Associate Director of Nursing, Consultant Midwife, Consultant Public Health Wales, Divisional Patient Safety

and Quality Lead, Royal College of Midwives Representative and Patient/Service User Representative and these meetings take place on a quarterly basis.

Deb Jackson, reported on a yearly basis to Welsh Government. Unfortunately the report is always a year behind so this reporting data is from April 2017 to March 2018.

It was reported that further work that has been undertaken in Wales. The Heads of Midwifery and Clinical Directors of Obstetrics are all devising one All Wales trigger criteria for reporting serious incidents.

The first 2 pages of the report state the processes that are in place to provide assurance to the Committee that everything is recorded through the Division then highlighted to the Maternity Services Board and then reported to the Quality and Patient Safety Group on a monthly basis.

It was noted that all Serious Incidents (SI) are Chaired by the Assistant Clinical Director or Director of Nursing. All SI concerns and maternity quality of care are all reported monthly supported by the Clinical dashboard for Maternity Services. Any increase in incidents, themes and trends are then further reviewed and findings presented to the Maternity Services Board with supporting action plans for improvement. Themes and trends were reported immediately through these forums and an immediate action is taken to ensure safe maternity care.

The Chair apologised on behalf of the Committee that the report had not been circulated with the papers, and thus there was not enough time to discuss this report in detail. The Chair requested that Deb Jackson be invited back to a future meeting to provide an explanation on the following key issues:

- The difference between clinical incidents at the Royal Gwent Hospital and Nevill Hall Hospital;
- Trends over time to allow for comparisons to be made (a 3 year period)
- Trends between maternity services offered on all sites within ABUHB;
- Unexpected admissions to the Special Baby Care Unit and the availability of adequate service provision at RGH and NHH;

- Patient Experience Issues

ACTION: Deb Jackson/Secretariat

QPSC 2111/12 Quality Dashboard

This item was removed from the agenda for this Committee meeting but was agreed to be put back onto the agenda for an update at the next Quality and Patient Safety Committee meeting. **ACTION: Secretariat**

QPSC 2111/12 Items for Board Consideration

- Quality of Care Issues at Nevill Hall Hospital in relation to Neonatal Unit – it was noted that this area required further investigation and explanation
- Winter Planning staff demands and requirements, and increased collaboration with Social Care Colleagues

QPSC 2111/13 Date of Next Meeting

The next meeting will be held on Thursday 7 February 2019 at 9.30am in Conference Rooms 1 & 2, Headquarters, St Cadoc's Hospital, Caerleon.

Quality & Patient Safety Committee
Thursday 7 February 2019

Action Sheet

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

Agreed Actions – Wednesday 21 November 2018

Minute Reference	Agreed Action	Lead	Progress/ Completed
QPSC 2111/04	**1209/06 – Learning Disabilities Audit** It was agreed for the new Project Lead to provide the Committee with an update at the next meeting.	**Martine Price/ Secretariat**	This item has been added to the forward work programme.
	1209/14 Update on Tawel Fan It was agreed that the draft report would be circulated to the Committee.	**Martine Price**	Update to be received at Mental Health and Learning Disabilities Committee on 7 February 2019. Full report will be provided at Mental Health and Learning Disabilities Committee meeting in April and Quality and Patient Safety Committee meeting in June.

Minute Reference	Agreed Action	Lead	Progress/ Completed
	It was agreed for the Mental Health and Learning Disabilities Committee and the Quality, Patient and Safety Committee should have a joint meeting in order to provide an accurate assurance report to the Board.	**Richard Bevan/ Secretariat**	It was subsequently agreed with the Chair of Mental Health and Learning Disabilities Committee that the Committee would undertake initial scrutiny and an assurance report would be provided to QPSC.
QPSC 2111/07	**Quality, Safety and Performance Overview** It was agreed for the Committee to have an update on the 30 day mortality for Stroke and Fracture Neck of Femur at the next meeting.	**Peter Carr**	This is included in the Quality, Safety and Performance Overview report for February's Committee Meeting.
QPSC 2111/08	**Risk Assessment Overview – Risk Register** It was agreed for the Committee to receive an update on Patient Experience at the next meeting.	**Martine Price**	This item is on the February Committee agenda.
QPSC 2111/11	**Maternity Services Board** The Committee agreed for Deb Jackson to be invited to the next meeting to provide an update on the key issues that are faced by the Maternity Services Board.	**Deb Jackson/ Secretariat**	Maternity Services Board is on the February Committee agenda.
QPSC 2111/12	**Quality Dashboard** The Committee agreed for the Quality Dashboard to be added to the agenda for the next meeting.	**Secretariat**	This item has been added to the forward work programme.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Thursday 7 February 2019 Agenda Item: 2.1

2.1

Aneurin Bevan University Health Board

Maternity Service Board

Executive Summary

This report outlines to the Quality and patient safety committee the purpose of the Maternity service Board

The maternity service board was set up in 2007 following maternity services in former Gwent Healthcare trust being placed in Special Measure, which was lifted in 2009. The maternity services board was set up to focus on quality and safety and thereby providing assurance to patients, staff and the board.

The report outlines the role and terms of reference of the maternity service board and all quality patient and safety dashboards are presented at the quarterly meetings. This is all link into the IMTP of maternity services

Recommendation:

The Quality and Patient Safety Committee is asked to accept the assurance that the maternity service board provides the quality and patient safety assurance of the maternity service to patients, staff and the Board.

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: Bronagh Scott			
Report Author: Deb Jackson			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	Quality and patient safety committee
Date of the Report: 9th November 2018			
Supplementary Papers Attached: Maternity Services Board Terms of Reference			

Purpose of the Report

The purpose of the report is to provide assurance to the quality, patient and safety committee of the compliance and purpose of the maternity service Board.

Background and Context

In 2007 Maternity Services in the former Gwent Trust were reviewed by Wales Audit Office and Healthcare Inspectorate Wales and subsequently placed into 'Special Measures' while they addressed a range of clinical governance issues. Special Measures were lifted in September 2009 when it was judged that the service had made real progress.

However, by their nature all Maternity Services are high risk and therefore require a particular focus on quality and safety. The Maternity Service Board (MSB) oversees the continuing focus on quality and safety in the maternity service, and thereby provide assurance to patients, staff and the board.

Assessment and Conclusion

Role of the Maternity Services Board

- To oversee delivery of the Health Board's Maternity Services Strategy.
- To inform the Board on all relevant issues concerning Maternity Services and provide assurance to the Board.
- To seek assurance on issues as requested by the Board.
- Consider and review progress with all major plans and agree any major deviations from these plans i.e. The Maternity Services Action Plan and related SBARs, The Antenatal Review Action Plan, any capital schemes.
- Monitor progress with any action or improvement plans; Eg plans to improve against Standards for Health Services.
- Establish and programme manage any task and finish project streams as required.
- Ensure the service is aware of, and contributes appropriately to existing and emerging National and local service developments and service and professional standards.
- Assist in problem solving and resolving issues brought to it.
- Provide clear and effective routes of communication and escalation with the Health Board's executive team.
- Provide a transparent framework for monitoring HR and staffing concerns.

Membership of the Board

Core Members:

- Health Board Nurse Director(Chair)
- Family and Therapy Services Divisional Director
- Family and Therapy Services General Manager
- Maternity Services Clinical Director
- Divisional Head of Midwifery / Associate Director of Nursing (Vice Chair)

- Royal College of Midwives Representative
- Consultant Midwife
- Divisional Patient Safety and Quality Lead
- Patient /Service User representative
- Consultant Public Health Wales

The Maternity Services Board may also co-opt additional members to provide specialist knowledge and skills, including professional advice from primary care and therapies.

At each meeting the Board will:

- Review progress with quality and safety issues and all Serious Incidents.
- Discuss key indicators in the Maternity Services Dashboard.
- Consider how the service is appropriately contributing to National and local quality improvement programs – e.g. 1000 Lives plus Maternity Mini Collaborative.
- Workforce/OD issues.

As a general rule the MSB will use exception reports to hear about improvements and barriers to progress.

The Maternity service board meets quarterly and has to has at least seven members must be present to ensure the quorum of the Maternity Services Board one of whom should be the Chair. The meetings are openly and transparently in a manner that encourages the active engagement of stakeholders. The full terms of reference are attached as appendix 1.

Recommendation
The Quality and Patient Safety Committee is asked to accept the assurance that the maternity service board provides the quality and patient safety assurance of the maternity service to patients, staff and the Board.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Reduces the risk through quality and patient safety assurance
Financial Assessment, including Value for Money	Not applicable fort his report
Quality, Safety and Patient Experience Assessment	Assurance of quality and patient safety with lay members as core members including representation from community Health council
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable for this report.
Health and Care Standards	This report is not a proposal.
Link to Integrated Medium Term	Maternity quality and patient safety linked within maternity and family and therapy IMTP.

Plan/Corporate Objectives	
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 – provide high quality and safe maternity service for the population of Aneurin Bevan university health board
	Integration- provide high quality and safe maternity service for the population of Aneurin Bevan university health board with primary, community and third sector organisations
	Involvement – provide high quality and safe maternity service for the population of Aneurin Bevan university health board with support from service users within the maternity service liaison committee
	Collaboration – work collaboratively with primary, community and secondary care including public health Wales
	Prevention – work collaboratively with primary, community and secondary care including public health Wales.
Glossary of New Terms	MSB - Maternity Services Board
Public Interest	No objection to this report being made public if required

MATERNITY SERVICES BOARD

Terms of Reference

Purpose

To outline the terms of reference for the Maternity Service Board.

Background

In 2007 Maternity Services in the former Gwent Trust were reviewed by Wales Audit Office and Healthcare Inspectorate Wales and subsequently placed into 'Special Measures' while they addressed a range of clinical governance issues. Special Measures were lifted in September 2009 when it was judged that the service had made real progress.

However, by their nature all Maternity Services are high risk and therefore require a particular focus on quality and safety. The Maternity Service Board (MSB) will oversee the continuing focus on quality and safety in the maternity service, and thereby provide assurance to patients, staff and the board.

Role of the Maternity Services Board

- To oversee delivery of the Health Board's Maternity Services Strategy.
- To inform the Board on all relevant issues concerning Maternity Services and provide assurance to the Board.
- To seek assurance on issues as requested by the Board.
- Consider and review progress with all major plans and agree any major deviations from these plans i.e. The Maternity Services Action Plan and related SBARs, The Antenatal Review Action Plan, any capital schemes.
- Monitor progress with any action or improvement plans; Eg plans to improve against Standards for Health Services.
- Establish and programme manage any task and finish project streams as required.
- Ensure the service is aware of, and contributes appropriately to existing and emerging National and local service developments and service and professional standards.
- Assist in problem solving and resolving issues brought to it.
- Provide clear and effective routes of communication and escalation with the Health Board's executive team.
- Provide a transparent framework for monitoring HR and staffing concerns.

Membership of the Board

Core Members:

- Health Board Nurse Director(Chair)
- Family and Therapy Services Divisional Director
- Family and Therapy Services General Manager
- Maternity Services Clinical Director
- Divisional Head of Midwifery / Associate Director of Nursing (Vice Chair)
- Royal College of Midwives Representative
- Consultant Midwife
- Divisional Patient Safety and Quality Lead
- Patient /Service User representative
- Consultant Public Health Wales

The MSB will have appropriate secretarial support.

The Maternity Services Board may also co-opt additional members to provide specialist knowledge and skills, including professional advice from primary care and therapies.

At each meeting the Board will:

- Review progress with quality and safety issues and all Serious Incidents.
- Discuss key indicators in the Maternity Services Dashboard.
- Consider how the service is appropriately contributing to National and local quality improvement programs – Eg 1000 Lives plus Maternity Mini Collaborative.
- Workforce/OD issues.

As a general rule the MSB will use exception reports to hear about improvements and barriers to progress.

Frequency of the Board meetings

Maternity Services Board will meet quarterly with provision for exceptional meetings in the interim if deemed necessary by the Chair of the Programme Board. All MSB members can raise urgent issues with the Chair.

The frequency of meetings will be subject to review.

Quorum

At least seven members must be present to ensure the quorum of the Maternity Services Board one of whom should be the Chair.

Decision Making Process

Decisions will normally be achieved through consensus.

In exceptional circumstances the decision may proceed to a vote. In these circumstances the each member will have one vote. The vote will be a simple majority.

Board Agenda and Papers

The Maternity Services Board Chair will determine the agenda for each meeting, taking into account any suggestions or requests from individual members. All members can discuss issues for inclusion with the Chair.

Members will be provided with the Agenda and supporting papers for each meeting at least five working days in advance of each meeting.

A schedule of dates for the meetings will be published for the year ahead.

Maternity Services Board meetings will be carried out openly and transparently in a manner that encourages the active engagement of stakeholders. This will be facilitated in a number of ways including:

- Active communication of forthcoming Maternity Services Board business and activities.
- Agenda published at least 5 working days in advance of each meeting; and
- The selection of accessible, appropriate meeting venues,
- An agreed record of each meeting will be published within 10 working days of the meeting;
- The Board agenda and papers /record will be published on the Health Board's intranet.

Reporting and Assurance Arrangements

In addition to reporting to the Board, the Maternity Services Board Chair will:

- Report formally, regularly and on a timely basis to the Health Board Executive Team including verbal updates, the submission of Maternity Services Board minutes and written reports, as well as the presentation of an annual report;

- Bring to the Health Board's Executive Team specific attention any significant matters under consideration by the Maternity Services Board.

- Ensure appropriate escalation arrangements are in place to alert the Health Board Executive Team of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Health Board may also require the Maternity Services Board to report upon the activities at public meetings or to partners and other stakeholders where this is considered appropriate.

Quality and Patient Safety Committee
7th February 2019
Agenda Item: 2.1 (b)

ABUHB Maternity

Performance Board

April 2017 – March 2018 data

Delivering high quality maternity services to the people of Aneurin Bevan University Health Board (ABUHB)

The aim of this report is to provide assurance to the Welsh Government on serious incident reporting and governance framework within Aneurin Bevan University Health Board (ABUHB).

All clinical and organisational incident are reported on Datix, the Health Board's risk reporting system.

These are reviewed weekly across sites within ABUHB by a multi-disciplinary team. This is led by the Consultant Obstetrician with the lead for maternity risk and the clinical governance midwife. Root cause analysis is undertaken for all incidents and reviewed with the trigger criteria for Serious Incidents (SI). These include Neonatal death, scar dehiscence, maternal death, unexpected Stillbirth and failings in care that have resulted in Harm. SI investigations are agreed by the multi-disciplinary team, Head of Midwifery and Clinical Director. This is then raised with the Putting Things Right team and an SI investigation is commenced. This is led by a clinical Executive Lead and reported to Welsh government.

The family involved are fully engaged and have a point of contact person to correspond with. Their concerns are dealt with and responded to within the SI report. The report is then signed off by the Clinical Executive Lead and Medical Director within the Health Board and shared face to face with the family. All findings are transparent and all failings shared openly with the family. Once the family have agreed the report this is then further finalised and signed off by the Medical Director to be sent to Welsh Government.

All reported SI and action plans are implemented and reviewed through the Clinical Governance Forum, Quality and Patient Safety Committee, Divisional Day, Divisional Assurance meeting and quarterly Maternity Services Board meeting Chaired by the Director of Nursing.

All SI, concerns and maternity quality of care are all reported monthly supported by the clinical dashboard for maternity services. Any increase in incidents, themes and trends are then further reviewed and findings presented to the Maternity Service Board with supporting action plan for improvement. Themes and trends are reported immediately through these forums and immediate action taken to ensure safe maternity care.

Above outlines the governance framework for maternity serious incident process. This process provides reassurance that all SI incidents are reported effectively within ABUHB to ensure safe maternity services.

Current ongoing Serious Incidents

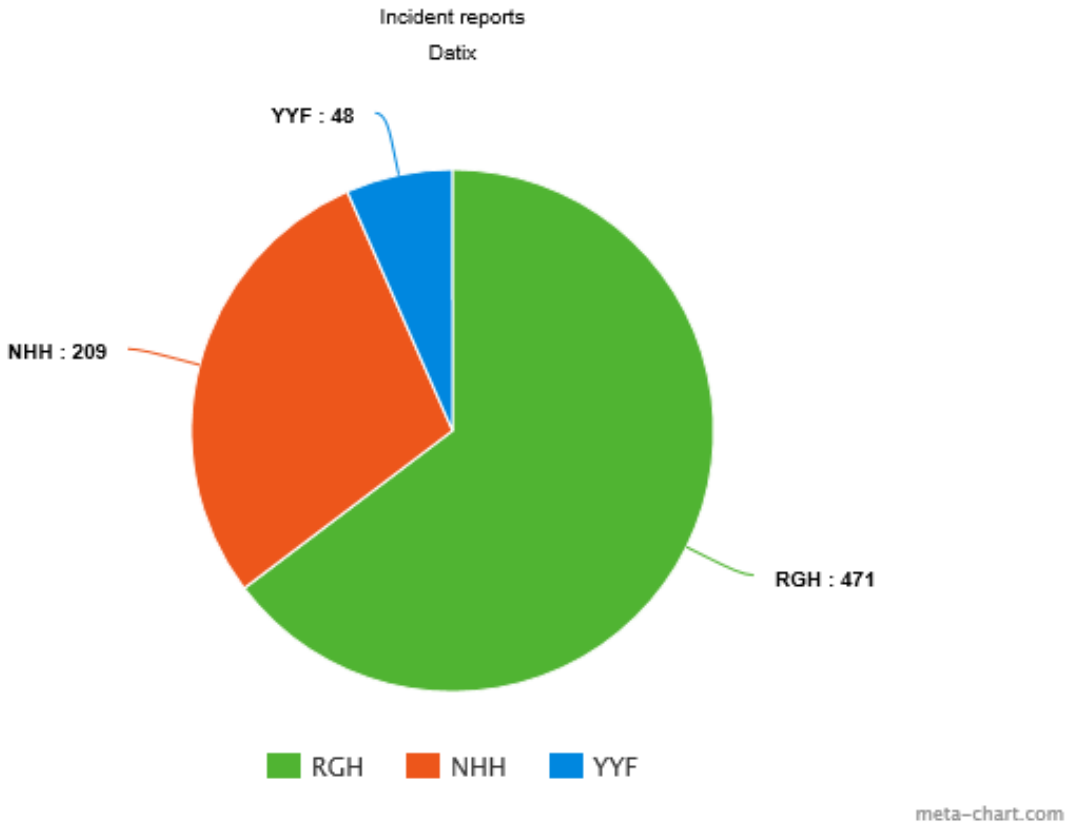
Date of incident	ABUHB No	Incident	Hospital	Area		Meeting update
21/09/18	ABHB148545	Unexpected admission to SCBU	RGH	MDU	Obs	TBC
20/09/18	ABHB148573	Missed opportunity to treat	YYF	ANC	Obs	05/02/2019
07/09/18	ABHB147606	Unexpected admission to NICU #skull	RGH	MDU	Obs	08/02/2019
05/10/18	ABHB149453	Intrapartum care 14 year old	NHH	Delivery Suite	Obs	TBC

Feedback to staff from the risk meetings occurs via monthly clinical govenance meetings , risk study sessions, lessons of the month as well as individual personal feedback where indicated.

The terms of reference for the local Maternity Risk Management Group, the maternity flow chart for reporting clinical incidents and the Maternity Risk Management Stategy were updated in April 2017 and will be reviewed in April 2019. The trigger list for incident reporting was updated in September 2018 and is enclosed as Appendix 1.

Reported incidents

Between 01-04-2017 and 31-03-2018 there were and 6026 births : During the same period there were a total of 764 incidents reported onto datix across the 4 sites. There was some duplication of incidents reported, thus the total incidents for maternity was 728.



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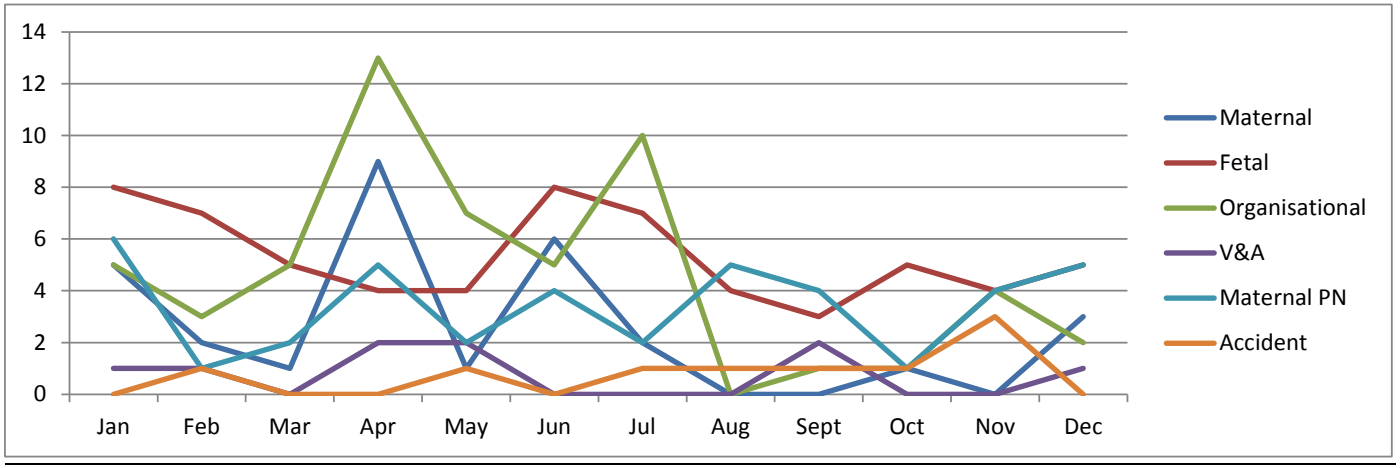
Royal Gwent Hospital

The highest number (471) of datix reported was at the RGH site, this includes community areas that feed into RGH.

RGH Incidents per month by category (as per trigger list)



The greatest number of incidents (186) reported on datix were classified as organsiational incidents. The main themes highlighted from these datixed incidents were as follows:

Organisational incidents	**188**
Staffing issues	37
Communication / documentation	62
Blood/ specimen	16
equipment	15
Medication related incidents	9
Child Protection	6
Service issues: Delay in review or treatment, lack of USS appointments, Difficulty with accessing NHS numbers for babies, Lack of SCBU cots.	17
Other: Firm alarm, lack of written consent, lack of security tags, pt declining care , pt experienced electric shock in theatre, birth filmed without consent, heating not working, milk out of date 3, lack of access to telephone and internet, surgical referral refused, biro on lscs tray, IUD inaapropriately transferred	26

The majority of Maternal/postnatal incidents reported were postpartum haemmorhage and postnatal readmssions. The PN readmission reported on datix were mainly for infection or bleeding.

Maternal/postnatal incidents	**92**
PPH > 1500 mls	66
PN readmission	10

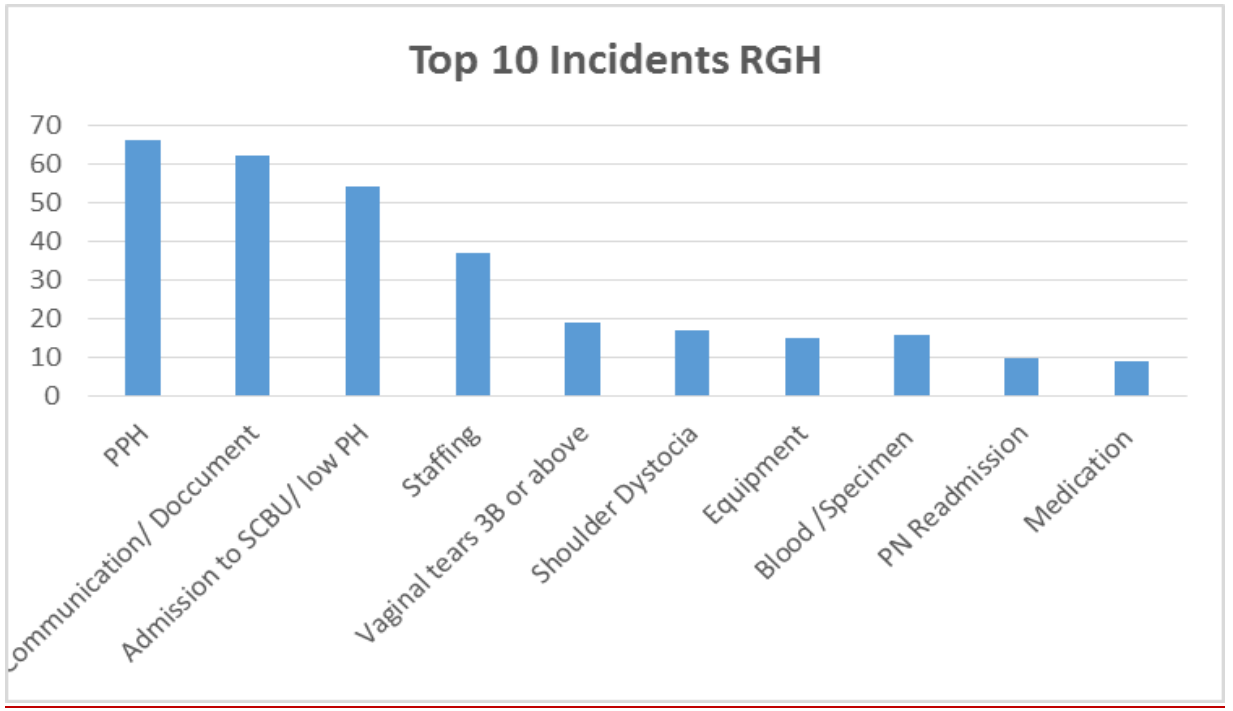
Of the 81 fetal incidents reported 54 were term babies that were unexpectadly admitted to the neonatal unit or were born with a Cord pH less than 7.1 Venous and 7.05 Arterial .

Fetal incidents	81
Unexpected admissions to scbu > 37 weeks or Cord pH less than 7.1 Venous and 7.05 Arterial	54
Interuterine Death	8
BBA	4
Abnormality not detected on USS.	3
*Other Poor communication between maternity and SCBU, Injury to baby at LSCS, Low BM's, failure to undertake PROM obs, Undetected SGA	12

Maternal incidents were mostly represented by shoulder dystocia or vaginal tears of 3b or above.

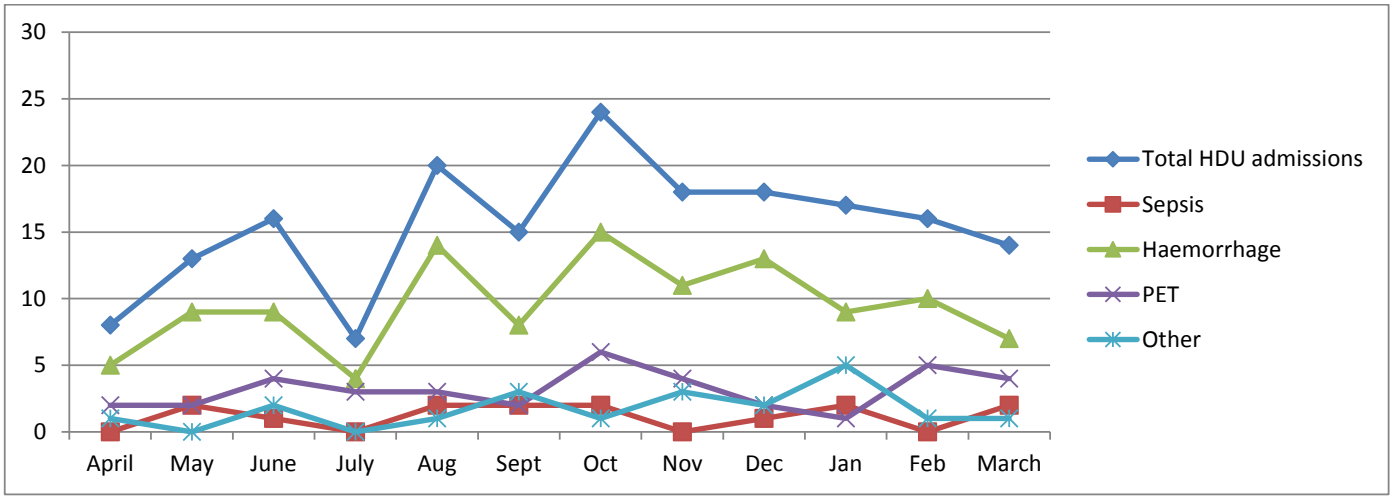
Maternal incidents	62
Shoulder Dystocia	17
Vaginal tears 3b or above	19
Double instrumental	5
Cord prolapse	2
Inverted uterus	1

RGH top ten incidents reported



HDU Admissions RGH April 2017- March 2018

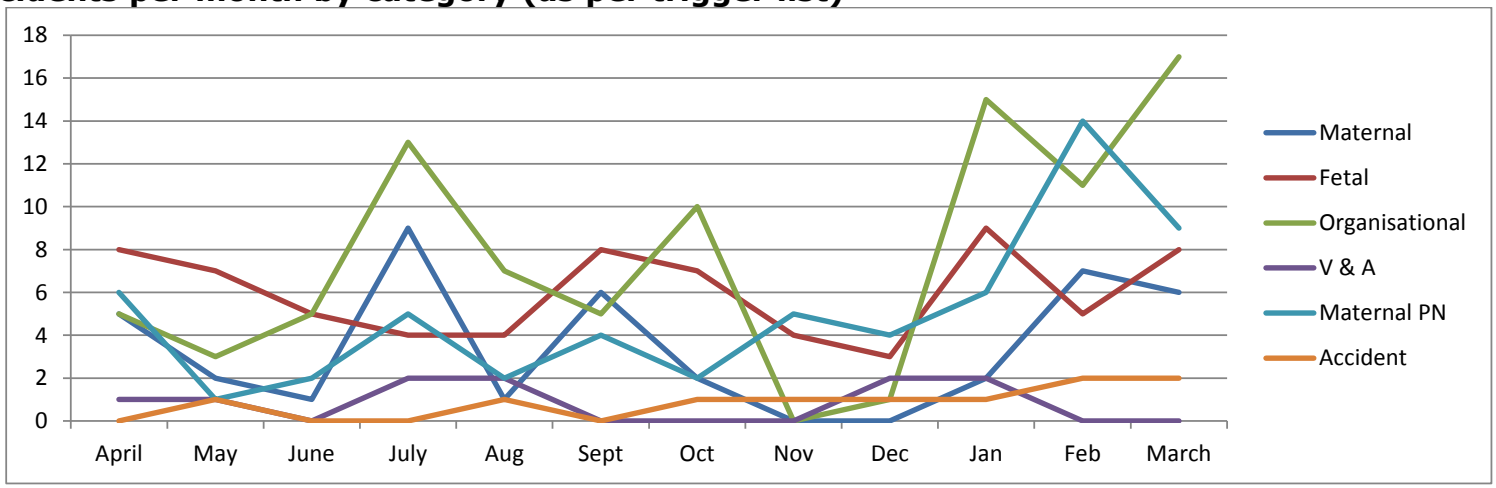
A total of 186 women recieved high dependency level 2 care within the Main Delivery Unit at the Royal Gwent Hospital, Haemorrhage being the highest recorded reason for admission. Rates for sepsis remain relatively low with a total of 14 admissions.



Nevill Hall Hospital

There were a total of 209 incidents reported at NHH including the community areas that feed into NHH.

NHH incidents per month by category (as per trigger list)



56 Datix were classified as organsiational incidents. The main themes highlighted from these datixed incidents were as follows:

Total Organisational incidents	56
Staffing	0
Communication/Documentation	9
Equipment/resources	6
Blood/ Specimen	4
Medication related incidents	2
Child Protection	3
Service issues: Lack of USS appointments, Lack of SCBU cots, Delay in review or treatment.	27
Other: Patients unable to get through to Brecon switch board, misplaced swab at MROP, Lack of avaialbility of vaccine, theft, Lack of interpreter	5

64 fetal incidents reported represent babies unexpectadly admitted to the neonatal unit or were born with a cord PH of < 7.1. However some of these babies had good apgars and did not require transfer to the neonatal unit.

Total fetal incidents	64
Unexpected admissions to scbu > 37 weeks gestation/ pH less than 7.1 Venous and 7.05 Arterial	48
IUD	3
BBA	5
Abnormality not detected on USS	3
Other Babies born at NHH below 35/40 gestation, Injury to baby at LSCS	5

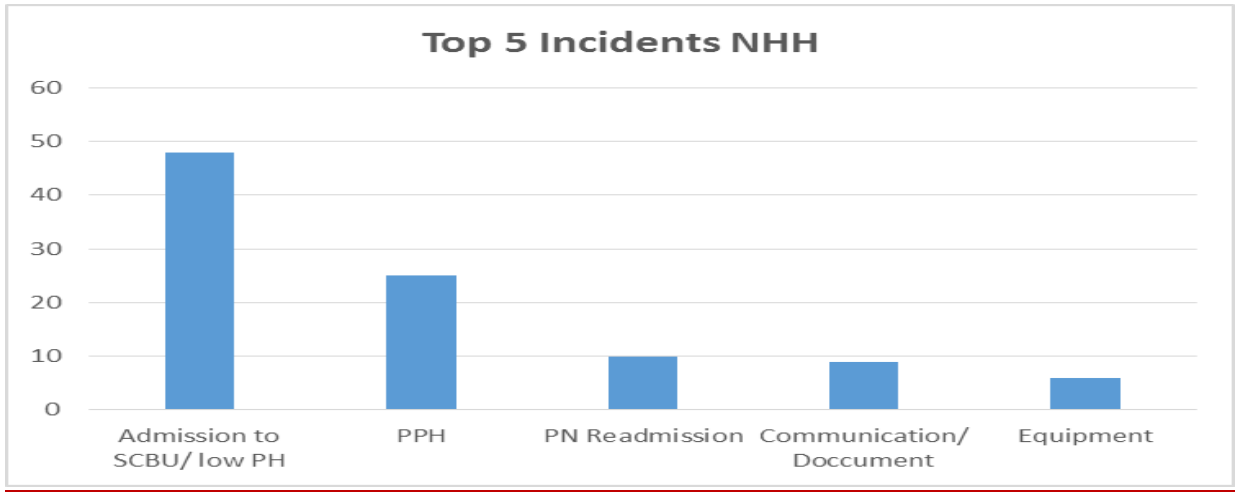
The majority of maternal postnatal incidents were Postpartum Haemmorhage above 1500 mls. 18 PN readmissions were reported, with the majority recieveing treatment for infection.

Total Mat /post incidents	44
PPH	25
PN readmission	18

The majority of maternal incidents report refer to shoulder dystocia and Breech diiagnosed in labour.

Total Maternal incidents	29
Shoulder Dystocia	5
Vaginal tears 3 b or above	2
Prolonged 2nd stage of labour	2
Breech diagnosed in labour	5
Inverted uterus	1
APH	2
Double Instrumental	3

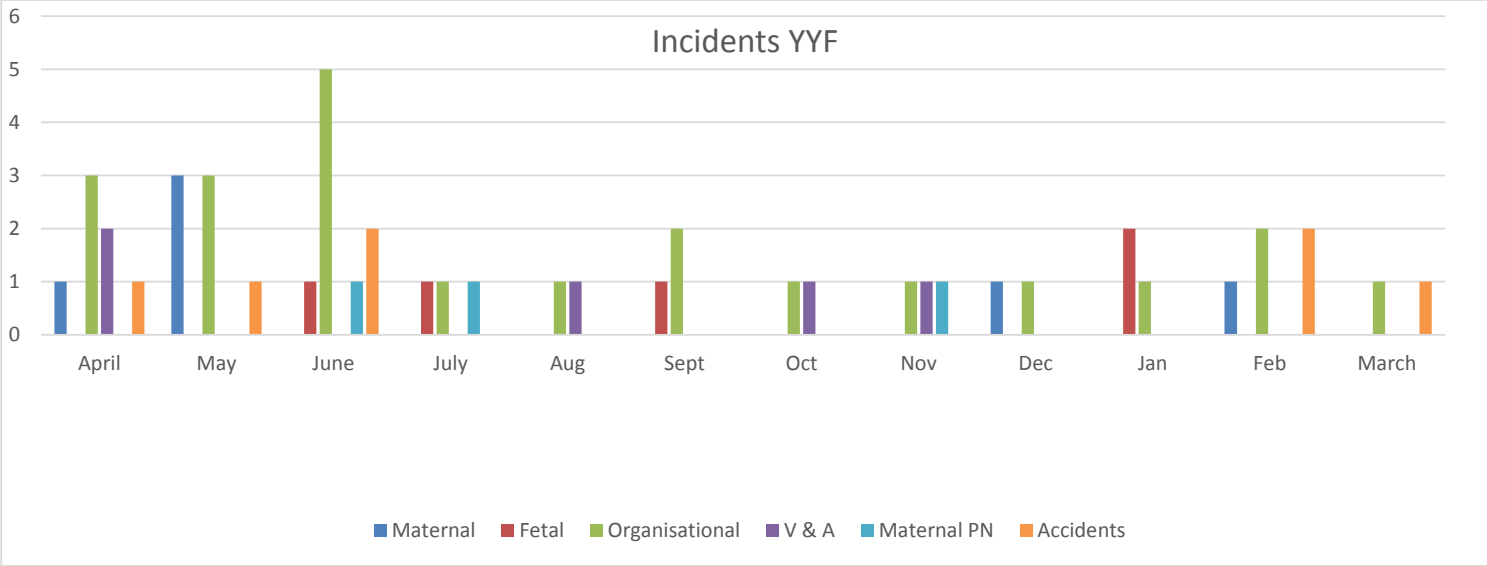
Top five incidents reported at NHH



Ysbyty Ystrad Fawr Hospital

There was a total of 43 incidents reported on datix for YYF site including the community areas that feed into YYF.

YYF incidents per month by category as per trigger list)



Of the 48 incidents reported on datix the majority (22) were classified as organisational incidents.

Organisational	22
Accident	7
Fetal	5
Violence + aggression	5
Maternal	6
Mat/post	3

Maternity indicators April 2017- March 2018

	No's of returns to theatre	P/N reads	pressure sores
April	1	4	1
May	0	1	0
Jun	0	1	0
Jul	1	0	0
Aug	1	4	0
Sep	2	2	0
Oct	2	3	0
Nov	0	3	0
Dec	2	3	1
Jan	0	1	0
Feb	0	1	0
March	0	5	0
totals	9	28	2

Maternity Dashboard 2017-2018

Appendix 2 and 3 provide the dashboards for 2017 and 2018 respectively. Appendix 4 is a presentation to the Maternity Services Board in October 2018.

Patient and staff experience

YOUR BIRTH- WE CARE (EICH BABI-EICH GOFAL) (Wales) - This is a survey of Women's View across Wales with online and face to face focus groups This is joint project by all Heads of Midwifery and Consultant Midwives across Wales, funded by WG, to understand women's views on giving birth outside of an Obstetric Led Unit and if they were supported in their decision making. The survey showed four key themes:

- continuity of carer
- models of care
- Antenatal information
- Enabling of Choice

Maternity are fully engaged with the patient and experience framework and the introduction of the patient experience strategy.

ABUHB Maternity Service Liaison Committee

The ABUHB Maternity Service Liaison Committee (MSLC) has been an active service user group for the past six years. The Committee meets four times a year and is well attended by women from all areas of the Health Board. The MSLC is advertised via the Health Board web page and face book page and also the maternity service face book page. Women are given information about it during their visits and there are posters on display. In addition to the service users on the group there is the support of the ABUHB Consultant Midwife, the Head of Midwifery, a Clinical Supervisor for Midwives, specialist midwives and maternity secretary. The Committee is currently chaired by service user Samantha Davies.

Topics that have formed part of the work programme over the last six years have been:

- Peer support
- Breastfeeding support
- Induction of labour

- Increasing women's use of midwifery led areas for birth
- Involvement in planning for the Specialist Critical Care Centre

As a result of information gained through discussion, service user audit and involvement in maternity service projects, the MSLC has provided valuable information to support the Head of Midwifery and Senior Midwives to modernise and shape our current service.

Developments include:

- Excellent breastfeeding support to the required Baby Friendly standards, including the introduction of peer support breast feeding counsellors on the post natal wards
- A standardised pathway for women wishing to have a vaginal birth after caesarean section that is supportive of their choice and empowers them to succeed
- The option of outpatient Induction of Labour for women experiencing an uncomplicated pregnancy that has continued post dates
- Midwifery led birth centres in all areas of the Health Board ensuring that all women experiencing an uncomplicated pregnancy have the opportunity to birth outside of an obstetric unit with access to birthing pools and a home from home environment

Serious incidents

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
ABHB120079 **30.6.2017**	IUD	Organisational and individual learning needs to take place in regard to this regrettable incident. The midwives and ST1 involved with this case will undertake some reflective learning with their respective clinical supervisors. Consideration will need to be given as to how the Locum Registrar learns from this case as he has left the employ of ABUHB. An anonymised version of events should be presented at the departmental Clinical Governance Meeting to remind all medical and midwifery staff that they need to be cognisant of:

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		• The need to consider continuous monitoring when a woman on the VBAC pathway starts to experience increasing or persistent levels of abdominal pain • signs of patient deterioration • when and how to access medical support when yellow and red scores are produced by application of the obstetric early warning system • the subtleties and classical signs of uterine abruption • the complete application of the sepsis six pathway, including the 'plus two' element used within obstetrics, i.e. consider delivery • the need for a 'fresh eyes' approach to patient review, taking into account all patient information including patient history, vital signs and investigation results • the need to communicate effectively, ensuring that women and their families understand a plan of care offered. Ensuring parity between information said and that documented. This should also be followed up with a set of learning points for dissemination across the service for all medical and midwifery staff to read and consider.
ABHB120953 **2.7.2017**	Maternal Death	**Conclusion** Due to a history of previous deep vein thrombosis the patient had a high risk of Venous thromboembolism in pregnancy. The history of previous DVT was noted on the first visit but not highlighted on subsequent visits. Following a second Trans-vaginal ultrasound scan a viable

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		uterine pregnancy of 7 weeks 3 days gestation was confirmed. Thromboprophylaxis was not prescribed at this time. **Recommendations:** The care pathway is updated for all women who have an increased risk of Venous thromboembolism in pregnancy. An organisational review of the Early Pregnancy Assessment Unit service at NHH. Education is provided to professionals in primary and secondary care, who care for pregnant women to raise awareness of the risk of Venous Thrombo Embolism in pregnancy
ABHB122282 **20.7.2017**	PN Readmission - Colostomy	**Conclusion:** It is standard practice not to close the peritoneal layer during caesarean section, however if it were closed – consider continuous closure rather than interrupted closure to avoid creating small gaps through which the bowel can herniate. If a patient has received Morphine for relief of acute pain, it is prudent to observe until its effects have worn off to see if the treatment initiated is working. When patients are assessed at multiple sites, ensure all information is gathered regarding what assessments and treatments have been undertaken.

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
ABHB126951 **127300** **16.10.2017**	Emergency LSCS for failure to progress. Major haemorrhage protocol initiated for MBL 2053 B Lynch suture Day 6- Transferred back to MDU- Sepsis- perforated bowel	**Conclusion** Learning outcomes from this case 1. Previous caesarean section patients have a 0.5% increased risk of uterine wound dehiscence in labour which will be increased 2-3 fold with the administration of induction agents. There was no documentation regarding the discussion of these risks, having taken place in the antenatal period. 2. The use of Prostin inserted into the vagina is impossible to remove and will not reduce its effect on uterine activity. It would have been preferable to have used Propess, however, given the history of previous caesarean section it would have been safer to have used the Dilapan as planned in the antenatal period. 3. The patient should have been transferred to the Main Delivery Unit prior to the second dose of Terbutaline. 4. We await the anaesthetic report regarding this case. **Recommendations** Discussions regarding the risks of uterine wound dehiscence in labour should take place in the antenatal period and be clearly documented.
0712/2017 **ABHB127300**	Unexpected bowel perforation	**Conclusion** There was extensive endometriosis leading to friable tissue in pregnancy resulting in bowel injury. Sepsis occurred in the antenatal period and there was a delay in recognising the deteriorating patient The patient was at an increased risk of difficult caesarean section due to

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		appendectomy during pregnancy and extensive endometriosis in bowel that was not known at the time of Caesarean Section. The whole clinical picture was not considered in the management of this case. The most probable cause of bowel injury was deep infiltrating Endometriosis in bowel. . Contributing factors like sepsis, extensive endometriosis leading to friable tissue in pregnancy may have resulted in bowel injury. There was a delay in multidisciplinary management of this case. Persistent tachycardia and deteriorating patient should have a senior review and multidisciplinary input as soon as possible. Multidisciplinary input in the management of patients with complex history reduces morbidity and improves clinical outcome. **<u>Recommendations</u>** 1. There should be development of the system; Drs rotas, to support the separation of teams providing elective and emergency procedures. 2. Complications of Endometriosis during pregnancy are rare although there is no evidence that the disease has any detrimental effect on pregnancy outcome, but rare complications should be highlighted in the educational program by case presentation.

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		3. Reinforcing the teaching and learning in recognising deteriorating patient and encourage jump call by midwifery staff and obstetric team**.** 4. There should be the correct use of MEOWS chart to escalate to seek medical advice when requiredThis can be achieved by ensuring attendance and monitoring of compliance for staff attending PROMPT and anaesthetic HDU training day at ABUHB. 5. Any Obstetric patient who becomes unwell needs to be reviewed by the most senior obstetrician available. Clear plan to be made. It is critically important to communicate among team members in detail and to follow SBAR. 6. MEOWS chart audit should be carried out annually. 7. Involvement of multidisciplinary team should be made at an earlier stage. 8. When surgical difficulties are anticipated a senior Obstetrician should be present at an earlier stage during caesarean section. Simulation training of deteriorating patient to encourage multidisciplinary management
05/04/2018	Neonatal Death	**<u>Conclusion</u>** From the post-mortem report it is evident that intrauterine infection is most plausible cause of death.

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		Intrauterine infection, also known as chorio amnionitis womb, is **infection within the womb**, which, in the context of pregnancy, usually means infection of: • the membranes that surround the baby • the umbilical cord and / or the amniotic fluid The clinical signs and symptoms of Chorio amnionitis are non-specific and challenging to confirm the diagnosis. Reflecting on Ms SG's presentation, she had no high temperature during labour, no history of prolonged rupture of membranes to suspect the infection. It is extremely difficult to pick up the changing trend of rising baseline of foetal heart rate and reducing beat to beat variability on intermittent auscultation every 15 minutes. High index of suspicion is needed to rule out chorio amnionitis. Continuous electronic monitoring might have risen the suspicion of possible chorio amnionitis. **<u>Recommendations</u>** All women with a BMI over 35, who wish to give birth in a midwifery led setting, should have an informed birth discussion in the antenatal period with a midwife or obstetrician regarding intrapartum complications associated with obesity. The discussion should include the limitations of the birth centre setting, particularly in relation to the incidence of transfer to an obstetric unit in an emergency. Women should be made aware of transfer distances and possible times for transfer during these discussions. Dissemination of ABUHB birth choices leaflet to all community midwives and hospital staffs

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		Promote vigilance during the Latent Phase of labour **Look and Listen** for the transition to active phase. Established labour is when there are regular painful contractions and progressive cervical dilatation from 4cms, a vaginal examination is not always necessary to determine the active stage of labour. Availability of an adequate ambulance facilities for maternity and neonatal transfers to be considered as part of clinical future when the Grange University hospital will be opened.
22/04/2018 **ABHB138606**	HIE	**Conclusion** According to medical literature nearly 70% of babies with HIE diagnosed in the neonatal period, the insult causing the brain injury has occurred in the antenatal period. There are multiple causative pathways of injury. The normal cord blood gas readings along with baby VC's initial condition at birth and good response to initial resuscitation suggests that there was no hypoxia during labour. For the baby, the timing, duration or the nature of the insult causing the HIE injury remains unknown though it is likely to have occurred in the antenatal period. **Recommendations** • Consider use of designated CTG analysis aids to be objective about CTG analysis in the antenatal period. E.g.-computerised CTG analysis • CTG teaching sessions should be continued on a 6 monthly basis for all obstetric and midwifery staff working in the obstetric led labour ward. The STAN teaching day should include discussion of local cases including this case.

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		• During record keeping for resuscitation- it would be good practice to make a note of the clock used • to record timings. If the resuscitaire clock has started at a later time- all team members should be notified of this and their documentation should reflect this. This is a learning point does it need to be here ? • Consider/ explore the feasibility of keeping the placenta for histological examination for babies where HIE is suspected as it may help reveal the cause. • Clinicians involved in this case to reflect on their practice. • Division will ensure the dissemination of learning
17/07/2018 **ABUHB 141731**	Retained swab	The count of swabs after the repair was incorrect. There was no track of the swabs used or counted. Contrary to theatre within the delivery rooms there is no identified person responsible for the swab count.More than one person could give the doctor swabs and count could be lost especially when suturing difficult. **Conclusion** This was a never event, that did not cause harm but gave the opportunity to learn and provide recommendations to improve patient safety. **Recommendations** • There should be a responsible person for giving swabs and counting them • If the midwife is busy she should ask for help and hand over the numbers at the end. • All involved in counting should have their name documented by the midwife • Swab count should be put on white board in each delivery room • Monitoring should include blood loss

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		• No swab should be disposed of before the final count • Use of orange bag: use to collect swab should be set by the end of bed during suturing. • Any handover should include number of swabs • Use of proforma for instrumental /suturing Findings learning and recommendations shared in clinical governance December 2018 and with family. Near Event - Jayne Beasley.pptx
25/07/2018 **ABUHB144296**	Neonatal Death	**Conclusion** Appropriately planned birth at YYF birth centre, preliminary PM results indicate baby died from undetected fetal Hypoxia. There were no identified system failures that contributed to the sad death, but there was a lack of recording of the fetal heart rate as per national and local guidance during the second stage of labour. The initial resuscitation did not follow recommended practice. **Recommendations** • Women in YYF are requested to attend YYF 4-6 hourly for assessment following SRM, there is no requirement for this. This practice needs to be reviewed. • All phone calls should be documented • All growth should be recorded on the gap and grow chart including in labour • There should be, as far as practicable continuous support from a midwife in labour • All clocks should be checked daily

Incident number Date of incident	Details of Incident	Conclusion and Recommendations
		• External signage to the birth centre to be improved • Documentation during neonatal resuscitation should be easily accessible • Reinforce to staff how to contact the neonatal unit in RGH in the event of an emergency, resuscitation should continue until assistance arrives. Individual action plan for midwife

Amber investigations

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
28.7.2017 **Datix 260744**	Abruption following IOL	**Conclusion:** Prostaglandin can cause a precipitant delivery particularly when administered to multiparous patients. There has to be a sound clinical reason for commencing an induction. The reason in this case is unclear. Precipitant delivery is associated with placental abruption. **Good Practice** The management of the patient following her transfer of care to MDU was excellent as is the documentation. A PPH was correctly anticipated and prevented with the use of a Syntocinon infusion and the Obs Cymru sheet was completed.
21.8.2017 **Datix**	Scar Dehiscence	**Conclusion/ Recommendations:** There was a delay in the vaginal examination from 10.00hrs to 17.00hrs. This was a 7 hour delay despite commencing Syntocinon at 12.00hrs. The guidelines suggest that a vaginal examination should have been performed at 14.00hrs i.e. 4 hours after the previous examination. There was a delay in the decision for caesarean section at 17.25hrs. It was evident from the partogram that this lady was in an obstructed labour. The decision to continue with the labour at this stage was made by the patient having been given the choice to continue or to undergo an emergency caesarean section. It is not appropriate to ask patients to make difficult obstetric decisions about their care during labour. The Consultant Obstetrician was present on labour ward at 20.00hrs and should have been asked by the incoming Registrar to stay as there were two patients requiring delivery simultaneously. It shows a lack of team camaraderie when the outgoing Registrar walks away from a busy labour ward with two patients that have been under their care throughout the day that need to be delivered at the same time. A second theatre should have been prepared and the caesarean section expedited.

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
		When the CTG started to cause concerns whilst the duty Registrar was in obstetric theatre the on-call Consultant should have been contacted and asked to attend. She had no knowledge that there were any difficulties with this case until she was asked to attend as an emergency when the uterine rupture was noted. The lack of ODP cover is not a satisfactory excuse to compromise patient care.
17.9.2017 **Datix:264006**	Scar Dehiscence/ PPH 4303mls	**Key Findings** The previous caesarean section note should have prompted a more cautious approach to the management of this lady's labour and plans should have been made for a short trial without any augmentation. There was a delay in decision making to perform a caesarean section. The delivery should have been expedited following the examination at 12.15hrs A multiparopus patient in spontaneous labour at full dilatation should not require Syntocinon augmentation and the risk of uterine rupture is significant. There was a further delay in decision to commencing a CS as a consequence of blood bank and anaesthetic difficulties **Conclusion** The patient experienced a spontaneous uterine dehiscence in the region of the previous uterine injury as a consequence. The delay of approximately 5 hours in expediting delivery of an obstructed labour at full dilatation by emergency caesarean section was most probably the root cause. **Actions** The investigating officer wrote to the LW lead re 3 index cases of uterine injury in RGH in last 3 months. Delay in decision making and/or expediting delivery in an obstructed labour being the root cause. The LW lead responded and is currently auditing the cases. The investigating officer informed the Consultant body on October 11th governance day.

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
ABHB126050 **1.10.2018**	Amniotic Fluid Embolism	**Conclusion** Amniotic fluid embolus is a catastrophic event which has sudden onset with an incidence of 1 in 8000 and 1 in 80,000; UKOSS recent report suggests that incidence is 2 cases/100,000 maternities. It is leading cause of Maternal Mortality and Mortality rates vary from 16 to 86%; UKOSS reported case fatality of 20%[5,6] in UK data. The criteria for its clinical diagnosis is acute hypotension or cardiac arrest, acute hypoxia, coagulopathy occurring during labour birth or within 30 minutes of puerperium. Both maternal and fetal mortality remains high and there is a requirement for rapid diagnosis and resuscitation to prevent mortality. As per the UKOSS definition she fits into the clinical diagnosis. She was managed appropriately with good outcome **Recommendations** • Women who are commenced antihypertensives or altered should be admitted to the ward for monitoring. • Recurrent reduced fetal movement to be reviewed by Senior Obstetrician.
19.10.2018	Difficult LSCS Baby cooled	**Conclusion** There was without doubt a global delay in expediting delivery of this baby. The mother had demonstrated a significant intrapartum sepsis and delivery should have taken place following the return of the blood results at 2300hrs. A caesarean section would have been necessary to deliver this baby. However, the degree of difficulty encountered in extraction of the fetus and subsequent uterine damage and post partum haemorrhage may have been avoided with an earlier delivery. The combination of sepsis, delay in decision making and protracted, difficult extraction of the baby at caesarean section are likely to have contributed to the poor condition of the baby at birth. **Key Events** Failure to expedite delivery following the return of the blood results demonstrating a significant sepsis at 2300hrs. Delay in making a decision to deliver at 01.47hrs when delivery was not imminent and there was clinical evidence of a cephalo-pelvic disproportion.

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
		There was further delay in theatre with anaesthetic difficulties and repeated attempts to facilitate a vaginal delivery. The decision to delivery time for this category 2 caesarean section has fallen outside RCOG guidance 2011.
30.10.2018 **Datix 266741**	Scar Dehiscence Prev LSCS X2	At the time of Caesarean Section there wan noted to be a complete scar dehiscence. The baby was born in good condition. **Key events** Propess was adminsitered to a patient with two previous caesarean sections It is known that induction agents will increase the risk of uterine dehiscence 2-3 fold following one previous caesarean section. Therefore the risk will inevitably be increase with the prescence of two nscars although the literature does not quantify this. The birth plan could have been made clearer in the notes and the midwife informed that Propess is Prostaglandin and should not have been administered in these circumstances. The presence of vaginal bleeding and frank haematuria during labour should alert the clinician to possible uterine dehiscence/ rupture. Therefore there should be a low threshold to expidite delivery, check platlets and clotting screen. The prescriber should have been made aware that the patient had had two previous caesarean sections before siging for the propess. A memo has gone out to all medical personel in RGH reminding them of the importance of checking the patients history , prior to signing the prescription chart. There is no documentation that the patient had been counselled regarding the risk of uterine wound dehiscence during labour in a patient with two previous caesarean sections. Neither is there documentation around the increased risk of using induction agents in these high risk patients.

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
ABHB126818 **25.9.2017**	Fistula	**Conclusion** This is an unfortunate incident of a recognised complication of an obstetric vaginal delivery. The only way to have prevented it would have been to have performed an elective Caesarean section and should the patient become pregnant again it would be my recommendation that she consider elective Caesarean section for the delivery
10.1.2018 **Datix** **ABHB132248**	IUD 38/40	Consider delivery when a fetus has reduced growth velocity and recurrent reduced FM discuss with patients >37 weeks. In view of tachycardia consider early sepsis and offer delivery as oppose to expectant management ie IOL 24 hours later. In view of maternal tachycardia on admission to triage and SROM consider sepsis: Often the first signs of sepsis are tachycardia and tachypnoea- FBC CRP and lactate could have been performed. **Recommendations** Learning to be cascaded **Arrangements for sharing and learning** Learning cascaded through Maternity Lessons of the month and at Clinical Governance Meeting.
2.2.2018 **Datix;272501**	Scar Dehiscence Delay in transfer to theatre	**Conclusion** Previous caeasrean section patients have a 0.5% increased risk of uterine wound dehiscence in labour which will be increased 2-3 fold with the administration of induction agents. There is no documentation of the discussion of these risks

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
		having taken place in the antenatal period. The use of Prostin inserted into the vagina is impossible to remove and will not reduce its effect on uterine activity. It would have been preferable to have used Propess, however given the history of previous caesaerean section it would have been safer to have used the Dilapan as planned in the antenatal period. The patient should have been transferred to MDU priro to the 2nd dose of Terbutaline. **Recommendations** Discussions regarding the risks of uterine wound dehiscence in labour should take place in the antenatal period and be clearly documented.
25.2.2018 **Datix: 274049**	Eclampsia	**Conclusion:** The patient was discharged home with untreated fulminating pre eclampsia which inevitably led to an eclamptic fit at home. She was subsequently managed in an inappropriate area of the obstetric unit and was therefore unable to access the expertise of the senior midwifery, obstetric and anaesthetic staff in a timely manner. The diagnosis of eclampsia was delayed and as a consequence the patient experienced a second eclamptic fit. **Root Cause** The patient was prematurely discharged home with proteinuric hypertension and abnormal reflexes without a senior review, management plan and treatment.

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
		Key Events No senior review prior to discharge post delivery despite a history of hypertension in labour, proteinuria, elevated uric acid and clinical symptoms of pre eclampsia. ***Recommendation:*** All women who have complications post delivery should be reviewed by a senior obstetrician prior to discharge. GP trainees are encouraged to attend ward rounds but should not be solely responsible for the delivery of care to obstetric patients.The GP trainee should be commended for their clinical acumen and contacting their seniors for help and advice prior to discharging the patient. The patient was inappropriately readmitted to an antenatal ward and consequently could not access immediate review by a senior Obstetrician, anaesthetist or physician. Post natal readmissions that have required a blue light ambulance transfer from home need to be admitted to an area that can access senior midwifery, obstetric and anaesthetic personnel without delay. The patient was reviewed by a junior member of the obstetric team and the diagnosis of eclampsia missed. The ST5 doctor was misled by the history of a difficult anaesthetic and further delay ensued. The discussion with the medical team was made at a very junior level. The on call Consultant Obstetrician was not informed of the admission and ongoing concerns. Patients who collapse at home post natally need an immediate review by the most senior obstetric/anaesthetic doctor on

Incident number Date of incident	Details of Incident	Conclusion/ Recommendations
		site. Common pathology is common and eclampsia has to be the first diagnosis and treated following a history of fitting in a pregnancy or post natal period. The actual blood pressure measurements are irrelevant. The on call Consultant needs to be informed of any obstetric patients who have been admitted following a collapse at home. The most senior on site doctors should be involved in the decision making. The anaesthetic team who responded to the cardiac arrest call should be commended for the accurate diagnosis and treatment of the patient. Case reviewed for redress

PROMPT implemented April 2018

Prompt Study Days	Location	Attendees Booked	Attended confirmed
April	RGH	30	30
May	NHH	23	25
June	RGH	30	30
July	RGH	Cancelled	0
August	No Study Day	No Study Day	0
Sept	NHH	22	21
October	RGH	34	
November	NHH	26	
December	No Study Day	No Study Day	
January	RGH	31	
February	RGH	28	
March	NHH	8	

Fetal Surveillance

Medical and midwifery staff attend CTG study day presented by Edwin Chandraha once a year. Ongoing ctg training sessions in medical teaching. Midwives attend the mandatory study day for CTG training. Review 5 CTG cases within the risk forums, team meetings RCOG case studies. Also every 5years the RCOG CTG package as per compliance.

Gap and Grow

Lead midwives attended gap and Grow training in 2017 cascade training provided to staff

Head of Midwifery competed and implemented a service improvement programme for gap and grow compliance. Compliance improved by 90%

Scanning provision continues to be an issue for fetal surveillance due to the shortage of sonographers. 3 weekly scanning cannot be met as set out in Gap and Grow. However Health board meeting RCOG standards for 4 weekly and this remains a challenge.

Midwifery sonography continues with quality assurance from Lead midwifery scanning and ASW and are running at full capacity. Retaining midwifery scanning proving a challenge due to noncompliance by other health boards. Additional training supported by WEDS and midwife commenced USS module January 2019.

Quality Improvement Programmes

The Lead Consultant for labour ward is taking forward the quality improvement programme in ABUHB these are linked to outcomes from the dashboard, concerns and service improvement. The programmes moving forward are:

- IOL QUIP in relation to increasing IOL rates.
- Training for ventouse delivery as instrumental rate is low
- QUIP on Keillands to reduce full dilatation section
- QUIP on ECV to reduce Breech presentation Sections has been planned and we may proceed further to
- QUIP for breech vaginal delivery

- Ongoing LSCS Audit
- Increase in emergency sections due to failure to progress. Next step to introduce lactate measurement in labour to reduce emergency sections

Aneurin Bevan Health Board
Maternity Services
Trigger List for Incident Reporting January 2019

Maternal /Postnatal		Fetal	Organisational
*Maternal Death	ITU admission	*Intrapartum fetal death	Delay following call for assistance
*Serious clinical incident	Organ damage/ visceral injury as a result of an intervention (bladder damage at c/s)	*Neonatal Death	Jump call procedure used
			Unplanned home birth
Near Miss		*Infant abduction	Interpersonal conflict over case management / inappropriate entry in notes
Blood loss > 2000mls			
BMI> 50	Hysterectomy/laparotomy	Stillbirth	Consent or treatment declined
Eclampsia	Anaesthetic complication – anaesthetists to clarify what they see as a complication	Apgar less than 7 at 5 minutes	Staffing issues / unit closure
		Unsuspected fetal anomaly	
DIC/ HELLP	Third degree tear grade B & C or fourth degree tear	Injury unknown cause	Unavailability of notes
			Potential service user complaint
Duration 2nd stage more than 3 hours active pushing (1st baby)	Prolonged postnatal maternal in – patient stay i.e. 5 days SVD	Undiagnosed small for gestational age < 5th Centile	Delay in blood products
Duration 2nd stage more than 2 hour active pushing (multiparous)	Uterine Rupture/ Inverted uterus/ Maternal collapse	Admission to NICU for hypoglycaemia	Retained swab / instrument Incorrect Swab/instrument count
Return to theatre/ EUA	Shoulder Dystocia	Cord pH less than 7.0 arterial, BE -12.00	Prescribing / administration / transfusion error
Double instrumentation	Postnatal readmission	Unexpected transfer to NICU	Departure form local protocol/ guideline
			Faulty equipment
		Neonatal seizures	Verbal or physical threat to staff
		Birth trauma – Brachial plexus.	Hospital –acquired infection
		Fetal laceration at CS	

Aneurin Bevan Health Board

2017

Maternity Dashboard :

Clinical Performance and Governance Score Card

		2017	Goal	Red Flag	Measure	Comment	Data Source	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	COMMENTS / ACTION THIS MONTH
	Organisation	Number of Labour Ward Forum	4 pa per site	<4	Minutes		Minutes														complete
Activity	Births	Benchmarked to 6000 per annum	500	525 >550	Births		information	492	446	471	486	519	533	526	515	514	484	494	541	6021	total
	Scheduled Bookings	Scheduled Bookings by intended hospital	6600	≥630	(1st visit) total	Tolerance 15%	information	514	514	611	556	582	578	505	507	497	579	609	510	6562	total
					Midwifery		information	193	199	276	203	244	247	192	186	189	224	239	204	2596	total
					Joint care		information	321	315	234	353	338	331	313	321	278	355	370	306	3835	total
	Instr. Vag Del	Ventouse & Forceps	10-15%	<5%or >20%	Inst Vag D/Birth		MIS	10.49%	13.06%	9.50%	11.60%	11%	10%	10.30%	8.20%	6.70%	8.40%	10.90%	9.70%	9.99%	average
	Induction of labour		20-22%	26%	UK data		MIS	26%	25.00%	24.00%	20.1%	24.7%	24.2%	28.65%	26.90%	22.50%	26.80%	26.90%	24.00%	25.01%	average
	C- Section	Total rate (planned & unscheduled)	≤23% -25	≥26%	C-section		MIS	24.49%	23.00%	24.60%	24.00%	24.50%	24.90%	22.80%	24.80%	22.70%	28.70%	24.40%	25.80%	24.56%	average
		ABHB SSI C/S	5.50%	7%	all wales average	5.50%				5.20%			6.18%			5.97%			5.8	5.80%	average
Workforce		Weekly hours of consultant cover on labour ward	>40 hours NHH > 60 hrs RGH	<36 hours NHH <54 RGH	Hours	Per week	Labour ward duty rota														
		Midwifery establishment in line with BR+	less than 3% discrepancy with BR+	more than 10% discrepancy with BR+			HOM														
		Supervisor to midwife ratio	<1.15	>1.20			HOM														
		Sickness m,n,support	≤4%	≥6%		(long and short term MW)	HR	7.10%	5.37%	4.88%	5.81%	5.45%	4.93%	5.46%	5.71%	6.75%	6.85%	6.11%	4.96%	5.78%	average
		Sickness medical	≤4%	≥6%				0.20%	2.50%	6.00%	5.10%	5.3%	3.8%	5.1%	6.10%					4.28%	average
		CTG RCOG	100%				prac dev														
	Staffing levels	Mandatory training	annual >90%	annual <90%		Review 6 monthly	prac dev														
Clinical Indicators		Eclampsia	<4 in any 2 month period	>4cases in any 2 month period	No. of patients		MIS	0	0	0	0	0	0	0	0	1	0	0	0	1	total
		ICU admissions in Obstetrics			No. of patients		MIS	0	0	0	0	0	0	2	0	1	0	0	0	3	total
		Blood Transfusions (4 units of blood)			No. of patients		MIS	0	0	0	0	0	0	0	0	1	0	0	0	1	total
		Post partum hysterectomies			No. of patients		MIS	1	0	1	0	0	0	0	0	1	0	0	0	3	total
	Neonatal morbidity	Number of cases of meconium aspiration			No. of patients		info	0	0	0	0	0	0	0	0	0	0	0	0	0	total
		Number of cases of hypoxic encephalopathy (Grades 2&3)			No. of patients		information	0	0	0	0	0	0	0	0	0	1	0	0	1	total
	NNU Status	total closure of neonatal units					NNU	0	0	0	0	0	0	0	0	0	0	0	0	0	total
		NICU admission >36 weeks	4.50%	5.50%	% of term births	AWNN Network	MIS	15	15	18	15	17	16	17	17	11	12	8	13	3%	total
		Number of SBs / IUDs	5.4	7	per 1000 registered births	AWPM national statistic	MIS	2	4	2	2	4	3	2	0	4	2	1	0	26	total
		Failed Instrumental numbers			Ins Del/Birth		MIS	2	1	4	0	1	2	9	1	1	9	3	6	39	total
		Massive PPH 2 L	<12/ month	15			MIS	5	6	9	7	6	3	4	6	7	7	6	7	73	total
		Shoulder dystocia	< 4 / month	> 7/ month	resulting in erbs palsy	0.5-1.5 % of Deliveries rcog	MIS	7	10	6	9	5	8	9	4	8	7	5	9	73	total
	Risk Management	3rd degree tear	<5% month	>5%month		RCOG	MIS	2.25%	2.00%	2.50%	2.60%	1.90%	0.50%	1.53%	1.18%	1.90%	1.68%	2.02%	0.18%	1.69%	average
	Complaints	Number of complaints		>10		threshhold for review	HoM	5	6	5	5	2	10	6	3	3	2	2	3	52	total
		Closure of total maternity service	<1 per month	>3 times per month			Senior managers													0	total

Aneurin Bevan Health Board

2018

Maternity Dashboard :

Clinical Performance and Governance Score Card

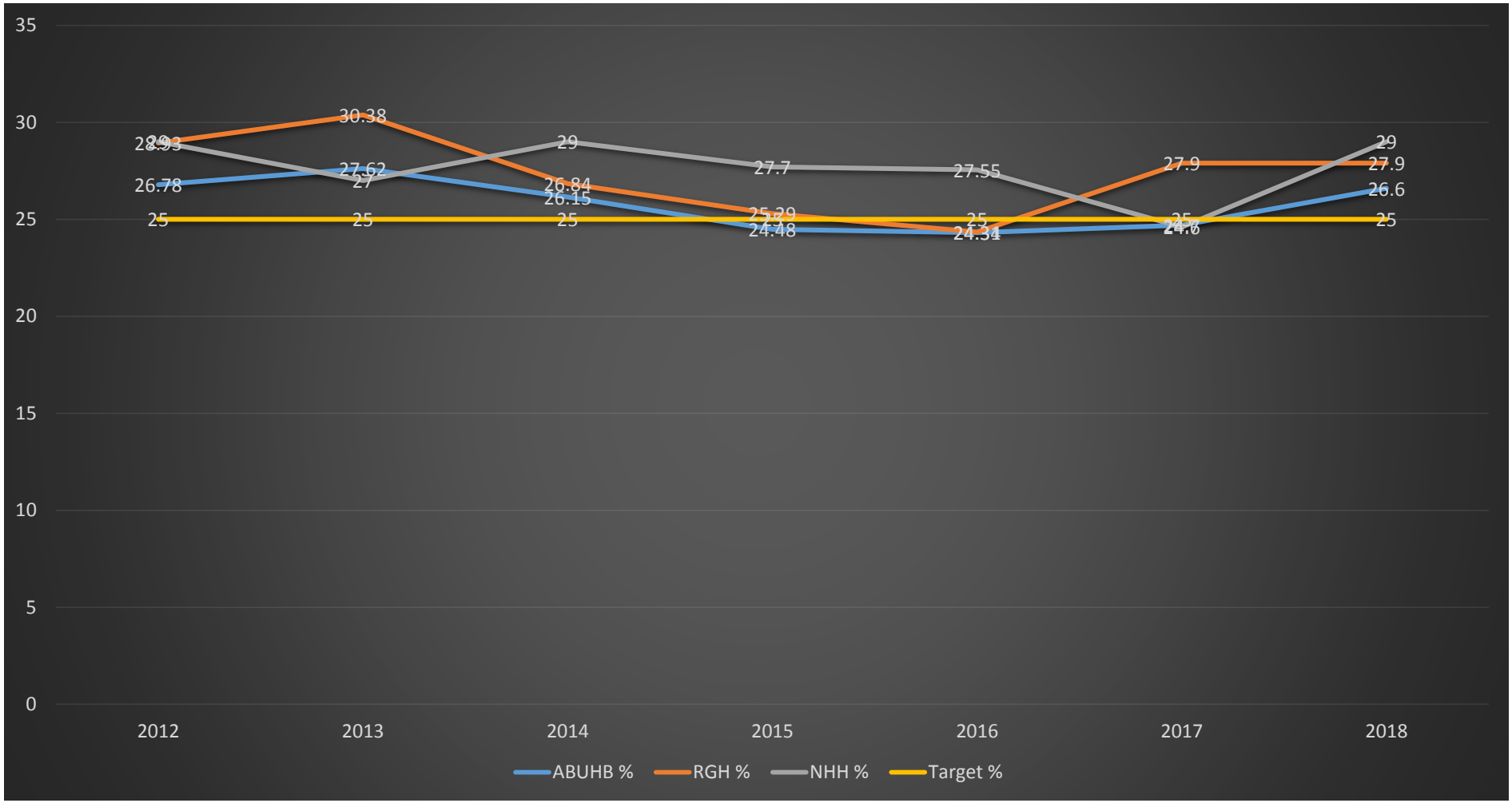
		2017	Goal	Red Flag	Measure	Comment	Data Source	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	Totals	COMMENTS / ACTION THIS MONTH	
	Organisation	Number of Labour Ward Forum	4 pa per site	<4	Minutes		Minutes															complete
Activity	Births	Benchmarked to 6000 per annum	500	525 >550	Births		information	492	444	480	463	471	488	522	527	463	493	485	485	5813	total	
	Home Births Scheduled Bookings	Scheduled Bookings by intended hospital	6600	≥630				8	7	9	5	9	5	5	5	16	10	9	8	96		
					(1st visit) total	Tolerance 15%	information	596	506	569	593	550	492	539	512	557	623	500	475	6512	total	
					Midwifery		information	239	198	193	222	215	173	196	175	261	229	205	211	2517	total	
					Joint care		information	357	308	376	371	335	322	343	337	296	394	295	300	4034	total	
	Instr. Vag Del	Ventouse & Forceps	10-15%	<5%or >20%	Inst Vag D/Birth		MIS	10.10%	7.40%	7.91%	8.40%	8%	9%	10.10%	8.40%	7.10%	8.30%	10.70%	10.70%	8.88%	average	
	Induction of labour		20-22%	26%	UK data		MIS	21%	23.87%	25.00%	28.5%	25.5%	23.1%	24.30%	28.80%	24.10%	25.30%	28.60%	27.20%	25.45%	average	
	C- Section	Total rate (planned & unscheduled)	≤23% -25	≥26%	C-section		MIS	26.80%	26.80%	30.83%	24.40%	27.60%	28.20%	24.52%	28.80%	22.00%	25.90%	26.80%	27.20%	26.65%	average	
		ABHB SSI C/S	5.50%	7%	all wales average	5.50%		9.52%	6%	2.80%	8%	4%	9.00%	2.40%	2.63%						average	
Workforce		Weekly hours of consultant cover on labour ward	>40 hours NHH > 60 hrs RGH	<36 hours NHH <54 RGH	Hours	Per week	Labour ward duty rota															
		Midwifery establishment in line with BR+	less than 3% discrepancy with BR+	more than 10% discrepancy with BR+			HOM															
		Supervisor to midwife ratio	<1.15	>1.20			HOM															
		Sickness m,n,support	≤4%	≥6%		(long and short term MW)	HR	7.24%	6.00%	6.10%	5.00%	5.20%	5.80%	3.38%	3.88%	4.18%	5.46%	8.25%	7.28%	5.65%	average	
		Sickness medical	≤4%	≥6%																	average	
		fetal surveillance training	100%				prac dev															
	Staffing levels	MDT PROMPT comoliance	100%			Review 6 monthly	prac dev															
Clinical Indicators		Eclampsia	<4 in any 2 month period	>4cases in any 2 month period	No. of patients		MIS	0	2	0	0	0	0	0	0	0	0	0	0	2	total	
		ICU admissions in Obstetrics			No. of patients		MIS	0	2	0	0	0	0	1	0	0	1	1	1	6	total	
		Blood Transfusions (4 units of blood)			No. of patients		MIS	0	2	0	1	0	1	1	0	0	0	0	1	6	total	
		Post partum hysterectomies			No. of patients		MIS	0	1	2	1	0	1	0	0	0	0	0	0	5	total	
	Neonatal morbidity	Number of cases of meconium aspiration			No. of patients		info	0	0	0	0	0	0	0	0	1	0	0	1	2	total	
		Number of cases of hypoxic encephalopathy (Grades 2&3)			No. of patients		information	0	0	0	1	0	0	0	0	1	0	0	1	3	total	
	NNU Status	total closure of neonatal units					NNU														total	
		NICU admission >36 weeks	4.50%	5.50%	% of term births	AWNN Network	MIS	1.62%	2%	2.20%	1.94%	1.60%	2.40%	3.40%	5.1	2.5	4.2	3.6	4.1	3%	total	
		Number of SBs / IUDs	5.4	7	per 1000 registered births	AWPM national statistic	MIS	2	5	0	3	3	2	0	2	4	4	2	0	27	total	
		Failed Instrumental numbers	<1%	>3%	Ins Del/Birth		MIS	0%	0.45%	1.60%	1.60%	1.06%	1.29%	0.70%	0.90%	0.64%	1%	1.23%	1.03%	0.115	total	
		Massive PPH 2.5L	<12/ month	15			MIS	1	2	2	1	2	3	2	2	3	0	0	2	20	total	
		Shoulder dystocia	< 4 / month	> 7/ month	resulting in erbs palsy	0.5-1.5 % of Deliveries rcog	MIS	2	10	6	4	4	5	0	4	1	5	8	5	41	total	not resulting in erbs palsy
	Risk Management	3rd degree tear	<5% month	>5%month		RCOG	MIS	1.20%	0.67%	1.87%	0.00%	0.20%	0.61%	0.09%	0.30%	0.86%	1.09%	1.40%	2.06%	0.86%	average	
	Complaints	Number of complaints		>10		threshhold for review	HoM	5	4	3	4	2	2	2	6	5	3	2	3	41	total	
		Closure of total maternity service	<1 per month	>3 times per month			Senior managers	0	0	0	0	0	0	0	0	0	0	0	0	0	total	

MaternityBoard

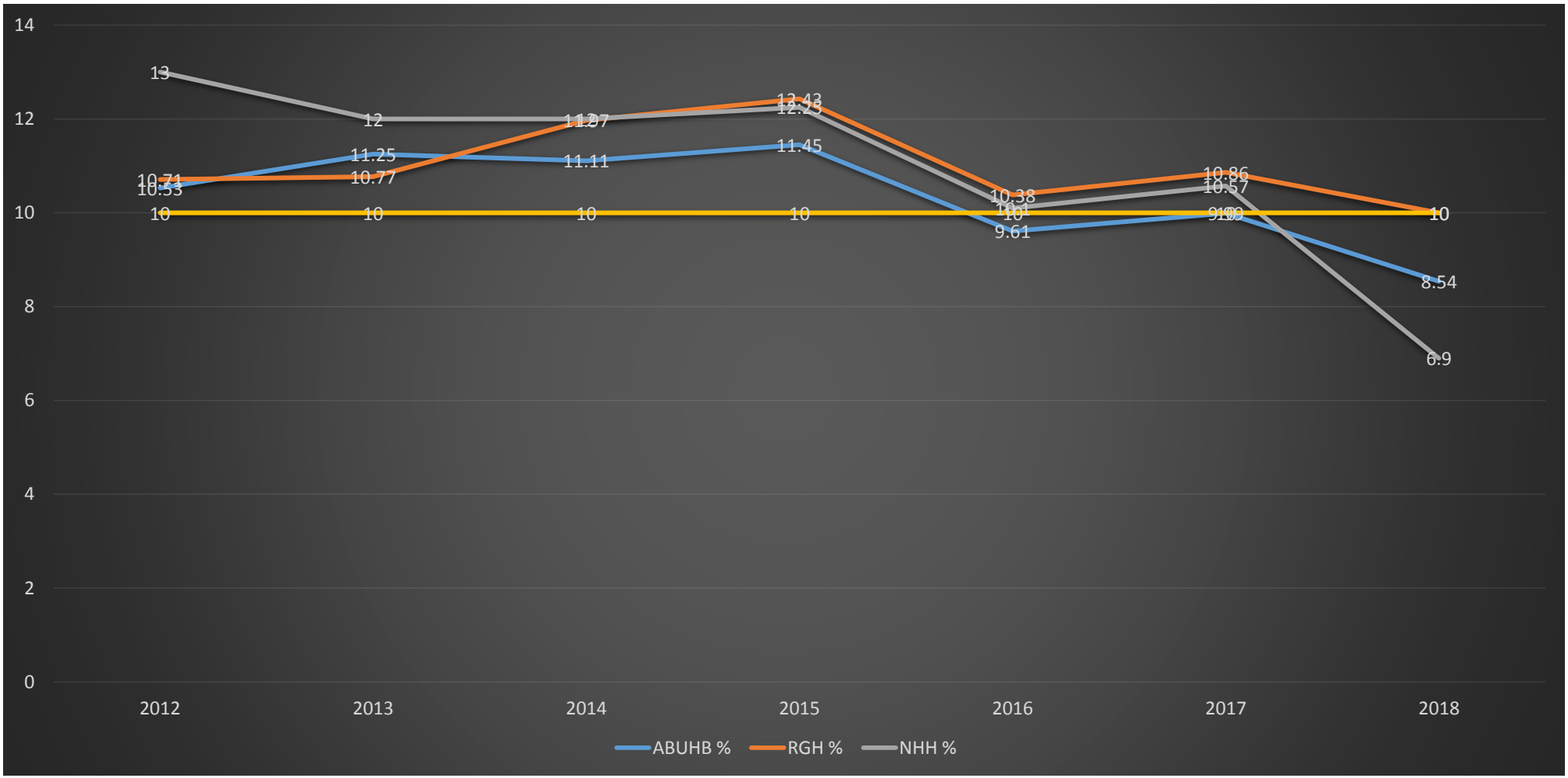
October 2018

	2017	Goal	Red Flag	Measure	Comment	Data Source	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT
Organisation	Number of Labour Ward Forum	4 pa per site	<4	Minutes		Minutes									
Births	Benchmarked to 6000 per annum	500	525 >550	Births		information	492	444	480	463	471	488	522	527	463
Home Births							8	7	9	5	9	5	5	5	16
Scheduled Bookings	Scheduled Bookings by intended hospital	6600	≥630	(1st visit) total	Tolerance 15%	information	596	506	569	593	550	492	539	512	557
				Midwifery		information	239	198	193	222	215	173	196	175	261
				Joint care		information	357	308	376	371	335	322	343	337	296
Instr. Vag Del	Ventouse & Forceps	10-15%	<5%or >20%	Inst Vag D/Birth		MIS	10.10%	7.40%	7.91%	8.40%	8%	9%	10.10%	8.40%	7.10%
Induction of labour		20-22%	26%	UK data		MIS	21%	23.87%	25.00%	28.5%	25.5%	23.1%	24.30%	28.80%	24.10%
C- Section	Total rate (planned & unscheduled)	≤23% -25	≥26%	C-section		MIS	26.80%	26.80%	30.83%	24.40%	27.60%	28.20%	24.52%	28.80%	22.00%
	ABHB SSI C/S	5.50%	7%	all wales average	5.50%		9.52%	6%	2.80%	8%	4%	9.00%	2.40%	2.63%	
Staffing levels	Weekly hours of consultant cover on labour ward	>40 hours NHH > 60 hrs RGH	<36 hours NHH <54 RGH	Hours	Per week	Labour ward duty rota									
	Midwifery establishment in line with BR+	less than 3% discrepancy with BR+	more than 10% discrepancy with BR+			HOM									
	Supervisor to midwife ratio	<1.15	>1.20			HOM									
	Sickness m,n,support	≤4%	≥6%		(long and short term MW)	HR	7.24%	6.00%	6.10%	5.00%	5.20%	5.80%	3.38%	3.88%	
	Sickness medical	≤4%	≥6%												
	CTG RCOG	100%				prac dev									
	Mandatory training	annual >90%	annual <90%		Review 6 monthly	prac dev									
	Eclampsia	<4 in any 2 month period	>4cases in any 2 month period	No. of patients		MIS	0	2	0	0	0	0	0	0	0
	ICU admissions in Obstetrics			No. of patients		MIS	0	2	0	0	0	0	1	0	0
	Blood Transfusions (4 units of blood)			No. of patients		MIS	0	2	0	1	0	1	1	0	0
	Post partum hysterectomies			No. of patients		MIS	0	1	2	1	0	1	0	0	0
Neonatal morbidity	Number of cases of meconium aspiration			No. of patients		info	0	0	0	0	0	0	0	0	1
	hypoxic encephalopathy (Grades 2&3)			No. of patients		information	0	0	0	1	0	0	0	0	1
NNU Status	total closure of neonatal units					NNU	0	0	0	0	0	0	0	0	0
	NICU admission >36 weeks	4.50%	5.50%	% of term births	AWNN Network	MIS	1.62%	2%	2.20%	1.94%	1.60%	2.40%	3.4	5.1	2.5
Risk Management	Number of SBs / IUDs	5.4	7	per 1000 registered births	AWPM national statistic	MIS	2	5	0	3	3	2	0	2	4
	Failed Instrumental numbers	<1%	>3%	Ins Del/Birth		MIS	0	0.45%	1.60%	1.60%	1.06%	1.29%	0.7	0.9	0.64%
	Massive PPH 2.5L	<12/ month	15			MIS	1	2	2	1	2	3	2	2	3
	Shoulder dystocia	< 4 / month	> 7/ month	resulting in erbs palsy	0.5-1.5 % of Deliveries rcog	MIS	2	10	6	4	4	5	0	4	1
	3rd degree tear	<5% month	>5%month		RCOG	MIS	1.20%	0.67%	1.87%	0.00%	0.20%	0.61%	0.09%	0.30%	0.86%
Complaints	Number of complaints		>10		threshhold for review	HoM	5	4	3	4	2	2	2	6	5
	Closure of total maternity service	<1 per month	>3 times per month			Senior managers	0	0	0	0	0	0	0	0	0

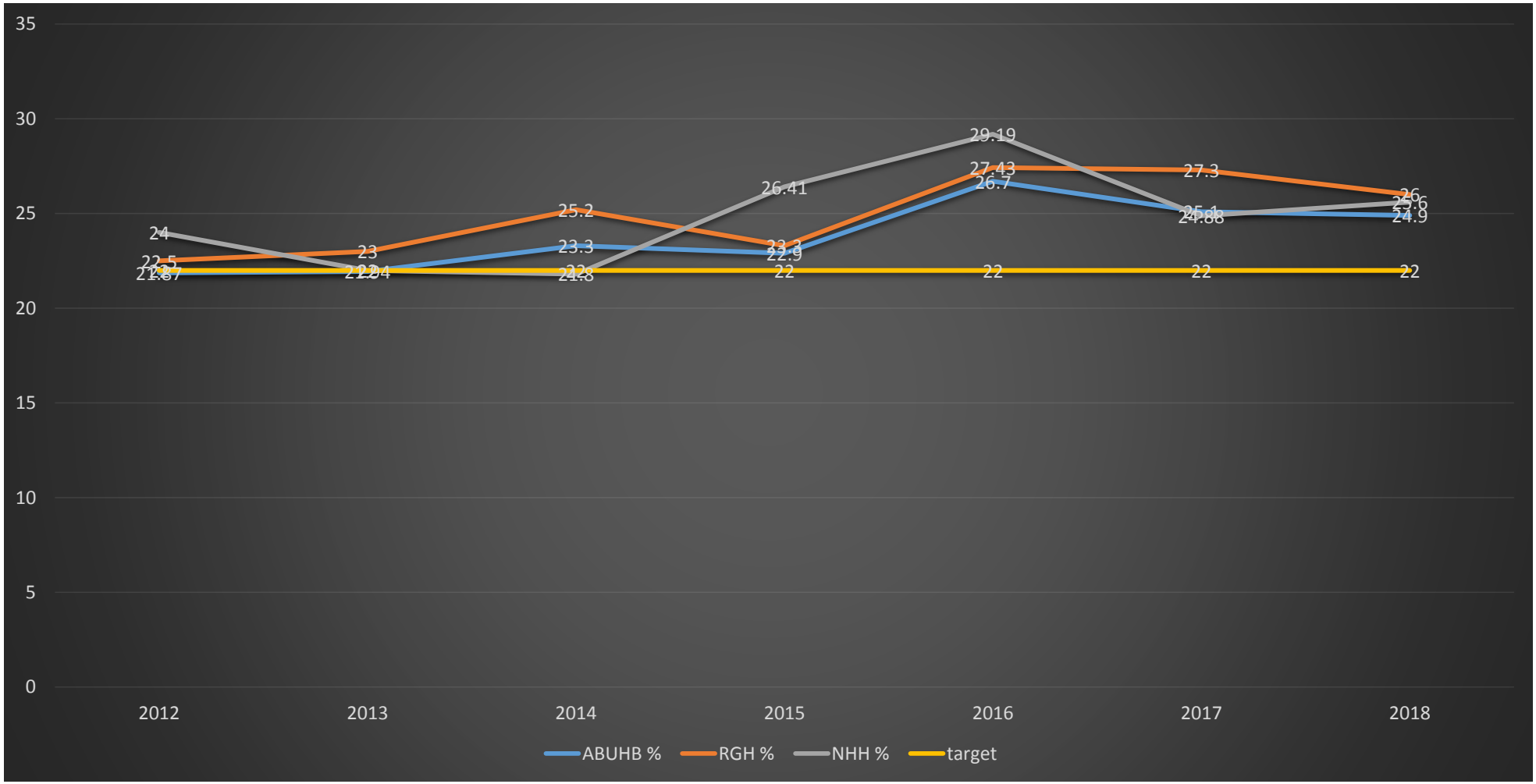
Caesarean section activity



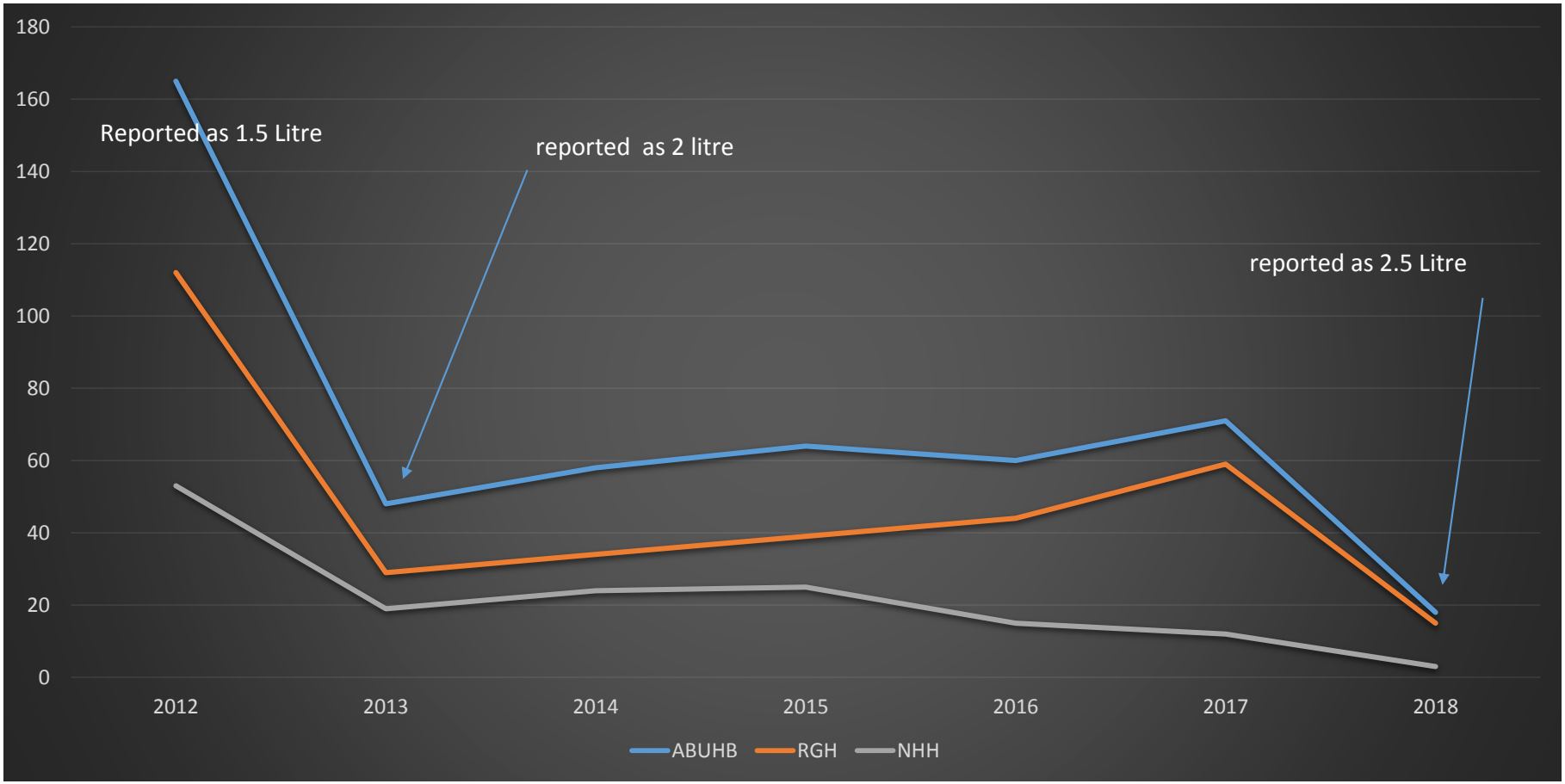
Instrumental birth



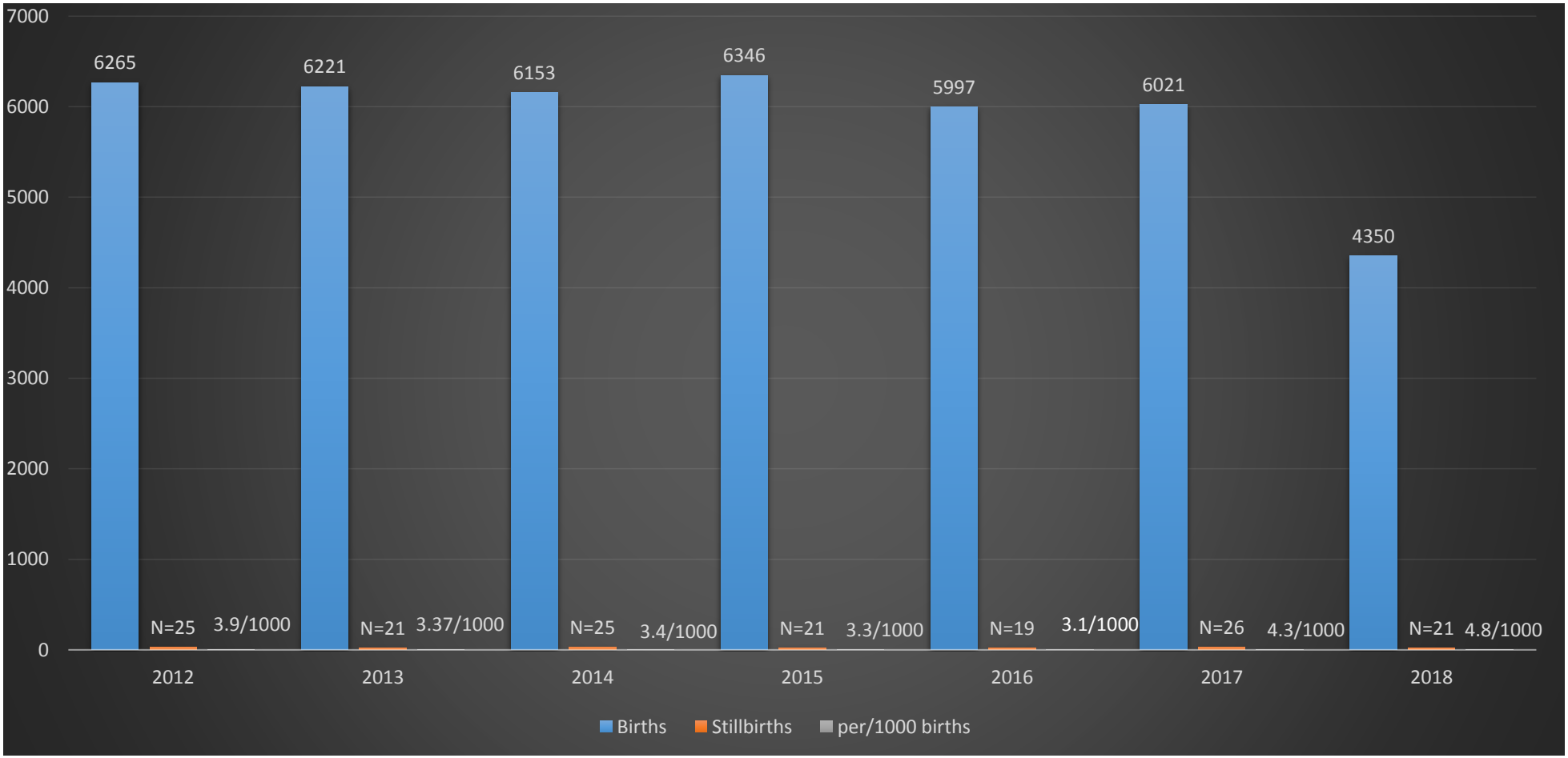
Induction of labour



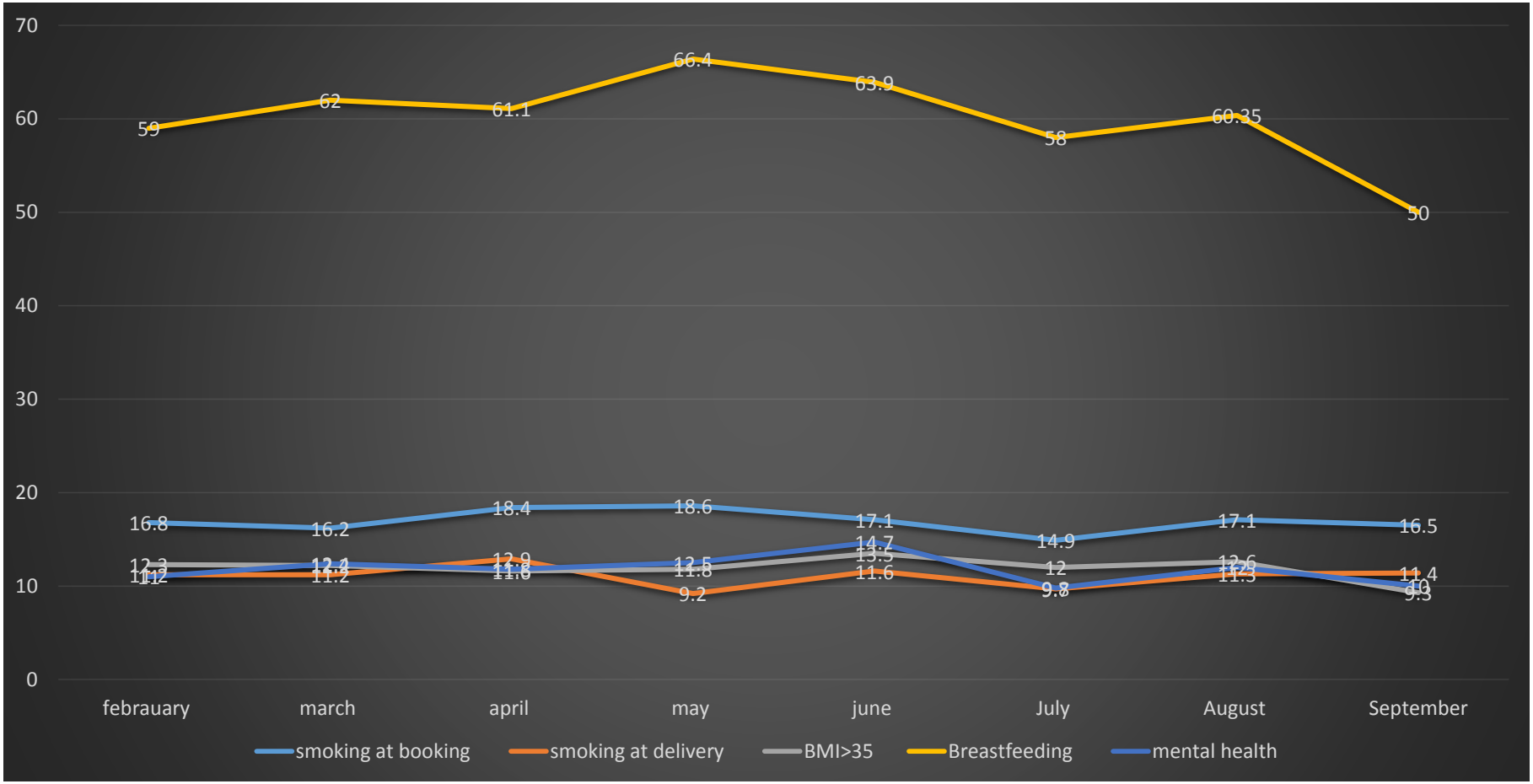
Post partum haemorrhage



Birth and Stillbirth Rates



Public Health Data 2018



Complaints

- SD- concerns raised around community care in the antenatal period, midwife care and attitude, being late, tests results communication
- RB- baby was 4.9 kg concerned that it was not identified that she was having a big baby, should have had a planned c/s, delay in iv antibiotcs discharge process did not identify anaemic
- AD- midwife led care birth midwife attitude
- SL- PN readmission abdominal pain, unlikely retained products, referred to general surgeons and for theatre, delay in theatre due to activity CEPOD, appendicectomy and dx Chrohns. Concern re delay in diagnosis and treatment.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Thursday 7 February 2019 Agenda Item: 3.1

3.1

Aneurin Bevan University Health Board

QUALITY AND PATIENT SAFETY REPORT
FEBRUARY 2019

Executive Summary

Summary of Key Points

The number of deaths and mortality rate have been at the expected levels over the summer period (section 1.1.).

The results of the Annual Report of the National Hip Fracture Database are given in section 2.2. Royal Gwent Hospital has been flagged as an outlier for the casemix adjusted 30 day mortality rate. The 2018 data (in section 3.7) shows an improvement, and this is being monitored monthly. If the improvement is not sustained, an external review of the fractured neck of femur service will be requested.

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

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

There has been a 50% reduction in the average number of pressure ulcers on ABCi collaborative wards (see section 3.4.)

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

Executive Sponsor: Dr Paul Buss, Medical Director			
Report Author: Kate Hooton, Assistant Director			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Quality and Patient Safety Committee]**	**X**
Date of the Report: 05 December 2018			
Supplementary Papers Attached:			

Bwrdd Iechyd Aneurin Bevan Health Board

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

3.1

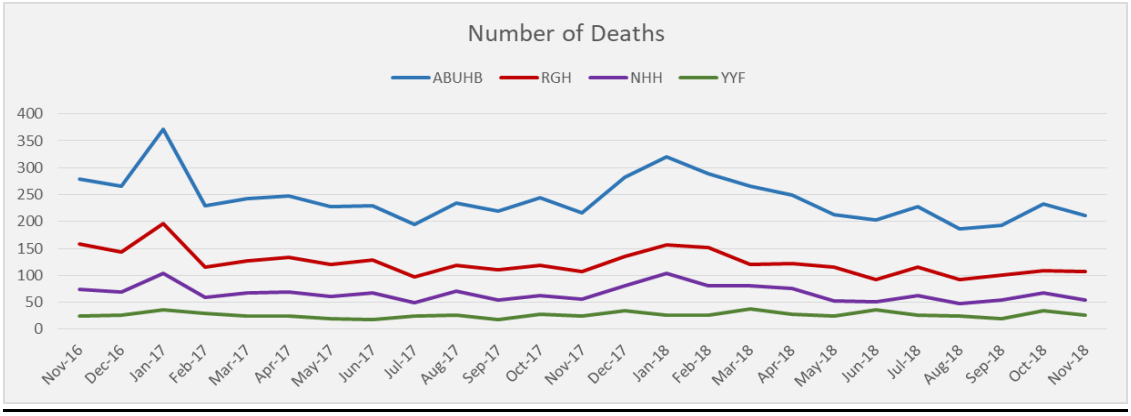
Purpose of the Report
The Quality and Patient Safety Report for the Quality and Patient Safety Committee provides information on the ABUHB main priorities in this area, as set out in the Integrated Medium Term Plan and the Annual Quality Statement. The Quality and Patient Safety Committee is asked to 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 throughout the report can be Welsh Government Targets, or targets set within the Health Board, where there is no Welsh Government Target.

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

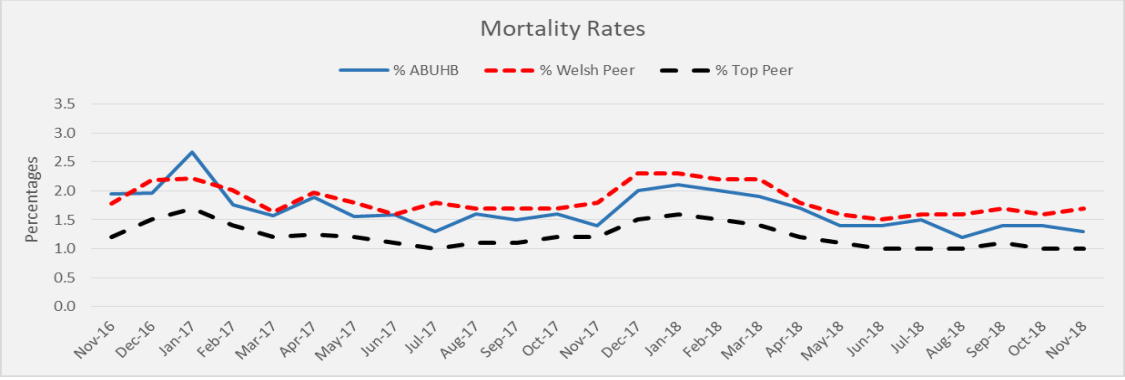
1. High Level Outcomes

1.1 Crude Mortality and Mortality Rate

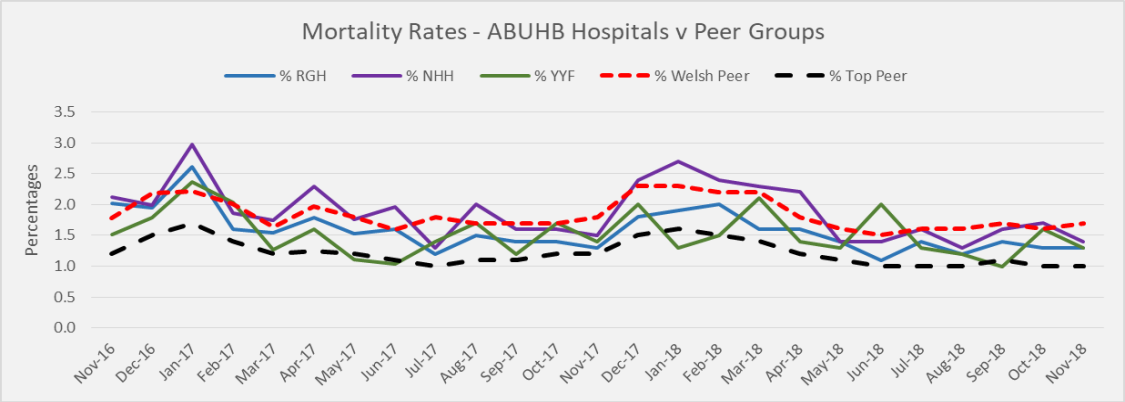
ABUHB and Hospital Crude Mortality Nov 16 – Nov 18



ABUHB Mortality Rate against Welsh Peer and Top Peer Nov 16-Nov 18



Hospital Mortality Rates with Welsh Peer and Top Peer Nov 16-Nov 18



1.2. Narrative on Mortality Data

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

The Crude mortality (number of deaths) in ABUHB and NHH and RGH has decreased steadily since the peak in January 2018, apart from a slight increase in July 2018, whereas YYF has remained relatively consistent.

The ABUHB mortality rate is generally lower than the Welsh Hospitals. The mortality rate for ABUHB has been at the level expected since the last winter, and has decreased steadily since January 2018, apart from a small increase in June and July 2018.

The mortality rate for NHH has been lower than the rate for Welsh Hospitals since May 2018. The mortality rate at YYF has been more variable, as would be expected with the lower number of deaths. It is usually below the rate for Welsh Hospitals, as is the mortality rate for RGH.

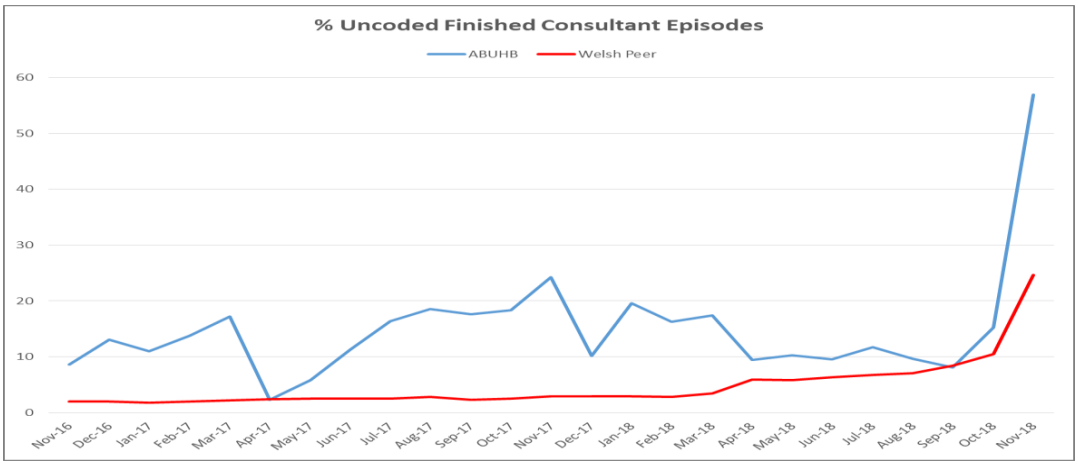
Coding completeness (p5) does not impact on the number of deaths or the mortality rate values. However, it is important for any more detailed analysis of the variation in the numbers or rates, and it impacts on the condition specific mortality rates. The Clinical Coding Department has filled its vacancies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

Completeness of Coding

ABUHB Coding Completeness (24 January 2019, CHKS):

June 18	90.7%
July 18	88.5%
Aug 18	90.6%
Sept 18	92.5%
Oct 18	88.2%
Nov 18	69.0%

Uncoded Finished Consultant Episodes Nov 16 - Nov 18



2. Surveillance and Review

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

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

2.1 Mortality Review

Percentage Completion of Mortality Reviews –The Welsh Government plan is that, when, in line with the recommendations of the Shipman review, the Medical Examiner role is introduced, the Medical Examiner will undertake the first level of the mortality review. This is part of their role, as they agree the cause of death with the responsible medical team and high light any concerns they have about care from their review of the clinical record. They also talk to the relatives of the deceased person to ensure that they agree with the cause of death and were happy with the care provided. The Health Board will undertake a more in depth, second level review into any deaths that the Medical Examiner highlights. The new role will be introduced from April 2019 on a non-statutory basis for deaths in acute hospitals. It has recently been proposed that the Medical Examiners and the Medical Examiner Officers who support them, will be employed by Shared Services.

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

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

	Jan 18	Feb 18	Mar 18	April 18	May 18	Jun 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Total
No. Reviewed	161	107	111	128	143	128	139	129	150	165	93	50	1502
2nd Stage Review	11	11	10	10	12	16	12	12	17	13	16	5	145
Total Deaths	309	254	264	247	212	200	221	182	172	218	187	252	2718
% Reviewed	52%	42%	42%	52%	67%	64%	63%	71%	87%	76%	50%	20%	55%

Learning from Mortality Reviews – The last meeting of the Mortality and Harm Review Group identified the completion of DNACPR forms as an issue in the notes that have been reviewed recently. In particular, it was felt that in some cases, a DNACPR had not been completed because of the views of the family, although the clinician knew that any attempt to resuscitate the patient would be futile. A letter will be sent out with an example of a situation where a DNACPR form should have been completed, and some links to advice about having difficult conversations. It was agreed that the Group would also send out a letter on Advance Care Planning in the New Year.

There was also an example of a patient deteriorating on the Green Ward, but not being transferred back to an acute ward. It was felt that the Green Ward was not the right environment for a patient at the end of their life.

2.2 National Clinical Audit (NCA) – NATIONAL HIP FRACTURE DATABASE

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.

As a Health Board we aim to participate in all the NCAs on the Welsh National Clinical Audit and Outcome Review Programme 2018-19. However, there are 3 NCAs that we do not participate in, and a small

number where case ascertainment is lower than required. More information will be included in the next Quality report to QPSC. The results of one of these National Clinical Audits are included in this report. The results of all the National Clinical Audits are now being reported to the Quality and Patient Safety Operational Group.

The National Hip Fracture Database Annual Report 2018 was published in November 2018, covering the period 1.1.17-31.12.17. The Royal Gwent Hospital and Nevill Hall Hospital both participate in the audit, and in 2017 there was good case ascertainment on both sites (426 patients for RGH and 283 patients for NHH).

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. The evidence based standards in the audit are taken from NICE guidance.

Based on the 2017 data, the RGH has been highlighted as an outlier for the case mix adjusted 30 day mortality rate. This is the rate that takes into account for example, the age and co-morbidities of the patients, so that the rates can be compared across hospitals. The RGH crude mortality was 9.2% and the adjusted mortality was 10.8%.

Based on the 2017 data, Nevill Hall Hospital has a higher than expected case mix adjusted 30 day mortality rate and registers as an "alert" requiring further investigation and an examination of data quality. The NHH crude mortality was 9.5% and the adjusted mortality was 11%.

In the light of the improvement in the RGH 30 day mortality rate in the 2018 data (see section3.7), it has been agreed that the data will be monitored on a monthly basis. If the improvement is not sustained, then ABUHB will ask for an external review of its fractured neck of femur service.

Generally, Welsh Services as a whole compare poorly with the UK averages for the NHFD. This has been the case for a number of years, and to address this in ABUHB actions have been taken to improve the care and outcome for patients with a fractured neck of femur at RGH and NHH, these include:

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

In summary:

RGH has improved in 11 out of the 20 standards compared to last year. It is in the top quartile for the overall audit in 4 standards and in the bottom quartile for 11 standards.

NHH has improved in 5 out of the 20 standards compared to last year. It is in the top quartile for the overall audit in 3 standards and in the bottom quartile for 8 standards.

The detailed results for the National Hip Fracture Database are shown below, for RGH and NHH compared to the Welsh Average and then the UK average.

Much of the improvement at the RGH has come from the appointment of an Orthogeriatrician for the fractured neck of femur service, which has driven improvements in the ward based assessments. There has been an Orthogeriatrician in post at NHH for a number of years, and therefore the improvements to these processes had already been made. A detailed action plan is being developed to further improve the ward based assessments, and also to ensure that patients with a fractured neck of femur get to the ward as quickly as possible, and that surgery takes place on the day of or day after admission.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Quality & Patient Safety Committee
Thursday 7 February 2019
Agenda Item: 3.1

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									
	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

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3. Optimising Care Delivery

3.1. Deteriorating Patient/Sepsis – ABC Sepsis

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

The Collaborative's outcome measures are:

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

The process measure for the collaborative is:

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

3.1.1. Review of Results from ABC Sepsis

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

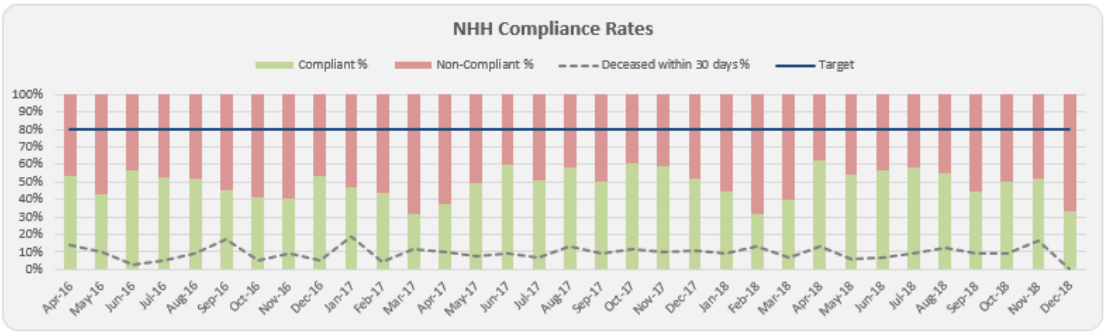
While the ABC Sepsis process is bedding in on the wards at NHH and RGH, the data for the wards is taken form the Outreach databases for NHH and RGH and from ABC Sepsis database for YYF wards.

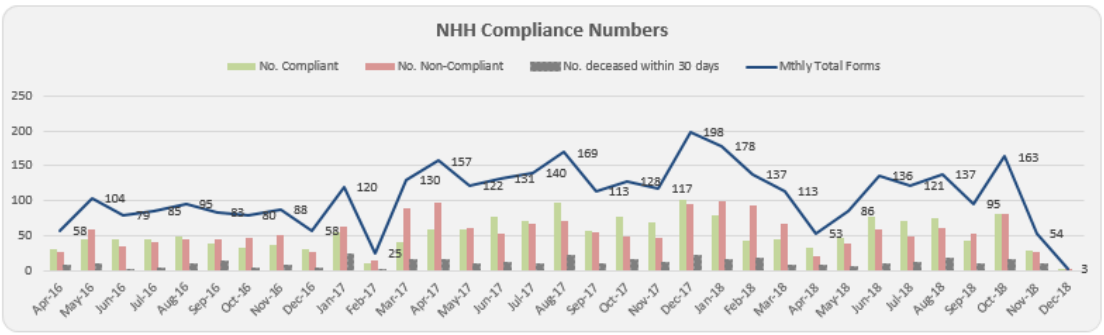
The data for the Emergency Departments is all from the ABC Sepsis database. It should be noted that ABC Sepsis applies the criteria for compliance with the sepsis 6 bundle within 1 hour robustly.

DATA ENTRY FOR NHH IS NOT UP TO DATE FROM NOVEMBER 18 DUE TO STAFF SICKNESS BUT THIS IS NOW BEING ADDRESSED, ALTHOUGH THE MOST RECENT DATA IS BEING ENTERED FIRST.

Emergency Departments:

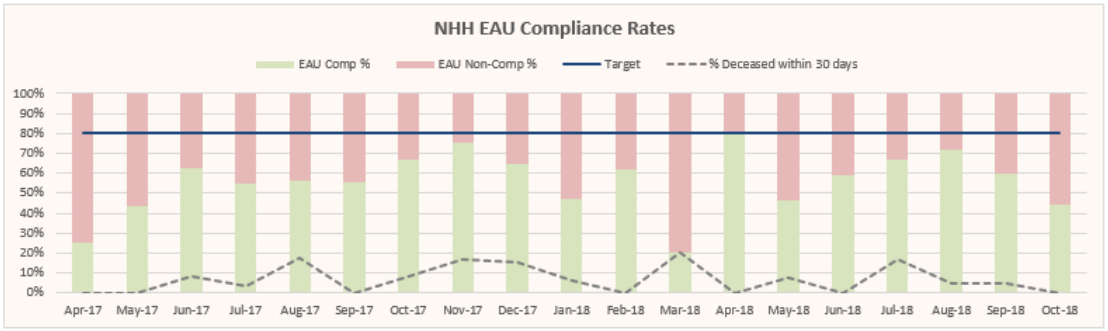
***Nevill Hall Hospital A and E*:** The number of forms at NHH has been maintained over the summer. It has increased into the winter period, but compliance has dropped off. This is being addressed within the department, through discussion with the nurses about completing the form with all the necessary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

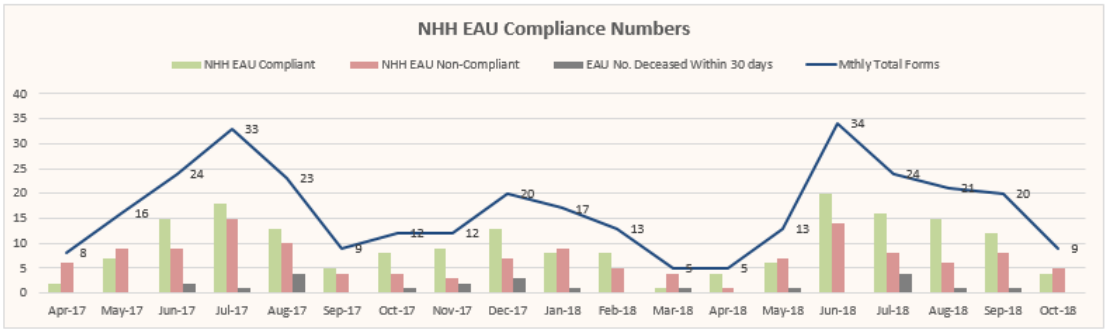




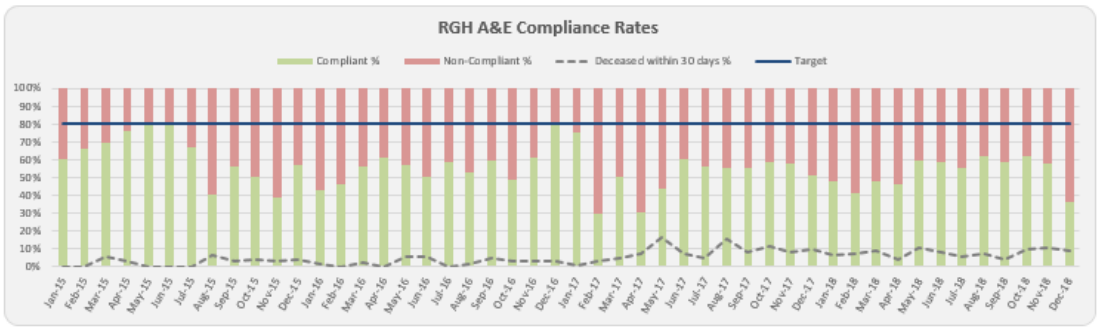
For those patients not given the sepsis 6 within 1 hour, the bundle is usually completed within 1-2 hrs, which is still good care. The factors that are barriers to the completion of the bundle vary at NHH, but it is usually a delay in the prescription of antibiotics.

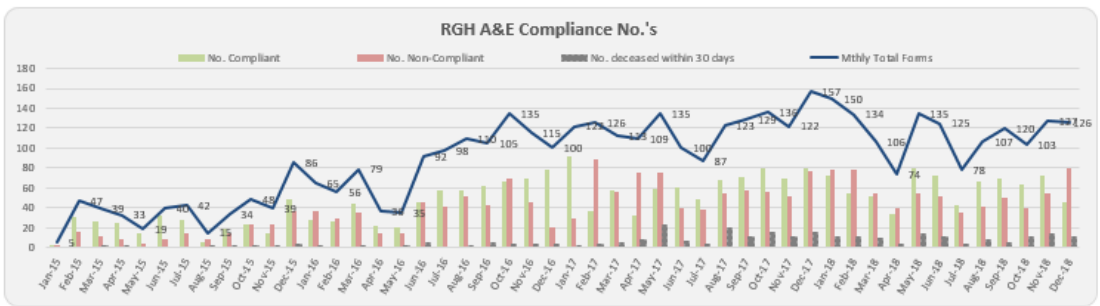
EAU at NHH is now engaged with ABC sepsis. Both the recognition and response to sepsis have improved in the department, and the DRIPS meetings are well attended.



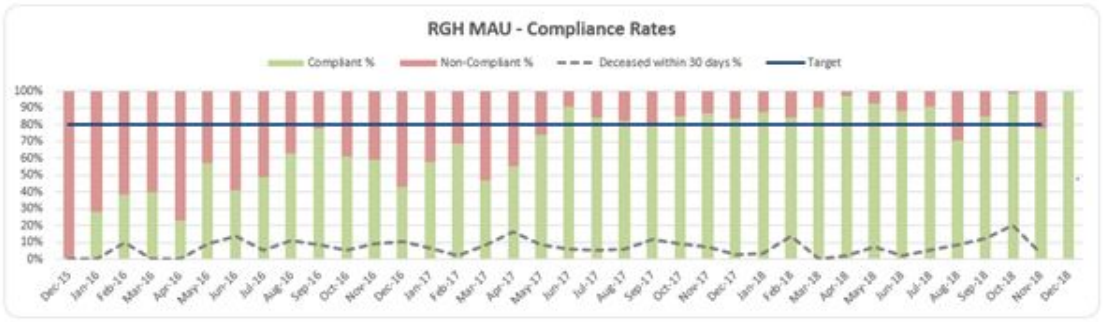


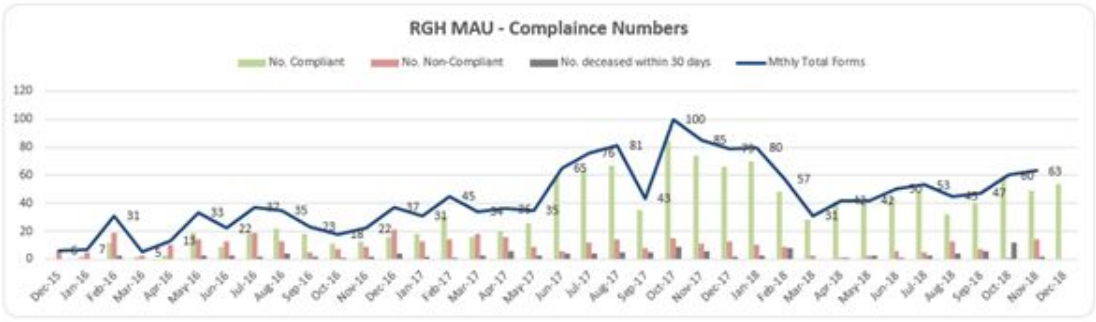
***Royal Gwent Hospital A and E*:** The number of forms from RGH A and E has been high over the summer. The department has shown full participation in the sepsis meetings, and compliance has improved since the winter period. However, this has been challenging to maintain as the winter period has begun.





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



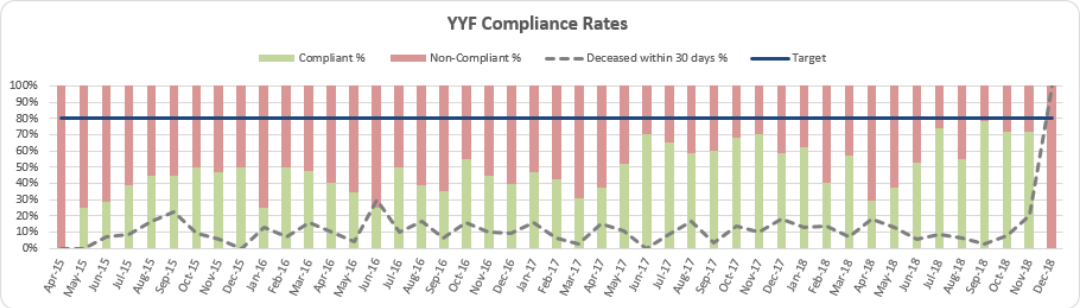


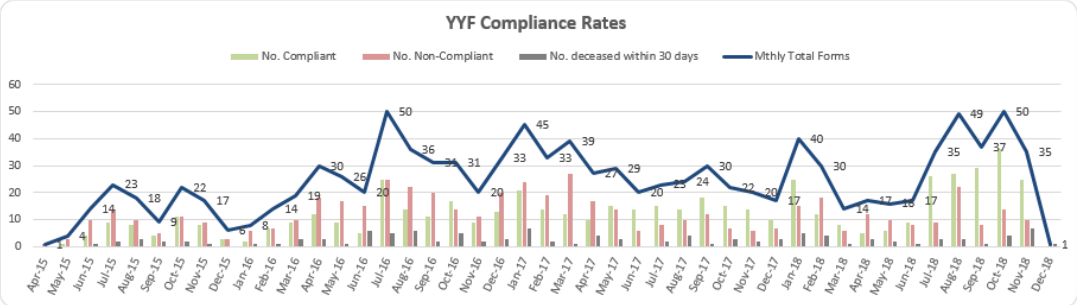
Ysbyty Ystrad Fawr**:** ABC Sepsis covers the whole of YYF, wards and Emergency Department. The Vital Pac Pilot started at YYF in September 2017, and the ABC Sepsis Team have worked closely with the IT Staff so that the system supports the recognition of deteriorating patients on the wards

Since the Vital Pac pilot started, the number of patients recognised with sepsis has decreased. This is thought to be due to different trigger points in the original set up of vital pac, which has now been rectified. There was an increase in cases for January and February 2018, but this dropped off again through the Spring, and compliance with the sepsis 6 bundle also decreased.

This decrease was escalated to the Divisions. They have undertaken focussed work to ensure that the Health Care Support Workers are fully trained on taking physiological observations. Pilot work is now underway on one ward to improve compliance with the frequency of observations required by the Policy. A Senior Nurse has been working at YYF to support this area of practice. Senior Medical Staff are feeding back to Junior Doctors when antibiotics have not been prescribed for patients who have triggered for sepsis. A half day workshop on the Deteriorating

Patient and Sepsis took place at YYF in September 2018. The number of forms and compliance has now improved and this has been maintained.





Community:

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

Wards at NHH and RGH:

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

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

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

Vital pac has been rolled out across the wards at NHH, with the introduction planned using the learning from the roll out at YYF.

3.1.2. ABC Sepsis Steering Group

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

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

The Peer Review Team action plan covered five areas: Structure and process to co-ordinate all the elements of acute deterioration, moving towards a Core Site Safety Team 24/7, improved focus on Acute Kidney Injury, Continued learning from vital pac and a more integrated approach to training on acute deterioration across the whole of ABUHB. The action plan is being reviewed with the Divisions, and will be finalised by the end of February.

3.2 Reducing C Diff and Healthcare Associated Bacteraemia

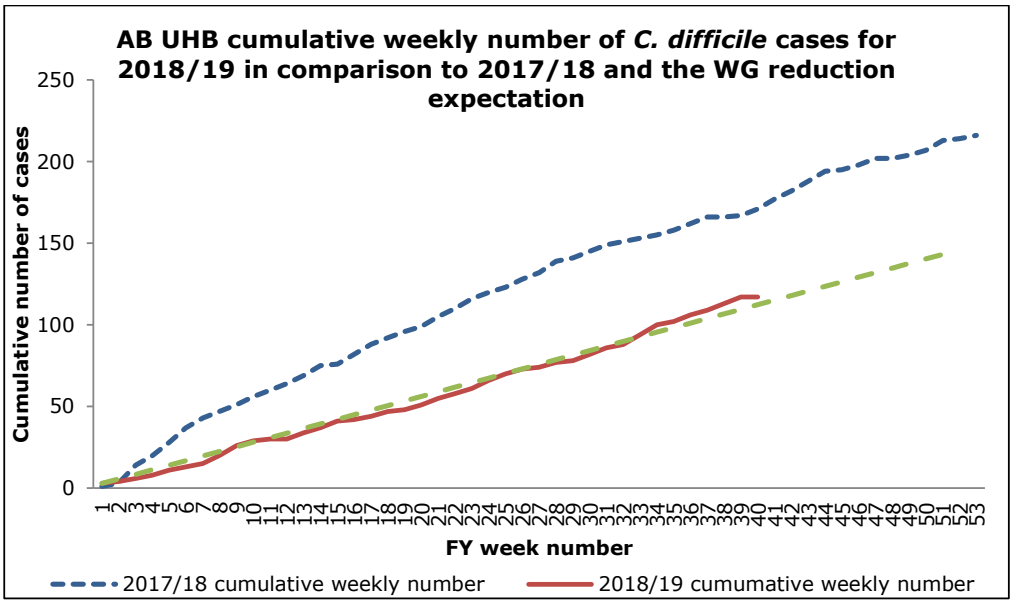
Aim: Welsh Government 2018/19 HB reduction target for C *difficile*, Staph *aureus (MRSA and MSSA)* and E*Coli* bacteraemia are:

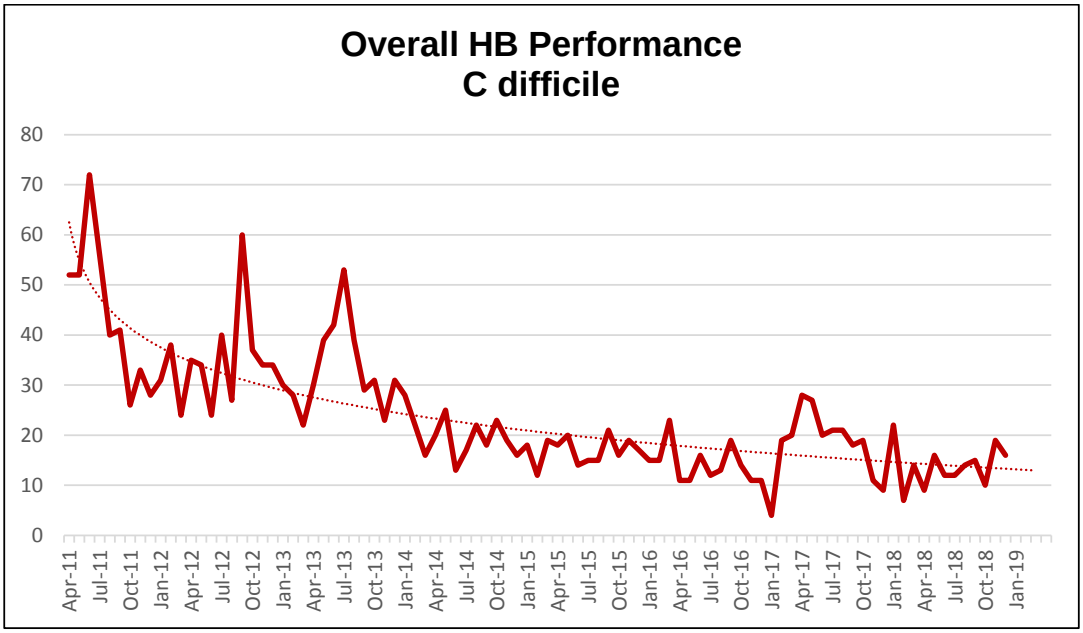
- **C difficile - 25 per 100,000 population**
- **Staph aureus – 19 per 100,000 population**
- **E Coli – 61 per 100,000 population**

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

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

3.2.1. Total C diff. Cases



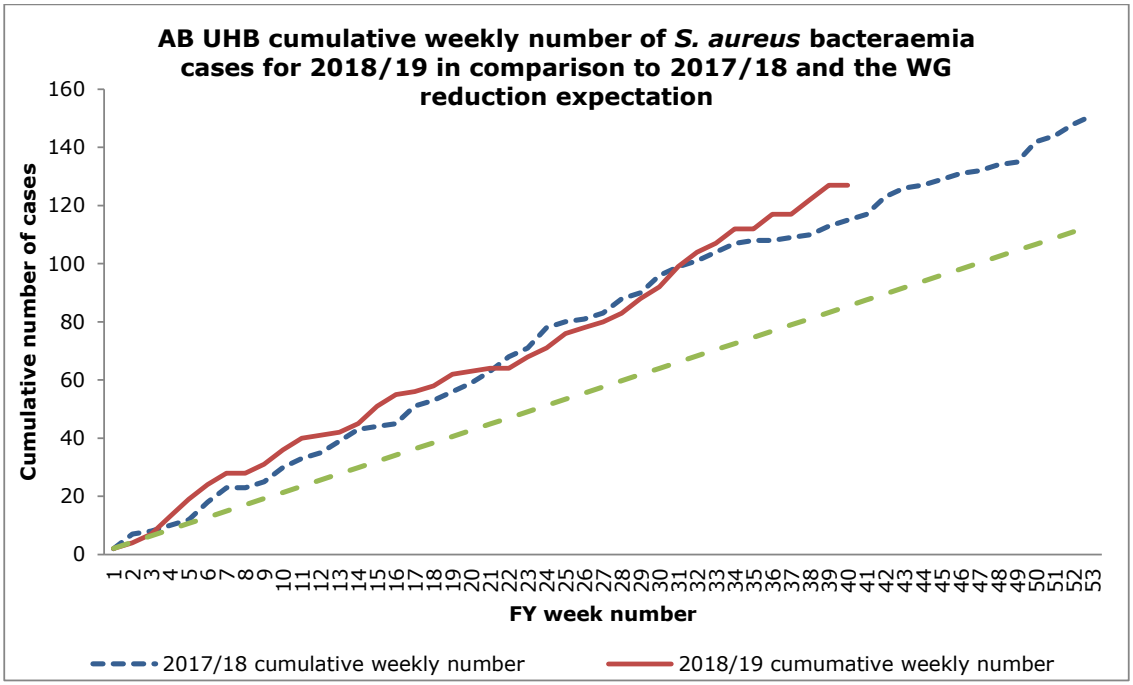


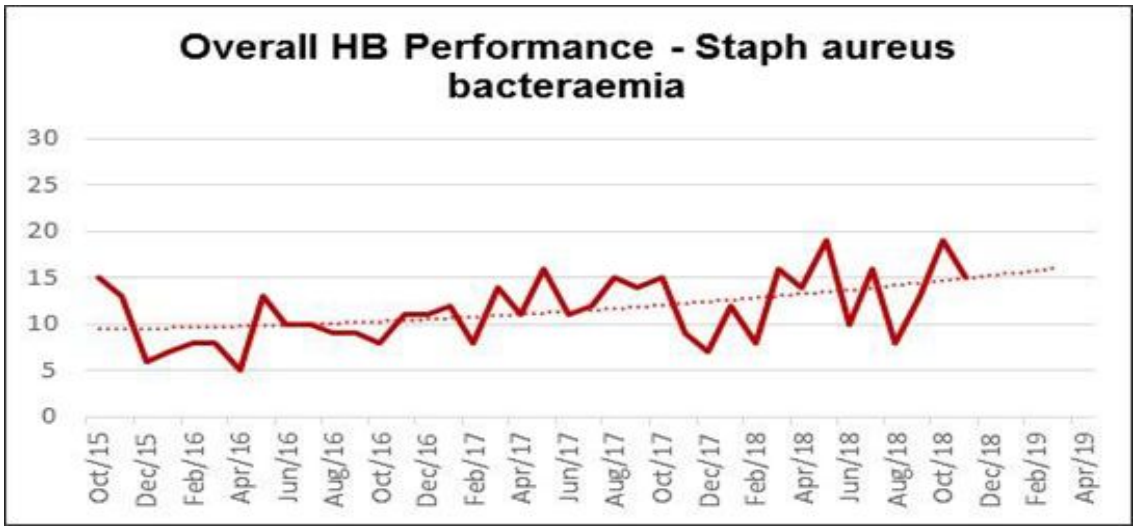
Good progress has been made in relation to C.difficile but the Health Board is just above the number of cases to achieve the required reduction. The Health Boards strategy to reduce cases is heavily reliant on hospital cleans using Hydrogen Peroxide Vapour (HPV).

A second important intervention relates to antibiotic guidelines. A change of guidelines utilising co-trimoxazole as the broad spectrum antibiotic of choice was introduced in Cardiff & Vale and Cwm Taff UHBs approximately 2 years ago - with what appears to be positive results. This change in antibiotic use was discussed at ABUHB Infection Control Committee at the time but the proposal was rejected.

The situation has been reviewed by the ABUHB Antimicrobial Working Group and guidelines as introduced by Cardiff and Vales and Cwm Taff have been agreed and launched. If the guidelines are implemented with a tight programme of close monitoring, there is an expectation that it will have a positive effect on C.difficile rates.

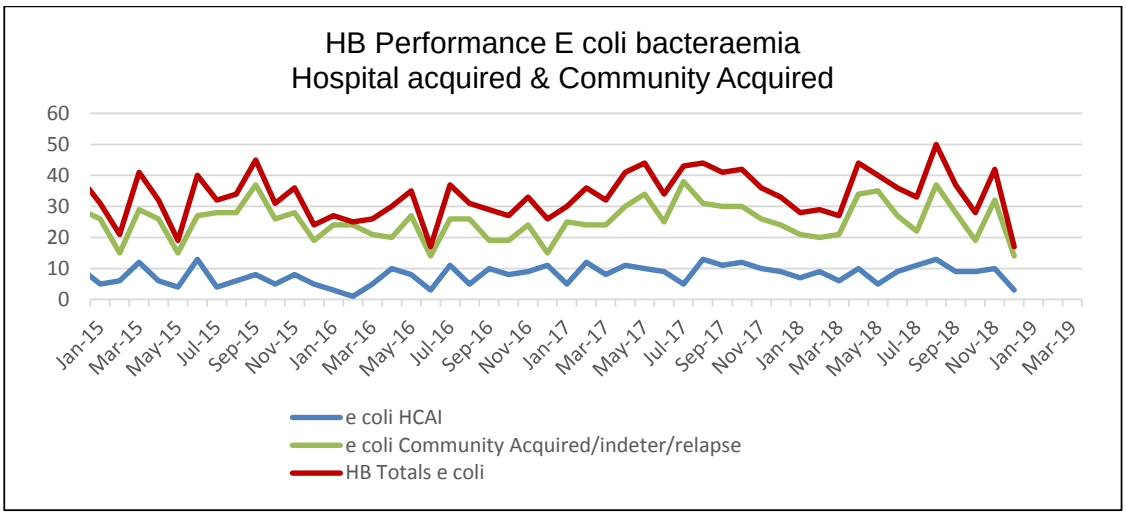
3.2.2. Total MRSA and MSSA Cases

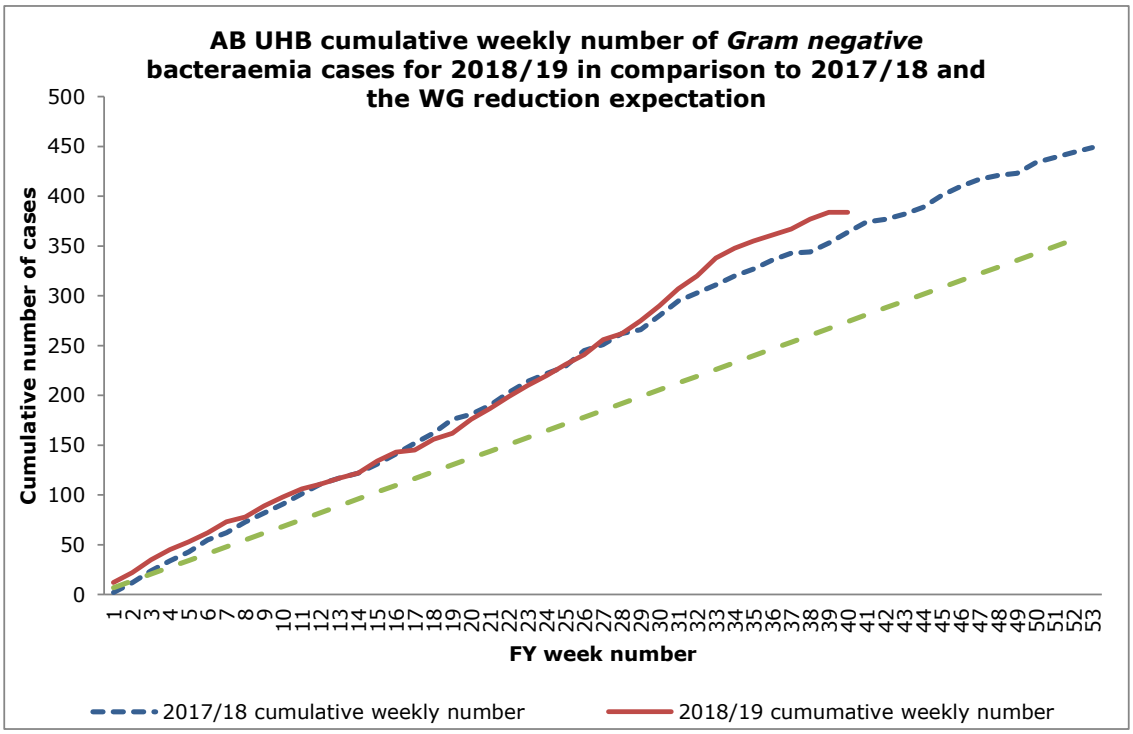




Hospital acquired staph aureus blood stream infections are associated with poor IV line and urinary catheter management. The infection prevention team has heavily invested time in educating, auditing and monitoring such devices with some success.

3.2.3. E Coli





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

Public Health Wales is monitoring Health Boards closely for appropriate urinary tract infection and urinary catheter management in Primary Care

as there is a clear evidence base in which to take this agenda forward. Antimicrobial pharmacy will play a key role in the appropriate management of urinary tract infections (UTIs) in Primary Care. Public Health Wales have provided comprehensive standards in relation to UTI prevention and management.

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

Individual case reviews for EColi in hospital have commenced but not enough reviews have been undertaken to establish any common themes. Community acquired EColi reviews have not started because no antimicrobial pharmacy resource is available until the new Consultant pharmacist post has been filled.

3.2.4. Klebsiella – Number of cases

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

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

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

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

3.2.5. Pseudomonas *aeruginosa* – number of cases in

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

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

3.2.6. Prescribing Performance

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

- A 50% reduction in the number of E. coli bacteraemia cases by March 2021 against a baseline rate of 2015–2016.
- An overall reduction in inappropriate prescribing of antimicrobials of 50% by 2021.

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 % of the 3 specified antibiotics (Quinolones, Cephalosporin, Co-amoxiclav) as a % of all antibacterial items	Grand Total	6.2%	Oct 2018	6.1%	6.4%	
		Blaenau Gwent East	7.8%		6.2%	6.5%	
		Blaenau Gwent West	4.8%		5.1%	5.4%	
		Caerphilly East	6.6%		6.2%	6.5%	
		Caerphilly North	6.2%		5.9%	6.2%	
		Caerphilly South	6.1%		6.1%	6.4%	
		Monmouthshire North	8.6%		7.5%	7.9%	
		Monmouthshire South	6.8%		6.9%	7.3%	
		Newport East	4.8%		6.4%	6.8%	
		Newport North	6.6%		6.2%	6.5%	
		Newport West	5.0%		4.6%	4.9%	
		Torfaen North	5.6%		5.9%	6.2%	
		Torfaen South	5.6%		5.6%	5.9%	

Prescribing: The latest reported position as at Oct 2018 was reported as 6.2% which is a variance of -.2% compared to the same period the previous year. 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 Group sent out a HAT Newsletter across ABUHB to disseminate the data on HATs by specialty and to re-inforce the key messages about preventing VTE and correct thromboprohylaxis.

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

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

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

3.4 Pressure Damage

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

A pressure ulcer reduction collaborative is in place targeting wards on the Royal Gwent Hospital site. Learning sessions have focussed on PDSA cycles based on evidence based pressure ulcer reduction guidelines. The number of wards in the collaborative has increased from 12 to 19 – Nevill Hall wards are now included.

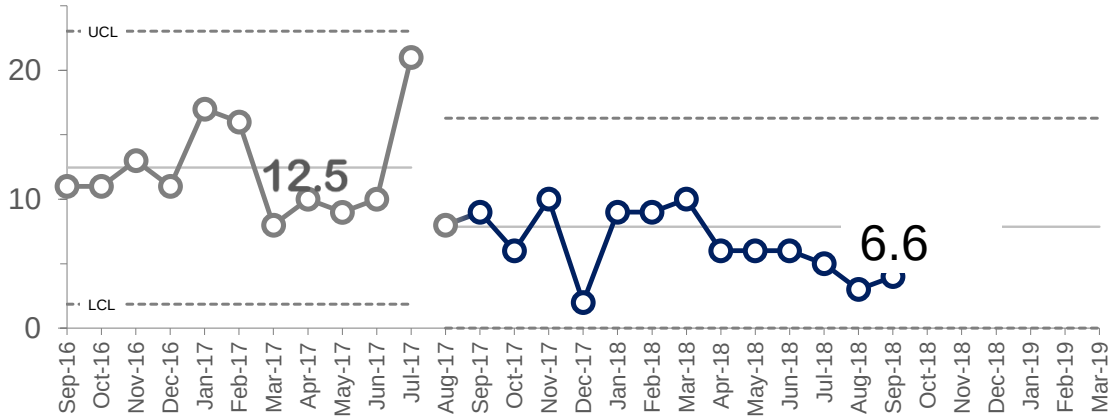
All grade 3 &4, and unclassified pressure damage is systematically reviewed in all settings, with learning from the review taken back to the wards/Nursing Homes. The responsibility for reviews is in the process of transfer to divisions - with oversight by Corporate Nursing.
Significant investment has been made in pressure relieving mattresses, with use monitored to ensure at risk patients receive the most appropriate mattress at the right time.

Data cleansing is in place to ensure that Pressure Ulcers are not double counted and classification is accurate. Review of access to the Tissue Viability Service now ensures that significant pressure damage is reviewed by a member of the team in all settings. The numbers of

pressure ulcers (all grades) are now reported to Welsh Government on a monthly basis.

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

Total number of HAPU incidences on MAU, ED, ITU, C4W, C5W and C7E (C chart)
Demonstrating a 50% reduction in the average number of pressure ulcers on ABCi collaborative wards



Next Steps to Maintain a reduction trajectory.

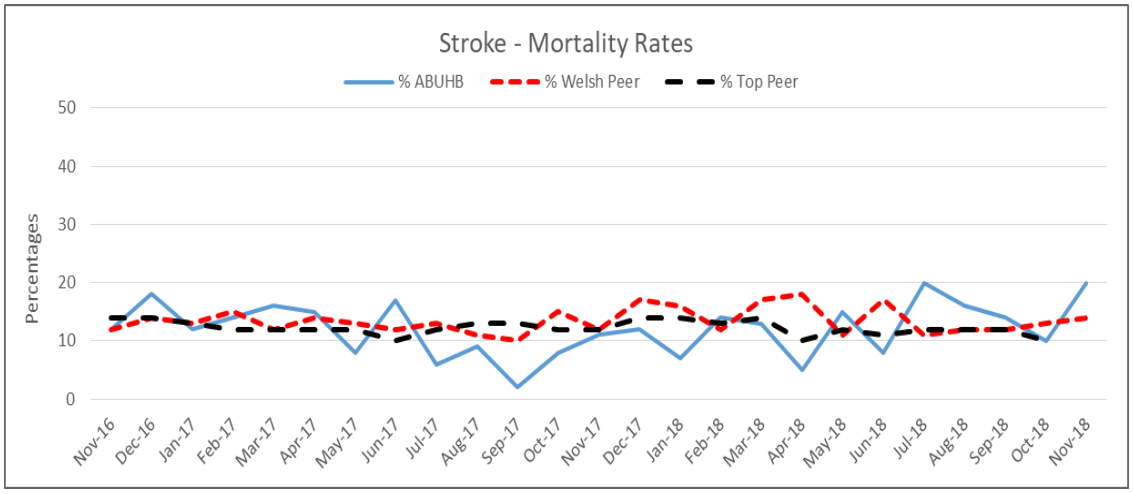
- Embed the systematic review of pressure damage into core services in the acute sector
- Phased approach to embed the systematic review of pressure damage across the care home sector.
- Development of new Dashboard system to make data available from the ward to the Board along with other health board quality and patient safety metrics.
- The use of technology using hand held scanners to assess a patients risk from pressure damage
- Review of Tissue Viability Education across the Care Home sector

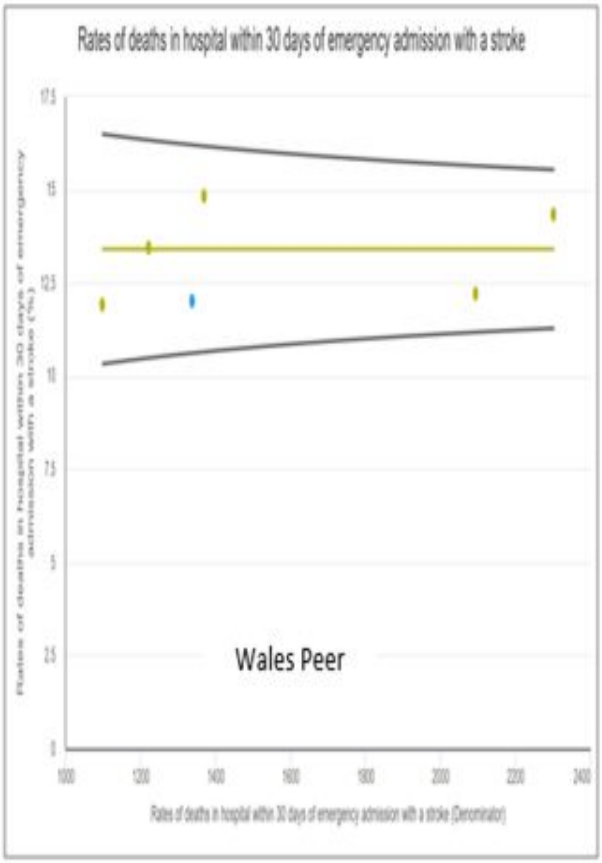
Bwrdd Iechyd Aneurin Bevan Health Board

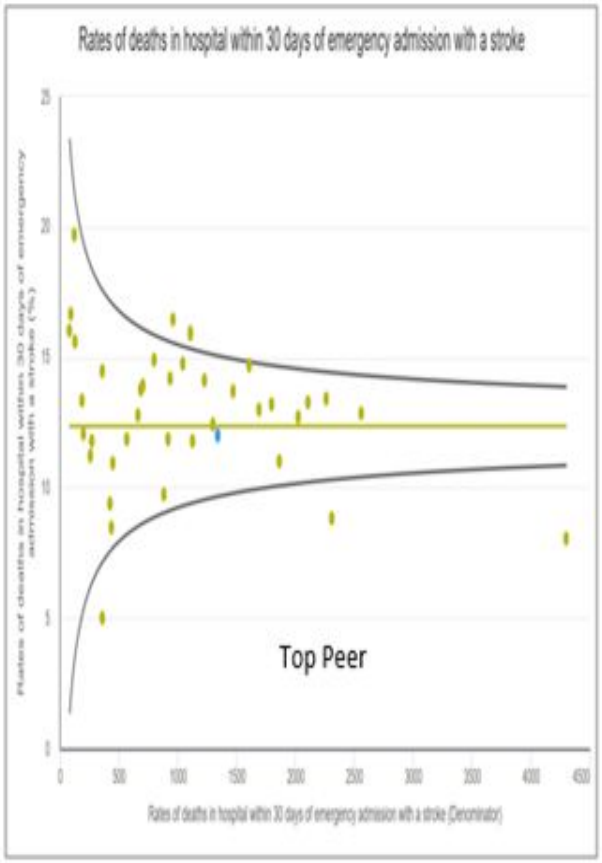
Quality and Patient Safety Report
Quality and Patient Safety Committee
Agenda Item: 3.1

3.1

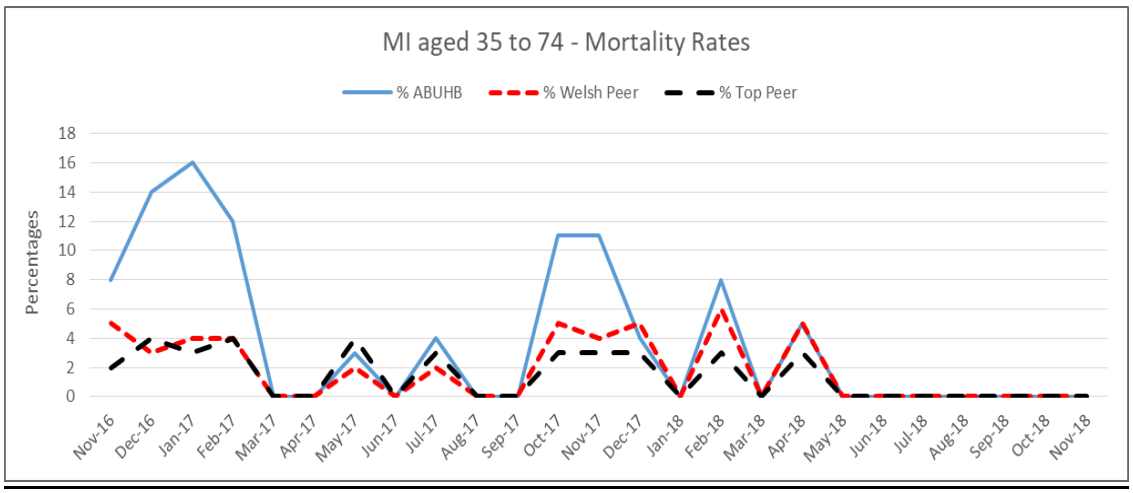
3.5 Stroke Care - Stroke 30 day mortality against Top Peer

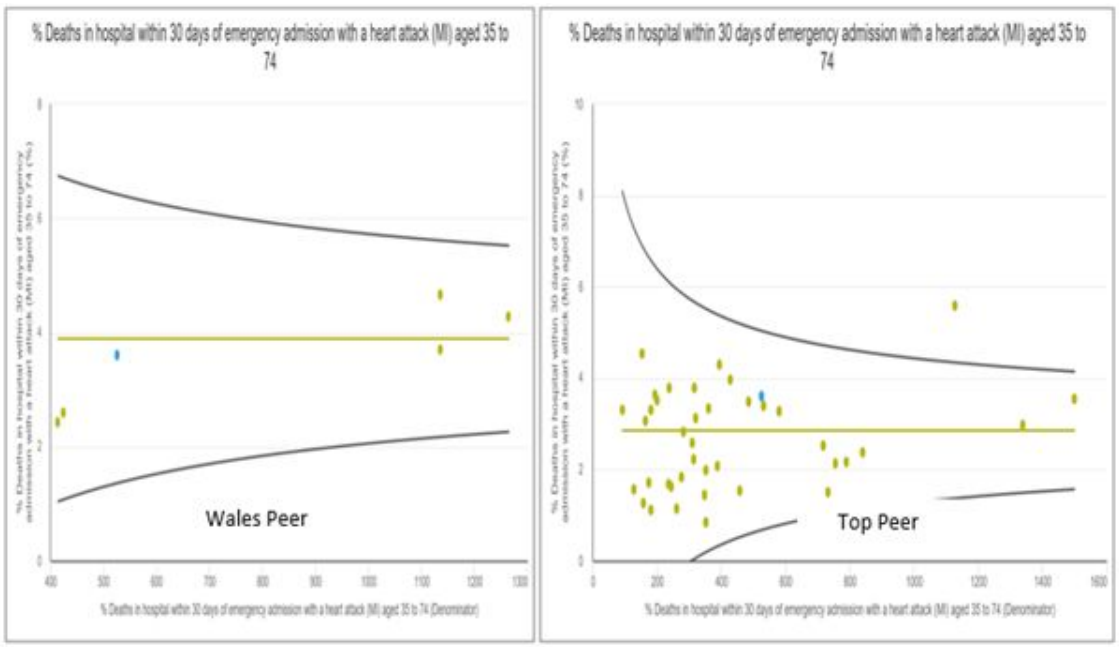






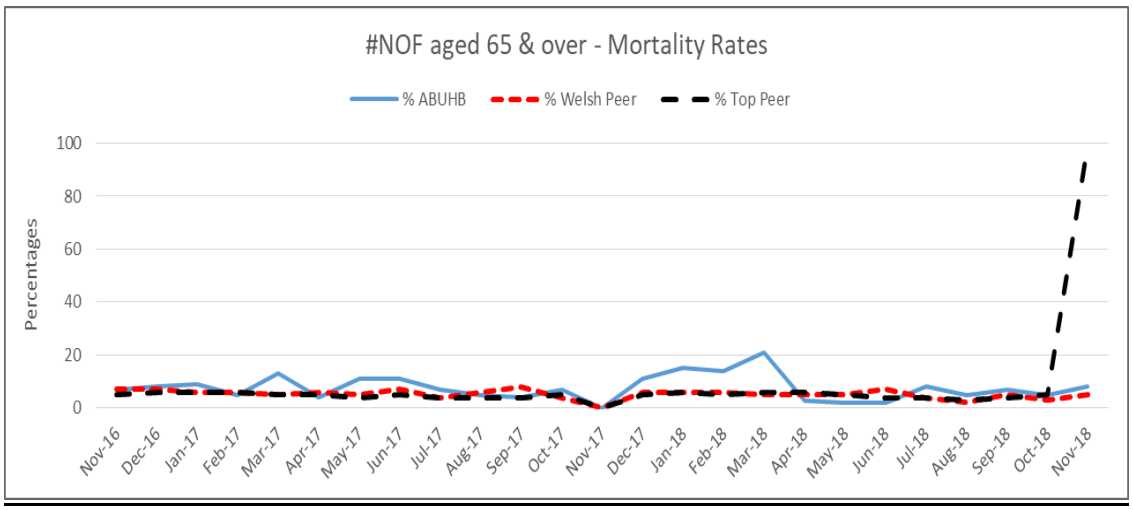
3.6 Myocardial Infarction 30 Day Mortality Ages 35-74 against Top Peer

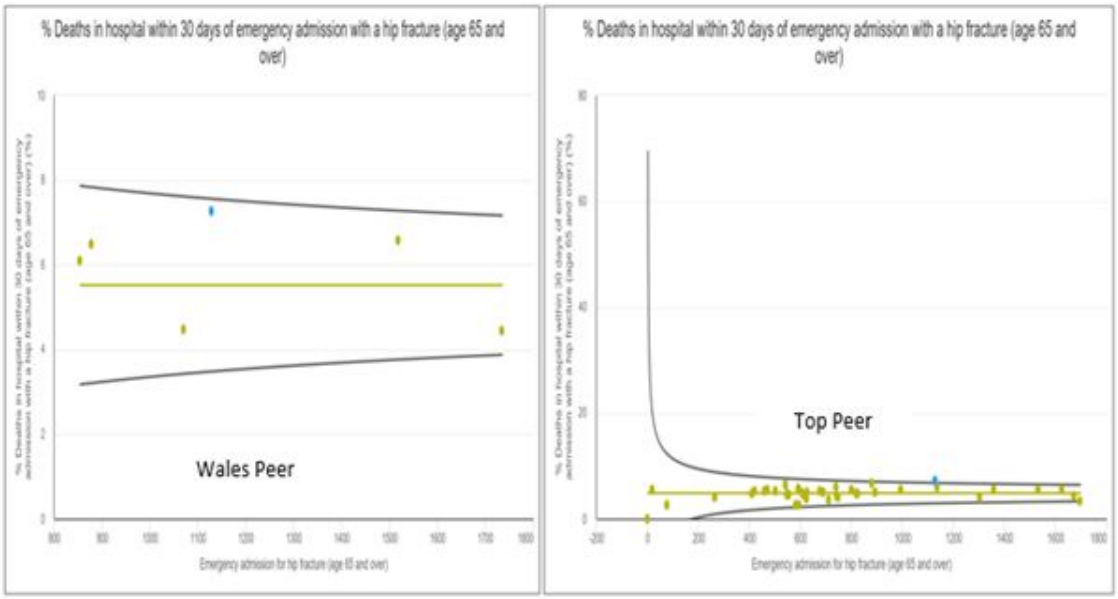




The CHKS data for this measure is under review because of the 6 month period with no deaths. It will therefore either be corrected or another measure substituted in the next report.

3.7 Fractured Neck of Femur 30 Day Mortality against Top Peer





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

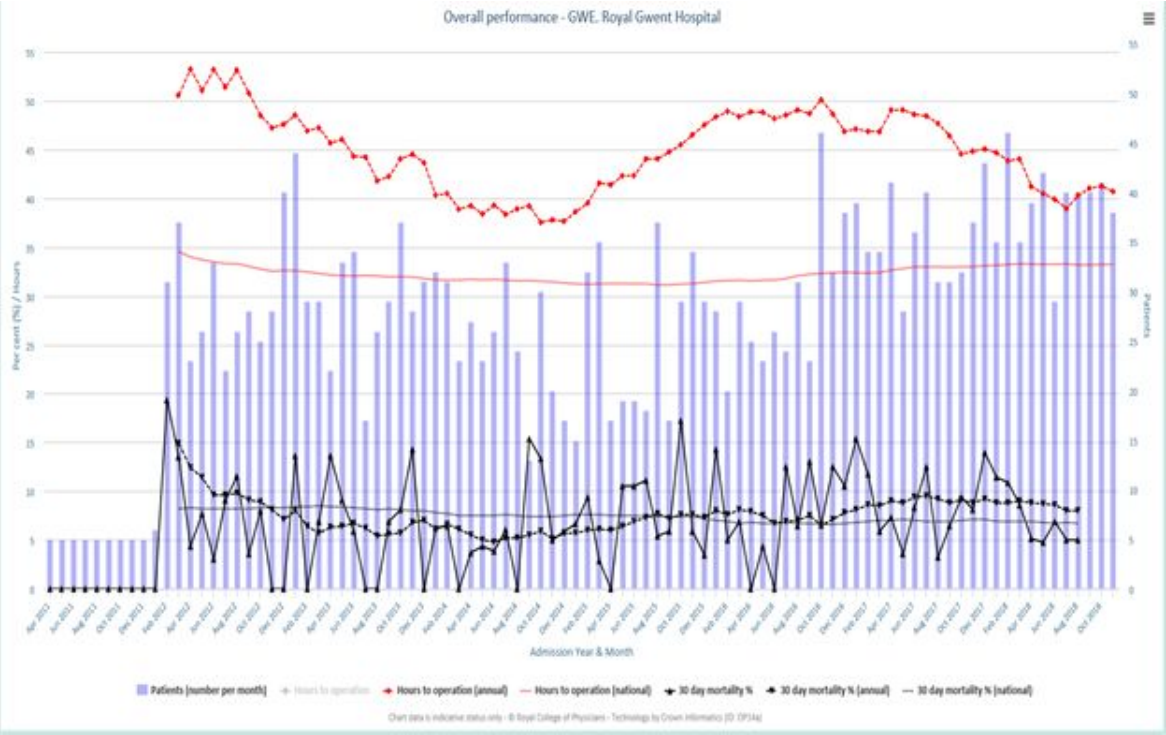
The RGH Adjusted Mortality Rate has been highlighted as an outlier in the 2018 annual report on the 2017 data in the National Hip Fracture Database. The adjustment increases the mortality rate for RGH from 9.2% to 10.8%. A number of changes have been made to the structure of the service and

the fractured neck of femur process during late 2017 and early 2018 and more recent data is showing a reduction in the mortality rate at RGH. This will be monitored on a monthly basis. If the improvement is not sustained, then ABUHB will ask for an external review of the fractured neck of femur service.

The detailed results of the NHFD for RGH and NHH in the Annual Report for 2018, based on 2017 data, are given in section 2.2.

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

RGH National Hip Fracture Database Results



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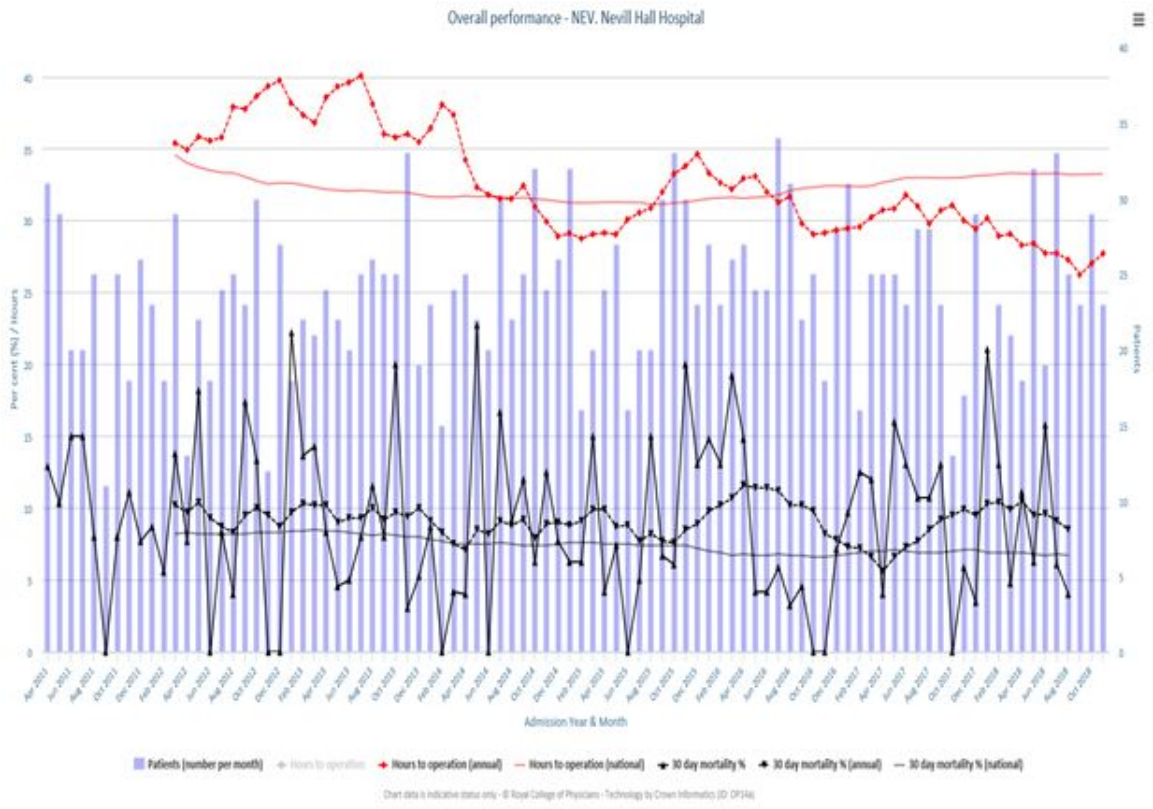
KPI overview: GWE. Royal Gwent Hospital

Annualised values based on 460 cases averaged over 12 months to the end of November 2018.

1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
94.1%	49.1%	79.8%
NHFD overall: 90.3%	NHFD overall: 69.2%	NHFD overall: 74.5%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
77.1%	78.2%	75.7%
NHFD overall: 80.7%	NHFD overall: 69.8%	NHFD overall: 70.4%

NHH National Hip Fracture Database Results



KPI overview: NEV. Nevill Hall Hospital

Annualised values based on 289 cases averaged over 12 months to the end of November 2018.

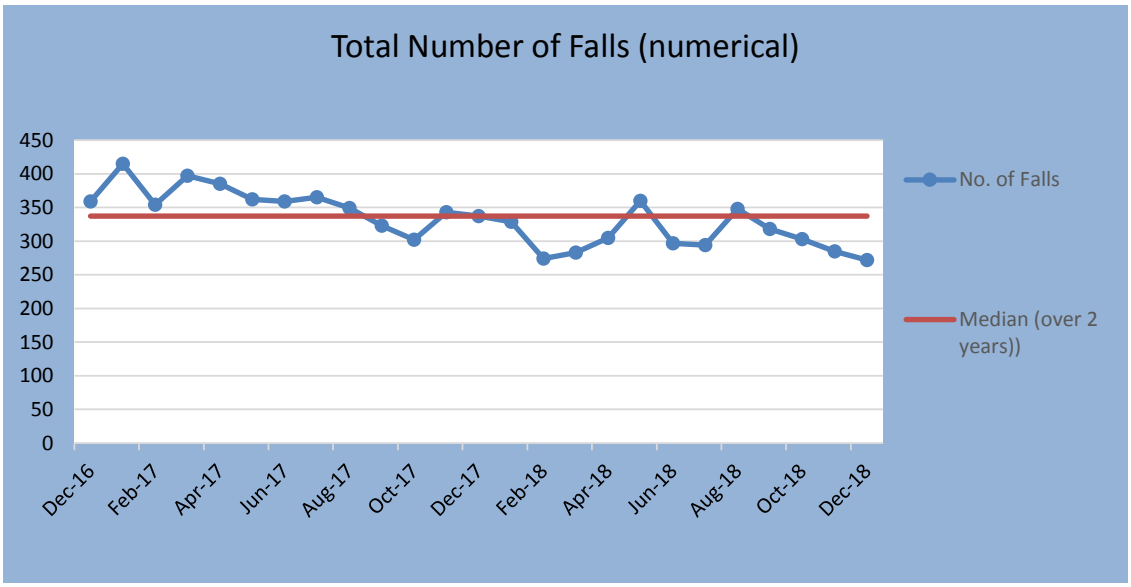
1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
93.4%	76.8%	70.1%
NHFD overall: 90.3%	NHFD overall: 69.2%	NHFD overall: 74.5%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
79.6%	72.5%	75.0%
NHFD overall: 80.7%	NHFD overall: 69.8%	NHFD overall: 70.4%

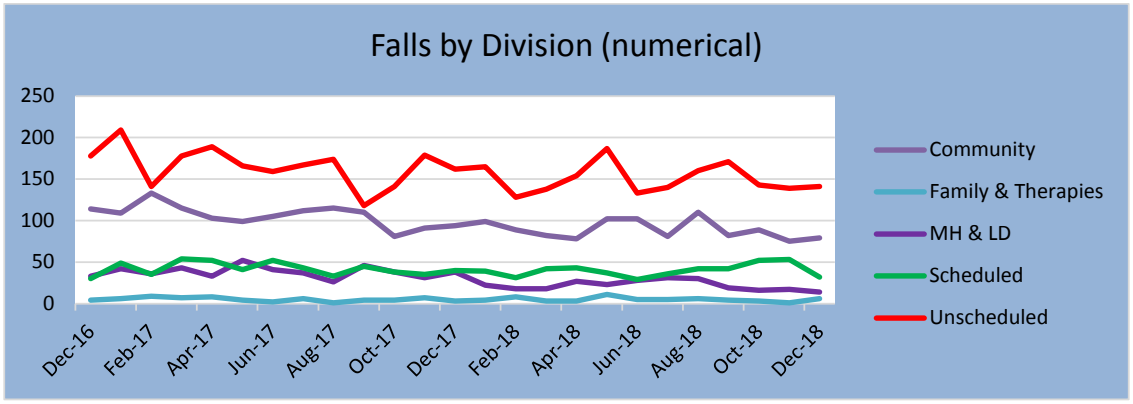
3.8. Preventing Falls

3.8.1. In-patient Falls Data

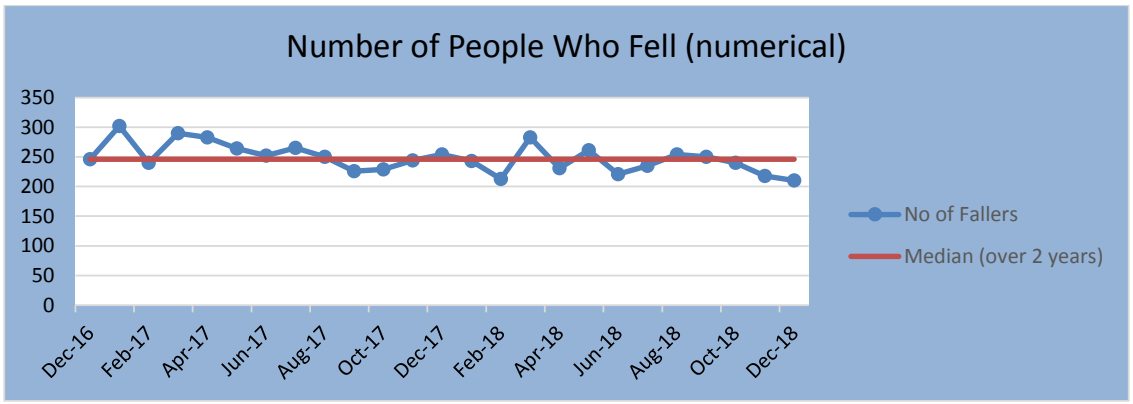
ABUHB Total Number of Falls



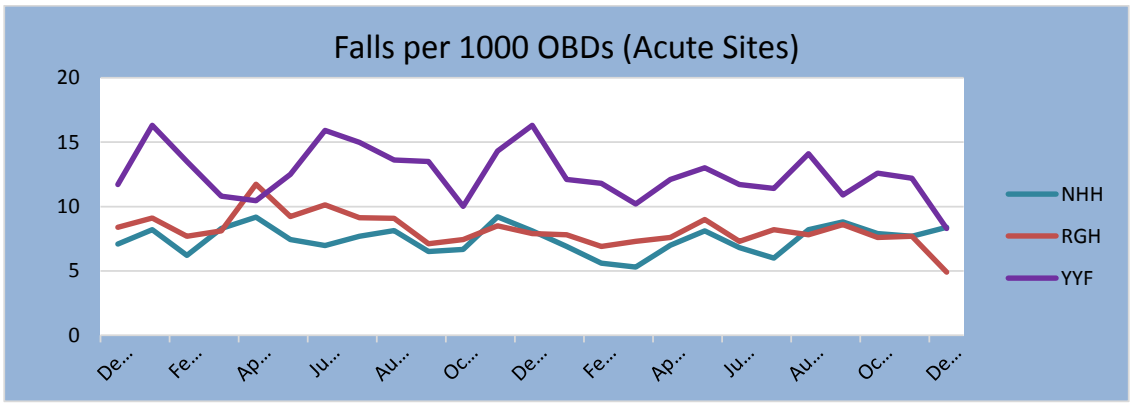
Number of Patient Falls by Division



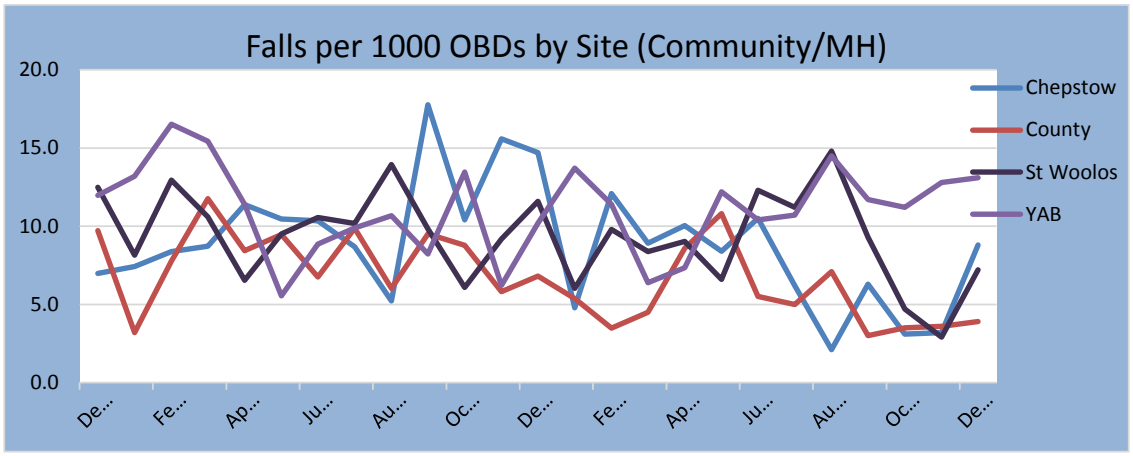
Number of people who fell



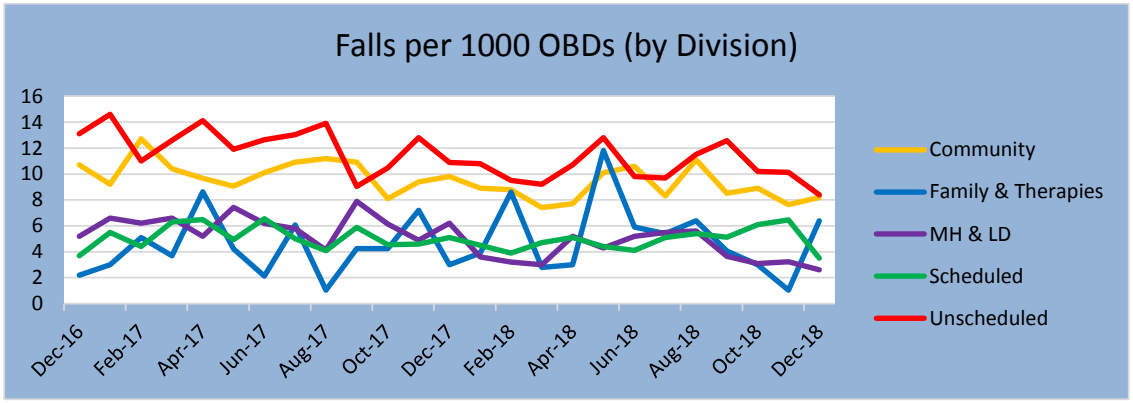
Number of Falls per 1000 Occupied Bed Days by Acute Site



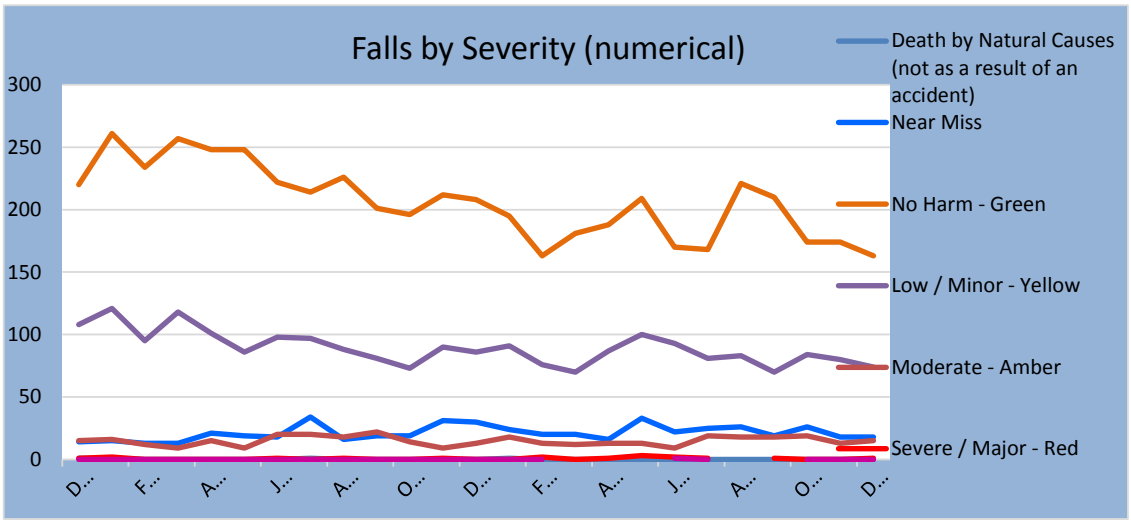
Number of Falls per 1000 Occupied Bed Days by Community/Mental Health Site



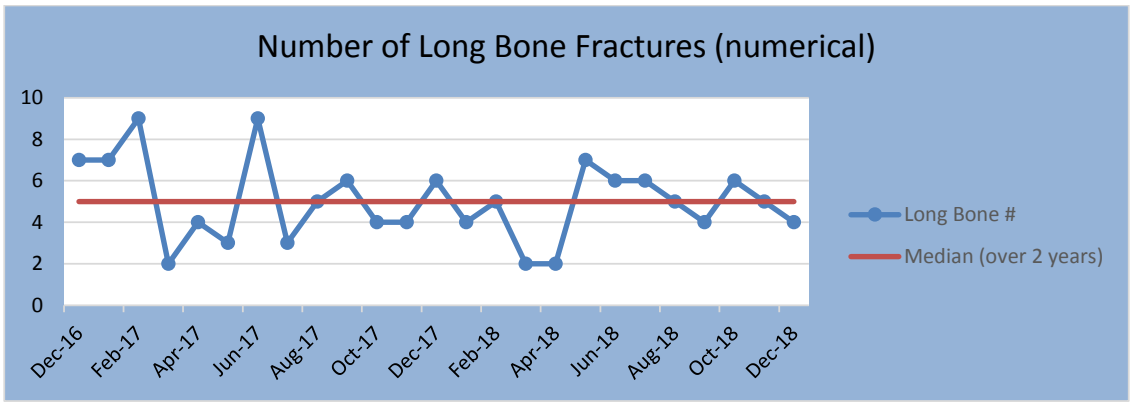
Number of Falls per 1000 Occupied Bed Days by Division



Number of Falls by Severity



Number of Long Bone Fractures



The overall number of falls reported on datix has reduced over the last year. The majority of the reduction is in the low or no harm falls. The falls per 1000 occupied bed days is high at both YYF and YAB. Both areas have a frail elderly patient population, and both have wards with single rooms so that it is harder to observe patients. Both hospitals have received targeted training on falls prevention

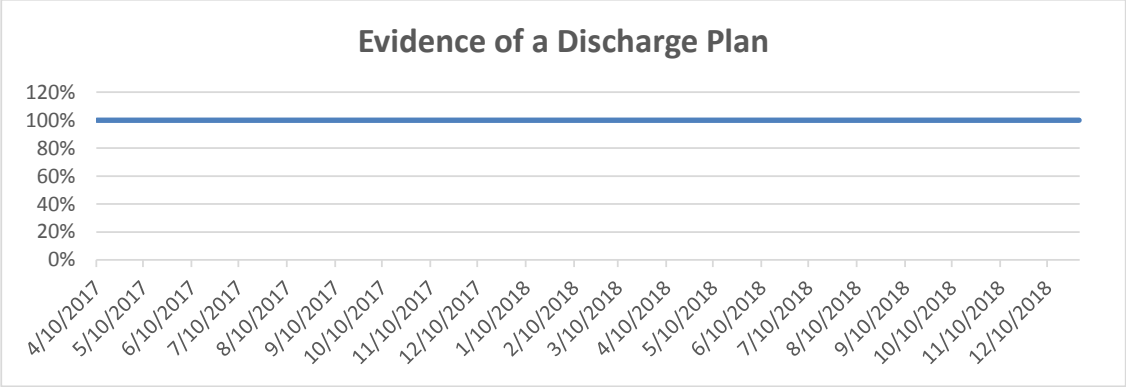
Training has taken place on every ABUHB hospital site on Falls Prevention and the use of the ABUHB Multifactorial Risk Assessment tool for falls. The training has been well received. The Falls Steering Group is going to review how best to take forward the need for there to be training on falls prevention and management regularly for all clinical staff.

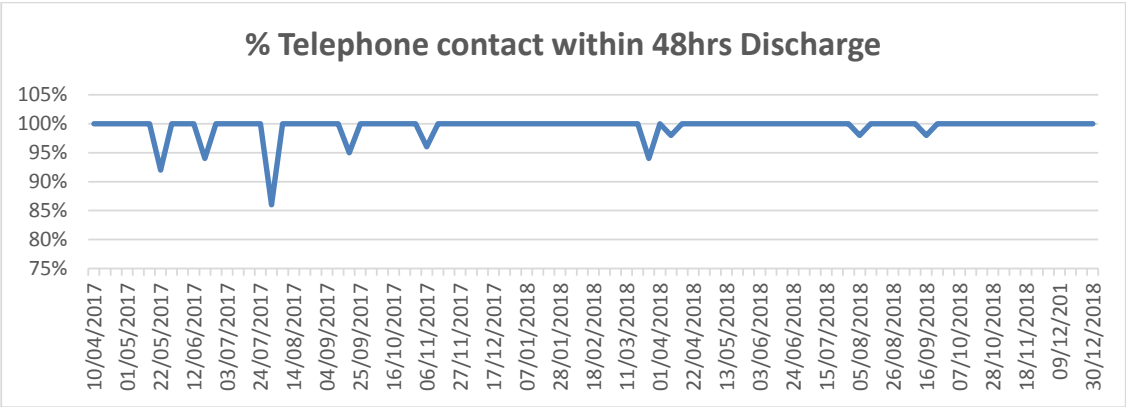
3.9. Mental Health – Compliance with Discharge Plans

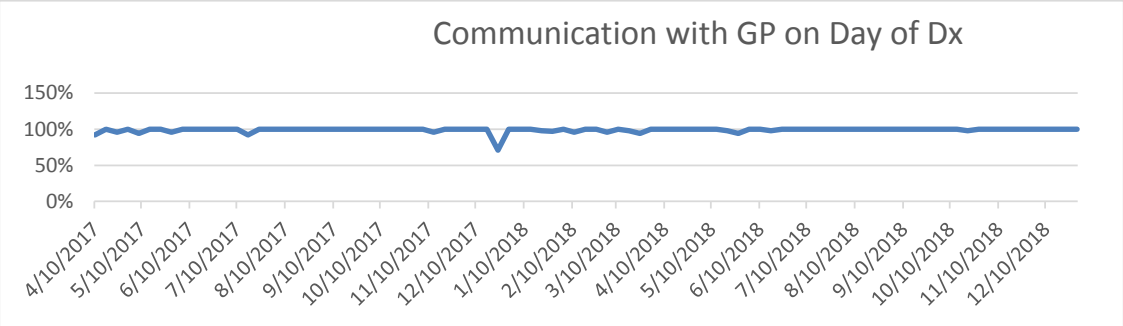
In December 2016 the Coroner issued a Regulation 28 report to the Health Board following the inquest for the death by suicide of a patient on discharge from one of the health board's acute mental health wards. These reports are issued when a Coroner believes that action should be taken to prevent future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

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

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







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

3.10. Primary Care – Referrals to Secondary Care

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

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
Secondary Care Demand							
ABUHB A&E Activity	New A&E Attendances - Patients Aged >65 Years	**Grand Total**	1290	Dec 2018	1,145	1,204	
		Blaenau Gwent East	106		105	110	
		Blaenau Gwent West	112		99	104	
		Caerphilly East	156		145	153	
		Caerphilly North	79		66	69	
		Caerphilly South	111		92	97	
		Monmouthshire North	126		109	115	
		Monmouthshire South	93		61	64	
		Newport East	97		91	96	
		Newport North	101		95	100	
		Newport West	101		87	92	
		Torfaen North	114		105	110	
		Torfaen South	94		89	94	
A&E Attendances: The latest reported position as at Dec 2018 was reported as 1290 which is a variance of 86 compared to the same period the previous year which equates to an Increase of 7.1%. For NCN benchmarking please see table at foot of this report.							

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ABUHB Assessment Unit Activity	GP Referrals to Assessment Units	**Grand Total**	3403	Dec 2018	3,074	3,236	
		Blaenau Gwent East	180		175	184	
		Blaenau Gwent West	240		162	170	
		Caerphilly East	462		365	384	
		Caerphilly North	252		262	276	
		Caerphilly South	255		255	268	
		Monmouthshire North	199		183	193	
		Monmouthshire South	238		222	234	
		Newport East	308		265	279	
		Newport North	328		307	323	
		Newport West	333		333	350	
		Torfaen North	321		284	299	
		Torfaen South	287		262	276	

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
ABUHB Emergency Admissions	Emergency Medical Admissions to ABUHB - Patients Aged > 65 years	**Grand Total**	1917	Dec 2018	1,900	2,000	
		Blaenau Gwent East	131		146	154	
		Blaenau Gwent West	163		161	169	
		Caerphilly East	193		195	205	
		Caerphilly North	87		94	99	
		Caerphilly South	153		136	143	
		Monmouthshire North	175		175	184	
		Monmouthshire South	157		134	141	
		Newport East	152		155	163	
		Newport North	167		181	191	
		Newport West	183		162	171	
		Torfaen North	190		172	181	
		Torfaen South	166		189	199	

Assessment Units: The latest reported position as at Dec 2018 was reported as 3403 which is a variance of 167 compared to the same period the previous year which equates to an Increase of 5.2%.

Admissions: The latest reported position as at Dec 2018 was reported as 1917 which is a variance of -83 compared to the same period the previous year which equates to an Decrease of -4.2%.
For NCN benchmarking please see table at foot of this report.

The table below shows the NCN Benchmarking of variance to the reported position for the same period the previous year.

ABUHB Provider Data	A&E (>65Yrs) Attendances	Assessments (>65Yrs)	Admissions (>65Yrs)	Prescribing	OOHs
Grand Total	7%	5%	-4%	-0.2%	5.8%
Blaenau Gwent East	-4%	-2%	-15%	1.3%	4.9%
Blaenau Gwent West	8%	41%	-4%	-0.6%	8.4%
Caerphilly East	2%	20%	-6%	0.1%	7.4%
Caerphilly North	14%	-9%	-12%	0.0%	2.2%
Caerphilly South	14%	-5%	7%	-0.3%	1.2%
Monmouthshire North	10%	3%	-5%	0.7%	3.8%
Monmouthshire South	45%	2%	11%	-0.5%	9.2%
Newport East	1%	10%	-7%	-2.0%	11.7%
Newport North	1%	2%	-13%	0.1%	7.9%
Newport West	10%	-5%	7%	0.1%	3.6%
Torfaen North	4%	7%	5%	-0.5%	2.9%
Torfaen South	0%	4%	-17%	-0.3%	6.9%

Out of Hours demand

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
GP Urgent OOHs Service							
Ensure that patients accessing Primary Care OOH are advised in line with tier 1 targets	% Triaged Within Limit (Reception) (Combined Urgent & Routine Measure)	Grand Total	74.6%	Dec 2018	98%	85%	
		Blaenau Gwent East	73.1%				
		Blaenau Gwent West	77.9%				
		Caerphilly East	76.7%				
		Caerphilly North	74.0%				
		Caerphilly South	74.1%				
		Monmouthshire North	76.7%				
		Monmouthshire South	76.4%				
		Newport East	75.6%				
		Newport North	72.7%				
		Newport West	74.2%				
		Torfaen North	73.1%				
		Torfaen South	71.6%				
OOHs: The latest reported position as at Dec 2018 was reported as 74.6% which is a variance of 5.8% compared to the same period the previous year. For NCN benchmarking please see table at foot of this report.							

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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 –	*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*

5 ways of working	*Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	The terms are all used routinely in the report, which is presented at every meeting.
Public Interest	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Thursday 7 February 2019 Agenda Item: 3.2

3.2

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT

Executive Summary			
This paper provides an overview of the profile of the current risks for which the Quality and Patient Safety Committee is responsible for monitoring, at the end of December 2018. The risk profile of the Health Board is continuing to be revised and reworked. Further rationalisation and redevelopment work continues and will further developed prior to the end of the financial year. This report is provided for assurance purposes for the Quality and Patient Safety Committee.			
The Quality and Patient Safety Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Paul Buss, Medical Director, Peter Carr, Director of Therapies and Health Science, Martine Price, Interim Director of Nursing			
Report Author: Claire Barry, Committee Secretariat			
Report Received consideration and supported by :			
Executive Team	N/A	**Quality and Patient Safety Operational Group**	✓
Date of the Report: 28 January 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 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, for which the Finance and Performance Committee have oversight.

Table from the updated Risk Management Strategy – January 2017.

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

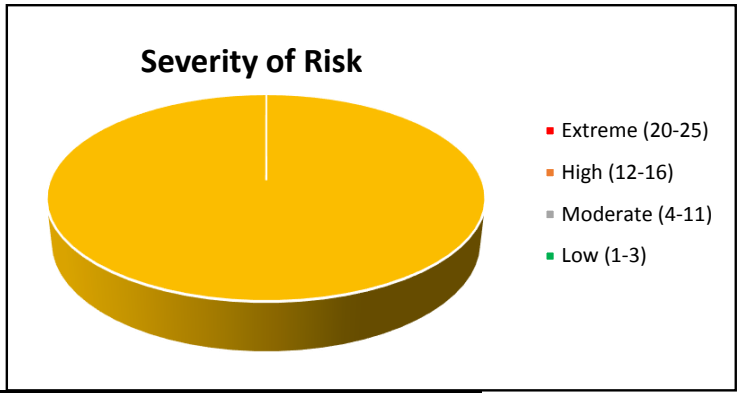
2. Corporate Risk Register and Dashboard Report

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

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

The risks for the purposes of the dashboards have been summarised to make them more accessible to the Committee. The detail of the risks, their assessment, controls and mitigating actions continue to be expressed within the full Corporate Risk Register, which is presented to the Audit Committee at each meeting.
There are currently 6 risks on the Quality and Patient Safety Risk Register. These are broken down by the following levels of risk severity.

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



There have been no changes to the assessed risks since the last report

Assessment and Conclusion
This paper provides an overview of risks as at the end of December 2018. Further development work is underway and will be reported in February 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 December 2018.

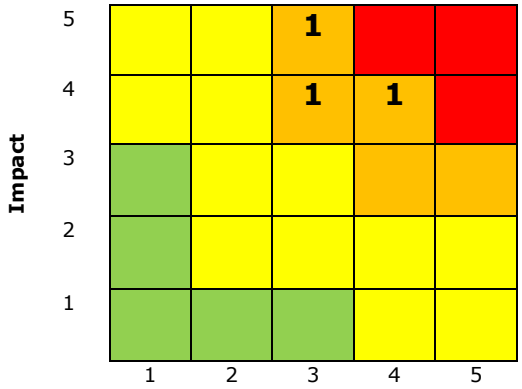
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	There may be financial consequences 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	The risks against delivery of key priorities in the IMTP, will be outlined as specific risks on the risk register.

Plan/Corporate Objectives	
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 Dashboard Report as at December 2018

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

RISK PROFILE REPORT



Key:

= Risk Worsened

= Risk Unchanged

= Risk Mitigated

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

16

Since July 2018

RISK: Poor patient experience and quality of care in hospital and community settings due to staff shortages and increasing acuity of patients

IMPACT: Deteriorating patient outcomes and quality of care resulting in increasing patient safety incidents, serious incidents, complaints, claims and legal cases

ACTION: Monitoring of quality measures are in place via Quality and Patient Safety Committee, patient experience is being captured and specific spot checks are being undertaken. Pressure Ulcer Collaborative launched and continued monitoring of HIW/CHC/Complaints/incidents to identify any areas of concern. These are reported to Executive Team and QPSC, along with lessons learned and a further review of the risk is planned for the February meeting of the Quality and Patient Safety Committee.

OWNER: Acting Director of Nursing

OVERSIGHT: Quality and Patient Safety Committee and Patient Experience Committee.

Corporate Risk Dashboard Report as at December 2018

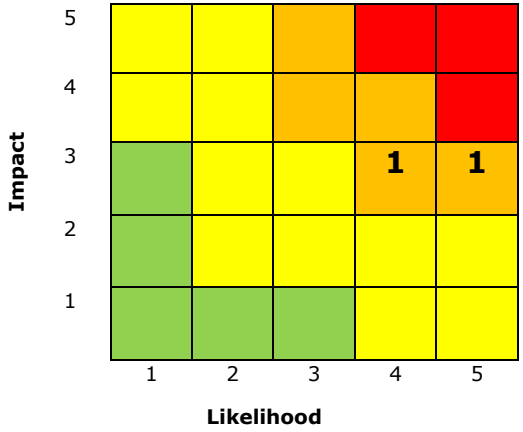
	15 **Sine July 2018** **RISK**: Lack of improvement in Healthcare Associated Infections **IMPACT**: Increase in Healthcare Associated Infections, in hospital and community, placing patients at risk and increasing costs and reducing quality of care. **ACTION:** There is an annual programme of HPV cleaning for all clinical areas and a ward refurbishment programme in place. Root cause analysis for all HCAIs. Deep Dive for primary and community acquired infection undertaken and action plan in place. Further investment in antimicrobial pharmacy agreed. Investment in new HPV equipment agreed and arrangements in place. Also, additional support provided during winter months. **OWNER**: Acting Director of Nursing **OVERSIGHT**: Quality and Patient Safety Committee
	12 **Since March 2017** **RISK**: Compliance rates of statutory and mandatory training of staff **IMPACT:** Risk of undermining the quality and safety of services. **ACTION**: Compliance monitored by the Health and Safety Committee. Access to on-line training has been simplified via ESR and training compliance rates are steadiliy improve. Each Division has received latest data and produce improvement plans. **OWNER**: Deputy Director of Therapies and Health Science **OVERSIGHT**: Quality and Patient Safety Committee

Corporate Risk Dashboard Report as at December 2018

IMTP STRATEGIC OBJECTIVE:	Supporting a further shift of services closer to home through building a NCN foundation for delivery of care (SCPs 2, 3 and 4)
KEY THEME ACTIONS:	• SCP 2 – Care Closer to Home • SCP 3 – Management of Major Health Conditions • SCP 4 – Mental Health and Learning Disabilities

The overall aim of these Service Change Plans (SCP) is to facilitate the development and sustainability of service improvement models that support the delivery of care closer to home. It also aims to deliver more systemic and proactive management of chronic disease to improve health outcomes, reduce inappropriate use of hospital services and have a significant impact on reducing health inequalities. The Mental Health and Learning Disabilities SCP seeks to provide an integrated, whole system model of care that improves the mental health and well being of our population.

RISK PROFILE REPORT



12

Since Nov 2017

RISK: Crisis services in Mental Health will not meet the needs of our population.
IMPACT: Risk to patient safety if services are appropriately not staffed and resourced.
ACTION: Gwent 'Whole Person, Whole System' Acute and Crisis Model being developed to support people with a mental health need who present in crisis. This will remodel the service to better meet local needs.
OWNER: Director of Primary, Community and Mental Health
OVERSIGHT: Quality and Patient Safety Committee

15

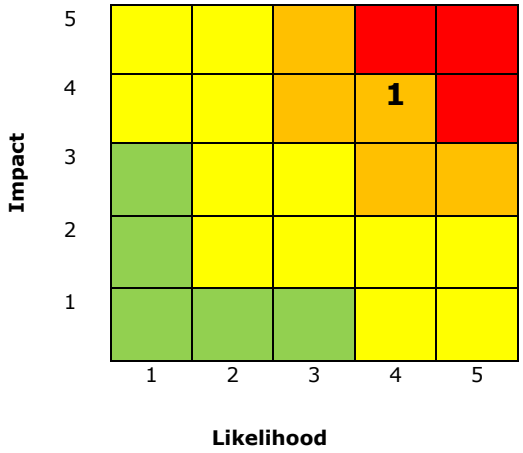
Since Dec 2017

RISK: Inadequate falls prevention on in-patient wards
IMPACT: Failing to protect patients and risk of increased fractures and harm.
ACTION: 'Prevention and Management of Inpatient Falls' Policy has been updated updated and disseminated widely across the Health Board. Training ongoing on wards/sites targeting hot spot areas in the first instance. The Falls Steering Group is exploring resources for consistent delivery of falls prevention training for all

Corporate Risk Dashboard Report as at December 2018

	inpatient areas. Monthly Falls Scrutiny Panel review and learning from all inpatient falls resulting in a fracture. Numbers of fractures from inpatinet falls is reducing. **OWNER:** Deputy Director of Therapies and Health Science **OVERSIGHT:** Quality and Patient Safety Committee

Corporate Risk Dashboard Report as at December 2018

IMTP STRATEGIC OBJECTIVE:	Improving access and flow and reducing waits (SCP 5 & 6)
KEY THEME ACTIONS:	• SCP 5 – Urgent and Emergency Care • SCP 6 – Planned Care
To develop coherent, co-ordinated, high quality urgent and emergency care that works seven days a week, and where possible 24 hours a day. In accordance with patient expectations whilst delivering the best clinical outcomes. To secure improvements in efficiency and productivity that in combination woth prudent healthcare, will improve access and deliver high quality, affordable and sustainable services.	
RISK PROFILE REPORT  	**16** **Since May 2018** **RISK**: Unsustainable model of care in Primary Care GP services **IMPACT**: Patients will not be able to access the level and quality of services they require in a timely way. **ACTION**: Widening skill mix (both managed and independent practices appointing to new roles). This will be tested at scale via pacesetter project backed by Welsh Government funding. Welsh Government announcement of solution for state backed indemnity in primary care. Ongoing discussions at NCN and individual practice level in relation to sustainability challenges. Work in relation to consolidating practice distribution through supported mergers and managed redistribution of patients to alternative practices. **OWNER**: Director of Primary, Community and Mental Health Services **OVERSIGHT**: Quality and Patient Safety Committee

Quality & Patient Safety Committee
7th February 2019
Agenda Item: 3.3.1

3.3

Aneurin Bevan University Health Board

Quality and Patient Safety Operational Group Assurance Report

Name of Group:	Quality and Patient Safety Operational Group (QPSOG)
Chair of Group:	Peter Carr, Executive Director of Therapies and Health Science
Reporting to:	Quality and Patient Safety Committee
Reporting Period:	10th December 2018

Summary of Key Matters Considered by QPSOG:

Quality, Safety and Performance Report
The draft report was presented and comments invited ahead of its presentation to the QPSC meeting in February 2019.

Putting Things Right Annual Report
The Annual Report was presented to QPSOG in advance of it being presented to the QPSC meeting in February 2019.

Health and Care Standards Audit Report
The report was presented to QPSOG in advance of it being presented to the QPSC meeting in February 2019

Labelling of Pre-Transfusion Blood Samples
The group received an update from the Transfusion Practitioners on a potential patient safety concern regarding the lack of understanding by clinical staff of the required protocol for correct sample labelling and requirements for the second 'confirmatory" sample. This matter had been the subject of a letter issued to all Welsh health boards by the Chief Medical Officer. The group received assurance on the action that has now been put in place in ABUHB to address these concerns, including issuing an alert and increased level of staff training on the correct protocol. The QPSOG requested an update at a future meeting in 2019 on the action taken and outcome.

Nutrition and Catering Mandatory Standards
The QPSOG received an update from the Catering Liaison Dietitian on compliance with the mandatory nutrition and catering standards (issued by Welsh Government in 2012).

Although there has been some progress, ABUHB is not fully compliant. ABUHB's compliance is 63% fully compliant, 29% partially compliant, and 8% yet to comply.

The standards cover:

- Assessing local hospital needs.
- Individual patient needs.
- Menu planning.
- To cater for those nutritionally well and nutritionally compromised.
- Food and nutrient standards for meals, snacks and fluids.
- Missed meal service.
- Best eating experience for patients.

ABUHB are doing well at:

- Food and snack provision for children.
- Offering three course lunch and evening meals.
- Using standardised recipes.
- Offering different portion sizes.
- Regularly refreshing water three times a day.

ABUHB need to improve on:

- Availability of snacks (this will be rolled out between March and August 2019).
- Increase compliance with bedtime snacks.
- Nutritional analysis of children's menus to meet standards of macro and micronutrients (expected to be achieved in the New Year, 2019).
- Reducing the gap between the evening meal and breakfast to less than 14 hours.

Further improvement is anticipated with the introduction of nursing e-documents which should improve completion of nutritional forms and the introduction of an on-line meal ordering system (both to be introduced in 2019).

The QPSOG requested an action plan to address the areas requiring improvement and this to be brought back to QPSOG for assurance in 6 months (May 2019). Compliance of these mandatory standards will be monitored on an ongoing basis by the Nutrition and Hydration Group which reports to the QPSOG.

Patient Discharge from Hospital to General Practice – Improvement Plan

QPSOG received an update from the Deputy Nurse Director on work started to develop an improvement plan in response to recent HIW recommendations. Further updates on the improvement plan will be received by the QPSOG in due course.

Informed Consent New Model Policy

The QPSOG received an update on work being undertaken and overseen by the Health and Care Standards Group to introduce the new policy in ABUHB. Further information, including guidance, will be brought back to QPSOG at a later date when the Assurance Framework has been updated.

Information Governance Dashboard
The ABUHB Data Protection Officer & Head of Information Governance provided a presentation to QPSOG. The presentation provided an overview of ABUHB current performance against the Information Governance key indicators.

In the past 12 months, 30 complaints have been made, 6 were upheld, 18 had no evidence and 6 are awaiting outcomes. 3 have been reported to the Information Commissioner's Office (ICO). 2 patients have reported ABUHB to the ICO

45% of staff within the Health Board have not completed their online IG training although compliance is believed to be higher as there is an issue transferring training records to ESR.

QPSOG noted that Information Governance delivery groups have been set up within each Division across the UHB.

QPSOG requested that the Head of Information Governance provide assurance to QPSOG with a report annually, capturing the key indicators and a Divisional breakdown including compliance for training.

QPSOG noted that Internal audit are carrying out an audit of compliance with GDPR and training in 2019.

National Clinical Audit Overview
The QPSOG routinely gets a report on current National clinical audits – ones highlighted in this report were:

- National Maternity and Perinatal audit
- Neonatal audit
- Breast Cancer in Older People audit

Divisional Risk Registers/Concerns
The QPSOG received the Divisional reports and Divisional leads were given the opportunity to flag any significant areas of concern. These are included in the Divisional risk registers with information detailing mitigating action being taken to ensure quality and patient safety; these risks are escalated where necessary by the Divisions or by QPSOG. A common theme across Divisions in terms of high risk was sustainability of the workforce (medical and nursing). Unscheduled Care also identified emergency pressures and flow in their top risks. The Complex Care team also raised nursing home and domiciliary care fragility as a high risk.

Matters Requiring QPSC Level Consideration:

- Quality, Safety and Performance Report (scheduled for QPSC meeting in February 2019)

- Putting Things Right Annual Report (scheduled for QPSC meeting in February 2019)

• Health and Care Standards Audit Report (scheduled for QPSC meeting in February 2019)
Key Risks and Issues/Matters of Concern
There were no key risks or matters of concern to note other than those already noted above.
Date of Next QPSOG Meeting: 19th March 2018

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Thursday 7 February 2019 Agenda Item: 3.2.2

Aneurin Bevan University Health Board

OVERVIEW OF HEALTH AND CARE STANDARDS PROGRESS 2018-19

Executive Summary

The purpose of this report is to provide the Quality and Patient Safety Committee with an overview of the embedding of the Health and Care Standards, including the 2017-18 Internal Audit Report, which is reported in 2018-19, and the progress that had been made overall and in implementing the management actions in response to the recommendations.

The Health and Care Standards form the cornerstone of the overall quality assurance system within the NHS in Wales. They create a basis for improving the quality and safety of healthcare services by identifying strengths and highlighting areas for improvement.

The Internal Audit of Health and Care Standards was undertaken in February and March 2018. The final report was issued in March 2018 and taken to the Audit Committee. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Health and Care Standards is **Reasonable** Assurance. Three medium priority recommendations were made in the report. These are given in this report with the management response and the action that has been taken to date. This report also gives good practice in relation to Health and Care Standards given in the Internal Audit Report.

The progress made in 2018-19 is described. This includes the review of the Guidance which is exploring how the process can provide assurance against the Health and Care Standards within the Quality Assurance Framework.

It is recommended that the Group receives this report for Assurance/compliance.

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	X

Executive Sponsor: Director of Nursing			
Report Author: Kate Hooton – Assistant Director – Quality and Patient Safety			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	**Quality and Patient Safety Operational Group**
Date of the Report: January 2019			
Supplementary Papers Attached:			

Purpose of the Report

The Quality and Patient Safety Committee receives a report every year on the embedding of the Health and Care Standards in ABUHB. In particular, the Internal Audit Department undertakes an annual audit of the embedding of the Health and Care Standards. This report provides the Quality and Patient Safety Committee with the 2017-18 Internal Audit Report, which is reported in 2018-19, and the progress that had been made overall and in implementing the management actions in response to the recommendations.

Background and Context

The Health and Care Standards for Wales, published in April 2015 and pull together the previous quality framework, the Standards for Health Services, and the Fundamentals of Care Standards. The Health and Care Standards for Wales provide an updated and integrated framework of standards aimed at helping people in Wales to understand what to expect when they access health services and what part they themselves can play in promoting their own health and wellbeing. They set out the expectations for services and organisations, whether they provide or commission services for their local citizens, and need to be owned by them. The Health and Care Standards provide the framework to help teams and services demonstrate that they are doing the right thing, in the right way, in the right place, at the right time and with the right staff.

The Health and Care Standards form the cornerstone of the overall quality assurance system within the NHS in Wales. They create a basis for improving the quality and safety of healthcare services by identifying strengths and highlighting areas for improvement.

The Health and Care Standards have been designed to fit with the seven themes of the NHS Outcomes and Delivery Framework. The themes were developed through engagement with patients, clinicians and stakeholders and identify the priority areas which they wanted the NHS to be measured against. Other key documents are also written using these themes.

The Themes are:

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

The principles of both co-production and prudent healthcare run through all the themes. Governance, leadership and accountability is a standards that wraps around all the themes, and the seven themes work together to deliver patient centred care.

The Health and Care Standards were launched in July 2015 in ABUHB. The approach to their implementation is to evolve the well established approach that was taken to implementing the Standards for Health Services. The underpinning principles of the approach are that:

- The Health and Care Standards have to be embedded in the Divisions and then into the Directorates and Teams

- The Divisions and Directorates of the Health Board use the standards on a continuous basis to:
  - Quality check services
  - Identify gaps
  - identify risks, and
  - Make improvements

Assessment and Conclusion

1. Health and Care Standards Internal Audit Report 2017-18

The Internal Audit of Health and Care Standards was undertaken in February and March 2018. The final report was issued in March 2018 and taken to the Audit Committee. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Health and Care Standards is **Reasonable** Assurance.

The Internal Audit Report was sent to all the Divisional Health and Care Standards Leads, and has been presented to the Health and Care Standards Group to ensure that all the Divisions are clear about the recommendations and their importance.

Three medium priority recommendation were made in the report. These are given below with the management response and the action that has been taken to date.

Recommendation 1: The Health Board should review whether assurance mechanisms for Health and Care Standards are suitable and ensure the Quality and Patient Safety forums are kept up to date on a regular basis, as stated within the terms of reference for those groups.

Where matters require escalation, e.g. lack of representation within service areas and / or progress on the driver diagrams, these should be reported into the QPSOG.

Management Response: The Health Board is reviewing the Quality and Patient Safety Corporate Assurance Framework, which provides an overview of the reporting relationships of all the main Committees and Groups related to QPS, including the Health and Care Standards Group.
A paper will be taken to the QPS Operational Group with suggested reporting arrangements for Health and Care Standards for discussion and agreement, to make sure that QPS Forums are kept up to date on a regular basis.

Action to date: The review of the Quality Assurance Framework has been brought together with the review of the assurance mechanisms for the Health and Care Standards. This has been described in the Guidance for the Health and Care Standards which has been agreed at the Health and Care Standards Group and taken to the Quality and Patient Safety Operational Group for discussion. The Standard Holders for the Health and Care Standards are now identifying the key measures for their standard which will provide high level assurance about the implementation of the standard. It is proposed that these will be monitored routinely and reported to QPS Operational Group as part of a developing assurance process.

Recommendation 2: The Health Board should ensure that the remaining driver diagrams are completed.

Where they remain incomplete or a standard is unassigned to a responsible individual, this should be escalated to the QPSOG for assistance in prioritising the actions.

Management Response: Meetings are being arranged to complete Driver Diagrams for these standards. It should be noted that as some of these standards are very broad, the driver diagram may not prove to be an appropriate tool, and if this is the case, we will look for another approach to provide guidance to the Divisions

Action to date: Three standards have been agreed as unsuitable for the diagram approach as they are so broad. The Health and Care Standards Group has discussed the most appropriate approach to reviewing against these standards, but this required further consideration.
The majority of the other driver diagrams have been completed. The meetings for the remaining standards have identified that more than 1 driver diagram is needed to cover the standard. The key individuals who can complete the outstanding driver diagrams have been identified and they will be completed by the end of March 2019.

Recommendation 3: The Health Board should ensure there is an updated terms of reference in place for the Health and Care Standards Group so that the role and remit of the group is clearly defined.

The list of members should be reviewed and refreshed where appropriate, to include sufficient representation from throughout the Health Board, but at an appropriate level to take responsibility for actions.

There should be a minimum attendance requirement for members each year and where there is a lack of attendance, this should be escalated to the QPSOG.

Where actions are outstanding for a defined period of time, these should be escalated to the QPSOG, alongside the responsible officer.

Management Response: The representative from Workforce and OD has attended a number of the recent meetings and liaised across the whole corporate department. Membership of the Health and Care Standards Group will be reviewed as part of the updating of the Terms of reference for the group, to ensure that the membership allows for sufficient representation across the Health Board.
Minimum attendance requirements will be described in the Terms of reference, with clear escalation mechanisms if these are not met

Action to date: The Terms of Reference have been updated, clarifying who should attend and giving minimum attendance requirements. The circulation list for the meeting will now be updated.

Good Practice: The following good practice was highlighted in the report:

- there is a regular review of the Health and Care Standards Implementation Plan at every meeting of the Health and Care Standards Group;
- the Quality and Patient Safety team offer the Health Board support and guidance in facilitating and monitoring the Health and Care Standards;
- we contacted standard leads during the audit, to collate their views on the driver diagram approach. The consensus was that the diagrams were a useful exercise

which allowed them to refocus on divisional / directorate objectives and identify any risks which may have been missed;

- a good proportion of the finalised driver diagrams are completed to a high standard, and feedback from standard leads confirms they have been a useful tool for divisions in refocusing objectives and identifying risks; and
- awareness slides have been introduced into the corporate induction presentations for new starters to the Health Board. This enables staff to be fully aware of the existence of the Standards and provides information points when further detail is required.

2. Compliance with Essential Implementation Criteria

The Health and Care Standards Implementation Plan is monitored at each meeting of the Health and Care Standards Group. The Divisions have all been asked to provide assurance that they have all the implementation criteria for the health and care standards in place. One Division has one item outstanding and this is being escalated to the Divisional Director. One Division has 2 items outstanding and the Divisional Lead is new to the role and is checking the current position. If they are not in place, this will be escalated to the Divisional Director. The other Divisions have all the implementation criteria in place.

Corporately, the Terms of Reference of the Health and Care Standards Group have been reviewed, the Guidance has been reviewed and revised, the driver diagrams have been reviewed and progress is being reported to QPSC through this report.

The revised Guidance has proposed implementation criteria for Standard holder, but this has not been finally agreed. When finalised and agreed, these will be included in the Implementation Plan for 2019-20.

3. Progress in 2018-19

In 2018-19, the following progress has been made overall:

- The Terms of Reference for the Health and Care Standards Group have been updated
- The Guidance for Health and Care Standards Assurance, Self Assessment and Improvement Planning Guidance has been reviewed and is being developed to provide assurance against the health and care standards within the Quality Assurance Framework, as well as identifying good practice and areas for improvement
- The driver diagrams have now all been updated, except for 4. Three have been highlighted as needing an alternative process as they cover such a broad area: Timely Care, Communicating Effectively and Planning Care to Promote Independence
- The driver diagram guidance for health and care standards has been reviewed
- The intranet site for Health and Care Standards has been completely reviewed and updated
- The Health and Care Standards Implementation Plan has been revised so that it separates out the actions that need to be undertaken annually, and the actions that are one-offs
- Information on Health and Care Standards has been provided to be included in the recruitment pack

Recommendation
It is recommended that the Group receives this report for Assurance/compliance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The Divisions and Directorates of the Health Board use the standards on a continuous basis to: o Quality check services o Identify gaps o identify risks, and make improvements The Health and Care Standards therefore support the Health Board in proactively identifying quality and patient safety risks and taking mitigating action.
Financial Assessment, including Value for Money	Actions to comply with the Health and Care Standards may require additional resource, but this will be identified as part of each individual business case. The Guidance for embedding Health and Care Standards has been developed to use existing meetings and processes as much as possible, in order to minimise additional workload.
Quality, Safety and Patient Experience Assessment	The Health and Care Standards are a framework to improve quality and patient safety in healthcare organisations, and embedding them will therefore improve quality and patient safety in ABUHB.
Equality and Diversity Impact Assessment (including child impact assessment)	Health and Care Standards will have been equality assessed by Welsh Government.
Health and Care Standards	This report is about compliance with embedding of Health and Care Standards as an overall framework across ABUHB.
Link to Integrated Medium Term Plan/Corporate Objectives	The Health and Care Standards are the Quality Framework for health care services in Wales and are included in the Guidance for the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Health and Care standards are about providing quality care and services for the population, and hence are about the long term needs of the population.
	Integration – Health and Care Standards emphasise joint working and co-production, and so require health services to work together to promote better outcomes.
	Involvement – The Health and Care Standards were developed through a broad process of consultation with the population and stakeholders.
	Collaboration – Health and Care Standards emphasise joint working and co-production, and so require health services to work together to promote better outcomes.

	Prevention The first Standard is "Staying Healthy" and so prevention is fundamental to the Health and Care Standards.
Glossary of New Terms	
Public Interest	This can be in the public domain

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee 7th February 2019 Agenda Item 3.4

3.4

Aneurin Bevan University Health Board

Putting Things Right Report

Executive Summary			
This report provides the Committee with an update on actions underway to improve quality and performance through implementation of a Putting Things Right/Organisational Learning Service Improvement Programme and Action Plan. The report also focuses on formal and informal complaints; Ombudsman cases and Serious incidents notified in November and December 2018, with a summary of themes from Ombudsman cases and areas for action specified in the Ombudsman's Annual Letter 2017-18			
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: Martine Price, Interim Executive Director of Nursing			
Report Author: Martin Lane, Interim Assistant Director of Organisational Learning; Ann-Marie Weller, Clinical Incident Manager			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board Quality and Patient Safety Committee**	
Date of the Report: 30th January 2019			
Supplementary Papers Attached: **Appendix 1** PSOW Section 16 Public Report Summary **Appendix 2** PSOW Annual Letter 2017-18 **Appendix 3** Open SI Monthly Report December 2018 **Appendix 4** DRAFT PTR Service Improvement Action Plan			

Purpose of the Report
To provide the Committee with an update on Complaints, Ombudsman and Serious Incident performance in November and December 2019 and outline a PTR Service Improvement Programme to address quality and performance.

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 taken forward. The need to ensure that these principles are implemented has been highlighted in the Evans Report 2014.

Assessment and Conclusion
Significant work is underway to improve performance and quality in the handling of concerns/complaints and Serious Incidents at Aneurin Bevan Health Board. The Quality and Patient Safety Committee is asked to note and support the service improvement work required to enhance performance and quality of response to concerns.

Recommendation
The Committee is asked to consider this report and the assurance it provides on actions being taken to improve quality and performance in management of Concerns and Serious Incidents

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Concerns raised under these regulations may pose a financial risk. There are also risks to the reputation of the Health Board. If a risk relating to a particular case or trend is found and assessed to be high this will need to be included in the appropriate risk register and escalated as necessary.
Financial Assessment, including Value for Money	The financial implication of the new regulations have to date been positive as more cases are being considered under Redress and thus these cases do not continue to a civil litigation case.
Quality, Safety and Patient Experience Assessment	The report provides a summary of patient concerns raised during the last two months and actions taken to improve patient experience.
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	*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** – 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	*All reports to the Board and Committee of the Board are routinely published – is there any reason why this document cannot be made public?* ***No***

Putting Things Right (PTR)/Organisational Learning Report for the Quality and Patient Safety Committee November and December 2018

1. Summary

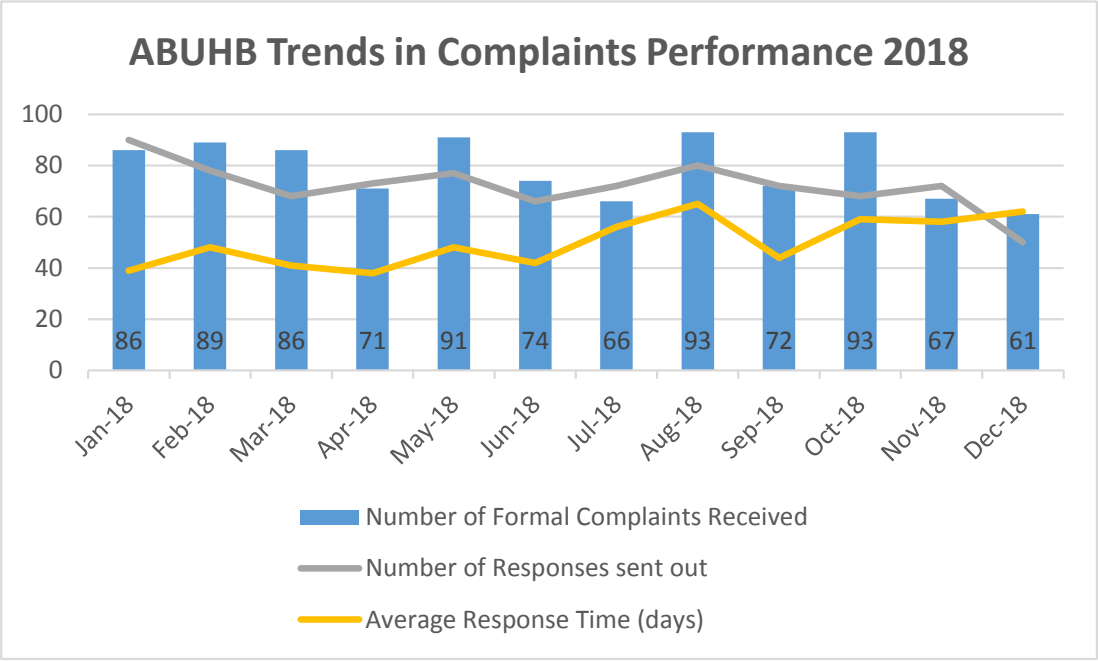
This report summarises data and information on performance for Putting Things Right/Organisational Learning for the period of November and December 2018, focussing on the themes and learning from the Annual Letter published by the Public Services Ombudsman for Wales and an internal thematic review of Ombudsman cases in the last 2 years.
The report includes an update on actions to improve quality and performance through implementation of a Service Improvement Programme for the PTR system.

2. Complaints

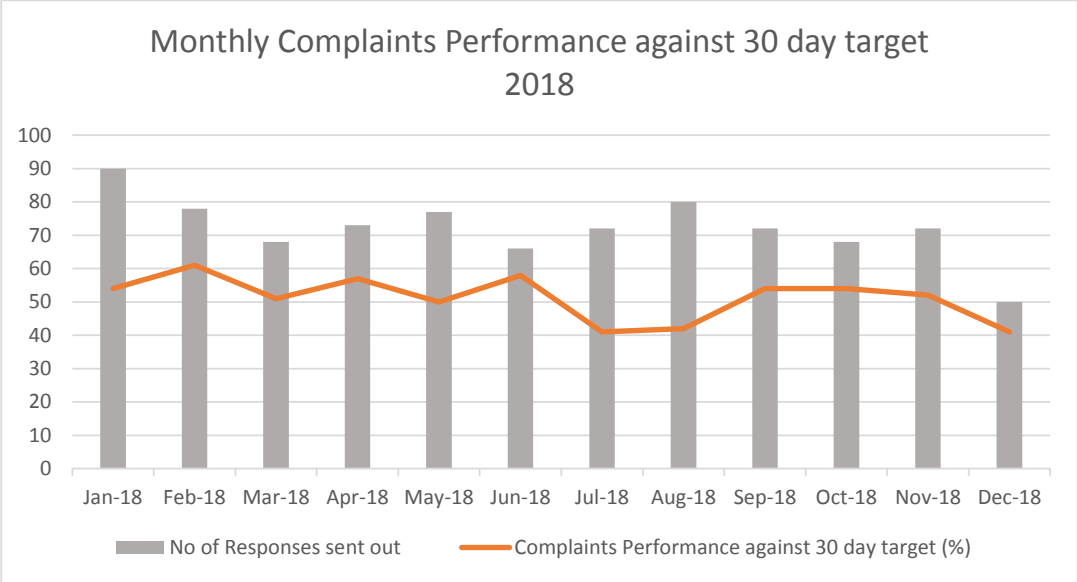
2.1. Trend in Complaints Performance

The Health Board responded to a total of 122 formal complaints during November and December 2018, with the overall performance against the 30 day target being November 52%, December 41% 2018.

Whilst the overall number of formal complaints received in 2018 reduced by approximately 22%, complaints performance also reduced along with an increase in average response time of 14% and lower number of responses sent. Review work has been undertaken to understand the reasons for current performance and this has informed the improvement actions that are underway and referenced later in this report.



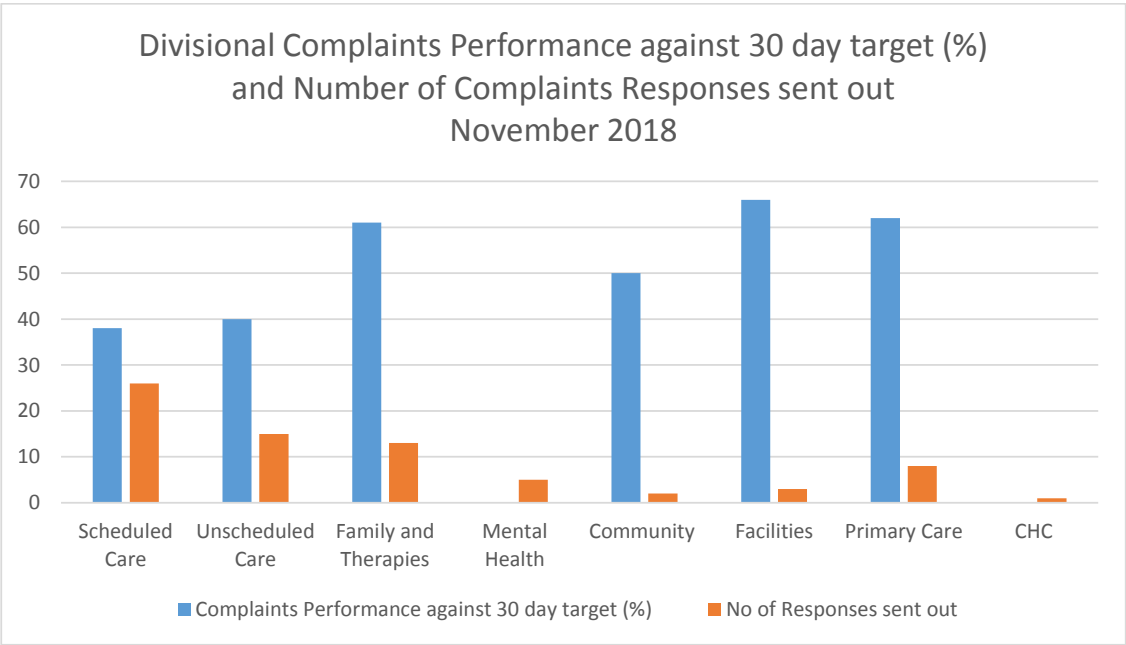
Monthly performance against the 30 day target has also reduced, despite a smaller number of responses being sent out.

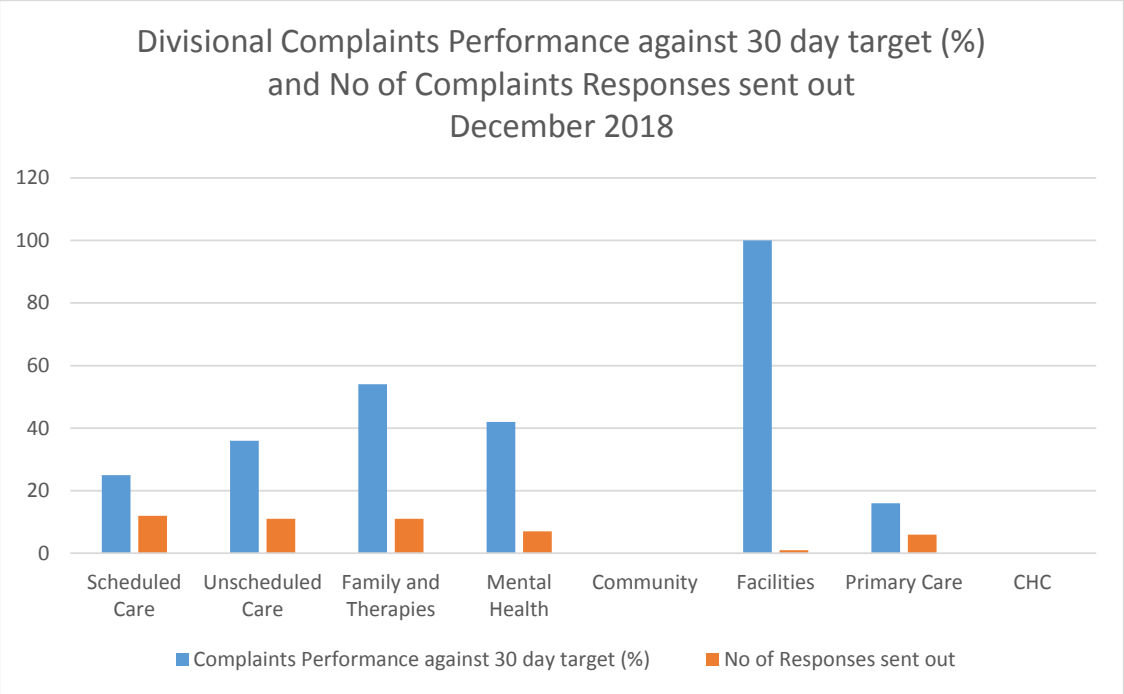


A total of 156 complaints were received informally in November and December 2018. Informal complaints are those that can be addressed within 2–5 days and which do not require a written response from the Chief Executive.

2.2. Divisional Complaints Performance

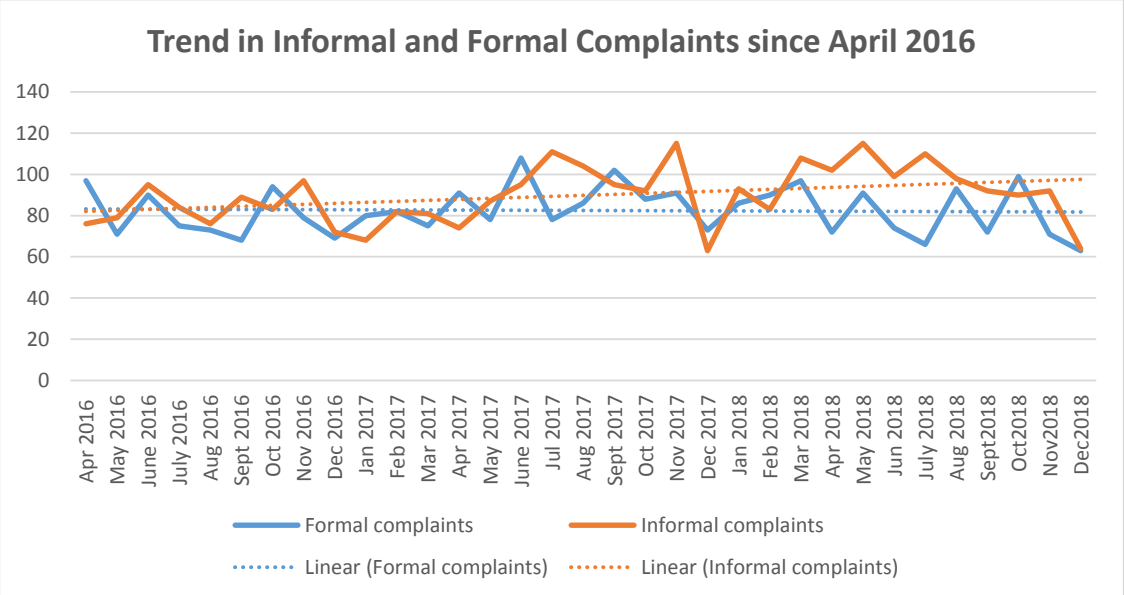
Complaints performance for each Division, together with the number of formal complaints responded to, is shown below.





2.3. Formal and Informal Complaints

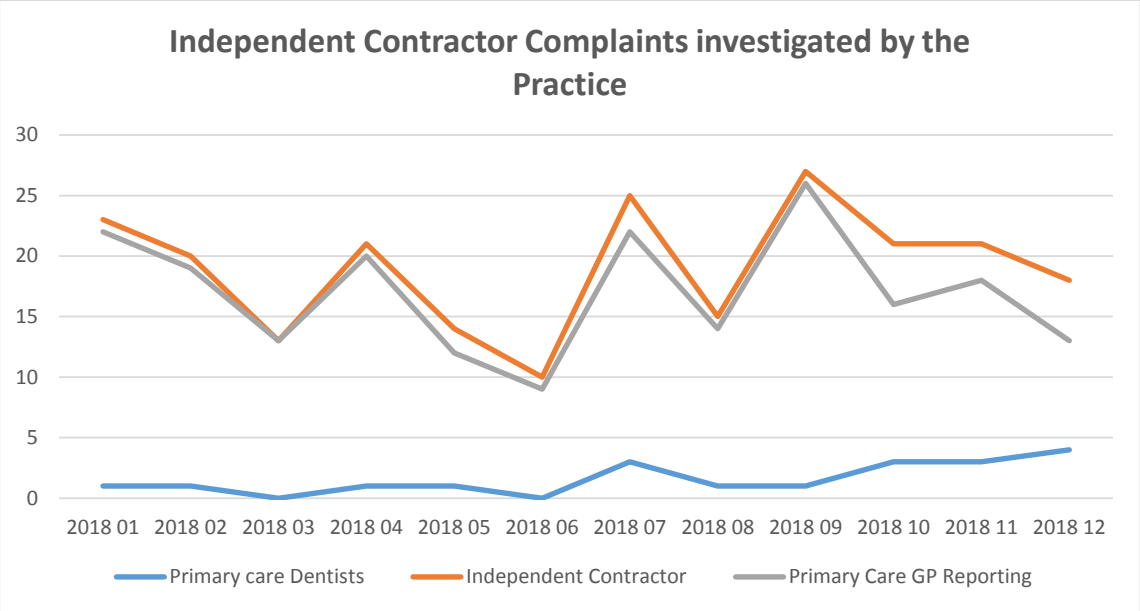
During November and December 2018 combined, the Health Board received 122 formal complaints and 156 informal complaints. Whilst the trend in formal complaints has remained static, informal complaints are increasing.



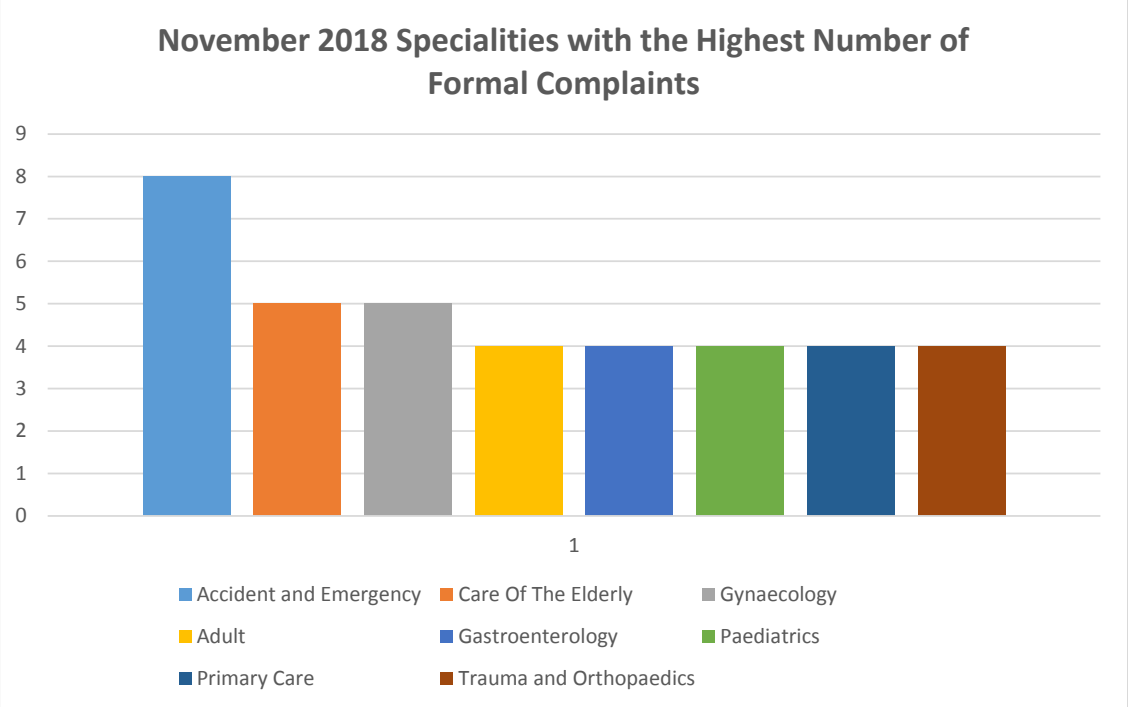
2.4. Independent Contractor Complaints

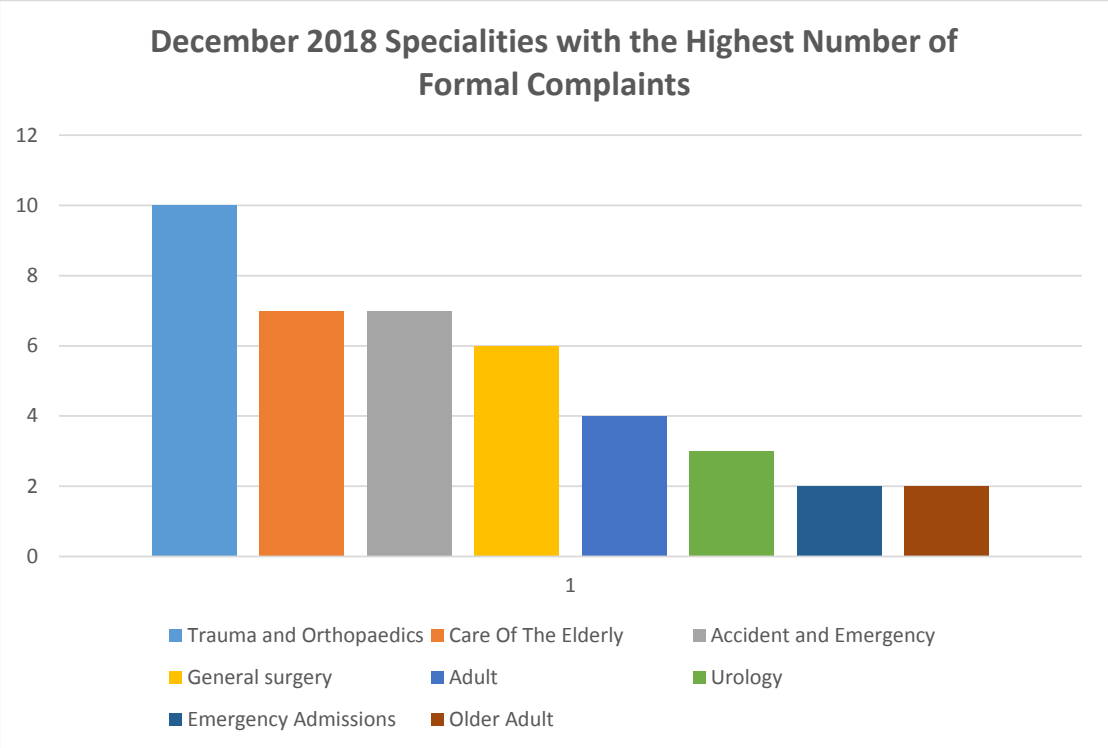
During November and December 2018, the Health Board received 47 complaints regarding independent contractor services, of which 39 were forwarded to the appropriate practice for investigation. The remaining 8 were investigated as formal complaints by the Health Board.

The trend in the number of independent contractor complaints which were directed to the practice for investigation is shown below. The number of complaints raised directly with independent contractors and not raised via the Health Board is not included in this report.

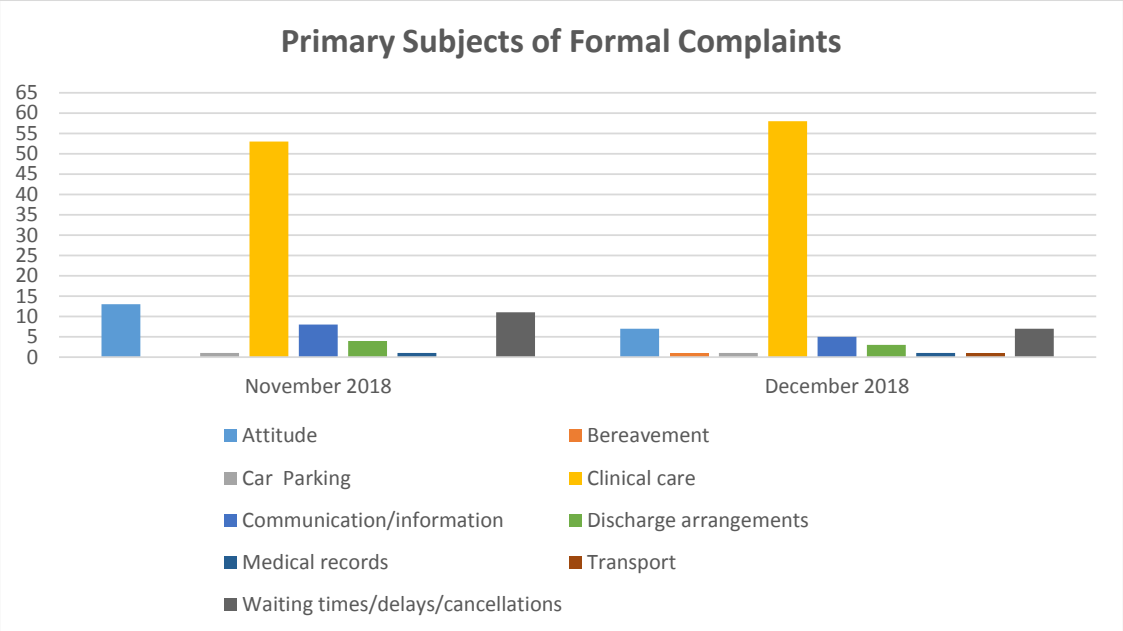


2.5. Specialties receiving the highest number of formal complaints in November and December 2018

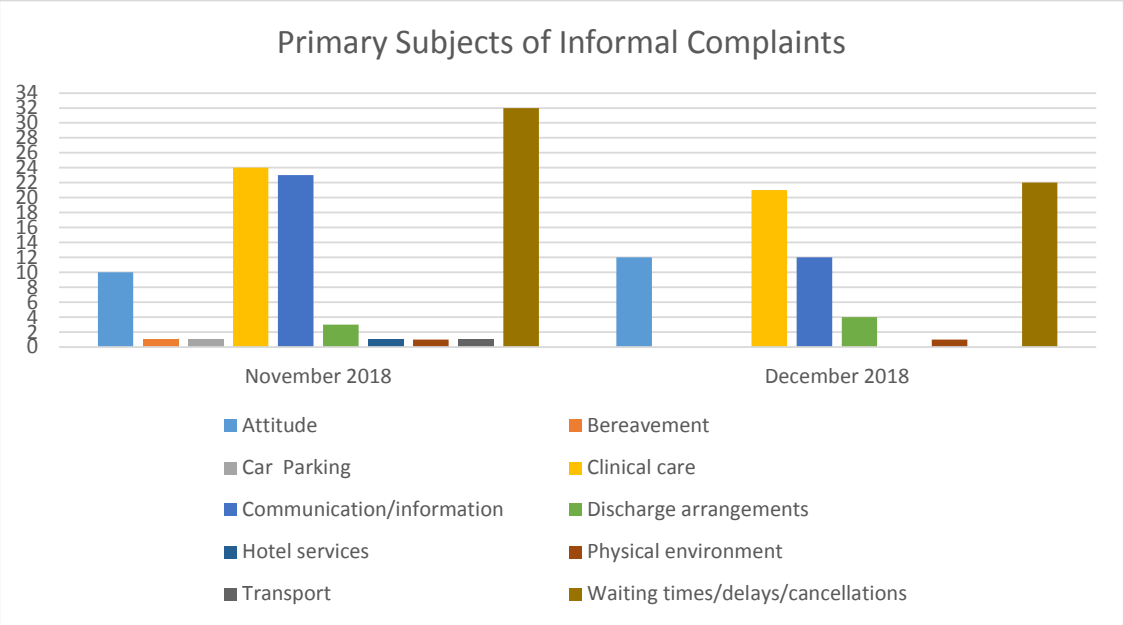




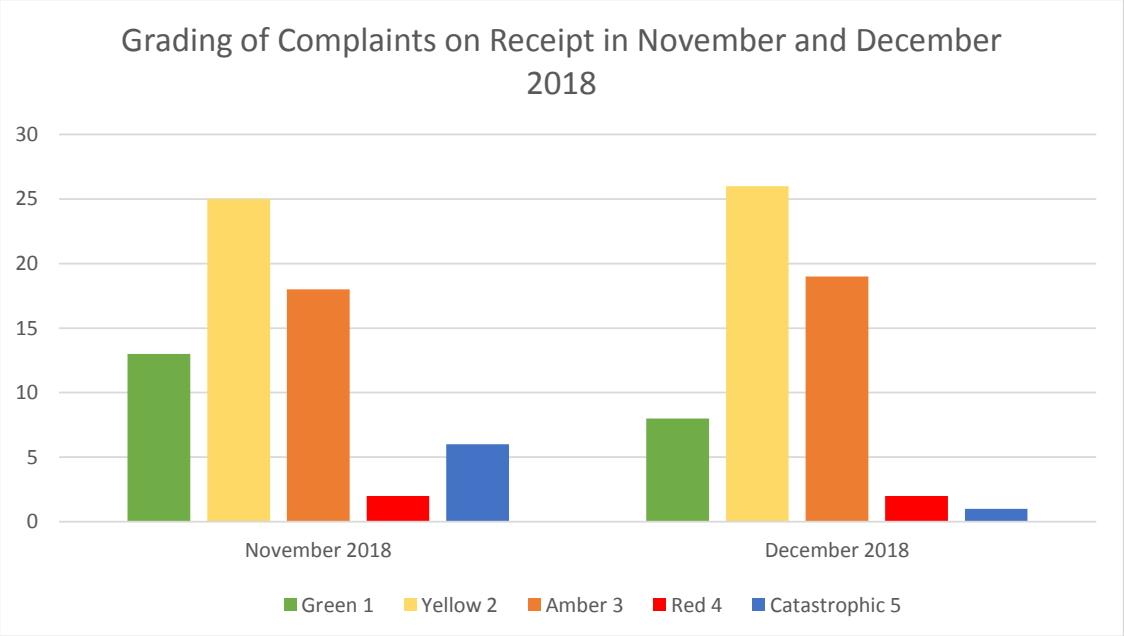
2.6. Primary Subjects of Formal Complaints



2.7. Primary Subjects of Informal Complaints



2.8. Grading of Complaints on receipt



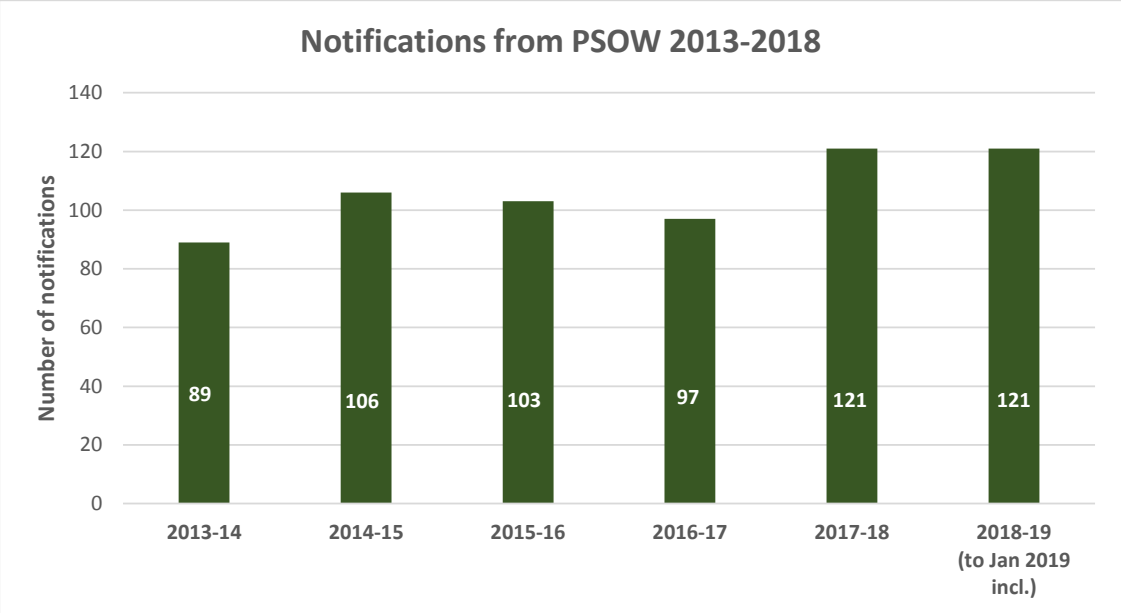
2.9. Serious complaints closed in November and December 2018

Of the 122 formal complaints which received a response in November and December 2018, 8 had been graded 4/5 on receipt (i.e. serious complaints). The investigation into 6 of these concerns found no breach of duty of care. One investigation is ongoing and one has been withdrawn.

3. Public Services Ombudsman for Wales (PSOW)

The number of concerns notified to PSOW increased significantly in 2017-18 as illustrated in the chart below. The number of concerns notified in 2018-19 to the end of January 2019 is 121, the same number as for the whole year in 2017-18. The number of concerns investigated by the Ombudsman at the end of January 2019 is 49.

The Health Board has taken action both to improve the working relationship with the Ombudsman and to improve the timeliness and quality of responses to PSOW. This is included within the service improvement programme.



During November and December 2018, the Health Board received 24 notifications from the Ombudsman, 9 of which were for new investigations. The remaining 15 were queries and notifications of Ombudsman interest.

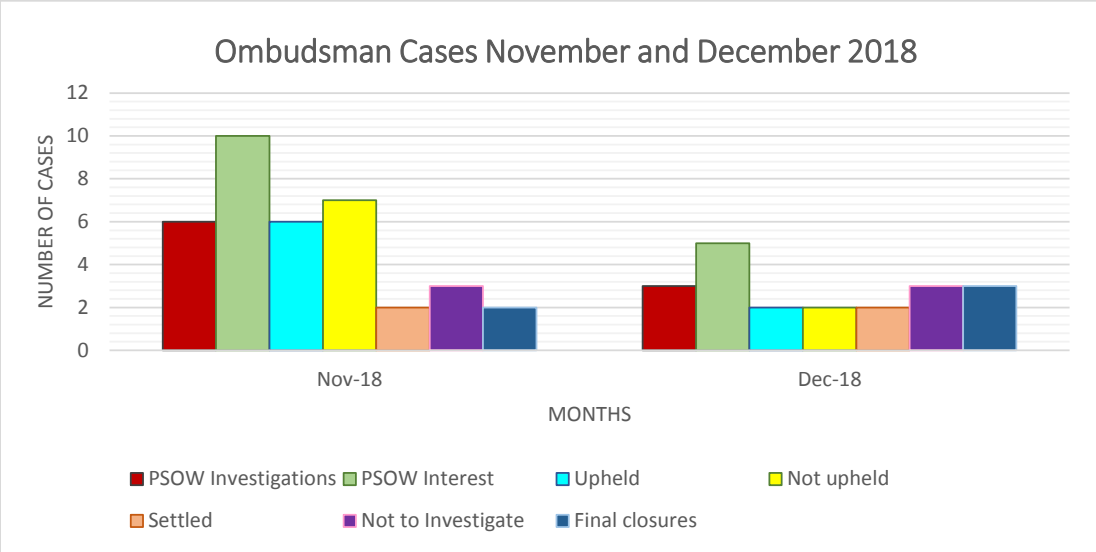
With regard to the cases already with the Ombudsman, the Health Board were notified that 9 cases investigated were not upheld. There were a further 6 cases that the Ombudsman decided not to investigate, based on the information provided by the Health Board.

The Health Board received 8 Final Upheld reports, 7 of which were determined as Section 21 Reports and one a Public Section 16 Report. A summary of the report is included at **Appendix 1**.

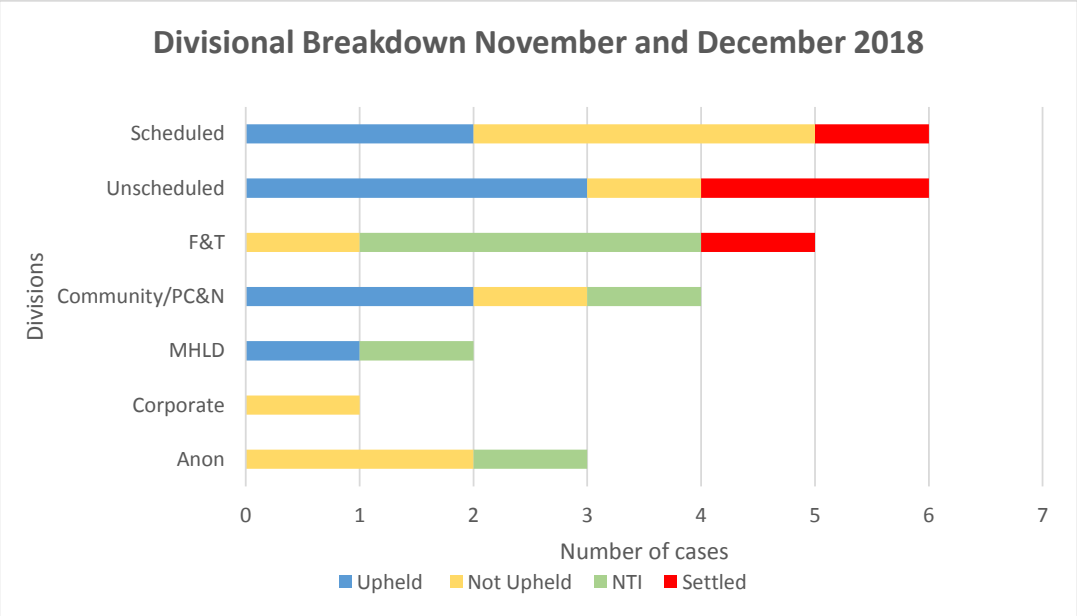
During this period, 4 cases were settled, meaning that the Health Board was able to agree to the Ombudsman's settlement proposal, mitigating the need to carry out a full formal investigation.

A total of 20 cases were closed by the Ombudsman including the 9 cases that were not upheld, the 6 where the Ombudsman had decided not to investigate, and 5 final closures (where evidence had been received of the Health Board's compliance with their recommendations).

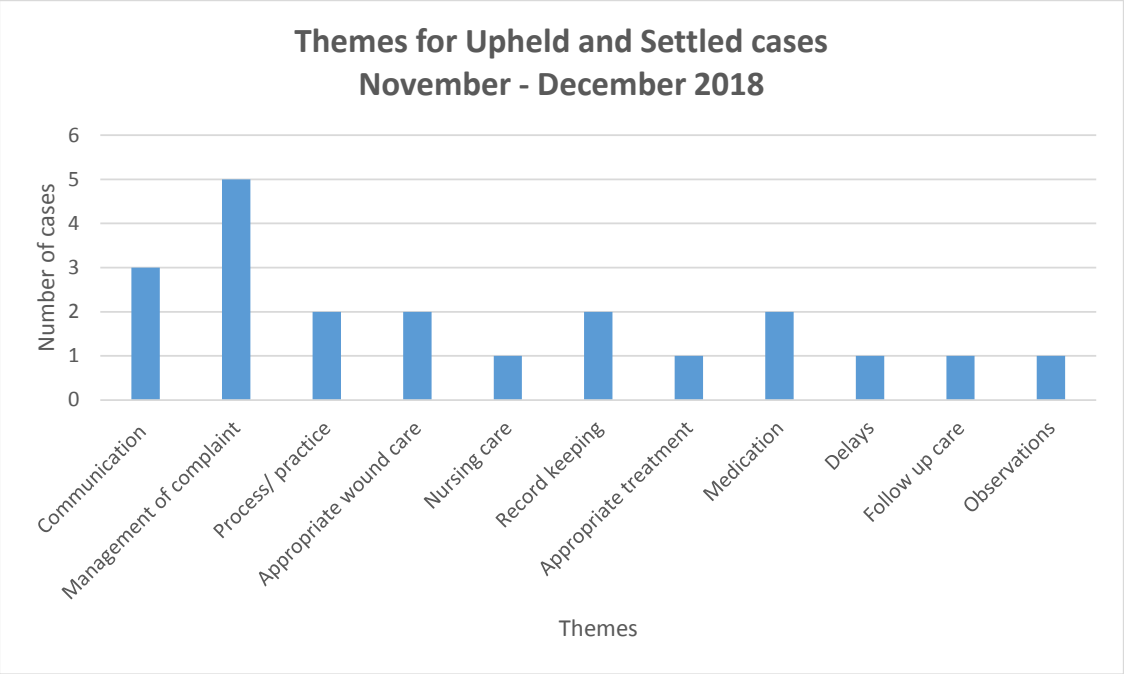
The chart below provides an overview of Ombudsman activity during November and December 2018.



The chart below provides a breakdown by division of Upheld, Not Upheld, Not to Investigate (NTI) and Settled cases over the 2 month period.

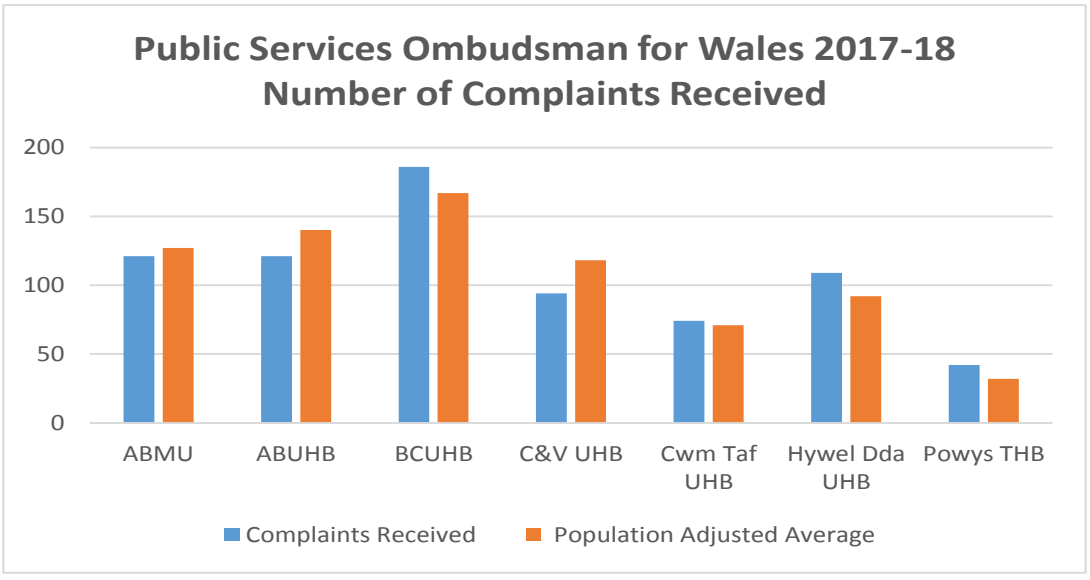


A review of upheld and settled cases in November and December identified that management of the complaint is the main reason why a case is upheld. This is followed closely by communication.

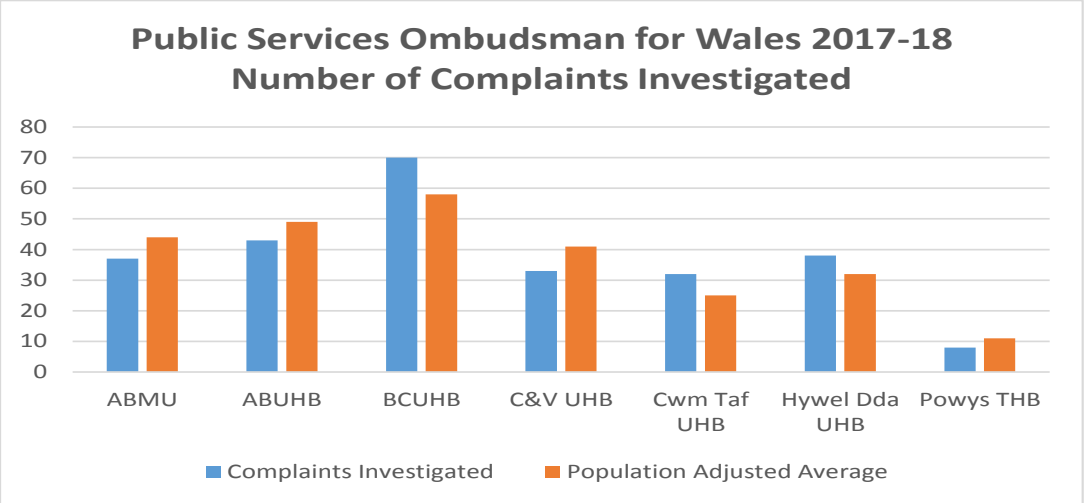


An area of concern for the Health Board has been the increased number of complaints received by the Public Services Ombudsman for Wales (PSOW). The Annual Letter from PSOW **(Appendix 2**) received in October highlighted an 11% increase in the number of complaints against all Health Boards referred to the Ombudsman from across Wales and a variance in performance in complaints handling despite a 2% reduction in the total number of complaints to the Ombudsman.

PSOW received 121 complaints concerning ABUHB in 2017-18, which is below the Welsh average (adjusted for population), but represents a 34% increase from the previous year. The graph below shows complaints received in comparison with other Welsh Health Boards.

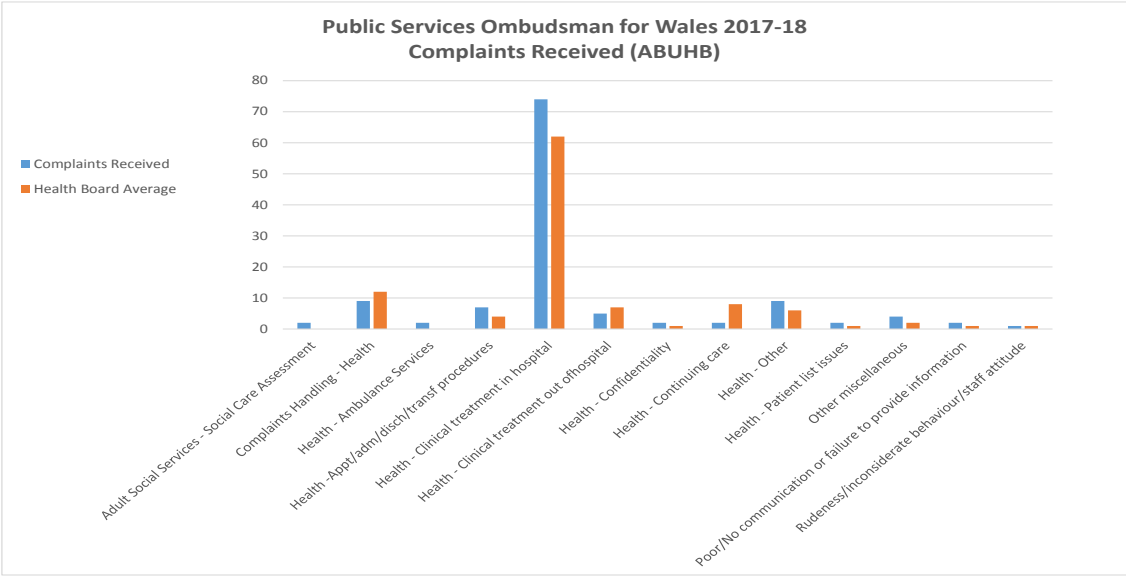


A significantly higher number of complaints (42) were investigated by PSOW in 2017-18 although this continues to be below the population adjusted average, compared with 26 in 2016-17 it is a 38% increase.

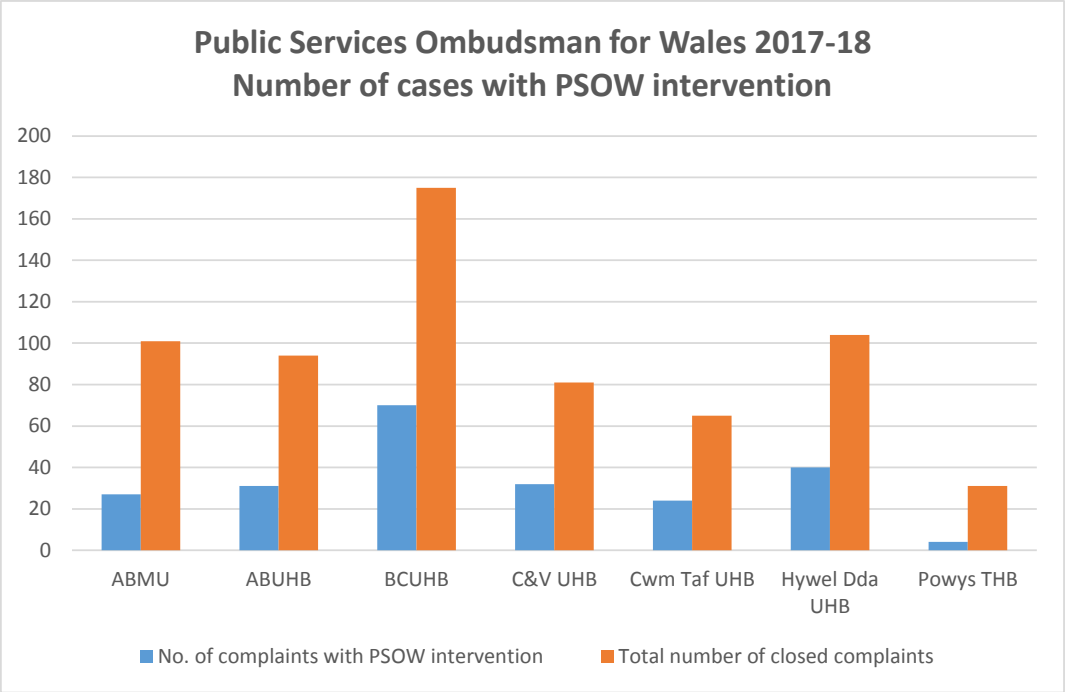


The services which received the highest number of complaints in 2017-18 were Trauma and Orthopaedics (16) and Accident and Emergency (10).

Complaints were generally about confidentiality; waiting list issues; poor or no communication; and failure to provide information; rudeness; inconsiderate behaviour; and staff attitude, but the number of complaints received about clinical treatment increased substantially by 37% from 54 in 2016-17 to 74 in 2017-18. The graph below shows the number of complaints investigated compared with Welsh Health Boards. The overwhelming majority of complaints to the Ombudsman related to clinical treatment in hospital as shown below.



33% of the 94 complaints closed by the Ombudsman in 2017-18 prompted an intervention which included upheld complaints, early resolutions, and voluntary settlements. 15% of cases with the Health Board were settled either via early resolution or voluntary settlement. There were no public interest reports published. However, 18% of cases were upheld in whole or in part, with only 6% of cases not upheld following an investigation.



3.1. Areas for Action from the Ombudsman's Annual Letter

The Ombudsman identified a number of areas for action and opportunities to improve both the relationship with the PSOW and performance in complaint handling:

- Present the Ombudsman's annual letter to the Board to assist Board Members in their scrutiny of the Board's performance
- Consider whether there are any learning points from the rise in the complaints against the Health Board
- Consider whether there any learning points from the systemic failures identified in the public interest reports (in respect of other health boards) issued during 2017/18
- Continue to work with the Improvement Officer to improve complaint handling, particularly in the parts of the Health Board that generate most complaints about complaint handling

- Improve performance when complying with any recommendations made to improve the Board's service delivery

3.2. Thematic Review

A thematic review of Ombudsman cases over the last 2 years was recently undertaken to inform the service improvement work required. The review identified initial complaint themes and complaint handling themes.

Initial Complaint Themes	
Theme	Number of Cases
Poor communication	10 medical 2 nursing
Care pathway failure	5 medical 1 podiatry
NEWS/Deteriorating patient	5 medical & nursing
Fundamentals of care	6 nursing
Record keeping	4 nursing 1 medical
Failure to refer for other expertise	2 medical 1 nursing
Discharge processes	2
Consent process	2 medical
Delay in diagnosis	2 medical
Patient Flow	1
Confidentiality	1
Delay in artificial feeding	1
Incorrect diagnosis	1
Non response to a referral	1 Speech and Language Therapy
Unnecessary invasive examination	1 midwife

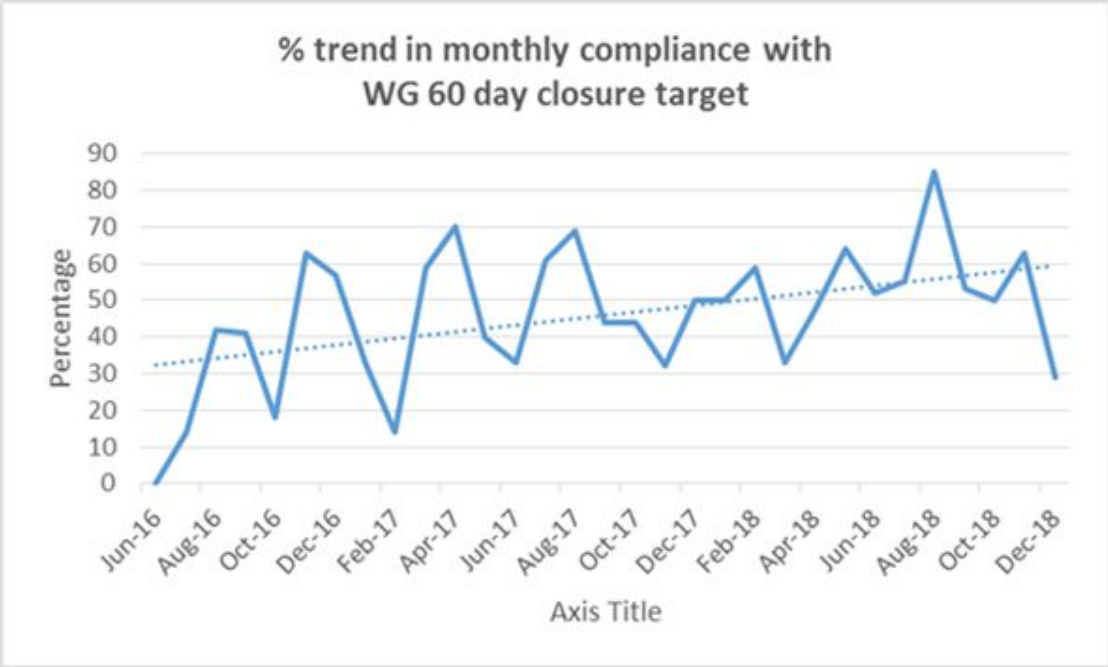
Complaint Handling Themes	
Theme	Number of Cases
Failure to respond to 30 day deadline	10
Failure to address concerns in the complaint/quality of the investigation	5
Failure to provide holding letters or updates	3
Failure to address ongoing concerns	3
Lost records	2

Areas for consideration in responding to address these issues are specified in the report of the thematic review and will be included in the PTR Service Improvement Programme plan.

4. Serious Incidents

Seven new Serious Incidents (SI) were notified during the reporting period under investigation.

4.1. Serious Incidents Performance



Total compliance with 60 day closure for Serious Incidents (SIs) was 63% in November 2018 and 29% in December 2018. Compliance for January 2019 is also 29%. A divisional breakdown of the December performance for SI is included at **Appendix 3**. Current poor compliance is related to a combination of an increase in the numbers of serious incidents reported; capacity and sickness within the PTR team; and a number of changes of senior personnel. Winter pressures have resulted alternate priorities and meetings not being held due to these priorities competing.

Action has been taken to refocus senior leadership in the team to enable the Interim Assistant Director Organisational Learning to focus on concerns/Ombudsman and the Interim Assistant Director PTR to focus on SIs and WG closures.

The PTR team are to hold weekly meetings to go through all closures to highlighting potential delays and escalation to divisions and an SI workshop will be held to review current processes, roles and responsibilities and foster ownership within the Divisions.

Senior leads will be identified within each division to take responsibility for WG closures and a system to prompt divisions when closures are due. In agreement with Welsh Government a revised and streamlined process for pressure ulcer reporting was introduced in January 2019 to assist in timely closure.

The SI policy is to be updated, ratified and circulated to all Divisions and a lead contact from the PTR team identified for each of the divisions to feedback performance. A renewed focus on Corporate-led serious incidents and monthly monitoring of the SI tracker and escalation of any issues will drive increased compliance.

5. PTR Service Improvement Programme

Working in collaboration with the Health Board divisions, the Assistant Director of Organisational Learning/PTR is leading on the development and implementation of a systematic Service Improvement Programme for PTR. The programme encompasses all areas of the PTR process including concerns, serious incidents and Ombudsman cases with a vision for high-quality management of all elements of the process and improved PTR service that ensures thorough, timely and sensitive engagement and resolution for patients, families and those who have found it necessary to raise a concern about the services provided by Aneurin Bevan University Health Board (ABUHB).

5.1. Service Improvement Group and Programme Plan

A Service Improvement Group is being established to oversee this programme of work. This will include senior members of the PTR Team and Divisions with the authority to make decisions on behalf of their department or service. The programme will be delivered through a service improvement plan. The plan will describe the future state for the PTR service and how this will be achieved together with a schedule of actions; risks; issues and resources required for delivery of the plan.

Several key actions have already been implemented to improve Quality and Performance in the PTR service. These have included:

- Strengthening of leadership in the PTR team, recruitment into vacant posts and temporary staffing.
- Review of PTR structure.
- Quality control process for complaint responses introduced.
- Work has progressed to more clearly define formal and informal complaints.
- PTR team members are working more closely with complaints co-ordinators.
- A complaints tracker has been developed to log and track all complaints. This is monitored by the PTR Team and is soon to be rolled out to the divisional co-ordinators through a shared IT solution which will enable ‘live’ updating and potential workflow

solutions as well as templating and joint authoring of complaints letters, the absence of which are currently a barrier to adoption of the Datix 'Web' platform. The system will also enable reduction of the risk of complaint sensitive information being sent to the wrong recipient.

- A thematic review of Ombudsman cases
- A programme of training dates for investigating officers (IO's) is being progressed.
- PTR workshop with divisional QPS leads and complaints coordinators held on 9th January 2019. A representative from PSOW supported collaboration and coordination in the development of the Service Improvement Plan.

6. Conclusion

Significant work is underway to improve performance and quality in the handling of concerns/complaints and cases referred to the office of the Public Services Ombudsman. Further focussed work is needed to support and enhance the timeliness and effectiveness of investigations into Serious Incidents

The Quality and Patient Safety Committee is asked consider this report and note that the PTR/Organisational Learning Service Improvement Group will be established in February 2019. The action plan **(Appendix 4)** will be monitored by this group with regular reporting to the Executive Team and Quality and Patient Safety Committee.

Appendix Summary of PSOW Section 16 Public Upheld Case November 2018

Ref	Summary of Upheld Cases	Division, Areas & Actions taken to meet Recommendations
November 2018 **PSOW ref 201707515** **HEALTH BOARD ref SH/OMB/ 2018002**	**Summary** Mr W complained that the Health Board failed to provide appropriate wound care to his father, Mr R, during his admission to a Community Hospital. Mr R had undergone a total hip replacement following a fall at home and was subsequently discharged to the Community Hospital for rehabilitation. Mr W said that staff at the Community Hospital failed to identify, manage and treat his father's post-operative infection, or arrange for his transfer back to the District General Hospital, for treatment, appropriately. He said that, as a result of the failings in care, Mr R succumbed to further post-operative complications, developed hospital-acquired pneumonia, and sadly passed away. The Ombudsman found that appropriate dressings were not used at any time throughout Mr R's care and his wound clips remained in situ throughout his admission, which was likely to have exacerbated his infection. In addition, there was no comprehensive review of Mr R or his wound by a doctor after the initial admission assessment, despite clear evidence that infection was present. Senior medical advice should have been sought promptly from the District General Hospital and the failure to do so delayed appropriate treatment for Mr R by	**Community, CotE,** **Phoenix Ward, County Hospital** **The actions taken to meet the recommendations:-** The Health Board apologised, in writing, to Mr W for the failings identified in this report and made a payment of £2000 in recognition of the service failures identified. The Health Board will share the outcomes of this investigation with relevant staff in both the Community Hospital and the District General Hospital, highlighting the important learning points including early recognition of signs in the deteriorating patient, comprehensive record-keeping and the sharing of appropriately detailed hand-over information. The Health Board will ensure all relevant staff are reintroduced to the current Wound Management Guidelines and reminded of the properties and appropriate uses of the listed dressings. The Health Board will undertake an audit to determine that all staff training on the Principles of Wound Management and the use of Aseptic Non-Touch Technique ("ANTT") for all wound dressing changes is up to date. Where training is not up to date, those staff members should be given training as soon as possible.

Appendix Summary of PSOW Section 16 Public Upheld Case November 2018

Ref	Summary of Upheld Cases	Division, Areas & Actions taken to meet Recommendations
	at least a week, which made it more difficult to treat the infection, and for Mr R to fight it. The Ombudsman also found that the HEALTH BOARD failed to ensure that it had fully informed the Welsh Ambulance Services Trust of Mr R's condition, or that appropriate transport was arranged to transfer him back to the District General Hospital.	The Health Board will ensure that it has robust handover systems in place at both the District General Hospital and the Community Hospital for arranging patient transfers, to ensure that WAST is fully informed of the patient's condition when they are moved between settings. The Health Board will provide evidence to the Ombudsman that the Health Board has adequate arrangements in place for senior medical review at the Community Hospital. The Community Directorate has agreed to undertake an audit and an action plan by 1st February 2019.

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Our Ref: NB/CW/MA

Catrin.wallace@ombudsman-wales.org.uk
Matthew.aplin@ombudsman-wales.org.uk

15 October 2018

Ms Ann Lloyd,

Chair of the Board

Sent by email: Sue.Squire@wales.nhs.uk

Dear Ms Lloyd,

Annual Letter 2017/18

Following the recent publication of my Annual Report I am providing you with the Annual Letter (2017/18) for **Aneurin Bevan University Health Board.**

The number of health complaints coming to my office and the variance in health board performance in complaint handling continues to be a concern. Whilst we saw a welcome 2% reduction in the total number of complaints, those against health boards increased by 11% from 676 in 2016/17 to 747 in 2017/18. As a result, my office organised two special seminars; one for health bodies in jurisdiction on health complaints and best practice in June 2017; and another on complaint handling culture for all public services in February 2018. At the latter event, I was very pleased to see further progress on Out of Hours services with the Rapid Response for Acute Illness Learning Set (RRAILS) project improving out of hours services in health boards across Wales, partly in response to my office's thematic report, "Out of Hours: Time to Care", on the subject.

Four public interest reports have been published in the past year. All were health-related. Whilst none of the reports were issued against your Health Board the cases raised issues which provide learning points for all health boards in Wales. I therefore urge the Board to consider whether any of the systemic failures identified in those cases provide opportunities for the Board to review and improve its service provision.

As you will be aware, a new Public Services Ombudsman Bill has been introduced by the National Assembly and is currently at the second stage in the legislative process. This means that Members have agreed the general principles of the Bill and a Financial Resolution was agreed on 17 July 2018. It is important that Wales continues to adopt best practice in complaints handling and public service improvement, and this new legislation would help drive up public service standards. If the Bill progresses I will be engaging with public bodies in Wales in preparation for the introduction of the new powers within the Bill.

Complaints Received – Aneurin Bevan University Health Board

The number of complaints PSOW has received in the year 2017/18 about Aneurin Bevan University Health Board was 121. While this figure remains below the Welsh average (adjusted for the Health Board's population), this does represent an increase of 34% from the previous year (2016/17).

The number of complaints investigated by PSOW in the past year is 42, significantly higher than the 26 in 2016/17, but continuing to be below the population-adjusted average of 49.

The **subjects** of complaints about the Health Board broadly reflect the Welsh average, with complaints generally being about confidentiality, patient list issues, poor/no communication or failure to provide information, and rudeness/inconsiderate behaviour/staff attitude.

The number of complaints received regarding clinical treatment in hospital has increased substantially by 37% from 54 complaints in 2016/17 to 74 over the past year.

We identify that the **services** which receive the highest number of complaints are Trauma and Orthopaedics (16) and A&E (10).

Complaints Closed – Aneurin Bevan University Health Board

The total number of complaints closed between April 2017 and March 2018 for Aneurin Bevan University Health Board was 94. 33% of these prompted an intervention by PSOW. These include upheld complaints, early resolutions and voluntary settlements.

15% of cases with the Health Board were settled either via early resolution or voluntary settlement. No public interest reports were published regarding the Health Board. However, 18% of cases were upheld in whole or in part, with only 6% of cases not upheld following an investigation.

Of the upheld cases, 10 were upheld against Royal Gwent Hospital and 4 were upheld against Nevill Hall Hospital.

For all Health Boards, agreed timescales for providing my office with evidence that agreed recommendations have been implemented were not met in 36% of cases in 2017/18. For Aneurin Bevan University Health Board, this occurred in 46% of cases. This is therefore an area in which I consider your Health Board should improve. As I share draft recommendations with public bodies for comment before they are finalised I expect any concerns about them to be raised with my office at an early stage, before a report on an investigation is finalised. Once I have issued my final report and bodies have formally agreed them I expect public bodies to implement them in full and in a timely way.

When I met with you and your Chief Executive on 30th August we agreed that officers from both our organisations would explore a pilot project to reduce the pockets of complaints about complaint handling which exist in your Health Board – for example 28% of complaints at the Royal Gwent this year were about this. I am pleased that your staff have recently met with my Improvement Officer to take this forward.

Action for the Health Board to take:

- Present my annual letter to the Board to assist Board Members in their scrutiny of the Board's performance;

- Consider whether there are any learning points from the rise in the complaints against your Health Board;
- Consider whether there any learning points from the systemic failures identified in the public interest reports (in respect of other health boards) I issued during 2017/18;
- Continue to work with my Improvement Officer to improve complaint handling, particularly in the parts of your Health Board that generate most complaints **about complaint handling**;
- Improve your performance when complying with any recommendations I have made to improve the Board's service delivery.

This correspondence is copied to the Chief Executive of your Health Board. I will also be sending a copy to your Contact Officer within your organisation. Finally, a copy of all annual letters will be published on my website.

Yours sincerely,

Nick Bennett

Public Services Ombudsman for Wales

CC: Judith Paget, Chief Executive

Martine Price, Assistant Director of Nursing

Anita Davies, Contact Officer

Factsheet

A. Complaints Received and Investigated with Health Board average adjusted for population

Health Board	Complaints Received	Average	Complaints Investigated	Average
Abertawe Bro Morgannwg University Health Board	121	127	37	44
Aneurin Bevan University Health Board	121	140	43	49
Betsi Cadwaladr University Health Board	186	167	70	58
Cardiff and Vale University Health Board	94	118	33	41
Cwm Taf University Health Board	74	71	32	25
Hywel Dda University Health Board	109	92	38	32
Powys Teaching Health Board	42	32	8	11

B. Complaints Received by Subject with Health Board average

Aneurin Bevan University Health Board	Complaints Received	Health Board Average
Adult Social Services - Social Care Assessment	2	0
Complaints Handling - Health	9	12
Health - Ambulance Services	2	0
Health - Appointments/admissions/discharge and transfer procedures	7	4
Health - Clinical treatment in hospital	74	62
Health - Clinical treatment outside hospital	5	7
Health - Confidentiality	2	1
Health - Continuing care	2	8
Health - Other	9	6
Health - Patient list issues	2	1
Various Other - Other miscellaneous	4	2
Various Other - Poor/No communication or failure to provide information	2	1
Various Other - Rudeness/inconsiderate behaviour/staff attitude	1	1

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/voluntary settlement	Discontinued	Other Reports- Not Upheld	Other Reports Upheld - in whole or in part	Public Interest Report	Grand Total
Aneurin Bevan University Health Board	19	10	26	14	2	6	17		94
Health Board average (adjusted)	22	14	33	22	1	10	20	1	122

D. Number of cases with PSOW intervention

Health Board	No. of complaints with PSOW intervention	Total number of closed complaints	% interventions
Abertawe Bro Morgannwg University Health Board	27	101	27
Aneurin Bevan University Health Board	31	94	33
Betsi Cadwaladr University Health Board	70	175	40
Cardiff and Vale University Health Board	32	81	40
Cwm Taf University Health Board	24	65	37
Hywel Dda University Health Board	40	104	38
Powys Teaching Health Board	4	31	13

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2017/18, with the Health Board average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2017/18 with the Health Board average for the same period. The figures are broken down into subject categories.

Section C compares the complaint outcomes for the Health Board during 2017/18, with the average outcome (adjusted for population distribution) during the same period.

Section D provides the numbers and percentages of cases received by the PSOW in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent to catrin.wallace@ombudsman-wales.org.uk or matthew.aplin@ombudsman-wales.org.uk

Open SIs – December 2018

Appendix 3

Division	Reported to WG in month	Total open SI's	Target for investigation 60 working days					Total compliance with 60 day closure
			In date	overdue 0-3 mths	overdue >3 mths	overdue >6 mths	overdue >12 mths	
Scheduled	1	19	9	5	2	1	2	25% (1/4)
Unscheduled	10	31	19	6	2	4	0	33% (2/6)
F&T	3	18 not including 14 PRUDiCs *	9	6	2	1	0	0% (0/1)
Community	2	12	4	1	1	6	0	100% (1/1)
Mental health	3	50	13	4	4	19	10	33% (1/3)
Primary Care	0	7	3	3	0	0	1**	0% (0/1)
Facilities	0							n/a
CHC	2	8	8	0	0	0	0	None due
Corporate	0							n/a
Total	**21**	**148**	**65**	**25**	**11**	**31**	**13**	**29% (5/17)**

*PRUDiCs are not calculated in closure performance as they have a separate process which ABUHB is unable to influence.

**WG will not close – awaiting GMC findings.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

DRAFT PTR Service Improvement Action Plan

Aim	Actions	Lead	Timeframe
Management of Concerns			
To support and enhance the performance within PTR and ensure clear lines of responsibility, leadership and appropriate resource.	Review the PTR Team structure/roles and responsibilities and assessment of any resource implications. Implement the structure	Martine Price/Alison Lewis Lin Slater/Martin Lane	Complete April 2019
	Provide interim senior leadership to the team until post of Assistant Director of Organisational Learning goes to advert full time.	Martine Price	Complete
	Increase capacity within the PTR Team with a Band 6 Concerns Officer.	Alison Lewis	Complete
	Replace Band 3 Concerns Administrator.	Alison Lewis	Complete
To streamline the current complaints pathway to improve performance against targets and quality of response.	Review operational management of the ABB Complaints inbox.	Martin Lane	Complete
	To have clear definitions and categorisation of formal/informal complaints to ensure concerns are responded to in an appropriate manner as per PTR All Wales Guidance.	Martin Lane	March 2019
	Process map a sample of complaints across the organisation to identify delays in pathway.	Martin Lane	March 2019

Aim	Actions	Lead	Timeframe
	Following the process mapping develop a flow chart with identified timescales available for all to use to ensure consistent approach and accountability and responsibility at each stage.	Martin Lane	March 2019
	The PTR team will take responsibility for logging, obtaining consent and sending out the initial acknowledgement letter for all concerns received via headquarters.	Martin Lane	Complete
	PTR will develop the use of a complaints tracker that will be updated weekly in partnership with the divisions and monitored via a traffic light system and highlight any delays to the complaints co-ordinators.	Martin Lane	March 2019
	Template letters will be reviewed through the Safety and Learning Networks to identify a consistent approach and best practice.	Martin Lane	March 2019
To develop a consistent approach across Divisions to share good practice and improve quality and timeliness of responses	Establish a workstream to clarify key roles and responsibilities.	Martin Lane	March 2019
	Establish Service Improvement Group, with senior divisional representation and support from Director of Operations. GMs to nominate representative. Director Operations to nominate representative	Martin Lane GMs Claire Birchall	February 2019
	Review and update the Concerns Policy.	Martin Lane	March 2019

Aim	Actions	Lead	Timeframe
Improve data quality in complaints handling	Establish data quality workstream to determine and implement actions to improve data quality.	Martin Lane	March 2019
To improve relationships with the Ombudsman and current processes	Undertake a thematic review of Ombudsman Findings over the last 2 years.	Liz Waters	Complete
	Share findings with divisions/PTR to Inform improvement work and learning at January Workshop.	Liz Waters	Complete
	Re-establish relationship and way of working with Ombudsman.	Lin Slater	Complete
	Develop Performance metrics and more robust monitoring processes.	Martin Lane	March 2019
Organisational Learning			
To have a training, coaching and mentoring programme that provide staff with the skills to carry out investigations.	Undertake training needs analysis to identify numbers of IO's per Division against number of complaints and serious incidents.	Martin Lane/Alison Lewis	June 2019
	Review training materials against needs.	Martin Lane/Alison Lewis	June 2019
	Agree programme of training dates and prioritise individuals for training.	Martin Lane/Alison Lewis	June 2019
Establish forums for sharing good practice and implementing Organisational Learning	Re-establish the Learning Committee.	Martin Lane/Alison Lewis	March 2019
	Develop forums for shared learning.	Martin Lane/Alison Lewis	March 2019
	Establish a register and learning log.	Martin Lane/Alison Lewis	March 2019

Aim	Actions	Lead	Timeframe
	Re-establish Organisational Learning bulletins.	Martin Lane/Alison Lewis	March 2019
Management of Serious Incidents			
Improve process around management of Serious Incidents and compliance with WG closures	Hold an ABUHB SI workshop to develop closer working relationships with divisions to improve compliance with WG closures.	Alison Lewis	March 2019
	Update the SI policy to clearly articulate closure process and identify roles and responsibilities of PTR Team and introduce an audit process.	Alison Lewis	March 2019
	Develop criteria for identifying what constitutes a serious incident and subsequent management.	Alison Lewis	March 2019
Performance			
Improve compliance with performance measures for concerns and serious incidents	Develop Key Performance Indicators for the PTR process for concerns, Sis and Ombudsman. Ensure monthly timely reporting of data to inform performance. Develop monthly and quarterly reporting framework	Martin Lane/Alison Lewis Martin Lane Martin Lane	March 2019
	Each division to identify trajectories for improvement in compliance with concerns and serious incidents Enhance link with Performance review meetings	GMs/Divisional Directors Nick Wood/ Claire Birchall	March 2019 February 2019